



**ACTION MEMORANDUM FOR THE USAID/RWANDA MISSION DIRECTOR**

**FROM:**

Claudia Cantell, PDO



**SUBJECT:**

Rwanda Integrated Maternal Child Health and Family Planning

**DATE:**

August 20, 1992

**Action Requested:** Your approval is required to authorize the Rwanda Integrated Maternal Child Health and Family Planning Project. An obligation of \$6 million is planned for FY 1992.

**Discussion:** The Rwanda Integrated Maternal Child Health and Family Planning Project (RIM) is a six-year, \$13.15 million project whose goal is to improve the reproductive health of Rwandan women and men in the project areas. The project purpose is to increase the capacity of the Ministry of Health to provide comprehensive reproductive health care including family planning and the treatment, prevention and control of sexually transmitted diseases (STDs).

The project consists of two mutually supportive Objectives as follows:

- The improvement and adoption of comprehensive reproductive health services (CRHS). CRHS includes pre and post-natal care, delivery care, family planning and STD diagnosis, treatment and prevention.
- The improvement of regional and health center level management. Management is used here in its broadest sense to mean all support activities related to delivering care. This includes financial management and accounting, human resource management, short-term and long-term planning, supervision, training, logistics support and information systems. Many of the interventions used to achieve the previous Objective will be implemented through mechanisms established under this Objective.

**Financial summary:**

The total cost of this six-year project is estimated at \$17.982 million. This estimate is based on a USAID contribution of \$13.15 and a GOR in-kind contribution of \$4.832 million as summarized below:

	A.I.D.	G.O.R.	Total
Technical Assistance	6,328		6,328
Training	1,398		1,398
Personnel		4,452	4,452
Commodities	1,333		1,333
Other Costs	3,446	380	3,826
Evaluations and Audits	645		445
<b>Total</b>	<b>13,150</b>	<b>4,832</b>	<b>17,982</b>

**Socio-Economic, Technical and Environmental Description:**

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 and benefits related to reduced mortality, morbidity and lowered birth rates are expected to give a 300 percent return on recurrent costs by the end of the project; and, (6) the financial plans developed for the project are adequate to ensure proper implementation to meet the requirements of the FAA Section 611 (a).

**Implementation Plan:**

**A. The Conditions Precedents (CP) established for the project are:**

1. Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- (a) A statement of the names of the persons holding or acting in the office of the Grantee specified in Section 8.2. and of any additional representatives, together with a specimen signature of each person specified in such statement;
- (b) A document acceptable to A.I.D. that designates by name the full-time individual at the Ministry of Health who will fill the following position:

MOH Project Manager - to serve as counterpart to the institutional contractor Chief of Party, allocating 50 percent of his/her time to RIM activities; and,

2. Prior to the first disbursement under the STD prevention and control component of the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D. a document acceptable to A.I.D. that designates by name the full-time individual at the Ministry of Health who will fill the following position:

STD Prevention and Control Expert - to fill the long-vacant position at PNLIS and to act as GOR specialist and point person on all RIM Project interventions in STDs.

**B. The Special Covenants established for the project are:**

1. Project Evaluation. 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. Prohibition of Support of Abortion Related Activities and Involuntary Sterilization. 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 or involuntary sterilization as a method of family planning;
- (b) motivation or coercion of any person to undergo abortion or involuntary sterilization;
- (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning; or
- (d) active promotion of abortion or involuntary sterilization as a method of family planning.

### 3. Additional Covenants

- (a) The Grantee covenants to facilitate the autonomy and self-financing of the regional health care network by taking, inter alia, the following actions:
  - (i) permit any resources that are generated at the regional level and its periphery to remain at that level;
  - (ii) permit cost recovery schemes to progressively achieve a self-financing component;
  - (iii) permit a variety of schemes, to be tested through operations research, which involve traditional birth attendants, abakangurambaga and other auxiliary health care professionals.
- (b) The Grantee covenants to convene a RIM workshop bi-annually which will bring together all Health Region Directors, ONAPO delegates, USAID, long-term technical assistance and interested donors, in order to disseminate information and review progress and problems.
- (c) The Grantee covenants to make available suitable candidates for Project-financed training for the public sector. This will be accomplished by developing an annual training plan, in collaboration with USAID, MINIPLAN and the institutional contractor.
- (d) The Grantee covenants to recruit and assign, in a timely manner, all GOR personnel (in addition to those specified in Sections 4.1.1.(b) and 4.1.2) necessary to implement the Project. The Grantee further covenants to assure that these positions remain filled for the life of the project and that should a position become vacant it will be filled in a timely manner.

GOR Project personnel should be of sufficiently high stature in the MOH organization to facilitate project implementation in order to achieve Project goals and objectives.

Specifically, the Grantee covenants to assign people to the following positions as soon as possible after the signing of the Agreement:

- (i) MOH Project Coordinator: Training. To serve as counterpart to the institutional contract training staff, and to allocate 50 percent of his/her time to RIM activities; and
  - (ii) MOH Project Coordinator: IEC. To serve as counterpart to the institutional contract IEC staff, and to allocate 50 percent of his/her time to RIM activities.
- (e) The Grantee covenants to nominate women, as well as men, in selecting candidates for participant training and in recruitment for positions under the Project.
  - (f) The Grantee covenants to assure that appropriate stocks of routine medical and office supplies are maintained in the regions where the RIM Project is being implemented.
  - (g) The Grantee covenants to assume, at the end of the Project, all recurring costs related to maintaining the equipment furnished under the Grant as well as maintaining the supply of expendable property necessary to ensure the continuation of successful new systems and procedures developed during the Grant period.

**Other:**

**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. Procurement of goods and services of other than Rwandan or U.S. origin must be specifically approved in writing by USAID/Kigali.

**Responsible Officer:** The Officer in USAID/Rwanda responsible for the project is William Martin, the Health and Population Officer. The responsible officer in AID/W is Barbara Howard, AFR/EA.

**Project Review:** The Project Review Committee reviewed the project paper and recommended approval on July 15, 1992. The Executive Committee recommended approval on August 20, 1992

**Notification to Congress:** RIM was included in the FY 1992 Congressional Presentation as three year project with a \$6,000,000 funding level. A revised Congressional Notification was submitted on June 12, 1992 indicating a change to a six-year project and a \$13,150,000 funding level. The CN cleared on July 14, 1992 (STATE 234399).

**Human Rights:** There are no outstanding human rights issues with respect to the U.S. bilateral assistance program to Rwanda.

**Recommendation:** That you sign below and the attached Project Authorization and thereby approve the life-of-project funding of \$13.15 million grant funds for the Rwanda Integrated Maternal Child Health and Family Planning Project.

APPROVED Gary Nelson  
Gary A. Nelson  
USAID Director

DISAPPROVED \_\_\_\_\_

DATE 8/21/92

**Attachments:**

- (1) Project Authorization
- (2) Project Paper

**Clearances:**

A/CONT:HHunter	<u>DFT</u>	Date	<u>7/06/92</u>
PRM:LDouris	<u>DFT</u>	Date	<u>7/17/92</u>
HPO:WMartin	<u>DFT</u>	Date	<u>7/06/92</u>
EXO:YKainth	<u>DFT</u>	Date	<u>7/06/92</u>
RLA:AVance	<u>DFT</u>	Date	<u>7/11/92</u>



## PROJECT AUTHORIZATION

Name of Country: Rwanda  
Name of Project: Rwanda Integrated Maternal Child Health and Family Planning  
Number of Project: 696-0134

1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Rwanda Integrated Maternal Child Health and Family Planning Project for Rwanda ("the Cooperating Country") involving planned obligations of not to exceed Thirteen Million, One Hundred and Fifty Thousand United States Dollars (\$13,150,000) in grant funds over a six-year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is six years from the date of initial obligation.

2. The goal of the Project is to improve reproductive health of Rwandan women and men in the project area of four regions.

3. The Project will support the implementation of integrated, comprehensive reproductive health services (CRHS) and the strengthening of management and supervision systems at both the regional and the central level. The Project will provide long and short-term technical assistance, long and short-term training, vehicles and commodities, and local cost support.

4. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. Regulations and Delegations of Authority, is subject to the following essential terms, covenants, and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

### 5. Source and Origin of Commodities, Nationality of Services

Except as A.I.D. may otherwise agree in writing, disbursements will be used to:

(a) finance the costs of goods and services required for the project having, with respect to goods, their source and origin, and with respect to suppliers of services, their nationality in Code 935 of the A.I.D. Geographic Code Book as in effect at the time orders are placed or contracts entered into for such goods or services ("Foreign Exchange Costs"), except as provided in the Project Grant Standard Provisions Annex, Section C.1(b) with respect to marine insurance. All reasonable efforts will be made to maximize U.S. procurement whenever practicable. Air travel and transportation to and from the U.S. shall be upon certified U.S. flag carriers to the extent possible.

(b) to finance ocean transportation costs under the Grant only on vessels under flag register of the countries included in AID Geographic Code 935 and the cooperating country, subject to the requirement that at least 50 percent of the gross tonnage of the cargo shipped be on vessels of U.S. flag registry, except as A.I.D. may otherwise agree in writing.

## 6. Conditions Precedent

The Project Agreement shall include, in substance, the following Conditions Precedent:

1. Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

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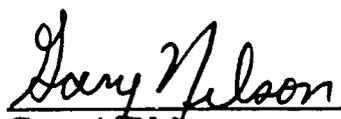
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  - (g) The Grantee covenants to assume, at the end of the Project, all recurring costs related to maintaining equipment furnished under the Grant as well as maintaining the supply of expendable property necessary to ensure the continuation of successful new systems and procedures developed during the Grant period.

8. Gray Amendment

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.

9. Involuntary Sterilization and Abortion

The Project will not directly or indirectly support any organization or activity which promotes or commits involuntary sterilization or abortion.

  
\_\_\_\_\_  
Gary A. Nelson  
USAID/Rwanda Mission Director

8/21/92  
\_\_\_\_\_  
Date

Draft: PDO: CCantell  Date 7/04/92

Clearance:

HPO:	WMartin	<u>DFT</u>	Date <u>7/06/92</u>
PRM:	LDouris	<u>DFT</u>	Date <u>7/15/92</u>
A/CONT:	HHunter	<u>DFT</u>	Date <u>7/06/92</u>
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\_\_\_\_\_  
**Gary A. Nelson**  
**USAID/Rwanda Mission Director**

\_\_\_\_\_  
**Date**

Draft: PDO:

CCantell \_\_\_\_\_

*b*

Date

7/4/92

Clearance:

HPO:

WMartin \_\_\_\_\_

Date

7-6-92

PRM:

LDouris \_\_\_\_\_

Date

7-15-92

A/CONT:

HHunter \_\_\_\_\_

Date

7/6/92

EXO:

YKainth \_\_\_\_\_

Date

7/6/92

RLA:

AVance \_\_\_\_\_

*AV*

Date

7/11/92

*Subject to indicated edits  
in this authorization and  
in the PP including the  
statutory checklist,*

*Ref fax dated 7/20/92  
(A.Vance Trip Report)*

*WBM*

**RWANDA INTEGRATED MATERNAL AND CHILD  
HEALTH/FAMILY PLANNING (RIM)  
PROJECT PAPER**

Project 696-0134

HPO Office  
USAID/Rwanda  
August, 1992

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## **EXECUTIVE SUMMARY**

The Rwanda Integrated Maternal and Child Health Project (RIM) is a six year, 13.15 million dollar health and population project with the goal to improve the reproductive health of Rwandan women and men living in the project area.

It will do this by improving both the quality and the quantity of comprehensive reproductive health services (CRHS) delivered in the project area. Comprehensive reproductive health services include pre and post-natal care, childbirth services, STD diagnosis, treatment, control and prevention, and a full-range of family planning services offered at most patient-provider interactions. As a package, these interventions interact synergistically to improve the health of women of reproductive age, improve the health of their children, improve the health of men with STDs, and, in line with Mission strategies and the MCH/FP II Project, increase the birth spacing and lower the fertility rate of Rwandan women which will result in a lower population growth rate.

The RIM Project's CRHS strategy will have a large impact on the health of both Rwandan women and the health of their children. A Rwandan woman faces a one-in-fifteen chance of dying from pregnancy-related causes. Furthermore, the health of a mother during pregnancy is intimately related to the health of her child. Approximately half of all infant mortality (less than 12 months - 111 per 1000 in Rwanda) occurs during the perinatal (less than 48 hours) or neonatal (less than 28 days) period. These deaths are unaffected by Rwanda's child survival strategy. The only effective way to address the problem of neonatal and perinatal mortality is through improving the health care the mother receives during and after pregnancy and during delivery.

Currently, public health centers and dispensaries are poorly utilized for all maternal and child health and family planning services. USAID sponsored training in maternal and child health, family planning services, and program management has been limited to the areas of family planning clinical services and family planning information, education and communication skills provided by the National Population Office (ONAPO) through the Mission's Maternal and Child Health/Family Planning II Project. Integrated maternal and child health and family planning service delivery and supervision, although ordered by the Ministry of Health, has not been achieved. USAID's approach with the RIM Project is to focus equally on the provider of maternal and child health and family planning services, the Ministry of Health, rather than only on the inputs to family planning provided by ONAPO. The Ministry of Health services must be strengthened to both create and meet the increased demands by Rwandans for a greater variety of reproductive health services delivered in an integrated manner.

The RIM Project will minimize the additional management burden at the regional level that introducing new health services would normally imply by integrating the regional support structures of maternal and child health services and family planning services. The project will increase available resources for reproductive health at both the regional and health center

levels by promoting a more efficient use of available resources rather than providing additional resources which the government will be unable to sustain after the project period.

The project will be regionally based, starting in two health regions and moving to two more after three years if the first mid-term evaluation shows that sufficient progress has been made to achieving project outputs in the first two health regions. The level of training and oversight needed to meet the project's objectives would be difficult to achieve by programming through the central level. Decentralization is also a goal of the Ministry of Health and of USAID assistance. The Mission is encouraging ONAPO to decentralize under the MCH/FP II Project (696-0128) and the Mission's strategies on governance and democracy are enhanced by decentralizing government services. Targeting aid directly at the regional and health center levels allows the project to increase the strength of technical and administrative skills at a level where activities are already de facto integrated. Evidence also suggests that personnel turnover should have less of an impact than it would at the central level; the project can be reasonably sure that the large majority of trained personnel will remain at their posts for the foreseeable future.

RIM will support conventional interventions such as technical assistance, training, IEC, operations research and commodity purchases aimed at enhancing comprehensive reproductive health service delivery. RIM's concentration on management and supervision at the regional level will promote improvements in the quality of care available, the efficiency of service monitoring and evaluation, and the utilization of health center-based preventive and curative care by Rwandans. The project will attempt to anchor health information system strengthening, financial management and administrative/logistic planning at the regional level, thus institutionalizing sound, decentralized decision making.

The RIM project will progress in a phased approach. The first phase will be largely assessments--operations research studies and small pilot projects. The project paper shall refer to this period as the "bridge" or the "bridge year." With the arrival of the institutional contractor, approximately one year into the project, "Phase I" of the project will commence. This implementation phase will occur in the first two health regions (Gitarama and Kibungo) and will continue for approximately two years. "Phase II" will commence at the beginning of year four of the project and be marked by expansion of project activities into two additional health regions (Kibuye and another to be determined).

## LIST OF ACRONYMS

AA/AFR	Assistant Administrator, Bureau for Africa, A.I.D.
A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
ACSI/CCCD	African Child Survival Initiative/Control Childhood Communicable Diseases Project
BUFMAR	Bureau des Formations Medicales Agrees du Rwanda
CBD	Community-based distribution system
CCCD	Control of Childhood Communicable Diseases Project
CCDFP	Centre Communal de Development et Formation Permanent
CDC	Centers for Disease Control
CDD	Control of Diarrheal Diseases
COP	Chief of Party
CPR	Contraceptive Prevalence Rate
CPSP	Country Program Strategy Plan
CRHS	Comprehensive Reproductive Health Services
CSM	Contraceptive Social Marketing
DAF	Direction Administrative and Financiere
DFA	Development Fund For Africa
DGC	Division Gestion des Credit
DHS	Demographic and Health Survey
DOA	Delegation of Authority
EPI	Expanded Program of Immunization
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
HIV	Human Imuno-deficiency Virus
HPO	Health and Population Officer (USAID)
IC	Institutional Contractor
IDA	International Development Association (World Bank)
IEC	Information, Education and Communication
KAP	Knowledge, Attitudes and Practices
LOP	Life of Project
MCH	Maternal and Child Health
MCH/FP	Maternal Child Health/Family Planning
MEDERISA	Medical Director of Regional Health
MINIFIN	Ministry of Finance

1.8

<b>MINIFONP</b>	<b>Ministry of State Service</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>NGO</b>	<b>Non-Governmental Organization</b>
<b>ONAPO</b>	<b>Office National de la Population (National Population Office)</b>
<b>OR</b>	<b>Operations Research</b>
<b>PACD</b>	<b>Project Assistance Completion Date</b>
<b>PASA</b>	<b>Participating Agency Service Agreement</b>
<b>PID</b>	<b>Project Identification Document</b>
<b>PIL</b>	<b>Project Implementation Letter</b>
<b>PIO/C</b>	<b>Project Implementation Order, Commodities</b>
<b>PIO/P</b>	<b>Project Implementation Order, Participants</b>
<b>PIO/T</b>	<b>Project Implementation Order, Technical Assistance</b>
<b>PME</b>	<b>Program Monitoring and Evaluation</b>
<b>PP</b>	<b>Project Paper</b>
<b>PNLS</b>	<b>National Aids Program</b>
<b>PROAG</b>	<b>Project Agreement</b>
<b>PVO</b>	<b>Private Voluntary Organization</b>
<b>REDSO</b>	<b>Regional Economic Development Services Offices (AID)</b>
<b>RFr</b>	<b>Rwandan Francs</b>
<b>RFMC</b>	<b>Regional Financial Management Center</b>
<b>RIM</b>	<b>Rwanda Maternal Child Health/Family Planning</b>
<b>RMA</b>	<b>Regional Management Advisor</b>
<b>RT</b>	<b>Regional Team</b>
<b>RTT</b>	<b>Regional Training Team</b>
<b>TBA</b>	<b>Traditional Birth Attendant</b>
<b>TFR</b>	<b>Total Fertility Rate</b>
<b>TOT</b>	<b>Training of Trainers</b>
<b>SAF</b>	<b>Service Administratif et Financier (ONAPO)</b>
<b>SOP</b>	<b>Standard Operating Procedures</b>
<b>TA</b>	<b>Technical Assistance</b>
<b>TBA</b>	<b>Traditional Birth Attendant</b>
<b>UNFPA</b>	<b>United Nations Fund for Population Activities</b>
<b>UNDP</b>	<b>United Nations Development Program</b>
<b>UNICEF</b>	<b>United Nations International Children Emergency Fund</b>
<b>USAID</b>	<b>United States Agency for International Development Mission in Rwanda</b>
<b>WB</b>	<b>World Bank</b>
<b>WHO</b>	<b>World Health Organization</b>

## **I. PROJECT BACKGROUND AND RATIONALE**

### **A. General Setting**

Rwanda is a small land-locked country in Central Africa with a population of 7,155,000. It has the highest population density in Africa at 271 people per square kilometer. The distribution of the population is heavily rural; fewer than 7 percent of Rwandans live in urban areas (urban is defined as towns greater than 5,000 inhabitants). The population is distributed relatively evenly over the country; there are very few villages or groups of houses.

Rwanda is one of the poorest countries in the world with a per capita income of approximately \$300 a year. Agriculture accounts for over 90 percent of employment and the agricultural sector is predominantly subsistence oriented. Major crops include bananas, sweet potatoes, beans and sorghum. Coffee and tea are the major cash crops with coffee accounting for the bulk of foreign exchange earnings.

Rwanda's poverty is reflected in its health and demographic statistics. With a growth rate of over 3 percent and a fertility rate estimated at 7.3 percent, Rwanda faces a demographic crisis if its growth rate is not slowed. The under five mortality rate exceeds 200 per 1000 children and the infant mortality rate is estimated at 111 per 1000, sixteenth worst in the world. Among children malaria is the primary cause of mortality, followed by respiratory infections, diarrheal diseases and other infectious diseases. All health problems are exacerbated by poor nutritional status. Studies indicate that over 30 percent of Rwandan children are chronically malnourished. Growth rates drop drastically at six months, indicating problems with the introduction of foods other than breastmilk into the children's diet; inappropriate foods and poor hygiene are both probable causes of growth faltering.

The Ministry of Health (MOH) has a budget of over 13 million dollars per year with which to run a system of 350 health centers and 20 hospitals. The official health policy of the government stresses the primacy of preventive and primary care; however, financial analysis of the MOH suggests that the majority of funds are still allocated to hospital-based curative care.

In 1981 the GOR established a National Office of Population (ONAPO) to serve as the primary body for family planning activities in the country. In the eleven years since ONAPO's founding the contraceptive prevalence rate for modern contraceptives has risen from essentially zero to over 13 percent of married women, making the family planning program one of the more successful in Africa.

Since 1981, USAID has supported the development of ONAPO as the institution responsible for population policy and family planning strategy. ONAPO is a multi-sectoral office responsible for all issues relating to family planning except the actual service delivery, which

is performed through MOH hospitals and health centers. The Mission's population projects support training, procurement of contraceptive supplies, information, education and communication (IEC), supervision and research related to population and family planning. Ministry of Health personnel have been trained and supplied with contraceptives. Family planning acceptors are increasing. Yet public health centers and dispensaries are poorly utilized for all maternal and child health and family planning services. Training in maternal and child health, family planning services, and program management has been limited to the areas of family planning clinical services and family planning information, education and communication skills provided by ONAPO. Integrated service delivery and supervision, although ordered by the MOH, has not been achieved. USAID's approach with the RIM Project is to focus equally on the provider of maternal and child health and family planning services, the Ministry of Health, rather than only on the inputs to family planning provided by ONAPO. The Ministry of Health services must be strengthened and enhanced to both create and meet the increased demands for a greater variety of reproductive health services.

From 1981 until 1988 USAID supported child survival activities with the MOH through the ASCI-CCCD project executed by the Centers for Disease Control International Health Program Office. The project had some notable successes. It began the expanded program on immunizations (EPI) and by project end Rwanda had achieved coverage rates for basic immunizations of over 80 percent, among the highest rates in Africa. Since CCCD ended, the EPI program has been supported by UNICEF and coverage rates have remained stable. CCCD also instituted the supervision strategies and information system still used by the MOH. RIM will build on the structures and successes of the CCCD project and provide much needed technical support to health system support services.

## **B. Project Strategy**

The strongest argument for the RIM Project is that the Mission will not achieve the population sector goals described in the CPSP by only working with the National Population Office through the MCH/FP II Project. Family planning service delivery is done by Ministry of Health service providers, the same people who give women prenatal care, treat sick children and promote preventive health care in the community. To these workers family planning is but one of many activities they perform every day. The fact that family planning training and supervision come out of a different governmental organization (ONAPO) than the Ministry of Health is irrelevant. They are simply trying to accomplish all the tasks required of them despite a bureaucratic structure that burdens them and a lack of resources that limits their scope of activities. The RIM Project will lessen the bureaucratic burden by integrating the regional support structures of maternal and child health and family planning and it will increase available resources by promoting a more efficient use of them.

The RIM Project has as a goal to improve the reproductive health of Rwandan women and men in the project areas. It will do this by improving both the quality and the quantity of comprehensive reproductive health services (CRHS) delivered in the project area.

Comprehensive reproductive health services include pre and post-natal care, sexually transmitted disease (STD) diagnosis, treatment, control and prevention, and a full-range of family planning services offered at most patient-provider interactions. As a package, these interventions interact synergistically to improve the health of women of reproductive age, improve the health of their children, improve the health of men with STDs, and, in line with Mission strategies and the MCH/FP II Project, increase the birth spacing and lower the fertility rate of Rwandan women which will result in a lower population growth rate.

Some of the interventions are new in the Rwandan context, notably a full package of STD services. Most of the interventions are not new, but are currently underutilized and are frequently of poor quality - one of the premises of the project is that increasing the quality of the services will increase the utilization rate. Another premise is that by decentralizing the service delivery structure services will be delivered both better and more efficiently. Decentralization means more than programming resources at the regional level. The health regions and the health centers will be taught skills with which they can manage their resources, no matter how limited, more skillfully, and with the authority and the autonomy to make decisions without constantly being second-guessed or over-ruled by organizational units higher up on the chain of command.

