MIDTERM EVALUATION OF THE
RWANDA MATERNAL AND CHILD
HEALTH FAMILY PLANNING II PROJECT
(696-0128)

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The USAID, the National Office of Population (ONAPO), Management Sciences for Health and SEATS made every effort to see that we were well briefed in Rwanda, received relevant documentation, had adequate travel arrangements, and had their full cooperation and timely response to requests for information. Our travel to regional offices and service delivery points and our understanding of the ONAPO program was greatly facilitated by the ONAPO representative, Mathias Ngendakumana, who made appointments and arrangements for us and accompanied us in a helpful way throughout our time in Rwanda.

The staff of ONAPO at central and regional levels as well as those of the Ministry of Health were gracious in receiving our visits, arranged travel to service delivery points and answered our inquiries frankly and openly. Clinic personnel were most helpful in permitting our observation of their services and taking time to explain their program.

The representatives and staff of other projects (RIM, AIDSCAP, PSI, CARE and ARBEF) and other donor agencies (UNFPA, World Bank, GTZ) helped us get a better perspective on population programs in Rwanda and potential for the future.

Finally, words cannot express our appreciation for the way the U.S. Ambassador, his Embassy staff, and the USAID staff responded to the requirements of an emergency evacuation. Others in the American community in Rwanda and citizens of the country were more inconvenienced and more endangered than was the evaluation team. That our difficulties were not greater was due in large part to the way the official community responded and handled the evacuation. Needless to say, our appreciation extends to the Embassy and EASED in Burundi and to the U.S. Marines who received us so kindly and transported us to Nairobi. There, we were treated with the utmost concern by Embassy and AID personnel and effective arrangements were made for our rest and onward travel. During our stay in Nairobi the hotel room Bible opened to Psalm 107, a fitting tribute to another source of much appreciated help.
ABBREVIATIONS

A.I.D.Agency for International Development
AIDSAcquired Immune Deficiency Syndrome
ARBEFAssociation Rwandaise pour le Bien-Etre Familial
AVSCAssociation for Voluntary Surgical Contraception
BUFMARBureau des Formations Medicales Agrées du Rwanda
CBDCommunity Based Distribution
CCDFPCentre Communal de Développement et de Formation Permanente
CPRContraceptive Prevalence Rate
CSMContraceptive Social Marketing
CYPCouple Year of Protection
DHSDemographic and Health Survey
EPIExpanded Program of Immunization
FPFamily Planning
GORGovernment of Rwanda
GTZGerman Development Cooperation Agency
HIVHuman Immunodeficiency Virus
IECInformation, Education and Communication
INTRAHALnternational Program for Training in Health
IUDIntrauterine Device
IPPIInternational Planned Parenthood Federation
JHPIEGOJohns Hopkins Program for International Education in OB/GYN
MCHMaternal and Child Health
MCH/FPMaternal and Child Health/Family Planning
MEDIRESAMédecin Directeur de la Région Sanitaire
MOHMinistry of Health
NGONon Governmental Organization
NFPNatural Family Planning
ONAPOffice National de la Population
PNLSProgram National de Lutte contre le SIDA
PSIPopulation Services International
RAPIDResources for Awareness of Population Impacts on Development
RIMRwanda Maternal and Child Health/Family Planning Project
TFRTotal Fertility Rate
SOMARCSocial Marketing for Change
STDSexually Transmitted Diseases
UNFPAUnited Nations Fund for Population Activities
UNDPUnited Nations Development Program
UNICEFUngted Nations International Children Emergency Fund
USAIDUnited States Agency for International Development Mission in Rwanda
VSCVoluntary Surgical Contraception
WHOWorld Health Organization

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PROJECT IDENTIFICATION DATA

1. Country: Rwanda
2. Project Title: Maternal and Child Health and Family Planning II Project
3. Project Number: 696-0128
5. Critical Project Dates:
   - Project Approval: 07/12/89
   - Initial Obligation: 07/12/89
   - Project Assistance Completion Date (PACD): 06/30/94
   - PACD (Revised): 09/30/95
   - Date of Audit: 10/93
   - Date of Evaluation: 03/94
6. Project Funding: (Dollars 000)
   - USAID bilateral: $10,893
   - Government of Rwanda: 8,170
   - Central AID population funds for core costs of certain projects (DHS, RAPID, AVSC, etc.) and central grant to CARE: total unavailable
7. Mode of Implementation:
   - Project agreement with GOR for local costs of ONAPO obligated through Project Implementation Letters (PILs)
   - Institutional contract Management Sciences for Health
   - Buy-ins to central projects (INTRAH, AVSC, Population Council, JHPIEGO, SOMARC, SEATS, RAPID)
   - OYB transfer presumably for contraceptive purchases
8. Responsible USAID officers at time of evaluation:

- Director (just left post)  Gary Nelson
- Acting Director  Dirk Dijkerman
- Health and Population Officer  William Martin
- Project Manager  Patrice Nzahabwanamungu

9. ONAPO Director:  Madame Gaudence Habimana Nyirasafari

10. Resident Technical Advisors:

- MSH Chief of Party  Richard Roberts
- MSH Financial Advisor  David Addison
- SEATS Resident Representative  Dr. Marcel Vekeman
EXECUTIVE SUMMARY

Introduction

Faced with one of the most critical population growth/land availability problems in Africa, (population growth rate about 3% and density of population allowing only .6 hectare per family), Rwanda has been developing a comprehensive approach to these factors for more than a decade. USAID began its first bilateral assistance to Rwanda with a Maternal and Child Health and Family Planning project in 1981. Building on the success of that effort, a follow-on project, Maternal and Child Health and Family Planning II was developed in 1989 to respond to the needs for improved management, a stronger population policy, increased information, education and communication (IEC) and training and expanded access to family planning through the Ministry of Health and increased efforts in the private sector. This $10.8 million project 696-0128 was signed in 1989 with a project completion date of Nov. 30, 1994, subsequently extended to September 1995. GOR contributions were estimated at $8.17 million.

The goal of the project was to increase knowledge of family planning to a level of 95% of the population, decrease the desired family size to 5 and increase the use of modern contraceptives to a prevalence level of 15%. The total fertility rate (TFR) was expected to drop from 8.6 to 8 and the population growth rate from 3.7% to 3.2% per year.

The project was to be implemented through a bilateral agreement with the Government of Rwanda to support the local costs of the National Population Office (ONAPO) which would be the responsible GOR agent cooperating with the Ministry of Health in the management of the project. A USAID funded institutional contract provided the bulk of technical assistance for financial management, program monitoring and planning and managed the out of country training aspects. Buy-ins to AID R&D Population central projects provided additional technical assistance and financial support for other specialized functions such as the RAPID models for policy development, the Demographic and Health Survey (DHS), in-country training and IEC and family planning service, especially the introduction of Community Based Distribution (CBD) and surgical contraceptives.

The early optimism for progress was dimmed by a series of limiting factors, the most dramatic being the warfare that started in 1990 and continued with varying degrees of intensity throughout the project life. This, coupled with the disruption caused by political change in the "democratization" process, made project success problematic.

This evaluation was carried out in March and early April, 1994 at a time when it appeared the August 1993 peace accord was about to produce a new and more stable government. Nonetheless, it was apparent that the problems mentioned above had taken a serious toll on ONAPO whose management processes were no longer appropriate for the changing situation, and whose staff capabilities had been gravely eroded. The evaluation carried out by a three person team provided by the central POPTECH project had proceeded through most of the process of data collection when warfare broke out again and the total US mission was evacuated. The evaluation report suffers from the inability to gather all the information, clarify certain matters with USAID, ONAPO and contractors, and finalize the report as a team effort. Nevertheless, it provides a relatively accurate assessment of project progress to date. It was difficult to make
recommendations in these circumstances. However, the report includes a substantial section prepared at USAID request with some suggestions for the future (made before the evacuation). Some recommendations are directed at a few things USAID and contractors might do in the process of terminating this phase; others are directed to elements to be considered in any future programming.

As the evaluation team approached this work, we were impressed with the difficulties under which personnel of USAID, ONAPO, MOH contract agencies, and other donor agencies were working during the time of this project. Though shortcomings in project performance were noted, we were impressed with how much was actually accomplished toward achieving the objectives of this population project, so critical to Rwanda's future.

Findings and Conclusions

Policy Development

Through the development and utilization of the Rwanda RAPID cost benefit model the project made a substantial contribution to the articulation and adoption of a very positive National Population Policy in 1990. Widespread dissemination of this information through seminars and workshops at the national and local levels no doubt contributed to the public approval of family planning and population programs. It strengthened the participation of the Ministry of Health and initiated greater involvement by Ministries of Agriculture, Education, and Women in a more comprehensive population program. Plans were being developed for the production of a revised model for future use.

Accomplishing a national DHS was complicated by national security problems but this instrument is now essentially complete and available for measuring program progress and use as a policy development instrument in the future. ONAPO would have required more help in analyzing the implications of the data for program planning purposes and to make it most understandable for the various policy development audiences with which it might have been used.

With its staffing problems ONAPO had less success in developing the research necessary to experiment with and analyze new service delivery modalities. Although not emphasized in project design, the issue of the status of women could have received more attention than it did in project implementation.

Information, Education and Communication (IEC)

Despite ONAPO's being largely unsuccessful in developing a national strategy for IEC, some important activities were carried out and objectives accomplished. A substantial increase in knowledge of family planning was accomplished and desired family size as measured by the DHS has decreased.

Much of the activity in this area was through ONAPO's training function. That which in other programs is often called IEC, i.e. popular education and audio-visual materials, received less attention. Limited mass media material was produced with some emphasis on radio spots, two
posters and a calendar produced each year and leaflets and comic books.

The greatest emphasis has been on interpersonal communication through cooperation with the Communal Centers for Development and Continuing Education (CCDFP) in the training of the Abakangurambaga ("awakeners of the people") community leaders, an apparently effective approach that has been weakened by the present political situation. Less attention has been given to developing the communication skills needed in family planning by health center personnel.

ONAPO has assisted the Ministry of Education to develop curricula for population education both in formal and non-formal education settings. Some teacher training has been initiated but more must be done to improve the quality of the curricula and accelerate the training programs.

Substantial improvement is required in ONAPO's institutional capacity to develop an effective IEC program, identify and test the most appropriate messages for particular target groups and evaluate progress in moving those who are knowledgeable about family planning into the group who are active users of modern contraception.

Training

Substantial progress was made in meeting the objectives of the project in providing both short and long term out-of country training. In-country training for trainers and medical and paramedical personnel was being provided through the assistance of INTRAH, JHPIEGO, AVSC and SEATS.

Although the project covenant calling for the national training center to become more autonomous has not been fulfilled, substantial training has been carried out at this residential facility. Other training has been carried out in the regions, resulting in a substantial corps of service providers available at most of the MOH health centers being trained in family planning service delivery. Specialized training has been introduced in the provision of more long acting contraception such as NORPLANT, tubal ligation and vasectomy. Pre-service family planning curriculum has been developed for the University of Rwanda medical faculty. By the time of the evaluation nearly 100% of the out-of country training objectives had been met and between 55 and 66% of the in-country objectives were met.

Problems have been encountered in the lack of follow-up in maintaining the data base for trainees; some question can be raised about the adequacy of the needs assessments for various levels of service providers and their curriculum; the shift toward training health auxiliaries who are increasingly the main providers of family planning services has been slow; training in family planning communication/counseling skills has been weak and the participation of several donors with different training objectives and different policies toward paying instructors and per diem for trainees has been a complicating factor.

Given the problems outside the project's control and those internal to the project itself, it is unlikely that the project's training objectives would be fully accomplished either in numerical or quality terms.
Service Delivery

Varied success has been obtained in achieving the project's objectives of improving access and quality of family planning services.

Access to services has improved considerably as by mid-1993 nearly all the 340 public health centers were providing family planning services -- although not all of the same quality or comprehensive nature. Although contraceptive supplies have been regular, most of the centers are missing items of essential equipment. Supervision of a supportive nature has been weak. About 60 secondary posts have been developed to provide family planning in areas served by religious centers which do not provide these services. Nevertheless, only some 60% of the women have "easy" access to services, spending less than one hour to reach them.

There has been a substantial expansion in the choice of methods available with significant increase seen in the provision of those contraceptives most appropriate for couples desiring to substantially delay or limit their child bearing. Injectables remain the method of choice for 55% of the clients and pills for 25%. However, NORPLANT is now used by 5% of the clients, tubal ligation by 3% and vasectomy by 0.5%.

Recent studies in two regions by the RIM project, a 1993 INTRAH evaluation, a 1993 ONAPO/MOH review of integration and observations of the evaluation team demonstrate there is much progress yet to be made in improving the technical competence of personnel, improving their attitude and comportment in handling clients, developing greater skills in counseling and provision of general family planning information. These factors vary with categories of health personnel and between the public and church owned centers but with all groups there is the need for better training and greater compliance with accepted standards.

The management of family planning services within the health posts has improved substantially with the RIM study indicating integration is well advanced in many centers. FP is no longer considered a marginal activity and is ranked third in order of importance after curative services and immunization. Yet less than half of the centers provide family planning five days a week and in 30% FP services are still available only one day a week. A note of caution is raised as to the desirability of full integration if it means that family planning clients will actually receive less attention from busy health care providers who are occupied with other responsibilities. One of the values of integration, the referral of clients who come to the center for other purposes to the family planning services, is apparently not well exploited.

The Bamako initiative with its policy of charging for services is not operational in all of Rwanda as yet. However, some concern has been expressed as to the potential depressing effect on family planning acceptors if they are required to pay for this preventive service.

Service statistics are maintained with considerable attention to detail and with means to identify new users, continuing users and drop outs. Although cumbersome to manage, especially as client loads grow, the completeness and timeliness of these statistics has provided a wealth of information for project management purposes. It has enabled the identification of a growing problem of increases in the numbers of drop outs at the same time new acceptor numbers were declining. Contraceptive prevalence levels measured by service statistics reached a level of nearly 15% at the end of 1991. They have subsequently declined to near 10%. Clearly these user rates have been influenced by
war and political disruption. However, valid concerns have been raised about continuity rates, particularly as they may indicate poor quality of service. It is noted that world wide statistics show similar or worse rates for temporary methods. Rwanda's growing success with promoting longer acting contraceptives with excellent continuation rates points toward this approach as an area for greater emphasis.

Initial efforts with community based distribution (CBD) supported by CARE, SEATS and GTZ as well as condom social marketing supported by SOMARC and PSI suggest that there is a demand and some market for outreach efforts that bring contraceptive services closer to the people. Early success in extending services through the Abakangurambaga community leaders have been marred by political considerations; this may not be an effective approach for the future. Efforts to stimulate the private sector to develop family planning services have identified an embryonic potential in the family planning association, ARBEF, and among private health care practitioners but have progressed little further.

In conclusion, the USAID MCH/FP II project has significantly contributed to improve access to and use of modern contraceptive methods. Through the integration of family planning in nearly all the MOH health centers and the development of outreach services, 60 to 70 percent of women have easy access to FP services. However, the services are not without their problems, problems which are addressed by the recommendations in the report.

Management Issues

Little progress was made in achieving the management improvement that was expected to be accomplished with ONAPO. Much of the problem of staff turnover and staff vacancies were outside ONAPO's control as national security issues and political changes impacted on availability of resources, personnel morale and sense of job stability and the appropriateness of ONAPO's authoritarian management style dependent on a strong political base. Whatever the reason, the end of project status will find ONAPO's former contribution primarily apparent in its early success and the presence of the best qualified former staff in other governmental agencies, NGOs and the projects of other donor agencies and USAID contractors. Clearly some progress was made in the utilization of the management systems introduced by the contractor, Management Sciences for Health. ONAPO staff have developed skills in carrying out the routine tasks made more efficient by computerized systems. However, ONAPO has not been able to take full advantage of the potential for imaginative and effective use of these systems for analysis of financial and programmatic progress or in program planning. Greater capability was developed at the regional level and collaboration with the Ministry of Health was improved at the regional level. The quarterly meetings that were held regularly with the ONAPO regional delegates and the central staff had much to do with stimulating and improving performance.

One of the more positive elements of project management was the regular and well documented meetings of the "Comite Mixte" or coordinating committee comprised of ONAPO, MOH, USAID and MSH. This regular opportunity to review progress and problems contributed to accomplishing the shift of responsibility from ONAPO to MOH for service delivery and in-country contraceptive logistics. This committee substituted in some degree for the expected project management team which was not functional. However, it did not fulfill a major role of the project management team which was to visit the field on a monthly basis. Had this been done there may have been an earlier
recognition of the shortcomings in the integration of family planning into MCH that were identified in a 1993 internal evaluation or the earlier identification of the importance of training health auxiliaries for family planning service delivery. The problem of integration may have been related to the project design not adequately spelling out MOH responsibilities or making the linkages with the MOH (largely supported by World Bank) that would have been possible through some financial participation in MOH MCH/FP operational costs.

A major gap in project performance was the inability of ONAPO to develop a support structure for private sector family planning activities, due in large part to their not putting their own financial management house in order.

MSH made highly qualified technical personnel available to ONAPO throughout the project. They very effectively developed modern computerized management instruments for financial management, monitoring and analysis of service statistics, logistics management, training and program planning. Not all of these systems have been fully documented. As ONAPO was unable to maintain adequate staff to develop skills in the use of these systems, MSH frequently was required to carry out some of the functions that should be done by ONAPO staff. This limited ONAPO’s taking full advantage of this technical assistance to improve their institutional capability. It also precluded MSH from doing some of the programmatic monitoring and field observation that was part of their technical assistance role.

MSH effectively fulfilled their responsibilities for the out of country training planned in the project design. Three of the participants remain in the United States at this time.

USAID carried out its responsibilities to the project through the effective participation of the Health and Population Officer and the Foreign Service National Project Manager. They were regular in attendance at coordinating committee meetings; assured the provision of adequate technical assistance through the MSH contract and through buy-ins to central projects; regularly assessed project progress and maintained USAID management apprised of problems through the Project Implementation Reports (PIRs); contracted for an audit to be carried out when conditions in country made it possible, calling relevant issues to the attention of the auditors; assured appropriate levels of local cost funding through Project Implementation Letters (PILs) and did all they could to maintain a flow of funds to ONAPO in spite of its financial management problems. Although donor coordination was not managed by ONAPO as planned, USAID and the other donors themselves met regularly to deal with mutual problems.

In its project management USAID could have used earlier and more frequently such instruments as PILs, other letters, or responses to MSH reports as a way of more formally calling attention to problems and successes in project performance.

Project Impact

The project had disappointingly little impact on the institutional development of ONAPO in a management sense or in the development of the private sector. It did make an important contribution through its training to the capacity of ONAPO training teams and MOH service providers. The development and adoption of a National Population policy, the RAPID models and DHS as policy development tools were significant contributions to institutional development and
population policy, although more could have been done to advance the status of women.

The most significant impact of the project was in the increase in knowledge and improved attitude toward family planning (97% knowledge, 93% favoring and desired family size 4.4) and prevalence of the use of modern contraceptives (13%) as measured by the DHS in 1992. Subsequent decreases in levels of use as measured by service statistics may have been related to service quality, but they were certainly also affected by the displacement of a million persons due to the war and because of political disruption. The startling reduction in fertility as measured in the preliminary report of the DHS has stood up to further scrutiny. The TFR was as low as 6 in 1992 and the rate of natural increase of the population may have been below 3%. While these calculations suggest that the original baseline estimates of the project were somewhat elevated, real increases in contraceptive prevalence and substantial reductions in fertility did occur as a result of project interventions. Despite this reduction in fertility it was still at a high level continuing to fuel the fires of rapid population growth inimical to Rwanda's future socio-economic development.

Future Directions

A discussion of future directions was developed during the evaluation. It has been reproduced in the report even though much of what was said has been overtaken by events. Nevertheless, the general thrust of the future thoughts will remain valid for future program direction, i.e. there will continue to be a population problem of considerable magnitude; it must be addressed with further attention to policy development, IEC and training, but increasing the access of the population to quality family planning services will be of paramount importance. This can be achieved through assistance both to the public and private sectors with careful attention to coordination with other donors and other projects.

Lessons Learned

The lessons learned raise a note of caution in the way independent FP structures which may be effective initially require changing policies with changing conditions and maturity of other approaches. Similarly, programs need to be wary of those structures that may be too closely identified with a particular political party.

Training in IEC requires a clear definition of IEC strategies. Participation of the private sector can be important in providing family planning services, but more initial support is required than planned in this project and the involvement of the public sector with the private initiatives is to be viewed with some caution.

The development and use of computerized systems for management information must be prioritized carefully with other requirements of programmatic monitoring and other means of gaining management information through field observation.
SUMMARY OF RECOMMENDATIONS

1. USAID should review with Macro the requirements for publishing the final DHS report with a Macro produced analytic addenda distilling the programmatic implications of the data. (Page 13)

2. USAID should continue in force its PIO/T with Futures for the development of a new RAPID Rwanda model. (Page 13)

3. ONAPO should develop a viable IEC strategy to guide its diverse and important activities. (Page 20)

4. ONAPO should re-evaluate the deployment of Abakangurambaga in light of both the strengths of this system and the weaknesses brought about by the socio-political changes taking place in Rwanda. (Page 20)

5. Once a strategy has been defined for FP/IEC, ONAPO must give serious attention to the skills and materials necessary to implement IEC activities. (Page 21)

6. Future Project efforts should support the institutionalization of integrated comprehensive reproductive health services as the most viable mechanism to improve access to, and quality and acceptability of public sector FP services in Rwanda. (Page 33)

7. Before any future training is done (either clinical, FP auxiliary or teacher training), ONAPO and MOH must clarify training needs and redefine curricula based on competencies needed by personnel to be trained. The donor community should provide technical assistance in needs assessment and curriculum development. (Page 33)

8. ONAPO should update and maintain the computerized list of health workers and the in-service training they have received needs to be up-dated. (Page 34)

9. ONAPO and MOH should reassess the efficiency and effectiveness of alternative mechanisms for responding to clinical FP training needs. (Page 34)

10. ONAPO, MOH and technical assistance agencies should give major priority to the training of health auxiliaries, due to their de facto role in the provision of FP services and their general lack of preparation for this task. (Page 34)

11. The USAID mission should seek a resolution to the issues of per diem, trainer compensation and participant "sitting fees" before agreeing to support further training. (Page 34)
12. ONAPO, USAID and the involved agencies should evaluate the Abakangurambaga and the three CBD programs conducted with the assistance of SEATS, CARE and GTZ; analyze in each one factors favorable and constraints to the recruitment of new acceptors and the promotion of continuing FP use; organize a workshop to discuss results, define an overall policy regarding community based approach and develop a strategy to implement ONE community based distribution system which, closely related to the social marketing program, would operate in a quasi-commercial fashion. (Page 53)

13. ONAPO, MOH or others developing service delivery policy should determine that using an appropriate check list, CBD agents should be allowed to provide the first supply of pills. Likewise, CBD with a paramedical profile (with the necessary technical skill and experience to correctly perform an injection in good aseptic condition) should be authorized to provide injectables in a convenient site for the population (at the village level, at market place, at their home). (Page 53)

14. The agencies establishing policy and program for CBD should develop an appropriate training curricula and a comprehensive training program for CBD with a strong component on counseling to counteract rumors, promote the adoption of long term methods and encourage continuity. (Page 54)

15. The agencies developing the CBD program should establish it as a "private sector initiative" with commitment, involvement and responsibility of the community. While the respective role that ONAPO and the MOH will play in the CBD system is still to be defined, overall managerial responsibility for the CBD program should rest in the private sector such as ARBEF for instance, with strong technical support of PSI. (Page 54)

16. ONAPO and the MOH should conduct an operational study in the best performing health centers in order to identify specific managerial factors that could explain or contribute to better accomplishment. (Page 54)

17. To recruit more new acceptors and increase continuing use, ONAPO, MOH and other public or private sector service providers should take action to improve access, acceptability and quality of FP services. (Page 54)

18. The agencies establishing service delivery policy should determine that health auxiliaries -as well as other paramedical personnel- should, after proper training, perform the full range of FP services (reception, presentation of various FP methods, medical history, physical exam and provision of all methods excluding IUD and NORPLANT) without having to systematically call upon the chief of health center to complete the physical examination for new acceptors. (Page 55)

19. ONAPO should take action at various levels to improve contraceptive stock management. (Page 55)

20. ONAPO and MOH should review modalities, instruments and purpose of supervision to enhance the contribution of supervision in the overall improvement of the quality of FP service delivery. (Page 56)
21. Program policy and programming should place greater emphasis on increasing acceptance of long term methods (NORPLANT, tubal ligation and vasectomy). (Page 56)

22. USAID should arrange with MSH to continue support for and possibly extend the academic programs of participants being trained in the United States under this project. (Page 67)

23. USAID should arrange with MSH enough additional contract time to provide for completing the documentation of the computerized instruments developed for project management. (Page 67)

24. The Agency for International Development should reconsider its policy of prohibiting any research on the prevalence of abortion whether legal or clandestine. (Page 74)

25. As soon as security and political conditions permit, the international donor community should stand ready to assist Rwanda in reorganizing well managed efforts to deal with the problem of rapid population growth which will continue to persist in critical proportions despite recent progress in reducing fertility. (Page 74)
1. INTRODUCTION

1.1 Background

Few countries in Africa face such a critical population vs. resource and development crisis as that seen today and expected to worsen in the future in Rwanda. Extremely high fertility rates apparently peaked at a total fertility rate (TFR) of about 8.6 in the late '70s and early '80s. The death rate has only decreased gradually from the highs above 20/1000 in the '60s and '70s. Some improvement in general health and welfare during the '80s and expanded programs of protection against childhood diseases may have been balanced by increases in deaths due to HIV/AIDS which entered the picture in the early '80s. Despite a remarkable decrease in fertility over the past ten years, the population growth rate may still be 3% per year. The prospects are for present population numbers approaching 8 million to double in less than twenty-five years in this country which is already the most densely populated of Africa.

Rwanda has experimented with the efforts many other countries have tried to cope with rapid growth, stimulating expanded and improved agriculture and encouraging both internal and external migration. Yet, Rwanda has seen population density increase to the degree that each family has only .6 hectare to cultivate and there is no more available arable land. The good soils of the mountainside are being depleted by short rotations and washed away by roaring, brown streams despite valiant efforts of terracing and reforestation. Unfortunately, the escape valve of external migration to neighboring countries has become less feasible. Job creation in the modern sector is extremely slow providing little employment potential for a portion of the 95% of the population living in rural areas who might leave the countryside for the cities. In light of these realities, Rwanda was the first Francophone Sub-Saharan African country to develop a population policy that frankly states the problem created by rapid population growth, adopts vigorous goals for reduction and focuses on the need to expand family planning services and use of modern contraceptives as the primary means to achieving these goals.

Along with other donors and as part of Rwanda's efforts to identify the problem and implement programs to deal with it, USAID has provided assistance to Rwanda's population program for a dozen years. The first USAID supported project was the Maternal and Child Health and Family Planning project signed in September 1981. A subsequent Maternal and Child Health and Family Planning II was signed with the Government of Rwanda in July of 1989 and is the subject of this evaluation.

1.2 The Project

The Maternal and Child Health and Family Planning II (MCH/FP II) project 696-0128 is a five-year, US $10.8 million USAID mission supported project signed in 1989. The original project completion date was November 30, 1994, now extended to September 1995. The project goal is to reduce the total fertility rate from 8.6 to 8.0 and the population growth rate from 3.7% per year to 3.2% per year. The project purpose is to expand and improve the delivery and use of family planning information and services through both the public and private sectors, as measured by increased contraceptive prevalence from 3% to 15% of
women in union between the ages of 15-49 (MWIFA). Knowledge of all available family planning methods is to increase from 70% to 95% of all men and women between the ages of 15 and 49. The desired family size is to decrease from 6 to 5.

The project was designed to build on the successes of the National Population Office (ONAPO) in developing population policy and initiating family planning services. It was to accelerate the shift of service delivery to the Ministry of Health and address management problems that became apparent in the implementation of the first MCH/FP project. The project consists of four mutually supportive components: a) Support for Policy Development and Research, b) Family Planning Services Delivery, c) Information, Education and Communication and d) Institutional Support to Increase Management Capability.

Responsibility for project implementation rests with ONAPO with day to day management to be carried out by a management team composed of a representative each from ONAPO, Ministry of Health (MOH), USAID, and the technical advisor in family planning. Local cost financing for project activities comes from USAID through its agreement with ONAPO; long and short term technical assistance (TA) and out of country training programs are provided through an institutional contract with Management Sciences for Health (MSH); additional local costs as well as foreign exchange costs for TA, equipment and supplies are accessed through buy-ins and add-ons to AID R&D Office of Population centrally funded projects. R&D Population resources supplement Mission funds through projects of the Population Council, SEATS, AVSC, IRD and CARE. The Government of Rwanda contribution is chiefly contribution in kind valued at US$8.17 million, including ONAPO salaries and offices and partial salaries of Ministry of Health personnel.

1.3 Inhibiting Factors

The evaluation of a project such as this should be approached with a good deal of humility. One can list some critical shortfalls in progress toward desired goals, but the list of serious problems outside the control of the project may be even more critical. Despite these problems, personnel of ONAPO, MOH, USAID, MSH, SEATS, INTRAH, JHPIEGO, IRD/FUTURES, AVSC and CARE are to be congratulated for their perseverance and dedication to a task that is so critical to Rwanda's future. Major (and reasonable) assumptions were made in the project design which did not prevail throughout most of the project. For example, the Project Paper includes assumptions such as "economic and political stability, - economic situation does not deteriorate, -ONAPO and MINISANTE obtain and retain adequate staff." The lack of political and economic stability was clearly outside the control of project managers and the ability to retain adequate staff was only partly controllable by the grantee.

Just as the project was beginning, in October 1990, revolutionary forces (RFP) invaded from the north to begin the war that has lasted with varying degrees of intensity throughout most of the life of the project. The RFP offensive of February, 1993 was particularly devastating to government and economic activity in the country. When the RFP advance stopped within 18 miles of the capital, Kigali, nearly one million people had been displaced. Implementation of most development activities ceased as bi- and multi-lateral donors responded to the needs of the displaced, some of whom had been displaced for the third time since 1990. (USAID Assessment of Program Impact in Rwanda, FY 1993)
At the same time the war was draining government resources away from development activities and disrupting their implementation, political changes brought their share of problems. Political change, even for the better, can be disrupting. In this instance the process of "democratization" brought an end to the one-party MRND control, spawning a multitude of other groups. The previous unified and rather effective system, albeit somewhat authoritarian, contributed considerably to the growing success of the ONAPO led population program. However, with "democratization" the political system became fractioned and fractious. Old styles of program management were no longer appropriate and the community participation in development which had been the hallmark of Rwanda's progress became badly frayed. One of the most serious results was the disruption of the communication systems at the grass roots level, particularly that produced by the Commune (county) Center for Development and Continuing Education (CCDFP). This institution, which had cooperated with ONAPO in training 17,000 of its Abakangurambaga ("those who awaken the people") community leaders had been perceived as a political instrument. Subsequently, economic support through the Ministry of Interior was essentially withdrawn and the CCDFP were left to the ability of local communes to support. Between the war and the disruption created by the multi-party process, it has become increasingly difficult to call local groups together for community planning or education, for example, in family planning.

Other assumptions were that "GOR staff, facilities and operational funds would be available in a timely manner, ONAPO planning and monitoring process would be adequate for managing the project, and the management team would be given responsibility and authority to manage inputs." These assumptions did not prove to be a reality during project implementation. They were influenced by the political and economic conditions described above. However, it is also fair to say they were within the purview of the grantee to some substantial degree. Finally, the assumption that the ONAPO financial management systems would be adequate was proven unjustified following further review.

These divergences from the assumptions of the project paper have contributed in large part to the shortfalls encountered in project implementation noted in this evaluation. Additionally, there were substantial periods of time when USAID could not disburse funds due to weaknesses of ONAPO's financial management. With GOR revenues decreasing, ONAPO was unable to implement programs in the countryside without the local cost currency which had been expected from USAID.

Despite the problems mentioned above, the project has made substantial progress toward attaining its goals of improved population policy; increased knowledge of family planning, changed attitudes toward desired family size and use of family planning; the shift of responsibility for family planning service delivery from ONAPO to the Ministry of Health and fertility reduction.

1.4 The Evaluation

Delayed by reason of instability in the country and then by contract procedures, the proposed "mid-term" evaluation is being carried out during the period March 17, 1994 and April 25, 1994. William Bair, Dr. Jean LeComte and Suzanne Plopper were contracted by the POPTECH project to conduct the evaluation according to the Scope of Work Appendix A and methodology of Appendix B. The POPTECH staff contributed to the
evaluation through analysis of the DHS and other demographic data as attached in Appendix E. The stated purpose of the evaluation was to "look not only at the effectiveness of the project, but also to assess the development, progress and status of the Rwanda family planning program and to make recommendations regarding the most appropriate type and level of USAID assistance for a future project..."

