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Management Development Plan
for
Family Planning Management Training
in Rwanda

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RWANDA
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I. EXECUTIVE SUMMARY

A needs assessment mission to Rwanda was carried out by the Family Planning Management Training Project (FPMT) from June 2-13, 1986. The purpose of the visit was to analyze the management problems being faced by the Rwanda National population Office (ONAPO) and to propose a training plan to address those problems. The FPMT team consisted of Mr. Ken Heise, FPMT Operations Officer for Africa and Asia, and Dr. Marc Mitchell, a specialist in health management at Management Sciences for Health.

The team conducted an extensive series of interviews with key members of ONAPO, USAID, officials from the Ministry of Health and Social Affairs (MINISAPASO), and others involved in health and family planning in Rwanda. Visits were made to ONAPO staff in the prefectures of Kigali, Gitarama, and Kibungo, and numerous clinics offering family planning services were visited. A visit was also made to the construction site of ONAPO's training center at Kicukiro, a large complex scheduled for completion during the fourth quarter of CY 1986. Further information was gathered from project documents and reports.

In the short span of five years, the Government of Rwanda, through ONAPO, has taken major steps to address its population problem. Realizing that high population growth (over 3.5% per year) was impeding economic and social development, the GOR created ONAPO in 1981 to study the population problem and design programs and strategies to reduce population growth. To this end, ONAPO has undertaken a large and diverse IEC program, has worked with many ministries and agencies to enlist their participation in the effort to reduce population growth, and has worked through the health infrastructure, both government and mission, to make family planning services available. In general, ONAPO has made a successful beginning, and the groundwork has been laid for an expansion of ONAPO activities in the coming years.

ONAPO is a highly-centralized, autonomous organization within MINISAPASO. Simple, top-down management systems are in place and generally work well, although they place inordinate demands on the time and energy of top-level management. Should ONAPO continue to grow, both in terms of staff and program activities, the management systems currently in place may no longer suffice. Shifting greater management responsibility to mid-level managers at the central level, and to the ONAPO field staff at the prefectural level, would help to alleviate this problem.

The team identified several factors and problems that serve to limit acceptance of family planning services in Rwanda. These are:

1. Coordination at the National level between ONAPO and MINISAPASO;
2. Coordination at the prefectural level between ONAPO and the MINISAPASO medical/supervisory staff;
3. Insufficient number of personnel trained to provide clinical family planning services;

4. Cultural and religious attitudes which favor large families and discourage use of modern methods of contraception. There is not a strong traditional belief in the value of child-spacing for reasons of maternal and child health;
5. Restrictive eligibility criteria and conservative medical attitudes concerning the distribution of contraceptives;
6. Variable quality of supervisory visits for family planning;
7. Absence of a problem-oriented evaluation system, particularly with respect to IEC activities;
8. Deficient financial management and long-term financial planning.

A training approach to dealing with these problems is presented in the body of this report.

ONAPO is eager to participate in the training activities proposed in this report. However, given current budgetary problems, ONAPO is not in the position to use project resources to fund additional training activities. USAID is reviewing different options for funding assistance to ONAPO, but it appears unlikely that additional funds will be made available in the near future. Therefore, ONAPO participation in proposed training activities will be contingent upon FPMT or other sources of funding.

The inclusion of ONAPO personnel in Africa regional training is one way to reduce direct costs to the Rwanda program. In other instances, short-term technical assistance may be a cost-effective way to address some of the management problems described above. The assessment team feels that FPMT should commit its own resources to training programs in Rwanda to the extent that it is possible. The problems associated with rapid population growth are more acutely felt in Rwanda than in most other African nations. Despite the political risks, the GOR and ONAPO have taken important steps to slow population growth. The population program in Rwanda is relatively advanced compared to many other African programs; course materials developed for training in Rwanda could be adapted for later use in other countries as their programs mature.

II. DESCRIPTION OF ASSESSMENT

In response to a request from the OAR/Kigali Office of Health and Population, the Family Planning Management Training Project (FPMT) undertook a needs assessment mission in Rwanda from June 2-13, 1986. The purpose of the mission was to work with the Rwandan Office National de Population (ONAPO) to identify problems in program management and to develop a management development plan addressing those problems.

The assessment team consisted of Mr. Ken Heise, the FPMT Operations Officer for Africa and Asia, and Dr. Marc Mitchell, health management specialist from Management Sciences for Health. They worked closely with ONAPO staff and members of the USAID mission to develop the management development plan.

Over the course of the two week visit, the assessment team conducted a series of interviews and group meetings with members of the ONAPO National and Prefectural staff, representatives of the Ministry of Public Health and Social Affairs, USAID, and other organizations and individuals involved in family planning in Rwanda. The discussions served to familiarize ONAPO with the goals of the FPMT project, and to identify problem areas in family planning program management which could be addressed through training and technical assistance. A thorough review of reports and documents was helpful in clarifying many of the management problems identified and in planning for possible training activities.

Field trips were made to clinics and hospitals offering family planning services in Kigali and the prefectures of Gitarama and Kibungo. In each instance, the team met with the ONAPO prefectural team to discuss their activities and management problems. The visits to the clinics permitted the team to examine many aspects of the service delivery program, including patient record and filing systems, IEC materials, patient examination procedures, contraceptive supply management, statistics, and supervision.

The final days of the assessment team visit were spent developing the proposal for management training and discussing it with the ONAPO staff and the USAID Health and Population Office. Upon returning to Boston the team and other members of the FPMT project will review and further develop the proposed management training plan and submit a draft proposal of training activities to AID Washington for approval. Copies of the Management Development Plan will be forwarded to OAR/Kigali in July, 1986.

III. COUNTRY PROFILE

A. Economic and Social Indicators of Development:

1. Background

The Republic of Rwanda is the smallest country in Africa, about the size of Maryland (10,000 square miles), surrounded by Zaire, Uganda, Tanzania, and Burundi. The capital city is Kigali, a small city of about 150,000 people. Rwanda's terrain is mostly grassy uplands and hills. The climate is mild and temperate with two rainy seasons.

The population in 1984 was 5.6 million with an annual growth rate of over 3.5% and a population density of 220 persons per square kilometer (the highest in Africa). The population doubling time is roughly 20 years. Rwanda is one of the poorest countries of Africa with an average per capita income in 1984 of only U.S. \$270 per person. The country is divided into ten prefectures and 143 communes. The urban population represents only 5% of the total, with 93% of the work force engaged in agriculture. An interesting aspect of life in Rwanda, and one which influences the delivery of social services, is that there are very few towns or villages; instead, small family groups are scattered across the hilly landscape.

2. Economics

Virtually all arable land (48% of the total land mass) is cultivated in Rwanda and subsistence food agriculture is the main economic enterprise for the majority of the population. Rwanda's major export crops are coffee and tea. Minerals also provide another source of foreign exchange. The food production system is fragile and emergency assistance is often required to stem shortfalls due to irregular rainfall, soil depletion and other problems caused by years of intense over-cultivation. In recent years there have been large reforestation campaigns, and hillside terracing is becoming increasingly widespread.

Rwanda's 300 miles of paved roads are well-built and maintained. There is at present no railway system, and with the ports of Mombasa and Dar-es-Salaam over 1000 miles away, transportation costs associated with imports and exports are very high.

Rwanda takes a liberal approach to trade and investment. Sound monetary and fiscal policies have helped cushion the effects of the worldwide recession, and the GDP grew by 5% a year between 1974 and 1981. The average inflation rate was 6.3% in 1983. The prospects for continued economic growth are dimmed by the limited possibilities for economic diversification, Rwanda's small size and geographic isolation, and the continued high rate of population growth.

3. Politics

The government is currently led by Major General Juvenal Habyarimana who came to power in a military takeover in 1973. In 1978 he was re-elected to the presidency in national elections; moves toward full civilian rule continue, although real power remains for the moment in the presidency. Adult suffrage is universal, as is membership in the country's one political party, the National Revolutionary Movement for Development (MRND). The MRND extends down to the level of the prefectures, communes, and cellules. An elected legislative body, the National Development Council, has limited power. The 17 Cabinet ministers form a Council of Government, which serves as a consultative body to the President. The government is characterized by political moderation and fiscal conservatism and is committed to development goals including population control and national unity among the different ethnic groups.

4. Cultural and Religious Characteristics

The indigenous population consists of three ethnic groups: the Hutus, who comprise 85% of the population, are farmers of Bantu origin; the Tutsis, who comprise 14% of the population, are a pastoral group who until recently formed the dominant caste in a feudal system based on cattle holding; the Twa pygmies who now are only 1% of the population and were the original inhabitants of the area. Rwanda was a trustee territory of Belgium from 1916 until independence in 1962. Tensions between the Hutus and Tutsis have plagued Rwandan politics and are an outgrowth of the previous feudal caste relations. The major religion of Rwanda is Catholicism, although several Protestant denominations are also present. Together, they claim approximately 74% of the population, while the remaining 26% are moslems (1%) are followers of traditional African tribal religions. The major languages are French and the national language Kinyarwanda (a Bantu tongue).

The population is strongly pro-natalist, with both desired and actual family size among the highest in Africa. In contrast to most African countries, there exists no traditional belief in the importance of child-spacing. In fact, traditional customs, such as having sexual relations eight days after childbirth, tend to reduce the likelihood of well-spaced births.

5 Social Characteristics

Literacy rates for males and females are quite low, though the exact rates are unknown. The Bank estimates that roughly half of the adult population is literate, with a higher rate for men than women. Eight years of primary school attendance is mandatory and attendance is estimated at about 70%. Education is highly valued, but opportunities for post-secondary school education are extremely limited, especially for women. Women bear the brunt of both domestic and agricultural work, and pass most of their reproductive years either pregnant or lactating. Marriage is nearly universal with the average age at first marriage for women being 21 years.

6. Health Characteristics

Data on morbidity and mortality are incomplete and unreliable. Many illnesses go unreported, and a significant proportion of health care takes place outside the formal health care system. Nevertheless, all indications are that mortality is high in Rwanda. Infant mortality is an estimated 106 deaths per 1000 live births, and one child in five never reaches five years of age. Average life expectancy is 47 years. Malaria is the main cause of illness and leading cause of childhood mortality with diarrheal diseases and measles next. Maternal mortality is high. Since only 1/4 of births are attended, accurate figures on maternal mortality are hard to obtain, but the 1982 figure from health facilities was 2.1%. Sexually transmitted diseases and AIDS are of growing importance in the health picture.

Government health services are organized and delivered by the Ministry of Public Health and Social Affairs (MPHSA). There are ten medical regions corresponding to the ten administrative prefectures. Health services in the prefectures are coordinated by a Medecin Directeur de la Region Sanitaire, supported by a small technical and administrative staff. Directors of vertical or specialized programs (family planning, EPI) report to the Medecin Directeur and form part of the regional supervisory team. The current MPHSA organigram is attached as Annex I.

