CURRENCY EQUIVALENTS

<table>
<thead>
<tr>
<th>Currency Unit</th>
<th>=</th>
<th>Rwandan Franc (FRW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US$1.00</td>
<td>=</td>
<td>FRW 118 (February 1991)</td>
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MEASUREMENTS

<table>
<thead>
<tr>
<th>Unit</th>
<th>=</th>
<th>Unit</th>
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<tbody>
<tr>
<td>1 meter</td>
<td>=</td>
<td>3.28 feet</td>
</tr>
<tr>
<td>1 kilometer</td>
<td>=</td>
<td>0.62 mile</td>
</tr>
<tr>
<td>1 square kilometer</td>
<td>=</td>
<td>0.39 square mile</td>
</tr>
<tr>
<td>1 hectare</td>
<td>=</td>
<td>2.47 acres</td>
</tr>
</tbody>
</table>

GOVERNMENT OF RWANDA - FISCAL YEAR

January 1st - December 31st

This report is based on the findings of an appraisal mission which visited Kigali in October 1990, comprising of Dr. J. Baudouy, Mission Leader; Dr. A. M. Pierre-Louis, Deputy Mission Leader and Task Manager; Mmes M. Schneidman, Economist, and E. Murray, Financial Analyst. Mr. B. Carlson is the lead advisor for this operation. Mmes V. Fauconnier, F. Duchesne, F. Ryckebusch and V. Vasilopoulos provided secretarial support in the preparation of this report. Messrs. A. Colliou and F. Aguirre-Sacasa are the Managing Division Chief and the Department Director, respectively for this operation.
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ARBEF</td>
<td>Association Rwandaise pour le Bien-Etre Familial (Rwandese Association for family welfare)</td>
</tr>
<tr>
<td>BUFMAR</td>
<td>Bureau des Formations Médicales Agrées du Rwanda (Association of religious NGOs involved in the health sector in Rwanda)</td>
</tr>
<tr>
<td>CBD</td>
<td>Community Based Distribution</td>
</tr>
<tr>
<td>CBR</td>
<td>Crude Birth Rate</td>
</tr>
<tr>
<td>CCDFP</td>
<td>Centre Communal de Développement et de Formation Permanente (Community Center for Development and Continuing Education)</td>
</tr>
<tr>
<td>CERAI</td>
<td>Centre d'Enseignement Rural et Artisanal Intégré (Post-primary Rural Centers of MINEPRISEC)</td>
</tr>
<tr>
<td>CND</td>
<td>Conseil National de Développement (National Development Council)</td>
</tr>
<tr>
<td>CPS</td>
<td>Contraceptive Prevalence Survey</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>GTZ</td>
<td>Gesellschaft für Technische Zusammenarbeit (German Cooperation agency)</td>
</tr>
<tr>
<td>HC</td>
<td>Health Center</td>
</tr>
<tr>
<td>HCR</td>
<td>Haut Commissariat aux Réfugiés (United Nations Agency)</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>INTRAH</td>
<td>International Training in Health</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
</tr>
<tr>
<td>JOC</td>
<td>Jeunesse Ouvrière Catholique (Catholic youth workers)</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MEDIRESA</td>
<td>Medecin Directeur de la Région Sanitaire (Regional Medical Officer)</td>
</tr>
<tr>
<td>MINIPRESEC</td>
<td>Ministère de l'Enseignement Primaire et Secondaire (Ministry of Primary and Secondary Education)</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MRND</td>
<td>Mouvement Révolutionnaire National pour le Développement (National Revolutionary Organization for Development)</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>NFP</td>
<td>Natural Family Planning</td>
</tr>
<tr>
<td>NFS</td>
<td>National Fertility Survey</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>ONAPO</td>
<td>Office National de la Population</td>
</tr>
<tr>
<td>ORINFOR</td>
<td>Office Rwandais d’Information (Rwandese Office of Information)</td>
</tr>
<tr>
<td>PAU</td>
<td>Project Administrative Unit</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PHN</td>
<td>Population-Health-Nutrition</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
</tr>
<tr>
<td>UNR</td>
<td>Université Nationale du Rwanda</td>
</tr>
<tr>
<td>URAMA</td>
<td>Rwandese Women Association (Association des Femmes Rwandaises pour le Développement)</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
</tbody>
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### Rwanda: First Population Project

**Basic Data 1/**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tr>
<td>Population (1990)</td>
<td>7.3 million</td>
</tr>
<tr>
<td>Rural</td>
<td>94%</td>
</tr>
<tr>
<td>Urban</td>
<td>6%</td>
</tr>
<tr>
<td>Population growth rate</td>
<td>3.6% 2/</td>
</tr>
<tr>
<td>Population density (per km²)</td>
<td>279 2/</td>
</tr>
<tr>
<td>Crude birth rate</td>
<td>53 per 1000 births 3/</td>
</tr>
<tr>
<td>Crude death rate</td>
<td>18 per 1000 deaths 3/</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>122 per 1000</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>8.5 2/</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (1989, all modern methods)</td>
<td>9% 2/</td>
</tr>
<tr>
<td>GNP per capita (1990)</td>
<td>US$310</td>
</tr>
<tr>
<td>Access to primary health care</td>
<td>40% of the population 2/</td>
</tr>
<tr>
<td>Number of physicians</td>
<td>272 2/</td>
</tr>
<tr>
<td>Number of nurses and medical assistants</td>
<td>1271 2/</td>
</tr>
<tr>
<td>Health expenditures as a percentage of budget</td>
<td>about 6% 2/</td>
</tr>
</tbody>
</table>

---

1/ Population and demographic indicators are taken from Population Reference Bureau, 1990, except where noted.

2/ Data are from 1987 and 1989 ONAFO reports and 1990 MOH annual report.

**DEVELOPMENT**

**Age Specific Fertility Rate:** Number of live births to women in a given age group per 1,000 women in the same age group, in a given year.

**Contraceptive Prevalence Rate:** The percentage of married women of reproductive age who are using (or whose husbands are using) any form of contraception.

**Crude Birth Rate:** The number of births per 1,000 population in a given year.

**Crude Death Rate:** The number of deaths per 1,000 population in a given year.

**Dependency Ratio:** The ratio of the economically dependent part of the population to the productive part, arbitrarily defined as the ratio of the young (those under 15 years of age) plus the elderly (those 65 years of age and over) to the population in the "working ages" (those 15 to 64 years of age).

**Infant Mortality Rate:** The number of deaths of infants under one year old in a given year per 1,000 live births in that year.

**Life Expectancy at Birth:** The average number of years a newborn would live if current age-specific mortality rate trends prevailing at the time of birth were to continue.

**Net Reproduction Rate:** The average number of daughters that would be born to a woman (or group of women) if during her lifetime she were to conform to the age specific fertility and mortality rates of a given year. A net reproduction rate of 1.00 means that each generation of mothers is having exactly enough daughters to replace itself in the population.
Rate of Natural Increase: The rate at which a population is increasing (or decreasing) in a given year due to surplus (or deficit) of births over deaths expressed as a percentage of the base population.

Rate of Population Growth: The rate at which a population is increasing (or decreasing) in a given year due to natural increase and net migration expressed as a percentage of the base population.

Total Fertility Rate: The average number of children that would be born alive to a woman (or group of women) during her lifetime if during her childbearing years she were to bear children at each age in accordance with prevailing age-specific fertility rates.
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<td>A. Status of project preparation</td>
<td>32</td>
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<td>B. Risks</td>
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11 - Detailed training plan
12 - Implementation schedule by project component
13 - Estimated schedule of disbursement
14 - Technical assistance requirements
15 - Procurement schedule
16 - References

MAP
RWANDA: FIRST POPULATION PROJECT

CREDIT AND PROJECT SUMMARY

**Borrower**: Republic of Rwanda

**Beneficiaries**: Ministry of Health (MOH) and National Office of Population (Office National de la Population - ONAPO)

**Amount**: SDR 14.5 million (US$19.6 million equivalent)

**Terms**: Standard IDA terms, with 40 years maturity

**Project Description:**

(a) **Objectives**:

The project will support the implementation of the National Population Policy and will contribute to: (a) reducing the total fertility rate (TFR); (b) improving maternal and child health (MCH); and (c) integrating the demographic dimension in cross-sectoral development activities. These objectives will be reached by: (a) improving the quality and efficiency of Family Planning (FP) service delivery; (b) increasing demand for and access to FP services; (c) carrying out a set of population studies and strengthening the FP information system; and (d) supporting multisectoral activities within the framework of the national population policy. Selected demographic targets for 1997 (last year of project implementation) include (figures for 1990 are in parenthesis): TFR at 7.2 (8.5); modern contraceptive prevalence rate (CPR) at 20.0 (9.0) and 276,000 FP users (100,000).

(b) **Components**:

The project will provide for: (a) improvement in quality and efficiency of FP services through in-service training of approximately 1,100 health workers, intensification of supervisory and management procedures and the provision of contraceptives and FF equipment; (b) expansion and promotion of FP services through the strengthening of 39 existing FP posts and the establishment of 44 new posts as satellites of the health center network, the mobilization of about 17,500 community volunteers and the support of a targeted Information, Education and Communication (IEC) strategy; and (c) implementation of population studies and promotion of multisectoral population activities through technical assistance, seminars and operational support.

(c) **Benefits and Risks**:

By rapidly increasing the contraceptive prevalence rate, the project will provide micro and macro benefits. At the individual level, reduced family size and increased birth spacing will have positive health effects on women and children and will diminish family expenses on schooling, health care and food. At the national level, the reduction in population pressure on scarce land resources, fragile eco systems, limited savings and employment/investment capacities will contribute to economic growth. The first risk is linked to the limited managerial capabilities of ONAPO. To address this risk, a project management structure will be put in place before credit effectiveness. The second risk is a lack of coordination between ONAPO and MOH. To address this risk agreement was reached during project negotiations, on the implementation of the collaboration mechanisms...
between MOH and ONAPO which have been developed during project preparation. The third risk relates to the capacity of Rwanda to find appropriate solutions to the lingering problems of Rwandese refugees in neighboring countries. Reinsertion of these refugees in Rwanda requires careful planning and a major support from the international community.

PROJECT COST ESTIMATES

<table>
<thead>
<tr>
<th></th>
<th>Local</th>
<th>Foreign</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- - - - US$ million - - - -</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement of quality &amp;</td>
<td>0.59</td>
<td>5.38</td>
<td>5.97</td>
</tr>
<tr>
<td>efficiency FP services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expansion &amp; promotion</td>
<td>7.18</td>
<td>4.52</td>
<td>11.70</td>
</tr>
<tr>
<td>of FP services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Studies and multi-sectoral</td>
<td>0.84</td>
<td>0.81</td>
<td>1.65</td>
</tr>
<tr>
<td>activities</td>
<td></td>
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<tr>
<td>Project management</td>
<td>0.45</td>
<td>1.22</td>
<td>1.67</td>
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<td></td>
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<tr>
<td>Total base costs</td>
<td>9.06</td>
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<td>Physical contingencies</td>
<td>0.10</td>
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<td>Price contingencies</td>
<td>2.50</td>
<td>1.46</td>
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<td>Total project costs</td>
<td>11.66</td>
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Financing plan

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<td>IDA</td>
<td>8.3</td>
<td>11.3</td>
<td>19.6</td>
</tr>
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<td>--</td>
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<td>1.9</td>
</tr>
<tr>
<td>UNFPA 1/</td>
<td>--</td>
<td>1.2</td>
<td>1.2</td>
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<td>Government 2/</td>
<td>3.4</td>
<td>--</td>
<td>3.4</td>
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<td></td>
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<tr>
<td>Total</td>
<td>11.7</td>
<td>14.4</td>
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ESTIMATED IDA DISBURSEMENTS

(US$ million)

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<th>FY93</th>
<th>FY94</th>
<th>FY95</th>
<th>FY96</th>
<th>FY97</th>
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<tr>
<td>Annual</td>
<td>1.00</td>
<td>6.00</td>
<td>4.00</td>
<td>5.00</td>
<td>2.00</td>
<td>1.20</td>
<td>0.40</td>
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<tr>
<td>Cumulative</td>
<td>1.00</td>
<td>7.00</td>
<td>11.00</td>
<td>16.00</td>
<td>18.00</td>
<td>19.20</td>
<td>19.60</td>
</tr>
</tbody>
</table>

1/ The figures represent estimates of the contributions of these agencies to the activities undertaken under this project. Their total support to population and FP activities in Rwanda is more substantial than the figures indicated in this table.

2/ Including $64,000 equivalent for taxes.
RWANDA

FIRST POPULATION PROJECT

STAFF APPRAISAL REPORT

I. BACKGROUND

A. Socioeconomic context

1.01 With a GNP per capita estimated at US$310 in 1989, Rwanda belongs to the group of the world's least developed countries. As common to poor nations, social conditions are bleak: malnutrition affects many women and children, maternal and infant mortality are high, illiteracy is high (60 percent of women are illiterate) and unemployment is a serious problem (less than 10 percent of those entering annually the labor market will find formal employment). What is particular to Rwanda as compared to other Sub-Saharan African countries (with the exception of neighboring Burundi which faces a similar situation) is the extremely high population density and the explosive rate of population growth. With a total population estimated at 7.3 million in 1989, this small landlocked country has a population density of 279 people per square kilometer, the highest in Africa. Such a density puts a heavy pressure on land availability and agricultural production in this essentially rural economy, where people live on small farms scattered across the hilly countryside. Population pressure will increase rapidly as a result of the current population growth rate of 3.6 percent per year (the fastest growth rate in Africa). At this rate, the total population will double in twenty years. While trying to avoid prediction of a doomsday scenario, it is difficult not to be apprehensive about Rwanda's situation in the year 2010. At that time, with 2 to 3 million job-seekers and landless farmers and a heavily deteriorated environment, Rwanda could be facing severe internal social unrest and external tension with neighboring countries unable or unwilling to absorb large numbers of illegal migrants. The potential resettlement in Rwanda of thousands of refugees as a result of recent political events will worsen the population pressure in certain parts of the country.

1.02 On the economic side, the situation is also worrisome. Rwanda is essentially an agricultural country, with agriculture accounting for half of GDP and 75 percent of total export earnings. The nation's balance of payment situation is heavily dependent upon a single export, coffee. During the 1970s, thanks to high coffee prices on the world's market and prudent government management, Rwanda's economic performance was good, particularly in comparison with other SSA countries. However, in the 1980s the situation progressively deteriorated for several reasons. The price of coffee fell and is not likely to rise in the near future. The government, by keeping a tight control on all segments of the economy, failed to make the productive sectors responsive to a new economic environment. Finally, an important compounding factor was the rapid population growth which largely outstripped government's capabilities in terms of investment and job creation. Confronted since the early eighties with the necessity to
take adjustment measures, the government delayed its decision until the situation became economically and socially unbearable and therefore more difficult to improve. In 1990, the Government finally agreed on a policy framework paper with the IMF and the Bank, and more recently adjusted its exchange rate, and liberalized most prices.

B. The PHN situation

1.03 Since the last population health and nutrition (PHN) sector report (1984), certain PHN indicators have improved, including an increase in life expectancy from 46 years in the early 1980s to almost 50 in 1990, mostly due to a decrease in under-five mortality from 230 per thousand in 1980 to 196 per thousand in 1990. On the other hand, several indicators have worsened, such as the total fertility rate (TFR) which increased to 8.5 in 1989 from 7.4 in the early 1980s. As a result, the annual population growth rate has increased from 3.3 percent in 1980 to 3.6 percent in 1989. The maternal mortality rate is still high, averaging 300 per 100,000 live births in health facilities. Food insecurity and widespread malnutrition are becoming major concerns. The food production per capita index which was estimated at 98 in 1980 was reduced to 87 in 19861/. The prevalence of moderate child malnutrition has reached 37 percent in 1989 (weight-for-age below 80 percent of Harvard Standard)2/. Between 5 and 10 percent of the children are severely malnourished (weight-for-age below 60 percent of Harvard Standard). Adult malnutrition is likely to become a serious problem in the future. In addition, two major public health problems have emerged: malaria (680,000 new cases reported in 1987 as compared to 85,000 in 1976) and AIDS (more than 20 percent of adults living in urban areas are seropositive) which have the potential to cause severe human and economic losses.

II. POPULATION SECTOR STATUS AND ISSUES

A. Demographic status

2.01 Demographic characteristics. The 1978 census estimated the population size at 5.6 million. The population is now estimated at 7.3 million, which implies an average annual population growth rate of

1/ Index of daily supply of foods per capita expressed in calories with the average of 1979-81 as base index.

2/ Harvard Standard is a reference population table derived from a sample study of relatively well nourished Caucasian children in USA. The data are expressed in percentiles of weight for age and height for age. Boston or Harvard reference population data have been used in designing weight for age growth monitoring charts in Latin America, Asia and Africa.
approximately 3.3 percent for the period 1978-90. The Total Fertility Rate (TFR) of 8.5 is the highest in Africa (Annex II, Figure 5). On the other hand, mortality has continued to decline during the last 30 years. The Crude Birth Rate (CBR) was estimated at 51 per 1000 in 1990 and the crude death rate at 17 per 1000. With its young age structure (46 percent of the population is under 15 years of age; (Annex I, Table 3), the population has an extremely high demographic momentum as shown in the projections below. If fertility remained constant, population growth rate would increase to 3.8 between year 2000 and 2010.

2.02 Population growth. Population projections for the period 1980-2010 have been prepared by the World Bank. The total population is projected to reach approximately 10 million by the year 2000, even with an effective FP program underway. The following table reflects the population growth (in absolute numbers, assuming no migration):

Table 2.1: Projected population size and growth

<table>
<thead>
<tr>
<th>Projections</th>
<th>Population (in million)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1990</td>
</tr>
<tr>
<td>Constant fertility</td>
<td>7.15</td>
</tr>
<tr>
<td>Moderate fertility decline</td>
<td>7.15</td>
</tr>
<tr>
<td>Rapid fertility decline</td>
<td>7.15</td>
</tr>
</tbody>
</table>

Growth rates

<table>
<thead>
<tr>
<th></th>
<th>1990-2000</th>
<th>2000-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant fertility</td>
<td>3.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Moderate fertility</td>
<td>3.6</td>
<td></td>
</tr>
<tr>
<td>Rapid fertility</td>
<td>2.9</td>
<td></td>
</tr>
</tbody>
</table>


B. Impact of population growth on socioeconomic development

2.03 Environment. The rapid population growth has forced people to occupy new land at the expense of natural forests, the size of which has decreased by 25 percent over the last 20 years, despite the reforestation program being implemented by the government. The demand for fuelwood (the main source of household energy) will triple in 25 years if the TFR and other conditions remain constant. Fuelwood deficits will increase the workload of women (and children) who are traditionally responsible for wood gathering. They would have to walk further and spend more time collecting it from increasingly distant areas. The size of cultivated land has increased significantly at the expense of pasture land, in order to meet the nutritional requirements of a fast growing population. Utilization of marginal land (slopes,
swamps) is creating erosion problems despite government efforts to implement conservation measures; it is estimated that 10 tons of soil per hectare are lost every year. Overall, the environmental impact of population growth is severe and can only worsen in the near future.

