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FINAL EVALUATION OF THE
MATERNAL CHILD HEALTH / FAMILY PLANNING
RWANDA (696-0113)
AUGUST, 1987

Table of Contents

	<u>Page Number</u>
I. Executive Summary	1
II. List of Acronyms	6
III. Evaluation Methodology	7
IV. The Project Environment	8
A. Change in Family Planning Policy at the National Level	8
B. Institutional Capacity for Operationalizing Policy	11
C. Socio-Economic Issues Affecting Project Achievements	13
D. Other Donors' Activities	18
V. Progress to Date towards Project Objectives	22
A. Project Goal	22
B. Project Purpose	22
C. Achievement of Outputs	22
1. Information, Education and Communication	23
2. Research and Policy Development Studies	25
3. Training	27
4. Service Delivery	30
5. Commodity Management	38
6. Facilities Construction and Renovation	39
D. Delivery of Inputs	40
E. Validity of Assumptions made during Project Design	44
VI. Summary of Recommendations For Implementation by PACD	45
VII. Future Directions	48
A. Resource Allocation/Management	
B. Sustain the Momentum of GOR Population Policy Reform	49
C. Continue Grass Roots Mass Education in Family Planning	50
D. Extend and Improve Family Planning Services Nation-wide	51
VIII. Studies Needed to Plan Future FP Interventions and Solicit Donor Support	53
 ANNEXES	
A. Evaluation Team's Terms of Reference	
B. List of ONAPO Research	
C. List of Persons Contacted	
D. President's July 1, 1987 Speech	
E. Map of Rwanda's Health Facilities	
F. Annual Evolution of New Acceptors Since 1976	
G. In-Country and External Training Funded by Project	

I. Executive Summary

The Rwanda Maternal Child Health/Family Planning Project (696-0113) was originally obligated in 1981 with an LOP funding level of \$6.25 million. The project was first evaluated in 1984, and on the basis of the findings, it was given a no-cost two year PACD extension, through 9/88. Supplementary funds in the amount of \$400,000 were added in July 1987 to increase LOP level to \$6.65 million over the seven year total life of project. The present external evaluation was undertaken in August 1987 (year 6 of implementation, one year prior to PACD) by a six person team including a REDSO/ESA Project Development Officer, two family planning consultants recruited by A.I.D., and three officials selected by the GOR representing the Ministries of Plan (MINIPLAN) and Health (MINISAPASO), and the Presidency of the Republic.

The team found that the project environment has changed considerably over the years, evidenced on the positive side by progress in population policy at the national level (Presidential support to reduce family size from an average of 8.5 children per household to four), and accelerating availability of multi-donor resources in support of family planning activities (notably UNFPA and IBRD complements to A.I.D. investments). In view of this more complex context for FP in Rwanda, it is recommended that ONAPO and MINISAPASO collaboratively establish a Donor Coordination Committee, including representatives from each FP donor resident in country, to meet quarterly to review all donors' work plans and budgets, and ensure complementarity in FP activities.

On the other hand, institutional capacity for implementing the new population policy is still greatly underdeveloped, particularly MINISAPASO capability for delivering family planning services. One major problem in this regard that needs to be corrected is that responsibility for MCH/FP has been assigned to a low organizational level within MINISAPASO. To establish sufficient weight of authority behind the strengthening and integration of MCH/FP services within health facilities nationwide, the team recommends that the MINISAPASO Director General of Public Health be given direct responsibility for MCH/FP, by directive from the Minister of MINISAPASO.

In addition, a large array of socio-economic issues continue to hamper the rate of growth of contraceptive prevalence; these factors must be explicitly taken into account in the design of any future new family planning project. Of these, demand for child labor (especially for carrying water and fuel wood, and for agricultural activities) is a major hinderance to widespread acceptance of reduced family size. For this reason, in any future new project, it is recommended that one component provide resources for NGO's to combine rural water projects and training in techniques for agricultural intensification with dissemination of FP education and services. Misconceptions about the effects of using contraception need to be addressed more directly in future mass education campaigns, and gender-specific roles and networks need to be exploited as part of a strategy for targeting specific regions and at-risk groups for FP information. Widespread reliance on traditional healers offers potential, in a future new project, for training these healers to provide FP counselling and distribution of oral and barrier contraceptives, though weakness of the professional midwifery tradition, caused by Rwandan women's preference for giving birth alone, presents an obstacle to paramedical MCH/FP service delivery. Further, conservatism of the

ONAPO's research to date (also supported by UNFPA) has been successful in developing the data base needed for national population policy, and to increase public awareness of the severe demographic crisis confronting Rwanda. The National Fertility Study was a particularly important project output. Though efforts are underway to provide much needed improvements in service statistics collection, handling and analysis, ONAPO has successfully developed a pool of FP users' statistics for use in tracking drop-outs, rate of new acceptance, and change in contraceptive choices. The team recommends that research through PACD focus on evaluation of the experimental/innovative contraceptive distribution programs now beginning with A.I.D. centrally-funded support (e.g. Columbia University community-based distribution program and SOMARC social marketing effort) to identify modes which could be replicated more widely in a future new project.

Though a great deal of training in IEC and (more recently) FP service delivery has taken place under the project, the team estimates that only 140 medical assistants and nurses have received some form of FP training, still short of the 250 person target in the original PP. A project-funded buy-in to A.I.D.'s centrally-funded INTRAH project is the core of national FP training activities for paramedics and nurses. The team recommends that ONAPO and MINISAPASO collaboratively place the greatest emphasis until PACD on the clinical training of physicians, nurses, and medical assistants in FP methods and counselling, including information on the use of service statistics (currently under-reported). As soon as possible, ONAPO should report fully to MINISAPASO on the number of health services personnel trained in FP, by name of facility in which they are working, and the content of the training each staff member has received. Project-funded technical assistance should be recruited to evaluate the impact of A.I.D.'s bilaterally and centrally-funded FP training to date, and to assist ONAPO and MINISAPASO to develop a national FP human resources strategy and training plan to serve all public and private sector facilities.

MINISAPASO is responsible for the delivery of health care nation-wide. FP services are reportedly delivered in the public sector through a network of 133 facilities, and in the private sector by 50 facilities, a total of 183 service sites, however the real number offering modern contraceptives is probably not more than 130 nation-wide, as this enumeration undoubtedly includes Catholic facilities only using the Billings method. The percentage of reproductive age women using contraception varies greatly from region to region, and from urban to rural areas. For example, in 1985, it was estimated that 30% of women aged 15-49 were using contraceptives in Kigali (though this is probably a much inflated figure), but only 2.3% in the Gikongoro region (relatively under-served, especially by non-Catholic health centers). The staffing of health centers also varies greatly, in both number of personnel and skill level. From intake to service delivery to follow-up there is little uniformity and not enough supervision. The team recommends that a major focus of A.I.D. and ONAPO collaboration through PACD be the improvement of FP service delivery, with a strategic work plan for use of project-funded technical assistance towards this end. As part of this work plan, pilot studies should be developed to test patient acceptance of different modes of FP service delivery: variation in hours of service, segregated FP versus integrated MCH/FP service delivery formats, delivery of services by different types of medical personnel and by male versus female providers, and by centers with or without FP counsellors. Standards for service delivery need to be

medical profession in Rwanda will slow the introduction of community-based distribution of contraceptives by volunteer health workers as, for the most part, medical professionals believe that pills should only be distributed by clinics, hospitals, and pharmacies by prescription. Other factors limit access to FP information and contraceptives, notably: strength of the Catholic Church and its importance in the health sector, low levels of literacy and school entrance, logistical constraints preventing access to service delivery sites, pro-natalist bias and attitudes to pre-marital sexuality (which deny access to FP services to an unmarried woman and even a married woman who is still childless, or who does not have her husband's consent to obtain FP services).

On the whole, the team found that original end-of-project outputs were unrealistic on several counts, as acknowledged by the July 1987 PP Amendment No. 1, given that Rwanda only began development of a national FP policy and institutional capacity in 1981 with the founding of the National Population Office (ONAPO) and the onset of project activities. Specifically, ONAPO research capacity was overly diffused by the PP target of accomplishing 25-35 studies by PACD, schedules for the construction of an FP training center and four health centers were unrealistic as sites were not identified nor plans prepared during project design, and expectations for the number of **contraceptive users to be recruited by PACD were overly optimistic (PP target of 84,500 by 9/86)**. Though contraceptive prevalence is still a low 1.7% nation-wide (24,697 users), the number of new acceptors is gaining momentum annually, and a target of 6.4% contraceptive prevalence by 1991 (end of the next Five-Year Plan period) seems achievable, if a future new project can continue the training of service providers and the extension of services to under-served areas through NGO's, community volunteers, and other innovative means.

The evaluation team has reviewed each of the six project components: **mass education in family planning, population policy studies and demographic** research, training, family planning service delivery, commodity management, and facilities construction and renovation. Major findings and recommendations relative to each project component are summarized below.

Mass education has been the project's most successful component, as 30% of Rwandan women have now been exposed to FP information through radio or direct contact with ONAPO personnel. The IEC program, however, now needs to enter a more specific phase in which the public is steered towards service delivery sites and the behavioral change needed to increase contraceptive prevalence. The team recommends that ONAPO identify the most important groups to be targeted for IEC activities, and focus on use of face-to-face interaction and radio, the most effective low-cost means thus far identified for quickly and convincingly spreading FP information. ONAPO should use A.I.D. technical assistance through PACD to develop evaluation capability within the ONAPO research section, and these new evaluation skills should be used to improve the IEC program's effectiveness. For example, ONAPO should evaluate the ways that local government officials are transmitting IEC messages, and the effectiveness of radio programs already broadcast, and use this feedback to improve all IEC investments through PACD and in future. ONAPO should also immediately begin negotiations with ORINFOR to increase radio air time for FP messages, as this requires a long lead time.

established, especially for pre-method counselling, supervision, use of gynecological exams, and follow-up. It may be appropriate to take regional differences in facilities, personnel skill levels, logistics, and cultural practices into account in setting these standards. A standardized home visit program, to expand the data base on causes for contraceptive abandonment should be developed within the context of this strategy for service delivery. In preparation for a future new project with a strengthened NGO FP component, ONAPO Regional Representatives should survey all Protestant health facilities to determine the level of services being provided, and the amount of FP training received and still needed by their personnel.

Purchasing and management of project-funded commodities needs improvement. Prior project-funded consultancy recommendations along these lines have still not been implemented adequately. The team recommends that, prior to PACD, ONAPO standardize its systems for control of finances, vehicles, equipment and supplies drawing upon these prior recommendations for guidelines. As first priority, ONAPO should improve car pool management and introduce mileage controls. Contraceptive handling should be reassessed particularly vis-a-vis quantities and frequency of orders for outlying rural centers. Only small quantities are currently kept on hand, requiring inefficient and frequent restocking, and producing an overly diverse supply of oral contraceptives in limited quantities. ~~Control of expiration dates~~ however, will need to accompany changes which increase the efficiency of restocking. Contraceptive storage will be greatly improved after completion of the UNFPA-financed ONAPO warehouse now under construction.

The project's construction component (31% of the project budget) has been fraught with delays and cost over-runs caused by inadequate pre-implementation planning, GOR adoption of an overly costly new prototype for rural health centers (actually a mini-hospital), and lack of adequate provision for the architectural and construction management skills needed for use of host ~~country contracting. Despite multi-year delays in construction activity,~~ construction plans were never reviewed by sectoral experts, thus design deficiencies in both the training center and the health/nutrition centers will hamper their effective utilization in future. For example, the training center has no break-out rooms for small group work, and inadequate and inefficient support facilities for the number of trainees to be housed, though cost savings from more efficient architectural design would probably have allowed these elements to be financed within budget limits. In the case of the health/nutrition centers, they will be difficult to operate, as they have no staff housing, though excessive in-patient beds were provided. The team recommends that construction be included in any future new project only if it is essential to allow NGO's to open new FP facilities in under-served rural areas. Even then, proposed sites will need to be carefully selected, and only designs appropriate to small scale MCH/FP centers should be considered for donor support.

Delivery of inputs has been problematic, as problems in financial tracking and planning were identified relatively late in project implementation, and the position of ONAPO Financial Manager has been vacant throughout most of project implementation. Among other financial management problems, construction's share of funds was allowed to increase at the expense of other budget items more central to the project purpose, notably, technical assistance and local costs of project activities. Additional complications

were caused by: frequent turnover in A.I.D. project management, hiatuses in project-funded advisors' residence, delay in GOR provision of counterparts for training, lack of a plan or accounting for GOR inputs to project activities, and lack of a strategy for use of A.I.D. centrally-funded interventions (with resulting confusion and discontinuity). In addition, externalities unforeseen during project design have limited project outputs, especially number of contraceptive users. These include: the strength of Catholic Church opposition (which caused the 80% drop-out in IUD use in Butare Region in 1984, as reported by ONAPO statistics and during an interview with the ONAPO representative at CUSP, Butare), and a hiatus from 1983-1984 in use of depo-provera in Rwanda during international controversy over contraceptive use of this drug.

As the resident advisor's position again became vacant in early August 1987, little over a year before PACD, the team recommends that remaining technical assistance funds be programmed only for short term technical assistance, using repeat visits and multi-purpose consultancies to maintain as much continuity as possible through PACD. To address the project's financial problems, and set the stage for a future new project, ONAPO should continue to press the Presidency to appoint a Financial Manager, and A.I.D. should provide training in project financial management and reporting procedures appropriate to his/her skill level as soon as this vacancy is filled. Further, the ONAPO Directrice should designate one of her staff members as GOR Project Manager, as a counterpart to the A.I.D. Project Officer, with responsibility for coordinating all A.I.D. project activities through PACD, reporting on progress and problems, and planning future activities. As input to the June 1988 GOR budget exercise, project-funded technical assistance should be recruited to assist ONAPO and MINISAPASO to prepare a plan for GOR recurrent cost support for FP activities which explains, in detail, the operating costs of the GOR's plans for FP training and service delivery nation-wide.

~~The final sections of the evaluation report recommend future directions~~ for donors' FP investments, and design studies needed for any new project. Overall, the team recommends three main emphases in future: sustain the momentum of GOR population policy reform, continue mass education in FP, and extend and improve FP service delivery nation-wide. To undertake these activities, future support will need to be divided between ONAPO, MINISAPASO, and the private sector (especially Protestant NGO's), as service delivery will need to increasingly become a public/private partnership effort. The team recommends that support for ONAPO be concentrated on policy studies, national strategies and guidelines for FP personnel training and service delivery, region-specific action plans for FP mass education, improved IEC strategies/materials for face-to-face interaction and radio, and a strategy for private sector FP counselling and contraceptive distribution. MINISAPASO should be supported in its role as major provider of FP services nation-wide through assistance with management, training, and logistical support (in part for work with private sector providers). A third share of future donor support should be channeled directly towards the private sector for FP counselling, mass education, and service delivery, especially NGO's willing to intensify out-reach in under-served areas. Pilot initiatives to expand community-based services, social marketing, and FP services through traditional healers, birth attendants, and private pharmacies could all be considered for support under this rubric.

9

II. List of Acronyms (Liste des Abreviations)

ABS	Annual Budget Submission
A.I.D.	U.S. Agency for International Development
ARBEF	Association Rwandaise du Bien Etre Familial (Rwandan branch of International Planned Parenthood Association)
BUFMAR	Bureau des Formations Médicales Agréées du Rwanda
CCDFP	Centre Communal de Développement et de Formation Permanente
CERAI	Centre d'Enseignement, Rural et Artisanal Intégré
CND	Conseil National de Développement
CUSP	Centre Universitaire de Santé Publique
FP	Family Planning
FRW (RWF)	Franc Rwandais (Rwandan francs)
GOR	Gouvernement Rwandais (Government of Rwanda)
IEC	Information, Education, et Communication
INADES	Institut National pour le Développement Economique et Social (headquarters in Abidjan, branch in Kigali)
IUD	Inter-Uterine Device
MCH/FP	Maternal and Child Health/Family Planning
MINAGRI	Ministère de l'Agriculture, de l'Elevage et des Forêts
MIJEUCCOOP	Ministère de la Jeunesse et du Mouvement Coopératif
MININTER	Ministère de l'Interieur et du Developpement Communautaire
MINIPLAN	Ministère du Plan
MINEPRISEC	Ministère de l'Enseignement Primaire et Secondaire
MINISAPASO	Ministère de la Santé Publique et des Affaires Sociales
MINESUPRES	Ministère de l'Enseignement Supérieur et de la Recherche Scientifique
MINITRAPE	Ministère des Travaux Publics et de l'Energie
MRND	Mouvement Revolutionnaire National pour le Développement
NFS	National Fertility Survey
NGO	Non-Governmental Organization
ONAPO	Office National de la Population (National Population Office)
ORINFOR	Office Rwandais d'Information (includes radio)
PACD	Project Activity Completion Date
STD	Sexually transmitted diseases
UNR	Université Nationale du Rwanda (Rwandan National University)

110

III. Evaluation Methodology

A six person team was brought together by USAID/Kigali and the Government of Rwanda (GOR) from August 7-21 to undertake a formative external evaluation of the MCH/FP Project prior to the last year of project activities. After the departure of one participant on August 21, and another on August 26, remaining team members worked until August 28 to refine and finalize the draft English version of the evaluation using feedback provided by USAID/Kigali, and to translate the document into French. A major output of the evaluation report was to be identification of the structure and focus for future AID/GOR collaboration in the family planning sector, after the current project's PACD. (See "Evaluation's Terms of Reference" in Annex A)

Though constrained by time availability, complex logistics, and the need to prepare both French and English versions of the evaluation report, the team was able to conduct intensive interviews with ONAPO's central office over the initial 2 1/2 days, to spend 4 1/2 days visiting public and private health clinics, hospitals, related training and research facilities, regional ONAPO offices, and selected local government authorities in five regions (Kigali, Gitarama, Gisenyi, Ruhengeri, and Butare), and 1/2 day to interview other donors and NGO's active in the MCH/FP sector. (Persons contacted are listed in the Annex.) Discussions in Kigali included meetings with the Minister of MINISIPASO and the Directrice of ONAPO. The remaining time available for intensive group work was devoted to review of the project-related documents provided by USAID/Kigali and ONAPO, report drafting, and team meetings.