The evaluation was carried out at a particularly difficult time for ONAPO. All the problems mentioned above seem to have converged to hasten staff turnover, create a sense of personal and program instability as political changes are bound to occur with the new government and make predictions about the future problematic. Nevertheless, the team was well received by all, USAID, ONAPO, MOH, MSH and SEATS and other donors and project officers and the evaluation proceeded on schedule. Despite some apprehension as to the clarity of our crystal ball, the evaluation team made some suggestions for the future which are included in Section 9. The evaluation was carried out under the assumption that the Peace Accord negotiated in Arusha August 4, 1993 would sooner rather than later produce a transition government enabling the country to return to stability and focus on social and economic development.

Just as the previous paragraph was completed, small arms fire erupted and an exchange of rockets lit up the sky. During the next day the team continued drafting sections of the report, but it soon became apparent that evacuation from Kigali would interrupt the process. We were unable to meet with USAID to discuss our initial findings and conclusions as planned; neither were we able to meet as a team to discuss substantial portions of our first draft. We were forced to leave behind many of the documents with which we were working and have not been able to confer with project implementing officers to fill information gaps or clarify our understanding of some situations.

The following report is a composite of individual reports completed in our respective residences without as much team review and consensus as would normally be expected. It is a generally accurate representation of the progress made in project development to date. The section of the report related to the future (Section 9) has been retained as some indication of what will still be required when it is possible to resume project assistance in Rwanda. On the other hand it is clear that the assumptions of what other donors or projects will be contributing to the population program and assumptions about the public and private sector potential must be reviewed carefully in the light of how circumstances change. It was the intention to make recommendations related to what could be accomplished in the next eighteen months, especially to pave the way for a new project. Most of those recommendations would no longer be practicable. Instead the recommendations either suggest things that might be done by contractors to complete their work and document and preserve for future reference some of the accomplishments and lessons learned to date or they are recommendations that would remain valid at least in a general way for any new start.

1.5 Previous Evaluations and Audits

This is the first formal evaluation of the project. Observations on service delivery were strengthened by a review of a joint ONAPO/MOH internal evaluation of the status of integration of family planning into maternal child health services carried out in 1993.
Observations on training profited from an evaluation of paramedical training conducted by INTRAH in 1993.

Although the project calls for independent audits to be carried out annually, conditions of political instability in the country made it necessary to delay the first such audit until October, 1993. The audit was conducted by the independent audit firm Andre Bonieux, Kemp Chatteris Deloitte and Touche.
2. POLICY DEVELOPMENT

2.1 Project Objectives and Strategy

Recognizing the demonstrated ability of the Government of Rwanda to formulate population policy, the project objective was to build on that strength to assist with the process of articulating, updating and refining the de facto population policy contained in the Fourth Five Year plan and MINISANTE (MOH) Family Planning guidelines of March 3, 1988. It was expected the GOR would use the research, data collection and analyses included under this element of the project to evaluate the impact of FP activities, define and target high risk groups and identify the obstacles which limit the delivery of family planning services. Emphasis was placed on achieving the full integration of family planning with maternal and child health services of the Ministry of Health. Mechanisms were to be developed to stimulate and coordinate the involvement of the private sector in the provision of family planning services.

The strategy was to draw upon two world wide central AID projects, RAPID III and Demographic and Health Surveys (DHS) to produce and analyze basic data. This was to be presented in a cost benefit model format that permitted projections of fertility change and its impact on several socio-economic development sectors. Additional research of an operational nature was to be carried out to improve the family planning service delivery system. The results of these research efforts would be disseminated through seminars for influential leaders at the national level and in-country seminars at the prefectural (region) and communal (country) levels including participation of community leaders from the sectors (township) and cellules (community). Improved coordination among donor and implementing agencies, clarification of Ministry of Health responsibility for family planning and continued collaboration with the Catholic Church was to be achieved by formal bi-annual coordination meetings. Procedures were to be developed with a private sector consultative committee wherein ONAPO would assist non-governmental organizations (NGOs) develop family planning projects, approve and fund such activities.

Quantitatively, the targets were to produce one DHS, several RAPID models, three national seminars, an undetermined number of in-country seminars and regular coordination meetings.

2.2 Findings

2.2.1 RAPID

The RAPID (Resources for the Awareness of Population Impacts on Development) project has made a substantial contribution to policy development in Rwanda. The first RAPID model was produced in 1981 to demonstrate the effects of rapid population growth and/or fertility reduction on various socio-economic development sectors. Actions to update and accelerate the use of this approach were initiated by The Futures Group/ Research Triangle Institute (RTI) participation in a one-week international symposium in Kigali in December 1987 followed by several other consultations at the end of MCH/FP I and the beginning of MCH/FP II. By early 1990 the Benefit-Cost model was completed and presented to a two-
day workshop of 35 representatives from the Ministries of Planning, Health, Education and Agriculture as well as representatives from churches, the National Party and Parliament. The model is a dramatic presentation of the demographic problem that will evolve over the next 20 years, predicts the mix and effectiveness of contraceptive use, estimates the cost of the FP program and shows the savings generated in the health, education and agriculture sectors by the FP program. The process of developing the basic data for this model and its presentation contributed substantially to the production and adoption in 1990 of the National Population Policy, one of the most well articulated, forward looking and positive population policy statements in Sub-Saharan Africa. The government adopted an accelerated family planning action program - the ambitious family planning scenario of the RAPID model with a new goal of achieving a 2 per cent growth rate by the year 2000 - also the ambitious family planning scenario of the RAPID model.

Plans for additional training of ONAPO and Ministry of Agriculture staff in the dissemination and modification of the model had to be postponed until March of 1991 due to the outbreak of war. The Ministry of Agriculture developed an additional model, building on that which was produced by RTI for the Cost Benefit model. ONAPO personnel were active in employing the RAPID model in national seminars, seminars in all 11 prefectures (regions) and 33 communes or counties (out of about 130 in the country). Although records were not available at ONAPO to produce quantified assessments of the numbers and types of persons involved or their reaction, it is apparent that this was a considerable effort. The four high quality, substantial monographs on "The Population Problem and Its Solution" that were produced and published in quantities of 1000 to 2000, the Population Policy itself and the Guide for the Integration of Population Factors in Planning at the Commune level, demonstrate that this action was taken seriously. Indications from public policy statements, interviews with those involved and the increased availability of family planning services suggest these actions were effective in producing changes in awareness and in public policy at the national, prefecture and commune level.

An indication of the spread of the policy development influence was found in a conversation with the burgomeister (mayor) of the commune at Kayore, which is at the far corner of the country. His clear understanding of the population problem and the need to deal with it was matched by that of the chief of the Communal Center for Development and Continuing Education (CCDFP) and a professor of Geography at the University of Rwanda in Ruhengeri with whom we also discussed these issues. In several regions visited we were shown evidence of ONAPO leadership in the formation of a prefectural population committee involving government, NGO and church leadership. Ongoing activities with regional and communal personnel of the Ministries of Health, Education, Agriculture and Interior suggest the Policy development action is having some effect beyond ONAPO.

A particularly important contribution of the RAPID model was to assist in developing a better understanding between the government and the Catholic Church on the issue of population programs and family planning. Meetings were held with church officials to convince them of the urgency of the demographic situation and the priority the GOR places on achieving its goals, to stress the GOR support for natural family planning (NFP) activities sponsored by the Church, and to request that Church officials suppress public criticism of modern FP methods. The success of this GOR intervention was evident during the September 1990 visit of the Pope to Rwanda. In contrast to his earlier condemnation of artificial contraceptive methods in Tanzania, he did not condemn or criticize the GOR FP program or the use of modern contraceptives.
Early in the project period it appeared that National commitment to the population policy would be expressed in increased budgetary contributions to ONAPO and the family planning activities of the Ministry of Health. Unfortunately, the government did not increase its budgetary support and in fact may have decreased it, presumably because of the increased financial demands of the war.

In October 1992 it became apparent that further policy development was needed to answer questions as to whether the HIV/AIDS epidemic made family planning no longer necessary, to develop fullest utilization of the DHS findings and develop prioritized action plans for all the development sectors involved in the National Population Program. Circumstances beyond the control of the Futures/RTI contractor only permitted return to Rwanda in Nov. of 1993. It was decided that attention should be given to quickly preparing a RAPID update for use in policy development efforts with the new government. Political instability delayed the update which was produced in March of 1994. Plans have been made for its use and funds are in place for the development of a new model.

The assessment of the evaluation team of the needs expressed in Rwanda for policy development and review of the present model confirm the need as planned for considerable modification of the 1990 cost benefit approach. That cost-benefit approach is still valid in use with national leaders who are responsible for funding allocation. However, more attention is needed to the impact of population growth on individuals, their families, their economic livelihood and their health. Subjects such as the following could be probed in greater depth:

- in demonstrating the detrimental impact of rapid population growth on socio-economic development more emphasis could be given to degradation of the soil and the environment that support the only two obvious opportunities for internal development and export earnings, namely agriculture and tourism. Attention should be given to rural family level income and future potential as well as to national level impacts. It would be useful to make contact with Dr. David Pimentel, an ecologist at Cornell University who has published some remarkable projections of this nature. In this regard serious question can be raised as to the demonstration in one scenario of the present model that greater population growth would at least in the immediate future produce more food. This is a classic presentation of labor as a key factor of production. However, it fails to fully recognize the present conditions in Rwanda where additional labor on limited land may indeed be counterproductive, hastening the depletion of the soil and destruction of the land's productive capacity.

- graphic projections of the impact of HIV/AIDS to call attention to the serious nature of this problem, but also to dispel any false sense of AIDS solving the population growth problem. The present model makes only a rather non convincing statement that the AIDS epidemic will have some effect but not too much on population growth. The Futures Group has the capability to make quantified projections, as evidenced by material produced by their technical personnel as part of this evaluation. For example, using U.S. Bureau of the Census data, which show substantially higher figures for rural sero-prevalence than those reported by AIDSCAP personnel (9.8% for the rural 95% of the
population as compared to AIDSCAP reported levels closer to 3%), they nonetheless demonstrate that AIDS will not produce a negative population growth. Even with this more alarming scenario the projections show a growth rate of 2% in the year 2006 if influenced by both AIDS and family planning as compared to a growth rate of 2.7% in the absence of AIDS. In both instances the population would have increased substantially (to 11 million without AIDS but still to 10 million even with a high level projection of the impact of AIDS). The population doubling time will have been extended from roughly 26 to 35 years, little demographic relief for a country whose population numbers are already stressing its carrying capacity.

- In demonstrating how family planning is related to household level health and welfare, DHS data could be analyzed to examine the relation of child spacing or parity to infant mortality or nutritional status. These relations were quite marked in Uganda and other DHS countries. The child spacing situation in Rwanda is unclear with some reports indicating there is not the same child spacing tradition as other African countries and sexual activity resumes eight days after birth; others say that the eighth day is largely ritualistic and there may be more postpartum abstinence than previously recognized. At any rate, more could be said to quantify the present model's statement that high risk is attached to children born to women too young or too old, children of high parity or of close spacing... what percent of the births in Rwanda fall in these categories and what could family planning do to reduce these risks? Attention could be given to the probable increase in AIDS attributable infant mortality and numbers of orphans in the absence of contraceptive use by HIV/exposed or HIV/positive persons.

- The ethnic animosities that are fueling the fires of the present conflict predate Rwanda’s period of rapid population growth; yet the extent of suffering and the relief requirements of this present conflict are certainly influenced by the greater numbers of people involved—millions being displaced; some aspect of the conflict is related to scarcity of resources compared to numbers of people searching for employment and sustenance (see the article "The Coming Anarchy" by Robert Kaplan in the Atlantic Monthly, Feb. 1994). One would be tempted to include these facets of the impact of population growth in the RAPID model but this is probably too sensitive a subject to be handled productively, especially if developed by foreigners. As the conflict has escalated in ensuing weeks to levels unprecedented in Rwanda, it may be that any discussion of demographics without reference to the effects of the war will be incomplete and inadequate.

2.2.2 The Demographic and Health Survey

With very substantial assistance from Macro International, ONAPO completed a nationwide survey of a sample of 6,947 women of fertile age and 715 men. The implementation of the DHS is another clear example of the program disruption inflicted by the war. The survey was initiated in Rwanda in August, 1990 and discontinued because of the war. Several attempts to restart failed. Data from interviews with 2,145 women had to be discarded and
the survey was begun again in August 1992. MSH reports suggest that the whole research section of ONAPO was occupied with this effort for the better part of a year. The preliminary report of the survey was produced in January of 1993 and the final report is expected while this evaluation is being written.

The DHS probed such questions as the extent of knowledge about and access to contraceptives, desired family size, desire to postpone or avoid another birth, use or intent to use family planning and such related demographic or health topics as age of marriage, infant mortality, breast feeding, diarrhea, immunization and nutrition. As reviewed in Section 7—Impact below and as the basis for the analysis of demographic data Annex E, it becomes clear what a powerful policy development instrument the DHS can be. The uses for measuring program progress in achieving knowledge and attitudinal changes, increases in contraceptive use and reductions in fertility are obvious. Such programmatic information as characteristics of users, contraceptive preference, sources of family planning information, attitudes toward the services, perceived barriers in time or distance, or differences in male and female attitudes can be used in expanding and improving service delivery approaches and selecting target audiences and messages for IEC. The degree of unmet demand represented in the responses is a strong argument for organizing services to meet this need. Further analysis will be required to fully exploit the data that may link family formation patterns to infant mortality or malnutrition. Presumably this can be part of the development of the next RAPID model.

ONAPO plans for interpreting the implications of the data from the DHS are not clear. Consideration is being given by USAID to the provision of some technical assistance to aid in this analysis before the results of the survey are presented publicly sometime in June or July. Much of the data speak for themselves, but it is important to assure that the presentation helps those unused to dealing with such information to comprehend its significance.

2.2.3 Operations Research Related to Service Delivery

With the ONAPO research section fully occupied with the DHS, other research moved slowly. Some of the most qualified personnel left the section. When their positions were filled after some delay, it was with recent graduates who had neither the training nor the experience of their predecessors. One operations research on the extension of family planning services by vaccination workers was carried out with the assistance of the Population Council. Some additional limited research was related to continuity rates and service delivery quality. Their implication will be discussed in Section 5—Service Delivery.

2.2.4 The Status of Women

The project design correctly focused most of its attention on policy and program development aspects designed to improve the delivery and availability of family planning services. It may have been productive to also give some emphasis to policy matters affecting the status of women. This has proven in many countries to be an important factor in determining the use of contraceptive services. Rwanda family formation decisions may be strongly influenced by the men who have nearly complete authority over the women in this
as well as many other aspects of life. There are some good indications from the DHS and from men's response to the availability of vasectomy that the male sense of responsible parenthood and positive attitudes toward family planning is growing. Nonetheless, this could no doubt have been enhanced by efforts to give women a more effective role in society and consequently in family formation decision making.

2.4.5 Coordination

Several approaches through coordinating and consultative committees were called for in the project design to assure better coordination between implementing agencies, the public and private sectors and between the various donor agencies. ONAPO was expected to take a lead role in establishing and maintaining these committees. Reports available suggest that early in the project some progress was made in this direction. However, rather soon the formal mechanisms became non-functional. With the exception of the project management coordinating committee (discussed later in Section 6), which brought together ONAPO, USAID and MINISANTE regularly and rather effectively, the coordination that occurred was informally organized by the interested parties. Regional delegates of ONAPO seemed to have had some success in working with regional representatives of the Ministries of Education, Agriculture and Interior.

The lack of follow up on coordination by ONAPO was especially damaging to the objective of seeking greater involvement of the private sector. One could question the decision in the first place to give a public sector institution the responsibility for developing activities in the private sector. This proved unproductive with the general family planning service activities expected. It was a particular problem as ONAPO is reported to have dictated conditions for the social marketing program that limited its potential. An oversimplified assessment of the private sector component is that it went nowhere in this phase of the program. Clearly the embryonic private sector required more assistance than the project was designed to give. The expectations that ONAPO could be the funding channel to the private sector foundered on the rocks of ONAPO's difficulty in getting its own financial house in order.

There is some overlap of programming for the future by the several donor agencies, especially as the World Bank initial proposal attempts to address almost every aspect of the country's needs. Some specific problems have developed by different approaches to such issues as paying salary supplements or paying trainees for their participation in courses. Yet, the evaluation team noted a very good relationship among the various donors, who have organized themselves to meet rather frequently.

2.3 Conclusions

The objectives of the policy development element of the project were valid concerns and the strategy for achieving them was appropriate. Very effective work has been accomplished in developing and utilizing the RAPID models for policy development throughout the country. The completion of the DHS will provide ONAPO with another powerful policy development instrument but further interpretation will be required to get the maximum benefit from its use. Effective technical assistance in both instances working closely with ONAPO and Ministry of Agriculture counterparts was key to success in these
ventures. Shortages of qualified staff have limited ONAPO research capability in a way that has become particularly critical at this time. Substantial technical assistance would be required to complete the tasks necessary for developing and utilizing a new RAPID model with the requisite modifications. Help would be required in interpreting the DHS in policy development seminars or workshops or as part of public information campaigns. If this assistance were to have been available, it is very likely that ONAPO would have accomplished the policy development objectives of the project, if not in number of specific activities called for, certainly in quality and effectiveness of the effort. On the other hand it is not likely that the research contemplated for improving service delivery would be accomplished and the coordinating role, especially with the private sector, would not have been fulfilled.

Though recognizing the potential importance of policy development activities directed toward enhancing the status of women, it would not have been practical to suggest emphasis on this at this time. Unfortunately, ONAPO capabilities have been sorely stretched to accomplish what they have in policy development. It is unlikely they could have effectively addressed the status of women in the remaining project period but it should be part of future planning.

2.4 Recommendations

An obvious recommendation would have been for Futures to assist ONAPO in developing a plan of action to utilize the recently updated RAPID model with new government leaders and at the same time to continue work on the new RAPID model. Another would have been to encourage Macro and ONAPO to proceed post haste with the publication of the final DHS report and with preparation of appropriate analysis to accompany its presentation to government and private sector leaders. In the present circumstances neither of these recommendations are practicable. However, there is enough to be learned from the Rwanda experience of interest to other countries that these actions should not be abruptly halted. One would hope that Rwanda itself will at some time be able to take advantage of more refined policy development instruments. Therefore, the following two recommendations are made even though both will be difficult without ONAPO participation/concurrence:

1. USAID should review with Macro the requirements for publishing the final DHS report with a Macro produced analytic addenda distilling the programmatic implications of the data.

2. USAID should continue in force its PIO/T with Futures for the development of a new RAPID Rwanda model.

The model should maintain some of the unique cost benefit analytic approach of the old model. It should expand its demonstration of the impact of population growth on soil, environment and family income, incorporating some input from Cornell ecologist David Pimentel as appropriate. It should develop further the health and family formation relationships as well as family planning program implications from the DHS. In consultation with AIDSCAP it should include the multiple health, social and demographic implications of HIV/AIDS and how these could be mitigated by family planning.
3. INFORMATION, EDUCATION AND COMMUNICATION

3.1 Project Objectives and Strategy

3.1.1 Objectives

- Increase the number of men and women between the ages of 15 and 49 having knowledge of all FP methods from 70 to 95 percent.

- Decrease in desired family size from 6 to 5.

3.1.2 Strategies

- Develop and test messages targeted to key audiences, emphasizing family planning method and source-specific information.

- Increase the number of paramedical and nonmedical personnel trained to provide quality FP information (to include participation of Village Community Development Centers, the Rwandan Women's Association for Development, the Ministry of Youth and Associative Movement, health educators of the MOH and PVO's, and agricultural extension workers).

- Expand teacher training and include population and family planning in the curricula at all levels of the educational system.

3.2 Findings

3.2.1 Access of the Population and Specific Target Groups to Accurate Information about FP, and Effectiveness of Information in Changing Attitudes and Behavior.

According to several recent studies, over 95% of the adult population can name at least one contraceptive method and where it can be obtained, and approximately 78% of couples/women of reproductive age define themselves as potential FP clients (either do not want more children or want to wait two years or more to have another child). The desired family size has gone from 6 to 4.4.

3.2.2 IEC Strategy Development

There is not a well-defined strategy for FP/IEC within ONAPO. In April-May 1992, UNFPA supported an examination of population strategies in Rwanda, with an emphasis on IEC. In March 1994, a workshop was held to facilitate the sharing of population/FP IEC strategies among the different institutions involved in population/FP activities in Rwanda and to begin to address the issue of IEC strategy development. Although the workshop was useful in terms of sharing ideas and facilitating collaboration, little progress was made in the direction of IEC strategy development. Following the workshop, the UNFPA Technical Assistant for...
IEC, in collaboration with representatives from the MOH and from ONAPO, began synthesizing the results of workshop activities in preparation for working with a consultant in the development of an IEC strategy.

3.2.3 Development of Institutional Capacity for IEC

There are three divisions in the Central ONAPO IEC Section. The training division organizes most in-service clinical and non-clinical FP training for MOH health workers, other social and extension agents, and teachers. The popular education division works with community-based IEC efforts (with the Abakangurambaga, women's groups, out-of-school youth, etc.). The audio-visual materials unit supports all IEC activities with audio-visual materials. In addition, there is an IEC agent in each ONAPO regional office.

The development of an institutional capacity for IEC in ONAPO has been slow. Although the IEC Section has received significant technical assistance, this has largely been in the area of clinical and non-clinical FP training. Other divisions (popular education and audio visual materials) have received less assistance over the course of the Project.

3.2.4 Mass Media

Mass media activities of ONAPO include the production of:

- **Radio:** one 15-minute program per week
  - one one-minute “spot” every two months, the content of which comes from the Abakangurambaga. Such spots are run twice a day for two weeks and cost approximately $140.

- **Posters:** one or two models produced per year, for public distribution. (The 1994 theme is “The male role in FP”). Posters tell people to “go to ONAPO for FP.” Staff explain that FP is synonymous with ONAPO.

- **Leaflets:** a variety of leaflets, one on the benefits of FP, the others on FP methods: for use by the Abakangurambaga.

- **Comic books:** for youth, especially primary school age. These are distributed primarily to primary school teachers and to the Abakangurambaga.

- **Calendars:** for public distribution

The only flip charts available on FP are a small flipchart produced by GTZ for Abakangurambaga, a large flipchart produced and sold by BUFMAR, and a large flipchart produced by IPPF and used by ARBEF. BUFMAR has also produced a substantial training guide for IEC.

3.2.5 Interpersonal Communication

Interpersonal communication as an IEC strategy has been largely focused on Abakangurambaga, somewhat less on other cadres of community development workers (for example CCDFP workers, women’s groups, youth groups etc.), and very little on health workers in the context of health facilities. Health center-based IEC activities are generally limited to the presentation of FP methods.
ONAPO is collaborating with the Ministry of Youth in preparing a strategy to educate out-of-school youth on population and FP issues. The Ministry of Youth has two approaches to working with out-of-school youth. There is at least one training center for youth in each region of the country where out-of-school youth can learn technical trades. For youth not involved in these training centers, there are youth associations within the community with which Ministry of Youth extension agents work. At present, ONAPO has organized seminars with Ministry personnel to begin planning IEC activities with the training centers. Training of extension agents is planned for June '94.

FP service providers have received some orientation to IEC "causeries" during FP auxiliary and FP clinic training. However, nurses have received little supervised practice in conducting participatory group discussions. Furthermore, contraceptive methods are the only visual aids to which they have access. The result is that there is minimal motivational FP/IEC activity at the health center level.

### 3.2.6 Activities in Formal Education System

The ONAPO training division has assisted the MINEPRISEC (Ministry of Primary and Secondary Education) with the development of training materials and the training of eight teacher trainers in population education. The MINEPRISEC trainers in turn assist their personnel at the secondary level to integrate appropriate aspects of the curriculum into their courses. Generally, population education is integrated into: nursing studies (MCH and clinical PF), civics (social and cultural development and consequences of rapid population growth), health education (morbidity, environmental pollution, nutrition etc.), biology (anatomy and physiology of reproduction). Regional ONAPO IEC staff have worked with regional MINEPRISEC staff to integrate population education at the primary school level.

During the past year, one follow-up visit was made (by a team of three MINEPRISEC staff and two ONAPO staff) to several secondary schools to evaluate the effectiveness of the integration of teaching of population education into the secondary school system. Among their findings were that teachers lack information and appropriate teaching methods to effectively teach the content.

### 3.2.7 Research, Targeting, Testing, Evaluation, Results

In the preparation of audio-visual aids, staff of the audio-visual division collaborate with a group of 15 Abakanguurambaga in each of four regions, to identify priority problems (in the acceptance of FP), target groups, objectives, messages, and channels.

### 3.3 Conclusions

#### 3.3.1 Progress Toward Meeting Project Objectives

Access of the Population and Specific Target Groups to Accurate Information about FP, and Effectiveness of Information in Changing Attitudes and Behavior. The objectives of (1)
increasing the numbers of men and women having knowledge of FP methods, and (2) decreasing desired family size, have largely been achieved. However, there exists a significant gap between these indicators of level of FP knowledge and need for services, and FP practice (see section 4.3.3.b).

**Mass Media.** The A-V materials division continues to produce messages and materials (see section 3.2.3 above) as per their resources. However, little evaluation is done as to the effectiveness of their efforts and inadequate attention is given to analyzing target populations to determine appropriate messages and approaches.

**Interpersonal Communication.** According to ONAPO, overall the approximately 6000 active Abakangurambaga are currently meeting their objectives of recruiting at least one FP client per month. However, it is not easy to verify this, due to the large numbers of these agents and the fact that the Abakangurambaga data base has been incomplete and unverified for some time.

Interpersonal communication as an FP/IEC intervention at the health center level is very weak. There is not an effective strategy, training is inadequate and there is a lack of appropriate visual aids.

**Integration of Population Education into the Formal Education System.** The integration of population education into the formal education system continues. However, if the quality of the teacher training curriculum is any indicator of the quality of classroom education, this activity needs further attention. Indeed, problems with the teaching of population education have been identified by ONAPO and MINEPRI/SEC trainers/supervisors.

### 3.3.2 Appropriateness of Proposed Strategies in Meeting Objectives

The proposed strategy of developing and testing messages targeted to key audiences appears not to have taken place. Family planning messages are almost uniformly population-oriented.

The strategy of increasing the number of paramedical and nonmedical personnel trained to provide quality FP information is sound and has been pursued. However, inadequate attention has been paid to the appropriateness of the messages and approaches for different populations.

The planned integration of population and FP education into teacher training at all levels of the educational system is sound and is being implemented. However, questions remain regarding the quality of teacher training curriculum and materials for classroom teaching.

### 3.3.3 Barriers, Constraints and Facilitating Factors

**IEC Strategy Development.** The lack of an IEC strategy has had several consequences for the FP program. Perhaps most importantly, there is a lack of direction in identifying the most appropriate IEC messages and approaches to be developed for different population groups.
Secondly, in 1994, 6 years after the MOH issued a directive making MCH/FP activities a priority focus of health centers and mandating the integration of FP activities into MOH service delivery, ONAPO continues to produce IEC messages that refer people "to ONAPO for FP." ONAPO staff claim that "FP is synonymous with ONAPO." This practice has had at least two negative effects. One, it has tended to support the primary ONAPO IEC population message which has become less and less effective, rather than developing an appreciation of the relationship between FP and MCH and other more personally relevant concerns which would be more effective in motivating women and couples to practice FP. Secondly, and perhaps even more importantly, such messages communicate to MOH personnel a certain "ownership" by ONAPO of the FP "program" when in fact Rwanda necessarily depends upon the MOH health center staff for the provision of virtually all FP services. This "FP = ONAPO" message is reinforced by the fact that although ONAPO is an entity within the MOH, it has since its creation 13 years ago controlled the vast majority of FP donor inputs while MOH health workers have been expected to be the providers of FP services.

**Institutional Capacity for IEC.** The fact that the IEC Section has not developed a strong institutional capacity to plan, implement and evaluate an IEC strategy for FP is a major barrier to the effectiveness of its activities. The training division has developed a certain training capacity but has not demonstrated the capacity to identify IEC training needs and develop, implement and evaluate training in response to these needs. IEC training is centered on population messages which have been found to be relatively ineffective on an interpersonal level, using training methodologies which are inappropriate for engaging people in discussions of the personal relevance of FP.

Although the popular education division has collaborated with MINEPRISEC in the development of population teaching materials and in the training of teachers, a continuing obstacle to the advancement of this effort is that it is still seen as ONAPO's effort. The sense of ownership and responsibility for population education in the schools has not fully shifted to MINEPRISEC. Similarly, population education activities with women's and youth groups remain dependent upon ONAPO leadership (as opposed to using ONAPO staff as technical resources).

The institutional capacity of the audio-visual materials division also reflects the institutional strengths and weaknesses of the IEC Section. This unit continues to produce radio programs and print materials according to its resources but is unable to assess the effectiveness of its efforts and to identify possibly more effective materials. In part, this is due to the fact that this unit is charged with producing materials which are to be used by other units. A striking example of the lack of direction in IEC is the fact that ONAPO has never produced any visual aids which can be used to engage people in discussions/dialogue concerning the benefits of FP. Obviously, this approach is not an important part of the ONAPO IEC strategy.

**Abakangurambaga.** The use of the Abakangurambaga as the primary communicator of FP messages is sound, based upon the dispersed nature of the largely rural population, the cultural importance of oral communication and the level of community participation entailed in this strategy. However, a major weakness of this strategy is its alliance with the former one-party political system. This may have made sense, and/or have been difficult to avoid, when the strategy was being put in place, given the existing political realities of the time.
However, given the current move toward a multi-party system, the credibility of the Abakangurambaga may be called into question due to its relationship with the former one-party state. In fact, the FP program has experienced a lack of support by local authorities since the beginning of the evolution of the multi-party system. Additionally, the fact that the Abakangurambaga were to be trained and supervised by the CCDFP has become problematic in that (1) the CCDFP is tied to the former one-party state, and (2) with spreading economic problems, many of the CCDFP have experienced severe staff reductions.

**Lack of Market Segmentation for IEC Messages.** The predominate population-orientation of IEC messages is a major weakness in the FP/IEC effort. While population awareness and attitude and behavior change is crucial to Rwanda, population messages need to be based on well-defined target groups and their perceptions and needs, and on the realistic potential for behavior change based on the message and how it is received. Employing broad population messages to motivate individuals to adopt FP may not be the most effective approach. Likewise, using a minimum of interpersonal communication approaches, and depending largely on one-way communication, may not reach more resistant target groups.

### 3.4 Recommendations

The following recommendations were developed related to the ongoing program. They are clearly not practicable at this time but will be relevant to any program as it is developed.

**IEC Strategy**

3. ONAPO should develop a viable IEC strategy to guide its diverse and important activities.

At a minimum, such a strategy will need to (1) address the different aspects of the population problem, (2) identify appropriate channels of communication, (3) identify priority target populations for FP messages and targeted behavior change, and (4) identify messages and approaches appropriate to the different target populations.

**Abakangurambaga**

4. ONAPO should re-evaluate the deployment of Abakangurambaga in light of both the strengths of this system and the weaknesses brought about by the socio-political changes taking place in Rwanda.

Serious thought should be given to a larger role of health center personnel in the training and supervision of these individuals if they are to be made maximally effective as FP/IEC agents.
IEC Training

5. Once a strategy has been defined for FP/IEC, ONAPO must give serious attention to the skills and materials necessary to implement IEC activities.
4. TRAINING

4.1 Project Objectives and Strategies

The following are the objectives and strategies of the training component of the Project:

4.1.1 Long-term (U.S. or Third Country)

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

4.1.2 Short-term (U.S. or Third Country)

Approximately 30 person months of short-term training.

4.1.3 Short-term ("Buy-in")

Development of a course for obstetrical/ gynecological skills.

4.1.4 Short-term (In-country)

In-service training of:
1. FP service delivery:
   120 physicians
   250 nurses and paramedical personnel
2. FP/IEC:
   75 trainers
   600 family planning auxiliaries
   600 teachers
   17,000 village level promoters previously trained by ONAPO
   refinement and integration of curriculum materials for the primary, secondary
   and university levels.