The RIM Project has two broad-reaching objectives:

- 1) The improvement and adoption of comprehensive reproductive health services. CRHS includes pre and post-natal care, delivery, STD diagnosis, treatment, control and prevention, and family planning. The need for improving both the quality and quantity of these activities in the Rwandan public health system has been determined in the field work and analyses leading up to the Project Paper. The determination to focus effort on these particular activities within the larger MCH umbrella is not an a priori judgment that the other MCH activities (immunizations, diarrhea control, acute respiratory infections, etc.) are less important or delivered at a high level of quality, but rather that the activities in CRHS have been neglected and are congruent with the USAID strategic objective of raising the contraceptive prevalence rate of modern methods of contraception.
- 2) The improvement of regional and health center level management. Management is used here in its broadest sense to mean all support activities related to delivering care. This includes financial management and accounting, human resource management, short-term and long-term planning, supervision, training, logistics support and information systems. Many of the interventions used to achieve Objective 1 will be implemented through mechanisms established under Objective 2. For example, after a curriculum for STD treatment, control and prevention is prepared, it will be taught through Regional Training Teams managed by the Regional Health Office. The training will be reinforced by more frequent and more supportive supervision, and the necessary equipment will come through a redesigned logistic system, which will better track supplies and ensure their timely replacement.

Because these objectives would be difficult to achieve by programming through the central level, the project will be regionally based. The RIM Project's strategy of working closely at the health region and health center level is resource intensive. The project would not be manageable on a national scale. Furthermore, there are several aspects of the project, initial STD work, outreach and promotion strategies for CRHS, pre-paid pregnancy services, that are experimental in nature and which must be tried in pilot areas before considering large scale expansion. Therefore the project is scheduled to begin in the prefectures of Kibungo and Gitarama. After two full years of work there the project will add the prefecture of Kibuye, as well as another, still to be determined. Part of the rationale for a regional project is theoretical. A project that is pushing for decentralization of resources and decision making should not itself be overly centralized. The second rationale is more conjectural. Given the present structure of the central offices of the MOH, it is difficult to imagine that the project would have much of an impact at the peripheral level if its activities were mainly at the central level. Both the resources and the energy of the project would be diffused by the time they reached the critical recipients of project activities, the peripheral health center.

The overall strategy of the project is to use the first two years and the first two prefectures to work very closely with health center and regional personnel to not only develop the standards and mechanisms for meeting the two Objectives, but also to assure the transfer of skills to regional and peripheral staff in the steps of development and application of these service standards. This will be a very "hands-on" period during which project staff (contractor, MOH, and USAID) will work in close collaboration with regional and peripheral MOH staff and will invest a level of human and financial resources far beyond what could be sustained by the MOH. The end products will be standardized protocols and operating procedures that will be codified in manuals, a set for the peripheral level and another set for the regional level. The manuals will represent the project's best determination of the mechanisms and standards that could be used by other prefectures to achieve the same objectives without the level of external assistance provided by the project. To achieve this consensus, the project will work with other regionally based projects working in the same direction. Currently the German Development Cooperation Agency (GTZ), the Belgian Cooperation and the United Nations Children's Fund (UNICEF) have projects with similar activities (see below, section 1.F).

The second two prefectures will serve as testing grounds for the manuals and associated training and supervision plans to implement the activities described in the manuals. These prefectures will receive help from the project team, but at much lower levels than the first two prefectures. The objective will be to continue to revise the strategies and the manuals through observing the implementation of activities with a lower level of support. One of the project's main products will be a set of manuals that delineate standards and protocols, and the processes for implementing them, that can be used by health regions and health centers without the need for large amounts of outside technical assistance (whether it be from outside or from within Rwanda).

## **C. Constraints and Opportunities**

### **C.1 Lack of Health Service Utilization**

It is estimated that only about 20 percent of the Rwandan population use public health facilities regularly. Approximately half of these users are pregnant women, but most Rwandan women only come in for a prenatal visit once very late in pregnancy. Studies suggest that the purpose of this visit is to assure that should problems occur during delivery the women will be accepted by the health center for treatment. Few deliveries in Rwanda occur in medically supervised settings; less than 10 percent of deliveries occur in health facilities. Anecdotal evidence points to poor quality of care and poor interpersonal relationships between patients and providers as the primary reasons for the low utilization rate.

Most STDs are not treated in health centers. Health center records indicate that women occasionally present with chronic STDs, but almost no men are treated for STDs in the health centers visited. It is unclear whether STDs are going untreated or whether they are being self-medicated (it seems unlikely that men are not treating gonorrhea in some way).

### **C.2 Human Resource Constraints**

Pre- and postnatal care training are insufficient. Few medical assistants or nurses are aware of the need for substantial weight gain during pregnancy. The means of identifying women at risk of poor birth outcomes are relatively unknown. There is an important lack of STD training. Most health center practitioners do not properly diagnose or treat STDs. There is also a general lack of awareness of STD drug resistance. The MOH lacks management depth at all levels. The large majority of MOH personnel in management positions (central and regional personnel, health center managers) have received no management training. They have clinical training only, either in medicine or nursing. Finally, the MOH is chronically understaffed. Most rural health centers employ fewer than 7 people, only three or four of whom are qualified to give care. The shortages have been aggravated by the recent hostilities and economic difficulties.

### **C.3 Structural Constraints**

The Rwandan public health system has developed somewhat haphazardly over time. Services have been added into the system by different donors at different times, leading to a set of vertical programs. Thus, while peripheral level delivery is accomplished by a few workers, de facto horizontal integration, supervision and logistical support is often accomplished by different supervisors at the regional level, wasting limited resources. Similarly, the central MOH structure has evolved in a way that has stopped divisions that should be working closely together from interacting. Different divisions in the MOH remain surprisingly unaware of each other's actions.

#### **D. Conformity with Rwanda's Priorities**

On June 22, 1990, the Government of Rwanda (GOR) Central Committee, headed by the President, adopted a policy paper titled: "The Demographic Problem of Rwanda and the Framework for its Solution." This document provides a frame of reference for the national population policy and a medium-term plan of action to achieve the agreed upon objectives:

--Reduce population growth rate from 3.6 percent in 1990 to 2 percent in 2000 by providing family planning methods that reduce the total fertility rate (TFR) from 8.5 in 1990 to 4 in 2000.

--Attain a 12 percent contraceptive prevalence rate (CPR) by the end of 1990, 15 percent by the end of 1991 and 48.4 percent in 2000.

--Reduce mortality rates so that the life expectancy rate increases from 49 years in 1985 to 53.5 years in 2000.

With the official pronouncement of these goals, Rwanda joins the ten African countries that have explicit national policies favoring lower population growth rates (see Target 1-3 of the DFA Action Plan, May 1989). In addition the current population portfolio addresses the key benchmarks identified in the DFA Action Plan (p. 16) including the CPR rate, percent of population with access to contraception, the total fertility rate, the population growth rate, and the involvement of the private sector in marketing of contraceptives. Consequently, the proposed GOR activity is entirely consistent with DFA targets and objectives.

To achieve the national goals, the GOR MOH, working with ONAPO, developed an Accelerated Program for Maternal Child Health/Family Planning (MCH/FP) which was officially adopted in August 1990. The basis for this program is the Ministerial Instruction on the Integration of Family Planning into the MOH Maternal Child Health Program, which was sent to the Medical Directors of the ten National Health Regions in March 1988. The Accelerated Plan calls for the strengthening of MCH/FP integrated services with improved standards, training and supervision for the program.

It is ONAPO's responsibility to see that the contraceptive prevalence goals are met. The MOH hospitals and health centers are the delivery sites for the MCH/FP services. ONAPO provides clinical training in FP for MOH personnel, and contraceptive supplies. New activities are being planned to improve training of MOH personnel in MCH as well as FP, and to include the management of contraceptive products in the Bamako Initiative program recently launched by the MOH. This year's goal for the MCH/FP Program is for each MOH health establishment (hospitals, health centers and dispensaries), to recruit at least 500 new family planning acceptors. Goals for subsequent years will be even higher. Significant improvements in the quality and quantity of MCH/FP services offered at MOH establishments will be necessary, if the GOR objectives for the year 2000 are to be achieved.

While ONAPO has been relatively successful in carrying out its mandate, the MOH, as the actual provider of FP services, has had many problems in expanding FP activities nationwide. The proposed project directly addresses the MOH constraints related to insufficiently equipped health centers, inadequately supervised workers and implementation of integrated MCH/FP services. By providing training, technical expertise and enhanced management capacity directly to the MOH to improve maternal health services, including family planning, the proposed project furthers the attainment of the objectives of the national population policy.

The DFA Action Plan stresses the importance of integrating health and child survival activities with family planning, "especially in the treatment of women who are likely to experience high risk births" (p. 16). It also points out the relationship between improved child survival and lowered fertility rates. By integrating family planning more significantly into the MCH/FP program of the MOH RIM directly addresses these issues.

#### **E. Conformity with A.I.D.'s CPSP**

The Rwanda CPSP recognizes that the rapid population growth rate constitutes the single greatest threat to the nation's economic and social development. In 1988 there were approximately 20,000 FP acceptors (approximately 3 percent of eligible women). By December 1991, the CPR rate reached 12 percent with over 100,000 acceptors. The progress made in four years is significant and encouraging, but only the beginning of a greater effort.

The CPSP calls for the decrease of the TFR from 8.5 in 1988 to 6.9 in 1997 by increasing the number of FP acceptors. This is to be accomplished by improving access to services, improving the quality of services and increasing the demand for services. Preliminary data from the Demographic Health Survey (DHS), which was halted after one third completion due to the October 1990 war with Rwandan rebels, indicated that several Action Plan targets had been achieved or surpassed. The DHS data showed a TFR of 7.3. The number of modern family planning methods available in Rwanda has also increased as tubal ligation, vasectomy and Norplant implants are now offered at hospitals in four health regions. Under the recently developed expansion plan, these surgical methods will be available in all eleven health regions by the end of 1992.

The RIM Project will enable the Mission to achieve the goals described in the CPSP by providing technical assistance, training and support to the MOH, which, in tandem with ONAPO, deliver family planning services in Rwanda. This complements the Maternal and Child Health/Family Planning II Project which currently supports ONAPO. Together, the two projects work towards the common goal of reducing the fertility of Rwandan women.

## **F. A.I.D. Support to FP/MCH in Rwanda**

In 1980 A.I.D. began the implementation of an expanded program for immunization (EPI) in Rwanda. This was a centrally funded activity through a PASA with the CDC's Africa Child Survival Initiatives - Control of Communicable Childhood Diseases (ASCI-CCCD) Project. The project was done in close cooperation with UNICEF and WHO.

In January 1981 the GOR established the National Office of Population (ONAPO) with the encouragement of USAID. In September 1981 USAID signed a five-year, 6.25 million dollar family planning project with ONAPO, Maternal and Child Health and Family Planning Project (MCH/FP, later MCH/FP I to distinguish it from the follow-on project). The project was later amended to a seven-year, 7.4 million dollar project.

The project had as major components: family planning information, education and communication (IEC); population research and policy formulation; and, family planning service delivery. The evaluations of the project were generally positive. The first two components were quite successful while service delivery lagged behind, due notably to an unclear relationship with the Ministry of Health, whose workers actually delivered the majority of services.

In 1984 USAID bought-in to the ASCI-CCCD project and intensified the level of its involvement with the Ministry of Health. The project continued the earlier centrally funded activity in EPI and in added activities in diarrhea control and diagnosis and treatment of malaria. It also instituted a regional supervision system and started the nationwide health information system, both systems continue to work essentially as originally designed and implemented by the ASCI-CCCD Project.

In 1988 the Mission made a determination to concentrate its efforts in the population sector (reflected in the 1988 CDSS) and the ASCI-CCCD Project was not renewed despite its significant success. In 1989 USAID reached agreement with ONAPO for a follow-on to the MCH/FP I Project, the five-year, 9 million dollar Maternal and Child Health and Family Planning II Project (the project funding was later amended to a 10.3 million dollars).

The project followed in the footsteps of its predecessor with increased attention to management and financial accounting, issues that became evident with the explosive growth of ONAPO through the first project. The project has been very successful; it is close to achieving its September 1994 EOPS now, in April 1992. The evidence suggests that the awareness of modern methods of contraception is close to universal in Rwanda and that the desired family size is slowly declining. Modern methods of contraception are available in 80 percent of health centers. The remaining 20 percent are almost all Catholic partnership health centers supported by the local diocese.

The biggest problem facing ONAPO and the MCH/FP II Project today remains its ambiguous relationship to the Ministry of Health. In 1988 the MOH issued a directive

making MCH/FP activities the priority focus of health centers. This same directive also mandated the integration of FP activities into MOH service delivery. FP was defined to mean both modern and natural methods, and everyone was to have free access and proper counselling on all methods. Furthermore, FP supervision and evaluation was to be integrated within existing health system mechanisms. While by 1990 the MOH and ONAPO claimed that the integrated MCH/FP services were being offered at all public health facilities, the subtler goals of tight coordination and cooperation have not been achieved.

The RIM Project will improve the MOH's capacity to deliver reproductive health services, including family planning. Furthermore, it will integrate family planning more tightly with the other, related services women receive from health centers. This will serve to improve family planning service delivery in two ways:

- 1) Family planning will not be adversely affected by poor service delivery in other reproductive health services - a woman is not likely to accept family planning services from a health worker who has poorly treated her previously during a pregnancy or when she had an STD. The fact that a limited number of health workers deliver all services is an inherent limiting factor on the MCH/FP II project. No matter how well they train health personnel in FP the FP service delivery is affected by non-FP service delivery.
- 2) Women will receive FP services more frequently. Currently, women receive family planning services only when they ask for them. The CRHS strategy, by integrating a set of related activities, would ensure that a woman receives family planning services during most contacts with the health system - during pre and postnatal care, while being treated for an STD and during well-baby visits.

#### **G. Other Donor Activities**

The World Bank has two health and population projects in Rwanda. One is with the MOH and the other is with ONAPO. A second phase of the MOH project is under development.

The \$10 million Santé Familiale Project was begun in 1986 with the goal of integrating FP and Maternal and Child Health (MCH) services and improving both the quantity and quality of care delivery in the country. The Santé Familiale Project set up the Regional Training Teams that will be used by the RIM Project and has worked with the MOH to set standards and protocols for service delivery that will be used as a starting point by the RIM Project.

The World Bank has negotiated a new population project with the Government of Rwanda (GOR). The project will provide \$19 million of support to ONAPO for 5 years. The agreement was signed in November 1991 financing was released in June of 1992. The

project has as goals: 1) lowering the fertility rate; 2) improving MCH services, and; 3) integrating the demographic dimension in cross-sectoral development activities.

UNICEF has numerous programs in both health and nutrition. Its major activity in Rwanda is a cost-recovery, improved primary care delivery project. They also support the expanded program of immunizations, maternal health care (developing and distributing mothers' cards) and nutrition center activities. The cost-recovery project has implications for the RIM Project as cost-recovery is managed at the health center level. The mothers' cards developed by the UNICEF maternal health project will be used for prenatal visits under CRHS.

The largest WHO project in Rwanda is the Global Program on AIDS (GPA) portion of the National AIDS Program (PNLS). WHO is funding an African Regional Center for Training and Research in Family Health based at ONAPO's Kicukuru training facility. WHO has also placed a technical advisor in the World Bank Santé Familiale Project.

UNFPA executes most of its projects through ONAPO. Support is divided into three areas: 1) furnishing equipment and contraceptives, 2) training, and 3) support for the activities of the volunteer FP workers (Abakangurambaga). UNFPA has also placed a demographer in ONAPO's office to work with the research division.

GTZ has been working with ONAPO on a FP/MCH Project in the Prefectures of Butare and Gikongoro for the past three years. GTZ expanded the project into the Prefecture of Cyangugu in 1991. The RIM Project has collaborated with GTZ during development and will continue to do so over the life of project. The RIM Project Staff will meet regularly with the GTZ Project Staff to compare the various models of service delivery used in the two projects' regions with the goal of producing the best collaborative model.

The French Cooperation's activities are essentially limited to placing cooperants into health related positions. Ten of the twelve health cooperants are medical doctors who work in the Ruhengeri Hospital. Two now work with the MOH. One is collaborating with UNICEF on activities related to the Bamako Initiative. One has been appointed to a post in the MOH's division of statistics, where he will participate in a major update of the Ministry's health information system. He is soon to move to a post with PNLS as an epidemiologist.

Most of the Belgian assistance is centered at the Centre Hôpital de Kigali (CHK). The Belgians have also started a program with eight hospitals in eight prefectures in which the hospitals will take supervisory responsibility for the 3-5 health centers in their catchment area. The project is just beginning. This new system of supervision will need to be looked at in each of the RIM Project's regions and the RIM Project will work with the Regional Teams to integrate the Belgian supervision strategy into the RIM Project's strategy.

The Canadians finance the Documentation and Information Center for AIDS (CDIC) in Kigali. The center represents a major effort to centralize and coordinate knowledge and information on activities related to AIDS in Rwanda and internationally.

## Donor Activities in the Health and Population Sectors

Donor	Family Planning				Maternal and Child Health			
	Service Delivery	IEC	Mgmt.	Research & Policy	Service Delivery	IEC	Mgmt.	Research & Policy
World Bank	✓	✓	✓	✓	✓	✓	✓	✓
UNFPA	✓			✓				
UNICEF				✓	✓	✓	✓	✓
WHO					✓			✓
GTZ	✓	✓	✓	✓	✓			
French							✓	✓
Belgian							✓	
EEC					✓			✓
Canada					✓	✓		✓
USAID	✓	✓	✓	✓	✓	✓	✓	✓

## II. PROJECT DESCRIPTION

### A. Overview

The Rwanda Integrated Maternal and Child Health (RIM) project is an \$13.15 million, 6 year project aimed at increasing the GOR's capacity to deliver comprehensive reproductive health services to Rwandan women in four prefectures of the country (Kibungo, Gitarama, Kibuye and one to be determined). RIM will concentrate resources on two objectives, namely: 1) the institutionalization of integrated, comprehensive reproductive health services (CRHS) in the project area; and, 2) the strengthening of management and supervision systems in the project's regions. The impacts and benefits of these two Objectives are discussed below in the introductions to sections D.1 and D.2.

In order to expand integrated reproductive health care in Rwanda, RIM will necessarily build upon the existing infrastructure of the MOH and complement other donor activities in the four project regions. RIM will proceed in a phased manner in order to thoroughly explore

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management and integration options in the initial two regions (Kibungo and Gitarama) and demonstrate successful implementation of a selected set of methods. It is anticipated that by the project's mid-point, project activities will be expanded to the second two regions (Kibuye and a prefecture to be determined). Transition of project interventions into the second two regions during Phase II will likely be easier since RIM will have identified problems and solutions and will have instituted a management and reproductive health care delivery system which can be replicated in other regions of the country relatively easily.

RIM will support conventional interventions such as technical assistance, training, IEC, operations research and commodities aimed at enhancing comprehensive reproductive health service delivery. However, RIM's concentration on management and supervision at the regional level will promote improvements in the quality of care available, the efficiency of service monitoring and evaluation, and the utilization of health center-based preventive and curative care by Rwandans. The project will attempt to anchor health information system strengthening, financial management and administrative/logistic planning at the regional level, thus institutionalizing sound, decentralized decision making. Although RIM will not directly address fiscal sustainability, it will address institutional sustainability through its focus on improved management and efficiency of supervision.

The Rwandan MOH has an annual budget of approximately \$13 million. It has central offices in Kigali that tend to be organized around specific health interventions. Thus there is a director of the immunization program, a director for acute respiratory infections, etc. The country is divided into 10 health regions, one for each prefecture (except for the prefecture Kigali-ville, the prefectures of Kigali-ville and Kigali-rurale remain one health region). Each health region is managed by a physician with the title of Chief Regional Medical Officer (MEDIRESA). The MEDIRESA heads a regional team which averages about eight people. Most of the team have specific program responsibilities, there is usually a team member assigned to be a secretary and another who does the accounting. All others head specific programs like MCH, immunizations, etc. This programmatic organizational structure mimics that of the central level.

Each region also has an ONAPO delegate who manages a separate office with a two or three person staff. While the MOH Regional Office and the ONAPO Regional Office are separate bureaucratic entities, the current World Bank project is building additions to the MOH Regional Offices for the ONAPO staff to use. In this vein, and consistent with the RIM Project's desire to include family planning into CRHS, when the term regional team (RT) is used in this document it is meant to include both the MOH and the ONAPO regional personnel.

There is a group of trainers in each region called the Regional Training Team (RTT). This is a semi-formalized group of eight physicians and nurses who have been designated by the MOH as responsible for training in each region. The MEDIRESA is the head of the RTT. The ONAPO delegate is a member, as are one or two other members of the RT. The

remainder of the team is composed of physicians from regional hospitals and health center directors.

It is only at the health center level that the vertical program structure ends. Health centers have a staff of approximately seven or eight people, three or four of whom deliver services. Of these, one is frequently a vaccination technician, s/he is more or less limited to immunization services. However, the health center director and the remaining one or two nurses tend to deliver all services, *de facto* horizontal integration. This is the group of providers that is the focus of the RIM Project's efforts to deliver CRHS - by integrating a set of related services the RIM Project will achieve both improved quality of services and increased efficiency in the delivery of those services.

## **B. Assistance Strategy**

The Mission's current Maternal and Child Health/Family Planning (MCH/FP) II Project with the ONAPO has had striking success in raising awareness of the importance of family planning at the highest levels of government and in the general population. The investment has leveraged a six year, twenty million dollar World Bank Loan to ONAPO, signed in June 1991. MCH/FP II is funding improvements in the delivery of family planning services through MOH facilities and the development of private sector FP services such as social marketing of contraceptives. New methods, including voluntary sterilization and implants, are being offered to the Rwandan population. The success to date has mainly been achieved by targeting women who desire to limit the size of their family (approximately 35 percent of Rwandan women).

RIM intends to build on the ongoing success of MCH/FP II and complement its outputs. However, RIM will focus on expanding the delivery of integrated reproductive health (preventive and curative) interventions. It is anticipated that this broader set of services together with expanded service promotion and information will increase utilization, while improved management, increased provider skills and an enhanced health center environment (supplies, equipment, physical plant) will increase the MOH capacity to provide these services.

RIM will address two fundamental weaknesses in the Rwandan health care system: 1) CRHS is not provided at the majority of health facilities; and, 2) an effective management structure is also lacking in most health facilities. Conceptually, the project fits well into the Mission's CPSP, directly linking the strategic objective of reduced population growth to improved utilization of a broader array of reproductive health services (which over the long term should contribute to reduced fertility). Notionally, the promotion of improved management should lead to a more easily sustainable, higher quality of care, evidenced (at least) by improved organization and administration of services coupled to a higher level of skills for health care providers. RIM will complement the "Bamako Initiative" through

support to district managers and small pilot efforts aimed at exploring alternative ways to recoup recurrent costs.

It is important to note that RIM is aimed at improving the capacity of the GCR/MOH to deliver CRHS in an efficient manner. Therefore, given the uncertainties and complexities of this target, project implementation will proceed at the regional level rather than the national level. At the PACD, it is anticipated that the management and service delivery experience generated by RIM will be sufficiently positive that RIM-derived management, training and service delivery models can be applied nationwide.

### **C. Goal, Purpose, Outputs and Inputs**

**GOAL:** To improve the reproductive health of Rwandan women and men in the project area (Kibuye, Gitarama, Kibungo and a prefecture to be determined). Achievement will be measured by increase in modern contraceptive prevalence to 28 percent of women of reproductive age; and a decrease in infant mortality from 111/1000 to 100/1000.

**PURPOSE:** To increase the capacity of the MOH to provide comprehensive reproductive health care including the treatment, prevention and control of STDs, family planning, pre and postnatal services.

**OUTPUTS:** By the PACD, to support the accomplishment of the goal and purpose-level, the following outputs will also be accomplished:

- **Service Delivery** - 75 percent of health facilities in the project area provide comprehensive reproductive health care. Fifty percent of women in the project area receive comprehensive reproductive health services at least 3 times during each pregnancy. Sixty percent of pregnant women in the project area will have at least one postnatal visit.
- **Standardized Record Keeping** - 75 percent of health centers in the project area maintain standardized patient records.
- **STD Policy** - A national policy for STD treatment is developed and instituted with treatment algorithms and standardized prevention guidelines.
- **STD Prevention and Control** - 75 percent of STD patients presenting to project area health facilities are treated correctly.
- **Reproductive Health Knowledge** - 50 percent of women in the project area understand the importance of pre- and postnatal care and preventive reproductive health services.

- **Training** - 500 service providers trained in CRHS and management skills.
- **Supervision** - 75 percent of health facilities in project area have institutionalized a standardized supervision system with supervisory visits made quarterly by district managers.
- **Regional and Health Center Planning and Fiscal Administration** - HIS instituted in 75 percent of the health facilities in the project area; data used for financial and technical planning; standardized regional accounting system instituted in project area.