The team recognizes that the constraints cited above have defined the evaluation as more qualitative than quantitative, but the report is designed to address the overall context of project activities and the broader project environment. As a large number of prior audits, technical assistance and short term consultancy reports had previously been prepared on selected aspects of project activities, plus the December 1984 midterm evaluation report, the team decided to concentrate on review and synthesis of this secondary data with a view towards implementation improvements still needed and promising future interventions. The team wishes to express appreciation for the logistic support and documents provided so willingly by ONAPO and USAID/Kigali, and we hope that this report will assist both partners to define directions for the future of MCH/FP in Rwanda.

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IV. The Project Environment

A. Change in Family Planning Policy at the National Level

In 1981 when ONAPO was created, the GOR still under-estimated the severity of the enormous development constraint imposed by the nation's high 3.7% annual rate of demographic increase. Early planning documents written shortly after independence referred to Rwanda's demographic problem, but did not take the next step of planning remedial action. Pro-natalism is culturally anchored deep in Rwandan society, as it is linked to the social needs of an essentially agrarian population, and is still supported by a legal and social system that will continue to resist change over time.

In creating ONAPO, the GOR took the first step towards development of a national population policy. Over its six year life, ONAPO has used mass information campaigns and several research activities to assist the GOR to better understand the impact of uncontrolled population growth on the quality of life in Rwanda. As a result, the President has become increasingly outspoken in support of ONAPO and its national population program. (See text of President's speech of July 1, 1987 in Annex D)

As input for the preparation for the fourth Five Year Plan (FFYP) 1987-1991, ONAPO has drafted a national population policy which sets a target of 15% contraceptive use by Rwandan women by 1991. If this goal could be achieved, the estimated current rate of population growth would decrease from 3.7% to 3.5% per annum, and the mean number of children per woman would fall from 8.5 to 8.0. Though laudable, this goal is ambitious, and will require a concerted effort on the part of MINISAPASO and ONAPO if FP services are to be provided to this number of women.

In contrast, the evaluation team believes that 6.4% contraceptive prevalence would be a much more realistic target for 1991, even with optimistic assumptions. The following table prepared by the team illustrates this scenario by extrapolating continuation of current percentage gains of new acceptors per year and assuming a significant decline in the current rate of annual discontinuation of contraceptive use. Calculations are based on ONAPO's 1984-1985 Service Statistics Analysis and its statistical projections for 1987. In our calculations we have assumed that the number of new acceptors per year will continue to grow at a sustained rate of 30% per annum. An important caveat should be noted- a severe epidemic of either AIDS or malaria could change attitudes negatively, by providing an incentive for a larger number of births, to ensure that a sufficient number of children survive to provide parental social security. This figure is fairly optimistic if we consider that family planning services are already offered in 183 facilities nationwide, with few new centers due to open over the next few years; we have assumed that the bulk of this new growth will come from the catchment areas of existing centers. We have also assumed that annual drop-out in contraceptive use can be reduced from the current rate of 33% to 20%. It is possible that this could be achieved if analysis of Butare data on reasons for contraceptive drop-out (now underway) can be used to develop an effective action plan for reducing the drop-out rate nationwide. Similar studies will also need to be conducted in other regions where the drop-out rate is a serious concern.

17

Since we have arrived at an estimated contraceptive prevalence target of 6.4% by 1991, even with this very optimistic scenario, we believe ONAPO could only reach the 15% target proposed for inclusion in the FFYP if a considerably more aggressive program is set in motion to accelerate current trends. New acceptors would have to be recruited at a much faster pace, and continuation rates would need to improve dramatically.

While it is understandable that the GOR and donor community are anxious to promote quick expansion of the family planning program in Rwanda, the realities of popular reaction to this new concept, and barriers to service delivery imposed by conservative elements of the Catholic Church and the limited number of health facilities and personnel, combine to force us to adopt a more realistic view of the future, thus the evaluation team suggests that ONAPO adopt the targets presented in Table 1, for inclusion in the 1987-91 Five-Year Plan.

Even so, innovative measures for the distribution of contraceptives will need to be introduced, e.g. community-based distribution by volunteers, or social marketing ventures of considerable magnitude. In addition, the array of easily available contraceptive methods will need to be diversified. A few percentage points increase in use of I.U.D.'s, Norplant, and male/female **voluntary sterilization could have a profound effect on continuation rate** calculations. Though Presidential support has been obtained for education and information campaigns on all contraceptive methods, **legislation permitting widespread access to voluntary sterilization has still not been enacted.** Future development of Rwandan population policies will need to consider all of these important issues.

10

Table 1

Potential Scenario for Increase in
Family Planning Activities in Rwanda
under the 1987-91 Five-Year Plan

	84	85	86	87	88	89	90	91
New acceptors	8587*	10765*	15780*	20514	26668	34668	45069	58590
Rate of increase of new acceptors based on previous year		25%*	47%*	30%*	30%	30%	30%	30%
Total current users	11421*	20699*	24697*	36169	42270	61550	85295	115108
Rate of increase of current users based on previous year		81%*	19%*	46%	17%	46%	39%	35%
Drop-out rate		7%*	33%*	20%	20%	20%	20%	20%
Theoretical ** contraceptive prevalence		1.4%	1.6%	2.3%	2.6%	3.7%	4.9%	6.4%
Number of reproductive age women	1455000	1455000	1508835	1564662	1622554	1682588	1744844	1809403

* Real numbers

** Calculation based on 1,445,000 women of reproductive age in 1986 and a population growth rate of 3.7% per year. Analysis of ONAPO service statistics for 1985 and 1986 provided the basis for these calculations.

14

B. Institutional Capacity for Operationalizing Policy

After five years of project activity, two or three governmental agencies have already taken steps to provide education and services in population and family planning. ONAPO, the principal agency for population activities coordination, has provided leadership for mass education campaigns, research, and the training of staff. Indeed, it is now estimated that 85% of the population is aware of the existence of ONAPO and the demographic pressures facing the country. However, only a much smaller percentage know about contraceptive methods and where they can obtain FP services.

Now that Rwandans are beginning to request more information about services, MINISAPASO, the agency responsible for the provision of all health services, has a key role. MINISAPASO must greatly strengthen its management, staffing, and supervision problems at all levels of service delivery, as it is responsible for staffing most of the private and public health facilities. Though government sources indicate that there are 183 health facilities which provide (or have the capacity to provide) family planning services, it is doubtful that they will be able to offer effective family planning services at all of these facilities given the limited trained personnel currently available. Of course, the array of services provided will largely depend on the contraceptive methods available at each site. The more medically oriented the method, the more trained the staff need to be. While the skills necessary to provide injectables do not require the same level of training as those needed for insertion of IUD's, MINISAPASO is responsible for training staff to be aware of signs which imply choosing one method over another and to provide follow-up care and counselling in the event of side effects from contraceptive choice. Where medically trained staff are unavailable, only distribution of barrier methods may be possible.

AIDS, malaria and diarrheal disease are critical national health problems which will require an increasing number of health personnel for patient care. These competing human resource requirements will become critical as more demand for family planning services is generated. Detailed studies should be conducted to ensure that adequate personnel will be available to staff the 183 health facilities with their varied preventive and curative functions. Furthermore, an inventory of the number of health facilities, their condition, and their usable equipment, will define the types and number of services that can be provided in the future.

Other ministries have the potential for providing leadership especially in creating demand for services. Among these, MINEPRISEC has begun delivering course material in demography and family planning at the secondary school level. Curricula have been prepared and some teachers have been trained in their use. While this affects only 2% of the population, it is nonetheless the 2% which will have leadership roles in the future. But more emphasis is still needed on the largest group of students, those in elementary schools. INTRAH has assisted the GOR to make a start on this, by helping to develop educational materials for the 7th and 8th years of primary school. More effort is needed to assure that the curricula prepared for this age group will not only include information regarding demographic issues, but also appropriate content on family planning in the context of family health and family responsibilities. Teacher training to ensure that proper teaching methods are used for delivery of this material will be critical in primary school family planning education. Unless a commitment is made to provide this type of education to future generations, Rwanda will continue to face even greater population pressure in the future.

Aside from medical students, University students are not, at present, exposed to curricula in family planning and there is no plan to educate all students in demography and family planning as well as family health. With adequate assistance and training, MINESUPRES should be able to provide this type of education. Furthermore, the UNR student health service should be providing a variety of counselling activities and family planning services.

The UNR Faculty of Medicine, though presently not too active in family planning, can begin to assume a more important role. As part of a larger issue, more instruction should be given to students on community health topics so that they are prepared to meet the needs of the Rwandan population.

MININTER has also participated in past educational efforts, primarily by giving permission to the nations' burgomasters, CCDFP's, and local government officials to participate in mass education campaigns. This ministry can build upon its past efforts and expand into new more in-depth activities.

As for the other ministries, there is no doubt that many can play a larger role than they have in the past. The Ministry of Defense, with both women and men in the most at-risk age, can take a larger role in the education of its employees and the delivery of family planning services to them. The **Ministries of Youth (MIJEUCOOP) and Agriculture (MINAGRI) have started small efforts in the direction of family planning education.** It is evident that much more can be done. However, it is doubtful that there is sufficient Rwandan expertise within these ministries or within ONAPO to provide the **technical guidance to greatly expand these activities without additional training.** While concerted effort by all relevant ministries is crucial to the success of the GOR demographic policy, a plan for its implementation must also be developed. Part of this plan should be a program to train key members of the various ministries in family planning information dissemination.

The historic importance of the Catholic Church in the delivery of health services is at the same time the major constraint in private sector service delivery. Some Catholic groups, nonetheless, do provide limited family planning services. Because they are discretely provided, and thus undocumented, it is difficult to ascertain their impact. BUFMAR, an NGO which procures drugs and medical supplies for private religious health care facilities is severely handicapped in its ability to provide leadership in the provision of education, supplies and services for family planning activities, due largely to its 80% Catholic membership.

Many Protestant groups offer family planning services as part of their usual health services. For example, ADRA, an Adventist organization, is providing family planning services at 8 sites. ADRA is currently working to open activities on two new sites and, given needed resources, could add at least one site per year to its FP service delivery system. CARE has also expressed interest in expanding its development activities in FP and could target areas where rural water supply projects will soon be underway, to establish a linkage between eliminating need for child labor to carry water and reduction in family size. ADRA has also opened a private university in Gisenyi which will train intermediary level health care providers, and family planning will be included in the curriculum. ARBEF, recently organized as a national NGO umbrella organization to represent Protestant NGO's active in the health sector, purportedly will take an active role in family planning activities. Since ARBEF has just been established, however, it still has not

defined its program, and it is not clear what role the organization will be able to play in future. With donor technical assistance, ARBEF could consider playing the following roles in design of a new project: (1) develop a national strategy for Protestant NGO activities in family planning and integrated rural development to reduce need for child labor; (2) recommend priority sites for the opening of new private sector FP facilities in Rwanda, based on an analysis of under-served areas within the country; (3) find new approaches for FP service delivery for logistically isolated areas where new facilities would not be cost-effective; (4) help members to prepare NGO sub-project proposals which could be funded by donors in future; and (5) serve as a clearing-house for IEC materials, training, the sharing of technical assistance, and contraceptive distribution in support of members' new initiatives in FP.

At present, private medical practice has just been authorized. There is a movement a foot to implement this new law which allows physicians to establish private practices. When this new policy becomes operational, it would be worthwhile to explore the role these physicians could play in increasing nation-wide FP service delivery (e.g. through providing GOR credit to open private health facilities in under-served parts of Rwanda).

In summary, many institutions have the capacity to provide more support for future family planning activities, but there is an acute need for more training, at all levels, for personnel in both government and the private sector. Availability of a sufficient number of trained personnel is a significant constraint on the opening of new FP service delivery sites, though funds for construction of new public health facilities are available from the World Bank. If personnel needs can be met, support for the construction of new private sector health service facilities, to increase the number of sites offering FP services in under-served areas, could be considered during design of the new A.I.D. project.

C. Socio-Economic Issues Affecting Project Achievements

(1) Demand for child labor is a major determinant of parents' decisions about family size. Essential household tasks performed by children include first and foremost transport of water, often located many miles away in the valleys below the homesteads, as Rwandan settlement patterns are dispersed. Farm families construct housing on their fields, and village clusters are virtually absent in rural areas. Child labor is also important in cultivating fields, carrying firewood, and leading animals to pasture. An integrated approach which combines development of rural water delivery systems with mass education that explicitly links this with reduced need for child labor, and the availability of family planning methods, would have a greater chance of success in fostering an increase in contraceptive prevalence. In selected target areas, NGO mass education on family planning could be combined with service delivery, dissemination of improved technologies for agricultural intensification, and water system extension and/or construction of cisterns to trap rainy season flows. NGO's already active in water development (e.g. CARE) and integrated rural development (e.g. ADRA) have expressed an interest in expanding their existing activities to test this approach to increasing contraceptive acceptance. In design and/or implementation of a new project, it is recommended that NGO's be invited to prepare these types of proposals for donor support.

(2) Misconceptions about the effects of using contraceptives were noted everywhere during site visits. It is commonly believed, even among women already using other contraceptive methods who have attended ONAPO training sessions, that I.U.D.'s can migrate within the body, even reaching the brain, requiring surgical removal! Many other common fears exist, such as the belief that women are likely to have multiple births after using injectable contraceptives or birth control pills, or that sterility can result from using these methods of contraception for child spacing. Further, women usually assume that any vaginal infections, venereal disease, or other gynecological problems they experience are being caused by the contraceptive they are using. This then becomes a cause of abandonment, as ONAPO no longer supplies antibiotics or other medications to treat users who experience these problems, and the women are unwilling to both pay for these drugs at pharmacies and continue to put themselves at what they perceive as a risk by using contraception. It is thus recommended that health workers receive more training in follow-up, and pre-contraceptive counseling. Mass education should also address these common misconceptions and fears.

(3) Attitudes towards premarital sexuality have left parents in a quandry. On the one hand, many fathers acknowledge that their daughters are having premarital sexual relations, though this is counter to traditional mores which still require female virginity on the wedding night. Fathers are reluctant to take on the economic responsibility for children born by their daughters out-of-wedlock, recognizing that this only accelerates the fragmentation of the family farm through the inheritance process, since these children will be entitled to a share of their grandfather's fields. On the other hand, they find it equally unacceptable to brave public disapproval by admitting that their daughters are having premarital sex by taking them to a family planning clinic for services. They also fear that it will be difficult to arrange marriages for their daughters if they are publicly known to be using contraception. Further complicating the situation, most clinics refuse family planning services to unmarried women. Though pills and barrier methods can be obtained from private pharmacies, at least in the country's few urban areas, cost is a disincentive as is the risk of public ridicule. This will be a difficult problem to solve, but in the short run, FP counselling could advise unmarried women to have their partners use condoms.

(4) Gender-specific roles and networks need to be considered in formulating a strategy for targeting specific regions and at-risk groups for mass education activities. The evaluation team observed a sectoral level family planning extension session, open to the general public during mid-afternoon in an open-air amphitheater in Shingiro. Many more men were present than women, and only the men participated in the question-and-answer session led by the regional ONAPO doctor. Development of an effective mass education campaign will need to include special attention to women's networks for receiving and sharing information within communities, and will need to provide sex-segregated sessions which will allow women to speak freely with health personnel on their fears and beliefs about contraception. To date, most sessions open only to women are taking place at health centers. A broader group of women's organizations and networks in both urban and rural areas needs to be integrated into the IEC program including, for example, women's cooperatives and savings associations, Protestant church women's groups, and women's groups associated with the CCDFP's. Providing information about family planning for men is also important, as her husband's permission

is almost universally required in Rwanda before a woman can obtain contraceptives from a health facility. In fact, most health centers will not provide contraception until a woman has had at least one child. On the whole, men are easier to reach institutionally than women, especially in urban areas. For example, most of the modern sector employees targeted by ONAPO's proposed strategy for collaboration with industries' dispensaries are male. Even in rural areas, 93% of Rwandan women work on farms, and few women are in political leadership positions at the regional, sectoral, or cellule levels. There are no female prefects or burgomasters; only 11 of the 570 prefectural officials are women. Thus, to ensure that mass education FP campaigns address women's issues, targeted activities only open to women must be planned.

(5) Reliance on the thousands of traditional healers is still widespread in Rwanda, though their services are extremely costly in comparison with treatment at public and private health centers. Many of them are herbalists specialized in the treatment of a select subset of medical and sometimes psychological problems. Some purport to offer cures for women's health problems including vaginal infections, gonorrhoea, position of the foetus in the womb, and others. The National University of Rwanda has begun experimntal research which chemically isolates the active ingredients of herbal remedies observed to be effective in clinical observations of traditional healing. Starting in September 1987, MINISAPASO plans to collaborate with this UNR research unit to enumerate traditional healers, identify the illnesses they treat, and analyze the economic returns that they receive. In collaboration with ONAPO, questions could be incorporated in the MINISAPASO survey form which would assess traditional healers' knowledge of modern contraceptive methods and their willingness to receive training from ONAPO on family planning. If responses to the survey are positive, a pilot training activity could be undertaken with follow-up monitoring of trainees' effectiveness in providing FP counselling and referrals. Based on the outcome of this trial, ONAPO may wish to consider training a wider-spread network of traditional healers to provide FP counselling and to distribute oral and barrier contraceptives.