2.04 **Agriculture.** Agricultural land availability is becoming a crucial problem, particularly in the southern part of the country. The density of population per square kilometer of land has significantly increased since 1970, reaching 279 in 1990 (Annex I, Table 4). With the projected population growth, the situation will worsen: while there is currently between 5 and 6 persons per cultivable hectare of land, in 2015 _16 persons_ would have to share a single hectare. At the moment, approximately 1.2 million rural families live on farms with less than 1.0 hectare of productive land (Annex II, figure 3). This situation has led to a reduction in family farm size beyond sustainability and an exhaustion of soils by abandonment of fallow periods in parts of the country. While in the past 20 years, Rwandese farmers have been able to keep pace with population growth, this equilibrium may be reaching its limits. Traditional methods of agriculture, even well applied, do not have the necessary productivity to respond any longer to a doubling in food demand in a period of 20 years. The outbreak of famine in 1989, affecting more than 600,000 people (almost 10 percent of the population) in the southern and eastern parts of the country, has brutally illustrated the fact that, in some areas of the country, current agricultural production is not sufficient to meet the demand for food.

2.05 **Health Status.** The high population growth rate (and to a certain extent the high population density) has several adverse effects on the health sector. First, the population pressure is an important contributing factor to the two major public health problems emerging in Rwanda—spreading malaria and the AIDS epidemic. In order to find available land, large groups of people (currently estimated at 500,000) have migrated from malaria-free highlands (the parasite does not breed above a certain altitude) to lower lands where malaria is highly prevalent. These migrants do not have yet a natural immunity to malaria and are affected by the most severe forms of the disease, with resulting high morbidity and mortality rates. As for AIDS, the high population density has increased rural-urban and urban-rural flows of population, thereby increasing the potential for the transmission of the disease to rural areas (usually less affected). Second, on the nutrition situation, while export earnings are insufficient to buy the necessary quantity of imported food, the population pressure has led Rwanda to a situation of permanent food insecurity: the country's current agricultural resources are increasingly insufficient to feed the entire population; there are no open land frontiers left; and households without land (or with very small holdings) cannot bring new land under production. Thus, even if per capita food production rose sharply, these households would not benefit without redistribution of productive land which may be politically difficult. Any regional imbalance caused by poor weather or a food crop disease could trigger a famine situation. Third, the high risk pregnancies experienced by most Rwandese women are
a major cause of the high maternal mortality and the high infant and child mortality and morbidity.

2.06 Investment Needs. The rapid population growth rate imposes a high investment rate to respond to social and employment needs of the population. In the Education Sector, schools should be built for the large number of children entering each year the schooling system. The government does not have sufficient resources to finance capital and operating costs of these new structures. In the absence of external funding and increased financial participation of the population (difficult to increase given the poor economic situation) the quality of education will start deteriorating: overcrowded classrooms are not propitious for improving the quality of teaching. Ultimately, enrollment rates will start diminishing. A study on the cost and financing of primary and secondary school conducted by the Bank in 1989, indicates that the primary school enrollment rate, already low today at 64 percent, might decrease to 43 percent over the next 10 years assuming that the population growth rate and the present policies in the education sector remain constant. In order to maintain this enrollment rate, the government has recently decided (February 91) to reduce primary education from 8 to 6 years. In the Health Sector, the situation is somewhat similar with the population growth rate imposing an expansion in health services beyond the government capabilities. This is felt already in certain areas, both urban and rural. For example, in Kigali, the capital city, certain wards of the central hospital are largely overcrowded and cannot deliver an adequate quality of care. In certain rural areas, there is no primary health care infrastructure at a reasonable distance and no plan to build one given the lack of financial resources.

2.07 In the Employment Sector, the population pressure is strongly felt. Since the economic situation precludes any rapid increase in employment demand, curbing the rate of growth of the working age population by effective family planning programs appears as a high priority. Assuming no reduction in the total fertility rate, the number of new entrants in the labor market will increase from 130,000 per year in 1990, to 360,000 per year in 2015. Rwanda's economy will have major difficulties in absorbing this workforce. As mentioned before, the formal sector can only offer a limited number of job opportunities and would require large restructuring and investments to increase its employment potential. This is unlikely to occur rapidly. The informal sector is poorly developed in Rwanda mainly because the Government has kept, until recently, a tight control on most productive activities and the urban sector (where informal activities usually flourish) is very small. Finally, the agricultural sector, which absorbs most human resources, is becoming acutely saturated and there are not many off-farm employment opportunities.
C. Population Policy and Family Planning Activities

Population Policy

1.08 Rwanda has been among the first African countries to initiate discussions on population issues. As early as 1966, the government had expressed increasing concern about rapid population growth. At first, efforts were mostly concentrated on the improvement of the nation's economic productivity, but in 1974 an advisory committee was created to study socio-demographic problems. As a result, in the second economic plan (1977-81), the emphasis was shifted from analysis to strategies aimed at reducing the population growth rate.

2.09 On several public occasions (official speeches in 1974; International Conference on Population in Mexico, 1984; in 1987 for the 25th anniversary of the Independence of the Country), the President of the Republic underlined the necessity to curb the country's explosive population growth rate. In his 1985 annual address, he advocated a family size of 4 children by the year 2000 (Annex VII, last para.). More recently (July 1990), he took for the first time a stronger official stand on the issue, stating that "People must limit the number of children they have or there will be no room for them". A recent breakthrough in the sector is the adoption of the Population Policy on June 6, 1990 by both the Party (Mouvement Révolutionnaire National pour la Développement) and the Parliament (Conseil National de Développement). The stated objective of the policy is to reduce the population growth rate from 3.6 to 2 percent by the year 2000. The decision of formalizing the population policy seems to have been prompted by the President's visit to the southeastern famine areas in March 1990. In addition, as shown by the minutes of recent meetings and seminars attended by decision makers and political leaders, a wide consensus had been building up on the necessity of forcefully addressing the population problem. This was further emphasized during the recent political events, with the President repeatedly mentioning population pressure as the major underlying factor of Rwandese problems. The National Population Office (Office National de la Population - ONAPO) has been instrumental in preparing the ground work for establishing a broad-based population policy. ONAPO has now been given the mandate to coordinate and support the implementation of this policy.

2.10 **ONAPO and its evolving role.** Created in 1982, ONAPO is a parastatal agency with financial and administrative autonomy, whose mandate is to collect population data, propose population policies and support action programs. Previously under the umbrella of the Ministry of Social Affairs it is now attached to the Ministry of Health (Annex II, Figure 1A). Since its creation, ONAPO has received strong support from USAID, and thereafter from UNFPA and, to a lesser extent from GTZ (German Corporation) and other international agencies. An administrative board is appointed for three years, renewable by the President of the Republic. ONAPO is divided into three main departments: (a) the financial and administrative department (which includes general accounting, management and procurement); (b) the study and program
department (which includes research, evaluation, family planning and communications); and (c) the general administration department (which includes personnel management) (Annex II, Figure 1B). From 1981 to 1989, ONAPO's personnel grew from 50 to 250 employees (including 110 high level staff). In addition to the central bureau, ONAPO has offices in all 11 regions of the country. The regional teams (which include 23 high level staff altogether) are responsible for developing and integrating FP services at the health center level, and for carrying out Information, Education and Communication (IEC) and multisectoral activities. ONAPO has also a training center (built with USAID funding) which is expected to progressively acquire a regional focus with the support of the World Health Organization (WHO) and the African Development Bank (AfDB). ONAPO's operating budget comes from two main sources: government allocation (30 percent, mostly salaries) and external aid (70 percent) (Annex VIII a and b).

2.11 ONAPO's efforts have followed a three-pronged strategy: (i) to increase awareness of decision makers, political leaders and the general public on the seriousness of the population issue and the need to address it; (ii) to improve the data base on population-related development issues and demographic indicators; and (iii) to support the implementation of an effective FP program, in collaboration with the Ministry of Health (MOH). Initially, ONAPO has concentrated its efforts towards sensitization and information activities. It has been successful in convincing decision makers to include demographic objectives in development plans, and more recently to formulate a formal population policy. ONAPO has also been effective in educating political leaders about population problems through seminars, mass media and several widely distributed publications. With regard to the general public, ONAPO has established a vast information, education and communication (IEC) program aimed at raising general awareness on population issues and the benefits of using family planning (FP). More recently, ONAPO has assisted the Ministry of Education in introducing population-related issues in the curricula of primary schools, together with the sensitization of school teachers and post-primary rural centers (CERAIs) personnel.

2.12 On studies and statistics, ONAPO has consolidated the data base on socio-demographic issues as a first step to the design of the population policy. Studies such as the national fertility survey (NFS) and the impact of population on health, nutrition, food security and economic development, have been carried out (Annex V). ONAPO is currently involved in the preparation of the 1991 census and the implementation of a demographic and health survey (DHS) with USAID support. Finally, ONAPO has also implemented in the northern region of the country (Ruhengeri), with assistance from Columbia University, a successful operational research project on community participation in FP activities (OR/FP). All these findings have been incorporated in the population policy statement which was adopted in June 1990.

2.13 ONAPO is supporting the implementation of FP services within the MOH facilities by providing the necessary contraceptives, equipment
and FP training. Joint ONAPO/MOH supervisions of these services are carried out from the central and regional levels. ONAPO has been reasonably successful in carrying out its tasks of sensitization, policy formulation and data collection. However, the support of FP activities has, so far, produced generally disappointing results (para. 3.16), after nearly a decade of family planning activities. The reasons for this limited impact are multiple, but three factors are particularly important. First, the poor performance of the public health facilities in integrating modern FP services into basic health services diminishes the effectiveness and quality of FP activities and explains part of the unmet demand for contraceptives. Second, the Catholic church's position on modern contraception has slowed down the growth of both demand for and supply of modern FP services because about 40% of PHC services are delivered by Catholic health facilities (see para. 2.21). Third, an insufficient demand for modern FP services from a population which remains traditional and pro-natalist.

Family Planning Activities

2.14 Demand for FP services. Data from the national fertility survey (1983) show that there is an unmet demand for FP services: 20 percent of the women aged 15-40 years in the sample did not want an additional child; 31 percent of the same age group said they intended to use contraception in the future. More recent data will be available soon when the on-going USAID-supported demographic and health survey (DHS) would have been completed. It is most likely that unmet demand is higher now than in 1983 because the population pressure has dramatically increased, much faster than FP services availability. However, despite this potential demand and the significant amount of resources already allocated to FP activities, the access of the population to modern contraceptive methods has been inadequate (para 2.21).

2.15 The Rwandese legislation is generally favorable to the promotion of family planning, even if the Civil Code tends to overemphasize the authority of the wife's father and husband over personal decisions. The new family code under preparation is expected to provide more freedom for women to have access to modern contraceptive methods regardless of their legal status (married or single).

2.16 FP service delivery. With assistance from ONAPO, the number of MOH facilities providing FP services increased from 25 to 182 during 1981-90, with over 80 percent of public health facilities currently delivering FP services. ONAPO also played a particularly useful role in providing assistance to health centers operated by non-Catholic NGOs, which have demonstrated receptiveness in promoting FP, with close to 68 percent of these facilities now providing these services. While this expansion in the number of facilities providing FP services is impressive, there is considerable concern over the quality of those services, which is generally believed to be inadequate due to the lack of motivation and poor training of health personnel. As the number of facilities providing services rose, the total number of contraceptive users grew from about 5,000 in 1981 to roughly 21,000 in 1985 and to
64,500 in 1989, which corresponds to an estimated modern Contraceptive Prevalence Rate (CPR) of 6 percent. Preliminary estimates for 1990 suggest that a boom is occurring with the number of users climbing to about 100,000, which corresponds to a CPR of about 9 percent and represents a 60 percent increase over the previous year. The major factor which seems to explain this rapid increase is the Government's staunch commitment to the FP program and the general public's awareness of shrinking land and increasing costs of living. During the past year, Rwandese authorities have placed this critical issue high on the political agenda, and have supported the elaboration and dissemination of a demographic policy paper. IEC activities were also intensified and the political network was well utilized to disseminate messages to the periphery, providing a more conducive environment for program implementation.

2.17 The evolution in the contraceptive mix during 1985-89 is characterized by a large expansion of injectables (from 48 to 70 percent) and corresponding declines in other methods such as pills (from 38 to 21 percent) and IUDs (from 12 to 3 percent). Barrier methods (i.e., condoms) still remain relatively unpopular (3 percent, 1989), and the AIDS epidemic does not appear to have given a boost to condom use. The promotion of highly effective FP methods such as sterilization and implants, is still at an early stage. In 1988, 332 tubal ligations (female sterilization) and 4 vasectomies (male sterilization) were performed. Norplant trials/ are being conducted in major hospitals in Rwanda, with the number of acceptors currently estimated at 460 (1990). The contraceptive mix during 1990 reflects a slight decline in injectables and an increase in pill use, as the MOH is striving to broaden the range of methods. Although illegal, abortion is reportedly widespread; but the abortion rate is difficult to estimate.

2.18 NGOs activities. NGOs of religious organizations play a key role in the provision of Health Care in Rwanda. The eight protestant churches and the Catholic Church have associated to create the Bureau des Formations Médicales Agrées du Rwanda (BUFMAR), a central management unit which provides medical supplies, logistic support and training to the 129 health facilities run by the churches. The collaboration between BUFMAR and MOH is good, although MOH does not perceive NGOs activities as an essential element of the national health strategy. Facilities run by the Protestant churches and other non-Catholic organizations provide modern methods of contraception; some of them have developed successful FP programs and collaborate closely with ONAPO. BUFMAR has been very active in IEC/FP activities and has produced audio-visual material to sensitize the population on the use of

3/ Norplant is an effective long-acting reversible hormonal contraceptive that provides protection for 5 years. Six thin flexible pellets made of soft silicone rubber and filled with a synthetic hormone are inserted just under the skin of a woman's upper arm in a minor surgical procedure.
modern contraceptive methods. It also organizes refresher courses in maternal and child health/family planning (MCH/FP) for its personnel. The non-catholic NGO overall impact on the sector is, however, limited due to the important share of Catholic health centers (which offer only natural family planning methods).

2.19 The Rwandese Association for Family Welfare (ARBEF), the Rwandan branch of IPPF4/, was created in 1986. The organization, which has become active only recently, counts presently 2000 members and supports IEC training activities aimed at the youth (part of these activities will be sponsored by USAID). It provides limited contraceptive supplies to ONAPO. In the long run, the association is expected to become increasingly involved in FP service delivery.

2.20 Other ministries and government agencies. Other ministries and government agencies provide limited support to ONAPO's program. The Ministry of Interior, the Ministry of Youth and the Ministry of Agriculture as well as other Government structures (Mouvement Révolutionnaire National pour le Développement, MRND; Union des Femmes Rwandaises pour le Développement, URAMA; Office Rwandais d'Information, ORINFOR) do not have a direct input into population/health programs. However, in many instances, ONAPO and MOH have used agents of these ministries and organizations, their physical structures and logistics to further enhance the IEC programs and the expansion of FP activities.

D. Major Sector Issues

2.21 Access to FP services. Approximately 60 percent of the population do not have easy access to modern FP services. The lack of access is due to the insufficient geographical coverage provided by MOH facilities (see below) and the unavailability of modern contraceptive methods in Catholic health facilities (which provide health services to approximately 40% of the population). While recognizing that rapid population growth is a major problem in Rwanda, the Catholic church discourages the population from using modern FP methods despite the President's appeal to all churches (July 1987) to leave the decision regarding adoption of FP principles up to individual couples. However, the Catholic church facilities do promote actively the use of Natural Family Planning (NFP) methods. This activity should be encouraged, even in MOH facilities, since it increases the range of FP methods available to Rwandese couples. Access to FP services is also limited by the fact that: (a) approximately 13 percent of public health centers (30) do not provide FP services; and (b) approximately 40-50 percent of the population does not have easy access to health facilities (given the mountainous configuration of the country).

4/ International Planned Parenthood Federation, based in London, is the largest international NGO involved in population and FP activities.
2.22 **Quality of FP services**. The quality of FP services currently provided in health facilities is severely hampered by insufficient training and inadequate supervision of health workers, and frequent shortages of contraceptive supplies. In 1986, out of approximately 2,120 professionals (health and social workers) in Rwanda who should be able to deliver FP services only 14 percent had been formally trained in FP. In addition, the health workers have not fully integrated FP services into their routine tasks (as is the case for other primary health care activities such as immunization and oral rehydration therapy). Many health centers at the peripheral level are understaffed and give priority to curative services at the expense of preventive services such as FP which requires relatively long and good interpersonal relationship and adequate counselling. At the central level, the MCH/FP division of MOH includes two technicians who are already overwhelmed by the task of implementing MCH programs countrywide and do not promote FP activities. Shortages of modern contraceptives (resulting from inadequate contraceptive management practices as well as from lack of financial resources) have been one of the major weaknesses of the program since 1981, and ONAPO organized in March 1990 a round table discussion to address this issue with the donor community.

2.23 **Demand for FP services**. According to the findings of the USAID-supported Fertility Survey (1983), the average ideal family size stated by the Rwandese women was 6.3 children. This figure is significantly higher than the 4 children per family suggested by the President, but considerably lower than the current TFR of 8.5. Several socio-cultural, economic and religious factors explain the desire to have numerous children. The factors most often cited include: (a) the fact that children represent an important workforce at the family level, particularly in rural areas; the young boys participating in agricultural work and the girls contributing to fuelwood and water gathering, care of younger siblings and other domestic chores; (b) the need for parents to have children (particularly male) as "social security" later in life; (c) the male having the prerogative for fertility decision-making; (d) the traditional African religions which encourage high fertility; (e) the influence of the Catholic church which discourages the use of modern contraception; (f) the fear of side-effects (particularly sterility) of modern methods of contraception; and (g) the high child mortality rates which lead parents to have as many children as possible. However, there are certain indications that the population's perception is slowly changing, even among the older generation. This change is primarily due to the awareness of land shortage, the culturally shocking fact that many male offspring cannot inherit a piece of land when they get married, and to the famine situation which prevailed in parts of the country in 1989. In addition, the rapidly increasing cost of schooling, child health care and nutrition is becoming an incentive to reduce the family size.

