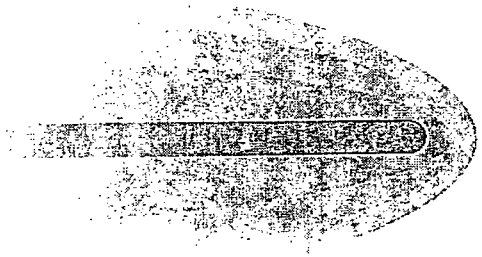
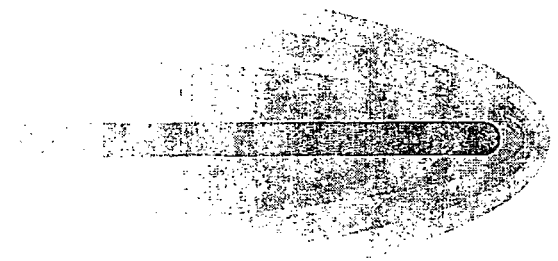
USAID Program Response

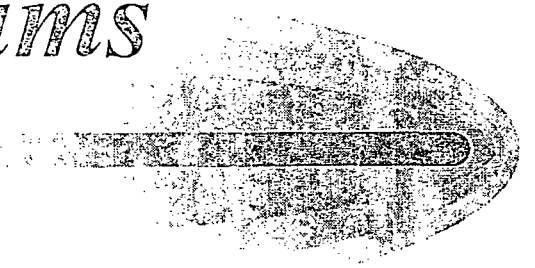


Rationalize accessibility



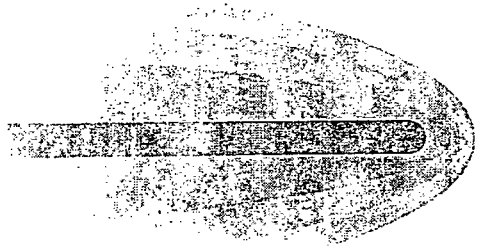
- Access to health services
- Data for decision-making (DHS, 2001 census)
- Cost recovery approaches
- Financial management
- Public health and clinical training
- Reproductive health post-genocide

Disease Control Programs



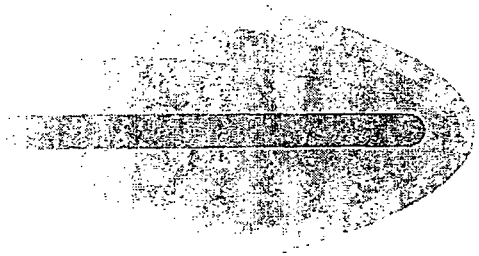
- Support National AIDS Program coordination
- Strengthen capacity for STD screening & treatment,
- HIV testing and counseling.

Improve service management



- Strengthen MOH financial management capacity through targeted technical assistance and training.

Community participation



- Partnership with the Rwanda Health Communications Center, PSI/Rwanda, and other social mobilization actors.

- accept reality of AIDS
- long term illness has little relevance where you might die sooner -

For BOD
critical to get training program (Sending)

(1) started!

(2) how to deploy a key person or ground ie Mark Kline - Romania for countries like

(3) PSA campaign

(4) Go to Coca-Cola - Lucent

Minister of Health

1993 - epidemic known hard to discuss at first
at first all off. releases ind. scientific results
needed to be cleared by President
Countries were ashamed to admit

1987 (?) First Commission on AIDS med docs only
considered med problem + nothing done to
change behavior

after genocide of 1994 real fight began
lost 10 years - can't be recovered
situation worsened by genocide

all govt officials now highly sensitized to problem
still at beginning campaign of awareness

signs of hope -

need labs
centers for vifo
centers for MTCT
all hospitals to care for AIDS

Constraints 1) financial
2) human resources - need to rebuild
3) lack of drugs

Sandy - be ambassador to work on making drugs affordable

getting message out to rural areas is key

300 doctors - need lecturers for univ.
- library
- training possibilities in other universities
- training nurses for testing + counseling sites
- need scholarships

Defense Educ
Good agenda shared by Ministries Implement

Cultural difficulties
no communication around sex
Christian culture makes it even harder (sex is sin)

HIV/AIDS IN RWANDA

UNCLASSIFIED
ICAS 01/05/2000
AMB: GSTAPLES
SO2: PMWANUYERA
DIR: DGOLDMAN, SO2:EKAGAME, DCM:DKORAN, MSC:SGIDDINGS,
DAO:RSKOW
AID

AMEMBASSY KIGALI
SECSTATE WASHDC PRIORITY
INFO RWANDA COLLECTIVE

USAID/W FOR G/PHN/HN/EH, LLOYD, J. FEINBERG;
AFR/EA, ULLRICH, GAMBINO, DANTONIO;
AA/AFR;DAA/AFR
REDSO/NAIROBI, J. DUNLOP/HPN AND CAROLYN JEFFERSON
DEPT PASS TO THE WHITE HOUSE FOR NATIONAL AIDS POLICY
DIRECTOR