**INPUTS:** RIM inputs into the project area are as follow.

- **Technical Assistance** - 17 person years of resident TA, approximately 252 person-weeks of short-term TA. Eight person years of assistance from the US Peace Corps.
- **Training** - Approximately 36 person months of short-term training (study tours, workshops, seminars); and approximately 1500 person weeks of in-country training one week courses and skill updating.
- **Commodities** - Commodities will comprise STD drugs, 6 4WD and 2 2WD vehicles, data processing equipment (computers, printers, software), office space (equipment and supplies), IEC and training materials production and distribution, health center equipment and supplies, minor rehabilitation of health center facilities.
- **Local Hire** - Approximately 6 years of local hire professionals (accounting/administration, operations research), 35 person years of semi-skilled labor (drivers, maintenance, data entry).
- **Other Costs** - External audits, evaluation, local costs for physical maintenance, supervision/transport operations, operations/applied research.

## **D. Project Components**

The RIM Project will progress in a phased approach. The first phase will be largely assessments, operations research studies and small pilot projects. The implementation plan refers to these activities as "Bridging", or the "Bridge Year". The arrival of the institutional contractor (IC) approximately one year into the project begins Phase I activities, which center on the introduction of CRHS and the development and implementation of standard management operating procedures (SOPs) at both the health region and the health center level in two health regions, Kibungo and Gitarama. Phase II will begin approximately two years later (3 years into the project) and will involve taking the CRHS strategy and the SOPs developed in Phase 2 and implementing them in a less resource intensive manner in two other health regions, Kibuye and one to be determined.

While the ultimate outputs of the project include such tangible products as manuals of standard operating procedures, training curricula, and IEC materials, an equally important outcome is the transfer to the MOH staff at the health center, regional and central levels of the critical skills and their application to these types of management and technical problems. All technical advisors as a matter of principle and practice must train and work in collaboration with MOH staff and related counterparts. Products, whether first drafts, revised, or final, must be relevant to and "owned" by the MOH personnel who will use them.

The project has four major components, and two of the major components have several sub-components as listed here and detailed below:

- 1) **The improvement and adoption of comprehensive reproductive health services.**
  - Assessment of existing activities and operations research;
  - Improve the delivery of comprehensive reproductive health services;
  - Institute the delivery of STD prevention and control activities at the health center level;
  - Increase the knowledge/understanding of the importance of CRHS and care;
- 2) **The improvement of management skills at the regional and health center levels of the public health system.**
  - Improve organizational and management skills at the health center level;
  - Increase regional training capacities;

- Improve management at regional level;
  - Improve the supervision at the regional, district and health center level;
  - Strengthen the health information and fiscal management systems at the regional level;
  - Test the feasibility and value of cost recovery opportunities.
- 3) Dissemination of products and results of RIM Project activities.
- 4) Monitoring and Evaluation

#### **D.1 The Improvement and Adoption of Comprehensive Reproductive Health Services.**

The RIM Project's CRHS strategy will have a large impact on the health of both Rwandan women and the health of their children. A Rwandan woman faces a one in fifteen chance of dying from pregnancy related causes. Furthermore, the health of a mother during pregnancy is intimately related to the health of her child. Approximately half of all infant mortality (less than 12 months - 111 per 1000 in Rwanda) occurs during the perinatal (less than 48 hours) or neonatal (less than 28 days) period. These deaths are unaffected by Rwanda's child survival strategy which concentrates on disease prevention and control after the neonatal period. The only way to address the problem of neonatal and perinatal mortality is through improving the health care the mother receives during and after pregnancy and during delivery.

The health interventions proposed during this period invariably help both the mother and the child; and almost all the health interventions are interrelated among themselves - because of this a "package" of services is much more effective than a single isolated strategy. For example, birth spacing permits the mother to recover between pregnancies, leading to increased birth weight of subsequent children, which leads to a decrease in neonatal and perinatal mortality and morbidity. This will decrease the fertility rate since studies in Rwanda show that death of an infant is one of the highest predictors of another pregnancy. This is undoubtedly partly conscious, a family may decide to "replace" the lost child with another one. But it is also physiological. Almost all Rwandan women breastfeed, the majority breastfeed exclusively for the first six months of a child's life. Exclusive breastfeeding is over 98 percent effective as a contraceptive method for the first six months post-partum. However, the leading reason that women stop exclusively breastfeeding before six months is that they "don't produce enough milk." While this is probably not true in an absolute sense, they do undoubtedly suffer a decrease in milk production due to the nutritional demands that breastfeeding places on the mother's body. The only way to adequately ensure that this doesn't occur is for the women to lay down fat stores before delivery. If they lay down adequate fat stores before delivery, they will have gained

substantial weight during pregnancy. Weight gain in pregnancy is strongly related to the child's birth weight, which is strongly related to increased child survival as discussed above relative to birth spacing. Taken as a whole, this all shows a complex, but nonetheless direct, relationship between maternal weight gain during pregnancy and the fertility rate.

These sorts of inter-relationships can be described at length for all of the CRHS interventions proposed in the RIM Project. The bottom line is that the CRHS package, delivered properly, will improve the health of Rwandan women, will improve the health of their children, will improve the health of their partners and will decrease the fertility rate in line with Mission goals as described in the CPSP.

#### **D.1.a Assessment of Existing Activities and Operations Research**

The RIM Project will support baseline and formative assessments in the two target regions during the first 12 months of project implementation. The purposes of these assessments are threefold: to provide a baseline regarding present levels of service utilization and reproductive health services quality and knowledge; to collect the information needed to prepare implementation strategies, approaches, and materials relevant to the real problems and constraints identified by the assessments; and, to identify priority problems to be addressed, define the specific interventions, and refine project inputs (e.g., equipment, materials, and other commodities) needed to assist in implementing the planned interventions.

The project will plan and conduct an assessment of quality of reproductive health care; plan and conduct related assessments of provider skills and practice (training needs assessment); plan and conduct knowledge, attitude and practice (KAP) surveys regarding reproductive health and health services in the communities served by the health centers; assess equipment and refurbishment needs of the health centers; and assess the management practices, management constraints, and management needs at the health center and regional levels.

##### **D.1.a.1 Assessment of Service Utilization and Quality of Reproductive Health Services**

The project will conduct an in-depth, systematic assessment of the quality of reproductive health care provided in the clinics of the two target regions. The assessment will be comprehensive, and include data collection on the following:

#### **Services Utilization**

Analysis of health center services statistics and census data to determine exact catchment areas and level of utilization by community

### Actual Service Delivery Practice

- Prenatal care
- Delivery care
- Postnatal care
- Follow up of postnatal care
- Integration of FP into other services
- STD services
- Integration of counseling and IEC into service provision
- Utilization of outreach for IEC or services

### Knowledge, Skills and Practice of Health Service Providers (Training Needs Assessment)

- Assessment of present practice and relevant skills
- Assessment of knowledge regarding services listed above
- Assessment of training skills of regional training teams and regional supervisors

### Knowledge, Skills and Practice of Target Communities regarding Reproductive Health Care and Health Centers

Small-scale surveys in selected communities to assess: KAP regarding importance of CRHS, nutrition and other health practices related to CRHS, and channels of communication regarding reproductive health

### Physical Inventory of Health Centers

- Availability of equipment and supplies needed to deliver CRHS
- Deficiencies in health center buildings
- Availability of drugs needed for CRHS

#### **D.1.a.2 Sexually Transmitted Diseases Program Operations Research and Technical Support**

The MOH does not yet have a well developed program to diagnose, treat and prevent sexually transmitted diseases (STDs). The RIM Project will use the management and IEC components of the project to institutionalize STD diagnosis, treatment and prevention activities in the project area. However, before that can be accomplished some work needs to be done to determine the appropriate standards and strategies for the project to use.

### Study of the Prevalence of Three Types of STD Antibodies in a Cross-section of Rwandans

To plan and evaluate a program to reduce the transmission of sexually transmitted disease it is important to know which persons have unprotected sex outside of mutually monogamous relationships. This is difficult to determine through survey research. The antibodies to

herpes simplex virus II, chancroid and syphilis all can be detected in blood serum, testing for the three disease antibodies using blood serum collected by the PNLS HIV sero-prevalence survey would give a good indication of the level of unprotected sexual activity in Rwanda.

The study would involve sending leftover (from HIV testing at the PNLS laboratory) serum to Antwerp and Atlanta for testing for the three disease antibodies.

### TRUST Comparison Test

The RIM Project proposes instituting regular screening of pregnant women for syphilis. WHO currently recommends using the rapid plasma reagin (RPR) test; this test is quick, simple, sensitive, specific and inexpensive. A variation of the RPR, the toluidine red unheated serum test (TRUST) has the advantages of the RPR test and the additional advantages of being cheaper, easier to read and using reagents that do not need to be refrigerated. Assuring a supply of refrigerated reagent to health centers is more difficult than assuring a supply of a reagent that does not need to be refrigerated. Although the TRUST test has been extensively used in the United States and Europe, it has never been field tested in Africa. The project will test the TRUST serum test for syphilis following the protocol in Annex K, Attachment B.

### Establishment of a Pilot STD Clinic

The RIM Project will institute a model STD diagnosis, treatment and control program in its project regions. While there is little question that such an approach should work and is not beyond the technical capabilities of current MOH employees, there are few models to work from in other countries in Africa. Therefore, during the first year of the project a pilot clinic will be established in the Kigali region to answer several operational research questions discussed in Annex K, Attachment C. Establishing the pilot clinic in the Kigali area will assure project oversight of pilot activities and facilitate the participation of a physician from the Kigali Hospital.

### The Nosology of STDs in Rwanda

Little is known about Rwandans understanding of STDs - how does one contract them, how does one prevent them, how does one cure them. One belief that was identified during project paper design was truly frightening, that men with HIV infection believe that they can be cured by sleeping with a virgin. The project will conduct a study of Rwandan beliefs and understanding of STDs, both rural and urban, following the guidelines in Annex K. Attachment D).

### STD Training

The project will provide short-term in-country training for MOH health workers in the project area. This will involve the development of an appropriate training curriculum

balancing the need for proper diagnosis and treatment with the level of skills and resources available to the MOH in the project area. It is anticipated that there will be two levels of training; selected Regional Team and Regional Training Team members, Health Center Directors and some central staff will receive a two week comprehensive course with a clinical practicum, the other health center workers will receive a one week course stressing prevention.

#### **D.1.b Improve the Delivery of Comprehensive Reproductive Health Care**

The institutionalization of comprehensive reproductive health service delivery, i.e., care for women of reproductive age throughout this period, whether pregnant, using family planning, or ill, is at the heart of the RIM Project. This will be pursued through the use of the Quality of Care report to identify and define priority interventions including related IEC, development of standards and protocols for their provision by health center staff, training, provision of needed equipment and supplies, and then supervision and monitoring of service delivery within the project area. Because RIM interventions and materials are intended to serve as future national models, monitoring of progress will be emphasized using criteria and benchmarks to be developed, implemented and refined for this purpose. (See Section D.9 on project monitoring for more details.)

This component will be implemented at the regional and health center level with the support of the RIM Project team, in close collaboration with the MCH Division of the MOH and the regional teams, and, where appropriate, with the regional training teams. The project will provide long- and short-term technical assistance, commodities such as clinical and office equipment, furniture, and materials needed for production and reproduction of manuals and clinic records, drugs and related supplies, materials for refurbishment, and local costs associated with preparations, such as per diem and travel for field trips and team meetings.

Specific activities required to institutionalize CRHS delivery are presented below.

##### **D.1.b.1 Institute Risk Assessment and Referral Criteria for Health Center Care Providers**

Perhaps the most important component of prenatal care is a referral system that ensures that women at high risk for a poor birth outcome (either maternal or neonatal) give birth under medical supervision, either at a health center or at a hospital depending on the nature of the risk. Worldwide, there is a large body of research that has identified risk factors for poor birth outcomes. Risk assessment systems are designed to identify a certain percentage of women as at risk. The project must design a risk tool that is sufficiently accurate at identifying women at risk (sensitivity) that at the same time does not overload the health system with women who end up having normal deliveries (specificity). Risk assessment criteria and systems already available from WHO, Rwanda, and other countries will be used as a base from which to start.

Once the criteria and system are defined, then an assessment tool (a checklist) will be designed; this tool will become the basis of the prenatal service delivery protocols, and then training and supervision, as described in the following sections. As part of system development, the regional team will work with each health center to determine the appropriate referral location and mechanism for transferring patients using whatever existing system is available and functioning (ambulance, taxi, shoulder stretchers, etc.).

#### **D.1.b.2 Development of Standardized Postnatal Care and Follow-up**

The project will assist in developing and institutionalizing a program of postnatal care in the project area. Postnatal visits are an important opportunity to assess the health of the mother and baby after birth, check on breast-feeding, and encourage the use of family planning for birth spacing. There are synergistic relations between child spacing, breast-feeding and maternal and infant nutritional status. Risk criteria to be applied, services to be provided for standard postnatal care, and timing of the postnatal visit will be defined. The project will also identify specific interventions regarding the mother's health (nutrition status, use of family planning, stress, etc.) which should be dealt with whenever the mother returns to the health center (whether for well-baby, illness, immunization).

Plans for how these services will be introduced in the health centers will also be prepared. The initial objectives will be relatively modest (EOPS are for 60 percent of women in the project area to have one visit), but the principle of keeping regular contact through the first year of the child's life will be maintained. This will permit the MCH system to continue to encourage breastfeeding and to work with mothers to introduce appropriate weaning foods in conjunction with well-baby visits.

#### **D.1.b.3 Develop Regional Guidance (Operational Protocols/SOPs) for the Delivery of Comprehensive Reproductive Health Care**

Working closely with relevant members of the regional teams, the RIM Project team (with some supplemental short-term technical assistance) will develop a set of standard operating procedures to guide the delivery and assure quality of CRHS. Existing guidelines now being implemented by the MOH and in other donor-supported projects will be reviewed and utilized as appropriate. It is anticipated that a draft of a standardized set of operational protocols will be developed and regionally implemented (tested) within the 24 months of project start up.

This guidance will contain checklists for the care providers to use in the delivery of preventive and curative care including relevant counseling and CRHS IEC messages. SOPs, for example, will cover such areas as the parameters of patient examination, client-provider comportment, identification of family planning information and counseling opportunities during CRHS contacts, application of prenatal risk assessment criteria, and risk assessment guidelines and monitoring procedures for delivery and postnatal care.

**D.1.b.4      Develop a Patient Record Form and a Mother Card**

At present only a few facilities keep patient records and these are non-standardized, individual-clinic efforts. In order to improve service delivery and patient tracking in health centers, patient record forms will be developed. The objective will be to establish a standardized form used by all health facilities in the RIM regions. RIM will endeavor to link the patient record forms to ONAPO family planning forms which at present have only a modicum of information beyond family planning data. Mother cards will also be developed to track prenatal and postnatal maternal status (this activity will be in conjunction with the UNICEF funded activity in the MCH Division). It is anticipated that improved record keeping will lead to better information on the general health of the populations served and clinic use, particularly by women at increased risk.

**D.1.b.5      Improve the Health Center Environment and Physical Facilities at 80 Regional Clinics**

Improved service delivery relies to some extent on the physical setting and availability of supplies and equipment. When existing conditions prevent the effective delivery of health care, the RIM Project will provide for the painting and minor repairs of physical structures and purchase of beds, mattresses, desks, furniture, and general supplies. RIM will not support construction or refurbishment which entails structural alteration of health care facilities. Annual plans for disbursement of funds for rehabilitation will be developed by the contractor in collaboration with Regional Teams and the RIM Project team and submitted as part of the annual plans. RIM will also provide funds for clinical equipment essential to the provision of quality CRHS in those clinics now lacking some or most of this equipment.

**D.1.b.6      Provide Specific Drugs Required to Efficiently Deliver Comprehensive Reproductive Health Care**

The RIM Project will provide an annual budget for supplemental drugs in project area clinics. The calculation of first annual requirements will be based on the Health Facility inventory component of the Quality of Care Assessment and will be updated annually by the RIM Project team in consultation with the Regional Teams. It is anticipated the majority of supplemental drug support will be dedicated to the treatment of STDs. However, other drugs (including vitamin and mineral supplements) required to effectively treat endemic diseases/nutrient deficiencies will be considered on an "as needed" basis. RIM, within its mandate for regional management and HIS strengthening component, will explore/facilitate the development of a standardized inventory system to monitor drug use and derive a system which articulates regional drug requirements based on consumption rather than quotas. Over the life of the project the USAID proportion of drugs and supplements will decrease and the proportion paid for by either the GOR or self-financing mechanisms will increase.

### **D.1.c Institute the Delivery of STD Prevention and Control Activities at the Health Center Level**

The RIM Project will support STD prevention and control through operations research and service delivery in the target regions. The project will implement three important activities:

- **Syphilis Screening** - expand screening to all antenatal and STD patients presenting at health centers; provide adequate supply of diagnostic materials; explore applicability of new diagnostics.
- **STD Case Management** - adopt Rwanda-specific treatment guidelines; implement case management protocols; standardize diagnostic protocols; strengthen STD (and HIV) surveillance (morbidity statistics); and, develop training and quality control regimens and IEC messages for health care providers.
- **Ophthalmia Neonatorum** - adopt application of preventive therapy (1 percent silver nitrate drops or 1 percent tetracycline ointment) for all newborns (this will be relatively easy for medically-assisted births, however, effective outreach beyond the health center will have to be explored).

The STD prevention and control activities will be pursued as part of the project's approach to CRHS delivery, and will emphasize the promotion of correct diagnosis, treatment and STD awareness building during pre- and postnatal care (and general health service delivery). STD case management will also include outreach to Rwandan men as part of clinical examination protocols whereby STD patients' contacts are requested to present for treatment, and provider IEC message delivery. HIV counseling and testing will not be included in RIM activities per se. However, HIV prevention and control messages will be incorporated in the provider STD training and these messages will be integrated into the general service delivery components of RIM. It is essential that STD activities are not pursued in a vertical manner, but rather as part of RIM's objective to deliver comprehensive reproductive health services. Prior to the implementation of any STD efforts, the MOH will identify and hire a Chief STD Coordinator within the PNLs.

### **D.1.d Increase the Knowledge/Understanding of the Importance of CRHS and Care (Information, Education, and Communication and Community Mobilization)**

MOH service statistics indicate that 80 percent of Rwandan women use prenatal services an average of two times. This may be misleading, as it appears that a few women near exceptional health centers or hospitals are seen four or more times, while most are seen only once, thus raising the average to near two visits. Fewer than 20 percent of women give birth under medical supervision and these women are not necessarily those at high risk of poor birth outcomes.

While the improved, integrated service delivery described above in Section D.1.b may lead to increased utilization of health service facilities, as demonstrated in studies elsewhere and in Rwanda in the greater utilization of partnership centers (in part from perceived higher quality of services), it is also recognized that the public and potential beneficiaries in particular must be informed about the services and their importance. Information, education, and communication (IEC) support and community mobilization are also critical to improving knowledge and practice of behaviors such as the importance of pre and post-natal care, early treatment of STDs and improved maternal nutrition practices.

RIM will support the development and implementation of a comprehensive IEC program aimed at increasing the knowledge and use of comprehensive reproductive health services, and adoption of improved reproductive health practices. Under the institutional contract, a long-term IEC advisor will work with key MOH counterparts drawn from the central level, and one-two individuals identified in each region. This IEC team will: utilize the formative research KAP studies conducted as part of the Quality of Care Assessment (D.1.a) and plan and conduct any complementary research needed for in-depth understanding of present knowledge, attitudes and practices, and appropriate communication channels and methods; prepare a CRHS IEC strategy and program plan; prepare for its implementation at the health center, community, and national level; and, monitor implementation and make appropriate adjustments.

#### **D.1.d.1 Formative Research for IEC Program Design**

The results of small-scale KAP surveys will be available from the Quality of Care Assessment conducted during the first year of the project. The IEC advisor and team will review the results and determine whether any additional information (quantitative or qualitative) is needed to prepare the IEC strategy and messages. As needed, the project will support this activity with technical assistance (long-term advisor and short-term TA) and related local costs for any complementary research.

#### **D.1.d.2 IEC Strategy Development/IEC Program Plan**

Once all the relevant data are collected, per Section D.1.d.1 above, the long-term IEC advisor and the RIM IEC team will convene a workshop for the preparation of an initial set of recommendations for the IEC strategy and plan. It is anticipated that the workshop will include participation of other key IEC experts in Rwanda (e.g., from ONAPO, MINAGRI), representatives from other MOH regions with similar project/regional activities, and representatives from selected health centers and community groups in the RIM regions. Following the workshop, the IEC team and IEC advisor would develop a more detailed strategy and plan, which would in turn be vetted with regional personnel, health center staff, and national level MOH personnel. A final version of the strategy and program plan should be approved within the first nine months of the project team's arrival by the relevant MEDIREASs, MOH/Kigali, and USAID/Rwanda.

Among the anticipated components of the IEC strategy are those described briefly below.

#### **D.1.d.3 Health Center Based Promotion Activities**

The overall capacity of the project health centers to inform, educate and communicate will be strengthened through more and improved IEC materials for clients, improved skills of clinic staff in leading group talks and discussions and individual counseling, activities associated with clinic-level (and national level) IEC campaigns, and, if deemed appropriate in selected health centers, testing of videos on related health topics.

#### **Develop, Produce and Distribute IEC Materials to Clients Attending Health Clinics**

The successful promotion of comprehensive reproductive health service delivery relies in part on the development and distribution of effective preventive and curative information. The RIM Project will assist in the development, testing, production and distribution of reproductive health IEC materials (e.g., posters, flip charts, body models) which can be used by health care providers to inform clients of health risks, preventive measures and effective treatment. The project will also help develop materials (e.g., leaflets, charts) which can be distributed to clients when visiting health care facilities. The RIM IEC coordinator will work with the RT, the MOH and the RTT to develop, test, and reproduce these materials and institute their application. The plan of action for pilot testing and production and distribution will be an integral component of the overall IEC strategy and work program.

#### **Train Health Care Providers in Delivery of IEC Messages**

IEC message delivery is viewed as an integral part of CRHS. Through CRHS curriculum development (see Section D.2.b), RIM will provide assistance for the development of one or more modules for training health center providers to strengthen IEC skills such as leading group discussions, how to present new concepts or information, counseling techniques, and use of visual aids and hand-out materials. The training modules will also address such critical areas as developing rapport with clients and ways to reduce barriers to communication.

#### **Clinic-based IEC Campaigns**

CRHS IEC campaigns will use the largest practical number of IEC interventions possible, including posters, group discussions (causeries), and handouts, as well as community networks. Up to three campaigns will be developed by the IEC resident advisor in collaboration with the regional team, the IEC division in Kigali and selected health center directors. The goal will be to develop a replicable activity that touches as many women as possible without demanding too much time from the already busy health center staff. Integration of services and messages is key to this concept. An immunization program outreach team can both give a short talk on CRHS to the assembled women and tack a few posters up along the route.

#### D.1.d.4 Commune-Based IEC Message Delivery

Linked to the training of health care providers to deliver IEC messages will be the development of commune-based IEC message delivery. RIM will build on the experience of ONAPO and the contraceptive social marketing scheme to identify effective means of getting messages to the rural communities, including village health workers (abakangurambaga) and traditional birth attendants (TBAs). RIM will have one or more models of effective, commune-based message delivery system established in the project areas by the PACD.

The project paper development has identified existing individuals in the community who might be formed into health center-supervised outreach networks. The most frequently mentioned are the abakangurambaga and TBAs. Both offer exciting possibilities of furthering the reach of the health centers and each provides unique advantages. The use of the family planning abakangurambaga extends the idea of integrating CRHS and FP to the furthest reaches of the system and ensures that the population will receive messages in an integrated fashion. The use of TBAs raises the possibility of moving beyond an IEC network to a network which could be used to deliver some services in the home.

The technical analyses done to date have not proven sufficient to evaluate the possibility of using either network. Both networks also have inherent potential drawbacks. The abakangurambaga were trained under the auspices of ONAPO and using them would entail an agreement between the MOH and ONAPO. Furthermore, there is no existing system of institutional support for the abakangurambaga sufficient to permit them to execute the added tasks this project would ask of them. Such a system would have to be created, once again in close collaboration with ONAPO. The use of TBAs poses different questions. While the Mission is relatively certain that the project areas contain a sufficient number of people identified as TBAs, and that many of these people have been trained and equipped over the years by UNICEF, the Mission remains uncertain about what they actually do, i.e., the current level of their intervention in the birthing process.

Therefore the project proposes that outreach networks be developed on an experimental basis with different models used in different health centers. The development and implementation of these models will be a very labor intensive activity involving the management and IEC resident advisors, short-term TA from an MCH specialist, the MOH MCH counterpart, the regional team and health center staff. They would plan and implement elements such as: IEC training for community workers, community-worker distribution of IEC materials, community "workshops" and active follow-up of mothers for pre- and postnatal visits. This plan will form part of the overall IEC strategy and work program. The labor intensive nature of the intervention suggests that a small number of health centers should be chosen for the initial experimental activities, perhaps two or three per region, and that they should be health centers that indicate an active interest in participating.

