

FOIA MARKER

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Rwanda

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Strategy HIV
Copies of Conference
Reports

1996

Jim -
Rwanda -

Since 1990 to aggravate HIV
★ war, displacement, infrastructure
★ genocide, 1,000,000 people in
90 days
★ 1994 - massive displacement
★ of 1,000,000 people

Seniors have repatriated over
4 M. refugees
0.7 per capita \$ for health
(5.6 on education)

World Bank, IMF

Aggressive public campaign -
local leadership,

INT - Countries -
Rwanda

Drug purchasing challenges -
TB

* Talk with USAID - How much for Rwanda
Pop will double in next 20 years

* World Bank - Wolfenson, call for them for an
update -

- Public Visits -

* Guy Pappas - office of international health



HIV/AIDS DIVISION FAX

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

DATE: 8/4/98

TO: SANDY THURMAN ORGANIZATION: ONAP

FAX PHONE: 202-456-2439 OFFICE PHONE: 456-2437

FROM: DELAH/GRISON OFFICE PHONE: 712-5212

FAX PHONE: 202-216-3046 NUMBER OF PAGES (INCLUDING COVER) 14

COMMENTS:

RWANDA DATA AS REQUESTED

(LAST PAGE 14 OF 14 PAGES) ~~4~~

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Annex: HIV Surveillance data by site

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Pregnant women	Outside Major Urban Areas	Myamata												9.6	
		?							89.1						
		Butare						10.2							
		Gikondo						24.6						22.6	
		Kabgayi												15.9	
		Kabutare												6.7	
		Kiriche												7.3	
		Muhuma						24.5							
		Nyagatare												10.2	
		Ruhengeri												10.2	
		Ruli												3.5	
		Rural areas								1.8					
		Semlurban areas								11.6					
	Major Urban Areas	Biryogo												32.7	
		C.H. Kigali					23.2			31.6				22.4	
		Kigali				32	30.3	26.2	26.7	26.1	33.4		25.4		
Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Sex workers	Major Urban Areas														
Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Injecting drug users	Major Urban Areas														
Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
STD patients	Outside Major Urban Areas	Kabgayi												42.3	
		Ruli												13.2	
	Major Urban Areas	Biryogo												54.5	
		Kigali		43.1		55.1	55.4	56.4	48.2	33.7				29.1	

Notes:



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RWANDA

Situation Analysis

In April 1994, extremist elements of the ruling regime launched a genocide, targeting Tutsis and the Hutu political opposition, to maintain power. Up to one million people were killed and over two million Rwandans were displaced in a three-month period. After the military victory of the Rwandan Patriot Front (RPF) in July 1994, an estimated 800,000 "old caseload"—the refugees of 1959 and their children—returned to Rwanda. In late 1996, an estimated 1.3 million "new caseload"—Rwandans who fled the country in 1994—came home in a sudden and massive return.

There are now 7.6 million people living in Rwanda. The situation is characterized by demographic shifts, massive resettlement and rehabilitation needs, a huge loss of human resources and a society struggling to overcome the polarizing effects of years of ethnocratic rule which culminated in genocide.

The new Government of Rwanda (GOR) has identified HIV/AIDS as a growing epidemic and priority health and development problem for Rwanda. Pre- and post-war surveillance data indicate high HIV infection rates throughout the country. Data gathered from ten sentinel surveillance sites in 1996 indicate that HIV prevalence rates remain high in urban Kigali (33 percent) and appear to be increasing in rural and semi-rural areas (3.6 percent to 9.9 percent). The National AIDS Program estimates that

the overall infection rate in the under 20-year-old age group is 9.7 percent.

REPORTED AIDS CASES: Not available

INCREASE OVER 1993 REPORT: Not available

TOTAL POPULATION: 7.6 million

CUMULATIVE INCIDENCE: Not available

HIV-1 SEROPREVALENCE IN URBAN AREAS: Not available

Population at high risk: 33.7%

Population at low risk: 10.2%

USAID Strategy

In late 1994, USAID provided significant support to Rwanda's National AIDS Control Program (PNLS) through the AIDSCAP Project. AIDSCAP/Rwanda was the first health development activity to be re-established in the post-crisis period and played a critical role in rebuilding the National AIDS Control Program and creating capacity within the Rwandan health system to combat STIs, including HIV. AIDSCAP was instrumental in launching a nationwide condom social marketing project; providing IEC material and media supports; establishing a peer education pilot program; and supporting education through the military and local associations.