(6) Weakness of the professional midwifery tradition presents an obstacle to paramedical family planning and MCH service delivery. Rwandan women prefer to give birth alone to avoid the risk of attracting the supernatural malevolence thought to be transmittable by third parties. In case of difficulties during the birth, a more experienced woman may be called in for assistance, but usually at the last minute, resulting in the relative underdevelopment of traditional midwifery skills in comparison with many other African countries. UNICEF is supporting MINISAPASO in development of trained midwives, however, so dissemination of FP services and counselling by midwives may offer potential for the future.

(7) Attitudes of the medical profession hamper the introduction of community-based contraceptive distribution by volunteer health workers, private pharmacists and traditional healers. At present, injectables and birth control pills are the contraceptives of preference in Rwanda, and there is little demand for barrier methods. Rwandan health care professionals still believe, for the most part, that pills should only be distributed by health clinics, hospitals, and pharmacies by prescription. Until this atmosphere is liberalized, first through medical training, and then by MINISAPASO directive, access to contraceptive supplies in rural areas will be restricted by logistical difficulties.

(8) Strength of the Catholic Church and its importance in the health sector, in which it provides 40% of all health facilities nation-wide, are major constraints on the rate of family planning service delivery in Rwanda, particularly in regions where large territories are served only by Catholic institutions. In Butare, for example, women near the border of Gikongoro prefecture must walk over 30 kilometers to reach a family planning clinic, though the standard adopted by the GOR requires a maximum service radius of 15 kilometers. This is true especially in Butare region, acknowledged to be the bastion of anti-contraceptive propaganda enforced by a written decree from its bishop. At this time the eight dioceses in Rwanda span the range of strongly conservative through somewhat liberal attitudes towards family planning, reflecting the attitudes of their respective bishops. ONAPO will need to continue to press the Catholic hierarchy to allow contraceptive distribution in Catholic-run facilities.

(9) Limitations on the use of mass media caused by low levels of literacy and restricted access to formal education are major factors which the ONAPO IEC program is still not addressing adequately. From 1962-1986, the percentage of the relative cohort attending secondary school has stagnated at only 2%, yet ONAPO's introduction of sex education and family planning curricula has to date only targeted this narrow spectrum of school age children. Only about one-third of high school students are female, though half of all primary school students are female. The curricula need to be introduced into the CERAI's (secondary vocational schools) and adapted for use in primary schools (which for the foreseeable future will be the limit of the formal educational system's access to a broad spectrum of the population). Two-thirds of Rwandan women and almost half of Rwandan men are illiterate, thus mass education materials (especially those aimed at women) need to rely on radio and face-to-face oral contact. Recommendations cited later in this report are designed to increase ONAPO's use of these two IEC methods.

(10) Logistical constraints on access to service delivery sites are major impediments to increase in contraceptive prevalence, especially for women using birth control pills, as only a one-month supply is currently distributed at a time by health clinics. The pilot Columbia University/ONAPO experiment in distribution of contraceptives by community-based health workers should be accelerated and carefully monitored to determine as soon as possible whether this is a model which could be extended more widely in future. MINISAPASO should also issue a directive approving distribution of multi-month supplies of birth control pills to women using this method in isolated rural areas.

(11) Structure of the private modern health service sector includes Protestant-run health centers and hospitals willing to expand the outreach of their family planning services if needed resources can be provided through future donor family planning support. The Association Rwandaise de Bien-Etre Familial (ARBEF), created by Protestant NGO's with support (prior to his appointment) from the now Minister of MINISIPASO, may eventually become an umbrella organization able to serve as the vehicle for this support. The newly formed association has not yet defined its program or structure, so at present working directly with individual NGO's through grant programs appears to offer the best opportunity for near term donor interventions. Private pharmacies in rural and urban areas could be targeted for training in family planning and distribution of contraceptives; as a first step ONAPO should survey pharmacists' attitudes towards and knowledge of contraceptive methods,

and availability for training, as input to the design of training formats. Now that physicians' private practice is legalized, this may also offer potential for an increase in private sector FP services in future.

(12) Rural-urban differences are important to consider in terms of: choice of contraceptive, relative accessibility of private pharmacies as alternative sources of contraceptives, frequency of venereal disease, and conservative versus more liberal attitudes towards premarital sex. Though injectable contraceptives are still preferred in both rural and urban areas over other methods, with pills in second place, the pill has become considerably more important in urban than rural areas. It is clear that a psychological connection has been made, however, between the success of general vaccination campaigns and the acceptance of injectable contraceptives as another preventive health measure. In urban areas, private pharmacies are more accessible, venereal disease is more common, and premarital sexual activity is more open and more accepted. Future FP interventions will need to be designed to take these rural-urban differences into account.

(13) Short post partum abstinence (8 days) coupled with a relatively short period of breastfeeding on demand (mean duration only 6.6 months) are the norm in Rwanda. Although breastfeeding may continue for a relatively long period, among older women for as long as 21 months, the anovulatory period during which they are protected from pregnancy is short leading to birth intervals of only 15 to 25 months. UNICEF is testing cooperative labor and child care programs designed to prolong post partum anovulation.

(14) Polygamy, though no longer legal, is found throughout Rwanda, affecting 18% of married women and 12% of married men (frequency increasing with age as 20% of men over 40 are polygamous). Regional differences are also a factor, with the incidence of polygamy increasing in the wealthier north and northwest portions of the country to include 30% of men over age 40. This probably increases national fertility overall by resulting in a higher proportion of women married throughout the reproductive portion of their lives. The ONAPO research unit should survey a sample of polygamous households to determine whether wives in polygamous households are willing to practice contraception even if their co-wives are not acceptors.

(15) Modesty of women as a cultural norm and inadequate training of health providers are resulting in inadequate gynecological examination practices. The modesty issue, along with hygiene problems, make barrier methods relatively unacceptable; this needs to be addressed in mass education campaigns. For women who prefer privacy over quick service, family planning services should be provided on a routine basis in health centers' multi-purpose consultation rooms, rather than only in segregated rooms (as is often now the case), and in a fashion which prevents public observation of the fact that the woman is receiving family planning services. Medical personnel should be made aware of the need to respect female clients' privacy and dignity in the way that exams are conducted and statistics collected.

(16) Age of marriage has been increasing over the past 30 years due to demographic pressure on the land, since rural men are expected to have access to land and to construct a house on it before marrying, and the cost of bride price is rising in both rural and urban areas, requiring a longer period of saving unless the partners enter into a "de facto" union (which happens frequently, especially in urban areas). Currently mean ages at first marriage

are over 21 for women and over 24 for men nation-wide. This is not necessarily a positive trend, given the suspected high prevalence of sexually transmitted diseases among premarital-age men.

D. Other Donors' Activities

Aside from A.I.D., the major donors active in family planning in Rwanda are the World Bank and UNFPA. UNICEF offers a relatively limited amount of direct support to ONAPO. Major elements of these donors' family planning programs in Rwanda are summarized below as background for the evaluation of A.I.D.'s contributions to date, and for recommendations on A.I.D.'s future role in this sector.

1. UNICEF

Family planning is a minor element of the UNICEF program in Rwanda though the organization's 15 year strategy (recently completed) acknowledges demographic pressure, and thus insufficient size of farm families' fields as a major cause of child malnutrition, morbidity, and death. Of the 214/1000 children who die before age 5, 127/1000 are under one year of age. UNICEF is devoting most of its resources (a minimum of \$1.1 million per year (which could rise up to \$5 million/year, depending upon other donors' contributions to the UNICEF budget) to primary health care, water supply projects, immunization, nutritional surveillance, and maternal health. **As an estimated half of all Rwandan women give birth alone at home, no strong professional midwifery tradition has developed within Rwandan society.** Through a sample group of health centers, however, UNICEF has been instrumental in establishing pilot censuses of those women who are sought, within certain communities, to assist on an adhoc basis with difficult births. Health centers willing to provide formal training to upgrade the skills of these midwives receive birth attendants' equipment kits from UNICEF to distribute to these women at completion of their training.

UNICEF is also concerned that child spacing is becoming closer over time, since Rwandan mothers' farm and off-farm labor reduces the frequency of breast feedings/day, and ovulation and next pregnancy are not deferred as long as they would be if at least six demand feedings could be given to infants daily. Thus, UNICEF plans to indirectly assist family planning by organizing 1,000 women's groups to undertake child care and farm labor collectively. Hopefully, this will allow mothers to breast-feed on demand at the fields, and prolong their post partum protection from pregnancy.

Direct UNICEF support for ONAPO activities was limited to \$41,000 in 1987 which supported selected communications/extension activities: three short term IEC consultant trainers, and the purchase of one vehicle, some videos, and other equipment. Over the next five years beginning January 1988, UNICEF plans to spend at least \$500,000 on further mass JP information efforts, but these funds will be shared by three organizations: CCDFP's, the GOR Office du Radio, and ONAPO. Funds for the CCDFP's will be used to train some 11,000 community volunteers in family planning methods to spread grass roots involvement in promoting family planning acceptance. Indirectly, other UNICEF program elements may support other donors' assistance in family planning. For example, UNICEF's functional literacy training for women could expand women's employment opportunities, expose them to written family planning information, and incrementally reduce incentives for large family size.

2. UNFPA

UNFPA collaboration with Rwanda began in 1976 with preparation for the 1978 census. UNFPA now has several assistance programs in place in the country:

- a. Basic data collection, census, demographic surveys.
- b. Studies of population dynamics to facilitate the formulation of population policies.
- c. Evaluation of population policies.
- d. Development of FP services integrated within national family health services.
- e. Development of IEC programs in population and FP.
- f. Family planning target programs for particular groups.

After the 1978 census, certain residual activities lasted through 1986, and then collaboration between Rwanda and UNFPA continued under an agreement with 2 major components. First, a project was conceived to provide institutional support to ONAPO, supported by the services of a demographer/economist advisor, with major project activities including the formulation of a population policy, the collection of basic data, and studies on population dynamics. Under this project, ONAPO carried out the 1983 fertility survey (in conjunction with the USAID MCH/FP project) and several 1986 secondary analyses on population models.

Secondly, ONAPO was given the responsibility for implementing an integrated FP program whose main components include long and short-term training for medical and paramedical personnel, provision of contraceptives (especially depo-provera), the organization of an extension seminar, and credit for the renovation or construction of several family health centers.

A new collaborative program has been designed, is already being implemented, and will cover the period 1987-1989. Its four components are:

(a) The New Family Health Project, being implemented by ONAPO, started during the second quarter of 1987. It focuses on the development of FP service delivery in rural areas that are far from health facilities. For this component, an experimental program of mobile teams will be established in several pilot zones, and agents responsible for FP service delivery outside health facilities will be trained. The project also has a video training program for ONAPO's IEC personnel. Observation visits to mobile and off-site FP programs in other countries are planned.

As in the past, the budget of the UNFPA project provides for the purchase of depo-provera and noristerat for the overall FP program in Rwanda. Norplant will be introduced as a contraceptive method by a specific sub-project which will include the training of medical personnel, the establishment of 2 pilot centers for service delivery, and evaluation of the first phase before considering expansion of the program to other centers.

Three other initiatives are still being designed:

(b) Support to the Census planned for 1988. UNFPA plans to contribute 10% of the total estimated cost.

23

(c) An IEC Project which will include a pilot program of home visits for family planning counselling and provision of contraceptives.

(d) A Project for the Reorganization and Development of Vital Statistics Registration

It is very likely that these three activities will also be implemented by ONAPO, except perhaps for the census, which is still being planned.

3. World Bank

The IBRD's five year Rwanda Family Health Project began in September 1986. Total project cost is estimated at US \$ 14,451,000 of which the Bank will provide IDA development credits in the amount of US \$ 10.8 million, the World Health Organization a grant of \$725,000 towards the technical assistance component, and the GOR a contribution of \$2,922,000 from regular budget sources.

The objectives of the project are to:

- a) improve the quality and coverage of integrated MCH/FP/Nutrition services;
- b) increase the number of paramedicals and improve the quality of their training;
- c) strengthen MINISAPASO management capability at the central and regional levels; and
- d) improve ONAPO's data base for policy formulation.

Emphasis has been placed on restructuring MCH by the addition of FP services and by the training of 1400 health center staff. The project is **expected to train 200 medical assistants, 400 nurses (A2 and A3 levels) and 800 nurses aides/social workers/nutritionists.** Duration of training programs would average about 7-10 training days per staff member per year.

The World Bank target for the number of new acceptors during the 1987 -1991 period is 200,000., representing 20 new acceptors per month at each health center. In comparison with our projections (see Table 1) this does not appear to be feasible. The IBRD's project design assumes that all private and public health centers will provide family planning services, and that all nutrition centers (162) will promote family planning.

The program proposes to achieve its objective of strengthening family health services through the implementation of a MCH/FP/Nutrition in-service training program for 1400 health center staff, including: (1) short and long-term foreign consultancies for curriculum development, training of trainers and operating costs; (2) medical supplies including modern contraceptives; and (3) the upgrading and equipping of 30 health centers including 2 staff houses per center.

Institutional strengthening of MINISAPASO will be implemented at the central level by providing the MCH and the Training and Studies Divisions with equipment, logistical support and a long-term WHO MCH/FP advisor. The decentralization process within MINISAPASO will be supported by: (1) training regional teams to implement in-service training programs; (2) strengthening

the management and supervision capability of the regional staff by providing short term consultancies, vehicles, supplies, equipment, and incremental funding for operating costs; and (3) by building eight MINISAPASO/ONAPO regional offices and 13 staff houses.

To relieve the shortage of paramedical personnel the project would provide pre-service training for 200 nurses aides, finance the construction of two new A3 level nursing schools, and provide technical assistance to improve teaching and curriculum development in the all the A3 schools.

The project will support ONAPO by providing funds for two operational research studies. The studies will focus on factors influencing the acceptance and continuation of contraceptive use, and maternal and under-five child mortality.

MINISAPASO project management capability will be strengthened by support for 48 staff-months of consultant architectural assistance for the project coordination office, a salary increment for a project coordinator, an accountant, equipment, and operating costs.



V. Progress to Date Towards Project Objectives

A. Project Goal

"To complement agriculture, energy, and other development projects to help bring the demographic situation in Rwanda into balance with development potential and to effect a general improvement in the status of health of the Rwandan population." (Quote from Project Paper)

The project goal is still well out-of-reach, given the limited number of family planning acceptors (less than 25,000 nation-wide). The project's mass education campaign has succeeded in establishing widespread awareness of the need to reduce family size in view of Rwanda's limited amount of arable land, and ensuing food production constraints. As the project's activities have focussed on family planning, investments have not impacted general health status in Rwanda.

B. Project Purpose

"To assist ONAPO and other concerned governmental entities (basically **the Ministries of Health and Social Affairs**) to **expand and improve their** capabilities to deliver family planning information and services to Rwandans." (Quote from Project Authorization)

To date of this evaluation, ONAPO has developed its capacity for delivering family planning information to Rwandans, but inadequate progress towards improved delivery of family planning services by ONAPO and MINISAPASO is a major issue still to be addressed by PACD.

C. Achievement of Outputs

On the whole, the team found that the original end-of-project targets were unrealistic on several counts, as acknowledged in the recent PP Amendment No. 5, given that Rwanda only began development of a national family planning policy and institutional capacity to implement that policy in 1981 with the founding of ONAPO and the onset of project activities. In particular, the following PP targets were not well thought out: (1) diffusion of research capacity and focus by defining research targets as a large number of studies (at least 25) rather than a focussed set of substantive products targeted towards specific objectives, (2) unrealistic schedules for the onset and completion of construction activities though sites were not identified nor construction plans prepared during original PP design, and (3) unreasonable expectations for the number of contraceptive users (84,000) to be reached by the original PACD (9/86). In mid-1986, a project implementation letter extended the project's PACD by two years until 9/88. Then in July 1987, PP Amendment No. 5 reduced all of these targets to more realistic levels based on empirical experience and added 400,000 dollars to the LOP funding level.

Though contraceptive prevalence is still very low nation-wide at an estimated 1.7 percent of reproductive age women, the number of new acceptors served is gaining momentum annually (30% from 1985-1986), with important regional differences attributable to the accessibility of service delivery facilities and the strength of Catholic Church opposition to modern family

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planning methods. First, by mobilizing Presidential support, ONAPO has catalyzed substantial improvement in national family planning policy, including Presidential support for training and dissemination of information on voluntary sterilization (which was forbidden until 1980). The announced ideal family size promoted by the Presidency is now four children per household, a relatively strong statement in a traditionally pro-natalist country, where the average number of children per mother still exceeds eight. ONAPO has taken the lead in confronting conservative elements of the Catholic hierarchy who contradict national policy reform by speaking against the use of modern contraceptives. Second, ONAPO has successfully initiated mass education in family planning by enlisting party officials at the communal, sectoral, and cellule levels in family planning information distribution. Third, ONAPO has successfully initiated research activities, notably completion of a National Fertility Study with A.I.D. financial support and AID/UNFPA technical assistance. Fourth, ONAPO has put considerable effort into collecting and compiling service statistics at three levels- service delivery site, ONAPO regional and central offices. Fifth, ONAPO is providing a wide range of contraceptive supplies free to public and private health centers and hospitals on a regular basis. Sixth, ONAPO has initiated the training of FP service providers at three clinical training sites (CHK Kigali, CUSP/UNR in Butare, and Ruhengeri Hospital) with assistance from A.I.D.'s centrally-funded JIPIEGO project in the case of doctors' training, and INTRAH in the case of medical assistants' training. Finally, in collaboration with MINEPRISEC, ONAPO has developed pilot curricula for extending information on sex education and family planning to secondary school students.