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5/ The results of the demographic and health survey (DHS) being carried out may reveal a different trend.
2.24 Demographic impact of the AIDS epidemic. The high prevalence rate of HIV infection in Rwanda, particularly in urban areas where it reaches 24 percent of men and women between the ages of 15 and 49, raises certain important questions, including that of the potential impact of this epidemic. A simplistic and cynical assessment already expressed in certain non-scientific publications can be summarized as follows: what is the need for investing resources and efforts in large fertility reduction programs when the AIDS epidemic will take care of the problem? The reality, however, is much more complex. Mathematical models have been developed by several researchers (including the Bank) to assess the demographic impact of AIDS based on various assumptions. These projections give diverse results, from a major reduction in population growth to a minimal population impact. This diversity is due to the uncertainties regarding changes in sexual behavior, which is the major determinant of AIDS transmission in developing countries. Nonetheless, even with the worst case scenario -- in which the incidence of the disease (new cases of infection per year) would continue unabated, and modern contraception would not be used -- a 3.6 percent population growth rate (like the one in Rwanda) would be reduced to 2.0 percent in about 25 years, still high enough to allow the total population to double within the next 35 years. Further studies and close monitoring are needed to assess the validity of various assumptions on the shape of the epidemic curve and to analyze the population's response to the AIDS-induced excess mortality.

2.25 Costs and Financing of the Population Program. The expansion of FP services and the development of multisectoral population activities require sizeable financial investments. Bilateral and multilateral aid accounts for the major share of ONAPO's budget. This aid contributes also significantly to FP service delivery in MOH structures. From 1982-1988, USAID's contribution accounted for almost 70 percent of all external aid in the population sector. However, USAID, the major sponsor of population activities in the country, does not provide injectable contraceptives which are by far the most popular contraceptive method currently used in Rwanda. Other donors, like GTZ, UNICEF, WHO, and UNFPA contribute significantly in specific regions of the country to the implementation of ONAPO's programs (Annex I, table 8). The other donors' contributions will become increasingly insufficient to cover the incremental recurrent costs required for the nationwide expansion of the FP program.

2.26 The refugee problem and its impact. In early 1991, at the government's request, ONAPO prepared an analysis of the national impact of the potential resettlement of thousands of Rwandese refugees living in neighboring countries. The analysis concluded that: a) the number of refugees to resettle might reach 450,000, which is the average population of a region in Rwanda, thereby increasing the population pressure in certain parts of the country; b) off-farm employment will have to be created since land availability is already a problem in the country; and c) new investments would be needed, particularly in the social sectors, to meet the needs of resettlement. A regional meeting to discuss the refugee problem took place in February 1991 in Tanzania.
The Government of Rwanda has agreed to welcome, once some prerequisites are met, all the refugees who want to return to their homeland. It has made an appeal to the international community to support this effort and to the United Nation High Commission for Refugees (HCR) to coordinate all aspects of the resettlement.

E. Sectoral Strategy and Bank’s Role

2.27 Sectoral Strategy. The government has established a set of ambitious demographic objectives, including the reduction of the population growth rate to 2 percent by the year 2000 (see para 3.02). While difficult to reach, the objectives represent a strong political statement and show a formal commitment to addressing forcefully the population issue. The first objective is to increase rapidly the contraceptive prevalence rate (CPR), by simultaneously stimulating demand and responding to the demand by provision of adequate FP services. For the past years, in order to reach this objective, the government had adopted a two-pronged strategy: the promotion of demand was ONAPO’s mandate and the supply of FP services was the MOH’s responsibility. While ONAPO has been relatively successful in carrying out its mandate, the MOH has had many problems in expanding FP activities nationwide, for the reasons described on sectoral issues (see para. 2.22 and 2.23). The government, aware of the MOH’s constraints, has decided to expand ONAPO’s mandate with the technical task of directly assisting the MOH in improving the quality and the coverage of FP services. This decision is justified by the relative institutional strength of ONAPO which can devote a large share of its resources to the improvement of FP services while the MOH has many other areas to cover. Another comparative advantage of ONAPO is its potential for establishing multisectoral action programs and expanding FP activities beyond the public sector network (NGOs, communities, private enterprises).

2.28 On the basis of its new mandate, ONAPO’s management has prepared a comprehensive work program whose main elements are to: (a) ensure the integration of the population variable in sectoral plans; (b) develop, in collaboration with other ministries and agencies, multisectoral activities which will address the issue of population growth; (c) organize training seminars and workshops for staff involved in population activities; (d) expand FP service delivery and increase the quality of these services; (e) strengthen the IEC program; (f) increase the involvement of the community in population activities; and (g) strengthen the population data base and analytical capabilities and incorporate research findings in economic plans.

2.29 The Bank’s role. IDA support to PHN activities started in 1982 with a pilot population component in a rural development project. The small-scale population activities implemented under this component allowed the Bank to develop a direct understanding of the population problems of Rwanda and establish at an early stage a good working relationship with ONAPO. This operation was followed by the family health project (US$10.8 million) which became effective in February
1987. The objectives of the first health project are: (a) to improve the quality and increase the coverage of maternal and child health (MCH)/FP services; (b) to emphasize nutrition activities and integrate them into primary health care activities; (c) to strengthen the institutional capabilities of MOH at the central and regional level; and (d) to increase the output and improve the quality of basic medical training. In this on-going operation, population issues have been addressed in two ways: strengthening the MCH/FP package delivery systems through the network of public health centers and assisting ONAPO in carrying out certain population studies. The most important findings from the implementation experience of the family health project which have been taken into account in the project design are the following: (a) the strengthening of family planning services and their integration into the MCH activities (pre-natal, peri-natal, post-natal care, nutrition) have been slower than expected, mainly because MOH does not have the internal resources and institutional capabilities to provide the necessary improvements (i.e. adequate training, supervision, organization and monitoring) to MCH/FP service delivery - this finding has led the government to develop with Bank's assistance a more forceful and focused approach, with the Minister of Health deciding to design a separate population project to be implemented by ONAPO - and (b) the inadequacy of overall local project management resulted in a slow disbursement rate, and underlined the need for a long-term technical assistance to provide support to the management, monitoring and implementation of project activities.

2.30 In this new approach, the Bank's objective is essentially to support ONAPO's leading role in implementing the national population policy and assist the MOH's efforts to expand access to and use of FP services. The proposed operation will mobilize the necessary MOH managerial resources towards specific population objectives without diverting staff from their basic and complementary goal of establishing a satisfactory PHC network where FP services can be efficiently delivered. IDA's resources will be used in close coordination with other donors support to avoid any duplication of efforts. IDA's support has been requested by the Government as a result of new awareness prompted by the degradation of social status in the country (including the recent famine already mentioned) and by a cost/benefit analysis of the national Family Planning program. The analysis, carried out by ONAPO with the Triangle Institute's support (see para. 6.03), shows the significant financial benefits to be gained from supporting such a program. The proposed population project, with its ultimate goal of reducing the population growth rate, represents an essential element of the Bank's lending strategy: in the absence of reducing the population growth rate, adjustment efforts will be ineffective in inducing sustainable economic growth.
III. THE PROJECT

A. Project Objectives and Design

3.01 The proposed project will provide comprehensive support to the implementation of the national population policy. It will focus primarily on meeting the existing demand for family planning services, while stimulating further demand for those services. This approach is consistent with one of the key recommendations of the national environmental action plan (NEAP), i.e. a greater accessibility to family planning services. The overall project objectives are to contribute to: (a) the reduction of the total fertility rate from 8.5 to about 7.2 by 1997; (b) a decrease in maternal and child mortality and morbidity related to reductions of birth intervals and to other risk factors such as extreme age (women below 15 or above 35-40 years of age); and (c) the integration of the demographic dimension in the overall socioeconomic planning process. These objectives will be reached by: (a) improving the quality and efficiency of FP services; (b) increasing demand for and access to FP services, to ultimately reach a modern contraceptive prevalence rate (CPR) of 20 percent by 1997 compared to the current level of about 9 percent; and (c) carrying out a set of population studies and analyses - the results of which will assist in translating the national population policy into multisectoral action plans. In order to carry out successfully these activities, ONAPO will collaborate closely with the Ministry of Health (MOH) and other relevant ministries. The project will build upon the experience gained in projects financed by other donors in the sector (USAID, UNFPA, GTZ) and will complement their activities. It was designed taking into account the lessons from experience under the ongoing Family Health project (para. 2.29).

3.02 The government in its population policy statement has set out a number of ambitious family planning targets. The demographic targets to be reached by 2000 include: (a) the decrease in the total fertility rate by 0.5 percent every year until 1997 and by 1.0 percent thereafter; (b) the reduction of the population growth rate from 3.6 percent to 2 percent; and (c) the increase in life expectancy from 50 years to 53.5 years. While these targets are extremely difficult to achieve within the time frame allotted, they nevertheless should provide an impetus to the program, by motivating providers and users. The medium-term objective to reach a contraceptive prevalence rate (CPR) of about 20 percent by 1997 takes into account the recent increasing trends in FP use and the substantial additional resources to be provided by the donor community (including this project). To attain a Total Fertility

6/ While this target might appear timid, particularly in view of rapid progress made in the past two years, it is consistent with experiences of other African countries where the CPR rose relatively rapidly and much slower thereafter. During the mid-term evaluation of the project, if it becomes clear that by 1997 the 20% CPR will be reached, adjustment will be made accordingly.
Rate (TFR) of about 6.4 children per woman (compared to 8.5 in 1985) after the turn of the century, the CPR would need to increase to about 30 percent by 2005. These targets have been calculated on the basis of a series of simulations carried out to evaluate the impact of a reduction in fertility on contraceptive use and births averted over the period 1990-2015. The simulations were done using the simplified version of the Bongaarts Model7/. The projections assume that: (i) no changes will occur in the contraceptive mix and effectiveness; and (ii) changes in marriage patterns and breast-feeding practices will have offsetting effects. To the extent that the duration and intensity of breast-feeding will decline more rapidly, the number of contraceptive users would have to be even higher to reach the same fertility target. If the CPR targets are achieved, it would imply an estimated 226,000 and 382,000 users by 1995 and 2000 respectively. These projections reflect more than a two-fold increase in the number of users during the next 5-year period. The births averted annually through the family planning program would increase from about 23,000 in 1989 to 88,000 in 1995, and to 145,000 in 2000.

B. Detailed Project Description

Part A: Improving the Quality and the Efficiency of FP Services.

3.03 The broad objectives of this component are to: (a) increase the quantity and quality of FP services delivered by health facilities; and (b) ensure an effective and efficient integration of FP into PHC activities through the health center network. The specific component objectives are to: (a) improve the capability of health staff to deliver and manage FP services offered at the health center level (including outreach activities) through basic and on-the-job training programs, and regular supervision visits; (b) improve the institutional capability of MOH/ONAFO staff to design, monitor, and evaluate FP training activities; (c) provide medical and non-medical equipment to 60 priority public and NGO health centers and hospitals which do not benefit from any external support; and (d) strengthen the logistic system mainly the procurement and management of contraceptive supplies. The family health section of ONAFO, in close collaboration with the Direction de Médecine Intégrée of MOH, will have primary responsibility for implementing this component. Field monitoring will be the responsibility of the regional team (MOH medical officer and ONAFO medical representative).

3.04 Training of health personnel. The project will support the training of several categories of health personnel, including medical assistants, nurses, nurse-aids and auxiliaries. The training program will complement other donors' efforts and will be organized along five

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7/ See Annex I table 7 for a description of model, assumptions and detailed results.
major themes: (i) managerial techniques to set up a FP clinic in a health center, including patient processing, scheduling of activities, supply management, data recording and reporting; (ii) communication techniques, including first interviews of potential acceptors, counselling and follow-up of users, promotion strategies and person-to-person communication skills; (iii) appropriate use of contraceptive technologies, including natural family planning methods (this module will enhance health personnel skills in the selection of adequate contraceptive methods for each specific case and the control of potential side effects); (iv) outreach activities towards the community served by the health center, with a specific focus on strategies to supervise a network of volunteers; and (v) the integration of FP services into MCH activities. Throughout the duration of the project, approximately 1,100 health workers (including medical assistants, nurses, auxiliary nurses) will be trained/recycled by joint ONAFO/MOH regional teams with support from trainers from headquarters and regional levels. Training sessions will be progressively decentralized in order to maximize the practical aspects of the training and to adapt it to the immediate environment of trainees. In order to create an enabling environment to the decentralization of training, medical and non-medical materials and equipment will be provided to 60 health facilities which are supported by other donors. FP training curricula are currently being jointly reviewed by the training divisions of ONAFO and MOH which will have responsibility for the implementation, monitoring and evaluation of this sub-component. During negotiations, it was agreed with the government that these curricula will be updated by March 1, 1992 to include all the training themes agreed upon during project preparation (para. 7.01(c)). An annual assessment of the training program (Annex XII) will be carried out by ONAFO to: (i) better adapt the training program to the needs of health staff and other categories of personnel, and (ii) strengthen the training capacity of the team ONAFO/MOH. In parallel with the in-service training program, ONAFO will provide technical assistance to the medical school and all paramedical schools for improving the training of students in FP.

3.05 Strengthening the supervision of FP activities. This activity is complementary to the training program. The intensified supervision of MCH/FP activities at the health center level will be part of the supervision visits that joint MOH/ONAFO regional teams are currently carrying out. New supervision guidelines will be introduced, focusing on: (i) the integration of FP into the MCH package that the health centers are providing; (ii) the practical application of the five training topics (management, communication, contraceptive technology, integration of MCH/FP services, outreach) already described; (iii) contraceptive procurement; and (iv) problem-solving when health staff are facing specific difficulties. The project will provide the necessary logistical support (vehicles for operations, per diem, supplies) for the incremental supervision visits.

3.06 Strengthening health education at the health center level. Health education is neglected in most health centers, whereas patients gathering in large waiting rooms represent an excellent opportunity to
communicate health messages and other health-related information. A special emphasis will be placed on the promotion of breast feeding given the fact that breast feeding duration has been falling in Rwanda over the past years. The project will help the MOH strengthen this activity by: (a) reorganizing the education sessions in the centers; (b) strengthening health and population messages; and (c) providing assistance for the additional IEC teaching materials and equipment required. During the supervision visits of health centers, special emphasis will be placed on the organization of these sessions.

3.07 Improving contraceptive supply and management. This activity will address the problem of contraceptive shortages which often hamper the delivery of FP services. Projections of contraceptive needs and costs have been made for the period 1990-1997. The quantities assume no significant change in the contraceptive mix by 1997. At present, the support of major donors in the sector is not sufficient to provide adequate contraceptive supplies. Consequently, the lack of steady financial resources has caused frequent shortages. Moreover, USAID does not provide injectable contraceptives which are currently the most popular method. Under the on-going Family Health project, the Bank has also contributed to the purchase of contraceptives for the FP program at times when the budget allocated by other donors for the procurement of contraceptives was insufficient to meet the increasing demand. Under the current estimates, the project will have to fill a financial gap of approximately US$6.8 million over a six-year period. In order to strengthen the MOH/ONAFO collaboration and thereby make the system more efficient, the directorate of pharmacy of the MOH will be associated to the procurement of contraceptives.

3.08 The strengthening of the management of contraceptives will complement USAID support through the improvement of several key activities: (i) inventory management; (ii) periodic reviews of projections of contraceptive needs; (iii) timely preparation of orders and their adequate follow-up; (iv) improvement of storage and logistics at the central, regional and peripheral levels; and (v) improvement of the dispatching system. These activities will be coordinated among the various donors to assess annual contraceptive needs and procurement. (Projections of contraceptive needs is provided in Annex I, Table 7). The local procurement specialist to be recruited under the project, will assist ONAFO’s personnel involved in the procurement of contraceptives in carrying out these activities. Workshops for selected ONAFO central and regional staff will be organized on this topic and field visits will be organized to monitor the above mentioned activities.

Part B: Expansion and promotion of FP services

3.09 The overall objectives of this component are to: (a) complement the efforts of health centers in the provision of FP services by developing an outreach strategy to bring FP information and modern contraceptive methods to poorly served communities; and (b) provide support to ONAFO’s IEC strategy and promote FP use among important
target groups (such as males and young adults) which have been so far neglected. Although ONAPO will have the major responsibility for monitoring the implementation of this component both at the central and regional levels, the MOH will also become more actively involved. The implementation strategies for this component include: (a) the strengthening of existing FP posts and the establishment of new FP posts in priority areas nationwide; (b) the improvement of community participation in FP activities by mobilizing a network of approximately 17,500 volunteers for community-based distribution of contraceptives and promotion of demand creation for FP services at the grassroots level; and (c) support of the design, implementation and evaluation of the IEC strategy and of specific IEC activities.

**Strengthening and establishing FP posts**

3.10 The objective of this sub-component is to increase access to FP services in areas that are currently poorly served because the variety of modern contraceptive methods are not offered, or the geographical access to health facilities is difficult. This objective will be achieved by strengthening 39 FP posts and establishing 44 additional FP posts beyond the health center level. These posts will operate as an integrated part of the health center network and will be closely supervised and monitored by health center personnel. This outreach strategy is justified because: (a) it will strengthen MOH capability to deliver FP services (which have been defined as a priority program by the government) in areas where the coverage is inadequate; (b) it will require minimal costs since the posts will be established within existing administrative structures (see para 3.12); and (c) it will increase MOH's involvement and effectiveness at the community level. To select the priority areas (see map section) for the implementation of FP posts, the following criteria have been taken into account: (i) the level of FP coverage presently provided through the health center network; (ii) the support offered by communal authorities for the expansion of the FP program; (iii) the distance to the nearest health facility from the peripheral level; (iv) the overall performance of the nearby public health centers; and (v) the availability of health center staff adequately trained in FP. This latter criteria was particularly important in selecting the location of the FP posts within the communes. The 39 existing FP posts will be strengthened during the first year. The establishment of the 44 additional FP posts will be carried out during the first four years of the project (approximately 11 new posts per year). Given the innovative nature of this approach, a performance review of the FP posts will be carried out after three years of project implementation prior to completing the establishment of the remaining posts. This performance review will be part of the mid-term review to be carried out in 1994 (see para. 5.08).