The MPHSA operates approximately 60% of Rwanda's health missions. The remaining 40% are operated by religious missions, primarily Catholic. Each mission facility follows GOR policies on health services, is the subject of a legal convention between the Government and the sponsoring church, and is supervised by the regional MPHSA team. Salaries of medical personnel employed in mission facilities are paid for largely by the MPHSA, with the missions frequently contributing a smaller percentage. The missions have formed a coordinating body called BUFMAR (Bureau des Formations Medicales Agreees du Rwanda) which represents the mission facilities in their dealings with the MPHSA. As the mission facilities often receive financial support, supplies and equipment from abroad, they tend to be in a better state of repair, and able

to offer a wider range of services, than the MPHSA facilities. At present, there are a total of 277 health facilities, as follows: 29 hospitals, 75 dispensaries, 136 health centers, 6 maternities, 25 infirmaries, and 6 specialized institutions. Many of the dispensaries will be upgraded to health center status during the course of a World Bank MCH/FP project with the MPHSA. The private sector for health care is very small. There are no doctors in private practice, and only a few commercial pharmacies exist. Traditional healers are numerous.

B. Demographic Information:

A 1983 National Fertility Survey in Rwanda has provided the first up-to-date demographic information in the country since the 1978 census. Of the total population of 5.6 million, over 46% are under age 15. The population growth rate of 3.6% is very high, reflecting both a very high birth rate of 53 per 1000 and death rate of 17 per 1000 (U.S., 6 per 1000). If current growth trends continue, the population will exceed 10 million by the year 2000. The total fertility rate (the average number of births per woman) of 8.6 is the highest in Africa. Knowledge of contraceptives is relatively high. Over two thirds of males and females of reproductive age know of at least one method of contraception. Contraceptive prevalence, however, is low. According to the 1983 survey, less than 1% of women use modern contraception, and 10% use traditional methods (abstinence, withdrawal). In contrast, about 25% know of a traditional method of abortion. More recent estimates place contraceptive prevalence (modern methods only) at approximately 3%. Out-migration reached major proportions during the 1960's, but has been reduced to very low levels in recent years. The government encourages internal migration towards less densely populated areas of the country. Rural to urban migration may become a problem as the pressures of population on available land increase. The capital city, Kigali, grew at approximately 9% per year during the 1970's.

C. Historical and Current Status of Family Planning:

Although Rwanda is hardly unique in terms of its rapid population growth and strong pro-natalist tradition, it differs from many African nations in two important respects: its high population density and small size, and the absence of a traditional emphasis placed on child spacing. The first factor has facilitated the adoption of a population and family planning program, while both have influenced the strategies used to develop support for it.

The pressures of the population on land and national development have been felt for many years. The size of family land holdings has decreased steadily, and nearly all arable land is under cultivation. Development efforts across all social sectors are hampered by the extremely rapid rate of population growth. Prior to 1981, family planning services were available in a few Protestant health facilities and government hospitals but had no

measurable impact on the growth of the population. The government's increasing concern throughout the 1970's over rapid population growth culminated in the creation of the National Office of Population (ONAPO) in 1981.

ONAPO is an autonomous agency under the Ministry of Public Health and Social Affairs. Its broad mandate is to plan and coordinate Rwanda's population program. Specific objectives, as stated in GOR Law No. 03 which created ONAPO, are as follows:

1. To study all matters relating to the growth of the population, and the impact of population growth on socio-economic development;
2. To sensitize all levels of the population to the demographic problems of the country (by means of) an information, education and training program that will respect the individual, and the liberty, moral and religious convictions of couples;
3. To ensure the appropriate use of family planning methods;
4. To study the means of integrating family planning services into primary health care, and advise the authorities at the Ministry of Health on how best to achieve this integration;
5. To propose natural solutions for achieving an equilibrium between production and demographic growth;
6. To participate in the elaboration of population education programs for schools.

The Office may engage in all other activities having a direct or indirect bearing on the accomplishment of these objectives.

ONAPO has grown dramatically in the past five years, now numbering approximately 150 central and prefectural employees. Support for ONAPO appears strong throughout the government hierarchy, although tension exists between it and the MPHSA, which is responsible for implementing family planning service delivery.

By sensitizing government officials and the population at large, and by making family planning services available in the country's health facilities, ONAPO hopes to attain a short-term stabilization of population growth at approximately 3.7% per year, and subsequently to effect a reduced rate of growth.

The use of family planning is completely voluntary in Rwanda. Motivated couples are urged to seek services from those hospitals and health centers (both government and church) where a variety of methods are generally available. Nurses and medical assistants provide most services, with doctors (at the hospital-level) available for referrals. Some contraceptives are sold in a limited number of pharmacies. CBD programs have not yet been tried in Rwanda and there is no private sector health structure through which contraceptives could be provided. All barrier and hormonal

methods are legal in Rwanda. Nearly half of all acceptors (1985) chose injectable contraceptives, followed by pills (38%) and IUD's (12%). Annex II shows the breakdown of contraceptive users by method and prefecture. The type of facility offering family planning services (by prefecture) is shown in Annex III. The status of sterilization procedures for non-medical reasons is ambiguous -- it is generally considered illegal but in the absence of a written policy, many doctors will perform tubal ligations as a family planning intervention. Abortion in Rwanda is illegal, and strict penalties may be assessed both the perpetrator and recipient.

Family planning services are not made available to adolescents or single adults. Women seeking services must generally be accompanied by their husbands or have his written permission.

In its first five years of existence, ONAPO has used a variety of methods and media to bring the population problem out into the open. High level conferences and meetings have served to focus GOR attention on the population problem, while a wide-reaching IEC campaign has sought to inform the general public of the growing imbalance between people, land, and resources. The growth in the number of family planning acceptors has been impressive, yet the total number of acceptors remains very low (less than 21,000 in 1985). Barriers to increased utilization include continued pro-natalist tendencies, deficient coordination and planning between ONAPO and the MPHSA, lack of trained personnel to provide services, and perhaps the position of the Catholic Church, although the degree of their influence on the contraceptive practices of the population is unknown.

Donors in the population/family planning sector channel their activities through ONAPO. Major donors include USAID and its cooperating agencies, UNFPA, and the World Bank. The UNFPA has financed long-term technical advisors to ONAPO, training for ONAPO staff, and supplied contraceptives and other equipment. The Bank has just begun a large MCH/FP project with the MPHSA, and will coordinate closely with ONAPO on family planning issues. The project calls for outputs in training, institution strengthening, human resource development, and population policy. See Annex IV for a listing of major project outputs. The IPPF supplies some contraceptives, and may support the creation of an affiliate family planning association.

IV. THE FAMILY PLANNING ORGANIZATION: ONAPO

A. Overview:

1. Background

ONAPO was created in 1981 in response to the GOR's concern over the impact of rapid population growth on the social and economic development of the country. Originally under the Ministry of Social Affairs, ONAPO is now an autonomous agency under the combined Ministry of Public Health and Social Affairs. Under the dynamic leadership of its director, Madame Habimana Nyirasafali Gaudence, ONAPO has grown in size and complexity while maintaining strong support from the top levels of government. Given its broad mandate (see above) this growth was inevitable, and ONAPO and the GOR should take no small satisfaction from the achievements so far attained.

To date ONAPO's main priority has been to raise and discuss population and economic issues at all levels of society, while proposing family planning as a viable intervention for bringing population growth into line with the country's economic potential. Less emphasis has been placed on training family planning service providers, although this is recognized as an important need and is being addressed through several cooperating agencies, notably INTRAH and JHPIEGO. In addition to training and IEC programs, ONAPO carries out family planning and IEC supervisory activities (largely through its prefectural offices), undertakes research and conducts studies, assures contraceptive logistics, and collects, analyzes and disseminates family planning services information.

ONAPO central staff occupy a large building in Kigali. This facility, which is rented, appears adequate for their needs. In addition to offices for ONAPO personnel, contraceptive and IEC materials are stored in the building, a room has been set aside as a computer lab, and there is limited space for producing audio-visual materials. Several large rooms at the new training center in Kicukiro have been reserved for producing audio-visual materials (dark room, studio, projection room), and should be more than adequate for ONAPO's needs.

In each prefecture ONAPO has an office staffed by a doctor, nurse, statistician, and IEC/social assistant. The bureau is often part of a hospital or health center complex. Vehicles placed at the disposal of each prefectural office are used for supervision and to assure the distribution of contraceptives. ONAPO does not own or operate any family planning clinics. Family planning services are delivered through the MPHSA health facilities and those hospitals and clinics operated by the Catholic and Protestant missions. ONAPO provides the training, some equipment and supplies, and the contraceptives necessary for delivering services.

2. Organizational Goals, Policies, and Strategies

The responsibility for studying and analyzing the country's population problem, proposing strategies to meet the problem, generating awareness and support for population initiatives, and organizing the delivery of family planning services, lies with ONAPO. It is to accomplish this mission through the definition of a population policy and the elaboration of programs that respect the rights, cultural values, and religious and moral convictions of the Rwandan people. ONAPO was created by Presidential decree and continues to enjoy strong support from the GOR. In many respects, it represents a model approach to dealing with questions of population, economic growth, and family planning. ONAPO is the policy-setting body in Rwanda for matters pertaining to population and family planning. It operates within the guidelines established by the Presidential decree of 1981, and in accordance with the GOR's Five-Year Plans.

Although family planning is recognized as being more than just a health intervention, the medical profession nonetheless exerts strong control over the delivery of services, often putting forth policies which effectively limit the potential number of family planning acceptors. These policies include: the limiting of family planning service delivery to hospitals and centres de sante; eligibility criteria which exclude adolescents, single adults, and couples with no children; extensive screening and laboratory tests for new users; and frequent follow-up exams for women using the Pill or IUD.

ONAPO is aware that these policies probably serve to discourage many women from accepting services. Steps are being taken, in fact, to introduce new client forms which do away with many of the screening and lab tests. On the other issues, ONAPO has chosen for the time being to accept the status quo and not risk alienating the medical and/or religious community. As the program grows and gains increasing acceptance, ONAPO may find itself in a position to work harder for changes which would favor increased availability and use of contraceptives.

3. Organizational Structure and Decision-Making

ONAPO is an autonomous agency within the Ministry of Health and Social Affairs. It is a relatively large agency, numbering approximately 150 employees, enjoys high levels of support from the GOR and the donor community, and is well known to the public. ONAPO has an Administrative Council made up of representatives from numerous ministries, including Health and Social Affairs, Agriculture, Interior, Higher Education, Primary and Secondary Education, and Youth. The Council provides ONAPO with broad program directives and approves ONAPO's annual work plan. It does not get involved in day-to-day operations at ONAPO, although individual members of the Council are in frequent contact with the Directrice of ONAPO.

Since its creation in 1981, ONAPO has been under the direction of Mme. Habimana Nyirasafali Gaudence. She has been and remains the driving force behind ONAPO's activities, and has effectively used her power and position to build up the resources and capacity of ONAPO. The growth of ONAPO has not come without a cost; namely, less than optimal relations with the MPHSA. The resultant lack of coordination and cooperation is unfortunate, as it has an impact on the delivery of family planning services.