4.1.5 Study Tours (U.S. and Third Country)

Two study tours for approximately two weeks for 6 ONAPO, MOH or private sector
individuals.
4.2 Findings

4.2.1 Numbers and Types of Training Programs and Trainees

Long-term U.S.-based Training. Four Rwandans (three from ONAPO and one from the MOH) have been sent to the US for long-term training in public health, three in international health at Tulane University and one in health administration at Meharry Medical College. One has completed his studies and returned; he now teaches at the School of Public Health at the National University of Rwanda. The remaining three are scheduled to complete their studies by the end of summer 1994. The African-American Institute administers the training grants for MSH under a sub-contract.

Short-term U.S. or Third Country Training. Twenty-seven persons received short-term training in the U.S. or third countries for a total of 27 person months. They include 11 persons from ONAPO, five from MOH and one from the Ministry of Education (MINEPRISEC). Training subjects included: management of FP programs (7), management of FP training programs (3), contraceptive technology (1), management of FP IEC programs (1), research (2), communication and FP (1), training techniques (1), and demographic health surveys (1). Sources of training included: CAFS Center for African Studies, Kenya (9), U. Conn. (2), U. PITT (1), IHP (International Health Program, Santa Cruz, CA) (1), MSH (1), CAMPC (1) and IRD (2). (Ten more people received short-term training prior to the beginning of the MSH contract. Details of these trainings were unavailable due to the team's early departure and the mission's closing.)

An additional twelve persons received third country training in voluntary surgical contraception (VSC) and NORPLANT insertion; five surgical teams received third-country training in tubal ligation by mini-lap, two physicians were trained in vasectomy and six in NORPLANT insertion. They include:

- **Mini-lap:**
  - 5 physician-nurse surgical teams
  - 2 from the Medical School, National Univ. of Rwanda
  - 1 from the CHK (Kigali hospital)
  - 1 from Ruhengeri (ONAPO regional delegate, now SEATS/Columbia Univ. employee)
  - 1 from ???

- **Vasectomy:**
  - 2 physicians
  - 1 from the CHK
  - 1 from Ruhengeri (ONAPO regional delegate, now SEATS/Columbia Univ. employee)

- **NORPLANT:**
  - 6 physicians
  - 1 from MOH/World Bank Family Health Project
  - 1 from national FP training team (now INTRAH employee)
  - 2 from the Medical School, National Univ. of Rwanda
  - 1 from the CHK
  - 1 from Ruhengeri (ONAPO regional delegate, now SEATS/Columbia Univ. employee)

Development of a Course for Obstetrical/Gynecological Skills. The medical school at the National University of Rwanda has developed a course for obstetrical/gynecological skills and has integrated it into its curriculum.
Short-term (in-country). In-service Training:

(1) FP Service Delivery

Clinical Training for Physicians. Ninety-three physicians (OB/GYNs and general practitioners) received three weeks in-service training in reproductive health. Sixty of those trained are currently clinical providers of FP services.

Clinical Training for Medical Assistants and Nurses. Ninety-five medical assistants and nurses received three weeks clinical FP skills training. Virtually all clinical FP skills training was conducted in Kigali by three national FP trainers. (Some additional clinical training is being conducted in the regions. Central ONAPO staff have little information about this training due to the lack of a strategy for the decentralization of training and the lack of coordination and reporting to the central level.)

Additional training scheduled for 1993 was suspended due to the concerns (1) that the paramedical FP clinical curriculum needed revision, and (2) that another category of health worker, health auxiliaries, are the most frequent FP service providers at the health center level and these individuals have received virtually no training in PF. Thus, priority has been given to curriculum development for the training of health auxiliaries, to be followed at a later point by paramedical curriculum revision. Training which was suspended included basic FP clinical skills training for 115 medical assistants and nurses, refresher training for 75 FP service providers trained in 1987-88, and training of 60 FP auxiliaries.

Twenty-five FP service providers received three days training in FP counseling skills (organized under the Family Health Section).

Ten nurses were trained in VSC counseling skills.

(2) FP/IEC:

Training of Trainers (TOT). Two two-week TOTs for FP clinical trainers were conducted: (1) a refresher TOT for 18 trainers previously trained under INTRAH PAC IIa, and (2) a TOT for 15 new regional trainers. A fourth TOT is planned for '94.

Sixteen FP clinical trainers received two weeks training in training evaluation.

FP Auxiliaries. According to the central ONAPO office, over 150 "FP auxiliaries" have received one week of non-clinical training in FP at the regional level. Exact numbers were not available as information about this training is not communicated to, nor required by, the central ONAPO office. Participants included medical assistants, nurses, health auxiliaries, social workers, leaders of CCDFP and educational technicians from among the cadres of agronomists, agricultural extension agents and veterinarians.

Teacher Training in Population Education, and Curriculum Materials Development for Primary, Secondary and University Levels. One hundred twelve secondary-level
teachers received three weeks of training in population education. This training was conducted by personnel of the MINEPRISEC who collaborated with ONAPO staff in the development of the curriculum. (Additional training is planned for 60 secondary teachers in population education.)

Village-Level FP Promoters. In an assessment of the status of village-level FP promoters (Abakangurambaga) done in 1992, it was found that of the approximately 17,000 originally recruited, about 6,000 remain active. The central ONAPO office has little information regarding the actual training of these agents as it has been largely the responsibility of the CCDFP.

Study Tours. One study tour was organized in 1992 for five ONAPO and MOH staff to study community-based distribution of contraceptives in Zimbabwe and Kenya. The second study tour is being reserved for possible use during the last 12-18 months of the Project.

(3) Other

Clinical Preceptor Skills. Twenty-seven FP service providers received three weeks of training in clinical FP preceptor skills in preparation for their roles as preceptors for the practicum phase of FP clinical training.

Supervisory Skills. Fifteen regional supervisors (8 MOH & 7 ONAPO) responsible for the supervision of MCH/FP activities received two weeks of training in principles of supervision.

Paramedical Pre-service Clinical Training. The paramedical schools have received copies of the ONAPO FP clinical FP curriculum and have received training in population education. However, they have not yet received training in FP clinical skills and have, therefore, not integrated FP clinical training into their curriculum.

Training in Management. Thirteen ONAPO staff have received in-country training in administrative management (2), management of contraceptive supplies (2), and financial management (9).

4.2.2 Institutional Development (relation to INTRAH, AVSC, JHPIEGO, SEATS)

INTRAH, JHPIEGO, SEATS and AVSC training interventions have contributed to the institutional development of training capacity within ONAPO, the MOH, the medical school and the secondary schools. At the pre-service level, JHPIEGO's assistance to the School of Medicine has contributed to the development of a team of faculty capable of conducting reproductive health training.

INTRAH assistance with the training of FP trainers has contributed to the capacity of ONAPO/MOH to conduct in-service FP clinical and non-clinical training. More experienced trainers have been employed for clinical training and others for FP auxiliary training.
NORPLANT and CCV training supported by AVSC and SEATS has contributed very positively to institutional development. Due to on-the-job training by the SEATS Resident Advisor and colleagues who have benefited from AVSC and SEATS-sponsored training, 90 health facilities are currently inserting NORPLANT. Personnel trained in tubal ligations and vasectomies were certified as trainers, and their training of colleagues has helped make these methods available in an increasing number of health facilities.

4.2.3 Curriculum Development

The basic clinical FP skills curriculum for training paramedical personnel was finalized in November 1991. This curriculum was scheduled to be revised in March 1994. Due to the priority of developing training for health auxiliaries, this curriculum revision has been postponed.

The FP auxiliary training curriculum developed with INTRAH PAC Ila assistance was revised in 1992. However, it still needs further revision.

Curriculum was developed for the training of secondary school teachers in population education. This curriculum is in need of further revision.

A training needs assessment was done for health auxiliary workers. A FP service delivery guide and curriculum is currently being developed for their training in FP service delivery.

4.2.4 Follow-up and Evaluation

Training evaluation has been done as a part of training, using pre- and post tests, trainer observation during sessions and participant evaluation of the workshop at the end. Little has been done by ONAPO in the way of follow-up and long-term evaluation of training. The most thorough long-term evaluation of paramedical training activities was conducted by an INTRAH team in August-September 1993.

4.2.5 Involvement of Private Sector

The private sector has not been involved in training activities to date.

4.3 Conclusions

4.3.1 Progress Toward Meeting Project Objectives

The following summary of achievement of training objectives should be viewed with some caution. There is some confusion of terminology from the project paper to the reports, reports came from various sources (JHPIEGO, INTRAH, SEATS, AVSC, ONAPO, MSH and USAID PIR 9/93) and some of the training has not been reported. It was not possible to verify these figures since the evaluation was interrupted.
Long-term (U.S. or third country): 100% achievement (by the end of summer 1994)

Short-term (U.S. or third country): 90% achievement

Development of a course for obstetrical/gynecological skills: 100% achievement

FP service delivery:
- physicians 78% achievement
- paramedical personnel 66% achievement

FP/IEC:
- trainers 51% achievement (clinical & FP auxiliary trainers)
- FP auxiliaries 55% achievement (approximately)
- teachers 19% achievement
- village-level promoters ?? (data unavailable)

Study tours (U.S. and third country): 50% achievement

4.3.2 Appropriateness of Proposed Strategies in Meeting Objectives

The proposed strategy of training a minimum of two health workers per health center in FP is appropriate in terms of ensuring continuity of FP service delivery. A health worker data base has been established to help facilitate the implementation of this strategy, and to discourage repetitious training of personnel. However, it is not clear who is, or should be, responsible for maintaining, up-dating and making available this information. The data base, which was established at ONAPO, has not been up-dated since 1992. According to this most recent copy, some health facilities have up to 10-15 persons trained in FP and others have none. In that FP training is conducted through a variety of projects, consideration needs to be given to how to best use this data base in the selection of participants.

The strategy of using INTRAH and JHPIEGO as sources of technical assistance for training trainers and providing initial assistance to clinical and non-clinical training is logical, given their vast experience in FP training in Africa. However, some of their curriculum development procedures (for example needs assessment and the testing of curricula), and proposed cumcula (for example genital tract infection training) are unnecessarily costly in terms of the amount of time and resources committed to them, and do not necessarily correspond to local realities.

The objective of training 75 "IEC trainers" (called for in the Project document) is not very clear. Nor was it clear in discussions with ONAPO trainers who this referred to. The
approximately 33 trainers who have benefited from at least one TOT over the course of the Project were either FP clinical trainers or FP auxiliary trainers. Social workers/CCDFP agents (who could be considered "FP/IEC trainers" in terms of ONAPO IEC strategy) were not among this group. However, they were subsequently trained in FP/IEC by the above trainers and they, in turn, trained village-level promoters (Abakanguramba). Figures as to the number of such social workers/CCDFP agents trained were not available.

The training of the approximately 33 FP clinical/auxiliary trainers has provided a cadre of trainers at the central level who have been primarily responsible for clinical training plus two trainers per region who have been primarily responsible for FP auxiliary training. With few exceptions, this division of labor has not facilitated the regions' taking responsibility for their own clinical training and has been a limiting factor in the amount of clinical training which can be done. Weaknesses continue to exist in ONAPO in the areas of training needs assessment and curriculum design (see section 4.3.2).

The strategy of having all paramedical personnel pass first through the FP auxiliary training before receiving clinical training for service providers is not an efficient use of resources. Much of the content taught in the FP auxiliary training is repeated in the clinical training. (It is not clear in the Project document who the term "FP auxiliaries" refers to. In that it is discussed in the section IEC leads one to believe that it refers to a cadre of community worker.) The fact that FP auxiliary training is directed toward medical assistants, nurses, health auxiliaries, social workers, leaders of CCDFP and educational technicians from the cadres of agronomists, agricultural extension agents and veterinarians suggests that their intended FP IEC tasks, and contraceptive distribution tasks, are the same. The training content (community-based IEC activities, distribution of barrier methods, counseling on natural methods and breastfeeding, and distribution of pills on a follow-up basis) targeted for this diverse population of workshop participants suggests a lack of needs assessment. There are, in fact, differing opinions as to the logic and practice of service providers passing through this sequence of training.

The strategy of computerizing the list of public health personnel (including their professional training, place of employment and in-service training received) in order to better identify training needs throughout the country is a necessary and positive move. It remains to be seen how well this system will be exploited, especially if more than one "organization" (in this case, the MOH for example) becomes involved in FP training.

4.3.3 Barriers, Constraints and Facilitating Factors

There are a number of constraints and barriers to the optimal functioning, and ultimate productivity, of training efforts.

Responsibility for Training. The fact that the responsibility for FP clinical training resides in at least three different organizational units at the central level (ONAPO IEC Section, ONAPO Family Health Section, and MOH MCH Unit), combined with the existence of multiple international donor-assisted FP projects each with its own mandate, makes it difficult for the MOH to make maximum use of available resources. This problem affects nearly every aspect of FP training, including (1) establishment of a solid training strategy, (2) the establishment of central and regional training teams and the definition of their roles and
responsibilities, (3) the identification of training needs and training priorities, (4) the establishment of FP service policies and protocols, (5) the development and standardization of training curricula, (6) accountability for promoting and enforcing standards of practice, (7) responsibility for training follow-up and evaluation, and (8) the linking of FP training and supervision.

Quality of Training. A weakness which appears at all levels of FP service delivery concerns the quality of interpersonal communication/counseling. This has been mentioned in JHPIEGO and INTRAH training evaluation reports and was pointed out in the MCH/FP service delivery study done by the RIM Project. The problem of FP counseling is a possible partial explanation for the gap between the population's "need for family planning" (as expressed, in a 1992 study, by 78% of women who either did not want more children or who wanted to wait two years or more to have another child) versus the 12% to 15% of women actually using contraception, and the rising rate of drop outs. The apparent cumulative drop-out rate from 7/90 to 10/93, based on the difference between acceptors + users the previous month and users the current month, is nearly equal to the number of acceptors (new clients) for the same period of time. While this is a somewhat imprecise measurement, its magnitude is cause for concern. (In part, the difference between "potential demand" and practice, and the level of drop-outs, are likely also influenced by the more than two years of war which has displaced approximately 12% of the population. They could also in part reflect the quality of IEC efforts, namely the appropriateness and communication of FP messages.)

The quality of interpersonal communication/counseling has been cited most often as the reason for client drop-out, often related to inadequate explanations of side effects of contraceptive methods. In world-wide FP studies, interpersonal communication/counseling has been identified as a crucial element in clients' perception of the quality of service. The way in which clients are treated and the quality of explanations of methods and secondary effects are important factors in a client's confidence in her/his chosen method and in the service provider's ability and commitment to assist. Service provider communication skills are also an important factor in health center-based IEC activities and in a service provider's ability to integrate FP into other MCH and/or curative health care services.

The quality of training is an important contributing factor to the problems of FP service delivery described above. The quality of training is a function of the quality of training curricula and skill of trainers. The ONAPO training curricula for FP auxiliaries, paramedical FP service providers, and teachers are weak. If these curricula are used as they are currently designed, they are not likely to produce competent personnel. In all three curricula, the content and training methodologies are not sufficiently detailed for trainers to conduct competency-based training without considerable additional refinement on the trainer's part. It is unlikely that most trainers are in a position to adapt the curriculum, given their training and experience and the lack of time allowed for preparation of training sessions. In some cases, training methodologies are inappropriate. Trainers often resort to lecture-style training due to their inability to cover the intended material, using proposed teaching methods in the time frames given. (The fact that the curricula are bound as opposed to being loose-leaf in ring binders makes it difficult to modify individual sections as needed.) In neither the clinical nor the auxiliary PF curriculum is there adequate practical task-oriented content, training methodology, nor time, to begin to master either counseling nor IEC skills. (The team was not able to obtain copies of, and therefore comment on, the physician training curriculum.)
Additional weaknesses in the paramedical FP clinical curriculum include:

- important topics are given very superficial treatment (for example indicators of quality in the delivery of FP services, communication skills in FP counseling and IEC, and contraceptive logistics).

- the sequence of modules in the curriculum is not logical.

- time is devoted to superficially teaching certain content which service providers will be unable to use in health centers (example IUD insertion and diaphragms).

- the scheduling (one week theory, two weeks practice) may not be the most efficient use of time, given that (1) one week of theory is insufficient to adequately cover all subjects, and (2) training sites generally do not have eight full hours of FP activities five days per week. This organization of time was based upon the criteria for selection of practicum training sites and the numbers of participants (2) per site. The strategy of providing one week theoretical training and two weeks practicum, and the criteria of two participants per practicum site, necessitates six - eight practicum sites for each clinical training program and makes it virtually impossible to conduct regional training.

- practicum objectives are higher than can be met in two weeks of practice in some settings.

- FP service protocols are not given serious treatment during training. The IEC Section, Training Sub-section acknowledges having a copy of the FP service protocols (developed by the Family Health Project of the MOH) but is not sure of the distribution of this recommended training material; it is not distributed during clinical training.

- preceptors are often not advised of clinical training until trainees arrive at their health facility.

Additional weaknesses in the FP auxiliary training curriculum include:

- the sequence of some modules is not logical.

- some methodologies are inappropriate.

- inadequate attention is given to interpersonal communication and to IEC (causerie) practicums.

Additional weaknesses in the teacher training curriculum include:

- most modules have insufficient detail for a trainer to provide solid training.

- there is no suggested timing for any of the modules. It is questionable whether all content can be adequately taught in the time allowed (one week).
Training of FP Auxiliaries. As suggested above (section 4.3.2), there are several obstacles to the effectiveness of so-called “FP auxiliaries.” At a minimum, the roles and training needs of this diverse group are not well defined. Although FP auxiliary training (done at the regional level) is financed by USAID/Rwanda funds, the ONAPO central office does not follow up on this activity and, therefore, does not know what effect it has on the FP program.

Training of Health Auxiliaries. An important obstacle to the delivery of quality FP services is the fact that, due to an often serious lack of personnel at the health center level, FP services are frequently provided by health auxiliaries, very few of whom have had any FP training. This problem was first reported in mid 1992 and the decision was made to respond to it immediately. However, more than one and one-half years later, nothing had been done. It is only in early 1994 that a needs assessment and training plan have been developed to respond to this problem.

Staff Turnover Within ONAPO. For a variety of socio-economic reasons, ONAPO has experienced in the past several years a continuous and significant turnover in personnel. This has had an important negative effect on the intended benefits of training.

Per diems, Honoraria and “Sitting Fees”. At least ten USAID-financed training programs have been canceled in the past nine months due to trainers and/or participants refusal to accept logistical provisions made for these activities. At issue has been (1) honoraria for trainers (who most often are medical school faculty, ONAPO regional staff or FP service providers), (2) the requirement that trainers and participants be housed at the Kicukiro Training Center in Kigali when training is done there (as opposed to being given their per diem and freedom of decision regarding lodging), and (3) "sitting fees" for participants attending training. As regards honoraria for trainers, medical school faculty have often been paid as FP trainers under USAID-supported contracts while other trainers for whom training is likewise not part of their routine responsibility have received nothing. The policy of requiring participants to be housed at the Kicukiro Training Center has been resisted by some participants who preferred to find their own lodging and receive their per diem. Some participants have demanded "sitting fees" to attend training, based on experience with other projects and donors.

These logistical impasses are a result of the lack of uniformity of policies among donors and lack of uniformity in their application to different cadres of personnel. They are exacerbated by the difficult economic situation in Rwanda. This situation is contributing increasingly to an atmosphere of last-minute negotiation with trainers and trainees in which training programs are often canceled.

4.3.3 Likelihood of Meeting Objectives

For some training activities, for example the training of physicians in FP, the Project theoretically could achieve its quantitative objectives, given progress to date and the year extension. Other objectives, for example concerning the training of paramedical personnel, FP auxiliaries, teachers and village-level promoters, would appear impossible to meet. This
is due to (1) the low level of progress to date, (2) current resource constraints (especially in terms of personnel and time) exacerbated by the need to take on training a whole new cadre of health personnel, the health auxiliaries, and (3) the need to revise curricula before continuing to train paramedical personnel. Whether or not the Project will be able to progress toward meeting any of its objectives depends largely upon the evolution and outcome of the current war and Rwanda's ability to install effective leadership and move forward.

As pointed out earlier (section 4.3.3.b), even if the Project achieves its numerical training objectives, there is serious question as to the degree to which the current training of personnel is contributing to quality IEC activities and the delivery of quality FP services.

4.4 Recommendations

The following recommendations were developed related to the ongoing program. They are clearly not practicable at this time but will be relevant to any program as it is developed.

_Institutionalization of Integrated Comprehensive Reproductive Health Services_

6. Future Project efforts should support the institutionalization of integrated comprehensive reproductive health services as the most viable mechanism to improve access to, and quality and acceptability of public sector FP services in Rwanda.

This is the strategy spelled out by the MOH in 1988, and it is the strategy being adopted by the RIM Project and supported by the World Bank Family Health Project, GTZ and UNFPA. It is based on the fact that although MOH clinics are not highly subscribed to and suffer a variety of management and operational problems, still they are (and will be for some time to come) the primary source of health services at least for the great majority of the rural population in Rwanda. For this reason, and given the MOH's commitment to making the system work, combined with the inherent relationship between maternal and child health and family planning services, strengthening of the MOH's capacity to provide quality integrated MCH/FP services is essential to the success of the FP program in Rwanda.

Such institutionalization would necessarily address the constraints mentioned in 4.3.3 a. above. However, this needs to go forward with some caution and continued study as noted in section 5.2.

_Curriculum Revision (including needs assessment & training strategy)_

7. Before any future training is done (either clinical, FP auxiliary or teacher training), ONAPO and MOH must clarify training needs and redefine curricula based on competencies needed by personnel to be trained. The donor community should provide technical assistance in needs assessment and curriculum development.
Computerized Lists of Health Workers for Monitoring Training Needs

8. ONAPO should update the computerized list of health workers and the in-service training they have received needs to be up-dated.

ONAPO should establish a mechanism for keeping it current and for making it available to all parties who may be involved in FP training.

Decentralization of Training

9. ONAPO and MOH should reassess the efficiency and effectiveness of alternative mechanisms for responding to clinical FP training needs.

In particular, they should assess the strengths and weaknesses of the current centralized training strategy versus the possibilities of decentralizing training which would allow more training to be done (by more trainers) and would increase the capacity of regional staff to monitor training needs, train and evaluate training.

Training of Health Auxiliaries

10. ONAPO, MOH and technical assistance agencies should give major priority to the training of health auxiliaries, due to their de facto role in the provision of FP services and their general lack of preparation for this task.

Resolution of Logistical Issues in Training

11. The USAID mission should seek a resolution to the issues of per diem, trainer compensation and participant "sitting fees" before agreeing to support further training.

USAID should take the lead with other donors and the GOR to (1) establish a uniform policy regarding conditions under which trainers are, or are not, compensated for training, (2) establish uniform per diem regulations and rates, including allowing participants to choose their lodging, and (3) respond uniformly to the demand of some groups of participants to receive "sitting fees" for their participation in training.
5. SERVICE DELIVERY

5.1 Project Objectives and Strategy

The overall goal of the project was to reduce fertility rates in Rwanda by improving and expanding the delivery and use of FP information and services through both the public and private sectors. Regarding family planning service delivery, the major thrust of the project was to increase the availability, accessibility and quality of FP services.

Quantified targets to be reached by completion of the project were:

- to reduce the total fertility rate from 8.6 to 8.0.
- to increase the prevalence of modern contraceptive methods from 3 percent to 15 percent among women 15-49 in union.
- to reduce the annual population growth rate from 3.7 per year to an estimated 3.2 per year.
- to decrease the desired family size from 6 to 5.
- to increase the number of men and women between the ages 15-49 having knowledge of all FP methods from 70 to 95 percent.

The strategies to be developed to reach these objectives were to integrate FP services into the health care system so as to make FP information and services available in all MCH consultations; to target FP services to high risk audiences; to develop standards for FP service delivery; to improve the frequency and quality of supervision; to improve logistics and FP information system, to enhance the quality of FP services provided in health facilities; to support needed research and to expand FP service delivery beyond the public system through the extension of community based distribution and social marketing and supporting private sector delivery system.

5.2 Findings

5.2.1 Quality of Service Delivery in Health Facilities

Several interrelated factors mutually contribute to the overall quality of FP service: choice of FP methods; technical competence of providers; interpersonal communication, information and counseling of clients; mechanisms to encourage continuity and appropriateness and management of services.

Choice of FP Methods. Family planning methods available in the Rwanda FP program include hormonal contraceptives (injectable, pills, and NORPLANT); IUD; condoms and spermicide; tubal ligation; vasectomy and natural FP methods (calendar, thermometer and Billings'). Over the last ten years, as a result of intensive information and educational efforts
and increasing involvement of the MOH in the provision of FP service, the use of modern methods among women in union 15-49 has drastically increased from 1 percent in 1983 to 13 percent in 1992. By mid 1993, method mix, according to service statistics, were as follows: injectable 55.4%; pills 24.6%; barriers 5.3%; NORPLANT 5.2%; tubal ligation 3.2%; NFP methods 2.9%; IUD's 2.8% and vasectomy 0.5%.

The population policy adopted on June 22, 1990 emphasizes a shift from birth spacing towards birth limitation. There is no policy restriction to adopt voluntary surgical contraception and laboratory tests are no longer requested before the provision of hormonal contraception.

The recent introduction of NORPLANT and CCV (voluntary surgical contraception - VSC) has been a positive move to meet the needs of couples who want to limit or postpone, for a rather long period of time, further pregnancy. Although the program emphasizes the use of long term methods, (NORPLANT, CCV and IUD's) the IUD's are not promoted by providers, not much requested by clients and therefore not widely used.

Technical Competence of Providers. A study conducted in 1994 in two prefectures (regions) through the RIM project (new USAID comprehensive reproductive health and family planning project) investigated several components of quality of FP service delivery.

(1) Overall Quality of Care

Table 1 demonstrates the results of this two region study in summarizing the way various services are provided in the health facilities.

<table>
<thead>
<tr>
<th>TYPE OF ACTIVITIES</th>
<th>MEAN SCORE BY ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEW CLIENTS</td>
</tr>
<tr>
<td>Medical history</td>
<td>65</td>
</tr>
<tr>
<td>Physical examination</td>
<td>47</td>
</tr>
<tr>
<td>Attitude of provider</td>
<td>41</td>
</tr>
<tr>
<td>Explanation of various contracept</td>
<td>23</td>
</tr>
<tr>
<td>Contraceptive methods</td>
<td>22</td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
</tr>
</tbody>
</table>
With the exception of medical history taken by medical assistants at the first visit, the quality of all other activities performed by all categories of health personnel is below an acceptable score.

For all categories of health personnel, the quality of services related to medical history and physical examination (two major items to identify possible contraindications) drops from the first to follow-up visits. From first to subsequent visits, there is no significant change in the "quality" of activities related to counseling nor in the attitude of the providers.

Eighty percent of new cases are being given explanation for pill and injectable, only 50 percent receive explanation related to IUD or NORPLANT. Only about 12 percent of new clients are receiving information on tubal ligation and 10 percent on vasectomy. In half of the cases, new acceptors are not properly informed as to how to correctly use the method chosen. In 80 percent of the cases, no information is provided regarding side effects and, among clients who do receive this information, only 5 percent are informed of what to do if they occur.

For old clients, advice on major side effects is provided in less than 2 percent of pill users and in less than 10 percent of users of injectable and, except for weighing, physical examination is not properly performed in the majority of the cases.

The less attention given to the client when she comes back might be, through lack of detection and/or treatment of side effects and poor information/counseling, a contributing factor to drop out. Several studies conducted among clients have emphasized the need to provide complete information about the method chosen, especially with regard to occurrence of inconveniences, side effects and their management.

(2) Quality of FP Services by Categories of Providers

Medical assistants, A2 Nurses and Health Auxiliaries were scored separately on how well they performed various functions.

During the first visit, medical assistants provided the best medical history and explanation of contraceptives methods. But they are not as good as nurses are for counseling and their attitudes are not as positive as that of the nurses or the health auxiliaries. Lack of time due to other duties may be a reason for this situation. Performance of physical examination is equally poor, whether performed by medical assistants or nurses. This has also been confirmed by a performance evaluation conducted by INTRAH-ONAPO in August-September 1993. Nurses have the best attitude and are providing better counseling than other providers. The health auxiliaries are not as adequate as nurses and medical assistants are for taking medical history, performing physical examination and providing proper counseling.

Most service providers who have been trained in FP service delivery devote their time providing curative services, managing the health center and initiating cost recovery system. As a consequence, in the majority of health centers, FP services are provided by health auxiliaries, most of them without proper training to correctly
provide such services. Family planning methods are usually not presented with sufficient explanation to allow the client to make an informed choice. Respective advantages and disadvantages of various methods, possible side effects and proper use of the method are too often neglected.

(3) Quality of FP Services by Type of Facility

The way in which various functions were performed were compared in the public health facilities and in the semi-public religiously affiliated health facilities.

The family planning providers working in religious health facilities were judged to have a better attitude than their colleagues in public health centers. Both categories of providers are equally providing the same low quality of counseling. Medical history, physical examination and explanation of various contraceptive methods are more satisfactorily conducted in public than in religious health facilities.

Access to and Availability of Family Planning Services. During the 1970's and early 1980's, FP was a vertical program conducted with little implication of MOH infrastructure and perceived as a specific ONAPO's responsibility. In 1981 only 15 public health facilities were providing FP services. It then increased progressively to 152 health facilities in 1985, 184 in 1986, 223 in 1987 and 245 in 1988. In 1988 the MOH issued directives to all public and private health facilities urging them to integrate FP services within the health care system. As a result, at the end of 1989, out of 350 public health facilities, about 277 were providing FP services and by mid 1993, nearly all of them (about 340) were providing FP services. Moreover, between mid 91 and mid 93, the number of health facilities offering from 4 to 7 contraceptive methods have increased with concomitant reduction of the number of health facilities providing only three methods. About 55 to 60 secondary health posts have been created to provide modern contraceptive methods once or twice a week to the population served by catholic health facilities (where only natural family planning is offered) and/or living far away from a public health center. Nevertheless, access to FP services is still not easy for many women. According to the DHS study, 27 percent of users have difficulties reaching their source of supply. Only 60 percent of users have "easy" access to FP services, spending less than one hour to reach their source of supply. One woman out of four spends 2 hours and 14 minutes and more than 50 percent of users had to travel for two hours to be served.

Management of FP Services within the Health Centers. The process of integrating FP services within MCH activities is well advanced. According to a study conducted by the RIM project, FP is no longer considered by providers as a marginal activity. Eighty percent of FP providers have internalized FP and consider that FP activities are fully part of MCH services. Family planning is ranking third by order of importance given by health personnel, immediately after curative services and immunization. Family planning is often a theme of educational sessions organized in health centers. Yet, availability of FP services is still variable depending on the center. Out of 39 health centers investigated, less than half (41%) provide family
planning services five days a week and in almost 30 percent of health centers FP services are still available only once a week. In most health centers (22 out of 25) the delay between the arrival of the first client and the beginning of the family planning activities is less than half an hour. In more than half of the cases, (56 %) clients are seen by order of arrival.

An operations research project conducted by the Population Council demonstrated an increase in FP acceptors by integrating the provision of FP services with immunization: the average number of new acceptors increased from 60 to 130 per month and 85 percent of FP clients were satisfied with this new approach. In some health centers visited by this evaluation team, FP services were also fully integrated with prenatal consultations (same time, same person, same room). However, according to interviewed health personnel, FP users are not satisfied when mixed up with other clients of health centers: they feel isolated, they cannot exchange comments with other users, the wait is too long and they prefer to be seen as a "special group" on specific days or hours. The discretion that was supposed to be enhanced by integrating FP with other MCH services was not perceived as such by FP clients. In a study conducted in Butare, 95 percent of interviewed women preferred to attend specific FP consultations rather than be mixed with other patients. Major complaints of FP users include concern with poor reception, unfriendly attitude and lack of adequate and complete information on use and side effects of contraceptives, all of these being partially attributed to the lack of time of providers. Thus, the feasibility, acceptability and benefit of providing FP services along with other MCH services needs further investigation. And last but not least, there is no identification and in-house cross referral of potential FP clients attending other MCH services within a specific health center.

Cost Recovery of FP Services. The Bamako initiative (pay for service and drugs/community management health care delivery approach) is being progressively implemented throughout the country. While preventive services such as immunization and prenatal care are not subject to payment, in some regions, FP services are no longer free of charge. No comprehensive nor reliable information is available regarding the impact of payment for FP service upon acceptance and continuing use of contraception. However, some reports as well as incidents witnessed by this evaluation team indicate that payment for FP service might be a constraint for potential or actual FP users. In one health center in the prefecture of Giseny, one third of drop outs were attributed to the initiation of payment for FP services.