3.11 The performance of the 39 existing FP posts distributed in all the prefectures (except Byumba) is encouraging and confirms the existence of an unmet demand for FP services. On average, each post currently functions twice a week and enrolls 20 new acceptors every month. They are staffed on a part-time basis by health personnel from
nearby public or non-governmental health centers. The major constraints to the functioning of these posts have been: (a) their lack of management and overall organization (in terms of equipment, job descriptions of personnel), and supervision; (b) the difficulty in certain areas of obtaining the services of qualified MOH personnel working in Catholic health centers to staff the posts on a part-time basis; and (c) the insufficient linkages between the FP posts and the network of volunteers. To address these constraints, an implementation committee - including the regional ONAPO and MOH representatives, the mayor and the medical assistant in charge of the health center - will be created in each commune to oversee the establishment of these posts. A more specific definition of the overall objectives and management structure for the FP posts has been prepared by ONAPO and is described below.

3.12 The FP posts will be housed within existing available structures of the communes (Centre Communal de Développement et de Formation Permanente (CCDFP), city halls, public nutrition centers, etc.). The involvement of the community and of the local leaders will be a key factor to the success of this activity and will be closely monitored. In parallel with project implementation, quarterly meetings will be organized by the supervision teams (which will consist of ONAPO and MOH high and medium level staff) with communal authorities and community representatives, to discuss project activities and solutions to key problems identified (para. 5.07). To promote an efficient FP service delivery package, the respective functions of the health centers, the FP posts and the volunteers working at the community level (Annex IX), as well as their linkages to the communes, will be well coordinated. The specific mechanisms are being clarified by a joint ONAPO/MOH working group.

3.13 The FP posts will operate once or twice a week, depending on demand. Whenever possible, this schedule will be standardized by region in order to facilitate their supervision at the regional level. In each area, the staffing patterns will be adapted to the availability of adequate resources, but they mainly will be staffed by a MOH agent from a nearby health center adequately trained in FP. If such an agent is not available, he/she will be replaced by a qualified agent from the ONAPO/MOH regional team. Each FP post is expected to enroll at least 20 new acceptors per month. This number should increase if the posts operate three times a week instead of two. The project will provide medical and non-medical materials and equipment (including contraceptives) necessary to ensure the adequate performance of these posts. The project will provide health personnel with the necessary training (see para. 3.04).

3.14 An adequate supervision and monitoring system will be a key input to successful implementation of the FP posts. A supervision scheme has been developed, involving ONAPO and MOH central, regional and peripheral staff. Throughout project duration, the supervision pattern will be especially intensive at the peripheral level (the health center manager is expected to visit the satellite post once a month). Central
and regional level staff will intensify their supervision efforts during the first year of project implementation and maintain a schedule of two and three visits a year respectively thereafter. Supervision of the FP posts and health centers will be integrated by the regional MOH-ONAPO team. This scheme places emphasis on the responsibility of the regional and peripheral staff in the monitoring of the posts. To ensure the efficiency of this process, a specific checklist will be prepared for each supervision level and adequate logistics will be provided (at least two vehicles and five motorcycles per region). As part of the monitoring process, the data collection system will be revised and simplified in order to ensure timely analysis of the posts' performances.

Utilization of a network of volunteers for promoting the demand for FP services and for Community-Based Distribution (CBD) of contraceptives

3.15 The objective of this subcomponent is to strengthen the volunteer program developed by ONAPO as the major IEC strategy for the promotion of FP services at the community level. While ONAPO has been successful in sensitizing the political and social leaders and the general public with respect to population issues and FP, specific actions are now needed to maintain the level of motivation and encourage actual use of contraceptives at the community level. A network of approximately 17,500 \(^8\) community-based volunteers (Abakagurambaga) evenly distributed throughout the country has been working with ONAPO since 1988. These volunteers are located at the most peripheral political and administrative level of the country: the cellules which comprise 50 families each. They represent an excellent channel to convey messages and to affect changes in the community. ONAPO has already provided limited IEC and FP training to those volunteers. The project will considerably strengthen their training and will progressively involve them in the distribution of contraceptives, following a Community-Based Distribution (CBD) strategy\(^9\). The volunteers will perform the following functions: (a) inform the community regarding the importance and benefits of FP; (b) educate the

\(^8\) Two volunteers (male and female) per cellule (1 cellule includes 50 families), for a total of approximately 8,750 cellules throughout the country.

\(^9\) Community-Based Distribution (CBD) of contraceptives is an outreach strategy to provide FP services to the target population at the most peripheral level beyond the traditional health center network. It involves primarily community volunteers who are trained in delivering FP messages and certain contraceptive methods. This strategy has been successfully tested in many Asian, Latin American and a few African countries (including Rwanda) in increasing significantly the contraceptive prevalence rate, confirming the hypothesis that people would use FP services if they are made easily available to them.
community regarding modern and natural FP methods; (c) refer potential acceptors to nearby FP posts and health centers; (d) ensure the follow-up of current users with a specific objective to advise them properly in case of side effects, and encourage drop-out clients to resume modern contraception whenever deemed appropriate; and (e) distribute modern contraceptive methods. The distribution function will be integrated progressively into the work program of the volunteers, as follows: (i) beginning in the second year, only condoms and other non-medical contraceptive methods will be distributed; and (ii) after the third year, the resupply and supply of pills will be initiated. By that time, the volunteers will be properly trained, their monitoring and supervision functions well established and their role well understood and accepted by the communities.

3.16 The project will help ONAPO develop several training strategies to ensure the adequate work performance of the volunteers. Training will focus on: (a) contraceptive technology, including natural family planning; (b) communication methods; (c) FP counselling; (d) work organization; (e) use of checklists to screen clients eligible for hormonal contraceptives (pills, injectables, implants); and (f) report and statistical forms regarding FP service delivery. Emphasis will be placed on IEC messages for specific target groups (youth, males, females less than 15 years old and more than 35, women with high parity). A multi-disciplinary team from the prefectoral and communal levels (see detailed training plan, Annex XI), including the director of the CCDFP, the medical assistant of the communal health center and the communal agricultural agent, will be responsible for conducting the training sessions under the supervision of ONAPO’s regional staff. The project will also support refresher courses for the team of trainers of the volunteers at both the prefectoral (110) and communal (435) levels.

3.17 ONAPO will monitor and supervise the work of the community volunteers by: (a) providing “coupons" to the volunteers for issuance to clients referred by them to the health centers or the FP posts; (b) reviewing the statistical forms used by the volunteers to record data on the population served; and (c) conducting follow-up visits from the central, regional and peripheral levels. Supervision of this program will be the primary responsibility of ONAPO’s regional team which will work in close collaboration with the multi-disciplinary team from the prefectoral and communal levels (see para. 3.16 above). In addition, while the volunteers are not formally part of the MOH network, the medical assistant in charge of the nearest health center will closely monitor their work.

3.18 To ensure motivation of the volunteers, a system has been developed to provide annual incentives to communes and volunteers who perform satisfactorily. The award system will be based on a scale ranging from average to outstanding performance and awards will be provided accordingly. Awards will consist of radios, motorcycles, wheelbarrows and hoes (Annex IV, Table 4). The idea is to provide the volunteers with means to improve their work (listening to ONAPO programs on the radio, improving means of transport) and supplying useful tools
for their agricultural plots. The criteria for measuring performance are the following: (a) regular attendance in training sessions; (b) number of clients referred; (c) quality of statistical records; (d) work assessment by the community; (e) regular meetings with health center and FP post staff; and (f) number of drop-out clients traced.

Supporting the Overall Information-Education-Communication (IEC) strategy

3.19 To date, ONAPO's IEC programs have been oriented toward the general public. The project will support these activities and will assist in the design and implementation of more focused IEC strategies on specific segments of the population.

3.20 Introduction of population issues in school curricula. This activity will introduce population issues in the curricula of preschool, primary, secondary and higher education curricula. A needs assessment will be carried out in order to elaborate specific curricula and training modules to be used at the different levels. Once they are elaborated and tested, symposia and conferences oriented toward the respective users of those modules will be held. A mid-term evaluation of this activity will be carried out in order to assess its impact and modify the content of the curricula and modules if needed (para. 7.01). ONAPO and university staff will develop the curricula with external technical assistance when necessary.

3.21 Introduction of population and family planning issues in women's groups. ONAPO is currently elaborating a 5-year program aimed at integrating population and FP issues into women's groups in Rwanda. As stated in the assessment report of FP for the last decade (ONAPO, December 1990), this represents a priority area for IEC interventions in the future. Activities will include the organization of workshops and seminars in each region to encourage the integration of FP in women's work. It is expected that the Union des Femmes Rwandaises pour le Développement (URAMA), with staffing at the communal level will assist in the implementation of this activity.

3.22 Training/Refresher training in IEC. The objective of this activity is to strengthen and develop the technical capability of ONAPO's staff in the design, implementation, monitoring and evaluation of IEC programs related to population and family planning issues. Approximately 65 people10/ from ONAPO central and regional levels will benefit from such training. This core team of trainers will, in turn, organize training/refresher sessions in IEC for the multisectoral personnel involved in family planning at the communal level. In addition, refresher courses in IEC and family health education will be organized for approximately 360 people from the Centre d'Education Rural Artisanal Intégré (CERAI), 180 teachers from higher education schools, 10/ Five per prefecture and 10 at the central level.
250 people involved in family health education through their work, and 1629 social workers. All this training will be decentralized.

3.23 Organization of "Population Week". The objective of this activity is to reactivate each year national awareness on population issues. During this week, IEC programs will be oriented toward the general public through various communication channels (media, songs, plays, banners, brochures) and emphasize messages delivered by the volunteers at the community level. This activity will be carried out on nationwide. "Population Week" has been very successful in the past and has given the President of the Republic and other political figures the opportunity to renew their commitment to family planning.

Part C: Supporting population studies and promoting multisectoral activities

3.24 The objectives of this component are to: (a) strengthen ONAPO's data base and analytical capabilities; (b) integrate population variables into the overall planning process; and (c) promote multisectoral activities aimed at fostering demand for FP services. To attain these objectives, ONAPO will undertake priority studies in the sector, strengthen the FP information system and develop multisectoral activities with other ministries and institutions. The research division of ONAPO will be responsible for undertaking the research activities of this component, and will oversee in collaboration with the project coordinator the implementation of multisectoral activities being carried out by other ministries and organizations.

3.25 Strengthening the research program and the evaluation of FP activities. The objective of this subcomponent is to consolidate ONAPO's advisory and monitoring role in the implementation of the population policy. ONAPO has already carried out several population studies, the results of which have been incorporated into development plans. The project is expected to provide funding for priority surveys and research activities, including: (a) causes of maternal mortality, (b) determinants and consequences of migration (especially internal migration); and (c) assessment of family planning service delivery, to be undertaken at both the mid-term and final evaluation of the project. The latter would include both a quantitative and a qualitative assessment of the FP activities, focusing on such issues as provider performance and client satisfaction. The results generated from these studies are expected to enhance the implementation of the population policy and family planning program. The research division will provide IDA on an annual basis within the framework of the annual work program, its specific proposals, including detailed terms of reference, budgets and technical assistance needs.

3.26 Developing multisectoral activities. ONAPO has been active in developing the dialogue on population matters with different sectors, groups and agencies and has already developed joint activities with some of them (Ministry of Youth, Ministry of Education, enterprises, NGOs).
This approach will be expanded since ONAPO now has the mandate to take the lead in implementing the national population policy. ONAPO is currently in the process of helping several ministries (Planning, Agriculture, Health, Education) to integrate the population variable into their sectoral plans. The financial support for these plans will be provided through the budgets of these ministries. Multisectorial activities to be funded under the project will include seminars and workshops for higher level staff involved in development activities, associations, labor groups, youth organizations and agricultural extension workers in order to educate these segments of the population on population and FP issues. The Board of ONAPO will be responsible for the close monitoring and evaluation of these activities (para. 5.06).

IV. PROJECT COSTS AND FINANCING

A. Costs

4.01 The project will be implemented over a six-year period. Total costs for the proposed project are estimated at FRW 313.1 million (US$ 26.1 million equivalent). Base costs are calculated at US$ 21.0 million equivalent, including taxes and duties of US$0.06 million, and contingencies amount to US$ 5.1 million equivalent (24 percent of total project costs). Foreign exchange costs account for US$ 14.4 million or 55 percent of total project costs. Project costs by category of expenditure are summarized in Table 4.1 below and details are provided in Annex IV. Contraceptives account for 33 percent of base costs, training activities for 29 percent, equipment, vehicles, studies and supplies for 20 percent, and technical assistance for 3 percent of base costs.

Table 4.1: Cost Summary

<table>
<thead>
<tr>
<th>SUS million</th>
<th>% Foreign Exchange</th>
<th>% Total Base Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local Foreign Total</td>
<td></td>
</tr>
<tr>
<td>I. INVESTMENT COSTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Equipment, Furn., Mat.</td>
<td>0.4 2.0 2.4</td>
<td>82</td>
</tr>
<tr>
<td>B. Vehicles</td>
<td>0.6 0.4 0.4</td>
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</tr>
<tr>
<td>C. Contraceptives</td>
<td>0.6 0.0 0.6</td>
<td>100</td>
</tr>
<tr>
<td>D. Training and Seminars</td>
<td>6.7 0.3 6.9</td>
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</tr>
<tr>
<td>E. Technical Assistance</td>
<td>0.1 0.1 0.1</td>
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</tr>
<tr>
<td>F. Studies</td>
<td>0.7 0.7 1.4</td>
<td>60</td>
</tr>
<tr>
<td>Total Investment Cost</td>
<td>6.9 10.7 17.6</td>
<td>88</td>
</tr>
<tr>
<td>II. INCREMENTAL RECURRENT COSTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Equipment Maintenance</td>
<td>0.8 0.1 0.4</td>
<td>26</td>
</tr>
<tr>
<td>B. Vehicle Maintenance</td>
<td>0.9 1.1 1.4</td>
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</tr>
<tr>
<td>C. Government Salaries</td>
<td>1.0 0.0 1.0</td>
<td>0</td>
</tr>
<tr>
<td>D. Stipends and Travel</td>
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<tr>
<td>E. Supplies and Materials</td>
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<td>Total Incremental Recurrent Costs</td>
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</tr>
<tr>
<td>Total Baseline Costs</td>
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<tr>
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<tr>
<td>Price Contingencies</td>
<td>2.6 1.6 4.2</td>
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</tr>
<tr>
<td>Total Project Costs</td>
<td>11.6 14.6 26.1</td>
<td>85</td>
</tr>
</tbody>
</table>
4.02 Physical contingencies have been calculated at 10 percent for vehicles, equipment, contraceptives, furniture and materials. The following price contingencies have been included: (i) on foreign exchange expenditures, 3.6 percent per annum throughout project duration; and (ii) on local cost expenditures, 17 percent in 1992, 6.1 percent in 1992, 5.3 percent in 1993, and 4.5 percent every year thereafter. Price contingencies account for 19 percent of base costs. Project costs have been estimated in January 1991 prices and have taken into account the effects of the November 1990 devaluation. Estimates for equipment, supplies, materials and contraceptives were prepared by ONAPO and verified against USAID standard equipment lists. Estimates for vehicles are based on previous experience with other IDA-financed projects. Stipends and travel allowances are based on the current government scale.

4.03 Project costs by component are shown in Table 4.2 below. The improvement in the quality of FP services accounts for 28 percent of total project costs, the creation, expansion and promotion of FP services for 56 percent, the development of multisectoral population activities/research for 8 percent and project management for 8 percent.

Table 4.2: Project Cost Summary by Component

<table>
<thead>
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<th>Component</th>
<th>SUS million</th>
<th>% Foreign Exchange</th>
<th>% Total Base Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local</td>
<td>Foreign</td>
<td>Total</td>
</tr>
<tr>
<td>A. Imp. Qual. of FP Service</td>
<td>0.6</td>
<td>5.4</td>
<td>6.0</td>
</tr>
<tr>
<td>B. Expn. &amp; Prom. of FP Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. FP Posts Eqn. &amp; Supplies</td>
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<td>3.7</td>
<td>5.0</td>
</tr>
<tr>
<td>2. Volunteers Abaketaomggba</td>
<td>6.2</td>
<td>0.7</td>
<td>6.9</td>
</tr>
<tr>
<td>3. Support to IEC Strategy</td>
<td>0.0</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Sub-total</td>
<td>7.1</td>
<td>4.5</td>
<td>11.6</td>
</tr>
<tr>
<td>C. Multisec. Pop. Activ. Rco.</td>
<td>0.9</td>
<td>0.8</td>
<td>1.6</td>
</tr>
<tr>
<td>D. Project Management</td>
<td>0.4</td>
<td>1.8</td>
<td>2.2</td>
</tr>
<tr>
<td>Total Baseline Costs</td>
<td>9.0</td>
<td>12.6</td>
<td>21.6</td>
</tr>
<tr>
<td>Physical Contingencies</td>
<td>0.1</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Price Contingencies</td>
<td>2.6</td>
<td>1.6</td>
<td>4.2</td>
</tr>
<tr>
<td>Total Projects Costs</td>
<td>11.7</td>
<td>14.8</td>
<td>26.1</td>
</tr>
</tbody>
</table>

B. Incremental Recurrent Costs and Project Sustainability.

4.04 Incremental recurrent costs (salaries, equipment and vehicle maintenance and operation, per diem, stipends and supplies) amount to US$ 4.2 million, representing 16.0 percent of the total project costs (including contingencies). The Government will assume responsibility for salaries and stipends, with IDA financing 95 percent of the other incremental recurrent costs. During the six-year project, IDA will fund, on average, about 65 percent of the total incremental recurrent costs. Given the gravity of the financial situation in Rwanda and the Government's commitment to embark for the first time on a IDA-funded
adjustment program, IDA's contribution to the incremental recurrent costs over the life of the project appears fully justified. In fact, this will be particularly important during the medium-term since the macroeconomic adjustment program will lead to a significant and progressive curtailment in Government expenditures. The proposed financing arrangements are therefore intended to mitigate this effect, by minimizing the imminent risk of chronic shortages of budgetary resources for key project activities. Moreover, the Government's staunch commitment to addressing the demographic problem and its considerable efforts to mobilize financial and human resources towards this end augurs well for the success of this operation and adds further justification to the proposed financing pattern. Finally, it should be highlighted that, given the long-term nature of the project objectives, a discernable demographic impact will only become apparent in a decade. This implies that the potential economic benefits of the project (i.e., higher per capita incomes, lower investment levels associated with a more favorable age structure, and higher savings levels) will only materialize well after project completion; therefore, the Government's ability to assume a higher proportion of incremental recurrent costs will only be improved in the long-run.