Despite this good beginning, by PACD much remains to be done within all of these components of ONAPO activity: (1) consolidated strategies for training service providers and increasing the delivery of services need to be prepared, (2) mass education materials need to be evaluated and refined and more use of radio for mass education needs to be programmed, (3) ONAPO evaluation capability needs to be developed, (4) MINISAPASO needs to improve prototype plans for new facilities' construction, and (5) ONAPO and A.I.D. project management needs to be strengthened. The first four project elements are discussed below, and management problems are discussed in the following section entitled "Inputs".

1. Information, Communication and Education (IEC)

ONAPO has made considerable strides in mass education under the project. In 1981, the majority of the Rwandan population had never heard of FP and the subject was considered taboo. In 1987, it was been estimated that most had heard about ONAPO and its mission. In addition, FP is now publicly discussed by the President, the Ministers and local government officials, even in the most rural areas, in communal and cell-level meetings. Although the objective of awakening awareness of FP in the Rwandan population has been reached under this project, considerable effort is now needed to encourage the population to use FP methods.

In view of the low educational level of the Rwandan population, ONAPO has launched a mass education campaign which focuses on personal relationships and oral communication. Radio, the country's most efficient communication medium, and theater have been used as vehicles to deliver messages during the campaign. ONAPO's major theme is that overpopulation is not desirable and

will not lead to development and an improved standard of living. However, too few radio programs are broadcast despite the fact that this means of communication has been successful in Rwanda. ONAPO's weekly program lasts only 15 min. and is limited to the 6:45 p.m. Monday time slot. The radio programs should be modified as needed, based on periodic evaluations of the population's expressed FP information needs. Nevertheless, an estimated 30% of women know about FP through the radio or through direct contact with ONAPO personnel. ONAPO has set up three theatre companies, but this required considerable effort, in contrast with the small audience reached in this way. ONAPO has also prepared printed materials to disseminate its messages. These materials include a successful series of posters (around 20) and a useful leaflet which visually describes FP methods and benefits. In addition, a series of booklets have been prepared in Kinyarwanda and in French, as well as a periodical entitled "Family, Health, and Development". These publications are specifically directed towards the literate population, a rather limited audience.

Recently ONAPO began production of video tapes, including a 20 min. presentation on Rwanda's demographic situation and development, prepared for Population Week in June 1987, primarily a promotional effort for ONAPO as an institution. Video production appears to be overly complicated, expensive, and inefficient as a means of mass communication in Rwanda.

ONAPO's IEC program has been designed to inform the masses on general population and development issues. Specifically motivating the general population towards a change of attitudes in favor of the use of contraceptives, however, has proceeded very slowly. Future efforts should now be focused on informing people about where services can be obtained. This conscious-raising campaign has lasted for 6 years. Now it is time to revise the themes and help the Rwandan population internalize the message. Behavioral change should be encouraged in updating the messages. It is likely that the need for this reorientation would have been appreciated earlier in the project, if a systematic program of mass education and information program evaluation had been incorporated into the development of the IEC campaign. In fact, as IEC has not been continuously evaluated, the progress of the campaign could not be measured incrementally and no feedback could be incorporated into the planning of future activities. It is only now that the Rwandan population is starting to pose questions on FP and to request clear guidelines, legal statutes, services available within a short distance of isolated rural users, and detailed presentations on FP methods. This indicates the depth of penetration of the messages transmitted.

It is now urgent to redefine and to diversify the IEC program and to ensure that this program becomes more and more linked to service delivery. In contrast, the evaluation team observed that IEC activities are not directly serving clinical programs. Rather, it seems that ONAPO's IEC section plans unilaterally, without much coordination with other sections such as research/evaluation and family health services. Though this project component was successful overall, in terms of mass education aimed at the general population and local authorities, important weaknesses exist, especially over the last few years, as the IEC division should have diversified its messages, identified various target groups for more intensive emphasis, and coordinated its efforts with other ONAPO sections.

The written material serves the needs of the literate adequately, but as they represent only a fraction of the whole Rwandan population, it would be preferable to produce more fold-out leaflets and posters intended for the illiterate population. The only leaflet of this type so far produced by ONAPO was much appreciated in the rural areas, as it seems to meet a need by supporting local talks led by burgomasters and lower level officials. The booklets which are provided to local government officials should contain more illustrations and should be subdivided into modular units more easily used at read-aloud sessions. Currently the texts are too dense and are therefore difficult to read. These publications would be more useful if they were accompanied by lists of typical questions and answers for trainers, to help them better respond to questions from their audiences.

In future, ONAPO's IEC section should follow the recommendations of the project-funded PCS consultant (M. Grieser) and solicit INADES (headquarters in Abidjan, branch office in Kigali) technical assistance to convert ONAPO booklets to more effective illustrated modular teaching materials.

Using trainers who can serve as role models aids the acceptance of FP messages. ONAPO should identify influential and popular persons with small families, cite them as models for emulation, and request that they play a key role in FP mass education campaigns.

2. Research and Policy Development Studies

Research activities (see "List of ONAPO Research" in Annex B) are a major project component although they do not represent an important budget allocation. The main goals of ONAPO's research program, substantially supported by UNFPA, were to develop a data base on reproductive health in Rwanda, to support mass education on demographic issues, and to reinforce delivery of family health services. The work carried out by the ONAPO research section is therefore divided in 3 distinct categories treated separately below.

The original project paper stated that 25-35 research studies would be the life of the project output from this component. Planning a research program by number of studies to be undertaken is inappropriate. The same level of effort is not required for a National Fertility Survey as for a pilot study carried out by only one person during a few weeks at a relatively low cost. A more detailed research work plan should have been developed during PP design.

(a) Research and Studies on the Development of Rwanda's Population Policy

Fundamental research such as the National Fertility Survey (1983) has been completed and even more importantly, this data and analysis has figured in speeches, memoranda, evaluations, and studies on the country's family planning needs. Further, this research has allowed ONAPO to provide major input to the GOR's preparation of the third and fourth national five-year plans, work useful for the development of the country's health policy, which has thus achieved one of the major project objectives.

(b) Service Statistics

Service Statistics must be used to support IEC and service delivery programs. Statistical data collection is one of the fundamental components of FP programs, as data permits follow-up on users in the different regions, and should serve as the basis for program planning.

Rwanda's system of FP service statistics was designed at project inception. Though simple, these statistics allow ONAPO's central level to obtain useful information on contraceptive users. The system includes one intake form which is kept at the health center, one coded form which is sent to ONAPO's central headquarters through its regional offices, and summary tables for the monitoring of health centers' activities. These forms are sent to the ONAPO headquarters every month, and include both the number of new acceptors and of continuing contraceptive users. Information on continuation rates is monitored at the level of the service delivery site, where it is used to track the reasons for abandonment through selected home visits.

However, the existing system is weak in that, as the program expands, record keeping will become more and more difficult, especially at the beginning of the year, when information on the total number of current users is copied over into a new registry by hand. The development of a simplified system will have to be considered in the near future, especially in large centers where the number of new acceptors can exceed 400 per year. The CUSP Butare filing system is especially well designed, as it permits an easy determination of drop-out rates. Thus the Butare system could be used as a model for training purposes. Accurate tracking of annual drop-out rates for each center is particularly important, as this information can be used to set up IEC target programs.

The evaluation team was able to analyze the service statistics for 1984 and 1985, but even by August 1987, the end-of-year statistical report for 1986 was still not available. This situation should be corrected as soon as possible, and delays in end-of-year reporting should not be allowed to occur in future.

An effort is underway to improve the service statistics system, as an internal evaluation revealed weaknesses in certain centers, such as delays in their submission of statistics to the central level, and their incorrect completion of patients' intake forms (which are rather long and complex).

A new statistical intake form has been designed with assistance from the project-funded technical advisor, and is now being pretested in 10 pilot centers. However, this new form has the following problems: only one line is reserved for all menstrual cycle disorders, although the treatment of patients may differ by case; one line is reserved for leucorrhoeas, but there is no room to note other sexually transmitted diseases, risking diagnostic confusion; and the back of the form leaves no room to note blood pressure during periodic consultations, which could have a harmful effect on the monitoring of FP clients. In addition to the new intake form, the patient registry has also been modified. The pages of the new registry will need to be able to withstand continuous use during a three-year period without wearing out or tearing. In his consultancy report, CDC consultant Neal Ewen, a specialist in service statistics and in contraceptive storage, made useful recommendations to this effect.

Overall, there should be a closer coordination of the activities of ONAPO's three sub-sections: service statistics, research, and the IEC planning unit. Each year, service statistics should be the subject of thorough analysis as a basis for the planning of mass education and FP personnel training programs, and surveys on choice of contraceptives relative to observed drop-out rates.

(c) Operations Research

Operations research in support of service delivery seems to be virtually absent from ONAPO's research agenda. This is very unfortunate as several important clinical and service delivery issues need to be studied in order to provide Rwandan women with a more complete range of FP services.

Two experimental projects are now being developed, one with SOMARC and the other with Columbia University, both geared towards diversifying service delivery programs. These projects should be carefully monitored to assess their success. A third operations research sub-project, funded by UNFPA, will introduce Norplant in Rwanda. The acceptability of this method deserves careful monitoring, as the GOR needs to identify a new long term (but not permanent) contraceptive method, as IUD's are not attractive to either rural **medical/paramedical personnel or the Catholic Church (which is more opposed to this particular method than to all others).**

It is possible that IUD's could be rendered more acceptable after a **thorough clinical investigation of the obstacles to use of this method in Rwanda.** Research should also be conducted on rendering barrier methods (such as condoms, spermicides and vaginal tablets) more client-acceptable. Given the prevalence of AIDS in Rwanda, it would be desirable to help these methods play a more important role in the future. Overall, ONAPO needs to establish a set of criteria for deciding which FP methods to promote at each service **delivery site.**

3. Training

A great deal of training in family planning has taken place during the six years of the project. Considering the difficulty of freeing up individuals to participate in external training without totally disrupting services, the training goals of the project were, nonetheless, extremely ambitious.

The original PP identified the training outputs as follows:

(a) In-Country Training

Training for providers of MCH/FP services was targeted at 250 medical assistants and nurses in the original PP. There was no document or combination of documents which clearly identified this type of training by type of professional, by activity, and by donor agency. The best estimate available is that, to date under USAID sponsorship, 140 medical assistants and nurses have received some form of training. This falls short, so far, of the number targeted in the PP.

Efforts have focussed on improving the quality of FP services by means of a national retraining program for paramedics conducted by ONAPO with project-funded support from INTRAH. INTRAH has been working with ONAPO primarily to provide training in clinical practice and supervision. In all, INTRAH plans to provide clinical training for 100 service providers in 1987 and 1988, but it was decided that IUD insertion will be excluded from INTRAH training, due to lack of a sufficient number of clients to allow adequate practice for trainees. Additional activities scheduled for 1988 are planned to include two management courses, introduction of Family Life Education, and a proposed study tour for ONAPO staff in January 1988 (still tentative).

From June 15-27, 1987, INTRAH conducted a "training of trainers" course for the 10 ONAPO Regional Representatives and their assistants (who are nurses) to:

1. adapt prototype INTRAH clinical training to Rwandan needs
2. review clinical skills of the ONAPO Regional Representatives
3. develop their clinical evaluation skills
4. develop criteria for selection of clinical training sites
5. establish a calendar for clinical supervision.

INTRAH found that ONAPO cannot adequately provide logistical support for training programs, and that at times there are not enough participants in their courses, making them cost-inefficient. ONAPO's A.I.D.-funded training center provides space to impart didactic material in FP, but there is no space for clinical training. Thus, when planning these training programs, sites for the clinical training will also need to be arranged.

To date, the project has placed greater emphasis on training personnel to perform IRC functions and research than service activities. Large numbers of inspectors of primary schools, teachers in secondary schools, and some vocational school teachers were trained. This was a deliberate choice made by the direction of ONAPO, as the goal was to have a major impact on school children. It is hoped through this program to use school children to educate their parents in family planning.

(b) External Training

Health staff were to be trained to provide services, conduct in-service training programs for family planning service personnel, and provide supervision of their activities. This training was to take place in the U.S. and third countries. The PP target for number to be trained in these functions was 32: 10 physicians and 22 medical assistants or nurses. Again, there was no document or combination of documents which clearly identified how many of each type of professional had been trained, by activity or by donor agency. Our best estimate is that 16 physicians and 12 medical assistants and nurses have received some form of external training under this component.

(c) Suggested Activities to Explore through PACD, and Continue in Future

The project's long term IEC training goals have been achieved, however, this was a difficult task. In planning a future project, realistic goals for long term training must be identified. Compatible language training programs

will need to be developed. Time must be provided for development of language skills when U.S. programs are the most desirable. Though, for the most part, IEC training programs have been successful in reaching their goals, it is now time to concentrate on developing service capability in family planning.

The lack of an overall training and human resource development strategy, planned to meet the present and long-term need for personnel to implement national MCH/FP programs, is a glaring omission. Indeed, ONAPO's training requests appear to be more responsive to donor requirements than to an overall plan. At the central level, there is no formal plan for the coordination of MINISAPASO and ONAPO training activities.

In future, in developing a coordinated strategy and long-term plan for the staffing of health centers, it would be worthwhile to ask certain questions. Is the basic training of personnel adapted to the tasks to be performed? Is the present staffing situation the right mix, given the shortage of trained personnel? What is the optimal health provider coverage per unit of population, and what will be the requirements 10-20 years from now? What training and financial resources are needed? Some of these questions do not appear to have been thoroughly investigated.

As the team was not able to interview the Dean of the UNR School of Medicine in Butare, and medical students were on vacation, it is difficult to evaluate either the extent to which family planning training has been integrated into the UNR medical school curriculum, or medical students' perception of its relevance and presentation. These are important issues for future assessment. In addition to its role in the training of physicians, the Faculty of Medicine should be able to play an expanded role in continuing education of physicians in MCH/FP.

Neither schools of nursing nor schools which train medical assistants were included in our site visits. Thus, we could not assess the level of family planning instruction within their curricula. However, the World Bank FP project includes a large component for the training of paramedics, and activities have already commenced with the development of MCH/FP curricula for GOR Schools of Nursing.

While it appears that health center personnel are working well with communities to promote family planning education and activities, there is much that needs to be improved and amplified. In particular, more personnel need to be trained to provide community education and supervision. Not enough feedback is being sent from the communal level to the regional and central levels on problems encountered. Health personnel and communities lack educational materials and, in some cases, lack vehicles, motorcycles or bicycles for supervisors and community educators. Perhaps most important of all, there are no innovative regional strategies which would take into account major regional differences, and thus use health personnel for mass training most effectively.

In addition, several studies are underway which are looking for ways to provide quality services to a widely dispersed population (e.g. Columbia University CBD study, SOMARC technical assistance, and UNICEF training of CCDFP volunteers). Hopefully, they will identify cost-effective and client-acceptable ways of providing FP services. Enlisting the CCDFP volunteers may prove to be a successful approach, but they will only be able

27

to supply limited types of barrier methods (such as condom). Though the use of community volunteers by ONAPO/Columbia University will begin in Ruhengeri, because of regional differences, a broader approach to testing this method may be necessary, with implications for selection of follow-on training sites. Programs such as CBD have great potential as a point of entry for community health and FP education.

Opportunities have been missed to educate women and men in FP resulting, in part, from the lack of clear guidelines for hospital personnel regarding their role in FP. For example, there is little or no education of women in maternities or pediatric wards regarding FP and where to get FP services. There is no education of men or women who are in-patients in other medical wards such as internal medicine or surgery, though they are captive audiences with medical problems which could be exacerbated by the advent of more children.

The role of the schools and parent/teacher involvement in FP education and services could not be thoroughly assessed during this evaluation. It should be noted, however, that ONAPO, with the assistance of INTRAH, has developed modules for FP and population curricula for secondary schools. This is a good start. As only a very small percent of the population is enrolled in secondary education, however, expanded programs for primary schools, CERAI's, and the University should be next, by priority order.

4. Service Delivery

An assessment was made of : (1) the relationship between the regional health services of MINISAPASO and ONAPO's regional and central operations and (2) private organizations, operating under government subsidy, which offer health services. Some problem areas have been identified and recommendations suggested. In addition, several areas for USAID technical assistance have been identified. However, as we were only able to visit a few private health service facilities, a much more in-depth assessment of private sector FP services would be needed as input to future design.

MINISAPASO is responsible for the delivery of health care nation-wide. Several reports citing the number of health facilities, both public and private, have been reviewed, but as there is no consistency among the reports, the following statements represent an estimate of both the number of health facilities and the number providing family planning services, using the latest figures provided by ONAPO. However, we recognize the reason for at least some of these inconsistencies in the reports on number of facilities providing family planning services, after our interviews with ONAPO regional delegates. They indicated that in their regions many Catholic health centers provided no contraceptive services whatsoever. A total of only 9 sites could be visited of the reported 183 nationwide; of these, only 3 were private facilities (1 Catholic and 2 Protestant). All of the health facilities we visited offered family planning information and services, with the important exception that modern contraceptives were not available from the Catholic facility. Though we can offer some insights on services, a full scale evaluation would require observation of more than the less than 1% of total facilities seen by the team.

Services are delivered in the public sector through a network of approximately 16 hospitals, 81 health centers and 36 other types of

facilities, and in the private sector by 10 hospitals, 29 health centers and 11 other types of facilities. The total number of health facilities of all types thus appears to be 183. Though all 183 are reported to be providing family planning services, probably the real number offering contraceptives is not more than 130, as Catholic facilities using only the Billings method have probably been counted. (See list of private FP facilities in Annex, which includes Catholic facilities). This falls slightly short of the 143 targeted in the PP, however, considering that there were only 30 facilities providing these services in 1982, this is still a major achievement.