Family Planning Information System. Several instruments have been developed to monitor program accomplishments. An individual FP record form including a check list (medical history and physical examination) to identify contra indications is used in every service delivery point. While the purpose of this check list is laudable, the extent to which providers comply with those requirements is far from satisfactory. In some health centers individual FP record forms are properly filed according to i) the date of the next appointment, ii) a special box for no-shows users and iii) another box for drop outs. This system is easy to manipulate and useful to identify missing clients. Moreover, in each health center, clients are given registration cards, with date of next appointment and registration number, which permit easy retrieval of their clinical forms and their position within the FP Register. An interesting
An instrument called the "FP Register" allows identification every month of the number of continuing FP clients e.g. the monthly prevalence at each clinic site, and drop outs. However, the FP register does not provide information regarding the reason for drop out. The Register becomes cumbersome to manipulate when the center has a large number of clients and the room for error is proportional to the caseload of the center. In Ruhengery for instance, the statistician - the only person in the center who knows how to utilize the register - has to manipulate 7 registers of 25 pages each, with 30 lines on each page to make three subtotals on each page and to distribute in each sub total the types of contraceptive distributed.

**Follow up of Clients.** Service providers inform clients about return visits and at service delivery points there is an appropriate record keeping, filing and retrieval system to identify clients who miss their next appointment or discontinue family planning. Home visits to contact discontinuing users are performed by Abakangurambaga with variable degrees of organization, systematization and success. In many regions, due to lack of supervision, Abakangurambaga are either less or no longer operational. Therefore, by and large, home visits to recuperate drop outs is limited and not very successful.

**Contraceptive Supplies.** At the central level ONAPO makes annual estimates based upon previous distribution in the ten regions. These estimates are based on the monthly report of activities that ONAPO receives from the regions. This information is not always properly completed and data are not entirely reliable. Nevertheless, ONAPO Central makes global estimations by adding 10 to 25 percent to their calculation, according to the type and use of the contraceptive, and orders needed contraceptives from the various donors (USAID, UNFPA, World Bank and IPPF through ARBEF). In addition GTZ is providing contraceptives directly for its project zone. On the average, it takes six to eight months between ordering and receiving contraceptives. At the central level, ONAPO maintains a security buffer stock of about one year. Health regions are supposed to come every three months to Kigali to receive supplies from ONAPO.

Regional orders are checked by ONAPO staff and regions receive supplies according to availability of stocks and regional consumption during the last previous months. At the regional level contraceptives are stored at the Regional Medical Directorate which maintains a buffer stock of 3 months. However, in some region (at least in Butare), the Regional Bureau of ONAPO also keeps a stock of contraceptives. Health centers get monthly supplies from the Regional Medical Directorate or whenever they need. Health centers maintain a buffer stock of about one month. In some health centers, data on stock forms reasonably match actual number and type of contraceptives available. But in other, stock forms indicate different quantities from what is really available. Some health centers do not use stock forms and the need to order and/or to go to the Health Region to get contraceptive resupply is based upon "a look" at what is left in the cupboard. Despite its weaknesses at all levels, the system works reasonably well and no stock-out in contraceptives has been reported. This issue would be a greater concern in a larger country with more difficult road communication; it likely will become more of a problem in Rwanda as greater quantities of contraceptives are required by a growing program.
Equipment. Among 17 health centers checked by an INTRAH evaluation team for - among other aspects- the presence and the status of 32 FP equipment-related items, about one third of the centers (30 %) were satisfactorily equipped (missing less than 5 items); 23 percent were short up to 1/3 of needed equipment (missing 5 to 9 items); 23 percent were missing 10 to 14 items; 18 percent were missing between 15 to 19 items and 6 percent were missing more than 20 items.

In other words, about 3 quarters of the centers were missing up to half of the needed equipment and 25 % of the centers were in even worse condition. Appropriate sterilization procedures are not always followed for lack of proper equipment and/or insufficient knowledge and training in sterilization procedures of health auxiliaries to whom the chief of health center often delegates this task.

Supervision. At the health centers, health auxiliaries in charge of FP activities are supervised by the chief of the health center who is reported to observe the task performed by health auxiliaries and to discuss cases of FP clients referred to them by the health auxiliary. Health centers are supposed to be supervised every three months by a joint ONAPO-MOH regional team. However, this supervision seems far from being conducted as scheduled: the health center of Kibilisi has not been supervised for two years; and in Nyanza hospital, the last supervision was carried out so long ago that the chief of the FP clinic did not remember when it took place. On the other hand a health center in Kayove had been supervised three times in the last year. A performance evaluation conducted by an ONAPO-INTRAH team in 1993 noticed that supervision is sometimes carried out on a day with no FP activities and that no follow-up action is taken according to previous supervision findings. Supervision does not seem to be perceived by providers as an inter-active, problem solving, supportive/continuing beneficial learning experience.

Trends in FP users, Continuation and Abandons. Since 1983, impressive progress has been made in modern contraceptive use. From 0.9 in 1983, the prevalence of modern methods (including natural FP methods) increased to 11.8 in December 1990 and 14.8 at the end of 1991. It then dropped to 11.6 by December 1992 and went further downwards to reach a level of 9.9 in October 1993 (Service statistics, ONAPO).
As illustrated in Table 2, two factors seem to be responsible for the decrease in contraceptive prevalence: increased drop outs from 39,710 in 1990 to 80,364 in 1992 and was still as high as 56,858 by October 1993; and fewer new acceptors dropped from 89,977 in 1991 to 54,421 in 1992 and was still far below the level of 1990 or 1991 by October 1993. A study conducted in Kigali in December 1992 on drop out and continuation rates for users of pill and injectable provided the following information:

### TABLE 3

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td><strong>AFTER FIRST CONTACT</strong></td>
<td>14</td>
<td>22</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td><strong>AFTER 5 MONTHS OF USE</strong></td>
<td>22</td>
<td>32</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td><strong>AFTER 11 MONTHS OF USE</strong></td>
<td>41</td>
<td>52</td>
<td>33</td>
<td>36</td>
</tr>
</tbody>
</table>

The increase in discontinuation rate of pill and injectable users, especially soon after acceptance might suggest poor quality of services. Several studies conducted among FP users provided conflicting views regarding client satisfaction. While some reveal that 90% of clients are highly satisfied with the overall service delivery, others demonstrate frustration and discontent of clients. The most frequent complaints were insufficient information about methods in general and particularly regarding side effects and their management. In two studies, (one conducted in Butare in 1987 and one nation wide in 1993) respectively 42 and 80 percent of women who had discontinued using their method would be willing to resume FP if better informed about contraceptive methods. Another study, conducted by GTZ in 1992 concluded that besides the desire for an additional child, rumors, insufficient...
knowledge by Abakangurambaga to provide convincing arguments to counteract rumors, bad reception from the personnel at the health center, lack of time of health personnel to discuss client's concerns and to properly explain how to use the method chosen, what side effects to expect and how to manage them, are all important contributing factors to discontinuation.

Similarly, a study of NORPLANT users conducted in 1992 revealed that more than half the women using NORPLANT were dissatisfied with the attitude of health personnel. Yet, the high continuation of NORPLANT might reflect a strong motivation of clients to avoid further pregnancy, which would supersede whatever inconveniences they experience, whether minor side effects or during the visit at the health center. Also nature of method have to take initiative, i.e. request removal to discontinue.

TABLE 4

<table>
<thead>
<tr>
<th></th>
<th>CONTINUATION RATE: RWANDA AND INTERNATIONAL DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pill Users</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1 Year</strong></td>
<td></td>
</tr>
<tr>
<td>Rwanda 1989: Survey Data</td>
<td>59</td>
</tr>
<tr>
<td>Rwanda 1990: Survey Data</td>
<td>48</td>
</tr>
<tr>
<td>International Program Data</td>
<td>23-72</td>
</tr>
<tr>
<td>Clinic Data</td>
<td>40-64</td>
</tr>
<tr>
<td>Clinic/program/survey</td>
<td>45-50</td>
</tr>
<tr>
<td><strong>Injectable Users</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year</strong></td>
<td></td>
</tr>
<tr>
<td>Rwanda 1989: Survey Data</td>
<td>67</td>
</tr>
<tr>
<td>Rwanda 1990: Survey Data</td>
<td>64</td>
</tr>
<tr>
<td>International Program Data</td>
<td>50-75</td>
</tr>
<tr>
<td>Clinic Data</td>
<td>22-63</td>
</tr>
<tr>
<td><strong>NORPLANT</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1 Year</strong></td>
<td></td>
</tr>
<tr>
<td>Rwanda: Study Data</td>
<td>92-99</td>
</tr>
<tr>
<td>International Clinic Data</td>
<td>80-95</td>
</tr>
<tr>
<td><strong>2 Years</strong></td>
<td></td>
</tr>
<tr>
<td>Rwanda: Study Data</td>
<td>67-90</td>
</tr>
<tr>
<td>International</td>
<td>67+</td>
</tr>
</tbody>
</table>

Despite an increase in drop outs, one year continuation rates in Rwanda for both pill and injectable are still within an acceptable range when compared to international figures. For NORPLANT, after one or two years, Rwanda continuation rates are higher than international rates. These international figures show a wide range and have some problems with comparability. However, one might still conclude that Rwanda's problem is at least not much greater than that of other programs. Continuation rates are certainly worthy of concern. However, it may be productive to focus more on outreach to greater numbers of new users than to place excessive emphasis on maintaining a higher than normal continuation rate among users of resupply methods.

Undoubtedly weaknesses in service delivery and management do influence acceptance and continuation rate. Other factors indirectly affecting the quality of services and bearing direct impact on acceptance and use of contraceptives, such as war, displacement, political upheaval, insufficient support from political and other leaders, loss of motivation of Abakangurambaga, etc.) should also be considered while assessing the reason for the decrease in FP users.

From a programmatic point of view, the assessment of the magnitude of each of these factors - and the underlying causes thereof are important. Different remedial actions would be needed to decrease drop out or increase new acceptors. The need to understand the underlying causes of discontinuation argues for greater use of survey techniques which can measure the magnitude and explore the reasons more effectively than can use of service statistics.

At the international level, a pattern of low continuation applies to all re-supply methods. If the prevalence is to increase in Rwanda, some effort must be made to improve the continuation rate by better counseling, improving attitude and knowledge of providers and improving strategies to recuperate drop outs. However, even greater effort should be directed to recruiting more new acceptors, especially for long term methods -tubal ligation, vasectomy, and NORPLANT - for which the demand is high and continuation far better than for re-supply methods.

5.2.2 Special Interests

Outreach Activities.

(1) The Abakangurambaga (Volunteer Village Workers)

The number of registered Abakangurambaga, who have been instrumental during the past few years to inform the rural population on population problems and to recruit FP acceptors, has decreased from 17,016 in 1991, to 11,494 in 1992 and 9,186 in 1993. An evaluation conducted in 1993 among 5,478 Abakangurambaga has found that a large majority of them have participated in several refresher training sessions per year (67% attended 4 or more sessions, 85 % attended at least 3 sessions and only 2% did not attend any sessions). Most of the Abakangurambaga
are FP users (84% in 1992 and 87% in 1993). In 1993, the major task assigned to the Abakangurambaga was to recruit at least 12 new FP acceptors per year. Results were encouraging: on the average, each Abakangurambaga recruited 9.5 new acceptors. Only 9 percent did not recruit any acceptors; 55 percent recruited between 1 to 10 acceptors. In 1993 36 percent recruited 11 or more new acceptors while in 1992 only 14 percent of Abakangurambaga had recruited 11 or more FP clients.

Several factors are adversely affecting the performance of the Abakangurambaga. The major problems reported by the ONAPO evaluation are a loss of motivation and lack of concern of the personnel of the CCDFP and health centers resulting in poor supervision of the Abakangurambaga; inadequate content of training sessions; incomplete and defective registration of FP clients which makes it difficult to track drop outs, new cases and continuing users; poor collaboration between CCDFP and health centers which affect the overall management of the Abakangurambaga. The supervisors of the Abakangurambaga are leaving the volunteer system which reflects upon Abakangurambaga’s own motivation and performance. Moreover, in 1993 the suspension of the bonus in kind which used to be given in each prefecture to the best Abakangurambaga (bicycle, hoe, wheelbarrow, radio, umbrella) has had a negative impact on their morale and motivation. In the ONAPO study only one third of interviewed women would like to be supplied by Abakangurambaga. Among women who would refuse, 80 percent consider that the Abakangurambaga are not sufficiently trained to safely provide contraceptives.

Similar factors affecting the effectiveness of Abakangurambaga were identified by a study conducted by GTZ in 1992: lack of incentives, insufficient competency, lack of support from local authorities, poor supervision from CCDFP and inappropriateness of messages delivered by the Abakangurambaga. From the clients’ perspective, this study reveals that the majority of the population perceived the Abakangurambaga as solely concerned with family planning while nearly 80% of their target population would like to be informed on general health matters. In the training and further use of Abakangurambaga or other CBD agents this felt need of the community must be addressed. At the same time, it is recognized that family planning knowledge and communication skills of these agents are lacking and must be improved before additional responsibilities in general health are given to them.

(2) Community Based Distribution Programs

In 1992, a CBD initiative was launched on a research-cum-action program in several regions of the country with the assistance of SEATS, GTZ and CARE. The overall objective of this program was to stimulate community participation in the FP program. Specific objectives were i) to educate the population in FP, ii) to increase contraceptive prevalence, and iii) to initiate payment for FP services. Within this overall framework, each of the CBD programs developed different approaches regarding cost recovery and the package of services to be offered to the population. Within the CARE area, community development and maternal and child health were included in the CBD program; in the GTZ area, CBD were providing information regarding FP, STD and AIDS, diarrheal diseases, intestinal parasites and maternal and child care; they followed-up contraceptive users, provided pill resupply free of charge and sold basic drugs and condoms.
In the SEATS area (Ruhengery, Giseny and Kigali) 140 CBD (instead of 350 as initially planned because of the war) have been trained for two weeks to do home visits to promote family health, to introduce all contraceptive methods, to sell pill (resupply only), condoms and spermicide, to follow-up users and to encourage drop outs to resume contraceptive use.

These pilot experiments have already demonstrated some encouraging results: in Butare, after 10 months of CBD activities, contraceptive prevalence has increased from 7 to 20 percent; continuity has improved and the drop out rate has decreased to two percent. Through referral from CBD, NORPLANT users have increased from 2 to 35 percent of all FP users and 83 percent of FP clients (continuing users and drop outs) have been visited. By providing contraceptives at the door step the CBD program improves access to modern contraceptive methods especially for the population in the vicinity of catholic health centers which do not provide modern methods. Shortcomings of the program were poor supervision from the health center and from the monitors of the CCDFP and insufficient reward for the CBD agent to sustain long term motivation. In the SEATS CBD project, preliminary results indicate that in two months, 32 CBD have sold 1,283 condoms, 173 cycles of pills, and 43 units of spermicide. These quantitative results are still modest and the major constraints faced by the program were: i) the lack of supervision (which should have been provided by the health center and the CCDFP) for lack of personnel and lack of transport ii) too large a zone for each CBD to visit (about 6 "cellules" i.e. 300 families), iii) too much paperwork. The report of activity of the CBD agent includes: number of families visited, number of FP clients recruited, number of FP clients referred, number of meetings attended, number of drop outs recuperated, number of clients resupplied. In addition the CBD worker has to fill out a follow-up register for his/her clients comparable to that of the FP register of the health center; a stock form, a financial form for receipt and a checklist for contra-indications.

The CARE evaluation in process at the time of this MCH/FP II evaluation was interrupted by the outbreak of war.

Long Term Contraception. NORPLANT was initiated in 1988 at the Central Hospital of Kigali and at the University Hospital of Butare. It is now available in 90 sites throughout the country, ranging from 2 in Byumba region to 23 in Kigali. NORPLANT is also available on an outreach basis through mobile teams in at least five prefectures. About 150 doctors and nurses have been trained in NORPLANT insertion and removal. Yet, a study conducted in early 1992 found that 90% of providers started to insert NORPLANT before formal training. Fortunately, no troubles nor side effects that could have been related to this practice have been reported. To what extent non trained personnel are still inserting NORPLANT is not known.

Two interesting findings have been disclosed from a qualitative study on NORPLANT conducted in 1992: on the one hand, the majority of NORPLANT acceptors were dissatisfied with the reception and the poor information provided by health personnel; on the other hand they were satisfied with the method which meets the criteria of what they consider as the "ideal method", namely: efficient, safe, easy to utilize and requiring few visits to health centers. Altogether, it was
found that there is a demand for NORPLANT and that the method is well accepted. However, lack of appropriate counseling discourages potential acceptors who need more information to better accept the method and better cope with possible side effects.

In the method mix, the share of NORPLANT has increased from 0.3 percent in July 1990 to 5.2 percent in October 93 with 5,048 NORPLANT users. The continuation rate is excellent, reaching 92-99 percent after one year and up to 90 percent after two years.

VSC was introduced in April 1990 in the Central Hospital of Kigali. The three major objectives of the VSC/SEATS project were i) to train, in seven prefectures, 32 health professionals in vasectomy and minilaparotomy under local anesthesia and to train 64 counselors to promote long term methods (VSC and NORPLANT), ii) to integrate information on long term methods in IEC programs and iii) to decentralize responsibilities, to insure regular supervision and to provide technical assistance. Though the exact number of persons trained as well as the numbers of sites providing VSC is not known, the program has been extended throughout the country and VSC is reported to be available in one to three sites in each prefecture. VSC has met a growing demand: from 651 in June 1990, tubal ligation has increased to 3,128 in October 1993 while in the same period, the number of vasectomy increased from 57 to 513. Among all FP users, the share of VSC users has increased from 0.7 percent in July 1990 to 3.8 percent October 93. In Ruhengeri and Giseny clubs of satisfied users of vasectomy have been created. They constitute a useful asset of motivators, keen to dissipate rumors and from whom encouraging results in terms of recruitment and quality of information provided has been observed.

Progress in expanding long term methods is facing several constraints. Several actions foreseen in the plan of action did not take place: The National Coordinating Committee for Long Term Methods has only met once; the participation of the MOH in the program is still weak (MOH did not appoint a coordinator within this committee); the National ONAPO VSC Coordinator -who is also responsible for the Family Health Section in ONAPO- is not devoting required time and energy to the program; the nomination of three zonal Coordinators never took place (the idea was dropped in October 93) and no other decentralized organizational structure has been created. Coordination/collaboration between SEATS and AVSC is also weak.

Given this situation, and especially the lack of a working National Coordinating Committee, the SEATS resident advisor has organized a smaller but more active committee which has already met four times. Some slow progress has been made with regard to the identification of what needs to be done and who will be responsible for what, but implementation is not yet satisfactory. Kits for insertion and removal of NORPLANT are not always available in sufficient quantities, (trocars are worn out after about 10 insertions), quality of care is inadequate, lack of local funds limit the transport of VSC candidates and not enough attention is given to the development of priority health facilities within the "SEATS zones".

There is no geographical coordination between activities related to the creation of demand (IEC) and development of practical possibilities to offer the service (no
operational VSC training center in the prefecture of Gitarama, Byumba, Kibungo and Gikongoro. Supervision is weak; the respect (or lack thereof) of AVSC criteria needs to be checked; and the number of VSC performed or NORPLANT inserted at each site is not systematically recorded (official number of monthly activities does not match those verified during supervision).

Some positive moves have been i) the recruitment of a medical advisor, experienced in VSC and based at the SEATS Regional Office for West Africa, who will devote about one third of his time to the Rwanda VSC program and ii) an understanding between SEATS and AVSC for the SEATS resident advisor to become the coordinator of all VSC activities in Rwanda, both for AVSC and SEATS to improve communication between the two organizations.

Private Sector

(1) Social Marketing

The majority of FP users (96%) are served by the public sector, mostly through health centers and secondary health posts (74%) and hospitals (21%). The private medical and commercial sectors are providing contraceptives to less than one percent of users. However, 16% of users of barrier methods (especially condoms) are supplied by private commercial channels.

The first steps to develop a social marketing project were initiated in 1987. The selling of condoms (Protector) in bars, pharmacies and shops started in mid 1992 and during the course of the project, other sales agents were trained to promote and sell condoms (mobile vendors, volunteers of ARBEF and Abakangurambaga). Altogether, from June 1992 to December 1993, 881,227 condoms were sold through the SOMARC project. Several observers suggested that it was a mistake to accede to the ONAPO decree that the social marketing project be based in ARBEF, an NGO with no marketing experience. Additionally, cost recovery considerations produced a condom price too high for the market. Weak promotion and advertising may have been ameliorated had there been resident technical assistance to aid ARBEF with the marketing plan and implementation.

At the end of 1992 and during 1993, USAID decided to develop, on a competitive basis, a second condom marketing project with Population Services International (PSI). This proposition was subsequently dropped and USAID funded only the PSI condom project through AIDSCAP. The role of SOMARC and ARBEF became unclear and in 1993, the sale of Protector continued at minimal levels. By the end of the year, SOMARC reassessed the situation. It was decided that SOMARC should drop the condom social marketing project and start developing a marketing plan and budget to launch an oral contraceptive social marketing project with ARBEF. However, the required budget was about one million dollars i.e., 300,000 dollars in excess of available funds. It was then decided not to continue the SOMARC project. A consultant was in Kigali during this evaluation to close down SOMARC activities. His work was also interrupted by the evacuation, but he was making a substantial contribution beyond "shutting down" the CSM activity with ARBEF. His assistance to establish a working relationship between ARBEF and PSI was positive as was his helping ARBEF to more clearly identify its institutional goals and organizational development needs.
In March 1993 PSI initiated sales of "Prudence" condoms as part of an AIDS prevention campaign supported by the AIDSCAP project and GTZ. With an aggressive promotional campaign and its own sales force (three teams of two sales persons each which cover 1600 outlets nationwide every two to three weeks) total sales reached 1,060,000 condoms by Dec. 31. In March 1993 sales were about 100,000 with the price 20 Rwanda francs for a package of 4 as compared to the SOMARC price of 50 RF for 3. About 25% of total sales go to fifty businesses (of the 100 or so in Kigali with 30-200 employees). These businesses then distribute 8 condoms/month in their employees' paychecks. Another 15% of the sales go to projects like CARE and to a research on the transmission of AIDS from mother to child. A small portion goes through a few pharmaceutical wholesalers and direct retail sales by PSI staff at athletic matches in the stadium or at other promotional events. An innovative approach for information and marketing will be the use of several state of the art mobile audio visual units to visit the twice weekly markets that are so common throughout Rwanda, many reasonably easy to reach by good roads.

PSI has a good working relation with ARBEF and will be developing a parallel marketing scheme with them using their volunteers and FP clubs. PSI expects this will provide the logical bridge to move from an exclusive emphasis on condoms for AIDS prevention to a program including condoms and other contraceptives for family planning.

(2) ARBEF

The fundamental goal of ARBEF is i) to mobilize its members to inform various segments of the population and to distribute/sell contraceptives and ii) to collaborate with other organizations and associations. ARBEF counts one National Committee (31 members), Regional Committees in each prefecture (six members per committee) and Communal Committees in 34 communes (6 members per committee). ARBEF has recruited 3,400 members distributed over the hills, in cities and in various business and agricultural enterprises. Some communes report up to 300 members. ARBEF has also created five FP clubs to help new acceptors and users overcome fear of side effects and counteract rumors. ARBEF is also in relation with more than 15 other organizations such as scouts, guides, women's and youth associations. They meet with these associations regularly every three months and have agreed to develop three themes for the coming "Week of the Family": unwanted pregnancy among teenagers, AIDS and Code de la Famille. For IEC activities ARBEF is targeting non married mothers and youth with emphasis on family health, personal concern and AIDS rather than on demographic matters.

There are two ARBEF clinics: one in Butare, not yet operational for lack of funds and lack of personnel and one in Kigali with limited activities (about 10 patients per day, including FP, gynecological consultations, STD and prenatal care). The clinic is not well known yet and has recorded only a handful of new FP acceptors (about 60 since January). ARBEF plans to start ambulatory consultations for the population in the hills as well as using their paramedical members to provide contraceptives close to the population (home visit, market place and at the home of paramedical members). ARBEF has also initiated dialogue with SEATS and AVSC to eventually open a VSC clinic in the ARBEF clinic of Kigali.
While ARBEF has a built-in potential to play a leading role in promoting the involvement of the private sector in the national FP program; members, recruited with no criteria, are not adequately oriented nor supported by regional and communal committees which in turn have few directives as to what they are expected to do. The central level itself is still very weak in defining its role, developing strategies and making plans of action. As noted above, in phasing out the SOMARC project technical assistance was provided that helped ARBEF develop a basic framework to address these issues.

(3) Other Private Organizations

Although the private commercial sector is rather limited, the 1988 directives of the MOH making mandatory for all organizations to include FP services within their health and social services should facilitate the extension of FP services within the medical service of parastatal societies. Already in 1987, out of six parastatal enterprises investigated in a study to assess the role of the private sector in FP, 3 were providing FP services within the framework of socio-medical services. The "Office du Thé" which counts 25,000 employees expressed its interest in developing FP activities. Among 8 private enterprises also investigated by this study, two were providing FP services.

The 1987 law regulating medical practice did not authorize physicians and paramedical personnel to engage in both public and private practice. This interdiction has been abrogated and private practices (medical and paramedical) are emerging at least in major cities. They are either managed by individuals or by several doctors (polyclinic) and serve individual patients or could possibly provide medical services to employees of small enterprises on a contractual basis. Further investigation is needed to estimate what could be the role of ARBEF for instance in training and supporting these health personnel of the private sector to include FP services within their activities.

Relation with HIV/AIDS. In Rwanda, the AIDS epidemic is a major public health problem. HIV prevalence is 30 percent in Kigali and 4 percent in rural areas. In SDT clinics, 65 to 70 percent of clients are sero-positive; among 15-19 year old out-of-school girls, 5 percent are sero positive; in 1993, 1,500 babies died from AIDS and in the prenatal consultations at the Central Hospital of Kigali, 35 percent of pregnant women are HIV positive.

Such a dramatic situation calls for actions related to family planning activities: first leaders and decision making politicians should be informed that despite the heavy death toll of AIDS, the demographic implication will not be a reduction in the total population but only a slow down in the population growth rate, hence that family planning is still highly justified.

Second FP messages and appropriate contraceptive methods should be made available to all sero positive citizens and inversely information on AIDS and STD should be provided along with FP counseling, particularly for youth and high risk groups.

Operations Research. With the exception of the DHS and the Population Council research on FP associated with the vaccination program, much of the research expected in the project design has suffered from personnel shortages in ONAPO. Some of the small
studies described in sections above have helped to identify problems of service delivery and informational gaps. More work will need to be done in the future to build on limited information available from several studies listed below:

- A pilot experiment on CBD in Ruhengery which eventually leads to the expansion of various CBD strategies in some regions of the country
- A qualitative study on acceptability and demand for NORPLANT (January-February 1992)
- Perception et proposition sur les Abakangurambaga par la population et ses encadreurs (August 1992)
- Recherche opérationnelle sur l'intégration de la planification familiale dans le programme élargi de vaccination (October 1993)
- Acceptation, continuation et abandon des méthodes de planification familiale au Rwanda (performed ? published in May 1993)
- Etude sur les caractéristiques des utilisatrices des méthodes de planification familiale, sur la continuation et l'abandon de ces méthodes (October 1991-January 1992)
- Enquête Demographique et de Santé (1992)

5.3 Conclusions

The USAID MCH/FP II funded project has contributed significantly to improving access to and use of modern contraceptive methods. Through the integration of FP services in almost all health facilities, the development of outreach services (secondary health post, Abakangurambaga and CBD) and the implementation of social marketing activities for condoms, 60 to 70 percent of women in reproductive age have an easy access to FP services.

MOH personnel have become actively involved in the provision of a wide range of modern contraceptive methods, including needed and accepted long term methods. Management systems have been developed to insure regular contraceptive supply as well as monitoring of new acceptors, drop outs and continuing users.

However, there are still several limitations in the quality of FP services. In most health centers, untrained or insufficiently trained health auxiliaries are providing FP services. Their technical competence and attitude are far from satisfactory. In an environment saturated by discouraging rumors, incomplete information about contraceptive methods and insufficient concern regarding client's needs is not conducive to sustained use of contraception.

Inadequacies in the managerial skills of the chief of the health centers to better organize FP services also reflects upon the quality of services. FP services are available five days a week in less than half (41%) of the health centers; in about one third of health centers, they
are still provided only once a week. Many church owned centers provide only natural family planning. Patient flow is not organized as most FP clients would like; waiting time - although by and large reasonable - could be shortened; continuity of care (information, counseling, check up and provision of contraceptive performed in same place, by same person at same time) is not generalized and no FP advice, counseling or referral is provided for potential clients or high risk women attending various other MCH services. In most health centers, there is some deficiency of appropriate equipment and correct sterilization procedure is not always followed.

Supervision which is a key element for continuing improvement of technical competency and quality of services is weak. It seems to be more oriented toward administrative control and checking results of activities (records), rather than towards the evaluation of the process and the quality with which activities are being carried out.

Reliable information is not yet available to assess either the positive (valorization of a paid contraceptive) or the negative (cost not affordable for a poor population) impact of the Bamako initiative upon the acceptance and use of contraception. However, it should be kept in mind that the objective of the FP program is not (at least not yet) to achieve financial sustainability but to increase contraceptive prevalence. Anecdotal information calls for caution before generalizing payment for contraceptives.

Considerable concern has been expressed related to the decrease in contraceptive prevalence since 1992. Both decrease of new acceptors and increase of drop outs are responsible for this situation. It should nevertheless be noted that pill and injectable continuation rates remain within the range of international figures. Several factors such as discontinuation soon after acceptance, widespread complaints of women regarding insufficient information provided on contraceptive methods and side effects, dissatisfaction with attitude of providers indicates poor quality of FP services. If indeed the increase in drop out and decrease in new acceptors is at least partially related to poor quality of services, it implies that the provision of services was previously better. Hence, factors outside the control of the program (war, displacement, political upheaval, political ONAPO connotation, less local authority support for the program) have been at work to impact negatively on the quality of service. As far as drop outs are concerned it should also be kept in mind that many women accept FP to delay further pregnancy and that therefore a substantial number of users discontinue to become pregnant.

Three types of outreach activities are complementing FP services provided at health centers: (i) secondary posts whose number has increased from 35 in July 1991 to nearly 60 at present. In mid 1993, secondary posts were providing FP services to ten percent of all users who might otherwise have been deprived access to FP services. (ii) Abakangurambaga who provide FP information, follow-up FP users and encourage drop outs to resume contraception and (iii) CBD agents who promote family health including FP and sell or distribute contraceptives (resupply of pill, condoms and spermicide) along with other essential drugs. While the Abakangurambaga scheme, linked with the former political structure is facing functional constraints, the recent CBD system, disconnected from political connotation and providing a more varied package of health services seems to be a promising approach to bring comprehensive FP services (information, follow-up, referral, contraceptives) closer to the population.
While the project planned to provide support to at least eight private sector entities (NGOs, cooperatives and or private clinics), support to the private sector has been limited to the launching of a social marketing project with ARBEF. Although initial CSM progress was disappointing, the SOMARC supported effort demonstrated that there is a market for contraceptives in Rwanda and sales programs can be mounted without public criticism. The AIDSCAP supported condom social marketing/AIDS prevention activity has demonstrated that even more aggressive marketing techniques can be used and a larger market reached. This may provide the basis in the future for a family planning social marketing effort combined with CBD objectives and a growing participation of the private sector.

5.4 Recommendations

Several of the following recommendations have been overtaken by the events of recent conflict. However, they are still included to demonstrate the kinds of things that might have been accomplished in the latter months of the project. Other recommendations are more directed toward policies and practices that should be adopted in future programming.

The outreach system implemented in the past few years to promote family planning, recruit and follow up FP clients was based upon the Abakangurambaga. The political environment within which this system was developed and which provide them support (local authorities, CCDFP) is changing and the role of Abakangurambaga as solely FP motivators seems no longer to respond to the expectation of the population.

12. ONAPO, USAID and the involved agencies should evaluate the Abakangurambaga and the three CBD programs conducted with the assistance of SEATS, CARE and GTZ; analyze in each one factors favorable and constraints to the recruitment of new acceptors and the promotion of continuing FP use; organize a workshop to discuss results, define an overall policy regarding community based approach and develop a strategy to implement ONE community based distribution system which, closely related to the social marketing program, would operate in a quasi-commercial fashion.

An important factor that might boost acceptance and continuation rate is to provide contraceptive services as closely as possible to clients.

13. ONAPO, MOH or others developing service delivery policy should determine that using an appropriate check list, CBD agents should be allowed to provide the first supply of pills. Likewise, CBD with a paramedical profile (with the necessary technical skill and experience to correctly perform an injection in good aseptic condition) should be authorized to provide injectables in a convenient site for the population (at the village level, at market place, at their home).