These models will be evaluated on criteria of cost, management burden to the health centers and effectiveness. RIM will then support in the expansion of the most cost-effective

community outreach models to the other areas of the regions or other project regions. Additional operations research may be conducted to assess various incentive packages and supervision approaches to maintain the performance and contribution of these volunteer workers. Benchmarks of achievement will be based on numbers of community workers trained, amount of information distributed, reproductive health knowledge of women, and number of women attending pre- and postnatal clinics. RIM will provide support for technical assistance, community worker training and IEC materials. By the PACD, each of the four project regions will have a health center-coordinated community outreach system which distributes and collects reproductive health information and which provides appropriate risk assessment and referral service.

RIM will explore and test the development of a regional training network to reach TBAs, extension workers and Abakangurambaga. Existing, commune-based options such as the Centre Communal de Development et Formation Populaire (CCDFP) may be the most appropriate forum to conduct initial training and follow-up (workshops, additional training, assessments). The long-term training advisor under the contractor will work closely with the IEC advisor and relevant counterpart groups, e.g., the RTT and the RIM IEC team, to prepare curricula, test them in the pilot areas, and train trainers for wider dissemination and training programs. In addition to technical assistance, RIM will also provide local cost support for the preparation and production of training materials and conduct of training sessions. It is anticipated that training will be held for 1-2 weeks, for 20-25 per group, for 10 groups during the project period.

#### **D.1.d.5 Nationally Based Promotion Campaign - Mass Media**

The potential effectiveness of mass media for the promulgation of reproductive health IEC is not yet known in Rwanda, but could be very relevant given experience in other countries. Therefore, RIM will support the assessment of the feasibility of using radio as a means to transfer information and promote service utilization during the first year of the project. The institutional contractor's IEC advisor with the assistance of short-term TA will conduct this assessment and propose possible areas for development. Assuming a positive response, it is anticipated that RIM will support the development and diffusion of approximately 10 radio spots and one "serial" or soap opera type of program. One problem to address will be how to target radio messages to the RIM Project area. The impact of radio messages will be assessed by specific surveys and/or linked to the KAP surveys.

## **D.2 The Improvement of Management Skills at the Regional and Health Center Levels of the Public Health System**

The RIM Project is designed not to be yet another donor-driven vertically structured program. Vertical programs meet the need of donors to show population based impacts related to specific projects, and they meet the desire of central health ministries for neat organizational divisions, but they have been proven to be both difficult and expensive to sustain. Therefore, the RIM Project has as a goal to implement CRHS interventions through the existing MOH regional and health center organizational structure.

The process of implementing the CRHS interventions will also allow the RIM Project Team to work closely with the Regional Teams and individual health centers' managers to increase the effectiveness and efficiency of regional and health center management systems. The benefits of this to Mission strategy are clear - not only will the delivery of CRHS be improved, both during and after the project, but the delivery of FP services to non-pregnant women outside of CRHS will also be improved. Improving the effectiveness and efficiency of health system management will be the most important contribution the RIM Project can make to the sustainability of both the CRHS and FP interventions integral to Mission strategy.

### **D.2.a Improve the Organizational and Management Skill at the Health Center Level**

Health centers are generally managed by nurses who have received no training in management. Most are assigned as health center directors straight out of school; they do not move up to the position based on experience within the health system. As a result, health center directors muddle through as best they can with no management training and no standardized management guidelines. In interviews many strongly expressed both the need and their desire for management training.

The management approach to be pursued under the RIM Project, for both health center and regional levels of management, is one of proactive problem solving. Emphasis will be placed on utilizing the data available from the HIS and supervision visits to identify problems and successes, and to transfer the learning from the successes to clinics and individuals facing specific problems. RIM will strongly encourage more efficient and effective use of resources available, but will provide the resources needed to support training, development of management tools and procedures, and to strengthen data management and use.

#### **D.2.a.1 Development of Standard Operating Procedures (SOPs) for Health Center Management**

Using the findings of the management assessment conducted soon after the arrival of the long-term technical assistance team, key team members with their counterparts will develop a Handbook of Standard Operating Procedures (SOPs) for health center management. The SOPs will be comprehensive, detailed and include instructions on how to do an activity. For

example, for the health information system (HIS), the project will develop a manual that will guide health center staff through the process of collecting information and data and reporting it correctly. It will contain a section on how to use the information for simple health center-level decision making (for example, graphically tracking certain disease incidence and relating the incidence to existing drug stocks). It will also guide health center staff on how to use the aggregated and comparative data that are returned monthly by the regional level in feedback reports. The section on patient flow would not prescribe one solution, but rather would describe a simple process for patient flow analysis by which the health center staff could determine how to better organize the passage of patients through services. By giving the process, instead of a canned solution, the SOPs can remain dynamic, and the health center able to adjust to changing environments.

#### **D.2.a.2 Health Center Level Management Training**

The management and the organizational skills at the health center level will also be improved through training. Health center directors of each RIM region will attend a week long training course on basic management skills and the SOPs described above. The first round of management training will be taught primarily by institutional contractor long-term and short-term advisors and senior MOH RIM staff. By the time refresher training is planned, two or three members of the Regional Training Team should be capable of teaching most course material. All health center providers will be taught basic management skills during the two week integrated reproductive health training course all will attend during the first years of project implementation. The project will have available four different management modules: initial management training for health center directors; refresher management training for directors (for subsequent years); initial management training as part of the first year two week integrated training course (service providers); and, refresher management training as part of the subsequent one week integrated training course (service providers).

#### **D.2.a.3 Improved Regional Support**

The improvements in the management of the health region that the RIM Project will implement (as described below) will also serve to improve management at the health center level. The regional inputs (supervision, training, planning, budget) will be more systematic and will be planned on a rational basis taking into account the needs and desires of the health centers. This will allow the health centers to become more proactive in their relationships with higher levels of the MOH. As a result of their training and with technical assistance from the long-term advisors and local MOH staff, health center staff will prepare annual work programs and budgets, which will be reviewed and revised or approved by the MEDIRESA and/or RIM Project staff. Once the plan and budget are approved, resources will be made available from the project through the regional office for health center-level activities.

## D.2.b Increase Regional Training Capacities

Part of RIM's agenda is to promote technical and management sustainability at the regional level. Given an acknowledged need to train the MOH staff in both technical and management skills, a large task lies ahead. Planning for training, curriculum development, conduct of training courses, and follow up will be guided by the RIM training team. The RIM training team will include: the long-term training advisor, a training specialist from the central level of the MOH, and selected members of the regional training team. One person in each region, one of the members of the regional training team who is also part of the Regional Team, will be a full-time RIM training coordinator in each region. For sessions on curriculum development the full team will work together; for other activities, the teams will work on a regional basis. RIM will rely on strengthening the Regional Training Teams so they may assume more of the training responsibility as the project progresses. Although this represents a dilemma in relation to the time RTT members may have to devote to training, the training capacity of the RTT and the RT is critical to the successful implementation and maintenance of RIM activities.

### D.2.b.1 Development of Regional Training Strategies and Programs

Using the training needs assessment data collected during the Quality of Care Assessment, the training advisor will assist the RIM training team to formulate a training plan which reflects mutual agreement of the RIM Project team, the Regional Team and the MOH/Kigali. The plan must be responsive to both the needs of the project to conduct considerable amounts of training, especially in the first years (see below), but also to the demands on the time and energies of the RTTs. It is anticipated the training plan will be developed within nine months of the institutional contractor's arrival.

Approximately 27 weeks of training will be required to enable health center and regional teams to implement RIM activities at an acceptable level of quality. An estimate of the number of person weeks of training and the number of participant trainees is presented below.

**Estimate of Person-Weeks of Training Per Region  
Required to Implement RIM Activities**

COURSE	TOTAL TRAINED	COURSE SIZE (AVG.)	COURSE LENGTH (WEEKS)	NO. OF COURSES	TOTAL WEEKS	TOTAL PERSON WEEKS
REGIONAL TEAM MANAGEMENT	8	8	1	2	2	16
TOT REGIONAL TRAINING TEAM	8	8	1	1	1	8

COURSE	TOTAL TRAINED	COURSE SIZE (AVG.)	COURSE LENGTH (WEEKS)	NO. OF COURSES	TOTAL WEEKS	TOTAL PERSON WEEKS
REGIONAL TEAM INTEGRATED CLINICAL TRAINING	8	8	1	2	2	16
MGMT TRAINING FOR H.C. DIRECTORS	25	12.5	1	2	2	25
INTENSIVE STD TRAINING	30	15	2	2	4	60
GENERAL STD TRAINING	50	12.5	1	4	4	50
INTEGRATED TRAINING FOR H.C. WORKERS	75	12.5	2	6	12	150
<b>TOTAL</b>	<b>184</b>	<b>N/A</b>	<b>N/A</b>	<b>19</b>	<b>27</b>	<b>325</b>

All training will have to be followed up by refresher training and/or skill upgrading, estimated to be 1 week/staff member/year.

**D.2.b.2 Develop Regionally Appropriate Training Curricula for Health Clinic Providers and Managers**

A high priority in the first annual training plan is the development of a "Reproductive Health" training curriculum aimed at health clinic care providers. The curriculum will be comprised of an integrated set of training aids, reference materials, practical guides (including clinic care SOPs) and IEC (handout) material. Existing curricula (from within and outside Rwanda) will be reviewed and new training components will be developed where appropriate. Levels of sophistication of the trainers and trainees and adult learning principles will be carefully considered when developing the training methodologies and preparing materials. Topics to be covered will be those relevant to addressing the priority problems and interventions defined from the Quality of Care Assessment and its related training needs assessment. Examples include: family planning, maternal/child nutrition, STD/HIV prevention and control, prenatal risk assessment, and postnatal examination and follow up. It is an objective of the project that all care providers in the project areas will receive integrated training by the PACD.

The integrated training curriculum will also contain modules on health center management. Examples of modules are: how to conduct a brief community based needs assessment; how to collect the information needed and to fill out the HIS forms; better time allocation; and, how to conduct a training needs assessment.

Initial training is estimated to be 14 days with 7 day follow-up training planned in subsequent years. A average of 5 weeks of integrated training will be made available to all health center staff over the LOP.

#### **D.2.b.3 Train Health Center Workers in Comprehensive Reproductive Health Service Delivery**

Training will be required at all levels of the health service delivery infrastructure in the project area. Approximately 220-275 MOH care providers will be trained (for 1500-2000 person-weeks of training) over the LOP. Two major courses are envisioned: 1) "Integrated Reproductive Health Training for Health Center Workers" (2 weeks) described in some detail above; 2) "Management/Supervision Training" (1 week)<sup>1</sup> as well as refresher training (see D. 5 a above). Regional Training Teams, initially developed by the Project Santé Familiale training will also be trained to assist in and eventually take over course instruction. Training will begin in year II of the project using standardized curricula throughout the project area. Frequency of updating training and/or technical follow-up will be articulated in the training plans. RIM will support the cost of external TA, local trainers, production of training materials, and per diems of trainers and participants.

#### **D.2.c Improve Regional Level Management**

As noted in the introduction to Section D.2 above, RIM emphasizes a proactive management approach, and will strengthen management skills of regional and health center managers and supervisors. In addition to the specific interventions identified in greater detail below, it is anticipated that on-going contact and direct technical assistance and support from the RIM contractor team will also have a beneficial impact on the management skills and performance of regional staff.

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<sup>1</sup>Intensive and Routine STD Prevention and Control courses will be developed and are discussed in Section D.7

#### D.2.c.1 Improve Regional Supervision of Health Centers

The current supervision structure of the MOH is somewhat contradictory. While the MOH has promulgated guidelines that advocate "integrated" supervision designed to save financial and human resources, many of the supervisory positions are associated with specific vertical programs and continue to be funded by a specific funding source. For example, EPI supervisors were a creation of ASCI-CCCD's EPI start-up and continue to be funded through UNICEF's support of the (vertical) EPI program. This sort of program development has led to regional teams in which the MEDIRESA supervises 6 or 7 people who are each associated with one particular function. Integration is implemented by sending teams of supervisors who, together, supervise all the activities in a health center. This serves the purpose of saving some financial resources in that only one trip is made instead of many, but does not save many human resources since most of the supervisors who would have gone out individually still all go out, albeit in a group.

##### Integrated Supervision

The RIM Project will train all members of the MEDIRESA's team to function as supervisors for all primary care interventions. This will enable only one or two supervisors to go to a health center to perform supervision of most of its functions, saving the region the per diem of the supervisors who now go but would not go under the new system. The supervision visits would be rotated among the MEDIRESA staff, but the supervision load, measured in person-days, to the overall team would be lessened by at least 50 percent, freeing the team members for other activities.

Supervision formats already used will be reviewed and revised, and, where appropriate strengthened to assure adequate assessment and follow up of CRHS and clinic management. For example, regional supervisors will monitor the records of women receiving prenatal care with the health center director to determine if the risk criteria are being used appropriately. The necessary skills will be taught during the Regional Team Management Training and the Regional Team Integrated Clinical Training and reinforced by the resident advisors through their contacts with the Regional Team.

##### Formative Supervision

The project's long-term contract advisors will provide training and on-going guidance to develop the style of supervision that has come to be known as formative. This involves a shift from the current approach, which is primarily critical, x was done, y was not, to a positive orientation where the supervisor uses the supervision visit to train and teach the health center staff concentrating on the problems identified during the supervision visit or prior to arrival through reports.

#### D.2.c.2 Strengthen the Health Information System at the Regional Level

The health information system (HIS) in Rwanda was established by the ASCI-CCCD project beginning in late 1987; by the end of the project, in 1988, the HIS had been completely planned and was half implemented. Funding for the rest of the implementation was picked up by UNICEF, and some assistance has been provided by the French Cooperation. The result is an HIS that functions about as well as any in Africa, but that has not been maintained and upgraded to reflect changes in service delivery or advances in computer hardware and software. The existing system collects only service-based epidemiological statistics. There is little evidence that anybody in the MOH uses the collected data for decision making. The primary use of the data seems to be by donors, either for project development or evaluations.

The system is now being redesigned so that each prefecture will be responsible for entering its own data (using a computer purchased for this purpose by the World Bank project) and sending feedback reports to each health center. The monthly data file will then be sent up to Kigali for national level aggregation.

In RIM Project regions, technical assistance will be provided to facilitate data entry, processing, and presentation of HIS data. Particular emphasis will be placed on analysis and interpretation of the data for use in decision-making at the regional level. Skills needed to accomplish these ends will be addressed in regional management training sessions and team meetings, where data will be used to identify and resolve problems, and identify centers which are particularly strong in certain areas. Regional level staff will use similar guides to those developed for clinic managers in how to use information for tracking disease incidence, and will use the data to compare and analyze the performance of clinics within the region.

#### D.2.c.3 Strengthen Fiscal Management Systems

The MOH operates two financial management systems, one serving the central level and the other serving the regions, both administered by the central ministry's Directorate for Administration and Finance (DAF). The regions are not involved in either the preparation of their annual budgets or in the disbursement of funds. The MEDIREASAs prepare their annual work plans and hope that there will be sufficient funds to meet all needs. Once funds are received, the MEDIRESA can spend funds as needed from whatever line item happens to have funds available. Each region has an accountant with varying levels of training in bookkeeping and accounting. However, bookkeeping practices are inadequate, no regions have financial management systems as such, and financial reports are close to useless.

The RIM Project's contractor will manage project local funds for the life of the project, but will, at the same time, provide long- and short-term technical assistance needed to develop a financial management system for the MOH with emphasis on the regional system, that will meet the needs of USAID, the MOH, and other donors. The development of this system will

be a high priority during the first 6 months after arrival of the contractor team and will require close collaboration of the DAF of the MOH, MEDIREASAs, regional accountants, and financial management staff of other donors.

Once the system is designed, the project will finance a 1-week training for all regional accountants, representatives from the DAF, and selected other staff as appropriate, in the implementation of the system. The project will also provide direct technical assistance to the accountants and MEDIREASAs in its implementation. Once the system is in place and operational, and is then certified by the USAID Controller as meeting USAID requirements, management of local cost disbursements may then be transferred to the MOH. However, the ultimate responsibility for the use of local funds will lie with the contractor and the determination of whether to transfer the accounting for the funds solely to the MOH will lie with the contractor. Complementary training courses/workshops in inventory control, vehicle management, etc. could also be developed and conducted as needed.

As part of management training, regional-level staff will gain skills in planning and budgeting for their activities. The financial management system will serve as a counterpart to this and reinforce principles of careful management of funds and encourage budgetary discipline.

#### D.2.c.4 Testing a Pre-Payment Scheme for MCH Activities.

There is a pressing need to develop incentives for women to seek out the MCH services that this project will enhance. In some of the areas where the project is operating, the project will experiment with a prepayment scheme to encourage women to make greater use of the ante and post natal services of the health centers. The contractor would need to undertake several preliminary analyses to design an approach which is consistent with current practices and known concerns; topics should include consumer willingness to pay and present payment patterns for health services (whether for modern or traditional); perceptions of desired maternal services and what makes for quality maternal care; cost and proposed price of the service package to be offered. The various pilot projects will be systematically evaluated on the basis of cost-effectiveness, the best model, or perhaps some combination of models, will be tried in other health centers (for more on assessment and evaluation see below, Section D.4.). The results will determine the feasibility of the plan and indicate the optimal price. It is anticipated that the package will be heavily subsidized by the MOH, but that it may be able to recover enough revenue to increase the quality and quantity of services delivered at no additional outlay by the MOH. Assuming no substantial change in MOH budgets, a fee that covered the increased cost of services would make the program sustainable over the long term.

### **D.3 Dissemination of Products and Results of RIM Project Activities**

The RIM Project concentrates its efforts in four regions because its goals are too ambitious to be realized on a nationwide basis within the six-year project period. Moreover, some proposed interventions, such as integration of STD treatment and prevention, and use of outreach networks are as yet untested in the Rwandan context. As noted earlier, the project will also prepare and test standardized treatment protocols and operating procedures, which, when documented and distributed, will have an impact well beyond the project-specific regions.

Early in project implementation, the RIM Project team, including the long-term contractor, the MOH coordinators, and the RTs will identify possible dissemination activities and incorporate these into annual work plans. Proposed activities include the following:

- Production and distribution of selected materials for national use. Once materials, such as pamphlets on danger signs during pregnancy, are developed, pre-tested, and tested for use in project health centers, they will be reproduced in large quantities for distribution in all MOH health centers. RIM will finance the production and will assist the MOH with arranging for widespread distribution.
- Quarterly meetings and annual seminars. MEDIREsAs from the RIM Project regions will give brief presentations during the quarterly MEDIREsA meetings to update others on project activities, problems, and accomplishments. At the national level, at least once each year, RIM Project staff will plan and conduct a 1-2 day seminar for Kigali and regional MOH staff to present findings relevant to other regions and activities and discuss issues and problems with implementation.
- RIM newsletter and related materials. RIM will support the costs of preparing and producing a quarterly newsletter to be distributed to all health centers in the country. Contents of the newsletter would include articles on RIM activities, summaries of reports/studies conducted under the project, and articles highlighting effective performance of health centers and/or staff, e.g., "health center of the month." Relevant materials in French from centrally funded MCH projects, such as "Mothers and Children" and "Safe Motherhood Newsletter" would be distributed along with the newsletter.
- In-country study tours. To supplement information disseminated by newsletter and during workshops, RIM will finance small teams (3-5 people) from other health regions to visit project regions and work closely with the RT and RTT and gain an understanding of project interventions and models in the field.
- Publications. It is anticipated that the findings from operations research studies and from analyses of data from the project monitoring system will have interest and utility beyond the context of Rwanda. Project staff, in collaboration with their Rwandan

counterparts, will publish articles in internationally recognized public health and development journals and newsletters. These publications and presentations have the further benefit of raising the profile of project activities and of the Rwandan health system in general and providing incentives for high levels of performance in project implementation.

#### **D.4 Monitoring and Evaluation**

The RIM Project will be continually monitored throughout the project period to assess the effectiveness of interventions on service delivery and utilization. The monitoring system will be composed of elements that exist already but operate less than optimally (the HIS) and elements that are introduced by the project (KAP studies, population-based impact studies). In all cases the goal is to arrive at a level of monitoring that is possible to sustain with existing MOH resources but that provides the information needed to make appropriate management decisions at both the regional and health center level.

The RIM IEC coordinator will be responsible for coordinating the TA which will be required to conduct initial, mid-term and end-of-term KAP studies. External TA will be required to design and conduct the surveys and analyze the findings. An important component of the KAP surveys will be monitoring the change from knowledge to behavior modification to action. RIM's success will be based on not only how Rwandans understand reproductive health, but how that knowledge is translated into action (i.e. service utilization). Thus, the KAP surveys should be designed to fully track action (practice) as well as understanding. KAP activities should be viewed as a significant component of the project's outcome monitoring system. Within 12 months of the IEC Coordinator's arrival, the initial and long-term KAP monitoring plan should be developed. The initial KAP studies will be relatively comprehensive, subsequent studies will be designed to be smaller and quicker and manageable at the health center level.

Evaluation of the project activities is vital to develop lessons learned for application to subsequent prefectures. The project will engage in an ongoing monitoring activity that will be able to compare activities that are being developed in different prefectures. This will be accomplished through a combination of population-based monitoring programs and regular reporting of activities in the MOH. It will be necessary to develop some population or community-based monitoring activities to appropriately judge the success of project interventions. If the program is successful in attracting high risk pregnancies, health center-based data may look as if MCH services have worsening outcomes when they are improving community services.

This same monitoring system will be used to assess and evaluate the performance of the various health center based pilot projects in pre-payment of services, outreach and promotion, home-based care etc. In all cases the evaluation will address issues of cost, management burden to health centers, sustainability and effectiveness and will attempt to

arrive at an evaluation/assessment structure that allows for the systematic comparison of different models.

The health center, and other participants in the MCH delivery system, would also keep records on the services provided for each woman. These records would include: types of services provided; condition of the woman, including risk factors and presence of STDs; and, outcomes of the pregnancy, including any morbidities and mortalities of the woman or child.

The project will assist the MOH to develop a semiautomated system of information analysis. This system will develop reports for health facilities of the quantity of services provided and the amount of resources being used by the facility. The MOH will be able to provide some measures of the cost of providing these resources as well. These reports will be returned to the health facilities on a regular basis to allow the facilities to continually revise their operations.

The project will experiment with methods of improving population-based information to increase the validity of periodic reports. The project will assist the MOH to develop the analytical capacity to provide these periodic reports. In addition, the MOH will receive assistance in the dissemination of these results both to health facilities and elsewhere.

### **III. COST ESTIMATE AND FINANCIAL PLAN**

#### **A. Cost Estimates**

The total cost of the Rwanda Integrated Maternal Child Health/Family Planning (RIM) Project will be \$17.982 million. This estimate cost is based on the assumption that \$13.150 million will be provided by A.I.D and \$4.832 million will be provided by the GOR. The total A.I.D and GOR contribution represents 73 percent and 27 percent respectively of total project costs.

Table 1 presents the project Illustrative Financial Plan. This is followed by Table 2 which describes the Planned Yearly Obligations and Expenditures. Table 3 indicates the summary Cost Estimates and Financial Plan. Tables 4 and 4.a show the Projection of Expenditures by Fiscal Year and Project Element. Table 5 indicates the Methods of Implementation and Financing for the Rwanda Integrated Maternal Child Health/Family Planning project. Annex E shows, in detail, a pro forma budget of the estimated project costs by each fiscal year. A weighted average of 10 percent was used as an estimate of the annual inflation rate for the local currency budget. A 7 percent annual inflation rate was estimated for goods and services procured in the United States.

An exchange rate of 125 Rwandan francs was used to estimate the U.S. Dollar equivalent for local currency costs. A contingency factor of 10 percent was used to cover unexpected changes in the estimated level of services and to reflect the fluctuation of the exchange rate

in Rwanda. This Cost Estimate and the Financial Plan reflect sufficient detail for project planning and current cost estimates. USAID 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 \$6 million will be made in FY 92 and subsequent obligations are planned for FY 95 (\$1.9 million), FY 96 (\$2.8 million) and FY 97 (\$2.45 million).

## **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 - \$6,328,484
  - a. Long-term Technical Assistance (\$4,564,647)

The project will hire four people in long-term technical assistance positions for a total of seventeen years of long-term technical assistance. These positions are: Chief of Party (5 years), Administrator (5 years), IEC/Training Expert (5 years) and an initial two-year Training Expert.

- b. Short-term Consultants (\$1,763,837)

The project will support approximately 54 months of short-term technical assistance over the life of the project.