4.05 In 1992, the incremental recurrent costs are equivalent to only about 4.0 percent of the total projected Government outlays on health (including population). In 1998, at project completion, the incremental recurrent costs are estimated to be about US$622,000, representing 5.0 percent of total projected Government health expenditures. The composition of these expenditures would be as follows: (i) salaries: 26 percent; equipment, vehicle maintenance and operation: 46 percent; per diem and stipends: 12 percent; and supplies: 15 percent. The expenditure projections are based on the following medium-term assumptions of the structural adjustment credit: (a) a reversal in GDP growth (real terms) from -2.0 percent to 4 percent; and (b) a reduction in the Government recurrent expenditures/GDP ratio from 18 percent to 10 percent. It was further assumed that the share of health in total Government recurrent expenditures would be maintained at the current level of 5.1 percent. In the event that this share is increased to about 8.0 percent, which reflects more accurately the sector's requirements, the incremental recurrent costs would represent only 3.0 percent of the Government health expenditures in 1998. The Government should be able to absorb these incremental recurrent costs. The public expenditure review will be used as a tool to mobilize additional Government resources for priority programs such as population. In addition, during the mid-term evaluation, options for financing project incremental recurrent costs will be assessed.

4.06 Contraceptives. With regard to contraceptive supplies, foreign exchange scarcity and competitive needs among various sectors would preclude that the government ensure an adequate supply without external assistance. In 1998, contraceptive supply needs will amount to $2.3 million, which represents approximately 40 percent of projected public expenditures on drugs for the same period. The potential for cost recovery through the social marketing of contraceptives is being
tested by the USAID-supported project and, if successful, could ease to a certain extent the MOH budget. This cost-sharing process will take time before becoming fully operational and it is unrealistic to expect this to occur during project implementation. Because the reduction of the population growth rate is so essential for the country's overall development, external assistance (including IDA) should continue and even increase, if the FP program is successful. In addition, during the course of project, implementation efforts will be made to mobilize additional grant funds to finance contraceptive requirements.

C. Financing

4.07 Of the total project costs of US$ 26.1 million, IDA will contribute US$ 19.6 million (75 percent). USAID is expected to allocate at least US$1.9 million (7 percent) and UNFPA US$1.2 million (5 percent) in parallel financing for contraceptives11/. The government will contribute US$3.4 million (13 percent). The financing plan by disbursement categories is summarized in table 4.3 below.

Table 4.3: Financing Plan by Disbursement Category

<table>
<thead>
<tr>
<th>Category</th>
<th>USAID</th>
<th>UNFPA</th>
<th>GOVT</th>
<th>TOTAL</th>
<th>For.</th>
<th>Local</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Case,Veh.,Furn.</td>
<td>9.3</td>
<td>0.0</td>
<td>0.0</td>
<td>9.3</td>
<td>1.3</td>
<td>10.6</td>
</tr>
<tr>
<td>B. Contraceptives</td>
<td>8.4</td>
<td>0.0</td>
<td>0.0</td>
<td>8.4</td>
<td>1.2</td>
<td>9.6</td>
</tr>
<tr>
<td>C. Tech. Assistance</td>
<td>0.6</td>
<td>0.0</td>
<td>0.0</td>
<td>0.6</td>
<td>0.6</td>
<td>1.2</td>
</tr>
<tr>
<td>D. Training &amp; Studies</td>
<td>7.9</td>
<td>0.0</td>
<td>0.0</td>
<td>7.9</td>
<td>1.5</td>
<td>9.4</td>
</tr>
<tr>
<td>E. Operating Costs</td>
<td>7.4</td>
<td>0.0</td>
<td>0.0</td>
<td>7.4</td>
<td>1.3</td>
<td>8.7</td>
</tr>
<tr>
<td>F. Govt. Salaries</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total Disbursements</td>
<td>19.6</td>
<td>1.0</td>
<td>1.3</td>
<td>22.0</td>
<td>10.0</td>
<td>32.0</td>
</tr>
</tbody>
</table>

11/ These figures represent estimates of the contributions of those agencies for the activities undertaken under this project and do not reflect their total contributions which are much more substantial.
D. Procurement

4.08 The procurement arrangements are summarized in table 4.4 below.

Table 4.4: Procurement arrangements 12/

<table>
<thead>
<tr>
<th>Project Element</th>
<th>ICB</th>
<th>LCB</th>
<th>IS/LS</th>
<th>ROC</th>
<th>N/A</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment/Materials</td>
<td>2.0</td>
<td>0.0</td>
<td>(2.0)</td>
<td>(2.0)</td>
<td>2.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>0.5</td>
<td>0.0</td>
<td>(0.5)</td>
<td>(0.5)</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Vehicles</td>
<td>0.5</td>
<td>0.0</td>
<td>(0.5)</td>
<td>(0.5)</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Technical assistance</td>
<td>0.5</td>
<td>0.0</td>
<td>(0.5)</td>
<td>(0.5)</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Studies/Training a. Consultants</td>
<td>1.0</td>
<td>1.0</td>
<td>(1.0)</td>
<td>(1.0)</td>
<td>1.0</td>
<td>1.4</td>
</tr>
<tr>
<td>b. Training materials</td>
<td>0.5</td>
<td>0.0</td>
<td>(0.5)</td>
<td>(0.5)</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>c. In-service training</td>
<td>0.5</td>
<td>0.0</td>
<td>(0.5)</td>
<td>(0.5)</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>d. Training abroad</td>
<td>0.5</td>
<td>0.0</td>
<td>(0.5)</td>
<td>(0.5)</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Operating Costs</td>
<td>4.5</td>
<td>0.0</td>
<td>(4.5)</td>
<td>(4.5)</td>
<td>4.5</td>
<td>4.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10.5</td>
<td>1.0</td>
<td>1.5</td>
<td>1.5</td>
<td>11.1</td>
<td>28.1</td>
</tr>
</tbody>
</table>

ICB: International competitive bidding  
LCB: Local competitive bidding  
IS/LS: International shopping/local shopping  
ROC: Bank guidelines on consultancy

4.09 Goods. Contracts for the supply of equipment, contraceptives, educational and training materials equivalent to US$300,000 or more will be procured through international competitive bidding (ICB). Contracts estimated to cost an amount equivalent to less than US$300,000 but more than US$100,000 will be procured through local competitive bidding (LCB) in accordance with procedures acceptable to IDA, provided the total of such contracts does not exceed an amount equivalent to US$600,000. Goods valued at an amount equivalent to less than US$100,000 per contract, up to an aggregate amount not to exceed US$0.7 million shall be procured through international and local shopping. In view of the small number and variety of vehicles and to ensure after sales service, they shall be procured by LCB. As far as possible, items for procurement will be bulked into packages to permit optimum use of competitive bidding.

4.10 Technical assistance, studies and training. For technical assistance, consultants will be selected in accordance with the Bank’s guidelines for the use of consultants, with qualifications and experience acceptable to IDA, to provide various forms of technical assistance in a number of specialized areas: project management, procurement, IEC, and research/development of multisectoral activities. The total technical

12/ Costs include contingencies.
assistance required would be about 210 person months, of which 162 would be recruited locally. A list of the specialist services which will be needed during project implementation is in Annex XIV.

4.11 For studies and training, the required consultants (foreign and local) will also be selected in accordance with the Bank's guidelines for the use of consultants, with qualifications and experience acceptable to IDA, to undertake studies on specialized topics. For training materials for ONAPO's regional offices, small office and training supplies will be purchased on the basis of local shopping with a minimum of three price quotations; individual contract amounts will not exceed US$10,000 with an aggregate amount not to exceed US$ 0.5 million. Training materials and supplies related to the overall training program will be purchased on the basis of local competitive bidding; contract amounts will not exceed US$100,000 with an aggregate amount not to exceed US$0.7 million. For in-service training, staff located in the communes will receive travel and subsistence allowances (US$5.6 million) to enable them to reach the regional training centers and attend courses for a maximum period of two weeks. These allowances are based on an official schedule agreed upon with IDA. For training abroad, the selection of training centers and specific courses will be done on the basis of international shopping. The timing, final selection of courses and candidates for this program will be submitted to IDA for approval and the overall amount will not exceed US$100,000.

4.12 Bank prior review requirements. All goods contracts for an amount equivalent to or more than US$50,000 and all consultancy contracts shall be made subject to prior review by the Bank in conformity with Appendix 1, paras 1 and 4 of the Bank's guidelines. Contracts not governed by the above shall be subject to review by IDA in accordance with Appendix 1, para. 3 of same guidelines. The procurement schedule (Annex XV) reflects the specific packaging requirements under the project. In order to expedite procurement matters, ONAPO will recruit a procurement specialist (see para. 5.05); it is anticipated that this person will also benefit from training courses abroad during the project.

E. Disbursement

4.13 The proposed IDA Credit of SDR 14.5 million (US$19.6 million) will be disbursed in accordance with Table 4.5 below.
Table 4.5: Disbursement Categories

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>US$million</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td>4.3</td>
<td>100 percent</td>
</tr>
<tr>
<td>Equipment, vehicles, Teaching material, supplies</td>
<td>2.3</td>
<td>100 percent of foreign exchange; 85 percent of local costs</td>
</tr>
<tr>
<td>Training, studies and technical assistance</td>
<td>7.8</td>
<td>100 percent of foreign exchange; 85 percent of local costs</td>
</tr>
<tr>
<td>Incremental Operating Costs</td>
<td>1.9</td>
<td>100 percent of foreign exchange; 85 percent of local costs</td>
</tr>
<tr>
<td>PPF</td>
<td>0.7</td>
<td>100 percent</td>
</tr>
<tr>
<td>Unallocated</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>19.6</td>
<td></td>
</tr>
</tbody>
</table>

4.14 Contracts for goods and services or single purchases of less than US$30,000 and all operating and local training costs will be submitted against Statements of Expenditure (SOE). All disbursements will be fully documented. The SOE and all records such as contracts, orders, invoices, bills, receipts, and local training expenditures will be retained by the Borrower for inspection by supervision missions and reviewed by the annual audit. It is expected that the project be fully disbursed by December 1997 in accordance with the standard disbursement table and the credit closing date will be June 1998. The estimated quarterly schedule of disbursement is in Annex XIII.

4.15 Special Accounts and Project Accounts. To ensure that funds are readily available for project implementation and to facilitate disbursement, an initial deposit of US$500,000 will be provided from the IDA credit to cover four months of operating costs financed under the credit. These funds will be deposited into a special account in a commercial bank acceptable to IDA. They will be managed by the project administrative unit (PAU) (para. 5.05) under close supervision from ONAPO's director, and will be replenished quarterly based on adequate documentation provided by ONAPO. The government will also open in the Central Bank a project account to cover the
government's contribution to operating costs (100 percent of salaries and travel allowances and 15 percent of all local costs). An initial deposit of FRW 70 million into this account will be a condition of credit effectiveness (para. 7.03 (c)). In addition, during negotiations it was agreed with the government that the project account will be replenished on a quarterly basis (para. 7.01 (f)).

4.16 Accounting and Auditing. In order to ensure that funds from this credit are managed properly, an accountant will be hired (para. 5.05). The main responsibilities will be: (a) to maintain separate accounts by project component; (b) to differentiate between expenditures at the central and regional levels; (c) to facilitate the quarterly and/or annual budgeting, reporting and auditing process; and (d) to ensure that SOEs are properly accounted. As part of the financial monitoring process (a) an annual audit will take place no later than six months after the end of its fiscal year beginning after the first year of project implementation (for the ongoing family health project, audit reports have been submitted in accordance with the Development Credit Agreement); (b) the project coordinator will submit to IDA quarterly expenditure reports; and (c) a project completion report will be submitted to IDA no later than six months after the closing date of the credit.

V. PROJECT IMPLEMENTATION

A. Status of project preparation

5.01 The proposed operation was identified in February 1990, initially as a population component of a second PHN operation. During the follow-up mission in May 1990, it was decided to prepare a free-standing population project for the following reasons: (a) the advanced status of preparation and the large size of the proposed component; (b) the limited institutional capability of the MOH to implement this component as compared with ONAPO's; and (c) the priority attached to this program by the Government. In May 1990, the government made a detailed proposal to IDA to support population activities' - including the overall objectives and strategy, the description of activities, cost estimates, and implementation schedule. High level staff from ONAPO and MOH were involved in the preparation and appraisal process of this operation and have expressed their commitment to the project. Appraisal of this operation took place in October 1990, followed by a post-appraisal mission in January 1991.

B. Organization and Management

5.02 ONAPO will be responsible for coordinating the implementation of this operation. ONAPO's responsibilities at the central level will include: (a) overall planning, budgeting and monitoring of project activities; (b) the design, computerization and monitoring of a financial, accounting/ auditing and procurement system acceptable to IDA; (c) consolidation and submittance to IDA of quarterly progress reports on project execution prepared by ONAPO's managers; (d) preparation of annual reports on project
implementation and related expenditures; (e) coordinating between section managers for the preparation of annual work programs and corresponding budgets; (f) implementation of a quarterly training program for all aspects of project and financial management; and (g) coordination of regional activities. In addition, it was agreed during negotiations that an annual donors meeting will be organized by ONAPO to review the implementation of the population policy (para. 7.01(b)). Further to this annual meeting, donors and local agencies will meet on a quarterly basis within the framework of a national MCH/FP projects committee which was created in March 1991. This committee is chaired by the MOH. With regard to technical implementation of the proposed activities, the primary responsibility will lie with the Project Administration Unit (PAU) (para. 5.05). Close collaboration of this unit will be sought with ONAPO's sections involved with: (i) Family Health, (ii) IEC/Training; and (iii) Research. The key personnel of these sections is already on board. Given the importance of the training activities to be implemented under the project, the elaboration of a detailed master training plan by ONAPO will be a condition of credit effectiveness (para. 7.03 (b)). This plan will be updated annually

5.03 At the regional level, the coordination of project implementation will be ONAPO's representatives' responsibility, in close collaboration with MOH's regional medical officers. ONAPO's central management will ensure that this collaboration actually takes place because it is crucial for an effective and efficient implementation of training and supervision activities which will affect the quality of FP services provided. ONAPO's and MOH's regional staff have been made fully aware that any duplication of activities and/or insufficient collaboration between the two institutions could be most detrimental to project implementation.

5.04 This project has been designed to fit into ONAPO's existing management structure (Annex VIII). ONAPO will release a high level staff from all other duties throughout the duration of the project to become the project coordinator and the counterpart to the project advisor. Terms of reference of the project coordinator have been agreed upon (Annex VIII). ONAPO's financial management system is weak, particularly with regard to accounting, budgeting and reporting. This fact, combined with the relative complexity and large size of the proposed project, will necessitate the recruitment of a qualified long-term project advisor. This person will have primary responsibility for assisting the day-to-day coordination and implementation of the project so as to minimize delays in implementing project activities. The terms of reference of this advisor (Annex VIII) have also been prepared (and agreed upon with ONAPO) to complement the profile of the USAID long-term advisors whose main functions will be to strengthen ONAPO's financial and planning capabilities.

5.05 In order for ONAPO to efficiently carry out its financial as well as technical tasks, a small Project Administration Unit (PAU) will be put in place that will report directly to ONAPO's director. It will be headed by the project coordinator, assisted by the project advisor (for the first three years of project implementation). In addition, an experienced accountant and procurement specialist will be contracted locally for the duration of the project (Annex VIII). The PAU staff will have functional...
linkages with ONAPO's financial, administrative and technical services. The compensation of this staff should be, to the extent possible, in line with that of similar civil servants. The staff of PAU will also be given the opportunity to obtain training abroad in their respective fields (accounting, procurement, financial management) with a special emphasis in computer applications. Performance reviews of PAU staff will be conducted on an annual basis by ONAPO's director and on a semi-annual basis by IDA's supervision missions. Given the importance of strengthening ONAPO's managerial capabilities during negotiations, it was agreed that, before credit effectiveness, the Government will recruit under terms of reference acceptable by IDA, a full-time project coordinator, a project advisor, an accountant and a procurement specialist, all with qualifications and experience acceptable to IDA (para. 7.03 (a)).

C. Monitoring and Reporting

5.06 The mechanisms for project implementation and supervision are described in Annexes X and XII. At the central level, monitoring of project activities will be the primary responsibility of ONAPO's director in collaboration with the PAU. With regard to FP activities, it was agreed that the MOH will designate a high-level staff member to work closely with the ONAPO project coordinator in the planning, implementation, monitoring, supervision and evaluation of activities. The ONAPO project coordinator and the MOH high-level staff together with their respective technical teams will meet quarterly. Minutes of these meetings will be included in the quarterly reports to be submitted to IDA. In addition, the government will designate an entity in charge of overseeing the progress of the multisectoral activities, within the framework of the implementation of the national population policy. During negotiations, it was agreed that the Board of ONAPO could play such a role and, prior to Board presentation, the government has submitted to IDA the minutes of the meeting of the Board of ONAPO confirming its new attributions (para. 7.02). At the regional level, with regard to FP activities, MOH and ONAPO physicians will meet monthly to monitor the MCH/FP program, including project activities, and on a quarterly basis to assess and update these activities. Minutes of these meetings will be included in the quarterly report which is submitted to ONAPO by field staff. In addition, monitoring of sectoral activities will be the responsibility of ONAPO's physicians who will work in close collaboration with other sectors involved. Finally, ONAPO will have overall responsibility for the monitoring of all multisectoral activities.

5.07 Each ONAPO section will be responsible for monitoring the implementation of its respective sub-component based on the annual work program that was agreed upon, consolidated by the PAU and submitted to IDA. The draft work program, plans of action and budget for the following fiscal year will be submitted to IDA no later than October 31 in each year, the detailed program and budget no later than December 31 in each year, satisfactory to IDA (para. 7.01 e). In addition, ONAPO's director and the PAU staff will meet on a monthly basis with ONAPO's section managers, and on a quarterly basis with ONAPO's regional delegates. In this context, each section within ONAPO will contribute to the preparation of a quarterly
report on the status and progress of each project component to be submitted to IDA no later than one month after the end of each quarter (para. 7.01 (d)). The PAU will coordinate this exercise (para. 5.05). The quarterly reports will include: (a) the status of project activities by component; (b) an overview of the coordination mechanisms between the central, regional, peripheral levels, and collaboration with the MOH; (d) an overall review of the progress accomplished against the goals set in the annual work program; (e) the status of procurement for all project components; (f) the status of disbursements against all categories and the status of the special and project accounts; (g) the status of the counterpart funds; and (h) problems encountered and recommendations for resolving them. The information from these quarterly reports would be consolidated and presented in the annual report.

5.08 During negotiations, it was agreed with the government that a mid-term evaluation of the project will be carried out no later than three years after the date of credit effectiveness under terms of reference acceptable to IDA and that the conclusions and recommendations of this evaluation will be taken into consideration for the remaining of project implementation (para. 7.01 (a)). This evaluation will focus mainly on: (a) the impact of the proposed volunteer program; (b) the overall efficiency of the establishment of FP posts; (c) the efficiency of the proposed training program - in-country as well as abroad; (d) ONAPO's managerial performance; (e) the technical problems encountered and recommended corrective measures; (f) the assessment of need for additional technical assistance; and (g) financing options for project incremental recurrent costs.