Competency of CBD agents should be broadened beyond the mere promotion of FP so as to respond to the expressed needs of the population and to increase their credibility.
14. The agencies establishing policy and program for CBD should develop an appropriate training curricula and a comprehensive training program for CBD with a strong component on counseling to counteract rumors, promote the adoption of long term methods and encourage continuity.

An ambitious nation wide CBD program would require efficient management, continuing formative supervision, and sustained motivation of CBD agents.

15. The agencies developing the CBD program should establish it as a "private sector initiative" with commitment, involvement and responsibility of the community. While the respective role that ONAPO and the MOH will play in the CBD system is still to be defined, overall managerial responsibility of the CBD program should rest in the private sector such as ARBEF for instance, with strong technical support of PSI.

Supervisors should be paid and CBD agents -and possibly the community- should receive incentives according to performance. Performance criteria should be assessed taking into account both quantitative as well as qualitative indicators.

While the CPR was dropping nationwide, in many health centers the numbers of new acceptors decreased and the numbers of drop outs increased, evaluative supervision of March 93 found that several health facilities managed to maintain or even improve their performance.

16. ONAPO and the MOH should conduct an operational study in the best performing health centers in order to identify specific managerial factors that could explain or contribute to better accomplishment.

These findings should be translated into remedial actions that could be applied in other, less successful sites. Following a subsequent evaluative supervision, a workshop should be organized to discuss findings and take concrete action to improve identified deficiencies.

17. To recruit more new acceptors and increase continuing use, ONAPO, MOH and other public or private sector service providers should take action to improve access, acceptability and quality of FP services.

- The MOH should pursue the expansion of secondary posts. For those far away from other health facilities, in addition to FP services, other needed MCH activities should be added. For those located in "catholic zones" MOH should negotiate with religious authorities to service the nearby secondary post with the MOH health personnel who are working in catholic health centers.

- A social marketing and CBD program should be developed in the private sector (see above).

- In training and refresher courses of service providers, emphasis should be shifted from information-giving towards the acquisition of counseling skills and improving attitude and behavior to better understand and meet client's need and expectations.
The integration of FP within other MCH activities should proceed with caution. While it is recommended that FP services become available every day in every health center, concerns of clients and need for appropriate client-provider interaction (time, intimacy) should be taken into account.

Within health centers, high risk women attending MCH services should be identified and referred to the FP consultation for further information and service.

In view of limited purchasing power of clients, the still low contraceptive prevalence rate, cumbersome managerial paperwork and control procedures and possible negative impact on FP acceptability and use, it is recommended to not apply cost recovery mechanisms for contraceptives.

Necessary missing equipment should be provided to health centers in need.

The system of filing FP clients by date of next appointment in each health center, with special boxes for lost of follow-up and drop outs should be generalized.

While Rwanda does not suffer from an acute shortage of paramedical personnel, there is nevertheless a tendency for newly graduated health professionals to not join the public sector. Hence, health auxiliaries (and nurses) will still for quite a time be the major providers of FP services.

18. The agencies establishing service delivery policy should determine that health auxiliaries -as well as other paramedical personnel- should, after proper training, perform the full range of FP services (reception, presentation of various FP methods, medical history, physical exam and provision of all methods excluding IUD and NORPLANT) without having to systematically call upon the chief of health center to complete the physical examination for new acceptors.

The management of contraceptive stocks is not conducted with enough precision to collect figures sufficiently reliable to calculate CYP with a comfortable range of confidence. Action should be taken at various levels to improve contraceptive stock management.

19. ONAPO should take action at various levels to improve contraceptive stock management.

At the ONAPO central level, further training should be provided for the ONAPO staff of the logistic section in computer use of stock management (movements, orders and follow-up and verification of client levels through contraceptive flow information). At the regional level greater emphasis should be placed on recording, analyzing and reporting on contraceptive stock movement as a means of logistic control and measurement of program progress. All service delivery points require stock forms and personnel must be trained in their use. Monthly reporting should accurately reflect contraceptive flow information.
Supervision focuses too much on "checking" rather than as an opportunity for continuing education and problem solving.

20. **ONAPO and MOH should review modalities, instruments and purpose of supervision to enhance the contribution of supervision in the overall improvement of the quality of FP service delivery.**

According to the DHS, 36 percent of women in union do not want any more children and there is a growing demand for the recently introduced long term methods which are well accepted.

21. **Program policy and programming should place greater emphasis on increasing acceptance of long term methods (NORPLANT, tubal ligation and vasectomy) through:**

- improving promotion of long term methods by (i) development of an appropriate IEC strategy including mass media programs, ii) improvement in the quality of counseling with emphasis on what the methods are, how they work, advantages, inconveniences and side effects and, for NORPLANT, possibility of easy removal.

- improving accessibility to long term methods by i) training more public and private health personnel in the technique of NORPLANT insertion and removal and VSC, ii) provide NORPLANT through outreach services by mobile team.

- improving management and organization of services (respect schedule of mobile team, insure availability of transport for VSC candidates, provide needed equipment at service sites, insure availability of appropriate data recording system to improve service statistics and calculation of CYP, generalize use of NORPLANT register to follow-up and to facilitate retrieval of NORPLANT users, strengthen participation of MOH in NORPLANT and VSC programs especially with regard to supervision and quality of care).

- establishing a list of personnel (category and location) trained in NORPLANT insertion/removal and in VSC as well as operational service sites to identify gaps and design training plans.

- finalizing training curricula for technicians and counseling.

- activating a council for quality control of long term methods to insure compliance with norms and standards.

- encouraging caution with respect to IUD promotion keeping in mind the lack of trained personnel, low demand hence few insertions generating poor confidence even among trained health personnel to insert the device, need of equipment and strict compliance with sterile procedures, questionable status of healthy genital tract among potential acceptors, persistent and powerful rumors which could easily take advantage of any incident to spoil efforts to promote the method.
6. **MANAGEMENT ISSUES**

6.1 **Project Objectives and Strategy**

Recognizing certain management deficiencies in ONAPO's performance under Maternal and Child Health phase I project, this second phase placed considerable emphasis on assistance to ONAPO to improve its financial management capabilities, its procurement capabilities and capacity to manage its vehicle fleet, its utilization of service statistics for project monitoring, its ability to maintain a record of trainees and develop annual training plans and its processes for forward planning and reporting. It was also expected that the MOH would refine and fully install a contraceptives logistics system and that local PVO's would be assisted to enable them to receive project funds to carry out family planning activities.

The strategy for achieving these objectives and to assist with other objectives of the project was to provide technical assistance through an institutional contract with Management Sciences for Health. A senior family planning advisor was to be provided for four years as well as a senior advisor in management and financial administration (initially for two years but later extended). Thirty two person months of short term technical assistance were also to be provided in various disciplines related to the project, most to be secured through buy-ins to centrally funded population projects.

Although the terms of reference for the MSH contract stated clearly that ONAPO was the responsible agent for project management, it was apparent that the MSH team was to provide technical assistance in all facets of project implementation and monitoring. Their work was to be carried out in cooperation with a project management team comprised of representatives of ONAPO, USAID, and MOH. The management team was to be responsible for the "day to day management of the project, meeting on a regular basis to facilitate the execution of the project activities, identify potential problems and resolve them... make monthly field visits to monitor project activities and the reports of these field visits are an important component of the project monitoring system." Other committees for project policy and coordination were to be formed with ONAPO, MOH and USAID comprising a "Comite Mixte" to oversee the public sector activities and to meet quarterly with the ONAPO regional delegates to review progress and problems in project implementation. ONAPO, MOH and USAID together with representatives of the private sector were to form a "Comite Consultative" to develop private sector initiatives. Additionally, ONAPO was to organize a twice yearly meeting of representatives of the MOH and the donor agencies which support FP activities in Rwanda.

The contract team was to assist USAID in its liaison with ONAPO and in coordinating and facilitating the work of centrally funded population contractors. They would also provide management assistance as requested to PVOs that were to receive sub-grants under the project.
6.2 Findings

6.2.1 The Project Management Team

There is little evidence that the project management team per se was ever constituted as indicated in the project paper, the project agreement and the scope of work for the MSH contract. ONAPO failure to designate such a group with clearly defined authority for day to day management decisions was one of the reasons why it was difficult for MSH to provide its technical assistance to a receptive audience that could act on recommendations and provide the Rwandan counterpart participation essential to the transfer of technology.

When interviewed, the previous head of the Studies and Program Section (SEP) of ONAPO stated that he had considered himself the project director. However, there were many suggestions in reports and from other interviews that indicated the ONAPO director took an active role in day to day project management in a way that diluted and confused the authority of the nominal project director. There was some indication that this was further complicated by the Secretariat and Communications and Records personnel taking a greater role in management decisions than consistent with their stated position.

Fortunately, some of the expected role of the project management team was fulfilled by the "Comite Mixte" or coordinating committee as it came to be called. After a slow start, this committee met regularly every two weeks with full participation of the requisite partners. Careful minutes of the meetings were recorded with specific assignments given to individual members and reports on action taken required at subsequent meetings. A full review of the minutes of these meetings was interrupted by the evacuation, but it appeared that the meetings were used as problem solving sessions to good effect. Further review may have indicated differently, but it seemed these meetings were so occupied with administrative problems that less attention was given to overall project policy direction, review of progress in programmatic matters and forward planning than should have been the role of the Comite Mixte. Nevertheless, this did provide the venue for bringing ONAPO, the MOH and USAID together on a regular basis and contributed considerably to the MOH taking an increasingly active role in integrating family planning into the maternal and child health services. The programmatic aspects were further advanced by the quarterly meetings with the ONAPO regional delegates which were held regularly with full participation. The evacuation precluded our attending the planned March meeting. However, all the regional delegates that we had interviewed spoke highly of these regular sessions which gave them program feedback and an opportunity to participate in overall program management.

The expanded role of the Comite Mixte substantially substituted for the Project Management Team. However, one role not fulfilled was seriously detrimental to project progress. The regular monthly field supervision required of the management team was not accomplished as a team and little was done by individual members. The ongoing supervisory visits by ONAPO staff as described in Section 5 were not an adequate substitute for this key function of project management.

6.2.2 ONAPO Management

Much of what was said regarding the project management team applied most specifically to ONAPO's management. In noting areas of concern, however, one must keep in mind that
some important progress was made while using a management approach somewhat different from that agreed upon from the outset. The more authoritarian centralized management style (based on strong political position) employed by the ONAPO director contributed much to the early successes of ONAPO in achieving many of its programmatic objectives. However, this management approach may have been one of the contributing factors to the decline of influence and capacity of ONAPO in the last few years. This was particularly noticeable in the turnover of personnel and the loss of many of the very effective program staff. Today one does not see the level of initiative, morale or dedication to program objectives that was said to characterize ONAPO personnel in earlier times. The evaluation team encountered outstanding former ONAPO personnel scattered throughout the population/family planning community now working for INTRAH, World Bank, SEATS, GTZ, USAID, CARE, the GOR Presidency and the Ministry of Health. This was not a loss to the total program, but they were no longer with ONAPO. Obviously, the security and political conditions cited in the introduction of this report had much to do with this deterioration of motivation in the central offices. However, it did not appear that ONAPO management had responded to mitigate these circumstances.

USAID and ONAPO had discussed the possibility of some organizational design or development (OD) activities and requested the evaluation to comment on this possibility. At one time an OD exercise might have increased personal job satisfaction and developed greater initiative and skills in cross departmental communication and task sharing. On the other hand, to be successful, such an effort requires a conscious decision and follow-up commitment by top management to permit, train for and reward greater subordinate initiative and participation in decision making. Lacking this top management commitment, organizational design efforts can be counterproductive by raising false expectations on the part of staff personnel. In any event, unless key vacant positions were filled in ONAPO, even a substitute approach which the evaluators considered would not likely be productive. The approach considered was to suggest organizing professionally facilitated task force meetings of personnel to plan for achieving specific near term objectives, such as the evaluation of CBD, the dissemination of DHS or the RAPID model, or another round of evaluation of the degree of integration of FP with MCH.

Several examples of the personnel situation (particularly those which affected the ability of MSH to effectively transfer to ONAPO the management skills and systems they had developed) are found in MSH reports. In July of 1992 a very competent head accountant went on maternity leave. Subsequent illness made it impossible for her to return to work and at the end of 1992 an economics graduate who was not an accountant by training and had no professional experience in the field was hired for the Accounting and Finance Section (SAF) and made acting chief accountant. This person was supported by a staff of seven, only one with any specialized post-secondary studies in accounting, none with a bachelor degree. Of the seven, only one had more than five years experience and five were in their first year. Only after substantial representations from MSH and finally intervention from USAID was a competent head accountant hired in October 1993. Since that time, two of the accounting staff who were making good progress in learning and applying the accounting systems left ONAPO; they were replaced in the past month by apparently competent personnel. The situation with the Head of the Studies and Program Section (SEP) was somewhat similar. Apparently due to a progressive illness, he submitted his resignation in late 1992. This was not acted upon until mid-1993 when he left. Since that time the main position providing overall strategic planning and program perspective to the project and the nominal counterpart for the MSH chief of party has been vacant.
Personnel limitations have also been noted in policy and research, training, IEC and service delivery.

Evidence of the problems that remain in ONAPO’S management capability was that rather than presenting semi-annual activity reports to USAID as the project required, the most recent annual report was for the year 1991. The MSH financial advisor estimated that at the end of 1992 only about 25% of the accounting activity that goes with the general accounting for the 1992 financial year had been completed. Monthly trial balances had not been possible during the year because accounting transactions had not been input into the computerized system on a regular basis, regular analysis and control of the accounts was impossible, periodic financial reports could not be produced and rapid response to requests for reliable financial information was beyond reach. The situation improved somewhat in 1993. However, at the time of the evaluation it was estimated that only by contracting two additional qualified accountants to clear up the backlog could the existing staff keep up with current requirements.

It is little wonder that for substantial periods of time during this project (most of 1990 and from March 1993 to Jan. 1994) USAID was unable to disburse funds to ONAPO or could do so only on a reimbursement basis. Nor is it remarkable that the audit carried out in October 1993 raised serious questions about ONAPO’s financial management and about several other management aspects, particularly its handling of the vehicle fleet. It is encouraging that ONAPO responded positively to the audit recommendations and has initiated steps to rectify problems including a documented follow-up system to insure compliance. It is even more reassuring that USAID follow-up of substantial amounts of questioned expenditures showed that the problem was not one of improper spending but incomplete documentation. In fact, much of the problem of incomplete documentation appeared to rest with the USAID controller’s office, which had not filed ONAPO justifying documents in a readily accessible manner.

On a more positive note, the evaluators were favorably impressed with the quality and activity of the Regional Delegates of ONAPO. The maintenance and support of these ten regional offices is no small accomplishment on ONAPO’s part. Reasonable progress has been made in improving coordination with MOH and other ministries, carrying out training and IEC activities and monitoring service delivery. Efforts to give the Delegates more autonomy, responsibility and budgetary resources have been limited by central staff’s own financial management problems. ONAPO has been unable to respond adequately to the management and cash flow requirements of a more decentralized system. Movement in the right direction was seen as regional officers are engaged in annual planning, receive budget approvals based on approved annual plans and, as funds are available, can exercise more authority and flexibility in their use. Further progress in regionalization would require regional staff development to handle the increased fiscal and program monitoring requirements and improved financial management and budgetary support at the central level to service these needs.

6.2.3 Ministry of Health Management

Only limited attention was given to the management inputs of the Ministry of Health in the evaluation. It was noted that although central office staff was limited in numbers they
demonstrated considerable interest in and knowledge about the project, which is still considered very much an ONAPO responsibility. The Chief of the MOH division in which maternal and child health is situated has taken an active and continuing role in the project coordinating committee (the Comite Mixte). The Regional Medical Officers with whom we discussed the project expressed their recognition of an improved coordination with ONAPO and a more fruitful working relationship. Section 5 discusses contraceptive logistics and supervision and service statistics; suffice it to say here that within the limitations of a system poorly financed in recent years, increasing attention is being paid to these matters by the MOH. Implementation of planned supervision is a major drawback and what is being done is done jointly with ONAPO, often depending on ONAPO resources.

One might question the project expectations of MOH participation, given that there was no specific agreement with MOH spelling out their role. There was no financial support provided for such things as supervision and logistics which may have been a way to gain more direct linkage with or influence on MOH performance. The project did provide substantial quantities of contraceptives to the MOH and training for MOH personnel, complementing a substantial World Bank assistance as planned in the project design. In so doing, the objectives of shifting service delivery and contraceptive logistics (at least in-country logistics) to the MOH was essentially successful.

6.2.4 Management Sciences for Health (MSH) Management

Management Sciences for Health placed two highly qualified technical professionals in country and maintained that presence (with one substitute who is doing excellent work) through some difficult periods until the recent evacuation. In addition to the resident advisors, MSH has provided eight person weeks of short term assistance in the management field. (It was not possible to quantify the additional short term technical assistance provided under buy-ins to centrally funded projects. MSH was not responsible for providing this assistance and USAID records did not provide ready access to this information. Nevertheless, a substantial amount of short term assistance was made available through these central projects.)

Some very impressive work was done in developing computerized financial management, program monitoring and program planning systems to aid ONAPO in the implementation of a multi donor supported nationwide population and family planning program. Much of the following description of the systems and their capability comes from MSH. However, judging from the quality of the reports and specific data produced, MSH has if anything understated the capabilities of these systems.

Accounting. ACCPac+ is a commercially produced accounting package widely used in the US and Canada (and introduced by MSH to the project). It generates all standard accounting reports. The fact that staff capacity to exploit it is currently rather limited is related more to staff qualifications, frequent turnover and vacant posts than it is to the system or MSH efforts to train in its use.

Payroll. The payroll program generates the monthly payroll list (taking into account salary, allowances, withholding, special deductions, reimbursements of advances and other relevant items) and the letters instructing the bank to make the appropriate payments to
employee accounts in the relevant banks. It produces regular reports for the social security
authority and for the tax authorities, and it could be used to produce other reports (e.g.
personnel list by organizational unit). It is fully operated by ONAPO staff.

**Training.** The training data base script set can generate reports on numbers of people
trained by -- or showing -- professional category, course attended (with date and place)
place of employment. In the case of participants working in health facilities, the same facility
codes used with service statistics are used in this data base, making it possible to relate
training data and service data. This data base has been used to generate prefecture-
specific reports listing all health facilities with FP clients and showing by professional
category which of their staff had ONAPO training, in which courses, when; these have been
distributed to the training section and to the regions. This program information has not been
up-dated since 1992 and the system is currently in need of some repairs.

**Contraceptives.** A wide variety of reports reflecting all aspects of stock management at the
national level can be produced from INVEC. There is also a small spreadsheet based
model that very easily shows the current and anticipated stock situation for each product
and facilitates estimating needs for ordering. Regional level stocks are taken into
consideration in ordering but not routinely managed by the INVEC system.

**Service Statistics.** (only in Rwanda has this evaluator seen the kind of complete and timely
reporting of client based service statistics that makes the computerized system described
here such a valuable tool that can be used with reasonable confidence in monitoring
program progress.)

The computerized system contains the number of new FP clients, continuing clients and
those who missed an appointment, by method, by month, by health facility; the facilities are
coded in turn by affiliation--public or agree' (semi-private mostly religious affiliation), by
category--hospital, health center, etc. and by prefecture. Numbers of clients can be
analyzed according to any combination of these characteristics for any period since January
1990. Three standard reports are produced regularly by the computer staff of relevant
progress related statistics broken down by prefecture. Other analytic reports are generated
from time to time. The fact that much of this latter work is done by the consultant instead of
ONAPO staff reflects more on staff continuity and ONAPO management allocation of
priorities than on the difficulty of the computer program or the training capability of MSH.

**Planning.** The planning system provides documentation of objectives, strategies, activities
and sub-activities along with the financial and other resources required. It makes it possible
to present coherent, non-overlapping, complementary programs to different
funding/technical agencies and to view the synthesis of these programs: the overall ONAPO
program. It provides tools that facilitate monitoring and reporting both implementation and
expenditure. And it makes accessible a variety of information that could be used to
increase the program results obtained for the resources consumed.

Timeline 5.0 can produce gant charts for activity lists of greater or lesser detail, with or
without start and/or end date, duration, budget detail. It can also generate a variety of
reports on all resources considered in the planning process (vehicles, training materials,
personnel by category or even by name if so desired, classrooms, etc.) and their cost, and
can do so by organizational unit and other user-selected criteria (e.g. training and supervision have been coded to permit review of all such activities and their resource requirements).

Limited staff capability in using this system reflects the lack of priority given to the planning process by ONAPO in staff assignment and in the time allotted to this function which each year of the project has been delayed and hurried.

The above systems are not fully documented; some are in process of revision, but the lack of documentation at this stage of the project is a troublesome reality. Further short term consultation to complete this facet of the work as part of a training exercise was under consideration.

It is apparent from the MSH semi-annual reports that they have given a great deal of their time to the frustrating pursuit of installing these computerized systems in the ONAPO management system hindered by lack of qualified personnel and in later months by greatly curtailed supply of electricity. More success has been obtained in the area of routine financial accounting, although even this has suffered from staff turnover. Less success has been demonstrated in ONAPO's utilizing the capacity of these instruments in the planning process which requires a more complex set of data for the system and a greater degree of proficiency in its use. One is tempted to suggest that the planning system may be too sophisticated for the needs of the program. On the other hand MSH makes a compelling case that the complexity of the population/family planning program with a variety of different activities, both central and regional concerns and with funding from different donors demands such a complex planning instrument. It is clear from interviews with MSH and such records as an early memo from MSH to the chief of SEP that they are cognizant of the needs for simplifying, speeding the process and making the plan as user oriented as possible while maintaining the integrity of the planning process.

Putting ONAPO's financial management house in order was a high order of priority and limited ONAPO staff put MSH staff in the position of actually being required to carry out certain routine as well as analytical functions. Thus, other aspects of MSH work received less attention. The areas of concern are those of monitoring such functions as training and IEC, assuring better management of the vehicle fleet, coordinating the various actions of the centrally funded contractors and work with the private sector. These areas received less attention in MSH reports to USAID. However, judging from interviews in the evaluation process and from memos and other reports available from MSH, it is apparent that these issues received more attention than the reports suggested and that informal contacts with USAID shared much of this information. It must also be recognized that much of the responsibility for technical assistance in programmatic activities rested with other contractors and their reports were part of the monitoring process. Nevertheless, one area of real concern clearly did not receive the planned or required attention and that is field observation of program implementation. MSH reports generally stated that there had not been time for field observation due to the pressure of work in the central office. Certainly the security situation in the country had a part to play. It is also very true that the quality of the service statistics and the imaginative use that was made of them by the MSH chief of party provided a rich source of information about the program. Nonetheless, it was disappointing to see that not until 1993 was a concerted effort of field visits made (with MSH participation in some) to evaluate the degree of success in integration of family planning into the MCH system. This effort produced valuable information which MSH very effectively analyzed. An
especially helpful suggestion was to focus on the "good performers" that had been identified and learn from them. These visits made real to the participants what the service statistics had been showing--a steady decline in client levels--something that might have been used to identify problems and improve performance a year or more earlier. Similarly, only recently has it become apparent that the training of health auxiliaries, those really providing much of the family planning services, should be given greater priority. An MSH memo raised the question of why the ONAPO delegates or ONAPO supervisors had not identified this need until October 1992; one might ask the same question of MSH. Additionally, there was little indication of knowledge of the degree to which ONAPO and MOH ongoing supervision was deficient. These are the kinds of things most likely to be found in visits to the program in operation.

The participant training managed by MSH is discussed in Section 4. It is mentioned here only to note that this was part of MSH's management role, carried out effectively but not yet complete. Three participants are still in the United States. Whatever the future holds for population programs in Rwanda, well trained persons will be required. Arrangements will be required for the continued support of these trainees.

6.2.5 USAID Management

Throughout the MSH reports, minutes of the coordinating committee meetings and internal USAID documents one can see evidence of close and effective USAID involvement in the implementation and monitoring of this project. As called for in the project design, USAID assigned a very competent foreign service national to be the project manager. He was supervised by a direct hire health and population officer who also took an active role in project management. The regular project implementation reports (PIRs) and the project implementation letters (PILs) indicate that the USAID/Health and Population Office kept up to date with its monitoring and reporting responsibilities and did all within its power to assure an adequate flow of funds to ONAPO. Additionally, the September 1993 PIR makes clear that the HPO took an active role in the field monitoring of the centrally funded CARE MCH/FP project. Evaluation team interviews identified the close working relationship established with the management of the MCH/FP II, RIM and AIDSCAP projects.

One of the most noteworthy aspects of the project is the way that through some very difficult times USAID personnel have maintained a positive attitude and a positive working relationship with their counterpart agencies in the GOR and in the donor community. It was encouraging to see the kind of concern for the country and dedication to the task that was apparent in the USAID Health and Population Office.

In a few instances one could question the conclusions of USAID in preparing the PIRs. For example, in September of 1989 the PIR states that 90% of the MOH health centers had integrated MCH/FP information and services; by September 1990 that figure was listed as 100%. Granted, the project did not clearly define (as it would have been well to have done) exactly what "integration" meant. Yet it was clear from the 1993 internal evaluation that quite a few of the centers still had some ways to go before one would call the services truly integrated. The September 1992 PIR clearly recognized "one of the main issues remains the turnover in qualified technical staff." However, the September 1993 PIR and a September 1993 report, CPS, COVENANTS, PACDS AND PROAGS/AMENDMENTS
STATUS, concluded that ONAPO was in compliance with the requirements to "recruit and assign, in a timely manner, all GOR personnel necessary to implement the project," an assessment that USAID agreed was erroneous. On the other hand, USAID continued to follow-up on the covenant related to ONAPO developing a more autonomous training center, especially by requesting particular attention to this by the audit. It became clear that this issue would not be resolved without a clarification of the WHO relationship to this center, an issue that at least for the foreseeable future is only of academic interest.

There is clear indication within the minutes of the coordinating committee that USAID used these meetings as a way to bring problems and concerns to the attention of ONAPO. On occasion more direct and formal communication was used to raise such issues as the personnel situation with the ONAPO director. However, one is led to wonder why some items were not dealt with in formal communication at all or earlier in the project implementation. For example, there is little indication that USAID formally expressed a concern for ONAPO's non-performance in semi-annual program reporting. Little seems to have been formally transmitted to ONAPO regarding the activation of the "project management team" which was to have the mandate of extensive field travel to review project performance. Although obviously an issue of considerable concern to USAID, little formal mention of the vehicle fleet management was transmitted to either ONAPO or MSH until late in the project. Some USAIDs have used the PILs to transmit these kinds of concerns to cooperating agencies. USAID used the PILs primarily as a means to authorize expenditures against an approved budget and to explain changes in the disbursement requirements.

USAID may have shared some of the concerns of the evaluators in the apparent lesser attention MSH was giving to monitoring general programmatic performance as compared to installing the computerized systems for financial management, service statistics analysis and program planning. If so, there is no indication of their calling this or other concerns to the attention of MSH through a formal response to the clear and frank MSH semi-annual reports.

This evaluation does not contain analysis of the disbursement pattern for the project or the future prospects. The day we expected to receive the financial reports from USAID was the day we packed our bags for the evacuation. USAID had indicated that with the possible exception of some funds in the buy-ins to centrally funded projects, all the project funds would have been disbursed by the end of the project. Table 5 is the financial information available mostly from the September 30, 1993 PIR. It is not clear where the additional funds came from for the 12/23/93 PİOT. The low level of cumulative accrued expenditures reported indicates the delay in receiving financial information from AID's accounting system. It may also indicate that further review would be in order to ascertain the likelihood of full expenditures of those funds listed as earmarks or commitments.
Table 5

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<th>FINANCIAL DATA (Dollars '000)</th>
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<tr>
<td>AUTHORIZED LIFE OF PROJECT</td>
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<td>MAJOR CONTRACTORS:</td>
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<td>MSH</td>
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<tr>
<td>INTRAH</td>
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<td>AVSC</td>
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<td>POP COUNCIL</td>
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<td>JHPIEGO</td>
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<td>SEATS</td>
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<td>TOTAL</td>
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<tr>
<td>CUMULATIVE OBLIGATION 9/30/93</td>
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<td>CUMULATIVE EARMARKS</td>
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<td>CUMULATIVE COMMITMENTS</td>
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<td>CUMULATIVE ACCRUED EXPENDITURE</td>
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* an OYB transfer of $1,320, was presumably for contraceptives
**12/21/93 an additional $209 was obligated to buy-in to the RAPID III project

6.3 Conclusions

Except for the management arrangement to have the private sector funded through a public sector institution with many management problems of its own and with the possible exception of expecting too much of the MOH without adequate agreement with them and provision of funding for MOH local costs, the design for the management of the project was appropriate. Shortcomings in management performance were largely related to the inability of ONAPO to recruit and retain the highly qualified personnel required to respond to the technical assistance provided. It is not likely this personnel situation will change to the extent that ONAPO will take full advantage of and sustain the improved management systems provided through the project technical assistance.

Although not using the project management team in the way contemplated by the project design, a reasonable substitute was the greater involvement in day to day management by the project coordinating committee. However, the fact that neither the project management team, nor the coordinating committee, nor the MSH staff were able to carry out the field visits envisaged substantially delayed the recognition of several key problems and opportunities.

Operating under very difficult conditions MSH has effectively fulfilled its role in project technical assistance. The limited degree to which this technical assistance was internalized by ONAPO and the technology transferred reflects more on the staffing situation of ONAPO than the quality of the assistance provided.

It is difficult to quarrel with the priority attention that MSH gave to developing the financial management, service statistics and planning systems. These had been identified initially by USAID as problem areas and they are essential to effective project implementation. In
performing this role very effectively, and often called on to perform ONAPO functions as well, MSH was not able to give as much attention to the overall programmatic concerns as might have been useful.

While noting some areas where the USAID might have operated more effectively, such as bringing problem areas more quickly and more formally to the attention of ONAPO and/or to MSH, the evaluators were impressed with the diligent and competent way in which the USAID Health and Population Office carried out its responsibilities of project management. Appropriate tools for project management (PIRs and PILs) were effectively used to monitor and record progress and problems. USAID participation in project and donor coordination meetings was a contributing factor to their success and forward movement.

6.4 Recommendations

The following recommendations are only those which relate to a few actions that can be taken now even though the project is essentially suspended due to the recent conflict.

22. **USAID should arrange with MSH to continue support for and possibly extend the academic programs of participants being trained in the United States under this project.**

Their studies should not be interrupted and there should not be any forced repatriation until conditions in Rwanda permit reasonable security.

23. **USAID should arrange with MSH enough additional contract time to provide for completing the documentation of the computerized instruments developed for project management.**

The unique features, such as the linkage of financial management with program planning and the more extensive use of service statistics in program monitoring, even though some were Rwanda specific, should be identified for lessons to other programs.
7. IMPACT

7.1 Findings

7.1.1 Institutional Development

Perhaps the most disappointing aspect of project progress was its inability to effect the kind of institutional development progress desired with ONAPO. In fact during the project period, with the departure of many key personnel and the loss of ONAPO's secure political status, there has been a marked digression from former capabilities. Research capabilities have declined and financial management and program planning capabilities have not grown to take advantage of the technical assistance provided. Skills have been acquired in some routine functions in financial accounting, reporting on service statistics and contraceptive logistics management. However, strategic planning and analytic use for management purposes of the products of the management information system have not developed as expected. On the other hand, while difficult to compare to the past, ONAPO capabilities at the regional level and cooperation with the Ministry of Health regional medical officers may well have improved.

Training elements of the project, especially those supported by INTRAH, JHPIEGO, SEATS and AVSC, have contributed more effectively to institutional development. These actions have prepared a cadre of trainers and trained medical and paramedical personnel capable of providing a wider array of contraceptive services within the MOH MCH/FP system. They have also developed a capability for preservice training in family planning within the University medical faculty.

The contribution of the IEC program of ONAPO to the network of Abakangurambaga community leaders and their sponsoring commune development agencies (CCDFP) has eroded with political changes. Yet, it had much to do with a considerable increase in public knowledge about family planning and will leave behind many community leaders with this concern and understanding.

The work with the Ministry of Education (MINEPRISEC) to develop a curricula for population education and to train teachers in its utilization was little more than a good start, but it was at least that.