The main problems identified were:

(a) The respective organizational structures of MINISAPASO and ONAPO, and the ambiguous nature of their relationship at the regional level, have limited national capacity to deliver efficient and effective FP services. Each of the 10 regions has both a MINISAPASO Regional Director of Health Services and an ONAPO Regional Representative. Policy has been formulated to define the relationship between ONAPO and MINISAPASO at the central level, but to date the relationship between MINISAPASO's Directors of Regional Health Services and the ONAPO Regional Representatives has not been clarified sufficiently. There is a wide range of informal collaboration between these two officials, **both of whom are physicians.**

In some of the 5 regions visited by the team, the ONAPO Representative serves as de facto "acting director" in the absence of the MINISAPASO Regional Director, in others he serves as the deputy to the regional director, and in some he has no duties whatsoever regarding mainstream regional health services delivery.

Recommendation: The Minister of MINISAPASO should clarify role of the ONAPO Regional Representative relative to the MINISAPASO Regional Director of Health Services.

(b) The ONAPO Regional Representatives are expected to perform a wide range of functions: administration, training, mass education, supervision, and clinical activities. The extent of involvement of each Representative in each type of activity appears to vary according to individual inclinations and aptitudes, however, the bulk of their time is spent on mass education, administration and statistics.

Recommendation: The ONAPO Directrice should issue guidelines to Regional Representatives on the percentage of time to be spent monthly on each of their functions, to ensure that each type of activity receives adequate attention.

(c) While ONAPO has prepared job descriptions for some central level FP professionals and for the Regional Representatives, there are no job descriptions for ONAPO's paramedics, to define their roles in family planning.

Recommendation: ONAPO should issue job descriptions for its paramedics at the regional level.

(d) MINISAPASO also has no job descriptions for its paramedics or even for Regional Health Directors. As there are no job descriptions, health workers are not able to situate FP goals and activities within a comprehensive conceptual and practical MCH/FP framework. As a result, many initiatives have been undertaken with little evidence of planning towards obtaining stated objectives. For example no guidelines have been issued by MINISAPASO to ensure integration of FP into the mainstream MCH service program. Because tasks and responsibilities have not been defined, health center personnel are inclined to concentrate their activities on clinical and curative MCH services rather than FP services and related counselling.

Recommendation: MINISAPASO should issue job descriptions for its Regional Health Directors and all categories of service providers, which clarify the role of each type of personnel in FP service delivery, and explain how delivery of FP services should be integrated with more comprehensive MCH service delivery.

(e) The health centers and hospitals refer all health service issues and information to the MINISAPASO Regional Health Director who, in turn, reports to the central level MINISAPASO Director of Integrated Services in Kigali. A new unit for MCH activities and a Bureau of Family Planning have been created at the central level of MINISAPASO, but their relationship with ONAPO's central and regional activities is still undefined. Both of these new MINISAPASO units do not appear to have developed protocols for coordination with ONAPO, and also have not developed norms either for the operation, supervision and evaluation of MCH/FP services, or for ensuring compatibility between the information systems of ONAPO and MINISAPASO.

Recommendation: MINISAPASO should issue a directive which clarifies the relationship between the new MCH unit and the new Bureau for FP, both within MINISAPASO's central office, and ONAPO central and regional offices. Implementation of this directive should include establishment of complementary information systems which can be aggregated at the national and regional levels.

(f) Services can be evaluated quantitatively and qualitatively. Quantitatively, the program has not reached one of the stated goals of the Project Paper: 84,500 acceptors by 1986. The actual estimated number of current contraceptive users is 24,697 (not including those who purchase contraceptives at private pharmacies). The percentage of reproductive-age women using contraceptives also varies from region to region. For example, it is estimated that, in 1985, 30.4% of women ages 15 -49 were using contraceptives in Kigali (a highly unlikely number), but only 2.3% in Gikongoro region. While the total number of users falls far short of the project target, given the low level of education and FP information among the majority of the Rwanda population in 1981, the sparsity of mass media communications, the opposition of the Catholic Church, the lack of public health facilities, and the shortage of trained and (available to be trained) FP personnel, the PP target was highly unrealistic.

Recommendation: Establish a more realistic target for the number of new acceptors to be reached over the next 5 years for inclusion in the Five Year Plan, and an action plan which directs public and private resources towards this end.

(g) The qualitative dimensions of the program are just as important. Services are delivered with differing degrees of competence, enthusiasm, and understanding. In spite of the extremely short time allocated for the evaluation, certain problems have been identified. As mentioned above, there are no job descriptions for physicians working in health centers and hospitals or for para-professionals. Therefore, their FP duties are not clearly defined

Recommendation: A pilot study in 3 or 4 sites should be introduced to test patient acceptance of different modalities of FP service delivery such as:

- (1) Variation in hours of service, morning vs. afternoon vs. evening hours.
- (2) Segregated FP services versus a format which integrates FP services into other health center activities.
- (3) Provision of services by a physician, or a medical assistant, or a nurse.
- (4) Differences in patient acceptance of services provided by a male vs. female provider.
- (5) Comparative rates of drop-out between centers offering in-depth FP counselling and centers without counsellors.

(h) Staffing of the health centers is extremely varied. Some centers have physicians and others only have medical assistants as directors. The number of and level of training of other staff members also varies considerably. The level of staff training in the delivery of MCH services as well as FP differs from center to center. From intake to services delivery to follow up there is little uniformity among health centers and not enough supervision. A lack of uniformity is not in itself to be criticized. If it is planned and is a means of taking into account regional differences and different levels of skill among health providers, it can be useful. In this case, it appears to be a deficiency in the planning process. While recognized as an important element in the delivery of FP services, supervision is not always well implemented. There is also a shortage of trained supervisory personnel at the central level. The regional ONAPO Representatives meet four times/year, a start in the right direction, but there is an urgent need for OPAPPO's central office to monitor regional activities by frequent site visits to the regional ONAPO clinics and communal health centers. There should also be more frequent site visits and more structured supervision of the communal health centers by the ONAPO Regional Representatives and by the MINISAPASO Regional Health Directors. There are also other problems to solve: availability of transportation, lack of training in supervisory techniques, and a need for a well developed and planned strategy for

the supervision of health centers offering FP services. This also leads to weak pre-method counselling and little follow-up on consumer satisfaction and side-effects of choice of method.

Recommendation: Each ONAPO Representative should report on the number of FP staff in each facility s/he supervises and the level of FP training of each. Uniform training standards should be set by ONAPO and a training plan for each region should be established.

(i) Health centers are generally equipped to provide a wide range of preventive and curative services. Newer health centers are now also integrating nutrition activities, while in the past, these were conducted at separate nutrition centers. Most centers visited by the team had in-patient beds for maternity and general medicine, and some had operating rooms for minor surgery. The new prototype governmental health centers will all have operating rooms, in-patient maternity, general medicine facilities, and nutrition centers. Many of the centers visited had a low bed occupancy rate for general medicine with a range from 0-30%, whereas maternity occupancy ranged from 20-60%. Of note, the center with a full-time physician had the highest occupancy rate as well as the highest out-patient load. Proper maintenance and appearance of physical facilities also attracts clients, but MINISAPASO does not have a plan in place for the maintenance of facilities, their equipment, or vehicles.

Recommendation: The prototype plan now in use for health centers nation-wide is over-designed, especially in terms of in-patient beds for general medicine, and for maternity. The GOR should revise the plan to ~~standards more appropriate to personnel levels,~~ construction and maintenance funds available. Also MINISAPASO should develop a maintenance plan for all A.I.D. funded health centers.

(j) The statistical form used for FP intake is too long, but even so, it fails to solicit some important information; the new pilot form now being tested, which was developed with project-funded technical assistance, has considerably more serious problems and deficiencies. Specifically, the new form lacks places to enter information on venereal disease, blood pressure, results of gynecological exams, and source of referral to FP services. Personnel responsible for completing these forms often confuse the columns which are designed to track the numbers of new acceptors versus the numbers of women merely changing their method of contraception, leading to misleading figures when statistics are aggregated at the regional level.

Recommendation: The pilot new FP intake form now being tested should be modified. A new FP intake form should be developed to replace the currently used forms, using guidance in this report.

(k) While there is a desire to provide more time-savings for patients, it may be an imprudent approach to provide FP services in an isolated setting, especially in those communes where the Catholic Church has taken a strong position against those services. Most of the health centers which provide family planning services on a daily basis have segregated family planning services from other MCH consultations. Services are generally provided in the morning, but some urban centers provide services in the afternoon in addition to the morning hours. In theory, FP clients do not have to wait for services in turn. It is said that they are brought to the front of the line ahead of those waiting for curative or MCH services. This can work either way: to encourage more participation in FP because women don't have to wait as long for these services (given that out-patient services at some centers usually attract 150 to 200 patients daily) or, conversely, this can create resentment in other patients as well as, in some cases, stigmatize women coming for FP services.

Recommendation: As a service alternative, MINISAPASO should issue directives that ensure that FP, when requested, can be provided as part of integrated MCH consultations, to serve the needs of women who **desire more privacy, or who come to seek services** at any time of day.

(l) There is no fee for FP services in government facilities, and although there is a fee for other medications, contraceptives are free. ONAPO formerly provided free medication to treat any side-effects from contraceptive methods. This practice has now been discontinued, a cause of contraceptive abandonment.

Recommendation: Free FP services should continue to be provided **at public health centers, and at private health centers** if possible. In future project design, donors should support free treatment (including medication) for the side-effects of contraceptive use, to discourage abandonment. (One evaluation team dissented from this recommendation as he believed that no medication should be subsidized in Rwanda).

(m) There is no standard practice regarding physical examinations at FP intake, nor any guidelines reflecting respect for the privacy and dignity of the patient during exams. Unfortunately, because of time constraints, there was no opportunity to examine this issue more closely by observing the patients during the entire process from intake through service delivery. Nonetheless, certain problems emerged. Notably, use of physical examinations varies from provider to provider. Some conduct a complete physical examination including gynecological examination, blood pressure determination, and laboratory tests, while others do none of the above. Furthermore, there does not appear to be enough consideration given to FP patients e.g. by providing a place to disrobe privately, or a drape to cover the patient during an examination if her clothes can not be used for this purpose.

39

Recommendation: In consultation with ONAPO, MINISAPASO should issue a directive which sets standards for the delivery of physical examinations within the overall provision of FP services, and establishes the frequency at which examinations should be conducted.

(n) Availability of contraceptives varies considerably, largely due to the level of training and interest of each health facility's staff, though patient demand is also a factor. At present, the method of choice everywhere is injection (62%), with oral contraceptives (31%) in second place, and the IUD a somewhat distant third (5%). Barrier methods have not reached any level of high usage but perhaps, with the threat of AIDS, the use of condoms and other barrier methods will play a more significant role in the future. Sterilization is practiced in most government hospitals, but usually only for medical reasons. The procedure currently used is the mini-lap, but JHPIEGO is planning to begin training in laparoscopy shortly.

Recommendation: Combined efforts by donors (UNFPA, A.I.D., etc.) and trainers (UNR, JHPIEGO, ONAPO, INTRAH) are needed to ensure that a more complete selection of contraceptives is made available at a wider range of FP service delivery sites nation-wide, to better meet client-specific needs.

(o) Follow-up on patients who appear to be dropping out varies from health center to health center. Visits are made to some households, but distances and the difficult terrain do not encourage great activity in this area. Other donors (e.g. IBRD and GTZ) are now funding FP abandonment studies in pilot areas.

Recommendation: ONAPO should fully review the findings of these studies, and identify follow-on funding for annual updates and/or abandonment studies in other regions, if needed, after initial results are analyzed.

(p) ONAPO's central coordination of investments in education and/or services in other ministries such as the Ministries of Defense, Youth, Labor, Agriculture, etc., should be strengthened.

Recommendation: ONAPO and MINISAPASO should collaborate to prepare a strategy for ensuring regular supervision of FP services provided within all public health facilities, including those managed by other ministries, for example, military camp dispensaries and health clinics run by the Ministry of Defense.

(q) It is difficult to evaluate the role of NGO's in the private sector in FP service delivery. First, an insufficient sample of facilities was included in the team's site visits. Second, those services which are available from Catholic facilities are so discretely provided that it is impossible to ascertain the number of

acceptors or the quality of the services. There is no doubt, however, that the Catholic Church has prevented FP service delivery in most (but not all) of its health facilities. The Protestant facilities, on the other hand, appear to be actively providing FP services.

Recommendation: ONAPO Regional Representatives should survey all Protestant health facilities in each of their respective regions, to determine the level of services being provided, and to report on the amount of FP training already received by, and needed by each staff member in these private facilities. This information will be needed to design a new FP project with a strong NGO service component.

(r) ONAPO has recently prepared a strategy for introducing FP education and services into the dispensaries run by private and parastatal enterprises for their employees. ONAPO should continue with these efforts.

Recommendation: ONAPO should assign a priority to implementing this pilot project by PACD.

(s) In general, data on users is not being provided to all levels within MINISAPASO and ONAPO for use in monitoring programs and services. The data system lacks timely monitoring of trends in the need for services and analysis of implications for the programming of services.

Recommendation: ONAPO and MINISAPASO should collaborately develop a plan for sharing and distributing FP service statistics, aggregated at the national level, to all FP service providers on a regular basis.

(t) A plethora of short and long term advisors have been provided to ONAPO to study the services aspect of its programs, but advisory activities have not been coordinated among the donors, and there is no clear indication that recommendations are being implemented.

Recommendation: ONAPO and MINISAPASO should organize a Donor Coordination Committee, to meet on a quarterly (or more frequent) basis to ensure complementarity in donor-provided technical assistance, training, commodities, construction, and research in family planning.

In conclusion, although this evaluation highlights some of the deficiencies in the delivery of FP services which must be addressed, the evaluation team acknowledges the effort already made towards the establishment FP services, and results obtained so far are noteworthy. ONAPO's present concern about the improvement and extension of its FP activities is an example of its realistic approach towards the search for new strategies and technologies for implementing national population policy.

5. Commodity Management

ONAPO's purchase and storage of contraceptives and other project equipment was reviewed twice in 1986: first CDC consultant Neal Ewen assessed contraceptive handling; and then Alain Joyal evaluated administrative activities involved in the management of project equipment with emphasis on the vehicle fleet. The part of the project budget allocated to the purchase of equipment is rather large, especially the level of funding for the purchase and maintenance of vehicles. Both assessments have made recommendations designed to improve ONAPO's management of equipment. Unfortunately greater effort should have been made in late 1986 and in early 1987 to implement these experts' recommendations.

While a program is still small scale, it is relatively easy to manage its equipment with simple administrative procedures, but as it expands, it becomes imperative to establish more complex controls. ONAPO has now become a large organization with more than 200 employees, which needs strict operational rules for all services and a control system in keeping with the scope of its program. At a minimum, controls which normally exist in GOR institutions should be rigorously implemented at ONAPO.

Management of the ONAPO vehicle fleet continues to be inadequate as the control of mileage suggested by a project-funded consultant has not yet been implemented. This situation is potentially problematic as the vehicle fleet is aging and no replacement program thus far exists. In view of present deficiencies in the management of the vehicle fleet, ONAPO may not be capable of being put in charge of the 1989 national census program, which would require management of a much larger fleet.

As to management of medicine stocks, contraceptives and supplies, recommendations made by Mr. Ewen should be implemented. One of the main problems is limited size of ONAPO storage facilities. This will be corrected after the construction of an ONAPO warehouse, to be completed during the coming year with UNFPA support. Nevertheless, strengthened control systems are needed, and inventories should be conducted more frequently.

Availability of contraceptives in rural areas does not seem to be a problem. The health centers visited by the evaluation team had a complete range of contraceptives stored appropriately, though stocks kept in each center were rather small. In fact, it is likely that quantities ordered and delivered are too small, requiring frequent restocking of these centers, an inefficient practice. However, the present system has one advantage: small quantity deliveries insure better control over expiration dates.

USAID and UNFPA adequately coordinated purchase of the equipment for renovated and newly-built health centers, assisted by a physician from ONAPO and an AID/W centrally-funded expert in medical equipment, who together helped to establish complementary purchase lists for the two donors. As the size of the project-funded health centers is much larger than the ones planned at the beginning of the project, the equipment budget was reduced to support increased construction costs, complicating the project's procurement activities and requiring donor coordination. It is thus of utmost importance that use of the project's equipment funds be well planned.

6. Facilities Construction and Renovation

The project's main objectives were to provide training and technical assistance for MCH/FP programs. Since 31% of the project budget was spent for construction and equipment, however, more rigorous design review by AID was needed, and a willingness to reduce the number of health centers, on the part of ONAPO, would have saved project funds for more central project components.

According to the PP, four health centers were to have been completed before PACD. Of the four health centers to be constructed, only one has been completed (in 1984), as most of the construction in this case involved remodeling and small additions to an existing facility and some extra equipment. Even so, to date, the center's operating room has still not been equipped. The remaining three health centers will be completed by 1988.

Original construction completion deadlines were unrealistic and, during project implementation, there was a change in design of the new health centers which required many institutional actions before final acceptance. The plan finally chosen for the three construction sites was the new national prototype health center design defined at the GOR's highest levels (Conseil du Gouvernement) in 1984. It is a plan more appropriate for a mini-hospital than a health center, as it has an operating room and in-patient beds for maternity and general medicine. Several specific problems, other than the delays in construction discussed in Section D. "Inputs" later in this report, have been noted during this evaluation:

- 1) Inadequate assessment of existing health facilities was undertaken before sites for the health centers were approved. For example, the Kibilizi center (already completed) is located in a village where the Catholic Church is particularly strong in its opposition to family planning, so very few family planning acceptors use these services. Staffing is also a concern at this center because of personnel shortages and lack of staff housing.
- 2) A critique of plans for the new health centers found that while the GOR provided a prototype health center plan, this plan was never redrafted for each site to fit the actual terrain. At the Nkuli new construction site, the team noted that no actual construction drawings had been prepared to guide the works; only the prototype plan was guiding the actual construction activity. The rooms are dark, cold and unwelcoming for services delivery and health education, because all windows are small and high up near the ceiling on the heavy masonry walls. "As built," the center is composed of four buildings separated by large distances which make staffing and maintenance difficult and waste what little land is available. Unless many more health providers than normal are to be trained and assigned to the facility in future, there is too much wasted space for certain activities. The operating rooms are too large for the type of paramedical activities usually performed in GOR health centers. Laboratories are also very large, implying that they will be used by a laboratory technician or laboratory aide. As these paramedics are in short supply, it is doubtful that one can be assigned to each health center.