The top management team at ONAPO would normally consist of the Directrice, the Chief of Studies and Programs, and the Chief of Administrative and Financial Services. Unfortunately, the latter position has been empty for over four years, leaving a functional and managerial void in a critical place in ONAPO's structure. With this position unfilled, an inordinate amount of administrative work falls on the Directrice and the Chief of Studies and Programs. Middle management consists of the heads of section of: General Accounting and Treasury, Management and Supply, General Secretariat and Public Relations, Research, Family Health, and Education and Communication. Middle level managers generally lack management experience, and are not encouraged to take initiative. Decisions are made, and planning is done, at the top levels with relatively little participation by mid-level managers.

General staff meetings are rare, perhaps non-existent. Top-level management meets frequently, though it is unclear how the results of these meetings are communicated to the rest of the staff.

ONAPO currently has three long-term advisors, one a general management expert supplied by USAID, the others a demographer and family planning expert supplied by UNFPA. In the absence of strong mid-level management, these advisors play a very important role in the design and implementation of ONAPO activities. They are also in an ideal position to transfer planning and management skills to their counterparts.

NOTE: At the time of the FPMT visit the ONAPO organigram was under review by the Administrative Council. One important proposed change is the creation of an evaluation unit reporting to the ONAPO director.

B. Planning:

ONAPO is an organization whose key decision makers understand what it is trying to do, what the major constraints to success are and what strategies are most politically and culturally acceptable in the Rwandan environment. As the most densely populated country in Africa, the government is motivated by the imminent problem of outgrowing the available land and other resources, and has a clearly stated policy of reducing the average family size from the current average of 8.6 children to approximately 6 children over the next 5 years. While even a reduction to 6 children per family may not be adequate to stem the significant increase in population expected during the next two decades, it is probably a realistic estimate of the impact one could expect from an active family planning program. The stated goal of stabilizing population growth at 3.7%, with a subsequent reduction, is probably realistic.

Consistent with its strategy of reducing average family size, ONAPO has planned and executed a multifaceted approach to achieving its objective. Because of the existing cultural and religious beliefs which are strongly pro-natalist and anti-family planning, ONAPO has emphasized the IEC component of its program in the first five years to make family planning understood and acceptable to a large segment of the population. They have done this through media campaigns, sensitization programs, and training of government workers, while at the same time making contraceptives widely available to those who desire them. Their campaign has consistently emphasized the economic and social imperative to reduce family size rather than the health aspects of child spacing. It is believed that by making information and contraceptives available to the population without trying to pressure people into their use, the population, confronted with smaller plots and rising financial expenses, will themselves embrace family planning. While this strategy may or may not be successful, it is at least rational and responsive to the difficult environment faced by a family planning program in a Catholic country.

While ONAPO's strength is in its development of a cogent strategic plan for family planning, its weakness is in the operationalizing of this plan in the day to day program at both the national and prefectural level. Although ONAPO has well-developed plans of what it will be doing next year, there is much less emphasis on what it will be doing next week. Its ability to manage the details of running a growing national program has at times been disappointing, as, for example, in the program planning for the training center soon to be completed; in its planning and supervision of the IEC program at the prefectural or communal level; or in its financial planning and control. To its credit, ONAPO does have a system of quarterly divisional workplans which appear to be regularly produced and reviewed. On the other hand, these workplans do not seem to have a significant impact on the organization's ability to effectively manage its operational program. A significant problem may be the inability to link the planning process with the

implementation process, a not uncommon problem in government organizations. To a large extent, this problem with operational management comes from the nature of the planning and decision making process at ONAPO.

ONAPO is a very centralized and hierarchical organization with virtually all responsibility for decision making vested in the Directrice. There is, in fact, an Administrative Council made up of senior members of the various GOR Ministries and other bodies concerned about family planning, but this council does not appear to have a significant impact on either the strategic or operational planning of ONAPO. It may be true, however, that in the earlier years of the program, this council helped to guide the initial policy decisions. At the present time, planning is strictly top-down since all financial and personnel decisions are made centrally, with little delegation of authority. This structure, which has facilitated the development of good strategic planning, has not been as successful at developing the ground-level operational planning required for day to day operations. Although a centralized planning structure may have suited ONAPO in the past, the rapid growth of the program and the organization have meant that top managers no longer have the time to focus on the operational issues for each division or prefecture. Although the implementation of decentralized decision making may be a difficult transition for ONAPO, its current ability to recruit well-trained and motivated staff puts it in a strong position to successfully delegate responsibility to the periphery, a necessary step for the long-term institutionalization of the program.

Another planning problem ONAPO faces is its ability to coordinate the resources of donor agencies to ensure the most efficient use of funds and expertise while at the same time satisfying the multitude of reporting requirements of these various donors. This is an area which has not been entirely satisfactory, particularly in the area of financial management and planning and is discussed further in that section of this report.

C. Program Management:

1. Service Delivery-Policy

The approach to the delivery of family planning services taken by ONAPO has been shaped by two key policy decisions made early in the development of the program. The first decision is that the quality of service delivery must not be compromised for the sake of expediency; the second is that traditional moral views must be considered in developing family planning eligibility guidelines. These policies, while certainly appropriate, have somewhat narrowed the availability of contraceptives to the general population.

It is important for any family planning program to ensure that the quality of service delivery is maintained. This quality assurance, however, must always be balanced with the desire to make contraceptives available to the widest possible audience. This

balance is highlighted in the area of community based distribution where wide access is provided at the possible expense of quality assurance of client screening and monitoring. Rwanda has chosen not to promote community based distribution. In the same light, Rwanda has pursued a policy of extensive medical and laboratory screening for all new contraceptive users, frequent checkups for continuing users, and dispensing of hormonal and IUD methods of contraception only by physicians and specially trained grade "A" nurses and medical assistants. The result is that contraceptives are effectively inaccessible to a large population who might otherwise use them.

While Rwanda has been somewhat narrow in its views of who can distribute contraceptives, it has been quite broad in its policies regarding what types of methods may be used. With the exception of abortion (which carries stiff criminal penalties for both doctor and patient) all other reversible methods, including injectables, are promoted. There was a controversy regarding the use of injectables, but that has since been resolved in favor of its use.

As with quality control, the decision to respect the traditional moral values, while no doubt appropriate, has somewhat narrowed the target population of family planning acceptors. In a society which promotes premarital celibacy but highly values marital fertility, the use of contraception before marriage or before the birth of the first child is not acceptable. For this reason, many family planning clinics do not distribute contraceptives either to unmarried females (or, theoretically males), or to married women prior to the birth of their first child. In a rapidly changing society such as Rwanda, this practice may withhold contraceptives from sexually active women who would prefer to postpone either marriage or the birth of their first child. A second factor limiting access for women is the requirement that the written consent of their husbands be obtained prior to dispensing of any contraceptives. Since many men are illiterate, their physical presence may be required to ensure their consent, a requirement which may be unacceptable or impossible for many men to satisfy. While consent of the husband is of paramount importance in matters relating to childbearing, the mechanics of this requirement may mean that many women are effectively restricted from using contraceptives.

2. Service Delivery-Program

Service delivery of family planning in Rwanda is provided through the existing Ministry of Health infrastructure. That infrastructure is a decentralized pyramidal system beginning with the central Ministry of Health and Social Affairs (MINISAPASO). At the prefectural level, the Medecin Directeur is in charge of all health services including family planning. Each prefecture has at least one hospital, and many centres de sante staffed by nurses and medical assistants. Below the centres de sante there are a variety of other health facilities including nutrition centers, maternities, and dispensaries. For all practical purposes, family planning is carried out only at the centres de sante and hospitals, since the other facilities do not have personnel trained in family planning.

The ONAPO structure parallels the MINISAPASO down to the prefecture level. ONAPO has a four person team in each prefecture including a physician, a nurse, an IEC coordinator, and a statistics clerk. The prefectural team provides three services to the system: training, IEC, and supervision. Since few MINISAPASO staff have prior training or experience in family planning, it is the responsibility of the ONAPO team and in particular the doctor to teach the health staff the basics of anatomy, physiology, and family planning service delivery. This program, while operational, has not had the success one might like, in part due to the absence of a specified curriculum or training materials. This problem is being remedied by ONAPO with the development of a manual to be used both in training and for reference by the health personnel. Further augmentation of the training component is expected from the upcoming World Bank project, and through assistance provided by INTRAH, JHPIEGO, and others.

These parallel MINISAPASO/ONAPO systems have posed significant organizational problems for the program. The ONAPO physician in each prefecture is responsible for the training and supervision of MINISAPASO staff in family planning. He does not have any line authority over these people, and relies on the Medecin Directeur to provide this authority. In instances where family planning is not a high priority of the Medecin Directeur it may be difficult to promote the program to these MINISAPASO staff. This problem is discussed more fully in section VII.

Another area where integration of ONAPO into the service delivery system poses a problem is the private, mostly church, health services, which represent 40% of the total health services delivered in Rwanda. A majority of these services are provided through Catholic missions which, with a few exceptions, will promote only the less effective "natural" methods. The church health services are organized through the BUFMAR council whose function is to coordinate these services with the government, provide some technical and logistical support, and provide a forum for policy discussions. Although most of the representation is from Catholic missions, this agency has been very careful not to intervene in family planning policies, and has been generally supportive of ONAPO's efforts. This remains a delicate balance for ONAPO since the support of this body is critical to the success of a nationwide family planning program.

The IEC activities at the prefectural level consist of two types of programs. The first is called "sensibilization" where large groups of men and women are gathered and discussions of the merits and techniques of family planning are presented by the ONAPO staff. The idea is to refute some of the more prevalent beliefs about the spiritual and physical dangers of family planning. The second type of program is to train selected women in the basics of family planning who then return to their villages and discuss these matters with others. These two programs have been quite successful in disseminating information but have had less success in convincing couples to actually use contraceptives. This lack of direct impact may be influenced by two factors. The first is the lack of

specificity of the messages being taught. Thus, while the merits of family planning and the dangers of unchecked population growth are emphasized, IEC activities do not usually confront the specific objections raised by the Church, among others, to family planning. There is not a clear strategy for dealing with the considerable opposition found in Rwanda to a family planning program. The second factor undermining the success of the IEC program is the absence of a strategy down to the commune level outlining how educational and informational material can be promoted. Each of these problems is considered later in this report in the section on training strategies.

The third area of responsibility for the ONAPO prefectural team is supervision. It is the responsibility of the ONAPO team to go out to each of the centres de sante and oversee the family planning work which is being done, provide help for any difficult or complicated cases, and collect statistical information from each of the centers. The teams are to be commended in that they do in fact make supervisory visits on a more or less regular basis and do try to collect the statistical data from each center. On the other hand, the quality of the supervision is uneven, and there is no formal planning of a regular supervisory schedule. Supervisors are often uncertain about what their role should be when they make these visits and, as a result, the visits are often short and rather perfunctory. This may in part result from the very brief pre-service and in-service training which is provided to ONAPO staff. What is needed is a standard supervisory protocol and clearly defined supervisory objectives to facilitate the supervisory process and improve the quality of this important function of ONAPO.