2. TRAINING - \$1,398,493
  - a. Short term participants (\$900,726)

The project will fund approximately 10-15 short-term participants a year. This line item includes all travel outside of Rwanda, including: training; study-tours and participation in seminars and meetings.

- b. In country training (\$498,182)

These line items represent the local costs of in-country training per GOR guidelines. These include per diems, honoraria and travel costs.

**3. COMMODITIES - \$1,332,643**

The project will purchase eight vehicles, household furniture and appliances to support the long-term technical assistance team, office equipment, health center equipment and STD drugs.

**4. OTHER COSTS - \$3,445,381**

Other costs include office rental, house rental, and office and vehicle operating costs.

**5. EVALUATIONS & AUDITS - \$645,000**

The project has budgeted for an audit every year and for three evaluations, two mid-term and one final.

**6. GOR CONTRIBUTION-\$4,831,970**

The GOR contribution is comprised of two categories: salaries and supervision costs. The percentage of salaries attributed to the project varied between 40 and 50 percent (depending on the position). The base estimate for supervision costs was two-person teams doing quarterly supervision visits to each health center.

TABLE 1

ILLUSTRATIVE FINANCIAL PLAN (US\$ 000)

	A.I.D. Grant		Total Costs	GOR Life of Project	Total LOP Costs
	FY 92 Curr. Ob.	Future Years Anticipated			
Technical Assistance	2900	3,428	6,328		6,328
Training	500	898	1,398		1,398
Commodities	900	432	1,332		1,332
Other Costs	1,475	1,970	3,445		3,445
Evaluations and Audits	225	420	645		645
GOR Counterpart				4,832	4,832
<b>TOTALS</b>	<b>6,000</b>	<b>7,150</b>	<b>13,150</b>	<b>4,832</b>	<b>17,982</b>

TABLE 2

PLANNED YEARLY OBLIGATIONS & EXPENDITURES

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
LOP Funding							13,150
Planned Obligations	6,000		1,900	2,800	2,450		13,150
Planned Expenditures (Table 4)	884	2,717	2,192	2,136	2,377	2,844	13,150
Projected Mortgage (LOP Obligations)	7,150	7,150	5,250	2,450	0	0	
Mortgage/LOP	54%	54%	40%	19%	0%	0%	
Projected Pipeline	5,116	2,399	2,107	2,771	2,844	0	
Pipeline/Obligation	85%	40%	27%	26%	22%	0%	
Planned GOR Counterpart							
In-Kind	388	427	470	1,071	1,179	1,297	4,832
Cash Outlays							
Total GOR Counterpart	388	427	470	1,071	1,179	1,297	4,832

TABLE 3

Summary Cost Estimates and Financial Plan (US\$ 000)

PROJECT ELEMENTS	AID LC	AID EX	TOTAL AID	TOTAL GOR
1. Technical Assistance				
a. Long-Term	0	4,564	4,564	
b. Short-Term	77	1,687	1,764	
2. Training	498	900	1,398	
3. Commodities	367	966	1,333	
4. Other Costs	2,714	732	3,446	
5. Evaluations and Audits	0	645	645	
6. GOR Counterpart				4,832
TOTAL	3,656	9,494	13,150	4,832

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TABLE 4

Projection of Expenditures by Fiscal Year and Project Element

Project Element	Year 1			Year 2			Year 3			Year 4			Year 5			Year 6		
	LC	FX	Sub	LC	FX	Sub	LC	FX	Sub	LC	FX	Sub	LC	FX	Sub	LC	FX	Sub
Technical Assistance	77	317	394	0	1321	1321	0	1191	1191	0	993	993	0	1047	1047	0	1382	1382
Training	35	110	145	77	138	215	42	147	189	131	157	288	106	168	274	107	180	287
Commodities	25	185	210	83	452	535	33	51	84	61	80	141	79	95	174	86	103	189
Other Costs	67	24	91	456	141	597	477	121	598	518	135	653	568	148	716	628	163	791
Evaluations and Audits	0	45	45	0	50	50	0	130	130	0	60	60	0	165	165	0	195	195
<b>Total</b>	<b>204</b>	<b>681</b>	<b>885</b>	<b>616</b>	<b>2102</b>	<b>2718</b>	<b>552</b>	<b>1640</b>	<b>2192</b>	<b>710</b>	<b>1425</b>	<b>2135</b>	<b>753</b>	<b>1623</b>	<b>2376</b>	<b>821</b>	<b>2023</b>	<b>2844</b>

Project Element	Local Costs	Foreign Exchange
1. Technical Assistance	77	6,251
2. Training	498	900
3. Commodities	367	966
4. Other Costs	2,714	732
5. Evaluations and Audits	0	645
<b>Sub-Total</b>	<b>3,656</b>	<b>9,494</b>
<b>GOR Counterpart</b>	<b>4,832</b>	
<b>Grand Total</b>	<b>8,487</b>	<b>9,494</b>

of

TABLE 5

Methods of Implementation and Financing - A.I.D. Inputs (US\$ 000)

Type of Assistance	Method of Implementation	Method of Financing	Total Costs
1. Technical Assistance	PIO/T	Direct Payment	6,328
	Direct A.I.D. Contracts	Reimbursement	
2. Training	Unfunded PIO/Ps (IC)	Direct Payment	1,398
	PIO/Ts/PASA	Reimbursement	
	Direct A.I.D. Contracts		
3. Commodities	Institutional Contract (IC)	Letter of Commitment	1,333
	Direct A.I.D. Contracts	Direct Payment Reimbursement	
4. Other Costs	Institutional Contract (IC)	Direct Payment	3,446
	Direct A.I.D. Contracts	Reimbursement	
5. Evaluations/Audits	PIO/Ts	Direct Payment	645
	Direct A.I.D. Contracts	Reimbursement	
Total USAID Financing (including inflation and contingency)			13,150

#### IV. PROJECT MANAGEMENT AND ADMINISTRATION

##### A. USAID/Rwanda Project Management

###### A.1 Project Committee

The RIM Project will be overseen by a Mission Project Committee. The Committee will be composed of the HPO Office Chief, the Project Manager, the PDO, and representatives of the Executive Office, the Program Office, the Controller's Office and the Project Support Unit. The Project Committee will meet a minimum of twice a year in conjunction with the PIR. It will also need to address any substantive changes needed in the project (Project Paper amendments, ProAg Amendments, etc.).

###### A.2 Health Population Officer

The primary responsibility for project management and implementation will rest with the Health and Population Office of USAID/Rwanda. The HPO Office Chief will be responsible for providing guidance on Agency and Mission programming and policy priorities to the USAID project manager, the MOH and the institutional contractor. Thus, s/he will be responsible for the general oversight of project activities. The HPO will review annual work plans and be available to discuss RIM Project directions with project implementation staff. S/he will maintain liaison with AID/W and REDSO and ensure that the project follows

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directions provided by project documentation and the Mission CPSP. S/he will oversee any redesign requirements.

### **A.3 Project Manager**

The project manager (PM) will be responsible for routine management of the RIM Project. S/he will be directly supervised by the HPO and will:

- maintain liaison with the regional MEDIREsAs, the MOH/Kigali (and other relevant GOR Ministries) and the institutional contractor;
- coordinate the implementation of RIM with the COP for the institutional contractor (technical quality, timely development of annual plans, design of applied research, organization of project monitoring, liaison with regional officers, general operations planning for the project, measurement of project achievements, etc.);
- review work plans and provide objective commentary on their quality for the HPO and the Mission Director;
- maintain technical and administrative links with technical officers in AID and other Federal Agencies--in particular the CDC. The PM will be the responsible officer for administration of project activities and in performing those responsibilities will necessarily liaise with USAID's Projects Development Office, Program Office, Controller, EXO, REDSO/PH, REDSO/CMO, REDSO/RLA, REDSO/RCO, RD/H, RD/POP and the CDC.

The PM will cultivate a "vision" for the project in collaboration with the MOH and the institutional contractor. S/he will be directly involved with the development of the annual implementation plans and semi-annual assessment reviews. The PM will be responsible for routine preparation/approval and presentation of RIM Project implementation activities including preparation of PIO/Ts, PILs and PIRs. S/he will provide concise monthly memoranda to the HPO and Director which describe project progress and shortfalls in order to keep the HPO well versed on project activities. S/he will coordinate all TA requests with the institutional contractor and be directly responsible for TA accessed through the first year bridge activity. All TDY visits of technical experts will be discussed with and approved by the HPO prior to their finalization.

The PM will also be responsible for accessing RD bureau resources when appropriate. S/he will prepare buy-in documentation for all evaluations and ad hoc TA, including centrally-funded TA, when deemed appropriate. S/he will be responsible for developing the final position descriptions for the PCV regional assistants and will provide technical supervision, guidance and support--in collaboration with U.S. Peace Corps/Rwanda--to those individuals during their tenure in the field.

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The PM will coordinate annual project assessments during the first two years of the project to "take stock" of progress and identify problems. S/he will help develop the procurement plan with the EXO/Project Support Unit (PSU) prior to the contractor's arrival. The PM will facilitate the relationship between the contractor and the EXO/PSU, as appropriate. The PM will not be responsible for direct procurement in any way but will be responsible for ensuring proper bureaucratic detail has been followed and for monitoring the procurement process.

During the first two years of the project the PM position will be filled by a CDC Technical Advisor for AIDS and Child Survival (TAACS). This mechanism has been deemed the most efficient since the TAACS Officer has played an instrumental role in project development since the PID stage. Funding is derived from outside the project and assured through approximately May, 1994.

#### **A.4 Project Management Assistant (Foreign Service National)**

The Project Management Assistant shall perform a variety of complex research, reporting, contract, monitoring and analytical duties in support of the implementation of the RIM Project. S/he shall assist the Project Manager in the development, day-to-day management and monitoring and evaluation of the project. S/he will assist the PM with tracking procurement, monitoring data collection, preparing PIOs, PILs and PIRs and writing letters, memoranda and waivers. S/he will serve as PM in the absence of the PM.

The prospective candidate will be hired under a contract with the Mission (OE funded) and shall have either a nursing degree or a university degree in a discipline appropriate to health and population. An individual with management experience, as well as experience with the MOH, is essential.

As this individual will have public health experience in Rwanda, it is envisioned that s/he will facilitate USAID communications with the MOH and play a major role in establishing relationships with host country ministries and agencies.

#### **A.5 USAID Procured Technical Assistance**

The Mission will sign a PASA with the Centers for Disease Control, International Health Program Office (CDC/IHPO) to provide services over the life of the project. During the first year of the project, before the institutional contractor arrives, the CDC will provide the bulk of outside technical assistance and will procure most of the supplies needed by the project for the bridging activities. After the contractor team arrives, CDC technical assistance will mainly concentrate on STDs. The CDC has a unique capacity and experience in STD research and programs in Africa that it is unlikely to be matched by the IC.

The Mission will also buy-in to the R&D/Health centrally-funded cooperative agreement on breastfeeding. Analysis for the project paper has shown maternal and child nutrition to be a

critical and neglected problem in the Rwandan health system. Breastfeeding and weaning activities will be an integral part of the pre and postnatal care offered by the RIM Project, not only due to the impact on child survival but also because of the need to reinforce and protect the natural contraceptive benefits of lactational amenorrhea. Breastfeeding and weaning assessments require particular skills not readily available either in Rwanda, through an institutional contract, or through the CDC.

## **B. Institutional Contractor**

### **B.1 Overview**

RIM will provide support for an institutional contractor (IC) who will be responsible for the implementation of RIM activities commencing approximately one year into the project. The contractor will be identified by a competitive bid process. The RFP will be developed by USAID/Rwanda in conjunction with REDSO/ESA/RCO. A Mission Review Committee will be established by the Project Development Officer who will serve as chair. Members of the review committee will include GOR representatives, HPO staff, EXO, Controller's Office, and the Program Office.

The contractor will provide seventeen (17) years of technical assistance: three resident advisors for a five-year period and one for a two year period. The IC team will consist of a Chief of Party, an Administrator, and a Training/IEC Expert for five years each and a Training Expert for the first two years of the project. An office will be established in Kigali with up to eight clerical and other support staff (a secretary, a receptionist, an accountant, chauffeurs and a laborer). The contractor will be responsible for routine project implementation and will directly liaise with counterparts at the GOR/MOH. It will be the contractor's responsibility to maintain cohesion among the various project activities, namely integrated service delivery, management and supervision, IEC, and STD control. This will involve close coordination with the USAID Project Manager, MEDIRESA units, the MOH/Kigali, ONAPO, the Peace Corps, the CDC, subcontractors (if any), and local PVOs/NGOs. Perhaps most importantly, the institutional contractor, through the COP, will help develop a "shared vision" for RIM with the HPO. Project Manager, and MOH/MEDIRESA's. This will be achieved within the first six months of the resident team's arrival and be manifested in the preparation of an initial life-of-project work plan to be followed by annual joint implementation plans.

### **B.2 Life of Project Workplans**

Within three months of arrival in Rwanda the IC will produce a first draft life-of-project work plan that will describe in detail the planned project activities for the five remaining years of the project and how the IC plans to achieve the defined outputs of the project. The IC will produce a final draft of the life-of-project work plan within six months of the team's

arrival in country (submitted jointly with the first annual joint implementation plan - see below).

### **B.3 Joint Annual Implementation Plans**

Within six months of the team's arrival in country, the first joint annual implementation plan will be developed (the timing used in the implementation plan is illustrative, annual plans will be submitted yearly beginning one year after the first plan is submitted). This initial plan may be formulated, in part at least, during a contractor TA visit prior to the arrival of the resident team. Annual implementation plans will be based on annual reports (see B.8 below) and submitted to the Mission and GOR for review no more than 60 days after the annual report. The COP will be the responsible officer for the development of these plans. The plans must be approved by both the MOH and USAID. (As noted below, quarterly reviews by the Coordination Committee will serve as an opportunity to "fine tune" implementation activities as required.)

### **B.4 Training Plans**

The IEC coordinator(s) will prepare annual training plans which will be incorporated into the joint annual implementation plans. The plans should be in concert with the management and service delivery objectives of the annual plan. The training plan will be reviewed semi-annually as part of the quarterly review process. There is no long-term training envisioned in the project.

### **B.5 Operations Research (OR)**

The first joint implementation plan should articulate OR requirements for the LOP which will be incorporated in the LOP plan. These might include KAP surveys and follow-up, STD monitoring, training evaluation, etc. It will be the contractor's responsibility to design and implement the OR deemed appropriate. OR design and outputs will be reviewed and approved by the PM prior to their implementation. The COP will be responsible for managing OR activities throughout the project period. The contractor will necessarily work with the CDC on the STD OR efforts (however, CDC will be technically and operationally responsible for the STD OR related to the interventions described in the PASA). Also, any OR which might be conducted in concert with the MCH/FP II project or other donors, or through RD bureau buy-in activities or centrally funded projects, should be coordinated to the greatest extent possible to avoid redundancy.

## **B.6 Short-term Technical Assistance**

Technical assistance will be coordinated through the COP with concurrence by the PM. The HPO will also approve all incoming TA via cable. It is estimated that 120 person-weeks of short-term TA will be supplied by the contractor during Phases I and II of the project. An additional 60 person-weeks of TA will be provided by PASAs as well as buy-ins and centrally-funded mechanisms set up with RD/H and RD/POP. Identical to the OR coordination (B.5), the COP and the PM will coordinate all contractor-based TA with other TA in order to avoid redundancy. The TA that is supplied through PASAs and buy-ins will always have a clearly defined scope of work that will define a product produced in concertation with the GOR - a set of treatment protocols, a specific training curriculum, etc. These "pieces" of work will bear the same relationship to the contractor's responsibility for the project's outputs that other MOH inputs will. It is anticipated that a broad array of TA skills will be required which include, but are not limited to expertise in: clinical medicine, training, behavioral research, program management, IEC, epidemiology, STD/HIV prevention, MCH, nutrition, logistics, procurement, tropical public health, data analysis, HIS, MIS, etc. The COP will provide Mission management with a "Contractor Evaluation Form" at the conclusion of each TDY. This form will provide a checklist for consultant performance and will be filled out by the PM and approved by the HPO. A separate form will be prepared for each short-term consultant. The completed forms will be discussed with the COP upon completion and filed at the Mission with other project documents.

## **B.7 Commodity Procurement**

Initial procurement will be done by the Mission's expanding PSU, which is supervised by EXO. This will include initial equipment and supply purchases as well as household effects and vehicles that will be required to be in-country prior to the resident team's arrival. After signing the contract, the contractor will be responsible for all remaining procurement for the LOP. All commodities will be procured according to USAID regulations and codes and in concordance with the terms of the project paper and project agreement. Most importantly, the contractor will be responsible for procurement of appropriate commodities on a timely and efficient basis. The procurement of all commodities will be approved on a semi-annual basis by the PM in collaboration with the HPO. This approval will be based on the submission of a procurement plan which will be part of the annual joint implementation plan.

## **B.8 Administrative Support to Institutional Contractor**

The IC will be supported by the PSU for the myriad of day-to-day maintenance support for households, location of housing prior to IC team arrival (including renovations), importation clearances and exonerations for personal and project goods, temporary warehousing, distribution to sites, etc. This will be funded directly by the Mission through a buy-in to the

PSU. Additionally, the PSU will have the capacity to arrange for financial audits, spot-checks and commodity end-use checks.

## **B.9 Financial Management**

The contractor will be ultimately responsible for the fiscal planning and financial management of the RIM Project throughout the LOP including the disbursement of local funds. USAID will not issue Project Implementation Letters to disburse local funds. All accounts and procedures will be in concert with Agency guidance as described in the RFP and project agreement. The IC's administrative procedures will be detailed in an operations manual that must be approved by USAID within six months of the IC team arriving in country. The resident Administrative Officer (AO) will prepare annual budgets, and set up computerized accounting, payroll, and general expenditure tracking for the project. S/he will also develop a system to track activities and expenditures at the regional level. The administrator will hire and supervise a Rwandan accountant and train him/her in program tracking and fiscal reporting. The AO will prepare quarterly budget reports with tables and figures to clearly illustrate proportionate expenditures quarterly and cumulatively. The administrator will work closely with the PM and the HPO, as well as with the financial management and accounting branch of the PSU, to prepare reporting statements which are most useful to the Mission in relation to project reporting and impact monitoring requirements. S/he will pay particular attention to the regional management component of the project and assist in the development of training courses and follow-up. Perhaps the most important function and impact of the AO will be to institute sound fiscal planning and management at the regional level in conjunction with the COP.

## **B.10 Audits**

The RIM Project will be audited six times by outside auditors contracted by the Mission and once by REDSO/ESA/RIG during the life of the project. The first audit will occur during the transition between the bridging activities and the IC beginning work, this will ensure that the IC starts with a clean financial record. Audits will then occur every year to ensure continued adherence to A.I.D. accounting standards. The project close-out audit will be done by REDSO/ESA/RIG.

## **B.11 Reporting**

**Joint Annual Implementation Plans - As per B.2, above.**

**Quarterly Reviews - As part of the annual implementation plans, the contractor will provide quarterly reviews to the Mission and GOR (HPO, MOH). These reviews will be verbal with a follow-up report in English and in French to the HPO. The structure and form of these**

reports will be determined by the HPO to meet the HPO's need to write biannual PIRs. Three copies of the report will be submitted to the HPO. The purpose of the quarterly reviews will be to assess progress, identify problems/shortfalls and derive solutions and approve actions for the next quarter.

**Project Implementation Reports** - PIRs will be the responsibility of the PM; however, the contractor will provide him with pertinent information and data required to present project progress. The quarterly review memoranda described above will be structured in a way to feed directly into the PIRs. It will be the PM's responsibility to explain the PIR process to the contractor and derive the elements of the PIR package required in a timely fashion.

**Annual Reports** - Annual reports will be submitted to the HPO 30 days prior to the completion of each implementation year (five copies in English and three in French). The report will address project benchmarks and note achievements, shortcomings and outstanding actions as established in the LOP and annual workplans. The annual report will be based on the contents of the quarterly reviews, PIRs and annual implementation plan. The contractor will work with the PM early in the project to determine the format and content of the annual report. The report will serve to identify issues which should be considered in the subsequent year's implementation plan.

### **C. GOR Coordination**

The MOH/GOR will be the recipient government institution of RIM Project support. The MOH will designate a RIM Project management team which will coordinate RIM activities from Kigali. The MOH will also delegate authority for RIM activities to the Regional Medical Directors (MEDIREASs) in the regions where RIM activities are implemented. The MOH project management team will be composed of the following positions:

**MOH Project Manager (MPM).** The MOH MPM will serve as the responsible counterpart to the COP for both technical and administrative duties. S/he will work with the COP to ensure that project goals and objectives are met and provide guidance and expertise on GOR policy and programs as well as cultural considerations. S/he will devote approximately 50 percent time to RIM activities, thus s/he will have a fully equipped office at the RIM Project office.

**Two (2) Project Coordinators.** These Project Staff will devote at least 50 percent of their time to RIM activities and share their expertise with the rest of the contract team. It is envisioned that one project coordinator will work with the Training/IEC Experts. They will also provide assistance to the AO when required. They will have offices at the RIM Project office.

**Regional Medical Support.** MEDIREASs will also serve as co-counterparts to the COP for implementation in the field. In the design phase, these individuals are seen as the keys to success or failure in the RIM Project. They are the GOR's regional

representatives on technical and administrative matters in health policy and programming. They are a vital link in the project and much effort will go into ensuring that these individuals work closely with RIM Project staff.

**STD Prevention and Control Chief.** The MOH will identify a Chief for the STD Prevention and Control Unit who will sit in the PNLs headquarters.

As a condition precedent to moving forward with the RIM Project both the MOH Project Manager and the STD Chief will be identified and assigned before money can be disbursed. The MOH will assist the COP and the PSU in the procurement of commodities required for RIM implementation as appropriate. Clearance at customs and transport of goods to the Kigali RIM office and the regions are of particular importance. The GOR will insure that routine supplies are maintained in the regions where RIM activities are implemented. Approval for training and participation in operations research will be facilitated by the MOH/Kigali and the MEDIREASAs.

Monthly project implementation meetings will be instituted by the MOH Project Manager and include regional authorities, the RIM Project management team (MOH, IC team members, USAID project staff), and others as appropriate. The MPM will be responsible for drafting the agenda in cooperation with the COP and the PM.

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

1. A Coordination Committee (CC), composed of representatives of the MOH, USAID, ONAPO, and others as deemed necessary. This group will meet quarterly to review project progress and adherence to EOPS and annual work plans as well as to identify and resolve problems and discuss future calendar of events. The IC will present the Quarterly Reviews, mentioned above at these meetings.
2. RIM Workshops will be held twice per year to present results achieved to date, discuss problems and progress, and disseminate information to Rwandan colleagues working in public health outside the RIM mandate. This mechanism is seen as a chance for the regional teams to discuss the situation from their perspective, brainstorm with their colleagues outside the reaches of RIM and formulate directions for the future. It is also a chance for the rest of the public health community to comment, critique and learn from those in the RIM regions. The Coordination Committee representatives will attend bi-annual RIM workshops.

The MOH will authorize external audits and evaluations of RIM implementation as required by A.I.D. regulations and the ProAg. The logistic capacity of the MOH may also be assessed during the initial phase of RIM and it is expected that the MOH will also facilitate this exercise.

In summary, the MOH at Kigali and in the regions will commit time, personnel and resources to the effective implementation of RIM. It is anticipated that over the project period, new methods of cost recovery will be tested, more efficient ways to deliver reproductive health care will be discovered as well as more effective STD protocols and standards. Genuine commitment to the concept and implementation of comprehensive service delivery and management is expected. At PACD, it is expected that the MOH will want to expand CRHS to other regions.

#### **D. The United States Peace Corps Regional Assistants (RA)**

As a way to bolster the human resources at the regional level and as well further integrate the Peace Corps into the Rwandan health program, the project plans to utilize the services of Peace Corps Volunteers, one per region, two for phase 2 and four for phase 3, to work directly with the MOH regional teams. They will report directly to the MEDIRESA and will provide a variety of technical and organizational assistance to the regional staffs. It is envisioned that these individuals will work primarily in the areas of improving administrative/organizational skills, providing the MEDIRESA, his/her staff, and the regional training team with a better, more efficient way to get the job done with existing staffing levels. Logical areas of assistance in the administrative domains would be in the areas of computer training, financial accounting, workload scheduling/planning, etc. Once the project plan is activated, it would be logical that the RA would be able to find one particular area where s/he, the MEDIRESA and the IC saw a need to reinforce. Thus, the IC COP, the MEDIRESA, the PM and Peace Corps senior staff will negotiate a more formal scope of work when the prospective RA's curriculum vitae is received. It will be adjusted after the first month that the PCV is at site.

The RAs will possess a B.A. and have some management experience. Ideally, they would have an M.P.H., though that may not be possible to ensure through the Peace Corps selection process. Knowledge of computer software, Lotus 123 2.2, WP 5.1 and a graphics program is a requirement.