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Since most deliveries take place at home, few patients use health centers or hospitals for normal deliveries. When pre-natal exams identify problems, the paramedics refer patients to health centers or hospitals where physicians can render the necessary medical care. These A.I.D.-funded health centers will all have maternities with a delivery room and in-patient beds, as well as beds for surgery and general medicine. As mentioned previously, at other existing health centers visited by the team, the bed occupancy rate was extremely low, except when a physician was in attendance.

It is difficult to predict when the three remaining health centers will actually become operational, as no provision has been made for staff housing at either the health centers themselves or in the surrounding communities. Staff housing should have been assigned a priority at the cost of reducing in-patient beds, since beds could always have been added later, as needed, through a future addition.

3) The project-funded training center was completed in 1986. Though land is scarce in Rwanda, the designs for this center squandered it, by spreading nine buildings over the site. This has caused two problems: (1) extra cost since construction costs rise significantly as wall area increases, and (2) cramped spacing between buildings, as new structures are added to the site using other funding sources. For example, a contraceptive warehouse is now being constructed with UNFPA funds in a place that will block light and air needed for the facility's main auditorium. There are 60 individual rooms, each with a sink, to house students and teachers, but an insufficient number of showers and toilets to serve this many beds. By eliminating walls, many of these rooms could have been enlarged to become double rooms, eliminating the unnecessary expenditures for extra sinks, and allowing needed **construction of more bathrooms. Teaching space consists only of two large auditoriums; no small break-out rooms were designed for small group discussions. Further, the laundry and kitchen areas were poorly designed and are thus not very functional, and the dining room is too small to comfortably seat the up to 60 persons housed on site.**

Since the opening of the center six months ago, only three groups have used this facility for no more than two weeks each. Of these groups, only one participated in a family planning program. Because there is not as yet a plan for the use of the center for FP training, ONAPO is trying to rent the space to other groups as a contribution to recurrent costs. Preparation of a plan for using the training center for FP education should be assigned a high priority in the 1987-1988 A.I.D./ONAPO work plan for project-funded technical assistance.

D. Delivery of Inputs

A combination of factors required a two year PACD extension in FY 85, and the addition of \$400,000 in supplemental A.I.D. funds which was obligated late in FY 87. Provision of inputs has been problematic because of:

- Less than adequate planning and negotiation prior to project approval

- delayed GOR provision of sites and prototype plans for construction
- delayed GOR identification of counterparts for external and in-country training
- gaps in the recruitment of long term technical assistance
- frequent turnover in A.I.D. Project Officers
- lack of a GOR Project Manager
- complex array of S&T/POP centrally-funded interventions and large number of discrete in-country and external participant training events, all requiring plans and monitoring
- vacancy in the position of ONAPO Financial Manager from 1983-1987 during project implementation
- identification of problems in financial tracking and planning relatively late in project implementation.
- no clear plan or accounting for GOR inputs to project activities.

As no construction sites were identified during project design and negotiation of the grant agreement, production of even preliminary construction plans was delayed until well into project implementation. In the case of the training center, more delays ensued when the site finally identified was found to be zoned for four story construction. Finally the GOR provided an alternative site where the one-story complex planned within the project budget could be constructed. As a result of these negotiations, reviews, and changes in plans, the training facility was completed three years later than expected in the original PP.

GOR prototype plans for the health/nutrition centers construction component were revised a number of times, as national standards for such facilities were upgraded to become specifications for mini-hospitals in rural areas. As a result, the covenant in the original PP which required sequential completion and start-up of services at each site prior to the construction of the next facility could not be honored, even with the PACD extension. Construction cost also rose significantly, requiring a budget revision at the expense of the training and technical assistance inputs. Even though these three combined health/nutrition centers will come on line two years later than scheduled in the original PP (expected inauguration date 12/87), plans for their staffing are still not in place.

Of all project-funded construction, only the renovation of the Kibilizi health center proceeded relatively smoothly with completion only one year later than planned. It is very unfortunate that the infrastructure component has absorbed such a large share of project inputs (31% of funds and a considerable amount of A.I.D. and ONAPO management time and attention), as these activities are somewhat tangential to delivery of improved FP services nationwide- the main thrust of the project. A greater share of the project's resources should have been devoted to training of FP service providers already staffing existing health centers. In-country training probably did not require a special ONAPO training center, as other facilities are available for training activities in country (e.g. the IWACU training center funded by the Swiss, and another facility in Remera).

The original PP did not provide a strategy for the use of external and in-country training to meet project objectives. As there are few Rwandan English language speakers available for external training, and since the project had to build and staff a national population institution before training candidates could be selected, considerable delays were encountered in delivery of the training inputs. There are built-in disincentives for long term participant trainees in the GOR system; returnees from both short and long term training receive the same 400 Rwandan francs/month salary supplement, and regular GOR salaries are discontinued and jobs put at risk after a six month stay outside the country. Thus, there is a preference for many short external training events, as a new salary supplement is earned for each trip regardless of duration. In-country training of paramedical service providers did not gain much momentum pending completion of the ONAPO training center in 12/87. A wide array of in-country training events have been supported by the project, but they have not been systematically planned and coordinated, so it is difficult to assess their impact.

In delivery of long term technical assistance inputs, provision has not been made for continuity, through overlap in recruitment or the planning of interim short term assistance. In line with the original PP, the first resident advisor focussed on developing IEC and research capacity within ONAPO. A seven month hiatus occurred at the end of his contract while A.I.D. and ONAPO defined the skills needed from a follow-on resident advisor. The evaluation team supports the decision reached at that time to recruit a physician experienced in the planning and management of improved FP service delivery systems, rather than a FP curriculum development specialist as called for in the PP. Provision should have been made, however, for interim technical assistance to fill the seven month gap between these two advisors, to maintain the momentum of project activities. The second advisor notified A.I.D. in April '87 that she would be departing-country by August, but again steps have not been taken for timely placement of a follow-on advisor. Though **adequate funds for a full year contract for a follow-on advisor were not** available until July 1987 obligation of a \$400,000 LOP supplement, technical assistance funds available could have been programmed for timely short term advisors to maintain continuity in project activities. As PACD will be 9/88, the evaluation team believes that time needed for advertisement, recruitment, and relocation of a new advisor would create another gap of up to six months, making it infeasible to contract for another resident advisor. A plan needs to be developed for using remaining technical assistance funds to establish the groundwork for a new project through short term technical assistance. Repeat visits and multi-purpose consultancies should be planned to maintain as much continuity as possible through PACD.

A.I.D. project officers turn over frequently in Rwanda. A.I.D. project management has changed hands five times over the course of the project, though one of these hand overs involved previous short term duty by the current project manager. These transitions were difficult, because the files have only included regular project implementation reports for the last few years of the project, a great amount of business was only handled orally in the early years, and overlap often was not possible.

An intricate array of A.I.D. S&T/POP projects and consultants have been used for project implementation. These include: (1) INTRAH training of paramedical personnel, (2) JUPIEGO training of physicians, (3) PCS recommendations on IEC strategies, (4) MSH technical assistance for management

and training, (5) PRITECH's midterm project evaluation, (6) CDC involvement in analysis of service statistics and contraceptive procurement planning, (7) FHI bio-medical research, (8) SOMARC recommendations on initiation of a social marketing program, and (9) Columbia University sub-project for community-based distribution of contraceptives. All of these activities, mainly consultancies and training, were supported by A.I.D.'s central funds, except for INTRAH training paid from the project's own budget. In addition, a number of outside short term consultants have been funded to provide recommendations designed to improve ONAPO's management and accounting. Follow-up consultancies by the same individuals have only occurred on occasion, making it difficult for ONAPO to implement the various sets of recommendations, particularly since the reports are often finalized without the benefit of the follow-on dialogue needed to adapt the recommendations to the Rwandan context. Further, backstopping this wide array of institutional and individual inputs has absorbed a large share of A.I.D. management time, diffusing attention needed for strategic planning, narrowing of focus to a manageable set of activities, and on-site monitoring in the field. In future, USAID/Kigali should use fewer S&T/POP resources, and maintain continuity in technical assistance by requesting repeat or multi-purpose consultancies by those S&T/POP resources that are most crucial to the project.

Near the end of 1984, relatively late in project implementation, A.I.D. became concerned about ONAPO's inadequate control over project funds for construction and local costs (per diems for field work, vehicle fuel and maintenance, supplies, etc.). Though a remedial consultancy by an accountant was provided at the end of December 1984, the recommended improvements in accounting procedures were not implemented for a year. The same consultant was then recruited for a second consultancy in 12/85, again updated the books, and finally succeeded in training ONAPO accountants to implement the new procedures. At this time, funds for construction and local cost expenditures were finally separated, and transfers of funds and incorrect attribution of expenditures between the accounts of A.I.D., UNFPA, and the GOR were finally rectified. A.I.D. and ONAPO were then dismayed to discover that almost all funds for local costs had already been expended, leaving little support for the two year PACD extension already approved. This situation is partially attributable to the fact that the position of ONAPO Financial Manager has been vacant since 1983, during most of project implementation. UNFPA is currently providing almost the only external support beyond GOR resources for the remainder of PACD and relations between ONAPO and A.I.D. suffered throughout most of 1986 over this shortfall in local costs. Lack of attention to the establishment of financial management procedures and training early in project implementation is at fault, and these abrupt remedial measures late in project implementation have strained relations between A.I.D. and ONAPO. As soon as a Financial Manager is appointed, A.I.D. should immediately provide training appropriate to his or her skill level in A.I.D. financial project management and reporting procedures.

As with previous consultancies and audits, the evaluation team was unable to obtain any reporting from ONAPO on the GOR's contribution to project activities. For example, ONAPO is receiving 67 million Rwandan francs in operating budget support from the GOR this year, but the budget is so general that it is impossible to determine what funds are complementing UNFPA versus A.I.D. or other donors' activities, and some categories (e.g. loans to

employees, largely for housing construction) are not eligible to meet the 25% project contribution required in a project funded by the A.I.D. Development Assistance account.

Even ONAPO's future research proposals only include a global cost figure, with no breakdown of how this is estimated or with any attribution of A.I.D. or GOR inputs to costs. As a result, ONAPO has little grasp of the recurrent costs necessary to sustain various levels of activity by sector. Any new project designed for the future will require a detailed budget plan for the GOR contribution, updated annually by A.I.D. and the GOR during project implementation. In addition, as part of the conditions precedent to any new project, the GOR should be required to identify a host country project manager as a counterpart to A.I.D.'s project officer, who will serve as A.I.D.'s contact for coordination of and reporting on all substantive project activities.

E. Validity of Assumptions Made During Project Design

A number of external factors, unforeseen during project design, have constrained project outputs, especially the number of contraceptive users. First, strength of Catholic Church opposition to the use of modern contraceptives was under-estimated. An estimated 80% of IUD users in the Butare region alone dropped out in 1984 because of Catholic Church pressure to abandon this form of contraception. This factor continues to exert considerable influence on contraceptive prevalence rates, though the President has challenged the Catholic Church on this issue.

Second, international controversy over the use of depo-provera in 1983 - 1984 caused a one year hiatus in use of this method, the most popular one in Rwanda. Early in 1984, a U.S. Review Commission under the auspices of the U.S. Food and Drug Administration approved the use of depo-provera for therapeutic but not contraceptive purposes. International press reports on the depo-provera controversy caught Rwandan attention and provoked a strong reaction in the country. Though depo-provera is purchased by UNFPA, A.I.D. efforts to promote family planning are extremely dependent on UNFPA provision of this drug, as other methods are relatively unattractive to Rwandans. A.I.D.'s project target for contraceptive prevalence to be achieved by PACD relied on the acceptability and availability of injectable contraceptives provided by other donors.

Third, the lack of an ONAPO Financial Manager during most of project implementation could not be foreseen during PP design, but this factor has contributed greatly to delays in construction, the shortfall in funds for local costs, and other problems in delivery of inputs.

Fourth, project design did take into account the prolonged absence during project implementation of participants sent overseas for training.

VI. Summary of Recommendations for Implementation by PACD

The recommendations are divided among the following topics, in priority order: management, policy, service delivery, training, IEC, and research. Within each category, the most important recommendation is presented first, with others following in descending order.

A. Management Recommendations to be Implemented by ONAPO and MINISAPASO before PACD:

1. An organizational weakness which needs to be corrected is the low level of responsibility for MCH/FP within MINISAPASO. To strengthen and integrate MCH/FP services within all health facilities nation-wide, and within MINISAPASO, it is necessary that the MINISAPASO Director General of Public Health have direct responsibility for MCH/FP. This should be implemented by directive from the Minister of MINISAPASO.

2. ONAPO and MINISAPASO should collaboratively establish a Donor Coordination Committee, including representatives from each donor resident in country and active in FP, and this Committee should be convened at least quarterly to review all donors' work plans and budgets to ensure complementarity in FP activities.

3. The recently appointed an ONAPO Financial Manager should receive training (appropriate to the person's skill level) in A.I.D.'s financial management, accounting, and reporting procedures.

4. The ONAPO Directrice should designate one of her staff as GOR Project Manager, to serve as a counterpart to the A.I.D. Project Officer. This ONAPO staff member will be responsible for coordinating all A.I.D. project activities through PACD, and for meeting regularly with the A.I.D. Project Officer to report on progress and problems, and to plan future activities.

5. As June 1988 input to the 1989 GOR budget exercise, A.I.D.-funded short term technical assistance should be recruited to assist ONAPO and MINISAPASO to prepare a plan for GOR recurrent cost support for FP activities which explains, in detail, what the recurrent costs will be for the GOR's targeted level of FP training and service delivery nation-wide.

6. ONAPO should standardize its systems for control of finances, vehicles, equipment and supplies, using the recommendations of project-funded consultants (e.g. Joyel, Even, and Dupras). As first priority, ONAPO should implement the recommendations of the Joyal management consultancy report regarding car pool management, especially control of mileage. Also, ONAPO should improve stock management and control systems, including those at the regional and health facility level, even if more paper work is involved.

B. Policy Recommendations

1. ONAPO must resolve the difference between the 15% contraceptive prevalence target proposed by ONAPO for the GOR's 1987-1991 Five Year Plan and the more realistic target of 6.4% contraceptive prevalence predicted by the evaluation team for 1991 on the basis of ONAPO's own service statistics.

2. ONAPO should develop the text of a law on MCH/FP which will actualize national MCH/FP policy, to permit health professionals to deliver all methods of contraception, including permanent methods. The Minister of MINISAPASO should take the lead in proposing this legislation for enactment.

C. Service Delivery Recommendations

1. A.I.D. and ONAPO should collaboratively develop a strategic work plan and budget for the provision of short term technical assistance for improved FP service delivery through PACD.

2. ONAPO should revise the new FP intake form currently being tested, to provide space for source of referral to FP services, blood pressure determination, venereal disease information, and results of gynecological exams.

3. ONAPO and MINISAPASO should collaborate to develop a standardized home visit program to follow-up on apparent abandonment of contraception. This home visit program should be executed in the regions by directive from the Minister of MINISAPASO.

4. By June 1988, for the next GOR budget exercise, ONAPO and MINISAPASO should collaboratively analyze requirements for vehicles, motorcycles, and bicycles for the supervision of FP services in the regions.

5. ONAPO should begin training health providers in the proper storage and filing of service statistics, using CUSP Butare's system as a model.

D. Training Recommendations

1. ONAPO and MINISAPASO should collaboratively place the greatest emphasis in training until PACD on the clinical training of physicians, nurses, and medical assistants in FP and related counselling, including information on the importance and use of service statistics (currently under-reported).

2. ONAPO must report fully to MINISAPASO as soon as possible on the number of health services personnel trained in FP, by name of facility in which they are working, and the content of the training each staff member has received. Using this information, ONAPO and MINISAPASO should collaborate to develop a national FP human resources strategy and training plan to serve all public and private sector facilities (including those run by other ministries, like military camp facilities). The training plan should provide regular refresher courses for all levels of personnel.

3. Project-funded short term technical assistance should be recruited to evaluate the impact of A.I.D.'s bilaterally-funded and centrally-funded training in FP to date, and to assist ONAPO and MINISAPASO with development of the above strategy and training plan.

E. IEC Recommendations

1. ONAPO should identify the most important groups to be targeted by IEC activities.

2. ONAPO should emphasize face to face interaction and radio in its mass education activities.

3. ONAPO should evaluate the ways that burgomasters, sectoral conseillers, cellule leaders, and CCDFP's are transmitting IEC messages, and use the findings to improve IEC training programs.
4. ONAPO should design and conduct an evaluation of the effectiveness of the fold-outs, posters, brochures, and radio programs already issued, and use the findings to plan an IEC strategy aimed at the priority target groups identified above. Any data already collected by ONAPO in collaboration with UNICEF, that would assist in evaluating FP radio programs' effectiveness, should immediately be analyzed.
5. ONAPO and MINISAPASO should immediately request feedback from their Regional Representatives to compile a list of the difficult questions most often asked about FP in mass education sessions, and should then start training community leaders at the communal, sectoral, and cellule levels in how to answer these questions.
6. ONAPO should immediately start negotiations with ORINFOR for an increase in radio air time, for broadcasts on contraceptive methods and more frequent airings at varied hours with peak audiences.
7. If budget permits, ONAPO should produce more illustrated fold-out brochures to publicize each of the FP contraceptive methods more fully, and explain where services can be obtained.