3. Referral System

As with the service delivery system, the referral system for family planning problems is primarily through the existing health system with supervisory back-up provided by ONAPO. Women who are found to have problems exceeding the competence of the nurse in the centre de sante are referred to the nearest hospital to be seen by a physician there. While in some cases the ONAPO physician may subsequently be contacted, in general, the next step of referral would be to the nearest gynecologist. While this type of referral pattern does tend to "medicalize" the use of contraceptives, in most cases, it probably functions quite adequately. The only concern is that it may tend to exclude women from using contraceptives because of minor medical considerations without fully weighing the associated risks of pregnancy and childbirth.

4. IEC

The strength and stature of ONAPO has been developed in large part through its IEC program. Because ONAPO recognized early that any hope of widespread use of contraception in Rwanda would require a prolonged and extensive IEC campaign, significant emphasis has been placed on this aspect of its work. This work has been helped by the information provided from the excellent National Fertility Survey done in 1983. Some key results from this survey which have shaped IEC programs are:

- o the average completed fertility is 8.6 children;
- o 20% of fertile women want no more children;
- o the desired live births per fertile woman is 6.3;
- o 67 % of women knew about at least one method of contraception;
- o 40 % of women would like to use contraception at some time;
- o < 1 % of eligible women were using modern contraception;
- o duration of breast-feeding averages 21.1 months;
- o post-partum abstinence averages only 8 days.

The IEC division of ONAPO headquarters has been unusually creative and productive in their efforts to promote family planning, with the result that ONAPO is widely recognized and well thought of throughout the country. Their efforts have focused largely on four strategies. The first is to work with key Ministers, top government decision makers, and other officials to help them understand the importance of family planning on the entire economic and social development of the country. This effort, supported by the President, has enabled ONAPO to integrate their program into other government Ministries. The second strategy is on the use of IEC coordinators at the prefectural level, which has been discussed above under service delivery-program. The third strategy has been the use of mass media and promotional material. For this, a popular weekly radio program has been developed which apparently is widely listened to and enjoyed. In addition, a wide array of expertly done posters, calendars, and other promotional material is produced and distributed throughout the country. The fourth strategy is the development of publications for use by both ONAPO staff and the general population. To this end, a quarterly journal is produced for ONAPO staff in which policy, descriptions of other FP programs around the world, and technical articles are included in French. In addition, a set of 3 pamphlets describing the rationale and use of family planning in the local language, Kinyarwanda has been produced. While unable to evaluate the messages in these pamphlets, the technical quality and the wide use of graphic illustrations were good. The new training center at Kicukiro, which will include extensive facilities to support the IEC program, will undoubtedly contribute to the already excellent production record of the IEC staff.

While the production of very high quality IEC materials has been impressive, the overall impact of the IEC program is less clear. To date, no evaluation of the IEC program has been undertaken, although it is recognized that this is an important area of consideration. One of our concerns is that most of the material has not been pre-tested, and no market surveys have been done to evaluate the current attitudes of the population toward family planning. Thus, while the messages promoted by ONAPO appear reasonable to us, there is no verification that they have had any impact on the target population. This concern, and a suggested strategy is discussed later under Proposed Training Activities.

5. Key Management Support Systems

ONAPO is largely the product of its Directrice, who continues to keep a very close rein over all its activities. As a result, the management systems which have evolved are very centralized and rely heavily on the skill and energy of Mme. Habimana. This type of system has been both effective and efficient in the development and early implementation of the family planning program in Rwanda. However, as the program grows, it will no longer be possible for a centralized bureaucracy to manage all the day to day activities. The concern, then, is not that the current systems are inadequate but rather that ONAPO may begin to outgrow these rather rudimentary systems in the near future. This concern was described earlier with regard to the operational planning function. It relates more broadly to many of the management systems which are currently in place.

ONAPO is responsible for the provision of all contraceptives within Rwanda, and as a result, operates an independent logistics system. Contraceptives are supplied entirely by donor agencies, the largest being USAID, but including also UNFPA and IPPF. On entering the country, contraceptives are stored at ONAPO headquarters in a small but adequate room used only for this purpose. Records kept there of inventories and use were, according to a CDC consultant in Rwanda at the time of our visit, reasonably accurate. A file clerk is responsible for record keeping and maintaining inventories, although it appeared that her supervisor in fact did the ordering. While record keeping was good, and inventories more than adequate for the very limited demand, the reordering of stock when inventories were low appeared to be somewhat random, and neither the clerk nor other ONAPO staff were able to specify how they knew when to reorder supplies. For the present, with very low demand and more than adequate storage, this does not seem to pose a significant problem, and stockouts are very rare. In the future, with greater demand, some more systematic procedure for ordering will be required to ensure an uninterrupted supply of contraceptives.

The system in the prefectures parallels the system at ONAPO. Supplies are kept in a cabinet at the ONAPO office in each prefecture, and are dispensed as needed to the centres de sante. Records are kept, stocks resupplied on an ad hoc basis, and stockouts rare. Perhaps the key to this simple but effective system is the small size of the country and the small demand. No

prefectural capital is more than a two or three hour drive on good roads from Kigali, and several months stock for any prefecture would easily fit in the trunk of a car. Resupply of prefectural stocks is simply a matter driving to the capital and taking home what is needed, a trip taken frequently by the ONAPO prefectural doctors. There is no need for a more sophisticated delivery system. Again, however, the concern is whether the program will outgrow this simple system as demand and required inventories grow. This is not to suggest that a new system will be needed; rather that the limits of the current system should be compared with the expected future demand of the program to see whether the current system will remain viable in the future.

5a. Financial Management

Financial management is an area of considerable concern for both ONAPO and USAID/Rwanda. As with other management systems, the financial control system is a very simple one. Records are basically kept on a cash basis (although accounts payable are recorded), and control is effected through the requirement that all commitments and disbursements (checks) be signed by the Directrice. Financial information is prepared on a 6-month basis and summarizes funding and expenditures to date. This system, while straightforward, may not be sufficient for managing the complex nature of the multiple donor reporting requirements and the many projects funded through ONAPO. While donors require the separation of funds, it is not clear whether separate accounts are, in fact, maintained. This has been rather frustrating for USAID, the largest single donor agency, as the most recent accounting audit indicates that ONAPO has presently overspent its total project operating budget by 200% despite previous quarterly reports to USAID which did not indicate that such a problem existed. There is no question of the integrity of the ONAPO staff, but rather a question of the adequacy of the financial control mechanisms in place.

One clear problem which ONAPO must face in this regard is its inability to fill a vacancy for the position of Financial Manager. At present, this function is more or less done by a junior accountant, and the need for a senior administrator in this key position is apparent. In addition, more complex systems will be required to ensure that financial management and expenditures are consistent with both the resources available for program implementation and the priorities which have been established for ONAPO. A USAID consultant has been hired on a temporary basis to try to sort out some of these financial management problems facing ONAPO and will begin his consultancy next month. Our findings were discussed with him.

With regard to funding options and long term sustainability of current funding levels, it appears that little consideration has been given to this problem beyond the end of USAID support. User fees have been rejected as nonviable given the low economic development of the country and the low use of contraceptive products compared to the overall cost of the program, and other

likely donors already contribute to the program. While it is probably realistic to assume that USAID will continue its funding beyond the end of the current project, the USAID mission director voiced concern over future funding levels, particularly for the short term given the very limited operational funding remaining for the final two years of the current project. Thus, the financial picture for both the remaining two years of the current USAID project and beyond is uncertain.

D. Evaluation Systems:

1. Management Information Systems

Information collection, processing and use is generally satisfactory. An excellent National Fertility Survey done by ONAPO in 1983 has provided a basis for planning and measuring future progress of the family planning program. Monthly reporting from each center to the prefecture and central office is generally complete for 1985 although 1986 figures have been slow in coming. Records are kept and analyzed on each acceptor using standard statistical packages and 2 IBM-PC's under the supervision of a well trained and very capable statistician. Records from each centre de sante are aggregated at the ONAPO prefectural office and then sent to headquarters on a quarterly basis. At the time of this writing, however, several prefectures were 1-2 quarters behind in their reporting. These records include the number of users, details on each new user, the number of people who listened to IEC talks, and the number of supervisory visits. Although it appears that little analysis of these figures is done at the prefecture, the ONAPO teams did have a general sense of where there were problems. Information collected and forms used were generally appropriate except that no mechanism was available to review dropouts and consider factors which might affect contraceptive user continuation rates.

The only significant criticism of the information system is with the use of information for planning and modification of existing programs. While ONAPO staff had a good idea of how well their program was doing, they did not have a good idea of how to use the available information to make the program better. This was a particular concern in the area of IEC, where no evaluation had been done, and in service delivery, where program staff had little insight into how best to modify the program to make it more effective. In general, this question of evaluation of existing programs is an area where ONAPO has been somewhat weak. Indeed, ONAPO itself has recognized this and is in the process of creating an evaluation and planning unit which will report directly to the Directrice. This will be a significant improvement in the way that program effectiveness is actually monitored.

V. TRAINING INSTITUTIONS

USAID is funding the construction of a large, impressive training facility at Kicukiro, located on the outskirts of Kigali, not far from the ONAPO headquarters. Progress towards completing the Training Center has been irregular, as problems were encountered initially finding a location for the Center, and later when plans for the Center changed and funding was temporarily halted. Current estimates call for a completion date of August, 1986, although we feel that October is a more realistic target.

When completed, the Kicukiro Center will offer ONAPO an excellent opportunity to provide a wide variety of training. The Center will be able to accommodate 60 residents, each with a private room, and food will be prepared and served in the Center's cafeteria. There are several large classrooms, one of which can be used for showing films. Several rooms are reserved for producing audio-visual materials, including a dark room, print materials workshop, and a studio. The Center will have a library and study area as well. One entire section will house the administrative staff of the Center.

Staffing for the Center has not been announced as of this writing. It is presumed that the head of training for ONAPO, Mr. Sixte Zigirumugabe, who has a master's degree in Psychopedagogy, will be the director of the Center. We were not able to determine the size of the training staff, the degree of administrative and financial autonomy the Center will enjoy, or, in fact, the precise role, goals, and objectives that the Center is to have. We suspect that these issues are delicate ones and will be clarified in the near future.

We feel that the Kicukiro Center has the potential to become an important training resource, not just for ONAPO or other GOR ministries and agencies, but for Africa region programs as well. To become an effective training center capable of providing diverse, quality programs, ONAPO will need to invest heavily in the development of a management and training team. INTRAH will work with ONAPO to help develop a training team at Kicukiro. We strongly urge that this important effort be complemented by training in the management of a training organization. This is discussed in greater detail in section VIII. PROPOSED TRAINING ACTIVITIES.