VI. PROJECT JUSTIFICATION, BENEFITS AND RISKS

A. Justification and Benefits

6.01 The proposed project has been designed to alleviate the key constraints facing the development of family planning services in Rwanda, namely, the limited access to FP services, the poor quality of FP services and the insufficient demand for FP services. The overarching constraint is the limited access of the general public to FP information and modern family planning methods. The project is expected to improve access to FP services through the establishment of family planning posts beyond the MOH network of facilities in poorly served regions and the promotion of community-based distribution schemes. A secondary constraint is the poor quality of family planning services. The project will tackle the quality issue by improving the availability of trained personnel in MCH/FP, as well as teaching materials, by making available a broad range of contraceptive methods and by strengthening supervision systems. Finally, to ensure sustained demand for family planning services, the project will support a series of IEC activities aimed at key target groups.

6.02 The project is expected to generate both micro and macroeconomic benefits. At the micro-economic level, the expansion in family planning services should lead to health improvements for the most vulnerable groups, particularly women and children, as family sizes are reduced and birth spacing increased. More specifically, the project will generate the
following benefits: (a) reduction in infant mortality and improved health and nutrition status of infants and mothers, as birth intervals are increased; and (b) reduction in maternal mortality, as high risk women are reached by the family planning program. Studies in many countries have documented the significant impact on infant and maternal mortality of longer birth intervals. These findings suggest that if all Rwandese women who want no more children use contraception, maternal deaths could be reduced by almost one-third per year, and if all babies were born after at least two-year birth intervals, one in every five infant deaths could be prevented. All the fertility reduction and health status improvements should not be attributed to the project alone but put in the context of the overall government and donor efforts.

6.03 At the macroeconomic level, reductions in fertility levels, which will ultimately translate into declines in the rate of population growth, will produce significant benefits by alleviating population pressures on scarce land resources, fostering food security, generating cost savings in economic and social services and improving prospects for entrants into the labor market. It should be recognized, however, that these macroeconomic benefits are of a long-term nature, and that during the six-year duration of the project, only the conditions will be set in place for a sustained reduction in fertility and related improvements in health conditions. The project will therefore lay the ground work for more substantive impact in the longer term. One method of quantifying the macroeconomic benefits of the family planning program is the government savings approach, which involves estimating the cost savings in sectors such as health and education of alternative fertility assumptions. Such an analysis was recently completed by ONAPO, with technical assistance from the Research Triangle Institute. The study was instrumental in raising awareness among Rwandese policy makers of the potential long-term benefits of the family planning program by quantifying public expenditure requirements with and without the program. The study was particularly useful in demonstrating the rapid decline in costs per contraceptive user since the inception of the FP program and the cost savings in different sectors of the economy (including health and education).

B. Risks

6.04 The first risk is that ONAPO's managerial capabilities could be overstretched by this operation. ONAPO is already involved in the implementation of USAID, UNFPA and GTZ projects. ONAPO's past performance in terms of financial and administrative management has not always been satisfactory. To address this risk, a financial management advisor has been recently appointed as part of a new USAID Project. In parallel, a Project Administration Unit (PAU) will be established to assist ONAPO's management in all administrative, procurement and disbursement matters and a long-term

13/ The conclusions of the study show a net gain of approximately FRW 219.3 billions on investments in health, education and agriculture for the period 1981-2011.
project advisor will be recruited for the first three years of project implementation. In addition, many day-to-day managerial decisions will be decentralized to the regional levels where MOH and ONAPO staff will receive support from PAU and central level staff to coordinate field activities.

6.05 The second risk stems from the fact that ONAPO might implement the FP program with insufficient coordination with MOH. While ONAPO operates under the umbrella of MOH, its active involvement in strengthening FP service delivery would imply a major intensification of functional linkages between the two institutions. The risk is that ONAPO's staff instead of collaborating closely with MOH staff as technical colleagues will start operating independently. This would increase the cost of service delivery and the potential for conflict between ONAPO and MOH personnel. To address this risk, specific collaboration mechanisms between ONAPO and MOH have been developed during project preparation (para. 5.06-5.07). Their execution will be closely monitored during project supervision.

6.06 Finally, a third risk relates to the capacity of Rwanda to find appropriate solutions to the lingering problems of Rwandese refugees in neighboring countries. Reinsertion of these refugees in Rwanda requires careful planning and a major support from the international community.

VII. ASSURANCES AND RECOMMENDATION

Agreements at Negotiations

7.01 During negotiations, it was agreed with the government that:

(a) a mid-term evaluation will be carried out under terms of reference acceptable to IDA no later than three years after the date of credit effectiveness and that the conclusions and recommendations of this evaluation will be taken into consideration for the remaining of project implementation; this mid-term evaluation will include the assessment of financing options for project incremental recurrent costs (para. 5.08);

(b) annual donors' meetings to review the implementation of the population policy will be organized by ONAPO (para. 5.02);

(c) curricula for the Family Planning training of health personnel will be updated by March 1st, 1992, to include all the training themes agreed upon during project preparation (para. 3.04);

(d) the Project Administrative Unit (PAU) will submit every three months reports on the status of project implementation and related expenditures (5.07);

(e) the draft work program, plans of action and budget for the following fiscal year will be submitted to IDA no later than October 31 in each year and the detailed work program, plans of action and budget no later than December 31 in each year satisfactory to IDA (para 5.07)
(f) the project account will be replenished on a quarterly basis (para. 4.15).

**Condition of Board Presentation**

7.02 Prior to Board presentation, the Government has submitted to IDA the minutes of the meeting of the Board of OMAPO confirming its role in overseeing the progress of the multisectoral activities within the framework of the implementation of the population policy (para. 5.06).

**Conditions of Credit Effectiveness**

7.03 Before effectiveness of the proposed credit, the government will:

(a) recruit under terms of reference acceptable to IDA a project advisor, a full time project coordinator, an accountant and a procurement specialist, all with qualifications and experience acceptable to IDA (para. 5.05);

(b) submit for approval by IDA a master training plan which will be updated annually (para. 5.02);

(c) make an initial deposit of FRW 70 million (US$590,000 equivalent) in the project account representing the government contribution to three months of local expenditures (para. 4.15).

7.04 Recommendation. With the above assurances, agreements and conditions, the proposed project would be suitable for an IDA credit of SDR 14.5 million (US$ 19.6 million).
ANNEXES
TABLES
### Table 1: Rwanda - Population Estimates by Region

<table>
<thead>
<tr>
<th>Préfecture</th>
<th>Pop. 1978</th>
<th>Per cent</th>
<th>Pop. 1990</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
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<td>892,945</td>
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</tr>
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<td>10.8</td>
<td>768,229</td>
<td>10.5</td>
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<td>494,157</td>
<td>6.7</td>
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<td>548,142</td>
<td>7.5</td>
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<td>7.0</td>
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**RWANDA**                                               4,831,527 | 100.0 | 7,336,241 | 100.0 |

Source: ONAPO 1990.

### Table 2: Evolution of Population of Rwanda, 1940-1985

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<tr>
<th>Year</th>
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<td>1950</td>
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</tr>
<tr>
<td>1955</td>
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<td>1960</td>
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<td>1970</td>
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<tr>
<td>1975</td>
<td>4,417,000</td>
</tr>
<tr>
<td>1978</td>
<td>4,898,000</td>
</tr>
<tr>
<td>1980</td>
<td>5,254,000</td>
</tr>
<tr>
<td>1985</td>
<td>6,300,000</td>
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</table>

Source: ONAPO, December 1985
### Table 3: Rwanda - Population Distribution By Age

<table>
<thead>
<tr>
<th>Age</th>
<th>S.M</th>
<th>S.F</th>
<th>Total</th>
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<td>0-4</td>
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<tr>
<td>5-9</td>
<td>587,513</td>
<td>583,222</td>
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<td>470,968</td>
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<td>15-19</td>
<td>385,834</td>
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<td>20-24</td>
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<td>261,308</td>
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<td>30-34</td>
<td>214,142</td>
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<td>436,751</td>
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<tr>
<td>35-39</td>
<td>172,828</td>
<td>182,824</td>
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<td>40-44</td>
<td>132,568</td>
<td>139,630</td>
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<td>45-49</td>
<td>97,314</td>
<td>100,476</td>
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<td>50-54</td>
<td>75,378</td>
<td>79,538</td>
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<td>65-69</td>
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<td>70-74</td>
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<td>75-79</td>
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<td>12,294</td>
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<td>80+</td>
<td>2,848</td>
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</table>

**Total:** 3,621,522 3,714,719 7,336,241

Source: ONAPO 1989

### Table 4: Rwanda - Estimated Population Density by Region

<table>
<thead>
<tr>
<th>Préfecture</th>
<th>Superficie totale km²</th>
<th>Superficie disponible km²</th>
<th>Densité brute</th>
<th>Densité physiologique</th>
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<td>443</td>
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<tr>
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<td>443</td>
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Table 5: Number of new acceptors per method and number of health facilities delivering FP services, 1981-1989

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<tr>
<th>Year</th>
<th>Pill</th>
<th>IUD</th>
<th>Injectables</th>
<th>Nor-plant</th>
<th>Condoms</th>
<th>Total</th>
<th>No. of Centers</th>
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<tr>
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<td>226</td>
<td>233</td>
<td>-</td>
<td>1</td>
<td>707</td>
<td>15</td>
</tr>
<tr>
<td>1982</td>
<td>417</td>
<td>307</td>
<td>453</td>
<td>-</td>
<td>1</td>
<td>1176</td>
<td>24</td>
</tr>
<tr>
<td>1985</td>
<td>1864</td>
<td>781</td>
<td>1486</td>
<td>-</td>
<td>15</td>
<td>3066</td>
<td>51</td>
</tr>
<tr>
<td>1986</td>
<td>3849</td>
<td>1060</td>
<td>3480</td>
<td>-</td>
<td>109</td>
<td>5667</td>
<td>93</td>
</tr>
<tr>
<td>1986</td>
<td>3775</td>
<td>625</td>
<td>5390</td>
<td>-</td>
<td>545</td>
<td>10765</td>
<td>159</td>
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<tr>
<td>1988</td>
<td>8096</td>
<td>838</td>
<td>5385</td>
<td>-</td>
<td>499</td>
<td>12697</td>
<td>184</td>
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<tr>
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<td>344</td>
<td>12900</td>
<td>-</td>
<td>1014</td>
<td>18513</td>
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<td>1988</td>
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<td>370</td>
<td>18110</td>
<td>-</td>
<td>1895</td>
<td>26038</td>
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<td>1989</td>
<td>9333</td>
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<td>31094</td>
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<td>4128</td>
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Table 5a: Total Number of Users and Contraceptive Mix by Method, 1985-90

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<tr>
<th>Year</th>
<th>Method</th>
<th>Pills</th>
<th>IUD</th>
<th>Injectables</th>
<th>Barrier</th>
<th>Traditional</th>
<th>Implants</th>
<th>TOTAL</th>
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<td>1985</td>
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<td>0.12</td>
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<tr>
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<td>1.00</td>
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<tr>
<td>1987</td>
<td></td>
<td>0.25</td>
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<td>0.02</td>
<td>0.02</td>
<td>0.000</td>
<td>1.00</td>
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<tr>
<td>1988</td>
<td></td>
<td>0.22</td>
<td>0.04</td>
<td>0.69</td>
<td>0.03</td>
<td>0.03</td>
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<td>1.00</td>
</tr>
<tr>
<td>1989</td>
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<td>0.21</td>
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<td>0.05</td>
<td>0.05</td>
<td>0.000</td>
<td>1.00</td>
</tr>
<tr>
<td>1990</td>
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<td>0.66</td>
<td>0.05</td>
<td>0.05</td>
<td>0.000</td>
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</table>
Table 5b: Total Number of users and Contraceptive Mix, by Region, and by Method (December 1989)

<table>
<thead>
<tr>
<th>Region</th>
<th>Pills</th>
<th>IUD</th>
<th>Injectable</th>
<th>Barrier</th>
<th>Traditional</th>
<th>Implants</th>
<th>TOTAL</th>
</tr>
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<tr>
<td>Butare</td>
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<td>471</td>
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<td>6488</td>
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<td>55</td>
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<td>66</td>
<td>652</td>
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<td>169</td>
<td>13381</td>
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<td>6460</td>
<td>165</td>
<td>25</td>
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<td>46226</td>
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<td>64485</td>
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<table>
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<th>Region</th>
<th>Pills</th>
<th>IUD</th>
<th>Injectable</th>
<th>Barrier</th>
<th>Traditional</th>
<th>Implants</th>
<th>TOTAL</th>
</tr>
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<tbody>
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</tr>
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<td>0.07</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
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<td>0.79</td>
<td>0.118</td>
<td>0.79</td>
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<td>0.05</td>
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<td>0.01</td>
<td>0.104</td>
<td>0.118</td>
<td>0.11</td>
</tr>
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<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
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</table>
Table 6: Distribution of new acceptors per method, 1981-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Pill (%)</th>
<th>IUD (%)</th>
<th>Condom (%)</th>
<th>Injectable (%)</th>
<th>Steril. (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>35.1%</td>
<td>31.9%</td>
<td>22.1%</td>
<td>30.5%</td>
<td>58.2%</td>
<td>100%</td>
</tr>
<tr>
<td>1982</td>
<td>35.4%</td>
<td>31.7%</td>
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Table 7: Estimation of Contraceptive Prevalence Required
To Reach Different Fertility Targets, 1990-2015
Application of the Simplified Version of Bangaarts Model 1/

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<tr>
<td>Total Fertility Rate</td>
<td>8.60</td>
<td>8.36</td>
<td>8.38</td>
<td>7.55</td>
<td>6.90</td>
<td>6.49</td>
<td>5.89</td>
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<tr>
<td>% change from previous 5 year period</td>
<td>0.08</td>
<td>0.09</td>
<td>0.09</td>
<td>0.07</td>
<td>0.07</td>
<td>0.08</td>
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<tr>
<td>Proportional Reduction in Fertility (PRF) from 1986</td>
<td>0.08</td>
<td>0.12</td>
<td>0.20</td>
<td>0.26</td>
<td>0.32</td>
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<tr>
<td>Contraceptive prevalence, u(t)</td>
<td>0.021</td>
<td>0.657</td>
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<tr>
<td>Total Women 15-40</td>
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<td>1841000</td>
<td>2287000</td>
<td>2671000</td>
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<tr>
<td>% Women at Risk (Ever Married)</td>
<td>0.72</td>
<td>0.72</td>
<td>0.72</td>
<td>0.72</td>
<td>0.72</td>
<td>0.72</td>
<td>0.72</td>
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<tr>
<td>Total Women at Risk 15-49</td>
<td>972440</td>
<td>1121700</td>
<td>1159227</td>
<td>1325628</td>
<td>1589840</td>
<td>1923120</td>
<td>2309760</td>
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<tr>
<td>Contraceptive Use Effectiveness:</td>
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<td>e(t)</td>
<td>0.939</td>
<td>0.946</td>
<td>0.942</td>
<td>0.942</td>
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<td>Prevalence in target year:</td>
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<td>Total Women at Risk 15-49</td>
<td>972440</td>
<td>1121700</td>
<td>1159227</td>
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<td>Number of users</td>
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<tr>
<td>Crude Birth Rate per 1000</td>
<td>54.2</td>
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<td>47.9</td>
<td>44.8</td>
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<tr>
<td>Total Population</td>
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<td>9830598</td>
<td>10969213</td>
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<tr>
<td>Gross Potential CBR 5/</td>
<td>57.2</td>
<td>61.9</td>
<td>61.1</td>
<td>61.0</td>
<td>62.4</td>
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<tr>
<td>Births Averted 6/</td>
<td>28359</td>
<td>88748</td>
<td>145258</td>
<td>287460</td>
<td>294231</td>
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</table>
1/ Multiplicative Model: \( TFR = Cm \times Cc \times Ca \times Ci \times TF \)

- \( Cm \): marriage pattern
- \( Cc \): contraceptive prevalence
- \( Ca \): induced abortion
- \( Ci \): post partum infecundability
- \( TF \): total fecundity

Assumptions:
1. No change in TF;
2. Induced abortion is absent; and
3. Trends in \( Cm \) and \( Ci \) compensate each other (i.e., increase in age at marriage and declines in breast feeding).

2/ Proportion of Ever Married Women of Reproductive Age (15-49 years) who are contracepting. According to ONAPO, in 1987 about 25,250 women were using some form of modern contraception; an undetermined number of couples were using traditional methods (e.g., abstinence); if the latter were taken into account the prevalence rate would be higher and the use effectiveness somewhat lower.

3/ To obtain the average use effectiveness, a weighted average of the method-specific levels is calculated (the weights are given by the proportions of all users that use the different methods). Since no data is available for Rwanda the following standard values have been used:

<table>
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<th>1989</th>
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<td>Injectables</td>
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<tr>
<td>IUD</td>
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<td>Pill</td>
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<td>Other</td>
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<tr>
<td>Sterilization</td>
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4/ The basic equation for estimating the prevalence level required to achieve a desired reduction in fertility is:

\[ u(t) = 1 - (1 - PRF) * (1 - 1.08 * u(o) / 1.08e(t)) \]

5/ GPCBR = \( \frac{CBR \times (1 - 0.9 \times u'')}{{\left[ 1 - 0.9 \times (u' + u'') \right]}} \)

- \( u' \): program contraception
- \( u'' \): non program contraception

6/ Births Averted = (GPCBR - CBR) * Population
### Table 8a: Ministry of Health and ONAPO Recurrent Budget

**Mill. RwF**

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Table 8b: Donors Contribution to ONAPO (in 000 RF), 1981-1987

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<th>Pathfinder Fund</th>
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Page 9 of 9
MINISTÈRE DE LA SANTÉ

MINISTRE

CRR

SECRÉTAIRE GÉNÉRAL

ONAPO

OPHAR

Direction Générale de la Santé

Direction Assistance de Santé et Enfants

Direction Médecine Intégrée

Direction Pharmacie

Direction Affaires Administratives

Direction Études et Enfance

Direction Épidémiologie

Direction Hygiène Publique

DIVISIONS

Lois, Règlementation, Interventions, Service Général, Politique et Coopération

médicalisation, Épargne et Gestion, Finance

Épidémiologie, Surveillance Épidémique, Service Hygiène

Surveillance, Intégration, Programmation, Initiatives et Éducation

DÉPARTEMENTS
Figure 2: Population projections, Rwanda 1990-2015

Population du Rwanda
Entre 1990 et 2015:
TRIPLEMENT

? DOUBLEMENT

Source: Population et Environnement au Rwanda, The Futures Group, February 1990
Figure 3: Projection of land availability, 1990-2015

Taille moyenne des fermes

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Source: Population et Environnement au Rwanda, The Futures Group, February 1990
Figure 4: Population Program in Rwanda

The effects of a reduction of the total fertility rate

PROGRAMMES DE POPULATION

Source: Population et Environnement au Rwanda, The Futures Group, February 1990
Figure 5: Contraceptive prevalence and total fertility rate in Africa's selected countries
### KEY PROJECT INDICATORS

#### A. PROCESS INDICATORS

I. **Expansion, promotion and qualitative improvement of F.P. services**

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<td>- Percentage of Public Health Centers delivering F.P. services</td>
<td>87 1/</td>
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<td>100</td>
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<tr>
<td>- Number of Health Centers/Hospitals equipped</td>
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<td>- Number of annual supervision visits</td>
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<td>- Health personnel trained in contraceptive technology, management and supervision of F.P. services 2/</td>
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<td>- Health personnel retrained (refresher courses) in contraceptive technology management and supervision of F.P. services 3/</td>
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<tr>
<td>- Quantity of contraceptives utilized 4/</td>
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<tr>
<td>- Number of users by target group 4/</td>
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1/ The quality of the F.P. services provided needs to improve significantly.