F. Research Recommendations

1. Accelerate and evaluate experimental/innovative distribution programs to identify successful experiences which could be replicated more widely (e.g. Columbia University community-based distribution pilot project and SOMARC social marketing recommendations).
2. Priority should be assigned to use of project-funded technical assistance to develop evaluation capability within ONAPO's Research Section. The team suggests that an in country training workshop be organized for this purpose. Evaluation skills thus developed should be used primarily to improve service delivery and IEC programs.

61'

VII. Future Directions

A. Resource Allocation/Management

To continue to build on the foundation laid by the 1981-1988 MCH/FP Project, future donor investments could be designed to:

- (1) Sustain the momentum of GOR population policy reform,
- (2) Continue grass roots mass education in family planning,
- (3) Extend and improve family planning services nation-wide.

The team believes that future donor funds could be most effective if used to support ONAPO, MINISAPASO, and the private sector in their respective roles in these three activities. All three components are needed, but the main thrust should now be extension of family planning service delivery, through a public/private partnership effort.

A share of donor funds could continue to support technical assistance, training and out-reach by ONAPO for specific activities including:

- policy studies
- development of a national strategy for FP personnel development and training (especially to accelerate training of clinical personnel in FP)
- development of region-specific action plans for mass education and service delivery
- improved guidelines for service delivery
- a strategy for private sector (including community-based) FP counselling and contraceptive distribution
- improved IEC materials (written materials for oral delivery and radio programs)
- strategies for working effectively with communal, sectoral, and cellule leaders to promote FP acceptance.
- research to improve IEC
- use of service statistics for improved service delivery

A second share (larger) of future donor funds could be productively used to support MINISAPASO in its role as major provider of FP services nation-wide, with specific attention to management planning, training and supervision of service providers, and logistical support for work with community leaders and private sector service providers. As the World Bank will already be financing a considerable amount of training, technical assistance, and facilities development for the public sector, other donors will need to develop a detailed plan for support which complements IBRD investments.

62

A third and important share of future donor funds for family planning could support private sector activities in FP counselling, mass education, and service delivery. In the near term, assistance channeled to the NGO's already active in FP and willing and able to intensify out-reach and services, or to open facilities in underserved areas, should be increased. Concurrently, pilot initiatives could be designed to more broadly test and then possibly expand community-based FP counselling and distribution of contraceptives, social marketing, collaboration with private pharmacies to increase their contraceptive stock in combination with ceiling prices for resale, FP training and distribution of contraceptives through traditional birth attendants and possibly traditional healers, etc. More detailed ideas for future interventions follow.

B. To Sustain the Momentum of GOR Population Policy Reform:

1. General

- First and foremost, in discussion with all donors, evaluate remaining absorptive capacity of ONAPO research section in view of priorities of each donor, if 1989 census will be conducted by ONAPO. This is absolutely essential if a realistic agenda of research and evaluations are to be funded in future.
- Continue to develop basic evaluation capacity within ONAPO, e.g. to support design of improved IEC programs and to improve delivery of services to target populations.

Study regional geographic, cultural, and religious differences and propose ways that national FP strategies should be adapted for each region, and integrate findings into implementation of future new projects.

2. Population Policy and Demographic Research

Continue providing secondary analysis and research support for preparation of policy documents for GOR on population issues.

3. Service Statistics

Continue to train centers in proper filling and storage of patients' service records (use CUSP in Butare as model).

Provide a thorough training program in use of the forms finally selected to improve accuracy and useability of service statistics.

Analyze data (including service statistics) on a timely basis and incorporate results into programs. Use service statistics to construct in depth longitudinal studies which track trends in patient profiles and abandonment of contraception annually. (Note: IBRD and GTZ are funding abandonment studies, so other donors' investment may not be required.)

67

3. Operations Research

- Train regional staff to conduct and use operations research studies.
- Continue to expand community-based distribution of FP counselling and services and social marketing of contraceptives, using lessons learned by PACD.
- Design targeted studies of small magnitude to answer program-related questions.

C. To Continue Grass Roots Mass Education in Family Planning:

1. Intensify Use of Face-to-Face Interaction (ONAPO, MINISAPASO, NGO's)

Strengthen communication directly with women through special groups such as cooperatives, savings associations, church women's groups, CCDPF women's and girls' associations, etc.

- Also target other at-risk groups for FP service distribution through community-based volunteers.

2. Radio (ONAPO, ORINFOR)

- Intensify diffusion of all existing programs. Greatly increase regularly scheduled air time devoted to family planning information and education with specific messages about types of contraceptives available, service locations, etc.

Programs could be used to provide a means of expression for **region-specific needs by providing air time for questions and answers region by region.**

Repeat each program several times especially those which explain methods available and how and where services can be obtained.

Continue use of theatre on the radio, song competitions, etc., to catch people's attention as a lead-in to more serious programming. (less important than the above recommendations)

3. Theatre (ONAPO)

- Invest less into use of live theatre, as it can not reach large audiences in a cost- and time-effective way, but develop theatrical radio programs which can reach more people.

4. Printed Materials (ONAPO)

- Continue to produce numerous fold-out brochures on specifics of PF.
- Illustrate materials more profusely with cartoons, continue use of calendars and small booklets.

54

- Lighten the weighty monograph series by inserting pictures and drawings.
- Seek help from INADES (central office in Abidjan, sub-office in Kigali) to train IEC staff to convert the monographs into appropriate modular distance-learning materials more suitable for oral reading at mass information events.
- Add a "questions and answers" section at the end of all major publications.
- Continue to train users of these materials on how to answer typical questions (including medical issues difficult for lay spokesmen to handle).

5. Video (ONAPO)

UNICEF and UNFPA are already providing adequate support for ONAPO's video efforts. This is not seen as a priority for new donor funds, as investment in radio, printed materials, and face-to-face interaction can reach a larger target group more quickly at lower cost.

6. Evaluation of IEC (ONAPO)

- Diversify messages/themes by:
 - Identifying target groups for IEC.
 - Evaluating all products to see which ones reach target groups most effectively.
 - Implementing strategies already suggested by consultants (e.g. PCS).

D. To Extend and Improve Family Planning Services Nation-wide:

1. Support for public sector services delivery should include the following:

Continue to train hospital and health center staff in family planning education and delivery of services. Train more clinicians in a wide variety of contraceptive techniques including at least one physician per hospital in IUD insertion. If necessary to provide adequate practical experience in IUD insertion, training should be conducted in other countries. (JHPIEGO, INTRAH, ONAPO, MINISAPASO)

Train traditional healers in community FP education, referral procedures for services, and distribution of condoms. (MINISAPASO, ONAPO, UNR)

Evaluate family planning curricula used by the UNR Faculty of Medicine, and recommend improvements if needed. (JHPIEGO, ONAPO, MINESUPRES)

- Develop guidelines for the delivery of MCH/FP services including qualitative aspects of service delivery. Use results of the pilot operations research studies proposed in Section V. C. "Outputs".
- Provide encouragement and training for more women to assume management roles in ONAPO and MINISAPASO regional activities.
- Continue to analyze need for vehicles, motorcycles, and bicycles for supervision of FP service activities annually.
- Consider adding an administrative assistant at the regional level, to assist the ONAPO Regional Representatives with supervision of IEC and administrative tasks. (ONAPO)
- Implement the national training plan for all FP service providers recommended for development by PACD in Section VI. (ONAPO, MINISAPASO)

2. Future directions in the private sector for services delivery should include the following:

- Develop a strategy for strengthening private religious groups already providing family planning services as well as those with the potential to provide these services.
- Explore capability of NGO's to provide services and community education.
- Provide support to local private enterprises who wish to develop family planning services for employees.
- Develop a mechanism to coordinate NGO participation in FP on a regular basis, e.g. within ARBEF.

Continue dialogue with Catholic hierarchy, especially with bishops and priests, to promote delivery of modern contraceptive methods in their health facilities.

Resume providing free medications to treat patients with gynecological complications resulting from contraceptive use (one team member did not concur with this recommendation).

Donor support for construction/renovation of health centers by NGO's could be used to expand FP services in under-served areas. If so, all NGO requests for the upgrading of facilities or the construction of new facilities should be carefully analyzed to ensure that sites are well selected, and designs appropriate to small scale MCH/FP health centers, before any decisions are made on proposals.

VIII. Studies Needed to Plan Future FP Interventions
and Solicit Donor Support

- Completion of "reasons for drop out" study that was conducted in Butare (pilot effort conducted with GTZ money). A larger nation-wide study is planned by the World Bank, to use the same questionnaire and methodology. Analysis of regional differences will be important.
- Comparative profile of FP acceptors between 1984 and 1986/1987, stratified by region.
- Complete audit of ONAPO internal structure and staff communications/supervision mechanisms.
- Identification of appropriate ministry to lead new project, and position held by host country project manager.
- Gisenyi management training workshop MINISAPASO, ONAPO, and donors with brainstorming sessions to identify the long term goals of ONAPO. This will be particularly important if the census is given to ONAPO.
- Evaluation of IEC products currently in use.
- Development of strategy for training service providers.
- Assessment of private sector FP potential:
 1. study of pharmacies and enumeration of points of sales - assess pharmacists' basic training needs.
 2. enumeration of Protestant FP services and needs assessment
 3. traditional healers and midwives - assess potential for training in IEC or distribution of contraceptives. Keep a close watch on UNICEF effort to train midwives.
- Follow up carefully on Columbia University CBD and SOMARC experiments and assess expansion potential.
- Monitor CHK barrier methods program (to control hetero sexual transmission of AIDS) to better understand the potential of FP barrier methods.
 - Assess radius/catchment area of service delivery points.
- Initiate contacts with parastatals and industries to expand FP services offered by their health facilities (maybe army for target programs).
- Study rural water programs for potential linkages through NGO's.
- Assess local recurrent costs of FP program as input to economic cost/benefit analysis for a new project.

61

Terms of Reference for the Evaluation Provided by USAID/KigaliA. BACKGROUND

In September 1981, the five year Rwanda Maternal Child

Health and Family Planning Project was approved for \$ 6.25 million. The project was extended in mid-1984 for two additional years, until September 1988. The purpose of the project is to assist the Government (through the National Population Office, ONAPO; and Ministry of Health, MOH) to expand and improve family planning information and services. The Midterm evaluation of the project took place in August 1984.

B. PROJECT OBJECTIVES

Develop an adequate population data collection and analyses, research, and evaluation capability;

- Develop mass media communications, training programs and evaluational materials;
- Provide delivery of mch/fp information and services in the ten prefectures;
- Construction of four health centers to provide additional health facilities;
- Constructions of one training center to increase training capability.

C. EVALUATION OBJECTIVES

The overall objectives of the evaluation are:

- (A) To assess progress toward project objectives -accomplishments made in the current mch/fp project;
- (B) Review appropriateness of logical framework and make specific recommendations for improving implementation of last year of project, and
- (C) Assist the GOR and DAR/R in developing future plans and directions for the follow-on family planning project.

D. SCOPE OF WORK

When discussing the issues listed below, the evaluation team will consider project targets, accomplishments, constraints on progress, and validity of potential institutional structures, policy formation and future priorities; and appropriateness of technical assistance, management, and construction and procurement issues and their impact. Analyses will be retrospective in their orientation.

- (1) Assess the project environment (including national policy) -high priority
- GOR support to family planning programs in Rwanda
- Mechanisms of coordination between ONAPO and MINISAPASO

- Donor coordination
- Current role of the Catholic church.
- (2) Assess ONAPO and A.I.D. administration and management -high priority
- Financial management (project budget utilization)
 - Procurement and management of material resources and construction
- Organization of ONAPO.
- (3) Assess the information, education and communications (IEC) components of the project
- Mass media communications
- Training programs
- Production of education materials
- Integration of IEC programs in the various health, education, and social welfare training institutions
- Development and implementation of IEC strategies, especially for specific target audiences.
- Performance of consultants and centrally-funded technical assistance.
- (4) Assess the training component of the project:
- Effectiveness of AID-sponsored training (long-term, short-term, and private sector)
- (5) Assess the family planning service delivery.

Component of the project:

- Availability of family planning services in the public and private health sectors
- Organization of family planning services
- Health personnel trained to deliver services
- Supervision of FP services
- Development and implementation of appropriate service strategies
- Logistical system
- Infrastructure and equipment.
- (6) Assess the research and data systems component of the project :
- Development and implementation of an appropriate information system
- Appropriate surveys and studies conducted
 - Definition of a population policy
- Research planning and prioritization
- Allocation of research.

(7) In addition, for 1-6 above, the team will be responsible for evaluating:

Performance of technical advisor and consultants to the project

-- Making recommendations to improve project implementation

-- Making recommendation for the design^g of the new family planning project including: discussion of objectives, activities, technical assistance, management and administrative issues, policy questions, role of the private sector, and other important issues to be resolved.

Annex B

List of CNAFO Research
1981-1987

- 1) Enquête nationale sur la fécondité 1983 (USAID/UNFPA)
 - Analyse des résultats
 - Version résumée
- 2) Enquête sur la contraception traditionnelle 1984 (USAID)
- 3) Etude de la relation population/développement 1984-1987 (UNFPA/USAID)
 - a. Analyse de la situation actuelle par des études sectorielles :
 - démographie
 - population et emploi
 - population et santé
 - population et alimentation
 - population et nutrition
 - population et agriculture
 - population et scolarisation
 - population, densification et urbanisation
 - population et évolution des mentalités
 - b. Modèle démo-nutritionnel (Twiyoungere twongera urusaruro)
 - c. Politiques démographiques et politiques de population
- 4) Perspectives démographiques 1985 (USAID/UNFPA)
- 5) Etude des besoins non satisfaits en planification familiale et en protection maternelle et infantile (WHO)
- 6) Sondage sur les attitudes et pratiques de la population à matière de fécondité dans les communes de Birenga et Rukira (Kibungo) 1982-1983 (IBRD)
- 7) Evaluation de la composante population dans les préfectures Kibungo et Kigali, (EGM II), 1983-1984 (IBRD)
- 8) Sondage sur les besoins des élèves dans le domaine de l'éducation pour la vie familiale. (USAID)
- 9) Rapport sur l'utilisation des différentes méthodes contraceptives, 1984 (Rapport de stage)
- 10) Rapport sur l'utilisation des différentes méthodes contraceptives, 1985 (Rapport de stage)
- 11) Rapport d'évaluation de l'appareil statistique de PF au Rwanda, 1986 (USAID)
- 12) Enquête sur la communication santé, 1985 (UNICEF)
- 13) Enquête sur les abandons de la planification familiale à Butare (en voie d'être saisie), publication : Octobre 1987. (GTZ)

61

- 14) Promotion et prestation de service de planification familiale à Ruhengeri (Rwanda), Etude de recherche opérationnelle (1987-1988) (Columbia University)
- 15) Possibilités d'intégration de la planification familiale dans les services de santé de base (Thesis)
- 16) Considérations sur le problème des infections gynécologiques dans le cadre d'un programme de FMI/FF d'un PVD, l'exemple des infections à chlamydia trachomatis et à Neisseria gonorrhoeae au Rwanda, 1986-1987 (Thesis)
- 17) Perspectives démographiques du Rwanda, (Rapport de stage, Tobossi).
- 18) Traitement informatique et analyse des données appliquées aux statistiques de PF au Rwanda. 1984, 1985 (USAID)
- 19) Méthologie d'une enquête sur les connaissances, les attitudes et les comportements de la population en matière de planification familiale au Rwanda.
- 20) Enquête sur les formations sanitaires. (UNFPA)
- 21) Besoins prioritaires pour les recherches opérationnelles et cliniques en FMI/FF au Rwanda. (Consultant)
- 22) Principales variables intermédiaires de la fécondité différentielle au Rwanda (Rapport de Stage).

List of Work Contributed by ONAPO to the Development of
National Population Policy

- 1) Collecte et analyse des données pour la préparation du 3ème plan quinquennal 1982-1986 (USAID)
- 2) Brochure sur la situation démographique au Rwanda (USAID)
- 3) Rapport du Séminaire "Famille Population et Développement" (USAID/UNFPA)
- 4) Correspondance, Note Technique et documents de base préparées par ONAPO pour l'élaboration du 4ème plan quinquennal et la politique de population (1986-1991) (USAID).
- 5) Rapport du Séminaire avant le 5ème congrès du parti (Décembre 1985) en vue de sensibiliser la population (UNFPA/USAID)

Annex C

List of Persons Contacted

CNAFO - Direction

Mre. HABIMANA NYIRASAFARI Gaucence : Directrice de l'ONAF
Dr. HAKIZIYANA Evaliste : Chef de Services d'Etudes et Programmes

CNAFO - Documentation

Mr. SENANA Emmanuel : Chef de la Sous-section Documentation
Mme. MUKANKUBITO Philonène : Courrier et Archives

CNAFO - I.E.C.