Though unsuccessful in developing either a general family planning program or an effective social marketing program with the private sector, the project provided some initial assistance to the growth and development of the private family planning organization, ARBEF. Assistance from SOMARC, especially in the technical assistance as part of the social marketing phase out, helped ARBEF more clearly identify itself as an institution and its institutional development needs, develop plans and actions for private sector commercially based family planning services and finally to ally itself with Population Services International in a new condom selling venture and with GTZ to provide clinical services in Butare.
7.1.2 Improved Access to and Quality of Contraceptive Services

As noted Section 5. Service Delivery, there has been substantial improvement in the access of the population to family planning services. Although still varied in the comprehensive nature and the intensity with which they provide services almost all the 340 health centers are now providing some form of family planning. Additionally, nearly 60 supplementary secondary posts have been organized and other outreach to the community has been developed through support of the abakangurumbaga community leaders, other CBD agents and social marketing. Estimates are that at this time more than 60% of the women have relatively easy access to contraceptive services. The improvements in quality of services are generally in the availability of a wider variety of contraceptives, especially those of a longer acting or permanent nature. Some 90 sites throughout the country are now providing NORPLANT and VSC is available in two or more sites in each region.

Most of this increased access was in the MOH system. The project made the preponderance of its inputs through ONAPO and not directly to the MOH. However, the increased MOH/ONAPO cooperation centrally and regionally, the training of MOH personnel, the supply of contraceptives and assistance with supervision made possible by the project contributed substantially to this increase in access. It was not feasible in this evaluation to disaggregate the contribution of the USAID supported activities from the contribution of the World Bank, GTZ, UNFPA, the GOR itself and others in achieving this and other objectives.

7.1.3 Improved Public Knowledge of and Attitude Toward Family Planning.

As noted in Section 3, IEC, and in Appendix E there has been a rather remarkable increase in knowledge about family planning, improved attitudes toward it and a substantial change in desired family size. Most of the change in knowledge must be attributed to the project which has been the primary source of such information. The economic and security conditions affecting families have no doubt contributed to changing attitudes as has the increase in female education. However, changing family formation patterns is more recognized as a practical option when families have learned through the project that there are alternatives available to postpone or limit childbearing.

The DHS of 1992 is perhaps the best source of information in this regard. As indicated Appendix E, in 1992 97% of the women surveyed were aware of pills and injectables as a family planning method as compared to 41% and 45% respectively in 1983; 75% were aware of female sterilization, 38% and 36% were aware of male sterilization and implants. These longer term methods were virtually unknown in 1983. Of those surveyed in 1992, 93% of the women and 92% of the men expressed themselves in favor of family planning. By 1992 the desired family size expressed had dropped to 4.4 putting Rwanda's desired family size in a category with Kenya and substantially below that of many other Sub-Saharan African countries. Of those surveyed, 37% expressed a wish to have no more children (up from 20% in 1983); an additional 42% wanted to delay the next birth more than two years. With more than 60% of those not currently using family planning expressing an intention to do so in the future it is apparent that a much more positive attitude toward family planning has been developed. This presents a substantial potential for increased contraceptive use if appropriate steps are taken to facilitate attitudes becoming practice.
As noted Section 5 of this report, there has been a significant drop in users of modern contraceptives as measured by project service statistics since the peak measured by the DHS in 1992. (At that time the contraceptive prevalence derived from service statistics was quite consistent with that measured by the DHS.) Service statistics, particularly as maintained in Rwanda, serve a valuable function in recording the number of clients served through the clinic system and raise a flag of caution regarding an increasing level of "drop-outs." On the other hand, service statistics are less effective in identifying the reasons for dropout. These reasons may be related to quality of service, but may also be influenced by substantial forced migration of the population (one million were displaced by war in 1993), the influence of a high fertility society in which a substantial number of women will "drop out" to get pregnant and the slowly growing possibility that some small number get services from sources that do not report to the national system. Recognizing that the situation may well have deteriorated since the 1992 survey (in large part for reasons outside the control of the project), it is still useful to identify what was probably the peak in performance under the project. Of those surveyed in 1992, 13% were using modem contraceptives and 8% traditional, as compared to 1% and 10% respectively in 1983. (and the 3% of modem contraceptive prevalence estimated at the beginning of the project).

Even more impressive than the increase in contraceptive prevalence was the decrease in fertility measured by the DHS. The striking decline from a total fertility rate (TFR) of 8.5 in 1983 to 6.2 in 1992 is a 30% decline in less than 10 years. To put this in perspective, Kenya went from 7.9 in 1979 to 6.7 in 1989, which is less than a 15% decrease in 10 years. This suggests that the project paper estimate of TFR in 1989 (8.6) was too high (and that possibly the use of modem contraception was somewhat higher than the estimated 3%). However, it also indicates that the project goal of a decrease of 0.6 in the TFR was substantially exceeded.

The report of a very remarkable drop in fertility as well as USAID request for the evaluation to explore the validity of the underlying demographic assumptions of the project required further inquiry. Lacking adequate demographic expertise to explore these issues fully, the team requested Futures to review it further with Macro, the contractor for DHS. The conclusions as demonstrated in Appendix E are that a) the drop in fertility was real, b) as much as .8 child of the TFR drop was related to increases in modern contraceptive prevalence largely through the project, (the use of traditional methods must have played a role previously, but there was little change in use during the project period) c) a quantifiable influence was a two year rise in the average age of marriage d) other influences of unknown magnitude may have been at work such as a possible increase in clandestine abortion, an issue well worth increased study from a public health perspective. (The only anecdotal information the evaluators received on this was from Rwandan physicians and social workers who said there was an unspecified "lot" of abortion or from the obstetric department of the main hospital in Kigali where it was estimated that 10% of obstetric cases were related to septic abortion; one World Bank report indicated that the third most common cause of women seeking assistance at the health centers was related to what was reported as spontaneous abortion.)
The project paper had also stated a goal of reducing the population growth rate from 3.7% to 3.2%. Often project "goals" are the overall global goal to which a project expects to contribute over time. In this instance, both the growth rate and the fertility rate "goals" were also listed as end of project status objectives. This may be reasonable for the reduction in fertility since project actions to increase contraceptive prevalence are expected to have the most direct and influential impact on this factor. On the other hand, to expect the project to achieve an end of project status objective of a particular population growth rate is questionable. Half of the equation for "the rate of natural increase" --the death rate-- is only influenced by the project in a limited way. If one includes consideration of external migration to arrive at an actual population growth rate (a distinction that the project paper is not clear on) the issue is even more problematic. Additionally, the death rate is not normally measured by the methods commonly used with family planning programs -- fertility or demographic and health surveys (which sometimes produce infant mortality but not general death rates).

The crude birth rate can be deduced from TFRs, with the information available to the DHS. In 1992 the crude birth rate was about 43 per thousand. Futures use of the data (Appendix E) suggests the birth rate may have been as high as 58 in 1981 (approaching biological limits) and 49 in 1986. (perhaps 47 in 1988/89). Death rate projections suggest levels of between 16 and 19 in 1988/89. This indicates that the project base line estimate for the growth rate, 3.7%, was too high, unless there had been substantially greater decrease in the death rate than was understood to be the case or unless a great number of Rwandans had returned to their country. The base line rate of natural increase may have been closer to 3%.

With death rates in the low twenties per thousand in 1981 and slowly declining, the Futures projection suggests a 1992 death rate of between 14 and 19 depending on assumptions about the impact of AIDS. This would suggest a rate of natural increase of the population of between two and a half and three per cent in 1992, an imprecisely measured/estimated decrease since the beginning of the project.

7.1.5 Impact on Policy

As noted in Section 2, the major policy development impact was the adoption and dissemination of a very positive national population policy. Efforts that were just beginning to bear fruit in actions beyond the Ministry of Health (family planning services) to address population objectives in the Ministries of Agriculture, Education and Women and Youth were interrupted by the conditions of national security and political change. Plans for policy use of the DHS and development of a revised RAPID model, which was so important for initial policy development, have had to be suspended.

Some limited progress was made in research to improve family planning service delivery through operations research associated with vaccination workers and initial experimentation with community based distribution. Additional research was constrained by limitations of ONAPO research capacity, much of which was dedicated to the DHS, an essential policy development instrument. Expected evaluation of the CBD efforts, studies of the effect of charges on family planning use and review of continuation rates and reasons for drop out will obviously not be accomplished due to the suspension of activities.
7.1.6 Impact on the Status of Women and on Youth

The project has had a positive effect on women who have been its beneficiaries. The ability to practice FP, using reliable methods often of relatively long duration (currently mostly injectables and increasingly implants) allows women to better regain their strength after each pregnancy, and allows them the possibility to make and act on other choices in their lives. As noted in Section 2 - Policy Development, substantially more could be done in this area with concerted efforts to enhance the status of women.

Through the various educational activities directed toward youth, the project is contributing to their greater awareness of the impact of their reproductive behavior on their future and the future of the country. It is perhaps too early to assess the long-term results of these activities.

7.2 Conclusions

The objectives and the strategy for achieving them in the project design were essentially correct in expecting to achieve a fertility reduction through increases in contraceptive use aided by a progressive shift of responsibility for service delivery to the Ministry of Health. Apparently, the project design did not recognize the degree to which fertility change had already started and did not predict the strength of factors other than modern contraception that were affecting fertility. Nevertheless, the sense of the fertility decline and contraceptive prevalence increase expectations was correct and the project was well on its way to following the trends predicted in the factors over which it had influence.

As noted in Section 6 - Management the project design may not have been fully accurate in terms of its approach to MOH management concerns and especially in its expectations regarding how to support the private sector. The expected need for management technical assistance to ONAPO was correct; the limited impact on institutional development was associated with ONAPO's ability to respond. The plan to use specialized cooperating agencies like INTRAH, JHPIEGO, AVSC and SEATS to provide technical assistance in training and service delivery was appropriate and the impact on institutional development was substantial.

Despite the limited direct assistance to the Ministry of Health, the contribution of the project through ONAPO did much to improve access to family planning. Though not feasible to disaggregate the project impact from that of other donors and the GOR itself, it is clear that the improved coordination with ONAPO, the training, and contraceptive supply made possible by the project significantly assisted the MOH in expanding the availability of family planning services within and beyond the MOH/MCH system.

In summary, it is clear that the project was making a substantial impact on fertility in the country with an increase to 13% modern contraceptive prevalence by 1992 and a concurrent drop in the TFR to 6.2. The remarkable drop in fertility merits further study, especially in relation to such possible influences as that of clandestine abortion. Increases in knowledge of contraceptives and positive attitudes toward family planning were especially noteworthy in a Francophone Sub-Saharan African country, with 95% of its population living in rural areas poorly served by modern mass media communication. Disappointing impact
on institutional development within ONAPO and in the private sector were offset by institutional development in training and policy development.

It is fair to say that despite the many problems of national security and political disruption, the project was well on its way to making a substantial impact, in some ways more than expected, in a variety of population related factors. At the same time, it must be recognized that the impact on fertility was a reduction from an exceptionally high level to a continuing high level; even with war and AIDS there will be an ongoing need for strong population programs, if Rwanda is to have any chance of avoiding the ecological disaster that is imminent.

7.3 Recommendations

24. The Agency for International Development should reconsider its policy of prohibiting any research on the prevalence of abortion whether legal or clandestine.

The refusal to review this issue limits ability to fully comprehend the components of fertility change. Worse yet, it fails to identify a serious public health problem if women are resorting to clandestine and unsafe abortion because their access to effective contraceptive services is limited.

25. As soon as security and political conditions permit, the international donor community should stand ready to assist Rwanda in reorganizing well managed efforts to deal with the problem of rapid population growth which will continue to persist in critical proportions despite recent progress in reducing fertility.

Such efforts should continue to focus on expanding access both in the public and private sector to modern contraceptive services. They should include effective training and IEC initiatives as well as a strong policy and research component including emphasis on improving the status of women.
8. LESSONS LEARNED

8.1 Creation of Quasi-independent FP Structures

While the creation of a quasi-independent FP structure such as ONAPO may be the most appropriate mechanism for launching a FP program in some situations, serious consideration needs to be paid (1) to its legitimate role (technically and politically), and (2) to its relationship to existing MOH structures and to MOH personnel who are ultimately the providers of the vast majority of FP services (this in terms of technical roles and in terms of access to and sharing of resources). When FP becomes "synonymous" with a structure whose message is "population control," it may become more difficult to appeal to some segments of society. When such a quasi-independent structure has, and guards, access to the majority of FP resources, MOH personnel may be less motivated to provide the necessary leadership for the success of the program.

8.2 Training and Supervision of Community FP Agents (Abakangurambaga)

While it may have been appropriate and legitimate that the Abakangurambaga be trained and supervised by CCDFP personnel, when such a structure (based on a one-party state) falls apart, the credibility of the Abakangurambaga may well go with it. In this sense, a wiser choice may have been for the Abakangurambaga to be more closely allied to a more neutral structure such as the MOH/local health center. NGO involvement could also be considered.

8.3 Training in IEC

Effective training in IEC requires a clear definition of IEC strategies, communication channels, messages and approaches, a clear definition of the roles of IEC agents and of the objectives of their efforts. Among other IEC lessons, this project demonstrated the need to place more attention on the communication and counseling skills of health care providers.

8.4 Participation of the Private Sector

The private sector is making an important contribution to family planning especially in Latin America and in some African countries such as Kenya, Nigeria and Cote d'Ivoire. Yet, development of this sector requires considerably more human and financial resources than was provided in this project. Nor is this process likely to be greatly facilitated by a public sector institution, jealous of its own prerogatives, in a country with little experience with the private sector.
8.5 Management Information

Computerized management systems can make an invaluable contribution to program financial, monitoring and planning responsibilities. However, they must be complemented by personal observation of the program in action to develop perspective, understand relationships and motivations, stimulate new initiatives, evaluate the quality of inputs to the computerized systems, and clarify underlying causes for trends noted, for example, in service statistics.

8.6 Prioritizing Concerns

It is essential that administrative, fiscal and management information issues are dealt with effectively in project management. However, if these receive such exclusive attention that programmatic issues such as the quality of IEC, training or service delivery receive inadequate attention, the result may be an excellent system for documenting failure.

8.7 Adverse Conditions

This project demonstrates how much external factors must be taken into account in assessing project performance; it also demonstrates that much can be accomplished even in the face of adverse conditions.
9. FUTURE DIRECTIONS

9.1 Findings

The following section (expanded per USAID request) was written before the conflict broke out again in Rwanda requiring the evacuation of the total US Mission. It served as a working hypothesis for some of the analysis of ongoing programs and as a basis for evaluation team discussion and review with several project leaders. Though much is no longer relevant, certainly not in the time frame originally contemplated, the section is included as an indication of what MCH/FP II might have made possible for a follow-on project. It may also provide some suggestions to be considered for a programming effort sometime in the future.


Much must be done if contraceptive prevalence is to reach either the moderate target of the GOR population policy, 36.6% (625,000 users), or the accelerated target of 50.5% (862,000 users). In 1995 contraceptive prevalence may be less than 15% with about 175,000 users. Contraceptive prevalence must increase more than three percentage points each year 1996-2001, a challenging, but not impossible, objective.

Stated differently, the challenge is to encourage more active use of contraceptives among the 78% of the women surveyed in 1992 who were "in need of family planning." (See section 7.1.3.) Informational approaches aimed toward shifting attitude to action will be required and service delivery systems must focus on improved quality and access to respond to this latent but unmet demand.

Policy Development. Presumably, early policy development efforts with the new government will have been successful in creating a global policy climate similar to that of the late '80s. However, there will always be changes in government leadership, especially in a multi party system, requiring continuing reeducation in population matters. These changes may well be accelerated as the new governmental system struggles to establish itself; high quality, imaginative leadership in the population policy field will be required to keep pace. There will also be a continuing need for policy development efforts at the Regional and commune level especially with a more decentralized system of government. Further attention will be required to develop or update RAPID and DHS policy tools as noted in section 2.2.1.

Policies should be developed or reemphasized that remove any barriers separating the population from easy access to family planning information or services. Policies will be required for the provision of long term/definitive (VSC) methods to assure voluntary, informed consent, adequate counseling and appropriate quality of care. Generally the policies in this regard are positive in Rwanda, even with some cultural and religious biases that might be expected to intervene. Yet more emphasis will be placed on integrating family planning with other health services and increasing attention will be given to VSC. Policy development must stimulate private sector activity including more aggressive outreach programs, social marketing and CBD. Advertising and public information programs will
more aggressively address the issues of human sexuality, procreation and method specific family planning, requiring capability to respond to controversy.

Attention should be given to a review of the Rwanda family code and how it impacts on the status of women. Stated or de facto policies affecting female education, participation or remuneration in the work force, access to credit, property and inheritance rights, leadership positions in family planning programs or any other which could tend to diminish or improve the status of women should be reviewed; actions will be required to build on the positive and eliminate the negative.

**Institutional Development.** The major concern must be for those institutions most likely to support the delivery of family planning services, to influence public policy, to influence or disseminate public information and to monitor and evaluate progress toward the achievement of the GOR targets 2001. Needs are seen in:

- Continuing development of a National institution (central capabilities with strong regional components) for policy development, public information and monitoring progress in implementation of the Population Policy and Plan of action. The organization would assist in the design of and monitoring of population action plans and activities of other ministries and the private sector. Priority attention would be given to coordination/stimulation/ and surveillance of family planning service delivery and assuring a full supply of contraceptives. However, actual service delivery would only be a function of this institution where it is clear that other institutions have not yet developed the capacity. The degree of involvement in standardization of training, or actual training of trainers would depend on the needs and capacities developed in the private sector and in the Ministry of Health or other Ministries (especially MinAgric, MinEd and Ministry of Family/Women/Youth). Stimulation and support would be given to universities, medical and nursing faculties and schools of health paraprofessionals. Students in health sciences and in the fields of demography and related population and development matters must exit their pre service training with the requisite knowledge and skills to fulfill appropriate roles in Population Policy development or family planning service delivery.

- Strengthening regional capabilities of the Ministry of Health where major responsibility would reside to plan, implement, supervise and evaluate integrated maternal/child reproductive health and family planning programs. The central level would also require assistance to enable internal monitoring of the total program and comparison between regions with different kinds of support and differing programming approaches. At this time the bulk of family planning service is being provided through the 340 public health clinics and 60 secondary posts in the country. The Bamako initiative notwithstanding, this system is unlikely to expand to any great extent its ability to serve the population given the continuing decline in government revenues and the shrinking of per capita government investments in social sectors.

Ministry of Plan statistical reports estimate a 10% reduction in the gross domestic product in 1994 (minus 12.6% in per capita GDP) following four years of decline or stagnant growth. More optimistic projections for 1995 and 1996
scarcely keep pace with population growth. According to USAID 1993 Assessment of Program Impact, real per capita income in 1993 was estimated to be 30 per cent lower than in 1985; the quality of health services and primary education continued to decline as expenditures in these areas dropped further. The availability of government resources for social sector investments was seriously constrained as military expenditures in FY 1993 surpassed 8 percent of GDP, almost equaling projected government revenues. Both this and the 30% drop in the value of coffee and tea production in 1993 (MinPlan statistics) may be considered temporary, but there is a real question as to whether the country's per capita investment in the social sectors will ever return to the levels of '80s.

This grim economic picture will be ameliorated by donor community investments in the public sector. This will no doubt prolong the transition seen in many other developing countries of a shift toward a more balanced relationship between public and private sector provision of many health services. Thus the public sector will continue to be the major provider of family planning services during the time frame of the project Population 2001.

- Private sector institutions and private practitioners (doctors and nurses) capable of planning, implementing and monitoring clinical (including VSC), CBD and Social Marketing family planning services and information.

The private sector has not yet developed to any great extent in Rwanda, either strictly commercial private enterprise or non governmental organizations. Only at the end of 1993 were government policies adopted lifting many of the regulatory barriers to free and active development of the private sector. It will be some time before the private sector can respond to the needs of the majority of the population on a purely commercial basis in this largely non-monetized mostly rural population. One should not discount the possibility that bartering of goods for services can extend to the health field. There are reports of health personnel leaving public service to open private practices and signs of increased availability of these services. Reports from consultants dealing with the private sector suggest considerable interest on the part of leading professionals in developing private initiatives. Associations for private physicians and for private nurses have recently been formed. What might occur following the establishment of the new government with the return of Rwandans who have lived in exile is conjecture. However, they may well bring entrepreneurial skills and capital that will be applied in the private sector. Similarly it is difficult to predict the positive or negative impact that may be seen in the private sector with the demobilization of some 30,000 troops, a number that represents roughly 50% of the total private sector employment in Rwanda's modern sector. Some will return to the collines (hills); others will be tomorrow's private sector entrepreneurs.

Rwanda may be ten years behind the trend toward private sector development seen in other countries, but one can expect the initial developments to gain momentum. Donor assistance should be planned to anticipate and to stimulate this trend and be in a position to respond with appropriate assistance.
Considerable financial support as well as technical assistance will be required to enable this sector to grow in appreciable numbers of family planning clients served. However, it has been the experience in many other countries that the flexibility and entrepreneurial spirit of the private sector can be drawn upon to develop a service delivery with more of a marketing approach, providing an important complement to public services. The initial substantial investment in the private sector can be cost beneficial in the long run. The investment in capital and recurrent costs even for a considerable period of time can be justified by the crisis nature of the population problem in Rwanda. Even at high initial costs there can be a good economic return as indicated in the Project Paper for MCH/FP II and the cost benefit study underlying the RAPID projections. Additionally, much of these private sector costs will eventually be borne by the private sector itself through sales of services. (As different from the costs of public sector services which may go on indefinitely.) Some of the costs will be time limited. For example, the extraordinary efforts to reach the dispersed rural population will become less necessary with increased commerce and communication and with the expansion and improved quality of family planning services in both public and private sector fixed facilities. Nonetheless, it should be recognized in program planning that the more successful the program, the more it will cost for several years. Increasing percentages of women and men from the cohorts of fertile age whose growing numbers will not be reduced for 15 years will require tremendous expansion of access to quality services.

A key concern will be to provide support in a way to not reproduce public sector institutional mentality in the private sector. Emphasis on efficiency of operation and a general approach of "payments to service providers for services rendered" after initial startup support (even though subsidized heavily by external support), could help to encourage a true private sector mentality. It would promote program efficiency and improve service quality and responsiveness to client needs.

- Private sector institution capable of carrying out survey and market research and providing modern financial management services to the private and public sector. Ceilings on low government salaries for some years, constraints of economic structural adjustment, political instability and lack of resources to enable personally satisfying work have made it difficult if not impossible to attract and hold well qualified personnel in the public sector. ONAPO has not been alone in seeing the flight of its best people as confirmed by technical advisors to the Ministry of Plan. The necessity to depend on foreign advisors to produce financial and statistical reports and to carry out needed survey or other research is a serious impediment to program performance, to meeting the reporting and fiscal requirements of donor agencies or to developing the skills of national personnel in these areas. This problem is not confined to public sector institutions. For example, the local affiliate of the International Planned Parenthood Federation, ARBEF would not be able to carry out the market research necessary to most effectively develop a pilot social market program initiative with PSI. Additionally, ARBEF is presently having difficulties with its parent institution over fiscal reporting requirements.
It is unlikely that public sector agencies can themselves provide the expertise necessary to implement the research required for Population Policy Development, improving the quality of family planning informational activities and service delivery, experimenting with new types of delivery systems, establishing effective marketing programs and repeating such a survey as the 1992 DHS. It is questionable whether they can develop their own financial management capabilities, but certainly they will be unable to assist the private sector in this area. A private firm could employ and utilize high quality personnel with more flexibility and provide conditions of employment necessary for their personal growth and retention. Providing research and financial management services to both public and private agencies on a task order/contract basis could both assure efficiency and eventual self sufficiency. This institution could be the repository and future user of the management tools developed through the technical assistance provided by the MCH/FP II project.

Service Delivery. The main thrust of any future population activities supported by the donor community should be to develop the kinds of family planning services and informational programs that vigorously focus on value changes toward smaller families and behavioral changes increasing contraceptive use. These programs, whether in the public or private sector, must assure increased access; remove barriers of distance, waiting time, unnecessary examinations, cultural or religious constraints or charges beyond purchasing power; provide a full range of contraceptive services and be aggressive in outreach to gain and retain new clients. Future population/family planning efforts should support the institutionalization of integrated reproductive health services as the most viable mechanism to improve access to, and quality and acceptability of, FP services in the public sector. This is the strategy spelled out by the MOH in 1988, and it is the strategy being adopted by the RIM Project and supported by the World Bank Family Health Project, GTZ and UNFPA. It is based on the fact that although MOH clinics are not highly subscribed to and suffer a variety of management and operational problems, still they are (and will be for some time to come) the primary source of health services at least for the great majority of the rural population in Rwanda. For this reason, and given the MOH's commitment to making the system work, combined with the inherent relationship between maternal and child health and family planning services, strengthening of the MOH's capacity to provide quality integrated MCH/FP services is essential to the success of the FP program in Rwanda. This strengthening of the capacity of the MOH must include assuring that there are adequate staff at the service delivery point and sufficient of them trained in family planning so that "integrated" and "comprehensive" doesn't result in more waiting time and inconvenience for family planning clients.

Relatively new elements of service delivery which should receive attention would be:

- further study (survey of client satisfaction with method and service, review of impact of charges, assessment of quality of service, etc.) and remedial action to increase client continuation rates.

- increased acceptability and availability of longer duration/definitive methods. Among other efforts to make these services more available, further attention should be given to "inreach" initiatives directing attention to obstetric clients at
hospitals and maternity clinics. Some emphasis would be given surgical methods in these clinical settings. IUD (consider newer progestin carrying IUDs inserted with prophylactic antibiotics to protect against STDs), NORPLANT and tubal ligation.

- innovative approaches to extending service availability beyond the present fixed facility base:

  * A hybrid of Social Marketing and Community Based Distribution would use marketing approaches and processes to provide management, training, supervision, logistics and advertising support to a network of community based contraceptive sellers/distributors in a quasi-commercial fashion. The Abakangurambaga community leaders would be involved in addition to other community leaders and a variety of commercial outlets which sell other goods in the community. Some way of including barter in the process should be reviewed. Mobile teams would visit the market places regularly to at least sell pills and condoms. As it becomes possible to arrange appropriate personnel and conditions for client privacy, it would also be possible to provide injectable contraceptives. The system would depend on the public and private clinical system for referral points and the general medical support that users would be expected to seek as part of their own responsibility for their family health. The system would operate independently of the health system using private enterprise incentives to make family planning and perhaps other health services more readily accessible to the population.

  * Support would be provided to various private sector service delivery initiatives. Attention would be given to establishing several high quality urban reproductive health clinics emphasizing a full range of contraceptive services together with other reproductive health care. These likely would be managed by ARBEF but individual private practitioners would be considered. A wider spread network of private physicians and/or nurse midwives would be developed with the capabilities to supply pills, IUD, injectables and NORPLANT. Capital investments for establishing their services could be repaid with services provided at low or no cost to the lower economic segment of the population. PVOs with clinical or community development programs appropriate to family life education or family planning service delivery objectives would be supported. Industry, tea plantation, unions or others with health programs would be assisted to provide family planning services. As noted above, insofar as possible, any subsidies to service providers after initial start-up should be on a payment for services rendered basis. Potential would be explored for forming an Association of Reproductive Health or Voluntary Surgical Contraception Service Providers (perhaps include users).

The public sector would be used as a source of contraceptives and training and informational materials to be adapted for the private sector. Reports of client use to the
public sector coordinating body would largely be based on contraceptive distribution since client based record keeping would not be appropriate for many of these efforts.

**Training.** Before any future training is done (either clinical, FP auxiliary or teacher training):

- training needs should be clarified and curricula need to be redefined based on competencies needed by personnel to be trained. Technical assistance in needs assessment and curriculum development will be necessary.

- the computerized list of health workers and the in-service training they have received needs to be up-dated. A mechanism needs to be established for keeping it current and for making it available to all parties who may be involved in FP training.

- ONAPO should reassess the efficiency and effectiveness of alternative mechanisms for responding to clinical FP training needs. In particular, they should assess the strengths and weaknesses of the current centralized training strategy versus the possibilities of decentralizing training which would allow more training to be done (by more trainers) and would increase the capacity of regional staff to monitor training needs, train and evaluate training.

**Information, Education and Communication.** ONAPO needs to develop a viable IEC strategy to guide its diverse and important activities. At a minimum, such a strategy will need to (1) address the different aspects of the population problem, (2) identify appropriate channels of communication, (3) identify priority target populations for FP messages and targeted behavior change, and (4) identify messages and approaches appropriate to the different target populations.

A strong role in IEC will remain with the public sector through broad based informational campaigns, work with formal and non-formal educational programs and as greater skill in IEC is developed within the health centers themselves.

A substantial portion of the IEC effort could be carried by the promotional/advertising and interpersonal communication activities of the private sector social marketing/CBD hybrid mentioned above.

**9.1.2 Support of other Donors and other USAID projects**

**World Bank.** The World Bank has recently shifted its approximately US$26 million seven year project from activities supported through ONAPO in a comprehensive variety of nationwide service delivery, training, CBD and IEC areas to activities of presumably somewhat the same nature to be developed and supported through the Ministry of Health. World Bank officials in Washington stated considerable interest in close collaboration with USAID in developing the actual work plans for the project which is in its early implementation stages; a project official in Kigali said the same. He also strongly urged USAID to support the private sector which he thought would be hard for World Bank to finance since this was a loan to the GOR.
United Nations Fund for Population Activities (UNFPA). Although UNFPA is also providing considerable support to service delivery with the Ministry of Health, the UNFPA representative urges donors to continue their support for the kinds of activities appropriate for ONAPO. He is an outspoken advocate of improved coordination. UNFPA support is planned as follows:

- **Family Planning with the Ministry of Health.** A five year project will provide $2,240,000 support for equipment, contraceptives, supervision in the regions of Ruhengeri, Gisenyi and Kigali. Two thirds of the project value is expected to be spent on contraceptives which will be procured by ONAPO. UNFPA would welcome USAID provision of contraceptives including Depoprovera.

- **Assistance to the Ministry of Family and Promotion of Women.** This three year project for $500,000 will begin this year to support economic development activities for women and education in family planning.

- **IEC.** This project which is expected to be approved in May for $700,000 over a three period will provide technical assistance in developing IEC strategies and support action programs.

- **Policy Development.** This project, to be developed in May by a technical assistance team including a FUTURES representative requested from USAID, will provide $300,000 from UNFPA and an undetermined amount from other donors for work with ONAPO.

- **Population and Environment.** This project is to be developed with $100,000 of UNFPA funds if support for cofinancing can be obtained from other donors.

**German assistance (GTZ).** GTZ has been and plans to continue providing comprehensive assistance in the three provinces of Butare, Cyangugu and Gikongoro, supporting general family planning program management of ONAPO delegates and regional medical officers, providing contraceptives, supporting public and private sector training, supporting social marketing of condoms and operations research in CBD, assisting development of secondary family planning posts near health centers run by religious groups which do not provide family planning, assisting the development of a regional office and clinic of ARBEF, assisting population policy development with local leadership groups and agricultural agents, supporting IEC including programs in local markets in cooperation with UNICEF.

GTZ assistance has been running at about 2.25 million German marks (approx. 1.25 million US) per year and is expected to continue at about that level. The GTZ representative expresses considerable interest in the private sector, especially the PSI social marketing activities and the concept of a private sector financial management and survey research firm. He put the evaluation team in contact with a German technical advisor to the Ministry of Plan who has made some progress in developing a plan for a private sector research (not financial management) institute. This plan, which may receive German, Belgian and European Community assistance, is much larger than that contemplated by this MCH/FP II evaluation. However, it would have the same private sector aspects and could possibly meet the requirements for social science/survey research of the population program.
International Planned Parenthood (IPPF). IPPF has been assisting in the development of a local affiliate, ARBEF, since 1987 at the present level of about $225,000 per year. ARBEF also received assistance from SOMARC which has helped some in its institutional development. In the close out phase of an unsuccessful social marketing venture a SOMARC provided consultant is assisting ARBEF to relate to PSI's condom marketing program and to develop a medium term strategy for the overall ARBEF program.

CARE International. With support from an AID central grant and its own funds, CARE is implementing a program with local ONAPO and MOH personnel in several communes of Byumba region. This project focuses on developing local participation, improving services in the health centers, developing CBD activities and encouraging the provision and use of longer duration/definitive methods. The project was severely hampered in its initial stages as Byumba was the center of recent warfare. Nevertheless, it is expected to have some significant success; one might see it expand to the rest of Byumba region during the period of USAID Population 2001.

USAID RIM. This comprehensive reproductive health and family planning project will provide $13.15 million assistance to the regions of Kibongo, Gitarama, Kibuye and a fourth to be identified from 1993 through 1998. The project will work with the regional health authorities to improve maternal child/reproductive health/family planning services principally in the public health facilities.