These individuals will live in the regional capitals and will report directly to the MEDIRESAs. S/he will look to the IC team, in particular the COP, for guidance and direction. Peace Corps hierarchy and reporting channels will be respected so it is essential that the Peace Corps senior staff become familiar with the project, its players and project goals and objectives. The candidates will receive French and cultural training prior to going to site as well as extensive briefing by the PM. The PM will take the staff members on a

one-week tour of the country, explaining the health care system and its nuances and answering the many questions that no doubt will be posed.

Maturity and integrity and a willingness to "make things work better" are essential elements of the RA's profile.

#### **E. Contracting and Procurement Procedures**

As noted above, contracting and procurement will be the responsibility of the institutional contractor. Contracting will be done in accord with applicable United States Government regulations. Within that contract, the IC will be responsible for all contracting actions. Procurement will be the responsibility of the IC after the contract is signed. Initial procurement will be done by the PSU or EXO. Additional short-term TA will be accessed via buy-ins to the RD bureau for breastfeeding activities and through a PASA with the CDC. The PM will coordinate the access of this additional TA. Additional contracting for audits and evaluations will be conducted by the Mission. Throughout all contracting and procurement actions, Mission oversight will be required. REDSO/RCO and REDSO/CMO will be involved as required to respectively review and assess contracting and commodity procurement procedures and actions.

#### **F. Monitoring and Evaluation**

**Monitoring and Evaluation:** The Grantee, Institutional Contractor (IC), and A.I.D. will monitor project implementation through the following monitoring and evaluation mechanisms:

1. **Progress Reviews of Health Clinics:** The IC team, MOH central staff delegates and health clinic staff will meet on a quarterly basis to review the progress of achieving annual workplan targets by the clinics in the project areas. These reports will list the activities accomplished during the reporting period, identify problems and recommend solutions, noting which have fallen behind their scheduled accomplishment date in the Project Paper Implementation Plan and/or the Annual Workplan and why. The results of the quarterly review meetings will be submitted to USAID in writing, to serve as the basis for the USAID quarterly Project Implementation Reports.
2. **Annual Contractor Report and Workplans:** Each year, annual workplans, including budgets, based on the evaluation of achievements of the year, will be prepared by each health clinic with assistance from the IC team, and submitted no later than November 1st to USAID for review and approval. The November 1st submission date will ensure sufficient time for USAID to review and return for modification, if needed, and approve prior to December 31 of

that year. This will allow for a continuation of funding without a break, as USAID will not approve retroactive payments.

3. PIRs: USAID will produce PIR reports for submission to AID/W based on the quarterly reports on the health clinics' activities. These semi-annual reports will list the activities accomplished during the reporting period, identify problems and recommend solutions.
4. Field Trip Reports: The field trip reports will also provide information for the PIRs.
4. Mid-term Evaluation: Approximately 18 months after the arrival of the IC team in Rwanda, 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.
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 assistance be justified, this evaluation will assist in defining priority areas for any 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. Commercial audits will be conducted each year of the project to ensure project compliance with USAID accounting requirements.

#### **G. Indicators of Performance:**

Crucial to the effective and cost efficient design and implementation of any development program is the donor's, as well as the recipient country's, abilities to assess the impact of various project activities. The RIM 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 to determine the level of further assistance to Rwanda should this be required and desirable.

The contractor's LOP plan and annual workplans will identify the indicators by which the project will be judged annually leading to the LOP targets identified in the logframe.

## **H. Training**

Training programs will be developed in accordance with the priorities outlined in this PP and will be specified in annual workplans. In the cases of third country training or study tours, participant selection will be approved by USAID and the GOR. The IC will make all necessary administrative and travel arrangements as well as paying for tuition, stipends, etc. The IC will monitor and report on the performance of trainees. In the case of third country or U.S. study tours, the IC will select institutions most appropriate to the needs of the project in collaboration with the USAID Training Office. All training and study tours will be included in annual workplans.

## **I. Audit and Financial Reviews**

The federal and non-federal audits planned for RIM will examine the financial management procedures and records of the MOH, the health clinics and USAID. The audits 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 USAID/Controller will have the responsibility of drafting necessary scopes of work and coordinating audits with pertinent organizations (RIG/N, REDSO, private firms).

## **J. Procurement Plan**

### **J.1 Technical Assistance**

#### **J.1.a Institutional Contractor (IC)**

The REDSO/ESA Regional Contracting Officer (RCO) will contract a U.S. based firm or institution to provide 17 person years of long-term technical assistance and 120 person weeks of short-term consultants to implement the RIM Project. The contractor must have demonstrated a strong track record in managing USAID child survival, health or population programs, have appropriate managerial and technical expertise and have procurement capabilities. As the contractor will be providing technical assistance and commodity procurement services, it will be allowed to charge overhead only on the technical assistance services portion. The procurement of goods will be based on a firm fixed fee which will be proposed as a separate line item.

The requirement will be advertised in the Commerce Business Daily and the proposals received will be reviewed by the Mission Technical Review Committee and the RCO. The RCO will issue the Request for Proposals (RFP) with assistance from the RLA and the Regional Health, Nutrition and Population Officer. The RCO will negotiate and award a contract to the most technically qualified offeror.

It has been determined that there are not at least three Gray Amendment entities with the required expertise amongst which this requirement could be competed. Therefore, the procurement will follow full and open competitive procedures. Notwithstanding, the offerors will be encouraged to use Gray amendments entities to the maximum extent possible.

When Needed: August 1, 1993  
Procurement Time: 9-12 months

### **J.1.b Personal Services Contractor**

The USAID/Rwanda Executive Office will award a third-country national or a cooperating-country national a project-funded personal services contract for a period of one year. The PSC will work under the supervision of the Project Manager and will assist in the management and implementation of the first year bridge activities. The job would require a mix of clinical, management and research skills. The Executive Officer will negotiate and award the contract to the most technically qualified individual.

When Needed: October 1, 1992  
Procurement Time: 2-3 months

### **J.1.c Buy-Ins/Add-Ons**

The IC will provide the large majority of technical services required to complete the project. However, two institutions will be contracted to provide technical assistance other than that of the IC.

#### **J.1.c.1 Centers for Disease Control (CDC)**

The Mission will reach agreement with the Centers for Disease Control to provide 93 person-weeks of technical assistance over the life of project. CDC worked in Rwanda as the implementer of the ASCI-CCCD project from 1981-1988. The existing supervision system and the current health information system were established by CDC. Through existing relationships with the MOH they have the ability to come into the country and start working quickly without laying the groundwork that a new contractor would need to establish to get started.

CDC will be the main provider of TA for the first year bridge activities, providing a total of 48 person-weeks of technical assistance. Technical assistance will be in the areas of sexually transmitted diseases, health information systems, quality of care, research design and maternal and child health. CDC will also be responsible for establishing the RIM Project Office for the first year of the project and for procuring all necessary equipment and supplies for the office to function. A strong justification for using CDC for this activity is that as a

U.S. government agency they will not be allowed to bid on the contract to provide services for the remaining five years of the project, ensuring that the Mission avoids possible protests to the contracting procedure.

CDC will provide 9 person weeks per year of technical assistance for the remaining 5 years of the project. This will be focussed on STD activities, where CDC has a unique capability. Public health programs for STDs in the developing world are relatively new and untested, and the large majority of work that has been done was done by CDC. No private contractor can presently match CDC in international STD programs.

#### **J.1.c.2 Expanded Program for Breastfeeding (EPB)**

The Mission will buy into the RD/Health cooperative agreement with Wellstart to provide 39 weeks of technical assistance for breastfeeding and weaning over the life of the project. An April 1992 assessment of breastfeeding and weaning in Rwanda showed a mixed picture of some impressive strengths and some surprising weaknesses. In general, women are not aware of the importance of weight gain during pregnancy, the need for extra calories during breastfeeding or the natural contraceptive effect of breastfeeding in the first six months after childbirth. The assessment determined that there is essentially no concept of weaning foods in Rwanda. These are critical issues for both pre and postnatal care. There is a lack of qualified technical assistance for both breastfeeding and weaning and it is not certain that the IC could assure high quality technical assistance of the sort provided by Wellstart.

### **J.2 Commodities**

#### **J.2.a Vehicles**

The Mission Executive Office will contract with a local firm for an immediate procurement of three four-wheel drive seven-person passenger vehicles. The HPO will write a justification for the purchase based on total reduced cost. Any cost savings from ordering from overseas would be negated by the need to provide transportation means for the start-up activities. Renting cars locally for the six to nine months an offshore procurement would take to deliver vehicles to Rwanda would cost far more than the difference in price between a local procurement and an offshore procurement.

All other vehicle procurement will be done with the assistance of the REDSO/ESA Regional Commodity Management Officer. The Mission will issue PIO/Cs, as appropriate, to purchase three four-wheel drive seven-person passenger vehicles and two five-passenger four-door two-wheel drive sedans.

It should be noted that at the time of this design there are no service and maintenance facilities for U.S. manufactured utility vehicles or sedans in Rwanda. If the Mission finds

that this situation has changed during the course of implementation of this project, appropriate action will be taken.

#### **J.2.b STD Drugs, Laboratory, Clinical and Medical Supplies**

All STD drugs and STD diagnostic supplies will be purchased by CDC. All other clinical and medical supplies will be purchased by the IC in accordance with the procedures set forth in Federal and A.I.D. Acquisition Regulations, Buy America Guidelines and according to A.I.D. Handbook 14.

#### **J.2.c Computer Equipment, Office Equipment, Furnishings and Supplies**

CDC will be responsible for procuring the initial order of computers and other office equipment, furnishings and supplies. This equipment will be passed on to the IC upon their arrival. The IC will be responsible for any subsequent procurement.

#### **J.2.d Residential Furniture, Appliances and Equipment**

With the assistance of the REDSO/ESA RCMO, the Mission will issue PIO/Cs to purchase residential furniture, appliances and equipment for the IC. It is anticipated that the following sources will be used:

Furniture: RCMO Nairobi

Appliances: RPSO Bonn

Misc. Equipment: RFQ to U.S. companies and/or GSA Federal Supply Schedules

#### **J.2.e Subgrantee or GOR Support**

Except for those items enumerated above, the Mission will have no direct responsibility for the procurement of commodities for the GOR or the IC once the contract is awarded. Rather, the IC will procure any required equipment or supplies for the GOR or subgrantees.

Notwithstanding, USAID will review the equipment, supplies and furniture lists before authorizing the IC to proceed with the procurement. The IC will be required to purchase all goods and services in accordance with the procedures set forth in the Federal and A.I.D. Acquisition Regulations, Buy America Guidelines and according to Handbook 14.

### J.2.f Equipment List

ITEM	QTY.	PROB. S/O	PROC. ENTITY	U.S.\$
Vehicles, utility, 4 door, 7 passenger, 4x4, manual transmission, 6 cylinder gasoline engine.	3 3	935/696 935/935	USAID	165,000
Vehicles, 4 door wagon, 5 passenger, 2x4, manual transmission, 4 cylinder gasoline engine	2	935	USAID	24,200
Computers, 486 DX IBM compatible, 200 MB Hard Drives, 8 MB RAM, 1.2 MB 5.25" and 1.44 MB 3.5" Floppy Drives, Color VGA Monitors, 220V/50HZ (includes replacements)	8 5	000 000	CDC IC	40,000 26,000
Network Printer, equiv. to HP III si	1	000	CDC	7,500
Peer to Peer Network Hardware and Software, equiv. to Lantastic	8	000	CDC	8,000
Uninterruptable Power Supply, 220V/50HZ	1	000	CDC	7,500
Software	8 sets	000	CDC	25,000
Locally Procured Office Furniture	8 sets	696	USAID	10,000
Office Furniture	8 sets	000	CDC	10,000
Office Equipment	1 lot 1 lot	000 000	CDC IC	10,000 32,500
Health Center Equipment	1 lot 1 lot	000 696	IC IC	341,715 341,715
Radios	4	000	USAID	8,800
Household Furniture and Appliances	4	935	USAID	200,000

### J.2.g Development Fund for Africa

This project will be financed by sources provided under the Development Fund for Africa (DFA). Per Congressional guidelines set forth in the legislation authorizing DFA, all

reasonable efforts will be made to maximize U.S. source and origin goods to the extent practicable. The above list was reviewed by the Mission Executive Office and the REDSO/ESA RCMO. Only those items which are currently not made in the U.S. or which because of the very nature of the item(s) cannot be purchased and shipped from the U.S. at a reasonable cost or for which there exists no service and maintenance capabilities in Rwanda, have been designated as eligible for purchase from Code 696/935 source/origin. When the IC procures the order of preference will be as follows: (a) U.S. only, (b) host country, (c) Code 941 (Selected Free World), and (d) Code 935 (Special Free World).

The authorized source for procurement of motor vehicles is AID Code 935 (Special Free World). This is justified based on the unavailability of service and spare parts for U.S. manufactured vehicles in Rwanda. No "Special Circumstances" waiver is required to be issued to purchase such items from non-U.S. sources.

Based on the above, the Mission Executive Officer and the REDSO/ESA RCMO have concluded that USAID/Rwanda has followed the guidelines of maximizing U.S. procurement whenever practicable. However, to ensure that the U.S. Contractor(s) comply with these guidelines, they will be required to provide an annual report no later than September 30th of each year to the USAID Project Officer of all commodities purchased during the period covered, the geographic codes, and the dollar amount per geographic code. This will enable USAID/Rwanda to report this information to AID/W on a yearly basis as required under both DFA and Buy America.

#### **J.2.h Commodity Marking**

Goods purchased by the project shall be appropriately marked with the AID emblem in accordance with AID policy set forth in AID Handbook 15, Chapter 9, entitled "Requirements for Marking AID Financed Commodities." It is the responsibility of USAID to ensure compliance with these requirements. When they have not been met, the USAID should initiate corrective action which could simply entail informing the contractor of the noncompliance and request correction, or may necessitate the submission of AID Form 1450-1, "Reporting of Violation - Marking Requirements", to AID/W.

### **V. IMPLEMENTATION PLAN**

The RIM Project will proceed in three phases. The first phase is a year long series of assessment activities under the direction of the USAID TAACS advisor as the RIM Project Manager. This is called the "Bridge" on the following tables. The following two phases will be implemented by the IC. The second phase will be the implementation of project activities in two health regions for the first two years after the arrival of the IC team. The last phase will extend the project activities to two more health regions and streamline the activities in the first two health regions. The table below illustrates these activities:

## RIM IMPLEMENTATION PLAN

	Bridge	Start of Phase I				Start of Phase II														
		Quarter/Recal Year	4/92	1/93	2/93	3/93	4/93	1/94	2/94	3/94	4/94	1/95	2/95	3/95	4/95	1/96	2/96	3/96	4/96	
<b>S.T.D. ACTIVITIES</b>		<i>CDC, MOH, USIAD</i>																		
STD Demonstration Clinic		X	X	X	X															
TRUST Testing		X	X																	
Herpes Marker		X	X																	
Nosology of STDs		X	X	X	X															
Prevalence of Ulcerative STDs		X	X	X	X															
Development of STD Training Curriculum				X	X															
STD Training						X	X													
<b>H.I.S. ACTIVITIES</b>		<i>CDC, MOH</i>																		
Development of HIS Manual		X	X																	
Development of HIS Training Curriculum		X	X																	
Equipment Purchase		X																		
HIS Programming						X														
<b>C.R.H.S. ASSESSMENT</b>		<i>CDC, USAID, MOH</i>																		
Service Utilization		X	X																	
Quality of Care		X	X	X	X															
Knowledge Testing		X	X	X	X															
Clinic Inventory		X																		
Community Survey		X	X	X	X															
<b>ADMINISTRATIVE ACTIVITIES</b>		<i>CONTRACTOR, USAID, CDC</i>																		
Life of Project Work Plan						X		X												
Annual Work Plan							X			X				X				X		
P.I.R. (Oral)					X			X		X			X			X		X		X
P.I.R. (Written)			X	X			X	X	X	X			X	X	X	X		X	X	X
Coordination Committee		X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Annual Report						X			X					X					X	
<b>DISSEMINATION</b>		<i>CONTRACTOR, MOH</i>																		
Newsletter			X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
RIM Workshops			X				X		X				X		X		X		X	
In-Country Study Tours													X	X	X	X	X	X	X	
<b>FINANCIAL MANAGEMENT</b>		<i>CONTRACTOR, MOH</i>																		
Design Financial Management System					X															
Health Region Implementation							X													
Follow-up and Supervision								X	X	X	X	X	X	X	X	X	X	X	X	X
<b>CRHS PROTOCOLS</b>		<i>CONTRACTOR, MOH</i>																		
Risk Criteria							X													
CRHS Standards and Protocols							X	X												
Patient Record Forms							X													
Annual Review									X				X			X				X

## RIM IMPLEMENTATION PLAN

		Bridge				Start of Phase I				Start of Phase II																		
		Quarter/Recal Year	4/02	1/03	2/03	3/03	4/03	1/04	2/04	3/04	4/04	1/05	2/05	3/05	4/05	1/06	2/06	3/06	4/06	1/07	2/07	3/07	4/07	1/08	2/08	3/08	4/08	
<b>IEC</b>	<i>CONTRACTOR, MOH</i>																											
Assessment						X																						
Assessment Update										X				X		X								X				
Strategy Document						X																						
Material Development and Testing							X	X																				
Curriculum Development							X	X																				
Curriculum Update											X			X		X									X			
<b>TRAINING</b>	<i>CONTRACTOR, MOH</i>																											
Assessment						X																						
Assessment Update										X				X		X								X				
Strategy Document						X																						
Development of CRHS Training Curriculum							X	X																				
Training of Trainers							X	X																				
Training (per Schedule)									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
<b>MANAGEMENT SOPs</b>	<i>CONTRACTOR, MOH</i>																											
Management Needs Assessment					X																							
Fieldwork					X	X	X	X																				
First Draft						X	X	X																				
Field Testing							X	X	X	X																		
Second Draft									X	X	X																	
Phase II Implementation by GOR Staff														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Monitoring of Implementation by Contractor Staff														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Thrd Draft																												
<b>EVALUATION</b>	<i>USAID, MOH, EXTERNAL CONTRACTORS</i>																											
Mid-Term														X														
Final																												
Internal Audit					X				X					X		X							X				X	
RIG Audit																											X	

## VI. SUMMARIES OF ANALYSES

### A. Economic Analysis

Rwanda is among the lowest income group of countries in the World Bank's World Development Indicators. Per capita GNP was \$ 320 in 1989, and growth over the last 25 years has only been at an annual rate of 1.2 percent. Life expectancy is only 49 years. Rwandans spend about three percent of household income on medical care, this amounts to about 200 to 250 francs per person. The World Bank projects the GDP to be rising at about 3.5 to 4 percent during the first half of the decade. While the health budget appears to be relatively protected from the impact of structural adjustment, the size of the population growth dictates an assumption that the Ministry of Health budget will continue at about the same per capita level of spending. Thus, spending for new activities must either be generated elsewhere or the money must be taken from existing activities.

During the first half of the project, services will be targeted at family planning services for about 1.5 million persons and MCH services for about 75,000 pregnancies. During the second half of the project this population could be expected at current fertility rates to have about 140,000 births per year. Actual number of births will vary with the success of the project family planning efforts. The four prefectures have about 600,000 women of child bearing age.

Outcomes of these services are expected to include a reduction in maternal deaths from 800 per 100,000 to 700 per 100,000, and of infant mortality from 112/1000 to 100/1000. Birth spacing is expected to increase from 22 months to 30 months. By the end of the project, the annual impacts of the project are expected to be the prevention of about 1,600 infant deaths per year, 130 maternal deaths, and a reduction in births of about 25,000. The economic value of these outcomes is estimated in the table below.

Table 4: Annual Economic Value of Project Outcomes at Project End

Outcome	Number	Value	Savings
Preventing Maternal Death	130	4,000	520,000
Preventing Infant Death	1,600	1,328	2,124,800
Preventing Birth	25,000	37	925,000
<b>TOTAL SAVINGS</b>			<b>\$3,569,800</b>

Project costs have been broken into investment and recurrent costs using the best judgments of project designers. Approximately 75 percent of the cost were judged to be investments and 25 percent to be recurrent. This breakdown was done in part to determine what the

annual recurrent cost of the project activities would be for the GOR at the end of the project. The recurrent costs total about \$ 750,000. This level of expenditure amounts to approximately \$.25 per capita in the four prefectures, and about \$ 1.25 per woman of child bearing age. With the expected reduction in pregnancies, recurrent cost would be about \$30.00 per pregnancy

With benefits of \$ 3.5 million per year by the end of the project, this activity appears more than economically justified. If the project attained only 20 percent of this benefit the first year, 40 percent the second, then 60, 80 and 100 percent in the last three years, respectively, total benefits during the project life would be \$ 10.5 million. Moreover, the annual benefits of the project's impacts will more than outweigh the costs, with a net benefit per year of more than \$ 3 million after subtracting recurrent costs from annual benefits. This provides a benefit cost ratio of about eight.

Although the project demonstrates strong economic benefits, there is a question of how long the benefits will continue. In terms of the economic issues, this is a question of whether the recurrent cost requirements of project can be sustained. As has been discussed earlier, there is very little discretionary revenue available from the MOH or other sources to finance these activities. However, there is a possibility of some local revenue generation through a prepaid plan for MCH services. In some of the areas where the project is operating, the project will experiment with a prepayment scheme to encourage women to make greater use of the ante and post natal services of the health centers.

It is anticipated that the package will be heavily subsidized by the MOH, but that it may be able to recover enough revenue to increase the quality and quantity of services delivered at no additional outlay by the MOH. If the package can be priced at about \$ 2.00 per woman, then about 50 percent of the recurrent cost can be recovered. This cost is not out of line with what traditional birth attendants are currently paid.

In addition to cost recovery, there are several other aspects that will contribute to the sustainability of project impacts. One of the most important is possible efficiency improvements in MOH operation. Given the \$ 10 to \$ 11 million size of the MOH budget, a four percent increase in efficiency would be able to cover the additional recurrent cost of this program, or a two percent increase if cost recovery covers half of the cost.

The RIM Project is not adding any personnel or any activities to the current MOH health system. Therefore there is no additional burden of sustainability. If the GOR cannot support the supervision and training activities proposed under the RIM Project it indicates that they would not have been able to support the supervision and training costs currently incurred. As indicated above the RIM Project should actually reduce operating costs through gains in efficiency.

Finally, even if the GOR is not able to sustain the current and required level of recurrent costs, the investment portion of the project (75 percent of the costs) will have a lasting effect

on the quantity and quality of services provided in the project areas. If there is some tapering off of the level and quality of services after the project ends, it is nevertheless likely that services will continue to be provided at a much higher level than prior to the project. If only half of the recurrent costs can be covered after the project there is every reason to believe that these expenditures will continue to have a high benefit cost ratio.

## **B. Social Soundness Analysis**

### **Introduction**

The Social Soundness Analysis examined the feasibility and appropriateness of the intervention proposed for the Rwanda Integrated Maternal Child Health/Family Planning Project (RIM) as well as the potential impact of the project on specific groups of potential beneficiaries. The analysis was hampered to a large extent by the limited availability of relevant data and the conflicting nature of the data that were available. As a result, the conclusions reached are tentative and strong recommendations made to conduct additional formative research and install and use a project monitoring system which incorporates criteria and measures related to the socio-cultural effects and impact of project interventions.

The RIM Project will be implemented in four regions, Gitarama, Kibungo, Kibuye and a health region to be determined with a total population of approximately 3 million people. The immediate beneficiaries of the project will be the health services providers in the 120 health facilities in these regions and the regional and central supervisory staff involved in implementation of project training and supervision activities. Assuming effective implementation of the training and other interventions to strengthen antenatal, delivery, postnatal, and STD services, and improve clinic level management, beneficiaries will include a high percentage (80 percent) of the women of reproductive age in these regions, approximately 500,000, and, to a somewhat lesser extent, their children under 5 and their spouses. Depending on how various networks for outreach to surrounding communities are activated, potential beneficiaries would also include traditional birth attendants (TBAs), other traditional healers, and the ONAPO-trained abakangurambaga, estimated at approximately 8,000. As noted in the project description, these may be somewhat conservative estimates given that the products of their project, e.g., manuals for training of service providers, service protocols, and outreach guidelines, may be disseminated and applied in other regions, thereby reaching other health care service providers and women of reproductive age and their families. The project design emphasizes improvements in reproductive health services and in information, education and communications, all of which will be affected by socio-cultural factors.