NOTE: The PRITECH mid-term evaluation recommended that ONAPO consider building its Training Center as a part of the proposed Kigali Regional Office and Family Planning Services Center. This would have enabled clinical training to take place at the Center. Unfortunately, this was not possible to do, so practical clinical training will continue to be provided in clinics in the Kigali area, primarily the Centre Hospitalier de Kigali (CHK).

VI. TRAINING ACTIVITIES

Training has always been a major focus of ONAPO activities, and this will continue in the coming years. To date, in-country training activities have fallen into three general categories: non-clinical training, clinical training, and training of trainers. In addition, a large number of ONAPO staff, and key persons from other ministries, have followed training courses abroad.

1. **Non-Clinical Training:** Given the newness of family planning in Rwanda and the obstacles (cultural, religious, traditional, medical) to its widespread acceptance, ONAPO has chosen to concentrate its training efforts on family planning auxiliaries. These trainees are frequently social workers, nurses, or nutrition instructors who work in a setting which affords them ready contact with the population. The purpose of this training, typically done in two week sessions, is to enable the participants to become effective motivators and advocates of family planning. The course content includes material on the demographic situation in Rwanda, its impact on development and economic growth, an overview of reproductive health and physiology, the relationship of family planning to maternal and child health, a discussion of different contraceptive methods, and the problems of infertility and STDs. In addition to these content areas, the course develops communication skills for use with adult audiences. At present, the course does not allow for practical training, a shortcoming that ONAPO is aware of and hoping to rectify. Participants with both medical and non-medical backgrounds currently take the course together. We were informed that in the future the participants will be divided and the training material adapted to each group's particular needs and level of understanding.
2. **Clinical Training:** In the future, ONAPO will place greater emphasis on clinical training for family planning providers. The current shortage of well-trained service providers could become critical as the program seeks to expand its scope and impact in the coming year. Doctors and nurses receive very little pre-service exposure to family planning, and most finish their studies with no practical family planning experience whatsoever. They are therefore unprepared to provide services or counseling, and must gain these skills either through in-service training courses organized by ONAPO or by "apprenticing" with an experienced person. Much of the in-service clinical training to date has been provided outside Rwanda by U.S. cooperating agencies. As the number of acceptors in Rwanda grows, clinical training will increasingly take place in-country. INTRAH has proposed collaborating with ONAPO to provide clinical training, develop family planning curricula for various levels of medical and non-medical personnel, in addition to providing non-clinical training (TOT, management training, secondary school curricula development, etc.) JHPIEGO will continue to play an important role in training for surgical contraception, diagnosis and treatment of STDs, and in the management of infertility.

3. Training of Trainers (TOT): With INTRAH's support, ONAPO has conducted and plans to continue offering TOT programs of both a clinical and non-clinical nature. The development of a strong cadre of trainers is critical to the success of the new ONAPO training center at Kicukiro, described in more detail above, and should in the long run enable ONAPO to realize important savings in their training budget.

VII. STRATEGIES FOR TRAINING AND TECHNICAL ASSISTANCE

A. Overview:

In many respects, ONAPO is the model of what a Government family planning organization should be. It has and continues to define and promote GOR population policy with the explicit support of the very highest levels of government. It strives to work through and support the existing health infrastructure through training, IEC activities, evaluation and provision of contraceptive supplies. It has attracted competent and apparently dedicated staff in most key positions at headquarters. Its output in terms of publications, workshops, supply logistics, and government support has been impressive in its first five years of operation. However, while the number of contraceptive users has grown rapidly in the past few years, the total number of acceptors remains disappointingly low. The National Fertility Survey carried out by ONAPO in 1983 indicated that less than 1% of eligible women had ever used modern birth control methods, although 2/3 had spontaneous knowledge of at least one modern method. More current information indicates that at present the number of users has risen only to 3%, with most of these in the urban areas, particularly Kigali. The question, then, is why ONAPO has not been more successful in promoting the use of modern family planning methods and what can be done to rectify the situation. Before looking at some of the problems facing ONAPO in achieving wider contraceptive use, let us first look more closely at how ONAPO has achieved the successes that it has.

ONAPO is a fairly small and very centralized organization under the very capable leadership of its Directrice. Through the selection of well-qualified and competent individuals in key management positions, her continued involvement in the policies and operations of the entire organization, political connections, and the ability to predict and pursue successful strategies in an environment which is both traditionally and religiously pro-natalist, Mme. Habimana has been able to considerably expand the organization and the range of its activities. Policy decisions which have been critical in promoting the long term survival of ONAPO have included pursuing a strong IEC program aimed at other government agencies and departments as well as the population as a whole, the integration of service delivery with the existing health infrastructure, and the concentration of the program on the demographic and economic imperatives of overpopulation in Rwanda. These strategies have prompted strong support for the program from the Government, including the explicit support of the President, while avoiding serious confrontation with the Catholic church, which predominates in the country.

A second area which has contributed to the relative success of ONAPO is the dominance of simple but effective management systems appropriate for a small organization. The entire management structure of ONAPO itself is, in fact, very simple. Within the national office, there are basically three levels of authority: the

Directrice, the section chiefs, and the staff. Decisions are apparently taken from the top down. While not participatory, the system is fairly efficient given a strong and capable directrice. While their success in designing strategies has avoided many of the more basic problems frequently found in family planning organizations, they now face the more complicated task of refining their program to confront those issues preventing more widespread use of contraceptives in Rwanda. Consequently, many of the training recommendations are for more advanced courses than will be needed at present in many other countries in the region. This presents a problem given the limited funding base and size of the country. One can perhaps justify committing resources, however, in the expectation of the development of training materials which will be of more general use in the future. Before moving on to discuss specific training options, however, we will first briefly review the existing management systems in place at ONAPO.

Contraceptive logistics are straightforward. Contraceptives are stored in a room in ONAPO headquarters, controlled by a stock clerk and distributed through the prefecture ONAPO doctors who must come to headquarters whenever they need more supplies. Because the volume of contraceptives is small and the distances to travel are generally short, this system functions well. No clear system has been developed for forecasting contraceptive requirements either at the national level or the prefecture. However, given the relatively large supplies on hand and the generally low demand stock-outs have been very infrequent. Thus, the system which has evolved is well-suited to a program with low demand and easy access to stocks. The only question here is whether the system will remain adequate with a continued growth in the number of family planning acceptors.

Information collection and supervisory systems, as with the logistics system, are uncomplicated and generally successful. Information is collected monthly from the centres de sante and hospitals and summarized by a full time statistical clerk at the regional ONAPO office. Records are relatively complete, and at the prefectural office which we saw, centres which did not report in the previous month were scheduled for supervisory visits to see what the problems were. While little analysis appeared to be done at this level other than data aggregation, the records did provide an easy reference for analyzing usage trends or comparisons. This information is then passed on to the national office and entered into a computerized system under the direction of a very well qualified and capable statistician. Yearly and semi-annual reports are then produced summarizing the contraceptive usage information. Copies of the yearly reports are sent to the ONAPO team in each prefecture. The ONAPO prefectural staff we visited performed supervisory visits, although not as often as they had planned. Despite the lack of supervisory instruments or protocols, the ONAPO staff did seem to have a sense of what the problems were and what activities were going on in the prefecture. Again, a simple, but somewhat informal system seems to be working well given the small size of the program.

The planning system is straightforward and seems to work relatively well. Global strategies are developed, some type of intermediate objectives are set (at times by external donors), and workplans are written. The workplans are reviewed at three-month intervals by the ONAPO senior managers. While the relationship between the workplans and the objectives is somewhat loose, there is at least some correspondence between the two. Furthermore, it appears that supervisory visits are actually made, vehicles are running, posters, pamphlets, and radio programs are produced and distributed, and yearly reports are written and circulated. In part this ability to generate outputs may be due to the fact that ONAPO has spent considerably more on operating expenses than was budgeted for, with the deficit being carried by USAID. Indeed, the one significant problem in the area of planning is financial planning and control which may in part be due to the vacant position which exists in ONAPO for a financial manager. Indeed, the whole area of financial management has been a concern of USAID and one which needs to be considered in planning for future needs of ONAPO management.

In summary, we find that ONAPO is a relatively well-managed, if highly centralized organization. Systems which have evolved are for the most part appropriate to the size and volume of work at ONAPO. On the other hand, the systems rely heavily on the energy and competence of a few individuals and may be less effective as the organization and its program grow, or as personnel changes take place. For the short to medium term, however, it is our impression that more formal and complex systems are not needed and might be counter-productive. The problem remains, however, that despite the relatively efficient and well-run organization at ONAPO, contraceptive prevalence rates are very low. We must turn our attention, therefore, to what factors contribute to this.

B. Constraints Limiting Expansion of Contraceptive Usage:

We have identified several constraints which may explain the low contraceptive prevalence rates: coordination between ONAPO and the Ministry of Health and Social Affairs (MINISAPASO); separation of responsibility and authority for family planning at the prefectural level; limited availability of trained staff at the service delivery level; cultural and religious attitudes of the population, and; the policies regarding eligibility criteria for contraceptive use.

1. Coordination between ONAPO and MINISAPASO

ONAPO has attained many of its impressive achievements through the efforts and energy of its Directrice. Under her guidance, ONAPO has grown in both size and stature as an independent parastatal organization, with its own program, personnel, and budget. Within the government bureaucracy, however, ONAPO is part of the Ministry of Health and Social Welfare and therefore comes under its direction. In part because of the autonomy and success of ONAPO's program, there has developed a tension between them and MINISAPASO, a not uncommon finding in situations of this kind. The result of

this tension is that while officially committed to family planning, MINISAPASO officials may in fact emphasize other aspects of their program to the detriment of family planning. This creates a problem for ONAPO as they do not provide direct client services but rather work through the existing health infrastructure. While this problem is central to the long term success of ONAPO, it can only be rectified through the political structure and processes of the country, and is an issue which should not be addressed within the context of the FPMT project.

2. Regional Coordination of the Family Planning Program

Rwanda, like many countries, has a decentralized health structure wherein the responsibility and authority for the provision of health services lies with the provincial rather than national health staff. In each prefecture the medecin directeur oversees all health services including the hospitals, centres de sante, and infirmaries. His authority also extends to the provision of family planning services through these facilities. There is, however, in each prefecture a parallel administration for family planning under the authority of ONAPO, consisting of a physician, a nurse, a statistician, and a "sensibilisateur". The link between these two structures is problematic. In theory, the ONAPO team in the prefecture should report to the medecin directeur on all technical matters; in practice, there is room for greater collaboration between the two. While it appears that the relationship between the ONAPO doctor and the medecin directeur is generally cordial, the latter sees family planning as largely the responsibility of ONAPO, while ONAPO has no authority over the health staff who must, in fact, implement any family planning services in the prefecture. This is a problem, for example, in the areas of supervision and data collection. Because few of the MINISAPASO staff have any training in family planning, supervision is left to the ONAPO staff. However, since the ONAPO staff have no line authority over the MINISAPASO staff, their advice may be neither sought nor listened to. Similarly, data collection for family planning is done through the health facilities and then sent to ONAPO; however, because ONAPO has no authority to demand this information, reporting is often delayed and incomplete. Unlike the first problem of coordination at the national level, the problem of regional coordination is more amenable to non-political interventions. Indeed, a workshop for this purpose was developed and run by ONAPO, and this would be an appropriate area for follow-up within this project, and is discussed below.