To better adapt USAID assistance to needs in the transition period and move Rwanda towards long-term stability and development, USAID is supporting GOR

Ministry of Health (MOH) commitments to decentralized and integrated basic health care. Future HIV/AIDS programming aims to integrate and improve the planning, management and implementation of STI/HIV services at the health district level.

USAID-Supported Country Programs Decentralized STI and HIV/AIDS Prevention Program

This activity aims to integrate and improve the delivery of STI/HIV services in four pilot regions. Through improved clinical skills and practices, provider and client information dissemination, improved information and IEC implementation, and improved management practices at the regional and district levels, quality STI services will be integrated into and strengthen the overall quality of the existing primary health care system in rural areas.

Ministry of Health Financial and Administrative Accounting and Transparency

Weak financial accounting and administrative systems impede the MOH and its National AIDS Program from efficiently managing and decentralizing its resources. Strong financial and administrative accounting and systems are needed for the GOR/MOH to assume ownership and provide leadership in the health sector. USAID will work with a recognized international accounting firm to build a solid financial and administrative capacity within the MOH at the central and

regional levels and to improve education and communication interventions at the community level.

HIV/AIDS Peer Education Prevention Program

USAID is supporting the second phase of a peer education pilot project in the Gitarama Prefecture. CARE International, the implementation partner, will refine peer education methodologies and activities initiated in phase I to build a local capacity to sustain peer education networks and create linkages between the education components of the formal health delivery system.

Rwandan Health Communication Center

The creation of Rwandan capacity to design and produce quality health education materials is key to the fight against AIDS and other communicable and preventable infections. Effective education and communications are critical tools in preventing and reducing infection transmission, particularly STIs. In collaboration with the World Bank, USAID, through its implementing partner Population Services International (PSI), will contribute technical assistance in the design and management of communications campaigns in addition to production skills in audio, video and print media. The Communications Center is designed to operate as a non-profit, private-sector organization and will be responsible for achieving a high degree of cost-recovery over time.

KEY

- AIDS cases reported to the World Health Organization.

-- The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

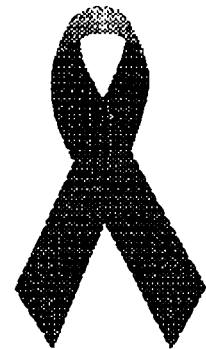
--- HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

---- Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

Rwanda

■ Epidemiological Fact Sheet

**on HIV/AIDS
and sexually
transmitted
diseases**



UNAIDS
UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

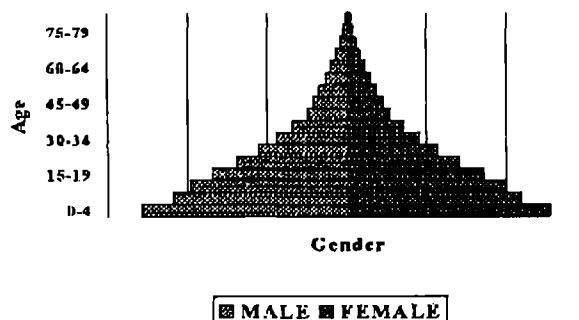


**World Health
Organization**

2 - Rwanda

Country information

Population pyramid, 1997

UNAIDS/WHO Working Group
on Global HIV/AIDS and STD
Surveillance

Global surveillance of HIV/AIDS and sexually transmitted diseases (STDs) is a joint effort of WHO and UNAIDS. The UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance, initiated in November 1996, guides respective activities. The primary objective of the working group is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STDs. For this purpose, the working group collaborates closely with national AIDS programmes and a number of national and international experts and institutions. The goal of this collaboration is to compile the best information available and to improve the quality of data needed for informed decision-making and planning at national, regional and global levels. The Epidemiological Fact Sheets are a first output of this close and fruitful collaboration across the globe.