Mr. MBOGABA Jean Damascène : Chef de la Section I.E.C.
Mr. HAKIRUWIZERA Célestin : Chef de la Sous-section Sensibilisation
Mr. UWAYO Charles : Chef de la Sous-section "Audiovisuel"
Mr. MBEFUSHIMANA Jean Nepomuscène : Production du Matériel
Didactique
Mr. MUNYAMUGA Emmanuel : Producteur des émissions radio-diffusées
Mr. MUNYAZIKWIYE Wenceslas : Chef d'Equipe Tribunes Radiophoniques
et Emission Radio
Mr. NYUNDAKOZERA Anastase : Chef d'Equipe "Théâtre"
Mme. MIVUMBI Rita : Agent de la Sous-section Sensibilisation

CNAFO - Santé Familiale

Dr. MUNYAKAZI Alphonse : Chef de la Section Familiale
Mr. KAYUMBA Anastase : Agent de l'ONAF
Mme. BAZIFAMWABO Madeleine : Responsable du Stock des Produits
Contraceptifs à l'ONAF
Mr. GATEBUKE Justin : Agent de l'ONAF

CNAFO - Secrétariat Général et
Relations Publiques

Mme. MUJAWAMARIYA Vénantie : Chargé de l'Administration du Personnel

CNAFO - Gestion et Approvisionnement

Mme. NZABONIMPA Donatilla : Responsable de la Section Gestion et
Approvisionnement (actuellement elle assure l'interim du Service
Administratif et Financier)
Mme. MUKABIDELI Thérèse : Responsable de la Section Comptabilité
Générale et Trésorerie
Mr. NKULIKIYINKA Vianney : Chargé des Infrastructures
Mr. NFEZIYAREMYE Albert : Responsable du Charroi

ONAPO - Formation

- Mr. KAMANZI Castule : Chef de la Sous-section Formation et Programmes Scolaires
Mre. NZAECNIPANA Cécile : Agent de la Sous-section Formation et Programmes Scolaires

ONAPC - Recherche

- Mre. MUKAMANZI Monique : Chef de la Section Recherches
Mr. NGENDAKUMANA Mathias : Maîtrise en Psychosociologie
Mr. SHICWANA J.M.V. : Géographie, diplômé en Démographie
Mre. MUKAKAYANGE Anne-Marie : Licenciée en Gestion
Mre. MUKAMUPWA Patricie : Sociologue
Mr. MUKAMFIZI Pascasia : Médecin

ONAPO - Planification

- Mr. NIHUMIZI Silas : Chef de la Section Planification
Mr. GAKWAYA Dominique : Assistant au Chef de la Section Planification

ONAPO - Statistiques et Informatique

- Mr. BUTERA Benoît : Agent de la Sous-section Statistiques et Informatique.
Mre. NTAMAZINA Drocella : Assistante Sociale, Agent de la Sous-section Statistiques et Informatique
Mre. MUKANCOGOZA Marie : Chef de la Sous-section Statistiques et Informatique

ONAPO - Assistance Technique

- Mre. Maryse Pierre-Louis : Technical Advisor to ONAPO under A.I.D. MCH/FP Project

ONAPO - Training Center

- Mre MUKAMUGENGA Winifrida, Intendante du Centre de Formation de l'ONAPO

BUFMAR (Ecumenical NGO)

Mr. Hornix, Director

MINISAPASO

Minister BIZIMUNGU Casimir

CARE

Mr. Mike Godfrey, Head of Water Development Projects

Adventist Development and Relief Agency

Mr. James Conran, Director ALPA/Rwanda

USAID/Kigali

Mr. Emerson Melaven, Mission Director
Ms. Rosemary Depp, Program Officer
Ms. Carina Stover, Project Officer/Health and Population
Mr. Andrew Sisson, Project Development Officer
Mr. Léon Nsengimana, Assistant Project Officer MCH/FP Project

Kibilizi Health Center

Dr. BAGWANEZA Madeleine, Déléguée de l'ONAPO -Butare
Dr. NTAMUHUNGAKAJE Célestin, Directeur Centre PMI/PF Kibilizi

CUSP - Butare

Dr. DUSHIMIMANA Abel, Directeur du Centre Universitaire de Santé
Publique
Dr. HABIMANA Phocas, Service de SMI/PF du CUSP

Université Nationale du Rwanda
CURPIANETRA

Mme. NYIRANKULIZA Spéciosa, Secrétaire du Centre
Dr. KAYONGA Athanase, Médecin du Volet Médecine et Pharmacologie
Four traditional healers at the University's Traditional Medicine Center

JHPEIGO - Butare UNR

Dr. KAGERUKA Martin, Chef de Programme Formation JHPEIGO

Commune Mukingo - Shingiro Secteur

Extension session led by ONAPO permitted dialogue with conseillers du secteur Shingiro and several hundred local inhabitants.
NKULIZA Stany, Assistant Médical A2 Centre de Santé Shingiro

Ferera Hospital (Presbyterian)

Dr. KAYIJAHO Josué, Médecin Généraliste
Dr. SEYONI Isaac, Médecin Délégué de l'ONAPO à Gitarara
Mr. RWANYABUZIZIRA Barnabas, Intendant de l'Hôpital Ferera Rukoma
Ms. Katrina Knox, R.N., Infirmière Stagiaire/Directeur Centre de Santé à Mukoma

Kigali - CHK

Dr. MUKAWENTIMANA Alexandre, Médecin Délégué Régional de l'ONAPO - Kigali
Dr. BAJINYA Vincent, Médecin de l'ONAPO au Centre Hospitalier de Kigali (CHK)
Mme. MUKAEAFISA Consolata, IEC - CHK
Mme. MBABAJENDE Véronique, Services Cliniques - CHK
Mme. RANYANGIRIKI Agnès, Assistante Sociale -CHK
Ms. Susan Allen, Researcher on AIDS

Rwankeri Health Center
(Adventist)

Mr. MASABO Samuel, Assistant Médical et Titulaire du Centre de Santé

Ruhengeri Hospital

Dr. PONNET, Directeur
Dr. SEBAZUNGU Philippe, Chef du Service Chirurgie
Dr. NZAMWITA Augustin, Médecin Délégué Régional de l'ONAPO - Ruhengeri

Nyundo Maternity (Catholic)

Mme. N.NZUBAHIMANA Laurence, Infirmière Accoucheuse et Hospitalière et Titulaire de la Maternité de Nyundo

Gisenyi Hospital

Dr. René Wolf, Médecin de l'Hôpital Maternité
Dr. BINYANGE Martin, Médecin de l'ONAPO de Gisenyi
Mme. MUKASINE Louise, Infirmière de l'ONAPO -Gisenyi

ANNEX D

PRESIDENT'S JULY 1, 1987 SPEECH

Le domaine de la maîtrise de l'accroissement de la population si jamais maîtrise il peut y avoir, tant ce domaine est délicat et rebelle à tout traitement mécanique, est pour nous Rwandais, chargé de beaucoup d'émotion.

Comme l'a constaté et le disait notre grand philosophe KAGAME, notre raison d'être, celle de notre peuple, a toujours été nos enfants. Pour nous, c'est la plus grande valeur que nous ayions, la plus importante aussi; l'attachement le plus fondamental, c'est à nos enfants que nous le consacrons.

Est-il alors concevable que d'un jour à l'autre le fondement même de notre façon de voir le monde, le sens de notre vie, puisse changer radicalement ?

L'explosion démographique nous a totalement pris au dépourvu. Sa violence, son envergure ont été telles que pendant qu'elle se manifestait, nous étions encore à nous demander comment il fût jamais possible que ce que nous regardions comme notre plus grande richesse, le sens même de notre vie, puisse se retourner contre nous et menacer nos acquis si durement arrachés.

Mais aujourd'hui, il faut affronter le problème dans toute sa gravité, sans pudeur et sans préjugés.

Il s'agit aujourd'hui de voir la situation telle qu'elle est; c'est cela notre responsabilité. Ce que nous pensons, ce que nous voulons, c'est que c'est dans sa conscience que chacun doit trouver la clé de son comportement face à ce problème national.

.../...

World Bank/Rwanda

Mr. DJIRIL Aw, Agricultural Officer and Acting Representative

UNICEF/Rwanda

Mrs. Bâigé Cgun, Representative

Ce à quoi nous continuerons à nous opposer, ce que nous refusons, c'est de violenter les consciences de nos compatriotes.

Ce que nous pensons c'est que chacun, en face de sa conscience doit trouver la solution qui lui convient et dont il peut assumer sa responsabilité.

Mais pour qu'il puisse agir en fonction de sa conscience, il doit savoir qu'il peut le faire et qu'il faut le faire.

Je lance ici un appel à l'Eglise Catholique, aux Eglises protestantes, à toutes les communautés religieuses de notre pays, pour qu'elles réfléchissent, au nom de la dignité de chacun d'entre nous, au nom de la dignité de notre pays, à leur rôle de responsables moraux de la formation de la conscience de la population, afin qu'elles légitiment cet arbitre suprême qu'est la conscience de chacun, pour que chaque couple puisse envisager comme sa solution à lui celle que sa conscience lui dictera face au nombre d'enfants qu'il veut avoir, face au problème grave que constitue la croissance démographique galopante pour la survie physique même de nos enfants.

.../...

TANZANIE

UGANDA

ZAIRE

Infirmierie Gisovu
C.A.P. Gisovu
Karongi
Elektrolog

Nyarugenge Kiceli
Centre de Santé Privé
Biryogo
Gikondo
:
Public
Muhima
Kacyiru
Kimisagara

Dist. privé
C. Culturel Islamique
B.C.A. - A.T.S.
Camp - Kiceli PB
Camp - Kacyiru PB
Camp - Kimihurura
B.H.R. PB

Infirmierie
D.K. - O.C.I.R. T.H.A.
O.C.I.R. - Café
C.S. André
SOMIKWA
SULFO
MAREKWA
ELALFRAGA
I.H.M.S.G.
K.W.A.N.D.A.M.I.T.O.A.S.
T.A.I.S.O. - M.U.H.I.M.A.
Camp - Muhima
C.S.R.
Liyica Kiyali
C.S. Rugunga
C.S. N.D.C.

ANNEX E

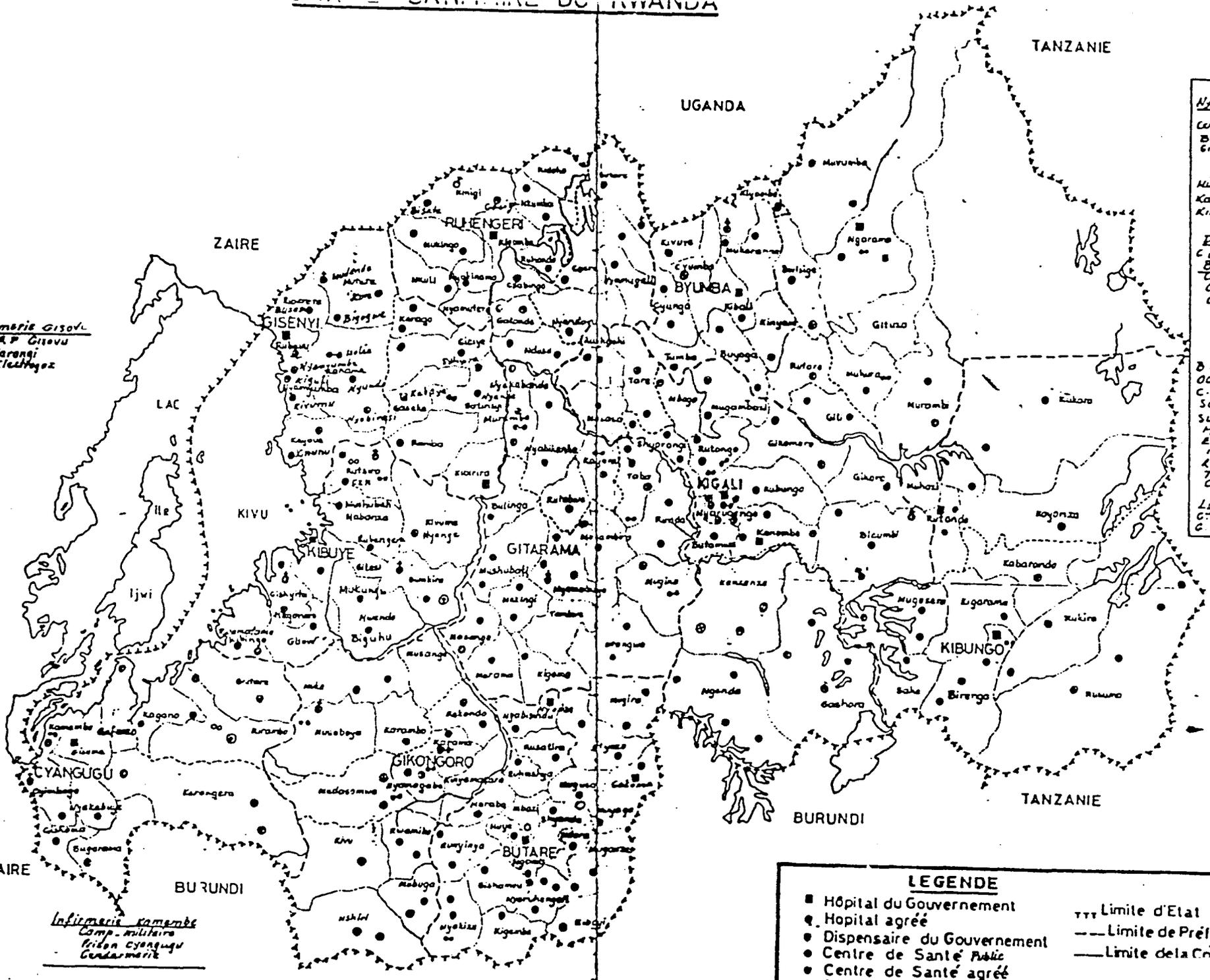
ZAIRE

BU RUNDI

BURUNDI

TANZANIE

Infirmierie Kamembe
Camp - militaire
Pilon Cyangugu
Gendarmerie



LEGENDE

- Hôpital du Gouvernement
- Hôpital agréé
- Dispensaire du Gouvernement
- Centre de Santé Public
- Centre de Santé agréé
- Maternité
- ⊕ Dispensaire agréé
- .. Infirmierie
- Limite d'Etat
- Limite de Préfecture
- Limite de la Commune

ANNEX F

Annual Evolution of New Acceptors Since 1976

<u>Year</u>	<u>Pill</u>	<u>IUD</u>	<u>Injection</u>	<u>Barrier</u>	<u>Total</u>	<u>No. of Centers</u>
1976	122	78	75	0	275	4
1977	119	99	75	0	293	6
1978	142	133	89	0	364	8
1979	238	233	173	0	644	11
1980	234	173	154	0	561	11
1981	248	225	233	1	706	15
1982	417	307	453	1	1,178	24
1983	1,654	781	1,406	15	3,856	49
1984	3,840	1,061	3,488	199	8,587	93
1985	3,775	525	5,900	565	10,765	159
1986	4,960	522	9,517	781	15,780	183

Source: ONAPO, August 1987

Évaluation des Nouvelles Acceptrices (Pays Total)
(1er Trimestre 1987)

Méthode	Pilule	DIU	Injectables	Barrière	Auto-observation	Total
Mois						
Janvier	505	48	943	42	10	1548
Février	372	35	1354	111	25	1897
Mars	465	34	940	58	212	1712
	1342	117	3237	211	247	5154

ANNEY G

MCH / FP - TRAINING STATUS AS OF AUGUST 1987 .

LONG TERM:

- PIO/P 696-0113-1-10035: one-MS STATISTICS, Indiana University, Bloomington- Completed
PIO/P 696-0113-1-10036: one - MS SOCIOLOGY, Indiana University, Bloomington - Interrupted by death.
PIO/P 696-0113-1-30036: one - MPH HEALTH EDUCATION, Tulane University, New Orleans- Completed
PIO/P 696-0113-1-40038: one - BS Nursing, Marquette University, Milwaukee - Underway
PIO/P 696-0113-1-10035bis: one- PHD STATISTICS, Indiana University, Bloomington - Expected completion date 8/88
PIO/P 696-0113-1-30113: one- MPH MANAGEMENT OF HEALTH SERVICES, Tulane University, New Orleans - Expected completion date 8/88

SHORT-TERM:

- PIO/P 696-0113-1-10042: one - ICORT+FDMS, Washington DC & Pittsburgh - 2 months
PIO/P 696-0113-1-10047: six- FP PROGRAM MANAGEMENT, Santa Cruz - 8 weeks
PIO/P 696-0113-1-10049: two - WOMEN IN MANAGEMENT, WashingtonDC - 5weeks
PIO/P 696-1-0113-1-10051: three - STUDY TOUR, HEALTH & FP FACILITIES, Mauritius - 1month
PIO/P 696-0113-1-20031: Four- Idem as #4
PIO/P 696-0113-1-20028: six - OBSERVATION VISIT OF HEALTH & POPULATION FACILITIES, WashingtonDC, Mexico, Jamaica - 3 weeks
PIO/P 696-0113-1-20036+ one - Population Statistics, ONAPFP, Tunis - 3weeks
P.A. 696-4-059 : one - CONGRESS ON STD, Montreal, Canada - 1week.
PIO/P 696-0113-1-30035: two - COMMUNICATION WORKSHOP, Cornell University - 5weeks
PIO/P 696-0113-1-30047: two - Population Conference in Mexico City, Mexico - 1 week
PIO/P 696-0113-1-30053: one - GRAPHIC ARTS, Tunisia - 3 months
PIO/P 696-0113-1-30050: six - idem as #2
PIO/P 696-0113-1-30059: one - AMERICAN PUBLIC HEALTH ASSOCIATION MEETING, Anaheim - 1 week
PIO/P 696-0113-1-30076: four - idem as #2
PIO/P 696-0113-1-40033: four - IEC, Santa Cruz - 1 month
PIO/P 696-0113-1-40034: two - COMMUNITY HEALTH DEVELOPMENT, Chapel Hill - 1 month
PIO/P 696-0113-1-40041: two - WOMEN IN MANAGEMENT, CEDPA WashingtonDC - 5 weeks

FP Auxiliaries
10 Training Trainers

1983

63 FP Auxiliaries
16 Contraceptive Technologies and Service Delivery

1984

228 FP Auxiliaries
567 CERAI Headmasters and Teachers

1985

291 FP Auxiliaries
365 CERAI Teachers in Child Sciences
321 MCH/FP, Biology, Demography, Geography, Civics Teachers

1986

134 FP Auxiliaries
81 Secondary School Headmasters & District Inspectors, & Professionals
from Pedagogical Offices
5 Clinical Training Curriculum Development

1987

24 Clinicians

74