3. Limited Availability of Trained Staff at Service Delivery Level

The training of health staff to provide family planning services is the basis of making contraceptives available to the population. ONAPO has organized several clinical training courses but there remain many centres de sante and other health facilities where trained staff are not available to provide family planning services. As long as contraceptives and family planning advice are not available at all health facilities, these services will

remain out of the reach of many women desiring contraceptives. At present, women in rural areas may walk 10-20 kilometers to obtain family planning services. Until services are brought closer to the population, a large unmet demand for contraceptives will remain.

4. Cultural and Religious Attitudes

A problem in many countries which mitigates against the widespread use of modern contraception is the cultural and religious beliefs of the population. This is especially true in Rwanda which is predominantly Catholic, and where the average number of live births per fertile woman exceeds 8, and where even today the median desired family size is over 6 children. Traditional practices such as prolonged periods of abstinence after childbirth, post-partum sexual taboos, and a wide range of traditional family planning methods, are for the most part not found in Rwanda. In fact, the custom is to recommence sexual relations 8 days after childbirth. The church, while officially not interfering in ONAPO's activities, is apparently cautioning churchgoers about the dangers of "unnatural" family planning and may significantly contribute to the low contraceptive prevalence rate. Given these major obstacles to widespread acceptance of family planning, the role of IEC takes on primary importance. The ONAPO IEC program, though impressive in terms of outputs, has not devoted sufficient time to the identification of appropriate messages or strategies, and has done little systematic evaluation of the impact of its activities. Improvements in these areas are critical to the long-term success of the program.

5. Policies Regarding Contraceptive Eligibility

In order to achieve the widest possible coverage in a family planning program, one would ideally like appropriate contraceptive methods to be available to anyone desiring them. Frequently, however, unduly restrictive eligibility requirements for screening and distribution of contraceptives limit the population for whom it is available. Unfortunately, this is the case in Rwanda, because of the conservatism and reluctance of the medical community to give up control of anything related to medical care. Screening procedures for most types of contraception require a complete physical exam, blood and urine testing and vaginal cultures. While perhaps desirable in a different setting, these requirements, if enforced, would limit the distribution of contraceptives to hospitals where physicians and laboratory facilities are available. In the centres de sante, where the majority of family planning service delivery takes place, lab tests are routinely waived because of the inability to perform them. The practice of requiring frequent follow-up exams for acceptors, and the limiting of pill distribution to three cycles at a time, also places a burden on the family planning user, who may live 10 or more kilometers from the nearest centre de sante. We are encouraged to note that ONAPO is in the process of revising its client forms, eliminating many of the lab and exam requirements. While the medical risk of inappropriate distribution of hormonal contraception should be considered, it must be weighed against the not insignificant risk of pregnancy-related morbidity, mortality,

and unwanted pregnancies, particularly in a country which is rapidly outstripping its capacity to produce adequate food and fuel supply for its rapidly expanding population.

A second factor significantly limiting the population for whom modern contraception is available is a policy limiting contraception only to married women who have the written consent of their husbands. This is further restricted in some instances to only women who have at least one child already. While it is of course desirable for a spouse to concur in decisions related to child-bearing, the mechanics of this requirement often necessitate the physical presence of the husband at the time of the consultation, which is in many cases impossible or unacceptable to the man. Again, the net effect of this requirement is to limit the number of couples or individuals for whom contraceptives are actually available. While the role of this project is obviously not to interfere in the policy decisions of the Government related to family planning, it may be appropriate to support key decision-makers in their understanding of the implications of many of these policy decisions.

A third area of concern is the policy, or lack thereof, defining who can distribute what type of contraceptive. At present all types of contraceptives must be distributed by doctors, high level nurses, or medical assistants, who do not commonly work below the level of the centre de sante. This means that couples seeking contraceptives must often travel long distances even when a lower level health facility is nearby. To a certain degree, this problem will be addressed in the World Bank Sante Familiale project, which will help increase the number of centres de sante offering family planning services. Alternatively, some mechanism could be adopted whereby after the initial visit, follow up visits could be done at these lower level health facilities in some cases.

Dealing with these constraints is important to the expansion of the family planning program in Rwanda. We support ONAPO's efforts in effecting policy changes supportive of family planning, and encourage them to continue. In addition, we note that some of the constraints will be met by training programs provided by JHPIEGO, INTRAH, and The World Bank.

VIII. PROPOSED TRAINING ACTIVITIES

To help address the problems described above, we have elaborated several specific training proposals. It should be noted, however, that other agencies (JHPIEGO, INTRAH) or donors (World Bank) may offer courses of a similar or complementary nature. Every effort should be made to coordinate eventual training in order to avoid any duplication of effort.

PROBLEM: MANAGEMENT OF ONAPO TRAINING CENTER:

The ONAPO Training Center at Kicukiro is expected to open sometime during the fourth quarter of CY 1986. To date much of the planning has centered on constructing the building. Specific program objectives and management systems have not yet been defined. A director has not yet been named, staffing is uncertain, and it is unclear what degree of financial and administrative autonomy the Center will have. As ONAPO's program activities expand, and as other population/family planning initiatives begin (World Bank, Family Planning Association) the role of the training center will become ever more important. A well-managed, effective training program could play a crucial role in enabling the GOR to achieve its demographic objectives. On the other hand, poor management and inappropriate training courses or methodologies would severely limit the impact of ONAPO's program and call into question the wisdom of financing a high-profile training center.

GOAL:

1. To develop management systems which enable the ONAPO training center team to effectively manage the training center.
2. To develop a cadre of effective management trainers through the training of ONAPO staff in management and Training of Trainers (TOT).

AUDIENCE:

The director and top-level managers/trainers of the ONAPO training center.

DESCRIPTION OF TRAINING:

FPMT has identified two components which are critical to the success of any management training center: a cadre of trainers having both a knowledge of management sciences and the ability to effectively transfer that knowledge to others, and; management systems for managing the training center itself. The FPMT project is in the process of developing a course which addresses these issues: Management of Training Organizations and Management Training Methodologies. The course, modeled after a course that MSH has offered for a number of years, will place emphasis on the management issues specific to family planning and training

organizations, as well as presenting effective training techniques. Participants will gain skills in the areas of organizational development, design of training systems, management of training organizations, in addition to skills in planning, policy formulation, program implementation and MBOR, monitoring and evaluation, and other basic management techniques. As this course is still being designed, it is not possible to provide specific details concerning its length or likely venue. Because some aspects of this course will overlap with the proposed training activities by INTRAH, close coordination with them will be required to ensure the most effective use of resources.

Two options appear likely.

- o U.S. or Regional Training: ONAPO participants would join trainees from other training organizations in the Africa region to participate in the course, which could be held either in the U.S. or in an African regional training center.
- o In-Country Training: A team of FPMT trainers would conduct the course in Rwanda for the ONAPO training center staff.

Both options would include a follow-up component whereby FPMT trainers would visit the trainees at six month intervals to reinforce the skills acquired and to offer technical assistance as required. Ideally, visits would be timed to correspond with on-going training activities.

RECOMMENDATIONS:

Subject to availability of funds, we recommend the second option as it would allow for more intensive and specific training. Both options, however, would meet the stated goals.

PROBLEM: LACK OF PLANNING AND EVALUATION OF IEC STRATEGIES:

ONAPO's strategy for a successful family planning program relies on a wide-scale, multifaceted IEC program. Given the strong pro-natalist sentiment of the people, the lack of traditional birth spacing practices, and the considerable influence of the Catholic Church, there are sound reasons for emphasizing the IEC component of the ONAPO program. Current IEC activities include radio spots, theater groups, the publication of brochures, posters and journals, plus an active community outreach program. While the volume of activities and outputs is certainly impressive, these materials have not been field-tested and to date no evaluation of their effectiveness has been attempted. This evaluation is critical given the low contraceptive prevalence rates. While IEC staff were aware of this need, they were not planning any program evaluation in the near future. In addition, the IEC activities at the prefectural

level have suffered from inadequate coordination and planning by prefectural IEC staff. Appropriate management training, emphasizing IEC evaluation and planning at both the national and prefectural level, can address these needs and will lead to more effective IEC strategies.

GOAL (NATIONAL LEVEL):

To develop audience testing and evaluation protocols for the IEC unit to evaluate the effectiveness of their materials.

AUDIENCE:

- o The ONAPO national staff involved in the design and implementation of IEC programs and perhaps the director of the evaluation unit when named.

GOAL (PREFECTURAL LEVEL):

To improve the planning, implementation and evaluation of IEC activities at the prefectural level.

AUDIENCE:

- o The person responsible for coordinating IEC activities for each of the 10 ONAPO prefecture offices (10 persons).
- o The head of the Centre Prefectural de Developpement et Formation Permanente (CPDFP) from each prefecture (10 persons).

DESCRIPTION OF TRAINING:

Two courses would be offered. The first, for ONAPO national staff, would discuss the design and evaluation of mass media campaigns, with emphasis on field testing, message and media selection and distribution. The second course would address the need to improve the planning, implementation, and evaluation of IEC activities (primarily non-media related) at the prefectural level. Participants would include prefectural level ONAPO IEC staff and Centre Prefectural de Developpement et Formation Permanente (CPDFP) staff. Participants would gain skills in the following areas: needs assessment, problem identification and problem solving, setting objectives, program planning, implementation, and evaluation, MBO, communication skills, and principles of group dynamics. As part of the training, each regional team (ONAPO/CPDFP) will be expected to develop an action plan for IEC activities in their prefecture. To reinforce the training and gain practical skills, each participant will conduct meetings and motivational sessions with selected community or neighborhood groups under supervision by FPMT staff. This training should be repeated for the benefit of workers at the communal level. The audience would be the heads of the Centre Communal de Developpement et Formation Permanente

(CCDFP). Training would be done primarily by ONAPO training staff, with the prefectural ONAPO/CPDFP team serving as facilitators. Regions would be paired, so a total of five workshops would be required. FPMT would co-train during the initial one or two workshops, then transfer total training responsibility to ONAPO.

DURATION: 2-3 weeks

LOCATION: Kicukiro with practical training in Kigali and environs.

TRAINERS: 2 FPMT staff, 2 ONAPO training staff.

PROBLEM: ABSENCE OF PROBLEM ORIENTED EVALUATION SYSTEM:

ONAPO has done well in developing and measuring indicators of both process and impact variables. What they lack, however, is a mechanism to relate these variables to their progress in achieving their program goals. This problem was discussed earlier in the context of the IEC program where they were unable to know whether their IEC program was having a favorable impact on the population; however a more general problem exists in their inability to know which parts of their program have been effective and which have not. They do not, for example, collect information about women who were contraceptive users but then prematurely dropped-out of the program, an important indicator in assessing whether the family planning program is meeting the needs of women who are motivated to use modern family planning methods. This problem is an important one since the absence of this type of information prevents program planners and managers from making informed management decisions.