Following a series of consultations, the working group and its partners established a framework standardizing the collection of data deemed important for a thorough understanding of the current status and trends of the epidemic, as well as patterns of risk and vulnerability in the population. Within this framework, the Fact Sheets collate the most recent country-specific data on HIV/AIDS prevalence and incidence, together with information on behaviours (e.g. casual sex and condom use) which can spur or stem the transmission of HIV. The data include prevention indicators developed by WHO's Global Programme on AIDS, which aim to measure trends in knowledge of AIDS, relevant behaviours, and a host of other factors influencing the epidemic. Additional indicators – for example, on care and support – will be included when available.

Not unexpectedly, information on all of the agreed-upon indicators was not available for many countries in 1997. However, the fact sheets do contain a wealth of information which allows identification of strengths in currently existing programmes and comparisons between countries and regions. The fact sheets may also be instrumental in identifying potential partners when planning and implementing improved systems. The fact sheets can be only as good as information made available to the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance. Therefore, the working group would like to encourage all programme managers as well as national and international experts to communicate additional information to the working group whenever such information becomes available. The working group also welcomes any suggestions for additional indicators or information proven to be useful in national or international decision making and planning.

Indicators	Year	Estimate	Source
Total Population (thousands)	1997	7,654	Socio-demographic Survey
Population Aged 15-49 (thousands)	1997	2,710	UNPOP
Annual Population Growth	1980-1995	2.9	UNPOP
% of Population Urbanized	1996	6	UNPOP
Average Annual Growth Rate of Urban Population	1980-1996	2	UNPOP
Net Migration Rate			
GNP Per Capita (US\$)	1996	182	Socio-demographic Survey
GNP Per Capita Average Annual Growth Rate	1985-1995	.5	World Bank
Human Development Index Rank (HDI)		152	Socio-demographic Survey
Real GDP Per Capita Rank - HDI Rank		1	UNDP
Gender Related Development Index Rank			
Gender Empowerment Measure Rank			
Human Poverty Index Value (HPI)		37.9	UNDP
% Population Economic Active	1996	71	Socio-demographic Survey
Unemployment Rate			
Total Adult Literacy Rate	1996	52.7	Socio-demographic Survey
Adult Male Literacy Rate	1996	56.8	Socio-demographic Survey
Adult Female Literacy Rate	1996	51	Socio-demographic Survey
Male Secondary School Enrollment Ratio	1990-1995	11	UNESCO
Female Secondary School Enrollment Ratio	1990-1995	9	UNESCO
Crude Birth Rate (births per 1,000 pop.)	1996	45	Socio-demographic Survey
Crude Death Rate (deaths per 1,000 pop.)	1996	17	Socio-demographic Survey
Maternal Mortality Rate (per 100,000 live births)	1990	1300	WHO/UNICEF
Life Expectancy at Birth	1996	49	UNPOP
Total Fertility Rate	1996	6.5	Socio-demographic Survey 19
Infant Mortality Rate (per 1,000 live births)	1996	129	Socio-demographic Survey, 1
Under Five Mortality Rate (per 1,000 live births)	1996	117	UNICEF/UNPOP
% Population Access to Safe Water	1990-1996	66	ONAPO
% Population Access to Adequate Sanitation	1990-1996	94	ONAPO

Contact address:
UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance
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<http://www.who.ch/emc/diseases/hiv>
<http://www.unaids.org>

Estimated number of people living with HIV/AIDS

In 1997 and during the first quarter of 1998, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations are based on the previously published estimates for 1994 (WER 1995; 70:353-360) and recent trends in HIV/AIDS surveillance in various populations. EpiModel 2, a microcomputer programme originally developed by the WHO Global Programme on AIDS, was used to calculate the new estimates on prevalence and incidence of AIDS and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV, taking into account age-specific fertility rates. An additional spreadsheet model was used to calculate the number of children whose mothers had died of AIDS.

The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance systems and collect more information. This includes information about infection levels in different populations, and behaviours which facilitate or impede infection.