2/ Total number of personnel adequately trained is not available.

3/ This training will be done according to the new F.P. curriculum being prepared.

4/ This data will be monitored annually.
FP Posts

- Total number of FP posts operational 39 5/ 72 83

- Number of new FP to become operational annually (first 4 years of the project) 11

- Number of weekly working days for FP posts 2

- Number of annual acceptors at each FP post 240

- Number of annual supervision visits by the health center manager

- Quantity of contraceptives utilized 4/

- Number of users by target group 4/

IEC Strategy

- Number of volunteers retrained each year 17,536

- Average number of acceptors recruited annually by each volunteer 12 24

- Percentage of volunteers distributing contraceptives at the community level:
  - condoms, vaginal foams 0% 100% 100%
  - pills 0% 10% 40%

- Number of social workers retrained in IEC/FP 996 1329

- Number of IEC trainers retrained in IEC/FP (65 at the central level, 110 at the prefectural level and 435 at the communal level) 610 610

- Number of people at CERAIS being trained in IEC/FP
  - Basic Training 180 360
  - Refresher courses 300 480

\* Will require substantial strengthening. This will take place during the first year of the project.
- Number of higher education teachers 6/ - 180 180
- Number of school board directors trained 6/ - 200 200
- IEC campaign completed - 3 6
- Elaboration of IEC materials completed
- Number of documentation centers equipped - 10 10

II. Research programs/Development of sectoral activities
- Number of studies completed 1 3
- Number of meetings organized with women's groups on population issues 12 30
- Strengthening of FP info system groups completed

III. Procurement/Management Training for ONAPO Central and Regional Staff
- Contraceptive procurement - 11
- Procurement/basic principles - 4
- Financial Management - 4

B. OUTCOME INDICATOR
- Contraceptive Prevalence (% modern methods) 9 7/ 10

C. IMPACT INDICATORS
- Total fertility rate 8.5 7.2
- Maternal mortality (% of change) - -30
- Infant mortality (per 1,000) 124 112
- Child mortality (%) 20.5 18
- Average birth interval

6/ Refer to Detailed Training plan in Annex XI.
7/ 1990 estimates. It might be higher by January 1992, when the project becomes effective.
## Table 1: Improving Quality and Efficiency of FP Services

### I. INVESTMENT COSTS

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<tr>
<th>Base Costs in SUS</th>
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<th>93</th>
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### II. RECURRENT COSTS

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### Table 2: FP Posts Equipment and Supplies (continued)

#### II. RECURRENT COSTS

A. Medical Sup. for FP Posts

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| Sub-Total                        | 25148| 35148| 45148| 53148| 60000| 70000| 289188|

B. Government Personnel

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| Sub-Total                        | 134230| 134230| 134230| 134230| 134230| 134230| 134230| 805320|

C. Motorcycle Oper. & Maint.

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| Sub-Total                        | 5498 | 5498 | 5498 | 5498 | 5498 | 5498 | 5498 | 21854|

D. Sup. FP Pos. &/MN MOH

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| Sub-Total                        | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | 82500|

E. Stipends Nat. Pop. Week

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| Sub-Total                        | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | 82500|

### Total RECURRENT COSTS

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| Total                            | 791195| 791195| 791195| 791195| 791195| 791195| 791195| 5002971|
### Table 3: Support to IEC Strategy

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## Table 4: Volontaires Abagangurambaba

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### II. RECURRENT COSTS

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### Table 5: Research/Development of Multisectoral Population Activities

| I. INVESTMENT COSTS                                      | 92  | 93  | 94-95 | 96-97 | Total
|---------------------------------------------------------|-----|-----|-------|-------|-------
| A. Studies                                              |     |     |       |       |       
| Infant/Maternal Mortality                               | 1   | 0   | 0     | 0     | 1     |
| Migration                                               | 0   | 1   | 0     | 2     |       |
| Strength of Info System                                 | 1   | 0   | 0     | 0     | 1     |
| Sub-Total                                               |     |     |       |       |       |
| B. Multisectoral Activities                             |     |     |       |       |       |
| C. Equipment                                            |     |     |       |       |       |
| Computer                                                | 1   | 0   | 0     | 0     | 1     |
| Printer                                                 | 1   | 0   | 0     | 0     | 1     |
| Software                                                | 1   | 0   | 0     | 0     | 1     |
| Sub-Total                                               |     |     |       |       |       |
| D. Seminars                                             |     |     |       |       |       |
| Population Seminars                                     | 1   | 1   | 1     | 1     | 1     |
| E. Technical Assistance                                 |     |     |       |       |       |
| S/T Intl. Consultant                                    | 0   | 0   | 0     | 0     | 6     |
| Sub-Total                                               |     |     |       |       |       |
| Total INVESTMENT COSTS                                  |     |     |       |       |       |

| II. RECURRENT COSTS                                      | 92  | 93  | 94-95 | 96-97 | Total
|---------------------------------------------------------|-----|-----|-------|-------|-------
| A. Equipment Maintenance                                | 1   | 1   | 1     | 1     | 6     |
| Computer                                                |     |     |       |       |       |
| B. Office Supplies                                      | 1   | 1   | 1     | 1     | 6     |
| Supplies                                                |     |     |       |       |       |
| C. Government Personnel                                 |     |     |       |       |       |
| HL Research Dept. (2)                                   | 24  | 24  | 24    | 24    | 144   |
| EL Research Dept. (2)                                   | 24  | 24  | 24    | 24    | 144   |
| IEC Specialists Cont. (7)                              | 28  | 28  | 28    | 28    | 168   |
| IEC Specialists (R) 10                                  | 30  | 30  | 30    | 30    | 180   |
| Sub-Total                                               |     |     |       |       |       |
| Total RECURRENT COSTS                                   |     |     |       |       |       |

| Total                                                   |     |     |       |       |       |

| Base Costs in SUS                                       | 92  | 93  | 94-95 | 96-97 | Total
|---------------------------------------------------------|-----|-----|-------|-------|-------
| A. Studies                                              |     |     |       |       |       |
| Infant/Maternal Mortality                               |     |     |       |       |       |
| Migration                                               |     |     |       |       |       |
| Strength of Info System                                 |     |     |       |       |       |
| B. Multisectoral Activities                             |     |     |       |       |       |
| C. Equipment                                            |     |     |       |       |       |
| Computer                                                |     |     |       |       |       |
| Printer                                                 |     |     |       |       |       |
| Software                                                |     |     |       |       |       |
| D. Seminars                                             |     |     |       |       |       |
| Population Seminars                                     |     |     |       |       |       |
| E. Technical Assistance                                 |     |     |       |       |       |
| S/T Intl. Consultant                                    |     |     |       |       |       |

| Total INVESTMENT COSTS                                  |     |     |       |       |       |

| Base Costs in SUS                                       | 92  | 93  | 94-95 | 96-97 | Total
|---------------------------------------------------------|-----|-----|-------|-------|-------
| A. Studies                                              |     |     |       |       |       |
| Infant/Maternal Mortality                               |     |     |       |       |       |
| Migration                                               |     |     |       |       |       |
| Strength of Info System                                 |     |     |       |       |       |
| B. Multisectoral Activities                             |     |     |       |       |       |
| C. Equipment                                            |     |     |       |       |       |
| Computer                                                |     |     |       |       |       |
| Printer                                                 |     |     |       |       |       |
| Software                                                |     |     |       |       |       |
| D. Seminars                                             |     |     |       |       |       |
| Population Seminars                                     |     |     |       |       |       |
| E. Technical Assistance                                 |     |     |       |       |       |
| S/T Intl. Consultant                                    |     |     |       |       |       |

| Total INVESTMENT COSTS                                  |     |     |       |       |       |

| Base Costs in SUS                                       | 92  | 93  | 94-95 | 96-97 | Total
|---------------------------------------------------------|-----|-----|-------|-------|-------
| A. Equipment Maintenance                                |     |     |       |       |       |
| Computer                                                |     |     |       |       |       |
| B. Office Supplies                                      |     |     |       |       |       |
| Supplies                                                |     |     |       |       |       |
| C. Government Personnel                                 |     |     |       |       |       |
| HL Research Dept. (2)                                   |     |     |       |       |       |
| EL Research Dept. (2)                                   |     |     |       |       |       |
| IEC Specialists Cont. (7)                              |     |     |       |       |       |
| IEC Specialists (R) 10                                  |     |     |       |       |       |
| Sub-Total                                               |     |     |       |       |       |
| Total RECURRENT COSTS                                   |     |     |       |       |       |

| Total RECURRENT COSTS                                   |     |     |       |       |       |

| Total                                                   |     |     |       |       |       |

| Base Costs in SUS                                       | 92  | 93  | 94-95 | 96-97 | Total
|---------------------------------------------------------|-----|-----|-------|-------|-------
| A. Equipment Maintenance                                |     |     |       |       |       |
| Computer                                                |     |     |       |       |       |
| B. Office Supplies                                      |     |     |       |       |       |
| Supplies                                                |     |     |       |       |       |
| C. Government Personnel                                 |     |     |       |       |       |
| HL Research Dept. (2)                                   |     |     |       |       |       |
| EL Research Dept. (2)                                   |     |     |       |       |       |
| IEC Specialists Cont. (7)                              |     |     |       |       |       |
| IEC Specialists (R) 10                                  |     |     |       |       |       |
| Sub-Total                                               |     |     |       |       |       |
| Total RECURRENT COSTS                                   |     |     |       |       |       |

| Total                                                   |     |     |       |       |       |

| Total                                                   |     |     |       |       |       |
### Table 6: Project Management Unit SAF

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<td><strong>B. Materials &amp; Supplies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>8333</td>
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</tr>
<tr>
<td><strong>C. Vehicle Oper. &amp; Maint.</strong></td>
<td>60000</td>
<td>75000</td>
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<td>91667</td>
<td>91667</td>
<td>91667</td>
<td>575000</td>
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<td><strong>D. Travel Allowance</strong></td>
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<td>417</td>
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<td>263417</td>
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Table 7a: Summary Accounts by Year

Base Costs
(thousand of FRW)

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<thead>
<tr>
<th>Base Costs</th>
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<tr>
<td>92</td>
<td>93</td>
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<tr>
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<td>-----------------</td>
</tr>
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<tr>
<td>A. Equipment, Furn, Mat.</td>
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<tr>
<td>B. Vehicles</td>
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<td>D. Training and Seminars</td>
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<tr>
<td>F. Studies</td>
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</tr>
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<td>I. Government Salaries</td>
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<td>J. Stipends and Travel</td>
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</tr>
<tr>
<td>K. Supplies &amp; Materials</td>
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**Taxes**

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**Foreign Exchange**

<table>
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Note: The table shows the summary accounts by year, including base costs and foreign exchange amounts. The accounts are categorized into investment costs, recurrent costs, and project costs.
Table 7b: Summary Accounts by Year

Totals Including Contingencies
(thousand of US $)

<table>
<thead>
<tr>
<th></th>
<th>92</th>
<th>93</th>
<th>94</th>
<th>95</th>
<th>96</th>
<th>97</th>
<th>Total</th>
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<td><strong>I. INVESTMENT COSTS</strong></td>
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<td>1021</td>
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<td>639</td>
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<td>203</td>
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<td>D. Stipends and Travel</td>
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Table 7c: Summary Accounts by Year

Totals Including Contingencies
(thousand of FRW)

<table>
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<tr>
<th>Year</th>
<th>92</th>
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<th>94</th>
<th>95</th>
<th>96</th>
<th>97</th>
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<td>3453</td>
<td>3805</td>
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<td>599472</td>
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</tbody>
</table>
Dans les domaines des études et de la recherche socio-démographique, l'ONAPO compte à son actif les réalisations ci-après:

1) L'enquête Nationale sur la Fécondité réalisée en 1983;

2) L'enquête sur la contraception traditionnelle réalisée en 1984;

3) L'étude de la relation population/développement commencée en 1984 et qui comprend trois parties, à savoir:

3.1 Analyse de la situation actuelle:
   - Démographie
   - Population et activité économique
   - Population et santé
   - Population et alimentation
   - Population et nutrition
   - Population et développement rural
   - Population et urbanisation
   - Population et scolarisation
   - Intégration de la femme au développement
   - Impact des projets de développement
   - Population et habitat

3.2 Modélisation

3.3 Détermination des politiques de population

4) Les projections démographiques de la population rwandaise, 1982-2000;

5) L'enquête sur les besoins non satisfaits en SM/PF réalisée en 1985;

6) Sondage sur les attitudes et pratiques de la population en matière de fécondité dans les Communes de Birenga et Rukira (Kibungo) 1982-1983;

7) Évaluation des activités de sensibilisation dans les zones pilotes des préfectures Kibungo et Kigali, 1993-1984;

8) Le sondage sur les besoins des élèves dans le domaine de l'éducation pour la vie familiale, 1985;

9) Le rapport sur l'utilisation des différentes méthodes contraceptives, 1985;

TARGETED DONORS INTERVENTION IN RWANDA

USAID

L'USAID a prêté son support à l'ONAPO depuis sa création et son apport a représenté 68,8% des contributions des apports extérieurs dans le domaine de la SMI/PF (1982-1988). Le gouvernement rwandais vient de signer un accord de subvention de 9 millions de dollars pour un projet de SMI/PF dont le but est de réduire le taux de natalité au Rwanda grâce à une meilleure disponibilité des services de PF à travers les secteurs public et privé (1988-1992). Les éléments du projet renforceront:

A) L'appui au développement de la politique de population et la recherche (l'ONAPO) par le projet RAPID III, l'étude coût-efficacité des programmes de PF au Rwanda, l'enquête démographique et santé (Demographic and Health Survey) et des études de recherches opérationnelles.

B) La prestation de services en matière de PF en apportant son soutien dans les centres de santé du MINISANTE pour l'intégration de la PF par:
- l'amélioration de la prestation de services;
- l'amélioration des systèmes logistiques et d'information sanitaire (distribution des contraceptifs); et
- dans le secteur privé et dans les circuits de distribution non sanitaires (distribution de certains contraceptifs - condoms et spermicides) par commercialisation sociale avec l'assistance du projet "SOMARC II".

C) L'Information, Education et Communication (IEC) à savoir formation du personnel public et privé, matériel didactique étendu à plusieurs groupes cibles, formation des Abakangurambaga et distribution des matériaux destinés aux programmes de PF.

D) L'appui institutionnel pour accroître la capacité de gestion.

Les activités visant à l'amélioration de la capacité de gestion de l'ONAPO se concentreront sur les systèmes de gestion comptable et financière, la planification et la budgétisation, la gestion des ressources humaines, l'achat et l'entretien des installations de l'équipement et des véhicules.

Par ailleurs le projet suivant est financé à partir de l'AID/Washington:

Le projet JHPIEGO, attaché à l'Université Nationale du Rwanda, prévoit la mise en place d'un nouveau programme de formation locale de trois ans en Santé Reproductrice axé sur les techniques de planification familiale (en particulier l'insertion du DIU) à l'intention de 120 médecins rwandais.
GTZ: Gesellschaft für Technische Zusammenarbeit (Coopération Technique Allemande).

Ce projet d'assistance à l'ONAPO a été initié en 1985 pour renforcer la prestation de services dans deux préfectures du pays "Butare" et "Gikongoro" (2 million de dollars E.U.). Les principales activités de ce projet sont:

A) recyclage du personnel de santé en SMI/PF;
B) séminaires de sensibilisation pour les bourgmestres, les jeunes et les assistant(e)s sociaux et autres cadres de développement;
C) introduction de matériel didactique sur la PF dans les écoles;
D) la construction d'un centre régional administratif à Gikongoro.

UNICEF

Les activités de planification familiale de l'UNICEF sont réduites au Rwanda et dépendent des contributions des autres donateurs. En 1987, l'UNICEF a financé un centre de production audio-visuelle à l'ONAPO et de l'équipement (TV vidéo) pour les activités de formation dans les bureaux régionaux.

Pour son programme 1988-1992 l'UNICEF s'associe aux efforts de l'ONAPO pour augmenter la prévalence contraceptive par l'intégration et la production de matériel audio-visuel des écoles d'infirmières et d'assistantes sociales et la formation en PF d'agents communautaires au niveau communal.

L'O.M.S. reçoit des fonds de la Banque Mondiale pour une assistance technique au projet Santé Familiale (MINISANTE). Par ailleurs, l'OMS est en train de mettre sur pied un Centre Régional Africain pour la Formation et la Recherche en Santé Familiale.

FNUAP (Fonds des Nations Unies pour la Population)

La contribution du FNUAP au programme de PF à l'ONAPO remonte à 1982. La troisième phase du projet (1987-1989) vient de s'achever. Le FNUAP intervient principalement dans:

A) la formation (recyclage du personnel de santé en clinique de PF);
B) la fourniture des équipements médicaux de SMI/PF;
C) la construction des structures de santé;
D) la fourniture des moyens logistiques (contraceptifs, véhicules...)
E) la fourniture d'une documentation en PF; et
F) la subvention à l'ONAPO en couvrant certains frais locaux (comme la maintenance des équipements et véhicules, fournitures de bureau...).