GOAL:

To develop a problem-oriented evaluation system for all ONAPO activities

AUDIENCE: ONAPO Evaluation Unit and Chefs de Service.

TRAINING OPTIONS:

As with several other management areas, ONAPO evaluation efforts, and in particular the National Fertility Survey, have been impressive. The problems that ONAPO faces are, accordingly, more complex and perhaps less easily solved than those of many other African countries. For this reason, a regional workshop is not likely to be available at a sufficiently advanced level. Accordingly, our recommendation is that an advanced evaluation workshop be held in Kigali. This workshop might provide an opportunity for participation by management trainers from other Francophone African countries who will be required in the future to design and teach courses in advanced evaluation techniques. In addition, the outputs of this workshop could include materials suitable for other workshops in the future.

This workshop would require two FPMT trainers for a one week period of training preceded by one week of preparation in Rwanda.

PROBLEM: VARIABLE QUALITY OF SUPERVISORY VISITS:

While ONAPO appears to have an admirable record of maintaining supervisory visits both at the prefecture and centre de sante level, the quality of these visits is variable, with the average time spent in any one supervisory interaction being approximately 10 minutes. No supervisory protocol is available and both supervisory staff and supervisees are unclear about what the content of supervisory visits should be.

GOAL: Development of Supervision strategies and protocols.

AUDIENCE:

Supervision is done at two levels at ONAPO: the Sante Familiale staff visit the prefectural ONAPO offices, and the ONAPO prefectural staff visit the centres de sante and hospitals where family planning services are actually carried out. Accordingly, the audience for this workshop would be both the national and prefectural staff, including MINISAPASO in the prefectures.

TRAINING OPTIONS:

- o Because this problem is a common one throughout Francophone Africa, an Africa regional workshop examining the relationships between national and prefectural strategies for supervision might be appropriate if a workshop output were the development of a supervision protocol for each country at both the national and prefectural levels.
- o An in-country workshop for both the national and prefecture ONAPO and MINISAPASO staff to develop supervisory protocols. A document being prepared by the research division of ONAPO which presents problem-oriented approaches to practical clinical problems might provide the basis for a part of this workshop. The duration of the workshop would be 2 weeks. A workshop output would be a written protocol for supervisory visits at both the prefecture and centre de sante level.

RECOMMENDATION:

Given the large number of participants and the availability of appropriate materials, an in-country workshop is recommended. Costs of this workshop might be covered by The World Bank Project beginning in 1986 should funds be unavailable through FPMT or ONAPO.

PROBLEM: FINANCIAL MANAGEMENT AND LONG-TERM FINANCIAL PLANNING:

To date, ONAPO has not developed financial systems which facilitate long-term planning and budgetary control. Several factors have contributed to this problem: the absence of a financial manager at ONAPO, the multiplicity of donor reporting requirements, and the passive financial control exercised in the past by USAID. As a result, there is uncertainty about the availability of funds for scheduled activities. As donor support for ONAPO increases and diversifies, the need for these financial systems will increase.

GOAL:

To develop and implement financial planning and control systems at ONAPO headquarters capable of matching available resources to the program's long-term priorities and goals.

AUDIENCE: Financial Manager to be named.

TRAINING OPTIONS:

- o A regional or inter-regional workshop in financial management which provides the new manager with both theoretical and practical information in the design of long-term financial planning, budgeting, financial control systems, financial information systems, and other general management issues. This workshop would be in French and last 3-4 weeks, with the location and trainers to be determined.
- o Technical Assistance on a 1:1 basis with the financial manager to develop and implement financial planning and control systems suitable to the needs of ONAPO. This option, while more expensive than participation at a regional workshop, would go further toward developing a finished financial planning and control system and would develop a basis for follow-up should that be needed. The anticipated duration of TA would be 2-4 weeks depending on the previous training and experience of the financial manager.

RECOMMENDATIONS:

- o While it is difficult to predict the most appropriate program for an as yet unnamed financial manager, it seems likely that the new manager could benefit from a workshop where he/she was able to gain from the experiences of those financial managers with more mature programs and be presented with some of the options available for financial systems. It also seems likely that the workshop training might need to be followed up by periodic Technical Assistance to provide ongoing support for systems implementation.

PROBLEM: POOR COORDINATION OF PREFECTURAL ONAPO/MINISAPASO TEAMS:

Family planning services are delivered by MINISAPASO personnel operating in MINISAPASO facilities. ONAPO has the responsibility for planning and supervising activities, but no direct authority over the personnel who deliver services. This separation of responsibility and authority creates an obstacle to the planning, supervision, and extension of effective family planning services in the prefecture.

TRAINING OPTIONS:

We note that INTRAH has developed a proposal to provide management training to the ONAPO prefectural teams. It is unclear whether the Medecin Directeur de la Region Sanitaire (MINISAPASO) will be included in this training. We strongly recommend that ONAPO and INTRAH consider including the MINISAPASO in the proposed training as this will help promote coordinated planning and the development of a unified program.

OTHER PROPOSED TRAINING ACTIVITIES (INTRA-AFRICAN)

SEMINAR FOR FAMILY PLANNING PROGRAM LEADERS

GOAL:

To identify and develop training course content for African Family Planning programs.

DESCRIPTION:

This workshop will further develop the management problem areas identified during the basic needs assessment visits. This activity will ensure that future course materials respond to the real needs of African family planning programs and help prepare leaders of these programs to participate in future training activities in their own countries.

AUDIENCE:

Leaders of family planning projects or organizations from five or six francophone countries and FPMT staff.

LOCATION: Boston, USA

DURATION: One week.

INTRA-AFRICAN CONFERENCE ON THE MANAGEMENT OF INTEGRATED HEALTH AND FAMILY PLANNING PROGRAMS

GOAL:

To exchange experiences and strategies on the integration of health and family planning program activities at both the policy and operational level.

DESCRIPTION:

This conference will bring together managers and decision-makers responsible for maternal and child health and family planning programs from different countries in the region. The conference will provide a forum for the development of effective strategies for the integration of family planning and maternal and child health programs. Case studies from a variety of countries, including perhaps Rwanda, will be used.

PARTICIPANTS:

Those involved in maternal and child health and family planning at both the policy and operational level. Both ONAPO and MINISAPASO should be represented.

LOCATION: Dakar

DATE: Not before May, 1987

INDIVIDUAL TRAINING

We strongly recommend that Dr. Evariste Hakizimana participate in a Management Course for senior health managers. We support ONAPO's current plan to send him to MSH's course in Haiti Nov. 3-28, 1986. In addition, we feel he should attend the technical seminar on health management information systems to be given immediately following the general management course.

LIST OF PERSONS CONTACTED

USAID KIGALI:

Mr. Emerson Melaven, Mission Director
Mr. Richard Thornton, Public Health Officer
Ms. Carina Stover, International Development Intern
Mr. Andrew Sisson, Assistant Program Officer

OFFICE NATIONAL DE POPULATION:

Mme. Habimana Nyirasafali Gaudence, Director
Dr. Hakizimana Evariste, Head of Studies and Program
Mr. Mbonigaba Jean Damascene, Head of IEC
Mr. Nzahabwanamunga Patrice, General Secretariat and
Public Relations
Mr. Kamanzi Castule, Head of Training Division
Mr. Kayumba Anastase, Family Health Division
Mme. Baziramwabo Madeleine, Contraceptive Stock Clerk
Dr. Mukamfizi Pascasia, Research Division
Mr. Niyikiza Clet, Head of Statistics
Mr. Nkulikiyinka Vianney, Infrastructure
Mme. Mukabideri Theres, Accountant
Dr. Muhamwenimana Alexandre, ONAPO Regional Doctor, Kigali
Dr. Bajinya Vincent, ONAPO Kigali
Mme. Mbabajende Veronique, ONAPO Kigali
Dr. Biziyaremy Pascal, ONAPO Regional doctor, Gitarama
Mme. Nzabonimana Cecile, ONAPO Statistician Gitarama
Mme. Lilimumutima Lucie, Social Assistant Gitarama
Mme. Mukamuhigirwa Daphrose, Infirmiere A3 Gitarama
Dr. Kaberuka Jean Bosco, ONAPO Regional doctor, Kibungo
Dr. Maryse Pierre-Louis, ONAPO Technical Advisor
Dr. Paul Casman, Advisor, Family Health Division (UNFPA)

MINISTERE DE LA SANTE PUBLIQUE ET LES AFFAIRES SOCIALES:

Dr. Nteziryimana Antoine, Planning and Evaluation
Mr. Munyankindi Alphonse, Assistant Medical, CDS Mukarange

OTHER:

Dr. Renard Pierre-Louis, Private Consultant
Mr. Neal Ewen, Centers for Disease Control
Ms. Joanne Csete, Nutritionist
Dr. Angelique Haugerud, Anthropologist
Dr. Robert Wilson, Hopital Gahini
Mr. Roger de Winter, Rural Development Expert

SCHEDULE OF VISITS

Monday, June 2:

- 10:00 Arrive Kigali
- 13:30 Briefing with USAID Health and Population Officer
- 15:00 Meeting with Technical Advisor to ONAPO
- 15:30 Meeting with ONAPO Director

Tuesday, June 3:

- 09:00 Meeting with Technical Advisor to ONAPO
- 12:00 Lunch with USAID Health and Population Officer
- 14:00 Meeting with Technical Advisor to ONAPO
- 16:00 Meeting with USAID

Wednesday, June 4:

- 07:00 Meeting with ONAPO, Chief of Studies and Program
- 08:45 Meeting with ONAPO, Family Health Division
- 09:30 Meeting with ONAPO, Contraceptive Supply Clerk
- 10:30 Meeting with ONAPO, Chief of IEC Division
- 14:00 Visit to Centre Hospitalier de Kigali
- 17:00 Meeting with ONAPO, Chief of Statistics and Computers

Thursday, June 5 (National day of mourning):

- 09:00 Consolidation of information collected and development of initial recommendations.

Friday, June 6:

- 08:00 Departure for field visit to Gitarama
- 09:15 Meeting with ONAPO regional team
- 11:00 Visit to Centre Rwandais de Formation de Cadre
- 13:00 Return to Kigali
- 14:30 Departure for Ruhengeri
- 18:30 Discussion with food and nutrition researchers

Saturday, June 7:

FREE

Sunday, June 8:

- 09:00 Consolidation of information collected and further development of initial recommendations.