Adults in this report are defined as women and men aged 15 to 49. This age range covers people in their most sexually active years. While the risk of HIV infection obviously continues beyond the age of 50, the vast majority of those who engage in substantial risk behaviours are likely to be infected by this age. Since population structures differ greatly from one country to another, especially for children and the upper adult ages, the restriction of the term adult to 15-to-49-year-olds has the advantage of making different populations more comparable. This age range was used as the denominator in calculating adult HIV prevalence.

Estimated number of adults and children living with HIV/AIDS, end of 1997

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1997

Adults and children	370000		
Adults (15-49)	350000	Adult rate (%)	12.75
Women (15-49)	170000		
Children (0-15)	22000		

Estimated number of AIDS cases

Estimated number of AIDS cases in adults and children that have occurred since the beginning of the epidemic:

Cumulative no. of AIDS cases	180000
-------------------------------------	---------------

Estimated number of deaths due to AIDS

Estimated number of adults and children who died of AIDS since the beginning of the epidemic:

Cumulative deaths	170000
--------------------------	---------------

Estimated number of adults and children who died of AIDS during 1997:

Deaths in 1997	36000
-----------------------	--------------

Estimated number of orphans

Estimated number of children who have lost their mother or both parents to AIDS (while they were under age 15) since the beginning of the epidemic:

Cumulative orphans	120000
---------------------------	---------------

Estimated number of children who have lost their mother or both parents to AIDS and who were alive and under age 15 at the end of 1997:

Current living orphans	84000
-------------------------------	--------------

4 – Rwanda

HIV Sentinel surveillance

This section contains information about HIV prevalence in different populations. The data reported in the tables below are mainly based on the HIV data base maintained by the United States Bureau of the Census and are a compilation of data from different sources, including national reports, scientific publications and abstracts. To provide for a simple overview of the current situation and trends over time, summary data are given by population group, geographical area (Major Urban Areas versus Outside Major Urban Areas), and year of survey. Studies conducted in the same year are aggregated and the median prevalence rates (in percentages) are given for each of the categories. The maximum and minimum prevalence rates observed, as well as the total number of surveys/sentinel sites, are provided with the median, to give the reader an overview of the diversity of HIV-prevalence results in a given population within the country.

The differentiation between the two geographical areas Major Urban Areas and Outside Major Urban Areas is not based on strict criteria, such as the number of inhabitants. For most countries, Major Urban Areas were considered to be the capital city and – where applicable – other metropolitan areas with similar socio-economic patterns. This distinction assumes that capital cities in many countries have specific characteristics related to the prevalence of higher risk behaviour and a concentration of HIV infections. The term Outside Major Urban Areas considers that most sentinel sites are not located in strictly rural areas, even if they are located in somewhat rural districts. Site/study-specific data on which the medians were calculated are printed in an annex at the end of this fact sheet.

HIV prevalence in selected populations in percent

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Pregnant women	Major Urban Areas	N_Sites					1	2	1	2	1			1	2	
		Minimum					32	23.2	26.2	26.7	26.1	33.4		25.4	22.4	
		Median					32	28.75	26.2	28.7	28.85	33.4		25.4	27.55	
		Maximum					32	30.3	28.2	28.7	31.8	33.4		25.4	32.7	
Pregnant women	Outside Major Urban Areas	N_Sites							3	12	2				9	
		Minimum							10.2	6.5	1.8				3.5	
		Median							24.5	2.55	6.7				10.2	
		Maximum							24.6	28.7	11.6				22.6	
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Sex workers	Major Urban Areas	N_Sites														
		Minimum														
		Median														
		Maximum														
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Injecting drug users	Major Urban Areas	N_Sites														
		Minimum														
		Median														
		Maximum														
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
STD patients	Major Urban Areas	N_Sites			1		1	1	1	1	1				2	
		Minimum			43.1		55.1	55.4	55.4	48.2	33.7				28.1	
		Median			43.1		55.1	55.4	55.4	48.2	33.7				41.8	
		Maximum			43.1		55.1	55.4	55.4	48.2	33.7				54.5	
STD patients	Outside Major Urban Areas	N_Sites													2	
		Minimum													13.2	
		Median													27.75	
		Maximum													42.3	