La contribution du FNUAP à cette phase qui s'achève s'élevait à US$ 1.124.580. Une autre phase de projet de 2 ans (1990-1991) pour un montant de US$ 1.300.000 est en cours de négociation.
OFFICIAL STATEMENTS ON POPULATION ISSUES IN RWANDA

Le Chef de l'Etat a fait plusieurs déclarations dans le domaine démographique; à titre illustratif nous présentons ci-après quelques unes d'entre elles pour montrer cette évolution des pensées.

1973: Discours programme du 1er août 1973 (extrait)

"Quant aux problèmes posés par l'accroissement démographique du peuple rwandais, nous en sommes conscients, et ils devront retenir constamment notre sérieuse attention. Nous estimons cependant qu'une mise en garde est nécessaire pour ceux qui sont tentés d'appliquer des solutions hâtives, fruit d'une certaine littérature dont l'égocentrisme de ses auteurs est à peine voilée. La solution que nous recherchons est une solution qui soit rwandaise, compte tenu de nos mentalités, de nos valeurs morales, de notre culture, de nos possibilités et de la solidarité humaine".

(Discours, messages et entretiens, 5 juillet 1973 - décembre 1974, p. 25)


"Pour la troisième fois depuis 1987, nous célébrons partout dans notre pays la semaine consacrée au Festival de la Jeunesse. Depuis l'année dernière 1988, le Ministre de la Jeunesse et du Mouvement Associatif, et l'Office National de la Population (ONAPO) ont décidé de préparer et de commémorer conjointement cette semaine afin d'aider la population rwandaise, en particulier la jeunesse, à réfléchir aux problèmes de développement en général et à ceux ayant trait à l'accroissement démographique de notre pays qui n'est pas proportionnel à celui de la production nationale et familiale. L'institutionnalisation de cette semaine par ces deux Départements vise aussi à faire comprendre aux jeunes que le pays attend beaucoup d'eux dans la recherche de solutions adéquates aux multiples problèmes d'actualité.

Pour que nous puissions aboutir au développement que nous recherchons, il importe que nous poursuivions notre programme de réaliser l'équilibre entre l'accroissement démographique de notre pays et celui de la production. Chaque Rwandaise et chaque Rwandais doit toujours s'efforcer de rechercher tout ce qui peut contribuer à l'amélioration de son bien-être, de bien-être de sa famille. Cela ne sera possible que si chaque famille élabore son plan d'auto-promotion, pour ses membres et ses descendants. Ainsi nos Jeunes, surtout ceux qui n'ont pas encore fondé leurs foyers, doivent comprendre qu'ils sont les premiers à être concernés par ce problème car c'est de leur comportement que dépendra la solution appropriée. "Tubyagoabo duchoboye hurera" (Ayons des enfants que nous sommes en mesure d'éduquer), tel est l'objectif ultime de l'Office National de la Population (ONAPO); c'est aussi l'objectif de notre pays et par conséquent de tout Rwandais quel qu'il soit. Je voudrais simplement
rappeler qu'éduquer ne se limite pas au seul fait de nourrir les enfants. Eduquer un enfant implique aussi lui procurer un logement décent, l'habiller convenablement, le mettre à l'école, le faire soigner s'il est malade (sans oublier l'achat des médicaments), l'aider à fonder son foyer le moment venu et j'en passe.

Le Gouvernement Rwandais a manifesté l'importance qu'il accorde au programme de planification familiale en créant l'Office National de la Population. Cet office a comme mission principale d'aider le Gouvernement et la Population Rwandaise à trouver des solutions au problème de déséquilibre entre la population et la production.

Aujourd'hui, l'on ne peut que se féliciter du pas franchi par cet Office et de ses réalisations. Actuellement, presque tous les Rwandais sont conscients de la portée du problème et sont sensibilisés aux solutions à adopter pour le résoudre définitivement. Il ne reste qu'à mettre en pratique les méthodes préconisées par nos techniciens, chaque famille étant libre de choisir la méthode qui lui convient selon sa conscience. Nous saisissons cette occasion pour demander à toutes les instances concernées, surtout celles ayant la Santé dans leurs attributions, de mettre davantage les services de planification familiale à la disposition de la population, de montrer clairement les méthodes qui conviennent et de réserver à la population l'accueil qu'il faut quand elle se présente pour demander les services.

A cette occasion, je ne manquerai pas de réitérer mes remerciements à tous ceux qui ont manifesté la volonté d'aider le Gouvernement Rwandais à trouver la meilleure voie à suivre pour chercher des solutions au problème démographique de notre pays. L'objectif premier de nous tous, c'est le développement des Rwandais pour qui nous devons chercher les voies et moyens de résoudre leurs problèmes. Que tout le monde parle réellement et publiquement de l'acuité du problème démographique de notre pays; qu'il y ait des discussions et échanges d'idées sur la façon de le résoudre. C'est un problème de premier ordre et d'actualité que nous ne devons pas léguer à nos enfants ou à nos petits enfants. Toute autorité doit en être préoccupée. Car même celui qui se croirait aujourd'hui autosuffisant ne devrait pas perdre de vue le fait qu'une vraie autosuffisance est celle qui tient compte du lendemain. Il doit donc être conscient du fait que lui aussi est appelé à la lutte pour la sauvegarde des intérêts de toute la nation et du Rwanda de demain.

Nous avons l'intelligence et les capacités. Servons-nous-en pour réaliser un développement harmonieux de nos familles et de notre pays.

Le Comité Central du MRND a émis le souhait d'un nombre de quatre enfants par famille. Il a aussi recommandé que la population rwandaise soit sensibilisée quant à ce nombre de quatre enfants comme étant idéal pour une famille rwandaise au stade actuel. Mais il paraît que même ce nombre serait élevé si l'on considère le revenu des familles rwandaises actuellement. Ce nombre devrait servir de suggestion à chaque Rwandais qui veut et cherche à planifier sa famille.
TERMS OF REFERENCE FOR THE PROJECT COORDINATOR

Position: Project coordinator

Duration: 6 years

Location: Kigali, Rwanda, ONAPO

Qualifications: Preferably a physician with adequate training in public health. This person should have at least 8 years of experience in the management of health and FP programs at the national level in Rwanda. He/she should be very familiar with ONAPO's activities and managerial procedures. This coordinator will be the national counterpart to the long term advisor. A good command of the English language is desirable.

Responsibilities/duties: The project coordinator will report to the ONAPO Director. He/she will also relate to the technical and administrative services of ONAPO in the implementation of his work. He/she will head the Project Administrative Unit, and the personnel working in this unit will report to him/her. He/she will assist the ONAPO Director in:

a) ensuring the efficient operation of the PAU which would have as primary responsibility the overall management and execution of this project while ensuring day-to-day supervision and coordination of short-term technical assistance;

b) coordinating the activities of and providing substantial technical input to the different activities of the project at the central, as well as regional levels (more specifically these activities would include: (i) the support to the implementation of the outreach FP strategy; (ii) the supervision of the FP service delivered at the SC level; and (iii) the support to the implementation of studies and surveys); and elaborating the annual work program including the budget to be executed in the context of the proposed project;

c) ensuring that the master training plan agreed upon is timely implemented;

d) designing, in close collaboration with the Project Advisor, a financial, accounting, and a procurement system that would be satisfactory in fulfilling IDA's requirements in these areas;

3) ensuring that procurement procedures acceptable to IDA are followed and that the procurement schedule agreed upon is monitored adequately;
f) ensuring that there is effective coordination between the project, the MOH and the donor agencies and organizing the annual donors meeting;

g) taking the initiative for problem solving;

h) during project implementation, ensuring adequate coordination between the technical sections of ONAPO and ensuring that these sections provide an adequate input to project activities; and

i) ensuring that the collaboration mechanisms agreed upon between MOH and ONAPO function adequately at the central and regional level.
TERMS OF REFERENCE FOR THE PROJECT ADVISOR

Position: Long-term Project Advisor

Duration: January 1, 1992 - December 31, 1994

Location: Kigali, Rwanda, Rwandese Population Office - ONAPO

Qualifications: preferably a physician with a MPH or a Master in management of health services. This person should have at least 6 years of experience in the management of population projects in Africa. Experience in francophone Africa preferable. Fluency in French is a prerequisite and a good command of the English language is necessary.

Responsibilities/Duties: the Project Advisor will report to the ONAPO Director. He/she will be part of the Project Administration Unit (PAU) and will be the counterpart of the local Project Coordinator. The main administrative and technical responsibilities of the Project Advisor will be to assist the Project Coordinator and the ONAPO Director in:

a) ensuring the efficient operation of the PAU which would have as primary responsibility the overall management and execution of this project while ensuring day-to-day supervision and coordination of short-term technical assistance;

b) coordinating the activities of and providing substantial technical input to the different activities of the project at the central, as well as regional levels (more specifically these activities would include: (i) the support to the implementation of the outreach FP strategy; (ii) the supervision of the FP service delivered at the HC level; and (iii) the support to the implementation of studies and surveys); and assisting the elaboration of the annual work program to be executed in the context of the proposed project;

c) ensuring that the master training plan agreed upon is timely implemented;

d) providing extensive training to the PAU and ONAPO staff in procurement and financial management;

e) designing in close collaboration with the Project Coordinator, a financial, accounting, and a procurement system that would be satisfactory in fulfilling IDA's requirements in these areas;

f) ensuring that procurement procedures acceptable to IDA are followed and that the procurement schedule agreed upon is monitored adequately; and

g) ensuring that there is effective coordination between the project, the MOH and the donor agencies and organizing the annual donor meeting.
BEGIN TERMS OF REFERENCE FOR THE ACCOUNTANT

Duration: 6 years (renewable every 2 years)

Profile:

This person must have at least 3 years of work experience as an accountant, preferably having worked on a donor-financed project. He/she will have a 4-year university degree with a major in accounting; familiarity with computers would be a strong advantage. He/she will have to become familiar with IDA accounting and disbursement procedures, hence, proficiency in English would be preferable.

Functions of the Accountant:

a) under the supervision of the Project Coordinator and the Chief of the Financial and Administrative Unit (FAU), he/she will be responsible for maintaining all accounting records and closely monitoring expenditures pertinent to the project;

b) in collaboration with the Project Advisor and USAID Technical Assistant who will be working in the FAU, he/she will provide input on IDA requirements for the automation of the accounting system;

c) he/she will produce quarterly financial statements on the financial status of each project component (and will maintain all background materials documented under SOE) and a budget for planned expenditures for the following 3-month period to be submitted to IDA;

d) in collaboration with the Project Advisor, the Procurement Specialist and the Project Coordinator, he/she will liaise for budgeting and accounting purposes for purchases of contraceptives and other equipment and supplies; and

e) in collaboration with the Project Coordinator, he/she will assist in the elaboration of a yearly budget based on work program to be submitted to IDA.
TERMS OF REFERENCE FOR THE PROCUREMENT SPECIALIST

Duration: 6 years (renewable every 2 years)

This person must have at least 3 years of work experience as a procurement specialist, preferably on a donor-financed project. He/she will have a 4-year university degree with a major in engineering or equivalent technical degree; familiarity with computers would be a strong advantage. He/she will have a thorough knowledge of contract practices in Rwanda.

Functions of the Procurement Specialist:

a) under the supervision of the Project Coordinator and the Chief of the Procurement Unit, he/she will be responsible for the preparation and follow-up of all bidding documents required for the project;

b) he/she will have to become familiar with the World Bank Guidelines for Procurement and Sample Bidding Documents;

c) he/she will have to become familiar with the World Bank Disbursement Procedures;

d) for the purchase of contraceptives and other large pieces of equipment, he/she will have to prepare procurement timetables so as to avoid shortages in contraceptives throughout the duration of the project;

e) he/she will work in close collaboration with the accountant in order to ensure that funds are available in a timely fashion for the purchase of local supplies and equipment;

f) during the preparation of the yearly budget, he/she will have to propose a timetable for the procurement of goods and services for the following year;
TERMS OF REFERENCE FOR THE FAMILY PLANNING POSTS

Family Planning posts will function at least twice a week and will be staffed by adequately trained health personnel working in near-by health centers, and, if health personnel is not available, by one of the ONAPO staff.

These posts will be housed in existing facilities. The following methods will be available: pills, condoms, IUD's, vaginal foams, tablets and other spermicide, natural family planning. These posts will:

- deliver adequate Family Planning services to the target population at risk;
- ensure the follow-up of current users;
- refer to higher levels of the health care system: clients presenting serious side effects or those who want to benefit from specific methods (Norplant, sterilization);
- work in close collaboration with the volunteer at the community level and the health center at the communal level.
Terms of Reference

Volunteers

1. Volunteers (ABAKAGURAMBAUA). Under the project, the tasks of the volunteers will be carried out primarily in his/her area (target population: approximately 50 families). He/she will be responsible for:

(a) providing FP information to the population with a specific emphasis to: high risk groups and the male population. The health benefit aspects of FP will be emphasized in their messages;

(b) discussing population issues (related to population pressure and its impact on environment, land, agriculture, education and health) during meetings and other events in the community;

(c) referring potential users to nearby FP posts and health centers;

(d) finding drop out cases and encouraging them - as appropriate - to re-enter the program;

(e) beginning the second year, supply in condoms and other non-medical contraceptives to the population as needed and refill them the beginning of the third year of the project;

(f) participating in regular meetings with multidisciplinary prefectoral and communal teams involved in the project;

(g) reporting on a periodic basis to Health Center and FP staff; and

(h) keeping adequate records of his/her activities.
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<tr>
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<td>July 1992</td>
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DETAILED TRAINING PLAN (*)

In Country

I. Family Planning Training

A. Basic Training in Family Planning for medical assistants, nurses, auxiliary nurses working in health centers. 820

B. Refresher courses for medical assistants, nurses, auxiliary nurses working in health centers. 269

II. IEC Training

A. Training of trainers (5 per region; 10 at the Central level of ONAPO) 65

B. Refresher courses for ONAPO, CPDFP, CCDFP personnel involved in the training of volunteers (Abakaguramsava):

- communal trainers (3 per commune) 435
- prefectural trainers (10 per prefecture) 110

C. Refresher courses for F.P. auxiliaries (involved in IEC training of volunteers). 1,329

D. School Program:

. Basic IEC training for people attending the CERAI 360
. Refresher IEC training for people attending the CERAI 480
. Training of teachers (Higher Education) 180
. Training of school board directors 200

III. Family Planning/A.I.C Training **

. Community volunteers 17,336

* An annual evaluation of the training plan will be carried out by ONAPO and MOH staff. Training will be progressively decentralized with each region taking the responsibility for organizing training sessions, as soon as some conditions are met.

** These volunteers will benefit from annual training in order to fulfill their main responsibilities as described in annex IX of this report.
IV. Procurement/Management Training

- Contraceptive Procurement
  (ONAPO Regional Delegates + 2 ONAPO Central Staff) 13

- Procurement/Basic principles (ONAPO Central Staff) 2

- Financial Management (ONAPO Central Staff) 4
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<td>o F.P Curricula reviewed</td>
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<td>o Basic clinical training in F.P./H.C. personnel (820)</td>
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<td>o Creation of 10 libraries</td>
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<td>o Strengthen Ref. Lib. ONAPO</td>
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<td><strong>Strengthening F.P. Education at the U.C. Level</strong></td>
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<td><strong>Contraceptive Procurement</strong></td>
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<td><strong>Equipment computers/printers</strong></td>
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<td><strong>Equipment for Health Centers and Hospitals (60)</strong></td>
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<td><strong>Supervision</strong></td>
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<td>B. EXPANSION AND PROMOTION OF FAMILY PLANNING SERVICES</td>
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<td><strong>Strengthening F.P Posts (39)</strong></td>
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<td><strong>Establishment of 44 new F.P. Posts</strong></td>
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<td>- <strong>Volunteers Program:</strong></td>
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<td>* Revision of IEC Curricula and Teaching Materials</td>
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<td>a) Refresher IEC Courses National Trainers (65)</td>
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<td>b) Refresher IEC for Prefectoral Trainers (10 per préfecture: 110 - 1 session per region)</td>
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<td>c) Refresher IEC courses for Communal Trainers: (3 per commune: 415 - 2 sessions per region)</td>
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<td>d) Training of volunteers (17536) 8 days/year (split) (IEC/F.P Technology)</td>
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<td>* Distribution of Condoms and Vaginal Foams (100% of volunteers)</td>
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<td>* Community Distributions of Pills (40% of volunteers)</td>
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<td>- Refresher IEC Courses for F.P auxiliaries (social workers) (1329)</td>
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<td>- Seminar/workshops for women groups (30 seminars)</td>
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<td>- School Program (IEC)</td>
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<td>* Needs Assessment Elaboration of Curricula (Preschool and Primary School level)</td>
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## IMPLEMENTATION SCHEDULE BY PROJECT COMPONENT

### B. EXPANSION AND PROMOTION OF FAMILY PLANNING SERVICES

- **Printing of Curricula**
- **Training of School Board Directors**
- **Higher Education:**
- **Printing of curricula**
- **Training of teachers (180)**

### CERAIS

- **Basic IEC Training** (360)
- **Refresher IEC Training** (480)
- **Technical Assistance**
  - **Short-Term International**
  - **Short-Term Local**
- **Contraceptive Supplies**
- **Motorcycles**
- **Supervision**

### C. RESEARCH, DEVELOPMENT OF MULTISECTORAL POPULATION ACTIVITIES

- **Technical Assistance**
  - **S/T International consultants** (6 months)

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# Estimated Schedule of Disbursement

**US$Million**

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TECHNICAL ASSISTANCE REQUIREMENTS

Project Management

Long-term local procurement specialist -- 6 years.
Long-term local accountant -- 6 years.

Support to IEC Strategy

Short-term local consultants -- 12 P. MOS. (1992-1993)

Program of Volunteers


Research/Development of Multisectoral Activities

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References

1. ONAPO: 1990 Annual Work Program

2. ONAPO: Le problème démographique au Rwanda et le cadre de sa solution, May 1990.


7. May John, Mukamgizi Monique, Vekemans Marcel: Family Planning in Rwanda; Status and Prospects, Studies in Family Planning, 21,1:xx-xx


11. ONAPO: Le Programme de l'Abagakuranmgasa (Volunteer).
Rwanda
First Population Project

Number of Family Planning Posts
By Prefecture:

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National Capital
Prefecture Capitals and Regional Office/Ministry of Health Headquarters
Commune Boundaries
Prefecture Boundaries
International Boundaries

Population Density (persons per km²)

- 0 - 100
- 101 - 200
- 201 - 250
- 251 - 320
- Over 320

Legend:

- Black
- Red

Map includes boundaries and population density in Rwanda, with prefixes for national capital, prefecture capitals, regional offices, and health headquarters. The map also highlights population density categories with corresponding color coding.