### **Socio- cultural Background: Relevant Characteristics**

Health status indicators and many socio-cultural characteristics are similar to those found in other "least developed" countries of Africa undergoing severe economic crisis and political

changes. Several characteristics of Rwanda stand out, however. Rwanda is the most densely populated country of Africa; Rwanda as a whole and the target regions are characterized by a high population growth rate over 3 percent per annum, and a fairly even, dense distribution, estimated at 271 per square kilometer. Over 90 percent of the population is considered rural, living in scattered homesteads on the hills, rarely in villages. Fertility is high, with a total fertility rate of over 7.5, and still valued. Infant mortality is also high at 112 per 1000 live births. Maternal mortality is estimated at 350 per 100,000 among the highest in the world, indicating that pregnancy and birth are high risk ventures. Women marry relatively late, usually after 20 years of age.

By any measure, Rwandans are very poor. Most families are engaged in subsistence agriculture, with women taking primary responsibility for work in the home and for a major amount of work in substance crop production. Sources on amount of time devoted to work every day varied, however, so that it is not clear how burdened women are, although all sources agree that women work longer hours than men.

Somewhat over 50 percent of women are considered "non-literate". While girls are enrolled in primary school (about 50 percent of enrolment), their attendance rates are lower than boys. Approximately half of the population is nominally Christian, mostly Roman Catholic.

The road network is very good, but lack of public transportation and restrictions hamper travel and contacts between regions: mass media are relatively underdeveloped, with only one government-owned radio station serving the whole country. However, all Rwandans speak a common language. Although ethnic conflicts continue between the two major groups, the top-down political structure to date has fostered a population accustomed to assemblies and "passing the word", facilitating message transmission, when messages are officially sanctioned. How this will change in the current, unstable political environment is not yet known.

Attitudes towards reproductive health and care are not well understood, and sources do not provide consistent information. Sexual modesty is very important, with women consistently noting the need for privacy when discussing sexual matters. Anecdotal evidence indicates that there is prestige in having a normal, vaginal delivery, and women express fear at the possibility of being "cut open" during birth. Post-partum sexual abstinence is short, with sexual relations often starting eight days after the birth.

The modern health care system is well-developed, relative to many other African countries. Women are well-represented among the cadres of physicians (21 percent), nurses (90 percent), and social assistants (95 percent), but not among the medical assistants (3 percent). Traditional healers and TBAs are commonly used, the former for a wide variety of treatments and the latter for assistance during births.

## **Appropriateness and Feasibility of Project Interventions.**

Although the proposed impact of the project interventions, i.e., improved maternal health, are inarguably of benefit to the target groups, the analysis also demonstrated that the proposed strategies and project interventions are appropriate and culturally feasible. Changes in level of knowledge and certain practices, such as greater participation in decision-making by health center staff and by women regarding their own health care, may change culturally established, traditional approaches, but are deemed to have benefits sufficiently important and carry no potential for direct harm. However, a number of issues related to the interventions remain unresolved and warrant further research before specific strategies are selected. These are summarized briefly below.

Utilization of Health Services. Lack of knowledge as to the importance and value of selected services, costs (financial, lost opportunity, etc.), distance from the health clinics, poor treatment by health staff, sensitivity of providers to client concerns such as modesty and privacy, and other factors would all appear to affect "service-keeping" behavior, but it is not known how important these various factors are. More systematic analysis would be useful so that interventions could be targeted at the most important.

Role of Men. While Rwandan society is considered male-dominated and men are known to make many critical family decisions, it is not known what role they play in decision-making about such matters as use of prenatal care services and behaviors related to nutrition during pregnancy. Assuming they have an important role in these decisions, we know equally little about how to influence their choices. Further research is needed so project interventions appropriately take into account men's roles and deal effectively with their attitudes and decisions.

Community Outreach. This preliminary analysis indicates that information and selected service provision at the community level would help to address some of these issues by making services and information available closer to home by individuals better known to and trusted by the clients. Three cadres of people have been identified as possible agents: the ONAPO-trained abakangurambaga, the TBAs, and traditional healers. Further information and analysis is needed to better determine their appropriateness and acceptability, and the feasibility of training and maintaining them in expanded roles.

Understanding of Own Health Risks and Consequences. Messages and information to women would need to address their own concerns about their health and welfare and their sexuality, but little is known about how Rwandan women view themselves and their health. Only limited information is available on women's understanding of HIV and STDs and their prevention. More research and testing of messages and materials will be needed to assure cultural appropriateness and understanding by the target groups.

Integration of Services. From the information available, women appear to prefer preventive services offered (e.g., family planning and prenatal) where they are separate from curative

services, and where they can receive the information they need to manage their own health care better. However, the data from which these conclusions are drawn are sketchy and ambiguous, and warrant further follow up and investigation. Services through outreach and improved management of health facility services may address these concerns.

### **C. IEC Analysis**

Traditional media-based IEC activities are hampered in Rwanda by the lack of villages or other population centers. Radio is the only available channel of mass media. However, IEC activities can take advantage of two positive factors in Rwanda, a tradition of voluntary community service and a highly structured social organization.

In general, MOH IEC activities have been conducted by the various vertically structured program interventions. In other words, the immunization program had an IEC component, the malaria program had an IEC component, etc. This has recently changed. In December 1991 the MOH formed a division of IEC and posted "social mobilization" personnel at the health region level.

Community-based IEC had been done through the MRND party structure, which until recently was essentially indistinguishable from the government structure. It is unclear how the MOH and the government plan to replace the MRND structure with a non-party affiliated rural government. One suggestion has been to use Rwandan Red Cross volunteers. The RIM Project must wait out the governmental changes and work with whatever takes root.

The project should hire a long-term technical expert in IEC to coordinate and help formulate IEC policy, this person should work in conjunction with the head of the IEC division of the MOH. The head of the IEC Division would benefit from further training in IEC.

The IEC strategy should be threefold:

- 1) train health center workers on how to deliver messages, including generalized training to improve their interpersonal skills;
- 2) develop messages and materials appropriate for CRHS in the Rwandan context. This will involve KAP studies and extensive pretesting of messages; and
- 3) explore the possibility of using videos to deliver messages, initially through some network of video recorders but eventually through television.

### **D. Financial Management Analysis**

#### **1. Context**

In the RIM project, USAID is planning to funnel resources to the MOH at the regional and national level, with a preponderance for the regional level. The MOH cannot at present

handle USAID funds and meet USAID's financial reporting requirements and/or the financial management requirements.

At the national level, the GOR budgetary system is very weak. A new system must be introduced or fiscal discipline must be re-introduced in the current one. The present situation has a strong impact on the ability of the MOH to manage the funds allocated for its activities.

At the regional level, the MOH's apportionment of funds to the regions is not based on need, nor is the process transparent. The amount of funds transferred in the last two years has clearly been inadequate to carry out the programs planned. The lack of a budget process at the regional level means that the MEDERISA does not have adequate information to apportion his funds based on the importance of his programs.

Regardless of the level of resources provided by the RIM project to the regions, a complete financial management system must be built at the regional level. This financial management system should be designed and introduced with the active participation of the MOH and other health sector donors. It should meet the requirements of the MOH, USAID, and any other donor who would provide resources to the region. It should be simple and easy to use. It should be designed with eventual computerization in mind, but be user-friendly to personnel with little background in finance and accounting. And finally, it should be easily replicated in other regions.

Because of the inherent heavy reporting load of USAID's requirements, an accountant will be hired by the project to handle reporting tasks. At the regional level, the RAs will assist the MOH's regional accountants.

## 2. Project Personnel

The management and financial advisor (MA) will be part of the technical assistance team to be provide by a prime contractor. S/he will be an expatriate, or third country national with extensive management and financial management experience. USAID project management experience and background in training will be required. Health project experience will be a plus.

The project accountant will hired locally by the prime contractor. Prior USAID project experience will be a plus but not essential. Training in USAID financial requirements will be provided by USAID/Rwanda if needed.

The Regional Management Advisors will be Peace Corps Volunteers assigned to the Region Sanitaire. As such they will not be project staff but be MOH personnel. They will have management experience and be computer literate. Financial management experience would be a plus. The project should be ready to provide funds to Peace Corps for training or to train the volunteers.

If Peace Corps volunteers are not available, the RMAs could be third-country nationals paid by the project, and thus be staff of the prime contractor.

### **3. RIM Inputs required**

#### **Technical Assistance:**

- Management and Finance advisor, 60 months (life of project).
- Accountant, 60 months (life of project), 1992 estimated monthly salary of RF 50,000.
- Two Regional management advisors, 120 person-months total (life of project), assuming that when the project is extended to two additional regions, the regional management advisors are re-assigned to the new regions.

### **E. MCH Analysis**

The MOH MCH system has as strengths:

- 1) a commitment from the GOR to the importance of MCH and family planning and a willingness to follow worldwide standards in implementing services;
- 2) good human resources;
- 3) good health infrastructure; and,
- 4) the GOR MOH decision to integrate MCH and FP services.

The MOH MCH system has as weaknesses:

- 1) some substandard health centers, poor hygiene in many other health centers;
- 2) poor distribution of MCH equipment, no system to ensure proper distribution;
- 3) spotty drug and contraceptive supply;
- 4) poor management at the health center level, especially in time allocation; and,
- 5) a poor IEC system.

Two other factors act as constraints on the system. The distance to health centers in combination with the hilly topography of the country make it difficult for women to frequent

health centers, and, the country has a pro-natalist tradition that encourages women to have many children irrespective of the effect on their health or the health of the children.

Recommendations to improve MCH services are:

- 1) implement a national MCH/FP training plan;
- 2) develop and implement a national MCH/FP supervision plan;
- 3) do a health center inventory of equipment, supplies and commodities;
- 4) establish and enforce worldwide standards and protocols for MCH/FP service delivery;
- 5) develop a good health information system;
- 6) improve patient flow at health centers; and,
- 7) establish community based distribution of contraceptives.

## **VII. CONDITIONS AND COVENANTS**

### **A. Conditions**

#### **Conditions Precedent To First Disbursement**

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- (a) A statement of the names of the persons holding or acting in the office of the Grantee specified in Section 8.2 and of any additional representatives, together with a specimen signature of each person specified in such statement;
- (b) A document acceptable to A.I.D. that designates by name the full-time individual at the Ministry of Health who will fill the following position:

MOH Project Manager - to serve as counterpart to the institutional contractor Chief of Party, allocating 50 percent of his/her time to RIM activities; and,

## Condition Precedent to Disbursement of Funds Under the STD Prevention and Control Project Component

Prior to the first disbursement under the STD prevention and control component of the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D. a document acceptable to A.I.D. that designates by name the full-time individual at the Ministry of Health who will fill the following position:

STD Prevention and Control Expert - to fill the long-vacant position at PNLS and to act as GOR specialist and point person on all RIM Project interventions in STDs.

### B. Covenants

#### Special Covenants

1. Project Evaluation. 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. Prohibition of Support of Abortion Related Activities and Involuntary Sterilization. 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 or involuntary sterilization as a method of family planning;
- (b) motivation or coercion of any person to undergo abortion or involuntary sterilization;

- (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning; or
- (d) active promotion of abortion or involuntary sterilization as a method of family planning.

### **3. Additional Covenants**

- (a) The Grantee covenants to facilitate the autonomy and self-financing of the regional health care network by taking, inter alia, the following actions:
  - (i) permit any resources that are generated at the regional level and its periphery to remain at that level;
  - (ii) permit cost recovery schemes to progressively achieve a self-financing component;
  - (iii) permit a variety of schemes, to be tested through operations research, which involve traditional birth attendants, abakangurambaga and other auxiliary health care professionals.
- (b) The Grantee covenants to convene a RIM workshop bi-annually which will bring together all MEDIRESA, ONAPO delegates, USAID and interested donors, in order to disseminate information and review progress and problems.
- (c) The Grantee covenants to make available suitable candidates for Project-financed training for the public sector. This will be accomplished by developing an annual training plan, in collaboration with USAID, MINIPLAN and the institutional contractor.
- (d) Project Personnel. The Grantee covenants to recruit and assign, in a timely manner, all GOR personnel (in addition to those specified in VII.A.b) necessary to implement the Project. The Grantee further covenants to assure that these positions remain filled for the life of the project and that should a position become vacant it will be filled in a timely manner.

GOR Project personnel should be of sufficiently high stature in the MOH organization to facilitate project implementation in order to achieve Project goals and objectives.

Specifically, the Grantee covenants to assign people to the following positions as soon as possible after the signing of the Agreement:

- (i) **MOH Project Coordinator: Training.** To serve as counterpart to the institutional contract training staff, and to allocate 50 percent of his/her time to RIM activities; and
  - (ii) **MOH Project Coordinator: IEC.** To serve as counterpart to the institutional contract IEC staff, and to allocate 50 percent of his/her time to RIM activities.
- (e) **The Grantee covenants to nominate women, as well as men, in selecting candidates for participant training and in recruitment for positions under the Project.**
- (f) **The Grantee covenants to assure that appropriate stocks of routine medical and office supplies are maintained in the regions where the RIM Project is being implemented.**
- (g) **The Grantee covenants to assume, at the end of the Project, all recurring costs related to maintaining equipment furnished under the Grant as well as maintaining the supply of expendable property necessary to ensure the continuation of successful new systems and procedures developed during the Grant period.**

A. PID APPROVAL MESSAGE

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ACTION: AID INTJ: AMB DCM

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AIDAC REDSO/ESA FOR RLA, ANTHONY VANDER

0888 E.O. 12356: N/A

TAGS:  
SUBJECT: ECPH REPORTING CASE FOR THE RWANDA INTEGRATED  
MCR/FP (RIM) PROJECT PID - 6960134

9-26-91

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0888 1. THE ECPH REVIEW WAS HELD ON AUGUST 15, 1991 CHAIRED BY AFR/PL AND WAS ATTENDED BY REPRESENTATIVES FROM AFR/PD, AFR/EA, AFR/DF, AFR/TN/MPH, AFR/ST/POF AND USAID REPRESENTATIVE JOAN LAROSA. THE COMMITTEE COMPLIMENTED USAID REPRESENTATIVE ON MISSION SUBMISSION OF A WELL-WRITTEN AND COMPREHENSIVE DOCUMENT AND EXPRESSED GENERAL SATISFACTION WITH THE GOAL AND PURPOSE. HOWEVER, SINCE THE PROPOSED PROJECT WILL BE A QUOTE PILOT EFFORT UNQUOTE AND WILL CONTINUE TO BUILD ON THE SUCCESS OF MCR/FP II, THE COMMITTEE QUESTIONED WHY THE MISSION DID NOT AMEND THE EXISTING MCR/FP II PROJECT TO ACCOMMODATE RIM ACTIVITIES. THE COMMITTEE ALSO FELT THAT SINCE USAID WOULD NOT BE SUBMITTING ITS CPSP UNTIL MARCH 1992, IT MIGHT WISE MORE TIME TO EVALUATE THE PROPOSED PROJECT AND DETERMINE WHETHER HEALTH WILL FIT INTO THE OVERALL MISSION STRATEGY. OTHER CONCERNS AND ISSUES ARE DISCUSSED BELOW.

0888 2. THE COMMITTEE QUESTIONED HOW THE MISSION WOULD ADDRESS BROADER SECTOR POLICY AND INSTITUTIONAL REFORM ISSUES SUCH AS THE HORIZONTAL INTEGRATION OF VERTICAL-TYPE PROGRAMS.

0888 THE PID NOTED THAT THE RWANDAN PUBLIC HEALTH SYSTEM HAS CREATED A SET OF VERTICAL PROGRAMS RESPONDING TO HIGH PRIORITY HEALTH NEEDS WITH SEPARATE SUPERVISION AND LOGISTICAL SUPPORT SYSTEMS THAT ARE NOT INTEGRATED AT THE CENTRAL LEVEL. THESE PROGRAMS STRAIN LIMITED RESOURCES. SINCE THE PID DID NOT ADEQUATELY EXPLAIN HOW BROADER SECTOR ISSUES WILL BE ADDRESSED UNDER THE PROJECT, THE COMMITTEE RECOMMENDED THAT THE PROJECT PAPER FULLY DISCUSS POLICY AND INSTITUTIONAL ISSUES IN THE FAMILY PLANNING/REPRODUCTIVE HEALTH SUBSECTOR. IN ADDITION, BECAUSE OF THE SENSITIVITIES IN THE POPULATION AREA, THE PROJECT PAPER SHOULD DISCUSS HOW THE PROJECT WILL COMPLY WITH EACH OF A.I.P.'S FAMILY PLANNING POLICIES (IE. VOLUNTARY, VOLUNTARY SURGICAL STERILIZATION, PROVIDING INFORMATION ABOUT ALL FAMILY PLANNING OPTIONS, ETC.).

0888 3. LIFE OF PROJECT: GIVEN THE PURPOSE OF THE PROJECT, THE COMMITTEE QUESTIONED WHETHER THE FOURTEEN LIFE OF

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PROJECT WOULD PROVIDE ENOUGH TIME FOR REALISTIC IMPLEMENTATION AND ACHIEVEMENT OF THE PROJECT PURPOSE.

RRR SINCE THE FIRST YEAR OF THE PROJECT WOULD BE OCCUPIED WITH CONTRACTING MATTERS, IT WAS FELT THAT THE REMAINING THREE YEARS WOULD NOT BE ENOUGH FOR IMPLEMENTATION OF WHAT SEEMS TO BE AN AMBITIOUS PROJECT. THE COMMITTEE RECOMMENDED THAT MISSION SHOULD DEVELOP A LONGER PROJECT (E.G., FIVE YEARS) TO PROVIDE ADDITIONAL TIME FOR THE PROJECT TO ACHIEVE ITS ANTICIPATED RESULTS. IN ADDITION, THE MISSION SHOULD ADVISE AID/W ON WHAT WILL BE ITS FUTURE INTENTIONS (E.G., IF SUCCESSFUL PFBX AIDS AND SEXUALLY TRANSMITTED DISEASES (STD) ACTIVITIES CAN BE DEMONSTRATED, WILL THE MISSION EXPAND ITS FOCUS IN THAT AREA AND HOW WILL THAT EXPANDED FOCUS FIT INTO THE OVERALL MISSION STRATEGY. AS INDICATED IN PARA 1, MISSION SHOULD PLAN TO DISCUSS THIS MATTER FURTHER IN ITS CPSP.

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4. SUSTAINABILITY: THE COMMITTEE QUESTIONED WHETHER THE GOVERNMENT OF RWANDA (GOR) WOULD BE ABLE TO SUSTAIN THIS PROJECT OVER TIME, GIVEN THAT THIS WILL BE ANOTHER HEALTH AND POPULATION-RELATED ACTIVITY WHICH WILL REQUIRE BOTH USAID AND GOR IMPLEMENTATION. THE PID WAS UNCLEAR ON WHETHER THE GOR WOULD COMMIT FUTURE FUNDS TO AN INCREASED EFFORT IN THE HEALTH AND POPULATION AREAS, GIVEN THE FRAGILE AND UNCERTAIN POLITICAL NATURE OF RWANDA. SOME ON THE COMMITTEE FELT THAT THE GOR'S COMMITMENT MIGHT WANE IF ITS MAJOR CROP PRICES DECLINE ON THE WORLD MARKET. IT WAS FELT THE MANAGEMENT AND SUPERVISION TRAINING COMPONENT OF THE PROJECT WOULD NOT BE SUFFICIENT IN THE LONG-TERM TO ADDRESS THE SUSTAINABILITY ISSUE. THE PROJECT PAPER SHOULD FULLY DISCUSS THE SUSTAINABILITY ISSUE AND ADDRESS

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THE QUESTION OF WHEN AND WHETHER THE GOR CAN SUSTAIN THE ACTIVITIES OF THE PROJECT OVER TIME. IT WAS FURTHER AGREED THAT THE PROJECT SHOULD BE DESIGNED AND A BUDGET WRITTEN TO SHOW AN INCREASING PROPORTION OF LOCAL COSTS FINANCED BY THE GOR FOR THE SECOND HALF OF THE PROJECT. THIS LOCAL COST FINANCING WOULD BE IN ADDITION TO CURRENT PERSONNEL COST COVERED BY THE GOR. ANNEX 1 OF THE PROJECT AGREEMENT SHOULD REFLECT THIS PRINCIPLE IN THE TEXT AND IN THE BUDGET.

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5. MISSION MANAGEMENT BURDEN: CONCERN WAS EXPRESSED THAT THE PROJECT MIGHT REPRESENT AN EXCESSIVE MANAGEMENT BURDEN TO THE MISSION GIVEN THERE WILL BE NO DIRECT HIRE HEALTH/POPULATION OFFICER ON BOARD FOR THE FORESEEABLE FUTURE TO MANAGE PROJECT ACTIVITIES. WHILE THE PID ATTEMPTED TO ADDRESS THIS CONCERN IN SEVERAL WAYS, THE

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COMMITTEE FELT THE PROJECT SHOULD BEST BE MANAGED BY A DIRECT RISE HEALTH AND POPULATION OFFICER. IN THE ABSENCE OF SUCH AN INDIVIDUAL, THE COMMITTEE FELT THE MISSION SHOULD GIVE MORE THOUGHT TO WHO WILL TEMPORARILY MANAGE THE PROJECT. THE PROJECT PAPER SHOULD SHOW HOW THE PROPOSED PROJECT WILL BE MANAGED DURING THE DURATION OF THE PROJECT BY AVAILABLE MISSION STAFF. TO REDUCE THE MANAGEMENT BURDEN, THE COMMITTEE RECOMMENDED THAT THE MISSION PLACE AS MUCH IMPLEMENTATION RESPONSIBILITY AS POSSIBLE ON THE INSTITUTIONAL CONTRACTOR, INCLUDING TRAINING, COMMODITY PROCUREMENT, POLICY STUDIES, AND A COORDINATING AND LOGISTICAL SUPPORT ROLE FOR PERSONNEL PROVIDED UNDER ST BUREAU PROJECTS. TO THE EXTENT THAT THE PROJECT WILL USE ST PROJECTS, THE MISSION SHOULD: (1) ASCERTAIN FROM THE AID/W ST BUREAU PROJECT MANAGER THAT THE PROPOSED STATEMENT OF WORK (SOW) IS APPROPRIATE FOR THE ST PROJECT; AND (2) ASCERTAIN THAT THE PROPOSED SCOPE OF WORK CAN BE ACCOMMODATED UNDER THE ST PROJECT CEILING.

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5. THE MISSION SHOULD INSURE THAT THE PROPOSED PASA WITH THE CENTER FOR DISEASE CONTROL (CDC) IS JUSTIFIED IN ACCORDANCE WITH THE CRITERIA CONTAINED IN HANDBOOK 12.

7. THE BUREAU ENVIRONMENTAL OFFICER AND GC/AFR HAVE CLEARED THE INITIAL ENVIRONMENTAL EXAMINATION AS CONTAINED IN THE PID.

2. PE APPROVAL AND AUTHORIZATION: THE PID IS APPROVED FOR A LEVEL OF DOLS 7.2 MILLION AND THE MISSION MAY APPROXIMATE THE PROJECT PAPER IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF EOA 551 AND IN ACCORDANCE WITH THE GUIDANCE PROVIDED IN THIS CABLE. IF THE MISSION DESIGNS A PROJECT OF MORE THAN FOUR YEARS AS DISCUSSED ABOVE AND THE

DOLLAR LEVEL EXCEEDS DOLS 7.2 MILLION, THEN IT SHOULD INFORM AID/AFR OF THE NEW DOLLAR LEVEL SO THAT AID/AFR CAN CONCUR. EAGLEBURGER

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B.