Assessment of epidemiological situation

Assessment of country epidemiological situation

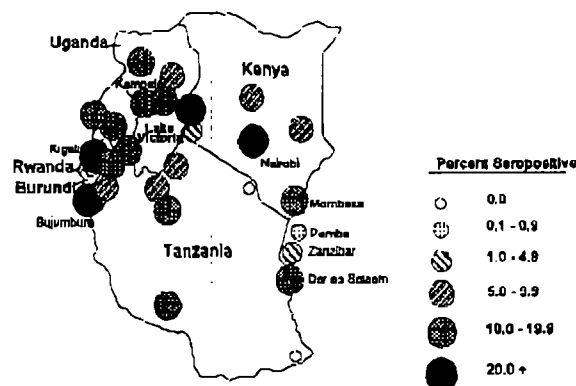
HIV information among antenatal clinic attendees is available from Rwanda since the late 1980s. In Kigali, the major urban area, 32 percent of antenatal clinic attendees tested in 1988 were HIV positive. HIV prevalence has ranged between 25 and 33 percent among antenatal clinic attendees in Kigali through 1996. HIV information by age is available for 1989, 1991 and 1992-93. Peak HIV prevalence of over 35 percent was seen among 20-24 year old antenatal clinic attendees in both 1989 and 1992-93.

Outside of Kigali, HIV prevalence among antenatal clinic attendees ranged from 10 to 25 percent among three sites in 1989-90 and from less than 1 to 30 percent in 1991 among 12 sites. In 1996, HIV prevalence among antenatal attendees tested in 9 sites outside of Kigali ranged from 4 to 23 percent. HIV prevalence by age is only available for 1989-90, where peak prevalence was seen among the 20-24 year old antenatal attendees.

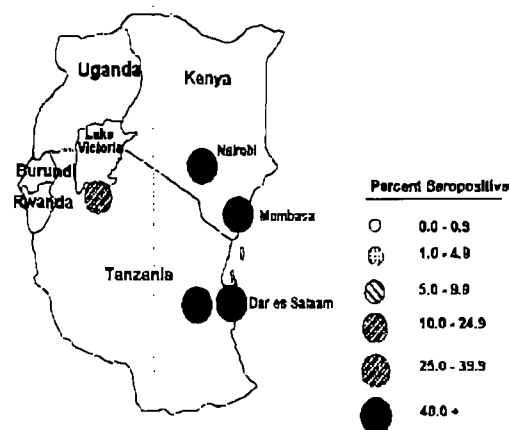
Information on HIV prevalence among male STD clinic patients is available from Kigali since 1986. HIV prevalence reached 55 percent among male STD clinic patients tested in 1988-1990. In 1996, 29 percent of STD clinic patients tested in Kigali and 55 percent of patients in Biryogo were HIV positive. In the rural areas of Ruli and Kabgayi, 13 to 42 percent of STD clinic patients tested in 1996 were HIV positive.

Regional maps

Seroprevalence of HIV-1 for Pregnant Women East Africa



Seroprevalence of HIV-1 for Sex Workers East Africa



6 - Rwanda

Reported AIDS cases

AIDS cases by year of reporting

1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total	Unknown
0	0	0	0	10	73	161	501	236	289	1005	2204	2089	2908	1220	0	0	0	1350		12056	

Date of last report: 30-Jun-1993

AIDS cases officially reported to WHO. Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a portion of all cases in a country. Completeness of reporting varies substantially from one country to another, from less than 10% in some countries with fewer resources to more than 80% in most industrialized countries (please also compare with the section on estimates). Therefore, distribution by age, sex and modes of transmission may not be representative for all people living with AIDS in a given country.

AIDS cases by mode of transmission

Hetero: Heterosexual contacts.

Homo/Bi: Homosexual contacts between men.

IDU: Injecting drug use. This transmission category also includes cases in which other high-risk behaviours were reported, in addition to injection of drugs.

Blood: Blood and blood products.

Perinatal: Vertical transmission during pregnancy, birth or breastfeeding.

NS: Not specified/unknown.