AIDS/CAP. The worldwide centrally funded AIDS/CAP project has selected Rwanda as one of its priority countries in Africa. A variety of interventions are involved dealing with the spread and containment of the HIV/AIDS epidemic. The project does not specifically address the issue of family planning but there are definite points of mutual support. AIDS/CAP personnel state that in the counseling centers, those who have been found to be sero-positive are counseled to give serious consideration to whether they should have more children. Transmission of HIV/AIDS to the fetus or children borne to be early orphaned are issues of concern. Outreach programs to men or youth organized by the AIDS program can contain a message of protection against unwanted pregnancy along with the message of disease prevention. Perhaps most important is the contribution the condom social marketing program is making to enable more aggressive promotion of condoms and open discussion of human sexuality. It is also building a social marketing network and body of experience with the private sector that can be helpful to family planning. The AIDS program can provide informational materials and technical guidance so that correct information is given to FP clients and so that proper clinical practices are developed to protect both provider and client from any danger of infection.

9.1.3 Possible Areas for USAID Population 2001 Support

In suggesting the following areas for possible Pop 2001 support, consideration was given to the past history of USAID support and investment in ONAPO, the importance of MOH service delivery capacity, the likelihood of other donor support in given areas (e.g. MOH, training and IEC), the key elements that might receive less than adequate treatment(e.g. social marketing/CBD, the private sector in general, full contraceptive supply and focus on long term contraception) and areas where USAID may have special expertise such as policy
development modeling, private sector, survey research and family planning management systems. The possibility of geographic division of responsibilities was discarded as it would not give opportunity to work across the board in several key areas. Prioritization of the following list would come with further review and the COORDINATION with other donors which will be a sine qua non for rational planning.

- Policy development and institutional development to and through ONAPO. The degree and nature of this USAID assistance will depend on the nature, status and role of ONAPO under the new government. However, it is expected USAID will be the major supporter with collateral assistance from UNFPA. Assistance would be provided for the kinds of policy and institutional development activities described above including assuring the country program has a full supply of contraceptives and that global monitoring of family planning programs is accomplished. Research required to support these activities and technical assistance required for financial management could be contracted from the private sector initiatives.

- Complementing expected support from other lead donors to MOH to assure the reality of the financial support that presently appears likely (possibly even beyond the immediate absorptive capacity of the MOH). Population 2001 support for the MOH might be required to extend the RIM initiative. Assuring adequate contraceptive supply and appropriate logistics would be important. Support could also come through Population 2001 supported private sector initiatives in research and financial management and in stimulus to provision of long term methods.

- Population 2001 would be the lead support in the private sector initiatives described above, with possible joint participation with the EEC in a survey research institute. However managed, support must be available and capabilities developed for market research, quality issues in family planning service delivery and a repeat of the 1992 DHS. Other donors, especially GTZ and IPPF, would be encouraged to continue and increase their support in the private sector.

9.1.4 Management Considerations

An institutional contract with direct responsibility for total project management reporting to USAID and working with local institutions would respond to USAID management requirements and staff limitations. Several programmatic aspects should be considered in developing such a contract:

- The contractor should have expertise in working with both public and private sector family planning programs with emphasis on the private sector and demonstrated skills in coordination among national institutions and among donor agencies. Capability in institutional development will be important especially in supporting a private family planning organization and developing private sector financial management consulting and survey research capability. Private sector and public sector arrangements should be separate, avoiding "going through"
the public sector to support the private.

- The contractor should be capable of relating contractually with the social marketing program presently funded by AIDS/CAP. There should not be two social marketing programs even though one might be specifically for HIV/AIDS prevention and the other for family planning.

- Arrangements should be made through sub-contracts or buy-ins to maintain the involvement of institutions that have specialized skills or status (e.g. JHPIEGO for medical education, RAPID for policy development, AVSC or SEATS for VSC) or are part of a world wide program (e.g. DHS).

9.1.5 Additional Analyses Required

Several important studies or internal evaluations should be available between now and September to aid in Population 2001 design:

- an additional round of supervisory evaluation of the degree of integration as carried out in 1993

- reports of the CARE internal evaluation

- reports of a joint evaluation of the several CBD efforts

- reports of the first round of use of the updated RAPID model with the new government

- sales and progress reports of the PSI social marketing program together with reports on joint accomplishments of PSI and ARBEF in the Butare experimental effort

- reports of ARBEF strategic planning

- study on the impact of Bamako Initiative on acceptance and continuing use of contraceptives ... additionally there may be some helpful data on the impact of charges for family planning in the experience of the "Borne-fondien" a Danish PVO headed by Paul Jorgenson

- analysis of the RIM surveys

- updated projections based on DHS and recent service statistics which should be possible from the FAMPLAN model to project user and contraceptive requirements and costs under different scenarios of contraceptive mix, continuation rates, and proximate determinants of fertility

- review of service statistics and consultant reports to estimate the status and trends of VSC service points, providers and users
• a feasibility study for developing a statistical and survey research center (see Helmuth Asche at Miniplan). Some additional insights might be gleaned from Phillipe LeMay of PSI who worked with the Institute Haitien de L'Enfance, a research institute similar in nature to the requirements of this project.

• an informal matrix of ongoing, intended or potential project support (amounts, timing, for what purpose, to what institution) developed jointly by the donor coordinating committee.

Additional analyses would be required for the project design such as the following:

• a review of private sector institutions and health practitioners which might become involved in family planning. This would include an assessment of their management capabilities, their potential clientele and kind and amount of support required to make them effective providers of family planning services. One should draw on AIDS/CAP supported PSI for as much of this as possible; ARBEF is developing a list of private practitioners throughout the country.

• A review of locally available research and financial management capabilities in the private sector (either individuals or corporations).

### 9.2 Conclusions

• Throughout the period 1995 through 2001 and beyond there will remain a critical need for substantial external assistance to deal with a population growth problem that is already of crisis proportions.

• As judged by the present level of programming and assuming a new government is established with a generally favorable attitude toward population programs, there will be a receptivity to coordinated donor efforts in collaboration with Rwandan institutions to develop population projects.

• In the event the GOR does not continue its support to a strong, independent, well-placed ONAPO, most of the key elements for increasing contraceptive prevalence could be addressed by the support of other donors to the MOH and Population 2001 support to both private and public sector institutions.

• Recognizing the number of potential donors, the quantity of their assistance and the comprehensive but varied nature of some of their programs, the requirements for close coordination in project design and implementation are imperative.

• While the bulk of its assistance may not go to the private sector due to its present reach and absorptive capacity, one of the more important contributions of Population 2001 may be to pave the way for and support this sector that may become key to success in the 21st century. Risk capital would be required in this area.
• Though the majority of assistance may be provided by other projects, it will be essential for Population 2001 to assure that full coverage (especially contraceptive supply) is assured for the sector which will provide the bulk of service in the next five to ten years. public sector integrated maternal and child health/FP clinics of the Ministry of Health.

• The majority of the information required for project design can be available before September, 1994 if some attention is given to follow-up. That which will not be available is neither so difficult to obtain, sophisticated or costly to impede project development. This is obviously no longer applicable.

9.3 Recommendations

• Go for it!

• Coordinate!

• Pray a lot!

If one hits it right two out of three that's pretty good in baseball. The above three "recommendations" were as far as we got before 9.3.3 became immediately relevant! About all that can be said about the future at this time is that if and when conditions in Rwanda permit reinitiating external assistance, population programs will still be high on the list of priority needs. Despite the terrible tragedy of warfare and the personal, social and economic costs associated with it, it is no more likely to produce negative population growth over time than is HIV/AIDS. Rwanda will still be packed with people; there will still be excessive pressure on land resources and a badly battered economy and government will be sorely tried to meet the needs of a stable population, to say nothing of those of a population returning to a rapid growth tradition. USAID response to this need will require careful review of the public and private sector institutions, policies and capabilities that emerge from the war. Coordination with other donors will be even more important than ever in assessing needs and potentials and developing complementary programs. Infrastructure and institution building and policy development will no doubt be required. However a central element of any program will continue to be the provision of contraceptive services both through public and private sector approaches. The recommendation of section 7.3.2 will still be valid. Thus, it is repeated here:

As soon as security and political conditions permit, the international donor community should stand ready to assist Rwanda in reorganizing well managed efforts to deal with the problem of rapid population growth which will continue to persist in critical proportions despite recent progress in reducing fertility. Such efforts should continue to focus on expanding access both in the public and private sector to modern contraceptive services. They should include effective training and IEC initiatives as well as a strong policy and research component including emphasis on improving the status of women.
APPENDICES
SCOPE OF WORK

RWANDA MATERNAL AND CHILD HEALTH/FAMILY PLANNING II PROJECT
MID-TERM EVALUATION

I. BACKGROUND

A. Family Planning in Rwanda

Rwanda's population growth rate estimated at 3.1% per year is one of the highest in the world and the country already experiences the highest population density in Africa. This rate of growth seriously affects Rwanda's development prospects. In 1981, the Government of Rwanda acknowledged the problem by promulgating a National Population Policy (developed beginning in 1985 and approved in June 1990) and establishing a National Population Office (ONAPO) charged with guiding its implementation.

Over the last ten years, the Government of Rwanda (GOR), with ONAPO taking the lead, has made significant progress in developing the technical and administrative capacity and structures to support the delivery of family planning services, including training of service providers and IEC. Services have expanded through the integration of family planning into Ministry of Health maternal and child health (MCH) services and the development of secondary family planning "posts" which extend services to under-served areas. In 1988-89 ONAPO trained some 17,500 outreach workers (abakangurambaga) to provide family planning information and referrals at the household level.

Fertility, however, remains high, with a total fertility rate estimated at 7.3, and prevalence of the use of modern methods of contraception estimated at 13% of women of reproductive age in union. While knowledge of family planning is high, this is not yet matched by practice, due to continuing problems with accessibility, quality of services and motivation of clients.

Donors have actively supported the Rwandan family planning program. In 1982, the World Bank financed a pilot population component in a rural development project; in 1987 increased support through the family health project with the Ministry of Health; and recently signed the First Population Project with a credit of US$ 19.6 million over a five-year period. UNFPA has financed contraceptives, vehicles, training of health personnel, and some recurrent costs of ONAPO. The German Cooperation Agency (GTZ) has an integrated MCH and family planning project in the
three Prefectures of Butare, Gikongoro and Cyangugu emphasizing the training of health staff, strengthened supervision and IEC activities.

A.I.D. has been providing support to ONAPO and the Rwanda family planning program since 1981, first through the Maternal and Child Health and Family Planning Project (project no. 696-0113, signed September, 1981) and continuing through the Maternal and Child Health and Family Planning II (MCH/FP II) Project (project no. 696-0128, signed July, 1989). Project no 696-0113 provided ONAPO with long and short-term technical assistance, staff training, equipment and supplies (including contraceptives), construction and rehabilitation of health and training facilities, and a share of the agency's operating costs. But this project also pointed out various deficiencies in program implementation and management. At the time of the design of MCH/FP II, the integration of family planning services into the MOH infrastructure was still incomplete and IEC needed strengthening, the private sector was not involved to any large extent in the implementation of MCH/FP activities, and ONAPO also had serious weaknesses in its management, budgeting, and financial accountability procedures.

B. MCH/FP II Project - Overview

The Maternal and Child Health/Family Planning II (MCH/FP II) Project is a five-year, US$10.8 million project signed with the Government of Rwanda in 1989, with a project completion date of November 30, 1994. Its goal is to reduce the total fertility rate from 8.6 to 8.0 and population growth rate from 3.7% per year to 3.2% per year. The project purpose is to expand and improve the delivery and use of family planning information and services through both the public and private sectors, as measured by increased contraceptive prevalence from 3% to 15% of women in union between the ages of 15-49, increased knowledge of all available family planning methods from 70% to 95% of all men and women between the ages of 15 and 49, and a decrease in desired family size from 6 to 5.1

1MCH/FP II Project indicators were developed using estimates of rates of population growth, total fertility, and modern contraceptive use. Results of the recent census, documented in the Recensement General de la Population et de l'Habitat (15 August 1991) Ministry of Plan, indicates that the intercensal
The project consists of four mutually supportive components and has four defined outputs to support the accomplishment of the project purpose. Project inputs and support have been accessed through a long-term technical assistance contract with Management Sciences for Health (MSH) and buy-ins and add-ons to R&D/Population centrally-funded projects. R&D/Population resources through CARE, SEATS, Population Council, AVSC and IRD have been made available to supplement Mission funds and to implement parallel, complementary activities. Key elements, outputs, and related activities under these project components are described briefly below. Additional details can be found in the Project Paper and the Detailed Project Description in Annex A of the Project Agreement.

Component 1: Support for Policy Development and Research. The project supports research, data collection and analyses to assist the GOR to evaluate the impact of its family planning activities, define and target high risk groups, and to identify and strengthen the critical factors that limit the delivery of family planning services (e.g., equipment, training).

a) Development and Utilization of RAPID Models. Through a buy-in to the RAPID Project, assistance has been given to prepare Rwanda-specific models projecting the costs and benefits of family planning and related variables and to assist in their utilization in national-level planning.

b) Demographic and Health Survey (DHS). Through a buy-in to the DHS II Project, USAID financed the first Rwandan Demographic and Health Survey, with preliminary results due in December 1992.

c) Operations Research. Six operations research studies were to receive funding. To date, one study to test the integration of family planning into the EPI program is being supported by the Population Council, which is also financing a Norplant Cost Effectiveness Study in conjunction with MSH. AVSC is supporting a vasectomy acceptability study. Additionally, there has been a survey of health facility records to define continuity and drop-

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population growth rate has been approximately 3.1% per year. It is anticipated that the results of the Demographic and Health Survey, expected in November 1992, will be available to the evaluation team so that they can evaluate, and eventually correct, the estimates used for the project start and accurately assess what has been accomplished.
out rates as well as acceptor characteristics.

d) **Seminars and policy implementation.** The project has been supporting the local currency costs of seminars for policy-makers related to population policy implementation. A total of 3 policy seminars were envisioned. In fact, seminars have been held in each of the ten prefectures (six financed by USAID and four by UNFPA) which included presentation of the RAPID cost-benefit model.

e) **Improved coordination.** Similarly, the project supports costs related to the mechanisms mandated by the project and managed by ONAPO for donor coordination and for coordination of NGOs and private sector organizations.

Component 2: Family Planning Services Delivery. The project provides long and short-term technical assistance, commodities and training to improve and expand family planning services in both the public and private sectors.

a) **Improved service delivery and supervision.** Through buy-ins to INTRAH for technical assistance to improve family planning training and supervision, to the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) to train physicians and interns, and to the Association for Voluntary Surgical Contraception (AVSC) and the Service Expansion and Technical Support (SEATS) Project for the training of surgical teams and counsellors in long-term and permanent methods, the project is supporting ONAPO and the MOH to train at least 120 physicians and 250 nurses and para-medics so as to expand services to all MOH facilities and improve their quality and upgrade supervision.

b) **Improved Logistics and FP/Health Information System.** The MSH technical assistance contract provides for technical assistance and training to enable ONAPO and the MOH to fully integrate family planning into the health information system. MSH assistance is also strengthening the distribution system for contraceptives and medical equipment and supplies. The Family Planning Contraceptive Procurement Project has assisted ONAPO in the forecasting of contraceptive needs. Over the life-of-project, responsibility for the distribution of contraceptives and medical supplies is to be progressively transferred from ONAPO to the MOH.

c) **Private sector family planning.** Private sector entities (with
MSH and ONAPO support) are to receive assistance to deliver family planning information and services. As sub-grantees they will receive necessary training, technical assistance, IEC materials, contraceptives, and operating expenses, so that by the end of the project, 50% of all private health facilities are offering FP information and services (of any type) and at least 8 NGOs, cooperatives, and/or private clinics are providing the full range of FP services.

d) Non-medical family planning distribution networks. To expand FP services beyond the public and private sector fixed facilities, the project envisions two operations research studies to test alternative delivery systems:

1) Community-based Distribution (CBD). During the MCH/FP Project, a system to extend FP IEC and the distribution of condoms and spermicides by non-medical personnel was tested in Ruhengeri. The IEC component of this system was expanded to the entire country. Now, with SEATS central funds and technical assistance, the distribution of non-medical FP methods is being tested further in Ruhengeri and Kigali Prefectures. Under its R&D/Population grant, CARE International is implementing a CBD activity in Byumba Prefecture; and

2) Contraceptive Social Marketing (CSM). In collaboration with the Rwandan Family Welfare Association (ARBEF), an affiliate of IPPF, SOMARC II has initiated a CSM program to promote the sale of contraceptives, starting with condoms in June 1992, in pharmacies and similar retail outlets. The launch of oral contraceptives is scheduled to take place in early 1993.

Component 3: Information, Education and Communication. The project supports the implementation of FP IEC and its integration into GOR and private sector political, socio-economic, educational, and cultural programs.

a) Training of public and private organization personnel. The project is to support the training of 75 trainers, 600 family planning auxiliaries and 600 teachers. The project provides for in-service training of the village level promoters (17,000 abakangarambaga already trained by ONAPO) and includes the participation of Village Community Development Centers, the Rwandan Women's Association for Development, the Ministry of Youth and Associative Movement, health educators of the MOH and
PVO's, and agricultural extension workers. The project also supports the strengthening and expansion of IEC activities within the formal education system, with assistance in the refining and integration of curriculum materials for the primary, secondary and university levels.

b) Development, testing and distribution of IEC materials. The national IEC strategy should be revised and updated based on marketing research and survey results. Mass media materials in Kinyarwanda are to be developed, tested, broadcast, published and distributed.

c) Targeting of IEC activities to specific groups, such as youth. IEC messages should reach 90% of the adult population (20 years and older) and 40% of youth (ages 10 to 20).

Component 4: Institutional Support to Increase Management Capability. The project provides support in this critical area to both public and private sector institutions.

a) Improved management capacity within ONAPO. Under the MSH contract, ONAPO has two long-term advisors: one for management and financial systems, who assists in the strengthening of financial management systems, planning and budgeting, procurement and management of equipment and vehicles, etc; and one, the family planning management advisor, who assists in strengthening long-term planning and organization. They provide on-the-job training to ONAPO staff in the development and management of these systems. This assistance should yield annual operational plans and budgets which are followed, improved accounting systems with timely liquidation of 90 day advances, and improved management systems as demonstrated by timely procurements and adequate controls of vehicle fleet. The MSH team has followed up initial work under the Family Planning Management Development Project is also assisting in the computerization of a participant tracking system which serves as a tool for developing annual training plans for ONAPO and MOH.

b) Improved management within MOH. The project is supposed to assist the MOH to develop its capability to distribute contraceptives and FP materials and supplies so that the contraceptive logistics system is fully installed.

c) Improved management in non-governmental and private sector FP providers. Potential organizations for family planning services delivery grants will receive technical assistance to assure the
capacity to manage services. The project envisions that at least 8 NGOs, cooperatives or other private organizations would have annual plans and budgets for FP activities, and that at least 3 local NGOs would be registered by USAID and receive funds to provide FP services.

II. OBJECTIVES

The purpose of this PIO/T is to provide funding for the fielding of a team to conduct the mid-term evaluation of the Rwanda MCH/FP II Project and prepare a final evaluation report. The evaluation exercise is seen as an opportunity to look not only at the effectiveness of the project, but also to assess the development, progress, and status of the Rwanda family planning program and to make recommendations regarding the most appropriate type and level of USAID assistance for a future project to be designed in FY 93-94.

The evaluation has three principal objectives:

1) to assess progress made in meeting the objectives of the project; identify barriers and constraints as well as facilitating factors to progress at mid-term; and, assess the likelihood of the project meeting its objectives by the PACD.

2) to assess the effectiveness of the project design and its implementation and management (proposed and actual inputs, outputs, and structure) to achieving the project's purpose of increasing modern contraceptive use.

3) to identify lessons learned from the implementation of this project and make recommendations regarding a) realistic priorities for action in the final year of project implementation, and b) the design and components of a future project to support the Rwanda family planning program.

Recommendations should clearly describe the implications for future project design, identify additional analyses needed to further define proposed project parameters and components, and explain relevant linkages between this future family planning project and other USAID-supported projects, e.g., the new Rwanda Integrated Maternal Health Project and the up-coming AIDS prevention and Control Health project as well as other donor projects in family planning.
III. TASKS

The mid-term evaluation will be conducted over a six-week period by a three-person consultant team consisting of: a Family Planning Policy and Management Analyst (Team Leader); a Family Planning Services Specialist; and an IEC/Training Specialist. To assure close coordination and input from the Government of Rwanda, a fourth team member will be a senior Ministry of Health or ONAPO staff member. The team will assess the Rwanda MCH/FP II Project by means of:

- field visits in at least three regions and Kigali to assess in-clinic and out-of-clinic delivery of family planning services, levels of service coverage, and quality of services and referrals; through interviews with clients, clinic staff, supervisors and ONAPO and MOH regional managers, and observation of service delivery;
- interviews with ONAPO and Ministry of Health staff at the central level, and other ministry, government and non-government staff, as appropriate;
- interviews with technical assistance personnel from the contract with Management Sciences for Health and from the cooperating agencies active in the Rwanda project, as appropriate;
- interviews with USAID personnel and representatives of other donors as appropriate; and
- review of all relevant documentation from USAID, ONAPO and other donors and statistics related to service delivery and coverage.

Below is an illustrative list of the specific areas to be examined by the individual team members.

a. Family Planning Policy and Management Analyst/Team Leader

Overall Project Structure, Components and Elements

- Appropriateness of the project components and inputs to achieving the project outputs;
- Review of 1) demographic data used in preparing initial end of project status assumptions and, 2) new DHS data and the
1991 census, with the goal of providing USAID and ONAPO with appropriate rates for the project start so that an accurate assessment of what has truly been accomplished may be made;

- Effectiveness of implementation of the project elements and quality of outputs.

- Appropriateness of technical assistance provided, commodities furnished, and other inputs to project and program needs (assess in terms of quality, timing, quantity, and effectiveness of delivery).

- Given other donor inputs into the sector, appropriateness of USAID assistance and mechanisms for coordination and management.

- Linkages of family planning services with other development programs and activities, and relationships with other Ministries.

Population Policy

- Effectiveness of planned set of activities to support policy development and implementation, and their execution.

- Results achieved in population and related policies from MCH/FP II support.

- Timeliness and effectiveness of support provided under MCH/FP II, e.g., RAPID III, DHS.

Project Coordination and Management

- Effectiveness and appropriateness of project coordination mechanisms as planned and implemented.

- Effectiveness of assistance provided by MSH to strengthen ONAPO, MOH and private sector management of family planning.

- Effectiveness of support given to strengthen contraceptive

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2This element may be more appropriately handled by one of the other team members depending upon who has the demographic background required to respond this element.
forecasting and logistics and information systems.

- Effectiveness of assistance provided to strengthen management systems and improve financial management and accountability for funds.

- Effectiveness of project inputs and interventions in addressing constraints in management and operations of the family planning program.

- In looking to the future, advise USAID and ONAPO of the feasibility of an organizational design activity with ONAPO and those areas which could most benefit from OD.

The team leader will also be responsible for coordinating and guiding the activities and inputs of the other team members, preparing the outline of the report, and assuring high quality draft and final reports. The team leader will work closely with the MOH/ONAPO representative on the team and assist in delineating the specific tasks and contributions anticipated from this person.

b. Family Planning Services Delivery Specialist

General (Public and Private)

- Appropriateness of the service delivery strategies (including CSM and CBD) to achieving the contraceptive prevalence targets and assuring accessibility of FP services.

- Quality of family planning services being provided with project assistance (and in program overall). Accessability to a wide range of family planning methods.

- FP services coverage achieved by Rwanda family planning program.

- Appropriateness of training manuals, supervision guidelines, service delivery policies and guidelines for the delivery of quality clinical services and high levels of access.

- Appropriateness of equipment, contraceptives and other supplies available to the delivery of quality family planning services.
Effectiveness of studies to test alternative approaches to delivery of family planning services; utility of studies to support the expansion of services beyond the level of the fixed facilities.

**Public Sector Services**

- Effectiveness of integration of family planning services into the delivery of MCH, preventive and other health services.
- Effectiveness of the referral system for handling problems and complications.
- Effectiveness of family planning supervision from the central, regional, and local levels.
- Utilization of family planning and related health information systems to assess service access and quality and make corrections.
- Availability and accessibility of family planning services in MOH clinics to populations in need and at risk.

**Private Sector Services**

- Effectiveness and coverage of the contraceptive social marketing program.
- Effectiveness of the project's strategy and support to the private sector to expand service coverage and achieve a measure of cost-recovery.

**c. IEC/Training Specialist**

**Information, Education and Communication**

- Access of population and specific target groups to accurate information about family planning services, methods, etc.
- Effectiveness of mass media programs, print materials and other communication strategies (e.g. folk media) in reaching target audiences and conveying relevant information.
- Effectiveness of family planning and other health personnel in conveying information and counselling clients on family
planning.

- Effectiveness of project-supported activities within the formal education system.

- Effectiveness of project inputs to achieving outputs and results.

- Monitoring and evaluation of IEC efforts.

**Family Planning Training**

- Effectiveness and appropriateness of training for IEC and clinical services delivery.

- Appropriateness of structure and materials for delivery of effective family planning training, e.g. training of trainers, availability of teams, sites, clinical practice when needed.

- Effectiveness of training follow-up and supervision.

- Adequacy of project inputs (e.g., technical assistance from INTRAH, JHPIEGO, and AVSC) to address family planning training needs (skills, numbers); training needs which still need addressing.

- Effectiveness of pre-service training and linkages with in-service.

- Extent to which training can be expected to reduce or eliminate performance shortcomings, and reasons for conclusions.

d. ONAPO Representative.

In order to make this truly an independent external evaluation, the MINISANTE/ONAPO representative will interface and provide general assistance to the team but will not participate in the actual drafting of substantive portions of the report. S/he will assist with making appointments and travel arrangements, will travel with the team outside of Kigali, and will participate in team meetings and deliberations. Additionally, it is expected that this person will assist in providing clarification for the team in the following areas:
IV. ROLES AND RESPONSIBILITIES

The contractor is responsible for: identifying the potential team members for USAID approval; developing an overall evaluation guide for use during field visits; conducting the field visits, interviews, etc. to collect the data needed to evaluate the project; develop and present findings, conclusions and recommendations; de-brief personnel at USAID/Rwanda and the officials at ONAPO and the Ministry of Health; write and finalize the report. The contractor will be responsible for all international and in-country travel arrangements and logistical support; arrangements for office space outside the USAID Mission and any needed clerical support; translation of written documents as required; and finalizing and distribution of the final report, in French and English, to USAID/Rwanda.

All consultants are to bring IBM compatible laptop computers for their work. (USAID printers can be made available.) All documents, unless otherwise noted, are to be produced in Wordperfect 5.1.

USAID/Rwanda is responsible for: approving final selection of all team members; selecting with ONAPO and the Ministry of Health the sites for field visits and helping with logistical arrangements; collecting and providing supporting documentation to the evaluation team as necessary; and reviewing and providing comments on the draft evaluation report. The USAID HPO and Project Manager will provide guidance and counsel as necessary but will keep a certain distance between himself and the evaluation team so as to ensure an independent evaluation exercise.

Management Sciences for Health team and other Cooperating Agencies are responsible for: making available all relevant documentation on the project and its implementation; assisting in the selection of sites for field visits and with logistical arrangements as appropriate; making staff available for
interviews and data available as requested by the evaluation team; and reviewing and providing comments on the draft evaluation report.

ONAPO is responsible for: ensuring that a senior level official from either the Ministry of Health or ONAPO is designated as counterpart to the evaluation team leader; assisting in selecting sites for field visits and with logistical arrangements; making available relevant documents and individuals for interviews to assure the team members full knowledge of all aspects of family planning program implementation; assisting in any other way needed to assure a successful data-gathering and analysis effort; and comments on the recommendations of the team. ONAPO will provide for per diems for this individual, as necessary.

Special Logistical Notes

Health room facilities: use of these facilities is on a cost-reimbursable basis only. All consultants are required to have SOS insurance for evacuation purposes and a medical certificate stating that they are able to work in Rwanda. Use of health room facilities will be denied unless the medical and insurance (SOS) certificates are on file. Copies of both are to be submitted to the Health Room and EXO upon arrival in Kigali.

Pouch: short-term consultants, in country less than six months are not authorized use of the Pouch. Short-term consultants in country more than six months are authorized Pouch use for only first class mail up to one pound in weight.

Exchange Accommodation: USAID-funded consultants may cash checks at the Embassy which are drawn on a U.S. bank account.

USAID suggests (and has provided budget for) the rental of a hotel suite so that the team will have dedicated workspace. Arrangements for table-top space can be made with the hotel.

For travel: Business class travel is authorized in lieu of an overnight stay in Europe.

V. REPORTS AND DELIVERABLES

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<tr>
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<tr>
<td>Work Plan and Schedule</td>
<td>3 work days after arrival in Rwanda</td>
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De-briefing with USAID 2 work days prior to departure from Rwanda

De-briefing with ONAPO/MOH 2 work days prior to departure from Rwanda

Draft Evaluation Report (with principal findings and recommendations) 4 days prior to departure from Rwanda

Draft Summary and Recommendations in French 1 day prior to debriefing with ONAPO/MOH

Final Evaluation Report 2 weeks from date of receipt of USAID comments on draft report

The draft report should include a section which summarizes the key findings and recommendations which shall be translated into French for review by ONAPO and MOH officials prior to debriefing. The Final Evaluation Report should follow standard USAID evaluation format as outlined in Handbook 3 Chapter 12, and Handbook 3 Supplement: AID Program Design and Evaluation Methodology, Report 7, April 1987. The report will be submitted in French and English and five copies of each will be required.

VI. TIME FRAME AND LEVEL OF EFFORT

The evaluation will be conducted o/a April 12 for a period of six weeks until o/a May 24. Up to 16 person-weeks of effort are anticipated: 15 person-weeks (3 persons for five weeks in-country each) plus one person-week for the team leader to complete the report. It is assumed that this will happen in-country but this is essentially a contractor decision. A six-day work week is authorized. The budget assumes two days paid travel to and from Rwanda.

VIII. QUALIFICATIONS

Family Planning Policy and Management Analyst/Team Leader. At least a masters level degree in public health, public administration, or other relevant field. At least 10 years of relevant experience in planning, designing, managing, and
evaluating family planning programs in developing countries; experience in logistics and financial management required.

Either this person or one of the other team members should be sufficiently experienced in demography so that, after a review and analysis of new and old demographic data, realistic beginning-of-project demographic variables can be provided which will aid the evaluation team in making a realistic assessment of what project impact has been achieved.

Experience in sub-Saharan and Francophone Africa highly desired. Must have French language capability at FSI 3+/3+ level.

Family Planning Services Delivery Specialist. At least a masters level degree in public health or other relevant field. Clinical training in reproductive health desirable. At least 10 years experience in delivery, management, and/or supervision of family planning services in clinical and non-clinical settings with at least 5 years experience in working with alternative delivery systems, such as community-based services, private sector clinical and non-clinical services, and/or social marketing activities. Experience in sub-Saharan Africa highly desired. French language capability at the FSI 3+/3+ level.

IEC/Training Specialist. Masters level degree in communications, adult education, public health or related, relevant field. At least 10 years experience in the development of and training in IEC and training for family planning and/or health interventions in developing countries, with experience in all aspects of IEC development, e.g. needs assessments and pre-testing. Experience in the evaluation of IEC and training programs in developing countries. Experience in sub-Saharan Africa highly desired. French language capability at the FSI 3+/3+ level.

All consultants must be literate in computer word processing. Additionally, all consultants must have proven capacity to communicate effectively in English, both orally and in producing written reports.

MOH/ONAPO Representative. Medical/Clinical advanced training to MD level; Public Health degree preferred. At least 5 years experience working at various levels of the MOH/ONAPO structure; experience in clinical services, training, supervision and management. Ability to provide guidance on ONAPO organizational operations and policy. English preferred.
EVALUATION TEAM

William Bair, Team Leader
Jean LeComte
Suzanne Plopper

Family Planning Policy and Management Analyst
Family Planning Services Delivery Specialist
IEC/Training Specialist

FIELDWORK

Planned: March 17–April 20, 1994
Actual: March 17–April 9, 1994, due to evacuation.
APPENDIX B

EVALUATION METHODOLOGY

The methodology employed by the evaluation team included the following:

- a review of Project, and Project-related, documents
- briefings in Washington with representatives of CA’s involved in the MCH/FP II Project
- briefings with USAID-Rwanda staff responsible for monitoring Project activity
- interviews with ONAPO staff responsible for the management of different aspects of the MCH/FP II Project
- interviews with USAID and project staff of related USAID projects, RIM and AIDS/CAP
- interviews with representatives of other donor agencies involved in FP in Rwanda
- interviews with other NGO’s involved in the provision of FP services in Rwanda
- site visits to health facilities in 3 regions (including observations of FP service delivery and interviews with personnel)
- meetings with ONAPO and USAID staff to discuss findings
APPENDIX C

BIBLIOGRAPHY

(interrupted by early departure)

Evaluation


Projects USAID and other Donors


Policy


"Le Probleme Demographique au Rwanda et le Cadre de sa Solution." Republique Rwandaise, Mai 1990.