## LOGICAL FRAMEWORK FOR SUMMARIZING PROJECT DESIGN

Rwanda Integrated MCH/FP Project 696-0134

NARRATIVE SUMMARY	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																
<p>Program Goal: The broader objective to which this project contributes:</p> <p>To improve reproductive health of Rwandan women and men in the four project health regions</p>	<p>Measure of Goal Achievement:</p> <p>Increase contraceptive prevalence to 25%</p> <p>Decrease infant mortality from 111/1000 to 100/1000</p>	<p>GOR Health Statistics</p> <p>GOR Population Statistics</p> <p>DHS II &amp; III</p>	<p>Economic and Political Stability</p>																
<p>Project Purpose:</p> <p>To increase the capacity of the MOH to provide comprehensive reproductive health care including the treatment, prevention and control of STDs</p>	<p>Conditions that will indicate purpose has been achieved: End of project status:</p> <p>Increase utilization rate of comprehensive reproductive health services from &lt;5% to &gt;50% of pregnant women.</p> <p>Comprehensive reproductive health services available in 90% of project area health facilities</p> <p>Implementation of GOR policy which incorporates STD treatment, preventions and control in MOH health service delivery</p>	<p>Health statistics</p> <p>Health records</p> <p>Project evaluation</p> <p>HIV/STD policy directives issued to regions</p> <p>National STD coordinator position filled by start of project</p>	<p>Affecting purpose-to-goal link:</p> <p>GOR endorsement of comprehensive health care services</p> <p>Economic and political situation do not impede project implementation</p> <p>GOR contribution sufficient to sustain project activities during and after project</p> <p>Rural infrastructure (roads, health centers, radio) adequately maintained</p>																
<p>Outputs:</p> <p>Improved delivery of pre and postnatal care, birthing care and STD treatment</p> <p>Increased use of health clinics for comprehensive reproductive health care</p> <p>Increased knowledge of importance of pre and postnatal care and STD treatment and prevention</p> <p>Improved organizational and management skills at the health center level</p> <p>Improved supervision systems</p> <p>HIS and fiscal management strengthening</p> <p>Improved regional training capacity</p>	<p>Magnitude of Outputs necessary and sufficient to achieve purpose:</p> <p>50% of women in project area receive services at least 3 times in each pregnancy, 80% have at least one postnatal visit</p> <p>90% of STD patients presenting to project facilities treated correctly by nationwide standards</p> <p>50% of women understand the importance of pre and postnatal care</p> <p>90% of health centers maintain standardized patient records</p> <p>6 regionally run training sessions held per year</p> <p>HIS data used in development of regional budgets/ Regional level accounting system instituted in project area</p> <p>100% of health facilities in project area supervised at least once every 3 months</p>	<p>Project impact monitoring system</p> <p>Pre and post KAP survey</p> <p>PIR reports</p> <p>MOH HIS reports</p> <p>Health facility records</p> <p>STD operations research studies</p> <p>DHS II &amp; III</p>	<p>Affecting output-to-purpose link:</p> <p>Improved services will result in increased use</p> <p>Small size of project area will facilitate achievements</p> <p>MOH maintains adequate staffing levels</p> <p>Research carried out and recommendations accepted</p> <p>MOH planners accept validity of HIS data</p> <p>Fiscal monitoring system accepted by GOR and MOH/ Qualified regional MOH financial and logistics personnel exist</p>																
<p>Inputs: Activities and Types of Resources:</p> <p>A.I.D.</p> <p>TA: Long and short term</p> <p>Training and study tours</p> <p>Commodity support</p> <p>Operations research</p> <p>IEC</p> <p>GOR</p> <p>Personnel</p> <p>Health facilities/operational costs</p>	<p>Level of Effort/ Expenditure for each activity:</p> <table border="0"> <tr> <td>1. Technical Assistance</td> <td>6,326</td> </tr> <tr> <td>2. Training</td> <td>1,399</td> </tr> <tr> <td>3. Commodities</td> <td>1,372</td> </tr> <tr> <td>4. Other Costs</td> <td>3,408</td> </tr> <tr> <td>5. Evaluation and Audit</td> <td>645</td> </tr> <tr> <td><b>SUBTOTAL</b></td> <td><b>13,150</b></td> </tr> <tr> <td>6. GOR Contribution</td> <td>4,832</td> </tr> <tr> <td><b>TOTAL</b></td> <td><b>\$17,982</b></td> </tr> </table>	1. Technical Assistance	6,326	2. Training	1,399	3. Commodities	1,372	4. Other Costs	3,408	5. Evaluation and Audit	645	<b>SUBTOTAL</b>	<b>13,150</b>	6. GOR Contribution	4,832	<b>TOTAL</b>	<b>\$17,982</b>	<p>PIO/Ts</p> <p>PIIs</p> <p>Vouchers</p> <p>Contractor reporting</p> <p>PIRs</p> <p>Audit</p>	<p>AID funds available for project</p> <p>GOR staff, facilities and operational funds available in a timely manner</p> <p>Management team given responsibility and authority to manage inputs</p>
1. Technical Assistance	6,326																		
2. Training	1,399																		
3. Commodities	1,372																		
4. Other Costs	3,408																		
5. Evaluation and Audit	645																		
<b>SUBTOTAL</b>	<b>13,150</b>																		
6. GOR Contribution	4,832																		
<b>TOTAL</b>	<b>\$17,982</b>																		

## C. ILLUSTRATIVE BUDGETS

### RIM PROJECT ILLUSTRATIVE BUDGET

Line Item	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
<b>BRIDGING ACTIVITIES</b>							
<b>Office</b>							
Rent	18500						18500
Communications	13200						13200
Utilities	2640						2640
Guard Service	5280						5280
<b>Subtotal</b>							<b>\$37,820.00</b>
<b>Commodities</b>							
Desks	2112						2112
Computer Tables	1408						1408
Computers	40000						40000
Printer	7500						7500
Network Hardware + Software	8000						8000
UPS	7500						7500
Software	25000						25000
Reference Materials	2500						2500
Miscellaneous	18500						18500
Telephones	2000						2000
Fax Machine	1000						1000
Copier	5000						5000
File Cabinets	1000						1000
Chairs	1500						1500
Desk Chairs	1760						1760
Bookshelves	1600						1600
Conference Table	440						440
3 4WD Vehicles	82500						27500
<b>Sub-total</b>							<b>\$207,320</b>
Procurement Fee (10%)	20732						20732
<b>Staff</b>							
Rwandan PSC	22000						22000
Secretary	6600						6600
Chauffeur	6600						6600
Data Entry	6600						6600
<b>Sub-total</b>							<b>\$41,800</b>
<b>Consultants</b>							
HIS - 3 Trips/4 Weeks							
Salary	26400						26400
Travel	16500						16500
Per Diem	9887						9887
STD - 3 Trips/4 Weeks							
Salary	26400						26400
Travel	16500						16500
Per Diem	9887						9887
Q of C - 6 Trips/4 Weeks							
Salary	52800						52800
Travel	33000						33000
Per Diem	19774						19774
Breastfeeding/Weaning - 6 Trips/4Weeks							
Salary	52800						52800
Travel	33000						33000
Per Diem	19774						19774
Local Survey Contract	55000						55000
<b>Sub-total</b>							<b>\$371,721</b>

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## RIM PROJECT ILLUSTRATIVE BUDGET

Line Item	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
<b>Operating Expenses</b>							<b>6600</b>
Gasoline	3600						26400
Per Diem	28400						8448
Training Travel Expenses	8448						110000
Participant Training/Conferences Outside	110000						3000
Car Repair/Maintenance	3000						2000
Paper	2000						500
Toner	500						\$156,843
<b>Sub-total</b>							<b>6936,141</b>

### BRIDGE TOTAL

### LONG TERM TECHNICAL ASSISTANCE CONTRACT

<b>Salaries</b>							
Chief of Party	77000	82390	88157	94328	100931		442807
IEC/Training Specialist	80500	84735	89266	74115	79303		347920
Training Specialist	55000	58850					113850
Administrator	49500	52965	56673	60640	64884		284682
<b>Sub-total</b>							<b>\$1,189,238</b>
Indirect (75%)	181500	194205	160572	171812	183839		891929
<b>Allowances</b>							
Chief of Party							
Post Differential	19250	20598	22039	23582	25233		110702
COLA	3300	3432	3569	3712	3861		17874
Storage	5500	5720	5949	6187	6434		29790
Shipment	44000	0	16500				123750
POV Shipment	8250						19064
Educational Allowances	11000	11440	11898	12374	12868		59580
IEC/Training Specialist							
Post Differential	15125	16184	17317	18529	19826		86980
COLA	3300	3432	3569	3712	3861		17874
Storage	5500	5720	5949	6187	6434		29790
Shipment	44000	0	16500				123750
POV Shipment	8250						19064
Educational Allowances	11000	11440	11898	12374	12868		59580
IEC/Training Specialist							
Post Differential	13750	14713					28463
COLA	3300	3432					6732
Storage	5500	5720					11220
Shipment	44000	55000					99000
POV Shipment	8250	8828					17078
Educational allowances	11000	11440					22440
Administrator							
Post Differential	12375	13241	14168	15160	16221		71165
COLA	3300	3432	3569	3712	3861		17874
Storage	5500	5720	5949	6187	6434		29790
Shipment	44000	0	16500				123750
POV Shipment	8250						19064
Educational allowances	11000	11440	11898	12374	12868		59580
<b>Sub-total</b>							<b>\$1,203,951</b>
Indirect (25%)	87175	92733	41818	31022	88240		300988
<b>Fringe Benefits</b>							
Chief of Party	23100	24717	26447	28298	30279		132842
IEC/Training Specialist	18150	19421	20780	22235	23791		104378
Training Specialist	16500	17655					34155
Administrator	14850	15890	17002	18192	19465		85398
<b>Sub-total</b>							<b>\$356,771</b>
Indirect (75%)	54450	58262	48172	51544	55152		267579

## RIM PROJECT ILLUSTRATIVE BUDGET

Line Item	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
<b>Travel</b>							
Chief of Party							
Trip Out		13200					13200
Travel Per Diem		1100	1210		1464	1611	5385
R&R		5500		6600			12100
Home Leave			16500		19250		35750
Trip Back						16500	16500
IEC/Training Specialist							
Trip Out		13200					13200
Travel Per Diem		1100	1210		1464	1611	5385
R&R		5500		6600			12100
Home Leave			16500		19250		35750
Trip Back						16500	16500
Training Specialist							
Trip Out		13200					13200
Travel Per Diem		1100	1210				2310
R&R		5500					5500
Home Leave							
Trip Back			14124				14124
Administrator							
Trip Out		13200					13200
Travel Per Diem		1100	1210		1464	1611	5385
R&R		5500		6600			12100
Home Leave			16500		19250		35750
Trip Back						16500	16500
<b>Sub-total/</b>							<b>\$283,938</b>
Indirect (25%)		19800	17116	4950	15536	13583	70984
<b>Consultants (8 Three Week TDYs a Year))</b>							
Salary		38077	40742	43594	46646	49911	218970
Travel		44000	47060	50376	53902	57675	253033
Per Diem		19774	21751	23926	26319	28951	120720
Miscellaneous		1960	2178	2396	2635	2899	12068
<b>Sub-total/</b>							<b>\$604,811</b>
Indirect (75%)		77873	83813	90219	97126	104577	453608
<b>Equipment and Supplies</b>							
Computers		15000	5000	6000			26000
Office Equipment		27500	5000				32500
Health Center Equipment - Local		82500	33000	61215	79200	85800	341715
Health Center Equipment - Dolar		82500	33000	61215	79200	85800	341715
<b>Sub-total/</b>							<b>\$741,930</b>
Procurement Fee (10%)		20750	7600	12843	15840	17160	74193
<b>Other Direct Costs</b>							
Home Rental		42240	42240	34560	37440	40320	196800
Home Utilities		10560	10560	8640	8360	10090	49200
Office Rental		13200	13200	16500	16500	19250	78650
Office Utilities		2750	3025	3328	3660	4026	16789
Office Supplies		6600	7062	7556	8085	8651	37955
Office Guards		12376	13614	14975	16473	18120	75559
Communications		19800	21760	23958	26354	28969	120881
Publications		13200	14520	15972	17569	19326	80687
Vehicle Maintenance (x8)		8800	9680	10648	11713	12884	53725
<b>Sub-total/</b>							<b>\$710,148</b>
Indirect (25%)		32382	33920	34034	36789	40412	177537
<b>Training Direct Costs</b>							
Participant Training Outside Rwanda		110000	117700	125939	134755	144188	632581
<b>Sub-total/</b>							<b>\$632,581</b>
Indirect (25%)		27500	29425	31485	33689	36047	158145

## RIM PROJECT ILLUSTRATIVE BUDGET

Line Item	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
<b>Local Staff</b>							
Administrator/Accountant		13200	14520	15672	17569	19326	80587
Secretary		6600	7260	7966	8785	9663	40294
Receptionist		6500	6050	6655	7321	8053	33578
Chauffeurs (4)		22000	24200	26620	29282	32210	134312
Laborer		4400	4840	5324	5856	6442	26862
Sub-total							\$315,634
Indirect (25%)		12925	14218	15639	17203	18923	78908
<b>Local Currency Costs - Training</b>							
Training Per Diem		52800	29040	89544	73920	73920	319224
Training Transportation		8448	4646	15206	10962	11827	51110
Sub-total							\$370,334
Indirect (25%)		15312	8422	28186	21226	21437	92584
<b>Local Currency Costs - Other</b>							
Gasoline		27500	30250	33275	36603	40263	187890
IEC Production and Diffusion		60000	55000	60500	66550	73205	306255
Non-cash Rewards/Incentives for Health Centers		16500	18150	39930	43923	48315	166818
Health Center Refurbishment		110000	121060	133100	146410	161051	671581
Sub-total							\$1,311,525
Indirect (25%)		51000	56100	66701	73371	80709	327881
<b>CONTRACTOR TOTAL</b>							<b>\$10,615,195</b>
<b>USAID DIRECT COSTS</b>							
<b>Consultants (4 Three Week TDYs a Year)</b>							
Salary		19036	20371	21797	23323	24958	109485
Travel		22000	23540	25188	26951	28838	126518
Per Diem		9887	10875	11963	13159	14475	60360
Miscellaneous		2500	2750	3025	3328	3003	14606
Sub-total							\$310,967
<b>Evaluations and Audits</b>							
Evaluations			75000		100000	125000	300000
Audits	45000	50000	55000	60000	65000	70000	345000
Sub-total							\$645,000
<b>Other USAID Costs</b>							
Radios		8800					8800
Home Security Renovations		16000					16000
Household Furniture (x4)		150000					150000
Household Appliances (x4)		50000					50000
Home Maintenance Costs		44000	48400	39930	43923	49315	225568
Guard Service (x4)		24000	26400	29040	31944	37921	149305
Temporary Lodging			20790				20790
Project Communications	3000	2000	2200	2420	2662	3252	15534
3 4WD Vehicles		82500					82500
2 2WD Vehicles		24200					24200
Sub-total							\$742,898
<b>USAID TOTAL</b>							<b>\$1,698,665</b>
<b>TOTAL RIM PROJECT COSTS</b>							<b>\$13,150,000</b>

## G.O.R. Contribution

### SALARIES

Kigali Staff	1920	3	5760			
Regional Staff	1680	8	13440	1680	8	13440
Health Center Staff	1440	240	345600	1440	240	345600
Sub-total			370091			362408

### SUPERVISION

Salary (2 Supervisors)	23	180	4229
Salary (Chauffeur)	8	180	1510
Vehicle Use	38	180	6912
Frais de Mission (2 Super)	20	180	3600
Frais de Mission (Chauf.)	5	180	900
Sub-total			18147

84

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Salaries	370091	407100	447810	492591	541850	596035	2855478
Expansion				482365	530602	583662	1596628
Supervision	18147	19962	21958	48308	53138	58452	219966
Expansion				48308	53138	58452	159899
<b>TOTAL</b>	<b>388238</b>	<b>427062</b>	<b>469768</b>	<b>1071572</b>	<b>1178729</b>	<b>1296602</b>	<b>4831970</b>
<b>TOTAL</b>	<b>\$4,831,970</b>						

10

USAID

REPUBLIQUE RWANDAISE  
MINISTRE DE LA SANTE  
B.P. 84 KIGALI.

Kigali, le 16/7/92

RECEVEUR	
DATE REC'D	07-29-92
REPLY DATE	08-06-92
TO	710-018-1100
FROM	
SUBJECT	
STATUS	
ASSIGNED TO	
COMMENTS	
APPROVED	
COPIES	
END	
CHRON	✓

NO. 15 018 1100 / SA 1.2.1/92

**ACTION**

Action taken .....

.....

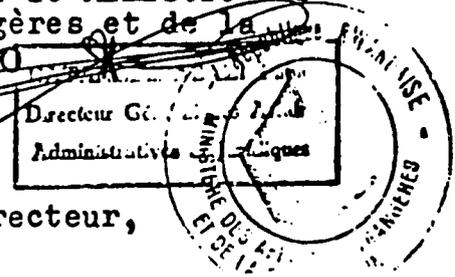
No action necessary

.....

(Initials) (DATE)

Monsieur le Directeur de l'USAID  
K I G A L I.

S/C de Monsieur le Ministre des  
Affaires Etrangères et de la  
Coopération  
K I G A L I.



Objet: Demande d'Assistance  
de l'USAID pour le  
Programme de SMI/PFB  
du Ministère de la  
Santé.

Monsieur le Directeur,

J'ai l'honneur de vous demander par la présente, l'appui de l'Agence des Etats-Unis pour le Développement International (USAID) à notre programme national de Santé Maternelle et Infantile et Planification Familiale (SMI/PF) sous forme d'un Projet Intégré de Santé Maternelle et Infantile et Planification Familiale pour une période de 5 ans allant de 1992 à 1997.

La Santé de la mère et de l'enfant constitue une grande priorité du gouvernement rwandais tel qu'il ressort de la politique Sanitaire au Rwanda.

En effet, celle-ci prône une médecine de masse, axée principalement sur les groupes les plus vulnérables dont les mères et les enfants constituent la grande majorité.

Le Gouvernement Rwandais a consenti et continue à consentir beaucoup d'efforts dans l'exécution des Stratégies de cette politique. Malheureusement, malgré les résultats remarquables réalisés, des défis très grands persistent: Les taux de mortalité maternelle et infantile restent très élevés.

C'est pourquoi je sollicite l'appui de l'USAID pour le développement d'un Projet Intégré de Santé Maternelle et Infantile et Planification Familiale ayant pour objectifs principaux:

- i) la réduction de la morbidité et de la mortalité maternelle et infantile,
- ii) une meilleure performance en prestation des services de Planification familiale,

.../...

iii) Un meilleur contrôle des maladies sexuellement transmissibles  
iv) et une amélioration du management des programmes de Santé au  
niveau des Régions Sanitaires et des Centres de Santé.

Je saisis cette opportunité pour vous réitérer, Monsieur le Directeur, mes remerciements pour la contribution importante que l'USAID apporte au gouvernement rwandais dans le domaine de la Santé et pour la suite favorable que vous voudrez bien réserver à ma requête.

Veillez agréer, Monsieur le Directeur, l'expression de ma haute considération.

Le Ministre de la Santé

Dr Casimir BIZIMUNGU.

C.P.I.à:

- Monsieur le Président de la République  
K I G A L I.
- Monsieur le Premier Ministre  
K I G A L I.
- Monsieur le Ministre du Plan  
K I G A L I.



INITIAL ENVIRONMENTAL EXAMINATION  
OR  
CATEGORICAL EXCLUSION

Project Country: Rwanda  
Project Title: Reproductive Health/STD Project  
Funding: FY 1992 \$7,200,000  
IEE Prepared by: ADO, Paul Crawford *P.C.*  
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:

Bureau Environmental Officer

*J. J. J. J.*

APPROVED

DISAPPROVED

DATE 24 Sept 1991

Clearance: GC/APR

*(draft)*  
See STATE 316961  
Date 24/9/91

## F. STATUTORY CHECKLIST

### 5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

#### A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance 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 loan associations;
- (d) discourage monopolistic practices;
- (e) improve technical efficiency of industry, agriculture, and commerce; and
- (f) strengthen free labor unions.

N/A

2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance 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).

N/A

### 3. Congressional Notification

a. General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be 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 (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

NOTIFIED IN FY92 CP

b. Notice of new account obligation (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. Engineering and Financial Plans (FAA Sec. 611(a)): 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?

N/A

5. Legislative Action (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, 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?

N/A

6. **Water Resources (FAA Sec. 611(b); FY 1991 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

7. **Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec. 575(b)):** Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

N/A

8. **Capital Assistance (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

9. **Multiple Country Objectives (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 loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

N/A

10. **U.S. Private Trade (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).

N/A

**11. Local Currencies**

**a. Recipient Contributions**

(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.

N/A

**b. U.S.-Owned Currency (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?

NO.

**c. Separate Account (FY 1991 Appropriations Act Sec. 575).** If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

## 12. Trade Restrictions

a. Surplus Commodities (FY 1991 Appropriations Act Sec. 521(a)): 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

b. Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)): 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?

N/A

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

N/A

14. Sahel Accounting (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. PVO Assistance

a. Auditing and registration (FY 1991 Appropriations Act Sec. 537): 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.?

N/A

b. Funding sources (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): 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?

N/A

16. Project Agreement Documentation (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).

It will be sent within 60 days of the signing.

17. Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the

NO.

extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

18. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

YES

19. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

NO

20. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

NO

b. Will any funds be used to lobby for abortion?

NO

21. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

NO

**22. U.S.-Owned Foreign Currencies**

**a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509):** Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. N/A

**b. Release of currencies (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? NO.

**23. Procurement**

**a. Small business (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

**b. U.S. procurement (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

**c. Marine insurance (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? N/A

**d. Non-U.S. agricultural procurement (FAA Sec. 604(e)):** 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

**e. Construction or engineering services (FAA Sec. 604(g)):** Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible N/A

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.)

f. **Cargo preference shipping**  
(FAA Sec. 603): Is the 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.

g. **Technical assistance**  
(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

h. **U.S. air carriers**  
(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

i. **Termination for convenience of U.S. Government** (FY 1991 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

**j. Consulting services**  
(FY 1991 Appropriations Act Sec. 524): 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)?

N/A

**k. Metric conversion**  
(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

NO.

**l. Competitive Selection**  
Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

YES

#### **24. Construction**

**a. Capital project (FAA Sec. 601(d)):** If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A

**b. Construction contract (FAA Sec. 611(c)):** If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

NO.

**c. Large projects, Congressional approval (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 Congressional Presentation), or does assistance have the express approval of Congress?

N/A

**25. U.S. Audit Rights (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

**26. Communist Assistance (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

**27. Narcotics**

**a. Cash reimbursements (FAA Sec. 483):** Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?

N/A

**b. Assistance to narcotics traffickers (FAA Sec. 487):** Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?

N/A

28. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing 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
29. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? YES
30. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? YES
31. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? N/A FOR DFA
32. **Military Personnel** (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? YES
33. **Payment of U.N. Assessments** (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? YES
34. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? YES
35. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? YES

36. Repression of Population (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing 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

37. Publicity or Propoganda (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propoganda 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 propoganda purposes not authorized by Congress?

NO

38. Marine Insurance (FY 1991 Appropriations Act Sec. 563): 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

39. Exchange for Prohibited Act (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

NO

**B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY**

**1. Agricultural Exports (Bumpers Amendment) (FY 1991 Appropriations Act Sec. 521(b), 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: (1) 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 (2) in support of research that is intended primarily to benefit U.S. producers?

N/A

**2. Tied Aid Credits (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"):** Will DA funds be used for tied aid credits?

NO.

**3. Appropriate Technology (FAA Sec. 107):** Is special emphasis placed on use of appropriate technology (defined as 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

**4. Indigenous Needs and Resources (FAA Sec. 281(b)):** Describe extent to which the activity 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 civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

The project assists the government to adopt policies and practices which improve the health and well-being of Rwandans. By training health service providers at the lower levels of the hierarchy, in management and clinical skills, it is empowering them to use limited human and material resources in more efficient ways.

5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

YES

6. Special Development Emphases (FAA Secs. 102(b), 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) encourage democratic private and local governmental 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.

a) N/A

b) N/A

c) Improving the reproductive health of the population ultimately leads to a healthier, more self-sufficient and more productive populace.

d) Improving women's reproductive health increases their capacity to participate in economic activity.

e) N/A

7. Recipient Country Contribution (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

8. Benefit to Poor Majority (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

9. Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

- a. 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
- b. 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
- c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO
- d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? YES
- e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? NO
- f. 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
- g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? NO

10. **Contract Awards (FAA Sec. 601(e)):** Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

YES

11. **Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567):** 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)?

TEN PERCENT MINIMUM

12. **Biological Diversity (FAA Sec. 119(g)):** 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 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?

N/A

13. **Tropical Forests (FAA Sec. 118; . FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):**

N/A

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent

feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) 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; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) 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; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

**c. Forest degradation:** Will assistance be used for: (1) 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; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded 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?

N/A

**d. Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

**e. Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

YES

14. Energy (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

15. Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): 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) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided in close consultation with 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; (e) being used 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; (f) 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,

a) Yes

b) N/A except to the extent that this project is working with the peripheral levels of the Ministry of Health, encouraging decentralization of resources.

c) Yes

d) There is not a PVO component in this project.

e) This project addresses the need to improve the health of Rwandans, particularly mothers and children, by encouraging the utilization of a comprehensive package of reproductive health care services including family planning. Likewise, it affects positive policy changes in reproductive health care which will lead to better health for Rwandans.

f) N/A

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?

16. Debt-for-Nature Exchange (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

17. Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

18. Loans

N/A

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

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b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

N/A

c. Interest rate (FAA Sec. 122(b)): If development loan is 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

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A

19. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out 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 the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

N/A

mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

22. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

23. **Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

24. Sahel Development (FAA Secs. 120-21). If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom).

N/A

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C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

THIS SECTION IS NOT APPLICABLE TO THIS PROJECT

1. **Economic and Political Stability** (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?

2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes?

3. **Commodity Grants/Separate Accounts** (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?

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106?

5. **Cash Transfer Requirements** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of a cash transfer:

a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds?

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b. Local currencies: Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated; the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

c. U.S. Government use of local currencies: Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available?

d. Congressional notice: Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?