Sex	Trans. group	<94	94/95	1995	1996	1997	1998	Unkn.	Total	%
All	All									
	Hetero									
	Homo/Bi									
	IDU									
	Blood									
	Perinatal									
	Other known									
	Unknown									
Male	All									
	Hetero									
	IDU									
	Blood									
	Other known									
Female	All									
	Hetero									
	IDU									
	Blood									
	Other known									
NS	All									
	Hetero									
	IDU									
	Blood									
	Perinatal									
	Other known									

AIDS cases by age and sex

Sex	Age	<1994	94/95	1995	1996	1997	1998	Unkn.	Total	%
All	All									
	0-4									
	5-9									
	10-14									
	15-19									
	20-24									
	25-29									
	30-34									
	35-39									
	40-44									
	45-49									
	50-54									
	55-59									
	60+									
Male	All									
	0-4									
	5-9									
	10-14									
	15-19									
	20-24									
	25-29									
	30-34									
	35-39									
	40-44									
	45-49									
	50-54									
	55-59									
	60+									
Female	All									
	0-4									
	5-9									
	10-14									
	15-19									
	20-24									
	25-29									
	30-34									
	35-39									
	40-44									
	45-49									
	50-54									
	55-59									
	60+									

Curable STDs

Control and prevention of sexually transmitted diseases (STD) have been recognized as a major strategy in the prevention of HIV infection and ultimately AIDS. Consequently, monitoring different components of STD control can also provide information on HIV prevention within a country. One of the cornerstones of STD control is adequate management of patients with symptomatic STDs. This includes diagnosis, treatment, and individual health education and counselling on disease prevention and partner notification.

Estimated incidence and prevalence of curable STDs

STDs	Incidence				Prevalence			
	Year	Male	Female	All	Year	Male	Female	All
Chlamydia trach.								
Gonorrhoea								
Syphilis								
Trichomonas								
Comments								
Source								

STD Incidence, men

Prevention Indicator 9: Proportion of men aged 15-49 years who reported episodes of urethritis in the last 12 months.

Year	Area	Age	Rate	N=
1996	All	15-49	27.7	

Comments:

Sources: PNLS/AIDSCAP

STD Prevalence, women

Prevention Indicator 8: Proportion of pregnant women aged 15-24 years attending antenatal clinics whose blood has been screened with positive serology for syphilis.

Year	Area	Age	Rate	N=
1993	Urban	15-24	5	765

Comments:

Sources: V. Leray, A. De Clercq, J. Ladner et al. Prospective Study done at the Centre Hospitalier de Kigali (CHK)

STD Case management (counselled)

Prevention Indicator 7: Proportion of people presenting with STD or for STD care in health facilities who received basic advice on condoms and on partner notification.

Year	Area	Age	Rate	N=
1996	All		56	

Comments:

Sources: PNLS/AIDSCAP

STD Case management (treatments)

Prevention Indicator 6: Proportion of people presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards).

Year	Area	Age	Rate	N=
1996	All		63	

Comments:

Sources: PNLS/AIDSCAP

8 – Rwanda

Health service indicators

HIV-prevention strategies depend on the twin efforts of care and support for those living with HIV or AIDS, and targeted prevention for all people at risk or vulnerable to the infection. These efforts may range from reaching out to vulnerable communities through large-scale educational campaigns or interpersonal communication; provision of treatment for STDs; distribution of condoms and needles; creating an enabling environment to reduce risky behaviour; voluntary testing and counselling; home or institutional care for persons with symptomatic HIV infection; and preventing perinatal transmission and transmission through infected needles or blood in health care settings. It is difficult to capture such a large range of activities with one or just a few indicators. However, a set of well-established health care indicators -- such as the percentage of a population with access to health care services; the percentage of women covered by antenatal care; or the percentage of immunized children -- may help to identify general strengths and weaknesses of health systems. Specific indicators, such as access to testing and blood screening for HIV, help to measure the capacity of health services to respond to HIV/AIDS-related issues.