Documents of the Resources for the Awareness of Population Impacts on Development (RAPID) project, The Futures Group, Washington.

- "Etude Cout-Benefices du Programme de Planification Familiale au Rwanda," April 1990

Service Delivery


"Manuel-Guide Pour le Programme de Distribution a Base Communautaire au Rwanda." ONAPO and Ministere de la Sante (MINISANTE), Kigali, August 1992

"Evolution du Programme de PF au Rwanda." ONAPO, Kigali, 1992


"Byumba Improved Maternal Health and Family Planning Service Project." CARE, Atlanta, Georgia, U.S.A., 1994


ONAPO Workplans


Management Sciences for Health(MSH) Kigali


"Description/Specs/Work Statement." Contract No. 623-0128-C-00-1002-00, USAID and MSH, 1990.


Information, Education, Communication


Training


"Plan de Formation de l'ONAPO 1990 - 1994."


APPENDIX D:

LIST OF CONTACTS

KIGALI

ONAPO

Mrs. Gaudence Habimana, Director
Mr. Mathias Ngendakumana, Research Section
Mrs. Athanasie Kabagwira, Chief Research Section
Mrs Madeleine Baziramwabo, Logistic Section
Mr. Sixbert Nduwimana, informaticien
Mr. Tatien Rutaganda, informaticien
Mr. Manuel Munyambanza, CBD
Dr. Evariste Hakizimana, Previous Chief of Research and Program
Mr. Celestin Tereraho, Chief of Administration and Finance
Mr. Dominique Gakwaya, Evaluation
Dr. Vincent Bajinya, Family Health
Dr. Martin Kageruka, President, Board of Directors
Mr. Charles Uwayo, Chief Audio-Visuel Section
Mrs. Rita Mirembi, Audio-Visuel Section
Mr. Anathase Nkumdakozera, Audio-Visuel Section
Mr. Castule Kamanzi, Chief IEC Section
Mrs. Marguerite UUwamariye, Training and School Program, IEC Section
Mrs. Josephine Mukakalisa, School Program, IEC Section

Ministry of Health

Dr. Sosthène Rukundo, Chief Family Health Division
Mr. Léon Nsengimana, Chief MCH/FP Section

Ministry of Planning

Dr. Helmuth Asche, Technical Advisor

USAID Health and Population Office

Mr. William B. Martin, Health and Population officer
Mr. Patrice Nzahabwanamunga, MCH/FP II Project Manager

MSH

Mr. Richard Roberts, Family Planning Management Advisor
Mr. David Addison, Financial Management Advisor
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Dr. Martin Binyange, Medical advisor

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Mr. Abdou Karim Diop, Country Director
Mr. Christophe Boneza, Program Officer
Mr. Abdoulaye Malik Traore, IEC Specialist

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Dr. Jean Bosco Kaberuka, Regional Deleguate, Regional Medical Director a.i
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MSP

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Mrs. Patricia Dusabemanya, social worker
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Dr. Jean Dindahabizzi, Coordonator SIDA

Private Medical Office

Dr. Claude-Emile Rwagacondo, General practionner
GTZ
Dr. Philippe Swennen, Chief of Project

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Ms. Kristin Smith, Program Officer
Ms. Naomi Rutenburg, Program Officer
Ms. Heather Bowen, Consultancy Information
Mr. Mike Welch, Logistics

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Mr. Juan Schoemaker, Country Monitor,

MANAGEMENT SCIENCES FOR HEALTH
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AVSC
Mrs. Beverly BenSalem, Program Director
CARE

Ms. Joan Schubert, Deputy Director of Population Unit
Ms. Thérèse Mc Ginn, Consultant

THE WORLD BANK

Mr. Raymond Martin (phone)
APPENDIX E

DEMOGRAPHIC DATA

Ms. Kristin Smith, The Futures Group
Dr. Juan Shoemacher, MACRO

It is possible that the 1983 ONAPO Fertility Survey captured an unique point in time where the fertility rate rose prior to a major decline, which is what seems to have occurred in Kenya in the 1970s and 1980s. Unusually high fertility in Rwanda during that period could have been due to a shift in social and economic conditions which resulted in changes in exposure, breastfeeding patterns, and fecundability (due to health improvements) that led to a temporary increase in fertility. Examples of this are changes in women's educational achievement and status that result in shortened periods of breastfeeding and reduced periods of post-partum abstinence. Increased women's education also contributed to an increase in contraceptive use, however, the pace of adoption of contraceptive methods can be hampered by the limited availability of family planning services. While the very high fertility in the early 1980s would understandably make a reasonable program manager cautious about the prospects of significant fertility decline, its is possible that fertility in this period was aberrant. And consequently it is not surprising that fertility declined much more rapidly during the project period than the 0.5 set out in the project paper.

We now turn our attention to the second part of the approach mentioned above, that is, the proximate determinants of fertility. Since you were primarily concerned with the relationship between contraceptive use and fertility, I will address this factor first. Contraceptive use experienced notable change in Rwanda from 1983 to 1992. As mentioned in my presentation at the Team Planning Meeting, "Analytical Review of Existing Data: Preparing for the Mid-term Evaluation of the Rwanda MCH/FP II Project", use of modern methods was virtually non-existent in 1983 (less than 1%) and shot up to nearly 13% in 1992. In addition, the 1992 RDHS reveals that all method use in Rwanda was 21% and the total fertility rate was 6.2 children per women.

The relationship between contraceptive use and total fertility rates is examined in 25 developing countries in the DHS comparative studies report regarding knowledge and use of contraception. As shown in the study, use of contraception and fertility are highly correlated: as contraceptive prevalence rises, total fertility decreases. More specifically, the study reveals that each 15 percent increase in contraceptive prevalence accounts for the reduction of one birth in total fertility. Plugging the Rwanda 1992 DHS contraceptive use figures (21%) into the regression equation yields a total fertility rate similar to the actual fertility rate measured by the 1992 RDHS (5.9 calculated TFR, in comparison to 6.2 measured TFR). The difference could be attributed to ineffective traditional method use.

This study can serve as a guide in producing an estimate of the contribution which the increase in contraceptive prevalence has made on the fertility decline in Rwanda. Given that with each 15 percent increase in contraceptive prevalence, one can expect a decrease in total fertility by 1 child per woman, we can apply this to the Rwanda experience. Contraceptive use of modern methods increased from 1% to 13% and all method use increased from 11% to 21% in the time period of interest. Simple mathematical calculations suggest that .7 children per woman (all method CPR) or .8 children per woman (modern method CPR) can be attributed to the increase in CPR in Rwanda. The remainder, 1.6 (all methods) or 1.5 (modern methods) children per woman, is probably due to other factors occurring in Rwanda during this time period.

---

Changes in other proximate determinants of fertility have occurred in Rwanda. Again we can refer to the discussion by Juan Schoemaker at the Team Planning Meeting. Exposure to intercourse directly influences fertility. Two factors which are integral in this determinant -- the age at first marriage and the age at first birth -- experienced a striking increase from the ONAPO 1983 Fertility Survey to the 1992 RDHS. (Refer to Schoemaker's notes for specifics) In addition, postpartum amenorrhea is an important determinant of fertility. The duration and intensity of breastfeeding is a key factor which influences postpartum amenorrhea. The end result of many of these determinants of fertility is the length of birth interval. We have requested from DHS to forward the tabulations already completed with the 1992 RDHS data on breastfeeding and birth interval, however, they have not arrived yet. If the team thinks these are important to the evaluation, the mission could contact DHS directly to expedite the process.

Another factor which could potentially play a role in reducing the fertility rate is abortion. As the DHS does not query women on this subject, and it is impossible to make comparable estimates of this proximate determinant, on the basis of the DHS results alone little can be said about the magnitude of abortion in Rwanda and its possible influence on the fertility decline witnessed in Rwanda. However, I remember during the Team Planning Meeting that many of the participants reported that abortion was not uncommon in Rwanda. Perhaps the evaluation team has uncovered information on abortion use during interviews with service providers and other individuals who have expertise in Rwanda.

The third step in this discussion is to look at the social and economic changes which may have indirectly led to changes in fertility by influencing changes in the proximate determinants. For example, increases in female education have occurred in Rwanda. Level of education achieved is significant because a clear relationship exists between education level and fertility: In general, as education level increases, proportionally more women who have attained that education level have fewer children. In addition, these same women have a higher rate of contraceptive use and tend to live in urban areas. Data from the 1992 RDHS show that more women aged 15-19 received any level of schooling than women aged 45-49 -- 79% versus 28% (see Analytical Review of Existing Data, slide 12).

Another social change which has clearly affected every aspect of Rwandan life is the war. There is reason to believe that civil unrest has impacted fertility in a variety of ways. For example, the war has caused major disruption of households, increased morbidity and mortality, and heightened uncertainty of the future could cause delays in births. Without in country collaborative research and much more data, it is impossible to measure the extent to which the war has reduced fertility.

A third social change is that increasingly Rwandan men and women are experiencing first hand the limits of resources -- land, jobs, etc. -- exasperated by the tremendous rate of population growth in their country. Examples were given by many of the participants at the Team Planning Meeting who have worked extensively in Rwanda (Joan Schubert, CARE; Juan Schoemaker, DHS; and Beverly Ben Salem, AVSC). Further, the USAID/Kigali Mission HPN, Bill Martin, mentioned to me that the most frequently stated reason for male sterilization given by the acceptor was lack of resources to give to their children, and thus the desire to prevent any further children.

On another note, also enclosed are the population projections from the computer model DEMPROJ, including the projected population growth rates. I did two projections -- one with AIDS and one without. Both start in 1980 and end in 2011. The AIDS assumptions are as follows: adult HIV sero prevalence starts in Rwanda in 1980 and increases to 11% by the year 1992. This reflects the US Bureau of the Census sero prevalence studies in 1992/1993 which observe urban, pregnant women with a sero prevalence rate of 33.4%; and, rural, pregnant women with a sero prevalence rate of 9.8%. The national rate of 11% is calculated by proportionally weighting the population (5% urban, 95% rural). According to urban sero prevalence studies over the past few years in Rwanda, it seems that HIV sero prevalence may have reached a plateau hovering around 35%. It is not clear at what level rural HIV sero prevalence will plateau, yet evidence from other countries shows that rural residents have different behaviors than urban residents and that the rural population in Rwanda may experience slight increases in HIV. Therefore, I assumed that by 2002 (a ten year time period) national HIV sero prevalence would increase to 15% and level off. The attached pages show the demographic indicators generated from this projection.
Demographic Projection Model
4/1/1994 17:18:18
Demographic Indicators

rwanda = aids with fp
REGION = Total

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Annual Rates of Change

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<td>GR percent</td>
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<td>2.4</td>
<td>2.2</td>
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= see letter for HIV/AIDS assumptions
Notes to Presentation

Analytical Review of Existing Data: Preparing for the Mid-term Evaluation of the Rwanda MCH/FP II Project

SLIDE 1: ANALYTICAL REVIEW OF EXISTING DATA

I'M PRESENTING AN OVERVIEW OF THE FERTILITY SITUATION IN RWANDA TO AID THE POPTECH EVALUATION TEAM IN THEIR ASSESSMENT OF THE RWANDA MCH/FP II PROJECT.


THE PROJECT PUT FORTH SEVERAL GOALS AND OBJECTIVES AS TARGETS TO ACHIEVE DURING THE LIFE OF THE PROJECT. FIRST, A REDUCTION IN FERTILITY FROM 8.6 TO 8.0 CHILDREN PER WOMAN.

SECOND, AN INCREASE IN MODERN CONTRACEPTIVE PREVALENCEx FROM 3% TO 15%.

THIRD, AN INCREASE IN KNOWLEDGE OF CONTRACEPTIVE METHODS FROM 70% TO 95%.

AND FOURTH, A DECREASE IN DESIRED FAMILY SIZE FROM 6 TO 5.

THIS PRESENTATION WILL ADDRESS THESE FOUR POINTS.

SLIDE 2: HISTORICAL OVERVIEW

HOWEVER, BEFORE I DISCUSS THE RECENT TRENDS, IT IS IMPORTANT TO LOOK AT THE HISTORICAL TRENDS IN DEMOGRAPHIC INDICATORS IN RWANDA.

SLIDE 3: TOTAL POPULATION

THE TOTAL POPULATION IN 1950 WAS JUST OVER 2 MILLION. AS YOU CAN SEE ON THIS SLIDE, TOTAL POPULATION HAS Risen DRAMATICALLY TO OVER 7 MILLION IN 1990.
SLIDE 4: CRUDE DEATH RATE

Mortality and fertility are key components which influence total population.

In Rwanda, the crude death rate has decreased since the 1950s.

SLIDE 5: TOTAL FERTILITY

The major contributor to the growth in the total population has been the continued high total fertility rate. Since the 1950s, total fertility has been steadily increasing from nearly 7.5 children per woman to 8.6 in 1978. As shown on the slide, recently there has been a dramatic decline in fertility from 1983 to 1992. Fertility was measured at 8.5 by the 1983 ONAPO fertility survey, and then at 6.2 by the 1992 RDHS.

As mentioned previously, one of the goals put forth by the MCH/FP II project was to decrease total fertility from 8.5 to 5.0 children per woman. Clearly this benchmark has been accomplished.

SLIDE 6: ASFR

With these long term trends in mind, we can now focus on the more recent trends in fertility. This slide illuminates the decrease in fertility from 1983 to 1992. What is interesting about this slide however, is that there are decreases at every age group.

SLIDE 7: TOTAL AND DESIRED FAMILY SIZE

As well as a decrease in total fertility, Rwandan women's desired family size has also fallen from 6.2 in 1983 to 4.4 in 1992. Research has shown that desired fertility is an useful indicator of future total fertility.

Another goal of the project was to decrease desired family size from 6 to 5. The RDHS reveals that this too has been accomplished.

SLIDE 8: DESIRED FAMILY SIZE IN SSA COUNTRIES

To put into context the desired family size of 4.4 in Rwanda, this slide compares Rwanda to other Sub-Saharan African countries. This slide demonstrates that Rwanda is comparable to the other Sub-Saharan African countries which have experienced significant reductions in fertility (Kenya, Botswana, and Zimbabwe).
SLIDE 9: HISTORICAL OVERVIEW -- CT USE

SINCE DECREASES IN FERTILITY ARE DIRECTLY LINKED TO CONTRACEPTIVE USE, LETS NOW EXPLORE WHAT CHANGES HAVE OCCURRED IN CONTRACEPTIVE USE.

SLIDE 10: TRENDS IN CPR

FIRSTLY, CONTRACEPTIVE PREVALENCE -- NOTABLY OF MODERN METHODS -- HAS INCREASED DRAMATICALLY. FROM ROUGHLY 1% IN 1983 (THE GREEN BAR) TO 13% IN 1992. THESE PIE CHARTS SHOW THE CHANGES IN THE METHOD MIX OVER TIME. USE OF INJECTIONS HAS SKY ROCKETED, FROM LESS THAN 1% TO 8.4%; THE PILL HAS INCREASED TO 3% FROM LESS THAN 1%, AND NOW STERILIZATION WHICH WAS VIRTUALLY NON-EXISTENT IN 1983 IS CLOSE TO 1%.

TRADITIONAL METHODS STILL PLAY A ROLE IN THE CPR, DESPITE DECREASES FROM 10% TO 8%.


SLIDE 11: TRENDS IN CPR BY AGE

ACROSS THE BOARD, A HIGHER PROPORTION OF WOMEN IN EVERY AGE GROUP ARE USING A METHOD OF FAMILY PLANNING IN 1992 COMPARED TO 1983. ROUGHLY HALF OF THESE METHODS ARE MODERN.

THIS MATCHES THE DECREASES IN FERTILITY AT EVERY AGE GROUP MENTIONED EARLIER IN THE ASFR SLIDE.

SLIDE 12: EVER USE AND CURRENT USE

METHOD TRIAL OF ANY METHOD IS ROUGHLY 40% AND ONE QUARTER OF WOMEN IN UNION HAVE TRIED A MODERN METHOD.

THE GAP BETWEEN THE TWO REPRESENTS DISCONTINUATION. DISCONTINUATION AMONG THOSE WHO USE INJECTABLES -- A LONG TERM METHOD -- IS PROPORTIONALLY LESS THAN THE DISCONTINUATION OF THE PILL -- A SHORT TERM METHOD.

SLIDE 13: TRENDS IN CPR BY EDUC

RWANDA EXEMPLIFIES THE COMMON RELATIONSHIP BETWEEN CONTRACEPTIVE PREVALENCE AND EDUCATION: WITH HIGHER LEVEL OF EDUCATION ATTAINED, A GREATER PROPORTION OF WOMEN USE FAMILY PLANNING.
SLIDE 14: INCREASE IN FEMALE EDUCATION

As you can see on this slide, a greater percent of younger women have received some schooling than older women. This demonstrates an increase in female education.

SLIDE 15: AWARENESS OF METHODS

A second factor which is related to a higher CPR is awareness of methods. An overwhelming increase in method awareness has occurred in Rwanda. As you can see, combined spontaneous mention and recognition of the pill and the injection is nearly universal (100%). In addition, another remarkable increase in awareness occurred with female sterilization.

The fourth goal put forth by the project was to increase knowledge of methods from 70% to 95%. In the major modern methods -- injection and pill -- this has been accomplished, and the other methods have experienced substantial gains in knowledge.

SLIDE 16: ATTITUDES TOWARD FF

This slide demonstrates that nearly all of the male and female respondents approve of family planning. This is important when considering program image and acceptance of family planning.

SLIDE 17: LIMITERS

There has been an increase in the proportion of women who state they do not want any more children over time from 20% in 1983 to 37% in 1992. This represents nearly a double in the proportion of women who want to limit childbearing.

SLIDE 18: SPACERS

In 1992, 58% of the women in union wanted another child, of which 42% want to space this birth years more than 2 years from the time of survey.

These two sub groups represent women with potential demand for family planning.

SLIDE 18: INTENTION TO USE BY AGE

Another subgroup of women who may need family planning services are those who intend to use in the future. In Rwanda, the intention to use family planning has also increased among all age groups.
SLIDE 19: INTENTION BY RESIDENCE AND PARITY

Also, intention has increased in both urban and rural areas.

This slide is interesting. It shows that a high percentage of women at all levels of parity intend to use family planning, even those with no children.

SLIDE 20: REASONS NON-USE

Women who do not use, and do not intend to use were asked their reasons for non-use. This slide shows that most women in this category have good reasons for not using, either they wish to become pregnant or they are infecund. Health concerns were another reason stated by 14% of these women.

SLIDE 21: SOURCES

Now let's look at the supply side of this equation as regards accessibility.

SLIDE 22: SOURCE MIX

The family planning program is basically a public sector program, with virtually all -- 98% -- of the users acquiring their method at either a health center, hospital, or family planning secondary health center. Health centers are used most frequently.

SLIDE 23: EASE OF ACCESS

The ease of accessing the source can be used as a proxy to measure accessibility. Three fourths of current users of family planning state it is easy to access their source. The remaining 27% may represent some of the discontinuation.

SLIDE 24: TIME SPENT GETTING TO SOURCE

A second proxy measure for accessibility is the time spent getting to the family planning source. 60% state they can get to the family planning source within one hour.

SLIDE 25: CONCLUSIONS

Read slide -- reiterations of project goals and targets

One of the challenges for the team is to determine how much of this decline in fertility is attributable to the MCH/FP II project, and what interventions contributed to the progress.
ANALYTICAL REVIEW OF EXISTING DATA:

Preparing for the Mid-term Evaluation of the Rwanda MCH/FP II Project
HISTORICAL OVERVIEW:
Demographic Indicators and Changes in Fertility
TOTAL POPULATION OVER TIME, 1950-1990

Source: 1992 UN, WORLD POPULATION PROSPECTS
CRUDE DEATH RATE OVER TIME, 1950-1990

Source: 1992 UN, WORLD POPULATION PROSPECTS
TOTAL FERTILITY RATE OVER TIME, 1950-1992

Source: 1992 UN, WORLD POPULATION PROSPECTS
AGE-SPECIFIC FERTILITY RATES, 1983 and 1992, Rwanda

Source: 1992 UN, WORLD POPULATION PROSPECTS and 1992 RDHS
DESIRED TOTAL FAMILY SIZE, Rwanda Compared to Other Sub-Saharan African Countries

Source: 1991 DHS Comparative Study 3
HISTORICAL OVERVIEW: Contraceptive Use
TRENDS IN CONTRACEPTIVE PREVALENCE RATE, 1983-1992

Contraceptive Prevalence Rate = 11

1983

Withdrawl 1.4%
Modern 0.9%
Other Trad. 0.3%
Periodic Abstin. 8.4%

Contraceptive Prevalence Rate = 21

1992

 Withdrawl 3.1%
Steril. 0.7%
Other Modern 0.7%
Injectable 8.4%
Pill 3.0%
Periodic Abstin. 5.1%

Source: 1983 ONAPO and 1992 RDHS
TRENDS IN CONTRACEPTIVE USE BY AGE, Rwandan Women in Union, 1983 and 1992

Source: 1983 ONAPO and 1992 RDHS
EVER AND CURRENT USE OF SELECTED CONTRACEPTIVE METHODS, Rwandan Women in Union, 1992

Source: 1992 RDHS
TRENDS IN CONTRACEPTIVE USE BY LEVEL OF EDUCATION,
Rwandan Women in Union, 1983 and 1992

Source: 1983 ONAPO and 1992 RDHS
INCREASE IN FEMALE EDUCATION
Rwandan Women With Any Level of Education, 1992

Source: 1992 RDHS
AWARENESS OF METHODS,
Rwandan Women in Union Who Spontaneously Mention or Recognize Method

Source: 1983 ONAPO and 1992 RDHS

POPTECH
ATTITUDES TOWARD FAMILY PLANNING, Rwandan Men and Women in Union, 1992

Actual Approval of Family Planning

Source: 1992 RDHS
LIMITERS (Women Who Want No More Children)
Rwandan Women in Union, 1983-1992

Source: 1983 ONAPO and 1992 RDHS
SPACERS (Women Who Want To Delay Next Birth), Rwandan Women in Union, 1992

Source: 1992 RDHS
INTENTION TO USE FAMILY PLANNING
BY AGE OVER TIME,
Rwandan Women in Union Who Are Not Currently
Using Family Planning

Source: 1983 ONAPO and 1992 RDHS
INTENTION TO USE FAMILY PLANNING,
Rwandan Women in Union Who Are Not Currently Using Family Planning

By Residence, 1983-1992

By Parity, 1992

Source: 1992 ONAPO and 1992 RDHS
REASONS FOR NON-USE OF FAMILY PLANNING,
Rwandan Women in Union Currently Not Using a Method Who Do Not Intend to use in the Future, 1992

Source: 1992 RDHS
FAMILY PLANNING SOURCES: Accessibility
SOURCE MIX

Source of Supply for Current Modern Methods Users, Rwandan Women in Union, 1992

- Health Center: 67.30%
- Hospital: 22.50%
- FP Secondary Center: 8.70%
- Other: 1.50%

Source: 1992 RDHS
EASE OF ACCESSING SOURCE,
Rwandan Women in Union Who Currently Use Family Planning, 1992

- Difficult: 27.1%
- Easy: 72.0%

Source: 992 RDHS
TIME SPENT GOING TO FAMILY PLANNING SOURCE, Rwandan Women in Union Who Currently Use Family Planning, 1992

Source: 1992 RDHS
PROJECT GOALS AND TARGETS ACHIEVED

✓ FERTILITY -- REDUCE FERTILITY FROM 8.6 TO 8.0 (1992 TFR 6.2)

✓ PREVALENCE -- INCREASE MODERN CONTRACEPTIVE PREVALENCE FROM 3% TO 15% (NEARLY ACHIEVED, 1992 MODERN CPR 13%)

✓ KNOWLEDGE -- INCREASE KNOWLEDGE OF AVAILABLE FAMILY PLANNING METHODS FROM 70% TO 95% (1992 KNOWLEDGE OF INJECTION AND PILL 97%, OTHERS INCREASED SUBSTANTIALLY)

✓ DESIRED FAMILY SIZE -- DECREASE DESIRED FAMILY SIZE FROM 6 TO 5 (1992 DESIRED FAMILY SIZE 4.4)

Source: POPTECH
TOTAL AND DESIRED FAMILY SIZE,
Rwandan Women in Union, 1983-1992

Source: 1983 ONAPO and 1992 RDHS

POPTECH
DHS surveys, no program goals as such, mostly data gathering (a hopeful side effect is to expand the survey-carrying capability in host country and implementing agency, but that is not always visible)

- the bulk of these surveys have been in Sub-saharan Africa.
- Rwanda started in September 1990, discontinued because of the civil war, several attempts to re-start failed. Data was discarded and the survey re-started in August 1992.
- I will not discuss the overall results but only those relating to fertility behavior and those that are more striking. Summary report is in the printers. Final report should be in a month.
- The most striking is the drop in TFR, from 8.5 circa 1983 to 6.2 in 1992 (three years prior to the survey (89-92). (GRAPH 1.2) This is a 30% decline in less than 10 years. (To put it perspective, Kenya went from 7.9 in 1979 to 6.7 in 1989 => 15% decline in 10 years; current is estimated at 5.4) These findings roused some commotion in the World Bank & UNFPA, judging from the number of phone calls I received from them. It is reasonable to doubt it. Now the question is Rwanda undergoing of a major demographic revolution or is it only data distortion? I will explain why I think these figures are accurate, i.e there is a real fertility decline.
Data quality

- There is no evidence of age displacement, which could distort fertility levels & trends

Some age displacement occurs in DHS surveys to avoid the health section. Heaping in the 6th year prior to the survey of children. This would tend to inflate the TFR for the preceding period and underestimate the current TFR. No evidence of that. As a matter of fact the birth year ratios is higher than in a number of countries (slightly above 100) for living children.

Besides we calculate TFRs for 3 year periods, so even if such displacement occurred, births would be displaced within the same reference period.

- The data is very consistent with:

  a) 1991 NON-ADJUSTED census data (GRAPH 1.1). This level was considered too low so it was adjusted upward;

  b) 1983 Enquête National sur la Fécondité. Retrospective data (8-11) coincides with ENF83 age specific fertility rates (GRAPH 1.3).

  c) Mean number of children ever born to women 40-49. Indicator of past fertility levels (15 or 20 years preceding the survey). (TABLE 1.1) In a population with constant ages specific fertility rate, CEB to women 40-49 should approximate the TFR. CEB in is almost 8.0 close to the TFR estimated in 1983.
• modern contraceptive use among currently married women increased more than 1000%, from 1% in 1983 to 13% in 1992 (GRAPH 2.1). (Used of traditional methods overestimated in 1983 because extended abstinence was defined as a traditional method).

i) Knowledge of modern contraception is almost universal, from only two thirds in 1983 (GRAPH 2.2).

ii) educated, urban women are spearheading that movement (GRAPH 2.3) (more that 25% use modern contraceptives, almost 40% all methods among women who went beyond primary school)

• Overall, the proportion of women in union (consensual or legal), decreased, while the proportion of single and formerly married increased (GRAPH 3.1)

• There is an upward trend in the age at first marriage (or union), age at initiation of sexual activity and age at first birth (2.2, 1.8 & 1.5, respectively) (TABLE 3.1)

**Future trends**

One question: is this a long term trend or merely circumstantial? The war that started in October 1990 caused much disruption. Probably the worst crisis since independence, worsening an already existing critical situation caused by the plunge of coffee prices the international market. Displacement of population, emigration, apprehension about the future, breakdown of families (husbands either killed, in jail or hiding), which may have contributed to the fertility decline.
However, the results of RDHS suggest that there is a definite downward trend and it will continue for some years to come.

- Total wanted fertility rate for 3 year period preceding the survey, is only 4.2 against actual TFR of 6.2. (Table 1.2) That means, hypothetically, that if women had perfect control of their fertility they would have fewer children (2 less on the average). TWFR is calculated as TFR except that unwanted births are removed from the numerator. DHS data allows to do that.

- The desired family size also declined substantially between 1983 and 1992, from 6.3 to 4.2 (Table 3.2) (It is not often that you get this level of consistency). Is actual behavior trailing the declared desired family size?

- Finally 50% of non-users declared they had they would use contraceptives within the next 12 months. 12% declared they would use them later (Graph 2.4)

Reason for this trend. Rwanda has the highest population density in Subsaharan Africa (crude density = 270/km²; density per arable land is probably much higher); people are running out of resources; men are unable to pay the dowry; is a crisis-lead fertility change. This is all consistent with my own field experience.
Graphique 1.2
Tendances de la fécondité par âge

Pour mille

Age de la femme

Périodes avant l'EDSR
- 0-3 ans
+ 4-7 ans
* 8-11 ans
■ 12-15 ans

EDSR 1992
Graphique 1.1
Graphique 1.3
Fécondité par âge 8-11 ans avant l'EDSR et 3 ans avant l'ENF

Pour mille

Age de la femme

Périodes avant l'EDSR
★ 8-11 ans
- ENF 1983

EDSR 1992
### Tableau 1.1
Indice synthétique de fécondité et nombre moyen d’enfants nés vivants chez les femmes de 40 à 49 ans.

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<td><strong>Urbain</strong></td>
<td>4,3</td>
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<td><strong>Sans instruct.</strong></td>
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<td><strong>Primaire</strong></td>
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<td><strong>Post-primaire</strong></td>
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Graphique 2.1
Prévalence de la contraception parmi les femmes de 15-49 ans en union, 1983 et 1992

Ensemble des méthodes*

Méthodes modernes

Méthodes tradition.*

Pourcentage

ENF 1983** EDSR 1992

* Y compris l'abstinence prolongée, pour 1983
** Femmes en union et fertiles
Graphique 2.2
Connaissance de la contraception par les femmes de 15-49 ans, 1983 et 1992

Pourcentage

Au moins une méthode 98 97 95 63 49 87
Pilule 67 41 45 21 18 11
Injection DIU Retrait Condom

ENF 1983 EDSR 1992
Graphique 2.3
Utilisation actuelle de la contraception par les femmes de 15-49 ans en union

E D S R 1992
Graphique 3.1
Etat matrimonial par âge en 1983 (ENF) et en 1992 (EDSR)
Tableau 3.1
Age médiane à la première union, aux premiers rapports sexuelles et à la première naissance. Femmes de 25-49 ans

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Tableau 1.2
Indice synthétique de fécondité et indice synthétique de fécondité désirée.

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<td>4,2</td>
</tr>
<tr>
<td>Urbain</td>
<td>4,3</td>
<td>3,3</td>
</tr>
<tr>
<td>Rural</td>
<td>6,3</td>
<td>4,3</td>
</tr>
<tr>
<td>Sans instruct.</td>
<td>7,0</td>
<td>4,8</td>
</tr>
<tr>
<td>Primaire</td>
<td>5,9</td>
<td>4,2</td>
</tr>
<tr>
<td>Post-primaire</td>
<td>4,3</td>
<td>2,8</td>
</tr>
</tbody>
</table>
### Tableau 3.2
Taille idéale de famille en 1983 et 1992

<table>
<thead>
<tr>
<th></th>
<th>1983</th>
<th>1992</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6.3</td>
<td>4.2</td>
</tr>
<tr>
<td>15 - 19</td>
<td>5.8</td>
<td>4.1</td>
</tr>
<tr>
<td>20 - 24</td>
<td>6.0</td>
<td>4.0</td>
</tr>
<tr>
<td>25 - 29</td>
<td>6.1</td>
<td>4.2</td>
</tr>
<tr>
<td>30 - 34</td>
<td>6.4</td>
<td>4.4</td>
</tr>
<tr>
<td>35 - 39</td>
<td>6.6</td>
<td>4.5</td>
</tr>
<tr>
<td>40 - 44</td>
<td>6.7</td>
<td>4.5</td>
</tr>
<tr>
<td>45 - 49</td>
<td>6.9</td>
<td>4.5</td>
</tr>
</tbody>
</table>
Graphique 2.4
Intention d'utiliser la contraception par les femmes actuellement en union et non utilisatrices

A l'intention d'utiliser bientôt 50%
A l'intention d'utiliser plus tard 12%
NSP/ND 2%
N'a pas l'intention d'utiliser 36%

EDSR 1992