E.O. 12958: N/A
TAGS: EAID, PGOV, MASS, RW
SUBJECT: WORLD AIDS DAY IN RWANDA

1. WORLD AIDS DAY OBSERVANCE SERVED TO STRENGTHEN OUR EFFORTS TO ADDRESS THE CHALLENGES OF THE AIDS EPIDEMIC, WHICH CONTINUES TO SPREAD THROUGHOUT THE REGIONS OF THE WORLD, PARTICULARLY AFRICA. THE 1999 THEME ADOPTED BY THE JOINT UNITED NATIONS PROGRAM ON HIV/AIDS (UNAIDS) "END THE SILENCE, LISTEN, LEARN, LIVE" WAS PARTICULARLY POIGNANT HERE IN RWANDA.

2. IN RWANDA, WORLD AIDS DAY ON DECEMBER 1, WAS NOT A CAUSE FOR CELEBRATION, IT WAS A MOMENT FOR SOBER REFLECTION. ALMOST EVERY FAMILY IN RWANDA KNOWS OR HAS SEEN SOMEONE DYING OF AIDS. THE JOINT UNITED NATIONS PROGRAMME ON AIDS (UNAIDS) REPORTS THAT RWANDA·IS ALREADY ONE OF THE NINE AFRICAN COUNTRIES MOST SEVERELY AFFECTED BY THE EPIDEMIC: MORE THAN 370,000 RWANDANS, ALMOST 13 PERCENT OF THE ADULT POPULATION, ARE LIVING WITH HIV. ABOUT 180,000 OF THEM HAVE DEVELOPED AIDS.

3. HIV PREVALENCE RATES IN URBAN AREAS RANGE FROM 32 PERCENT IN LOW-RISK GROUPS TO 56 PERCENT IN HIGH-RISK GROUPS. RURAL RATES RANGE FROM 10 PERCENT IN LOW-RISK GROUPS TO 11 PERCENT IN HIGH-RISK GROUPS.

4. AIDS CLAIMED 36,000 LIVES IN 1997 AND LIFE EXPECTANCY HAS BEEN REDUCED FROM 54 TO 42 YEARS AS A RESULT OF AIDS. AIDS IS ONE OF THE THREE LEADING CAUSES OF DEATH IN RWANDA. BY 2005, THE CRUDE DEATH RATE WILL BE 40 PERCENT HIGHER THAN IT WAS IN 1990 DUE TO AIDS. DATA CORRELATING HIV AND TB IN RWANDA ARE DATED, BUT INDICATE RATES RANGING FROM 50 PERCENT TO NEARLY 95 PERCENT OF TB PATIENTS INFECTED WITH HIV. ACCORDING TO THE MINISTRY OF HEALTH, THE UNDERLYING CAUSES OF THE EPIDEMIC ARE THE ECONOMIC CRISIS; HIGH RATES OF MULTIPLE SEX PARTNERS; THE EARLY ONSET OF SEXUAL ACTIVITY; THE PRESENCE OF SEXUAL TRANSMITTED INFECTIONS (STIS); THE AVAILABILITY OF COMMERCIAL SEX; AND RESISTANCE TO TALKING ABOUT SEX AND USING CONDOMS. BEFORE THE POLITICAL TURMOIL OF THE MID-1990S, MORE STUDIES HAD BEEN CONDUCTED TO UNDERSTAND THE HIV EPIDEMIC IN RWANDA THAN IN MOST DEVELOPING COUNTRIES. THE PATTERN OF INFECTION WAS A FAMILIAR ONE: HIGH RATES (MORE THAN 27 PERCENT OF PREGNANT WOMEN WERE INFECTED) IN URBAN AREAS, BUT FAR LOWER RATES (JUST OVER 1 PERCENT) IN THE RURAL AREAS THAT WERE HOME TO THE BULK OF THE POPULATION.

5. THE POLITICAL TURMOIL IN RECENT YEARS CHANGED THE SHAPE OF THE EPIDEMIC. A 1997 SURVEY INDICATED THAT THE GAP BETWEEN RURAL AND URBAN HIV PREVALENCE RATES WAS CLOSING. RURAL RATES SOARED FROM 1.3 PERCENT IN 1986 TO NEARLY 11 PERCENT IN 1998.