Access to health care

Indicators	Year	Estimate	Source
% of Pop. with access to health services - total:	1990-1995	80	UNICEF
% of Pop. with access to health services - urban:			
% of Pop. with access to health services - rural:			
Contraceptive prevalence rate (%):	1990-1996	7	UNFPA
% of births attended by trained health personnel:	1990-1996	26	UNICEF
% of pregnant women immunized against tetanus:	1995-1996	43	UNICEF
% fully immunized - Tuberculosis:	1995-1996	93	UNICEF
% fully immunized - DPT:	1995-1996	98	UNICEF
% fully immunized - Polio:	1995-1996	98	UNICEF
% fully immunized - Measles:	1995-1996	76	UNICEF
Proportion of blood donations tested:		100	CNTS
% of ANC clinics where HIV testing is available:			
HIV/AIDS Hospital Occupancy Rate (Days):			

Latex condoms are the only technology available that can prevent sexual transmission of HIV/STD. Persons needing protection in situations that carry risk should have consistent access to high quality condoms. National AIDS Programmes implement activities to increase both availability of and access to condoms. The two condom availability indicators below are intended to highlight areas of strength and weakness at the beginning and at the end of the distribution system so that programmatic resources can be directed appropriately to problem areas.

Condom availability (central level)

Prevention Indicator 2: Availability of condoms per capita in the country over the last 12 months (central level).

Year	Area	N	Rate
1997	All	360000	0.13
Comments:			
Sources: PSI/Annual Report, 1997			

Condom availability (peripheral level)

Prevention Indicator 3: Proportion of people who can acquire a condom (peripheral level).

Year	Area	N	Rate
1997			
Comments: Information not available.			
Sources:			

Knowledge and behaviour

Information on knowledge and behaviour related to HIV/AIDS is essential in identifying populations at risk for HIV infection. It is also critical in assessing changes over time as a result of prevention efforts. Guidelines and recommendations have been published in the publication: "Evaluation of a National AIDS Programme: A methods package. 1. Prevention of HIV infection. WHO/GPA/TCO/SEF/94.1 Geneva, 1994".

Knowledge of HIV-related preventive practices

Prevention Indicator 1: Proportion of people citing at least two acceptable ways of protection from HIV infection.

Year	Area	Age group	Male	Female	All
n/a		15-19			
n/a		20-24			
n/a		25-49			
n/a		15-49			

Comments:

Sources:

Reported non-regular sexual partnerships

Prevention Indicator 4: Proportion of sexually active people having at least one sex partner other than a regular partner in the last 12 months.

Year	Area	Age group	Male	Female	All
1988	All	15-50			

Comments: Information non disponible.

Sources: KABP/Behavioural Studies - GPA, 1992

Reported condom use in risk sex (gen pop)

Prevention Indicator 5: Proportion of people reporting the use of a condom during the most recent intercourse of risk.

Year	Area	Age group	Male	Female	All
n/a		15-19			
n/a		20-24			
n/a		25-49			
n/a		15-49			

Comments:

Sources:

10 – Rwanda

Knowledge and behaviour

Ever use of condom

Percentage of people who ever used a condom.

Year	Area	Age group	Male	Female	All
1992	All	15-19		0.2	
1992	All	20-24		0.9	
1992	All	25-29		2.5	
1992	All	30-34		1.4	
1992	All	35-39		1.4	
1992	All	40-44		1.6	
1992	All	45-49		0.3	
1992	All	Total		1.2	

Comments: All women

Sources: Demographic and Health Survey

Median age at first sexual intercourse

Median age of people at which they first had sexual intercourse.

Year	Area	Age group	Male	Female	All
1992		20-24		20.2	
1992		25-49		19.7	
1992		45-49		18.4	

Comments: Median 20-24 is for women ages 25-29; median 20-24 was not calculated since less than 50% had had sex or given birth.

Sources: DHS/1992

Adolescent pregnancy

Percentage of teenagers 15-19 who are mothers or pregnant with their first child.