Monday, June 9

07:30 Departure for Kibungo Prefecture
09:30 Meeting with ONAPO regional director
10:30 Meeting with Medical Assistant of Centre de
Sante, Mukarange
11:30 Visit to Hopital de Gahini
13:30 Return to Kigali
15:00 Logisit'cal arrangements for return to U.S.
16:00 Work on Management Development Plan

Tuesday, June 10

07:45 Meeting with MINISAPASO Planning and Evaluation Unit
09:00 Meeting with ONAPO Accountant
Meeting with ONAPO Director of Training
14:00 Meeting with ONAPO Director of Research
16:00 Meeting with ONAPO Technical Advisor

Wednesday, June 11

Elaboration of Management Development Plan (all day)
19:00 Dinner with ONAPO Technical Advisor and UNFPA expert

Thursday, June 12

09:00 Prepare final draft of Management Development Plan
14:00 Visit to Kicukiro training center
17:00 Prepare for ONAPO and USAID de-briefings

Friday, June 13

09:00 De-briefing with ONAPO
11:00 De-briefing with USAID
14:00 Incorporation of suggestions from de-briefings
into Management Development Plan
18:00 Leave hotel for airport

ANNEX II

Tableau III. 1. Répartition des femmes sous contraceptif au 31 Décembre 1985 par préfecture et par méthode.

PREFEC/METHO	PIL.	DIU	INJ.	BAR.	AUTO	TOTAL
BUTARE	817	247	786	32	19	1901
BYUMBA	321	73	446	20	5	865
CYANGUGU	881	248	1024	20	7	2180
GIKONGORO	141	39	284	6	1	476
GISENYI	671	241	1326	16	14	2268
GITARAMA	218	60	416	32	11	737
KIBUNGO	931	268	930	38	39	2206
KIBUYE	706	269	1155	46	30	2206
KIGALI	2601	799	2710	93	83	6286
RUHENGERI	562	189	808	14	6	1579
TOTAL	7849	2433	9885	317	215	20669

Source: ONAPO 1985.

Tableau III. 2. Nombre moyen de femmes sous contraceptifs par centre, par préfecture en 1984 et 1985.

Préfecture	1984			1985		
	Forma. Médic.	Fem. ss contra.	N moy fem. ss contra.	Forma. Médic.	Fem. ss contra.	N moy fem. ss contra. par form.
BUTARE	13	1199	92	11	1901	173
BYUMBA	7	251	36	17	265	51
CYANGUGU	5	1291	258	6	2180	363
GIKONGORO	1	183	183	5	471	94
GISENYI	8	891	111	14	2268	162
GITARAMA	3	194	65	22	737	34
KIBUNGO	12	834	70	18	2206	123
KIBUYE	9	1405	156	13	2206	170
KIGALI	28	4328	155	30	6286	210
RUHENGERI	11	845	77	16	1579	99
TOTAL	97	11421	118	152	20699	136

Source: ONAPO 1985.

ANNEX III

Tableau I. 1: Répartition des formations médicales prestant les services de P.F. par Préfecture et type d'institution.

PREFEC/TYPE	HOP	CSA	DISP	MAT	ETS	TOTAL
BUTARE	2	7	1	1	0	11
BYUMBA	4	4	7	0	2	17
CYANGUGU	3	1	2	0	0	6
GIKONGORO	1	3	1	0	0	5
GISENYI	4	7	2	1	0	14
GITARAMA	2	14	5	0	1	22
KIBUNGO	4	7	6	0	1	18
KIBUYE	3	9	1	0	0	13
KIGALI	2	23	5	0	0	30
RUHENGERI	1	12	3	0	0	16
TOTAL	26	87	33	2	4	152

Source: ONAPO 1985

Tableau I. 2. Taux de couverture des formations médicales par préfecture en 1984 et 1985.

Préfec. (1)	1984			1985			Accr. taux.
	Format. de P.F.	Total (2) format.	Taux couve.	Format. de P.F.	Total (2) format.	Taux couve.	
BUTARE	13	48	27.08	11	48	22.92	-15.36
BYUMBA	7	34	20.59	17	39	43.59	111.70
CYANGU.	5	19	26.32	6	20	30.00	13.98
GIKONG.	1	20	5.00	5	20	25.00	400.00
GISENYI	8	27	29.63	14	31	45.16	52.41
GITARAM	3	34	8.82	22	41	53.66	508.39
KIBUNGO	12	27	44.44	18	28	64.29	44.67
KIBUYE	9	24	37.50	13	23	56.52	50.72
KIGALI	28	63	44.44	30	67	44.78	0.77
RUHENG.	11	32	34.38	16	32	50.00	45.43
TOTAL	97	328	29.57	152	349	43.55	47.28

Source: ONAPO 1985.

(1) pour les abréviations: Cf. annexe III.

(2) Rapports d'activité MINISAPASO 1984 et 1985.

ANNEX IV

KEY PROJECT INDICATORS

	<u>1985</u>	<u>1991</u>
<u>Process Indicators</u>		
<u>A. Strengthening Family Health Services</u>		
(a) Number of health center staff retrained	200	1,400
(b) Number of additional A4 trained and deployed	-	200
(c) Number of peripheral health facilities upgraded or rehabilitated	-	30
(d) Percentage of health centers delivering FP services	33%	100%
<u>B. Institutional Strengthening</u>		
(a) Training of MOHSA/ONAPO regional teams	-	completed
(b) Fellowship and study tours	-	completed
(c) Supply of vehicles and equipment	-	completed
(d) Construction of Regional Offices	2	8
(e) Health financing study	-	completed
<u>C. Human Resources Development</u>		
(a) Construction of two A3 Nursing Schools	-	completed
(b) Training of teachers	-	completed
<u>D. Population Policy</u>		
(a) Operational research study No. 1	-	completed
(b) Operational research study No. 2	-	completed
<u>Outcome Indicators</u>		
(a) Contraceptive prevalence	1%	10%
(b) Child health monitoring	10%	30%
(c) Deliveries in health facilities	5%	30%
(d) Prenatal care	80%	80% ^{1/}

In 1985, the average number of prenatal consultations per pregnant woman was two. The objective for 1991 is to have at least four contacts.

ANNEX V

ESTIMATED BUDGETS FOR PROPOSED TRAINING ACTIVITIES IN RWANDA

I.	Management Training for Training Staff on ONAPO Training Center (2 weeks).		
A.	<u>Travel</u>		
	1 Round Trip Boston-Kigali.....	\$	2000
B.	<u>Per Diem</u>		
	21 days @ \$92/day.....	\$	1932
C.	<u>Fees and Overhead</u>		
	28 days @ \$261/day (trainer).....	\$	13,154
	5 days @ \$100/day (MSH support).....	\$	900
D.	<u>Other Direct Costs</u>		
	Communication.....	\$	300
	Materials.....	\$	200
	Shipping.....	\$	200
	Local Transportation.....	\$	200
			\$18,886
E.	<u>Contingency (10%)</u>	\$	1,889
			\$20,775

(NOTE: Participants would be staff of the ONAPO training center. Training would occur at the workplace; therefore, no participant costs have been budgeted.)

II.	<u>Workshop on Planning and Evaluation of IEC Strategies: National Level</u>	(1 week)	
A.	<u>Travel</u>		
	1 Round Trip Boston/Kigali.....		\$ 2000
B.	<u>Per Diem</u>		
	14 days @ \$92/day.....		\$ 1288
C.	<u>Fees and Overhead</u>		
	21 days @ \$261/day (trainer).....		\$10,017
	5 days @ \$100/day (MSH support).....		\$ 900
D.	<u>Other Direct Costs</u>		
	Communication.....		\$ 300
	Materials.....		\$ 200
	Shipping.....		\$ 200
	Local Transport.....		\$ 200
			\$15,105
E.	<u>Contingency (10%)</u>		\$ 1,511
			\$16,616

(NOTE: Participants would be IEC staff of ONAPO. No participant costs are budgeted as training will take place at the workplace.)

II. Workshop on Planning and Education of IEC Strategies:
Prefectural Level (2 weeks).

A.	<u>Travel</u>		
	2 Round Trip Boston/Kigali.....	\$	4000
	20 Participants @ \$25/Participant.....	\$	500
B.	<u>Per Diem</u>		
	21. days @ \$92/day (2 trainers).....	\$	3864
	14 days @ \$50/day (20 participants).....	\$	14,000
C.	<u>Fees and Overhead</u>		
	28 days @ \$261/day (2 trainers).....	\$	26,309
	5 days @ \$100/day (MSH support).....	\$	900
D.	<u>Other Direct Costs</u>		
	Communication.....	\$	300
	Materials.....	\$	400
	Shipping.....	\$	300
	Local Transportation.....	\$	300
			\$50,873
E.	<u>Contingency (10%)</u>	\$	5,087
			\$55,960

II. Workshop on Planning and Evaluation of IEC Strategies: Communal Level (a total of five sessions, each of 2 weeks' duration).

(NOTE: Training at this level may fall outside the scope of FPMT activities. Course materials used during the workshop for national and prefectural level personnel could be adapted for use in the communal level workshops. ONAPO staff should be responsible for conducting these workshops. An estimate of the cost, assuming no FPMT technical assistance, is given below.)

A.	<u>Travel</u>		
	30 participants @ \$25/participants.....	\$	750
B.	<u>Per Diem</u>		
	30 participants @ \$50/day for 14 days.....	\$	21,000
C.	<u>Fees</u>		
	No additional allowance made for ONAPO trainers.....	\$	-----
D.	<u>Other Costs</u>		
	Communication.....	\$	200
	Materials.....	\$	600
	Miscellaneous.....	\$	200
			\$22,750
E.	<u>Contingency</u> (10%).....	\$	2,275
			\$25,025

Five workshops would cost approximately \$125,125.

III. Workshop for Developing a Problem-Oriented Evaluation System
(1 week).

A.	<u>Travel</u>		
	2 round trip Boston/Kigali.....	\$	4000
B.	<u>Per Diem</u>		
	28 days @ \$92/day.....	\$	2576
C.	<u>Fees and Overhead</u>		
	35 days @ \$261/day.....	\$16,443	
	5 days @ \$100/day.....	\$	900
D.	<u>Other Costs</u>		
	Communication.....	\$	300
	Materials.....	\$	200
	Shipping.....	\$	200
	Local Transportation.....	\$	200
			<hr/>
			\$24,819
E.	<u>Contingency</u> (10%).....	\$	2,482
			<hr/>
			\$27,301

IV. Workshop to Develop Supervisory Protocols (1 week).

A.	<u>Travel</u>		
	2 round trip Boston/Kigali.....	\$	4000
	15 participants @ \$25/participant.....	\$	375
B.	<u>Per Diem</u>		
	28 days @ \$92/day.....	\$	2576
	15 participants @ \$50/day, 6 days.....	\$	4500
C.	<u>Fees and Overhead</u>		
	35 days @ \$261/day (trainers).....	\$16,443	
	5 days @ \$100/day (MSH staff).....	\$	900
D.	<u>Other Costs</u>		
	Communication.....	\$	300
	Materials.....	\$	200
	Shipping.....	\$	200
	Local Transportation.....	\$	200
			<hr/>
			\$29,694
E.	<u>Contingency (10%)</u>	\$	2,969
			<hr/>
			\$32,663