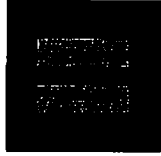
Year	Area	Age group	Rate	N
1992	All	15	0.4	280
1992	All	16	2.5	311
1992	All	17	7.7	304
1992	All	18	16.5	302
1992	All	19	26.7	267
1996	All	15-17	9	200

Comments:

Sources: DHS/1992

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HUMAN
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July 28, 1998

Dear Representative:

As you know, the House Appropriations Committee will mark up the FY 99 D.C. Appropriations bill on Thursday, July 30. As reported in the July 27 *Washington Post*, amendments may be offered to prohibit unmarried couples from adopting children and to prohibit funding of D.C.'s needle exchange program. The Human Rights Campaign strongly opposes including these riders in the bill, and we encourage you to attend the mark-up and vote against any such amendments.

Decentralizing federal government programs and giving local control back to the American people has been a major theme for the Republican-controlled Congress over the past few years. Inclusion of these riders in the D.C. appropriations bill is an example of congressional micro-management of the District of Columbia. Last year's D.C. appropriations process was almost derailed over deal-breaking measures included in the bill, such as school vouchers. With so few days left on the legislative calendar, Congress cannot afford to hold up the appropriations process by politicizing family and public health decisions.

Most Americans agree that the federal government should stay out of family law decisions. In fact, Americans categorically reject the notion that the government should take a greater role in deciding who can and cannot adopt children. By a margin of nearly four to one (74 to 19 percent,) voters say we should keep the system we currently have, rather than allow the federal government to take a greater role. Overwhelmingly, Americans believe that the issue of adoption is best decided by parents and trained professionals on a case-by-case basis, based on the best interests of the child -- not by politicians or the government (August 1997 poll conducted by Penn, Schoen & Berland Associates). The best interest of the child should be the deciding factor in setting adoption policy at the local level. That is best determined by local, trained professionals.

Further, the District of Columbia has one of the highest incidences of HIV infection in the country. Intravenous drug use is the District's second highest mode of transmission, accounting for over 25 percent of all new AIDS cases. Scientific evidence supports the fact that needle exchange programs reduce HIV infection and do not contribute to illegal drug use. The District of Columbia has had a local needle exchange program in place since last year, an important tool in the city's fight against the spread of HIV and an important bridge to drug treatment services. Now, Congress is considering telling D.C. that it cannot spend its own funds in this on-going battle. We oppose this effort.

Please oppose both of these amendments should they come up in committee or when the House considers the D.C. appropriations bill. Also, please call us if you have any questions or need any further information (216-1520). Thank you.

Sincerely yours,

Winnie Stachelberg
Political Director

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THE FEDERAL GOVERNMENT SHOULD STAY OUT OF FAMILY LAW DECISIONS

Congress has traditionally stayed out of family law, recognizing that state and local governments are better suited to address those issues. **The ability of parents and trained professionals to make a decision, on a case-by-case basis, based on the best interests of the child, should be preserved.**

Although unsuccessful during the last three District of Columbia appropriations cycles,

Congressman Jay Dickey, or another Member of Congress, may again introduce legislative language to the D.C. appropriations bill that would interfere with parents and trained professionals' ability to make decisions in adoptions involving unmarried couples.

Such congressional action would place D.C.'s children at risk:

- Under the proposed amendment, single DC residents would still have the ability to adopt children. The goal of the amendment is to ban joint adoption by unrelated persons. While both parties of an unmarried couple would obviously still serve as parents to the child, the second parent would have no legal responsibility or protections for the child, including financial. In unfortunate circumstances, such as a break up or the death of a legal parent, the non-legal parent would have no legal responsibility to care for the child.
- Having two legal parents is in the best interest of the child because it gives children greater financial security and ensures that the adopted child can receive health and other benefits from both parents.
- As of June 22, 1998, there were 3,600 children in the D.C. foster care system waiting to be adopted. It is hard enough to find good homes for children. It would be an outrage to make children languish in institutions at great cost to taxpayers when they can have caring, loving homes.
- The American Psychological Association reports that studies comparing groups of children raised by gays and by non-gay parents find no developmental differences between the two groups of children in their intelligence, social and psychological adjustment, popularity with friends, development of sex role identity or development of sexual orientation. In fact, in 48 states and the District of Columbia, lesbian and gay people are permitted to adopt when a judge finds that the adoption is in the child's best interest.

6/23/98

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