6. MUCH OF THIS SHIFT IN THE EPIDEMIC CAN BE ASCRIBED TO THE HUGE POPULATION MOVEMENTS DURING AND AFTER THE YEARS OF ETHNIC CONFLICT. NEARLY THREE-QUARTERS OF 4,700 RWANDANS SURVEYED IN 1997 HAD LIVED ELSEWHERE IN THE PRECEEDING THREE YEARS. REFUGEES WHO SPENT THOSE YEARS IN COUNTRIES WITH RELATIVELY STRONG PREVENTION PROGRAMS HAD LOWER RATES OF HIV INFECTION THAN THOSE WHO STAYED IN RWANDA. PEOPLE WHO HAD LIVED IN RWANDAN REFUGEE CAMPS, HOWEVER, ENDURED OVERCROWDING, VIOLENCE, POVERTY, AND DESPAIR CONDITIONS THAT OFTEN LED TO RAPE OR CONSENSUAL BUT UNPROTECTED SEX.

7. THE SOCIAL STRUCTURE WITHIN THE COUNTRY HAS ALSO CHANGED IN WAYS THAT THREATENS TO EXACERBATE THE HIV/AIDS EPIDEMIC. THE WAR BROKE DOWN SOCIAL TABOOS AGAINST PROMISCUITY, AND THE CONSTANT THREAT OF VIOLENCE HAS MADE IT DIFFICULT TO CONVINCE PEOPLE OF

THE SEVERITY OF A DISEASE THAT TAKES YEARS TO DEVELOP. REMAINING MEMBERS OF DECIMATED FAMILIES SEARCH FOR COMPANIONSHIP AND OPPORTUNITIES TO START NEW FAMILIES.

8. IN SOME COMMUNITIES, THE PRE-COLONIAL TRADITION OF POLYGAMY IS BEING REVIVED AS MANY WOMEN WHO LOST THEIR HUSBANDS AND SONS IN THE GENOCIDE NOW SHARE MEN IN ORDER TO HAVE MORE CHILDREN.

HIV/AIDS AND WOMEN
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9. IN RWANDA, AS IN MANY OTHER COUNTRIES, WOMEN'S LOW SOCIAL AND ECONOMIC STATUS, COMBINED WITH GREATER BIOLOGICAL SUSCEPTIBILITY TO HIV, PUT THEM AT GREATER RISK OF INFECTION. DETERIORATING ECONOMIC CONDITIONS, WHICH MAKE IT DIFFICULT FOR WOMEN TO ACCESS HEALTH AND SOCIAL SERVICES, COMPOUND THIS VULNERABILITY.

A. YOUNG WOMEN OF CHILD BEARING AGE (15 TO 24) ARE MORE LIKELY TO BE INFECTED THAN MALES IN THE SAME AGE GROUP.

B. URBAN WOMEN ARE AT MUCH GREATER RISK OF HIV THAN RURAL WOMEN. THIS TREND IS MORE CONSISTENT ACROSS AGE GROUPS FOR WOMEN THAN FOR MEN.

C. IN 1997, 30 PERCENT OF PREGNANT WOMEN IN URBAN ANTENATAL CLINICS TESTED POSITIVE FOR HIV, COMPARED TO 10 PERCENT IN RURAL CLINICS IN THE KIGALI REGION.

D. WOMEN WITH HISTORIES OF STDS (GENITAL SORES) ARE MUCH MORE LIKELY TO BE HIV POSITIVE, 26 PERCENT, THAN THOSE WITH NO SUCH HISTORY, AT ONLY 10 PERCENT SEROPOSITIVE.

E. A 1998 SURVEY OF PROSTITUTES IN THE COUNTRY FOUND THAT 95 PERCENT OF THEM KNOW THE RISKS OF HIV TRANSMISSION AND ONLY 50 PERCENT OF THEM USE CONDOMS, DUE TO OBJECTIONS OF THEIR CUSTOMERS. IN THE SAME SURVEY, 76 PERCENT OF PROSTITUTES TESTED WERE HIV POSITIVE. TWO THIRDS WERE AFRAID TO BE TESTED OR DID NOT KNOW WHERE TO BE TESTED.

F. RAPE HAS NO DOUBT PLAYED A PART IN SPREADING THE

VIRUS IN RWANDA. SOME 3.2 PERCENT OF WOMEN SURVEYED BY UNAIDS AFTER THE WAR REPORTED BEING RAPED, OVER HALF OF THEM DURING THE CONFLICT ITSELF. RAPE WAS USED AS A WEAPON AND MEANS OF HUMILIATION OF WOMEN DURING THE 1994 CONFLICT. WOMEN WHO REPORTED RAPE WERE THREE TIMES AS LIKELY TO HAVE SUFFERED FROM GENITAL SORES AND OTHER SYMPTOMS OF THE STIS THAT INCREASE THE EFFICIENCY OF HIV TRANSMISSION. SEVENTEEN PERCENT OF THE WOMEN WHO HAD BEEN RAPED WERE HIV-POSITIVE, COMPARED WITH 11 PERCENT OF THOSE WHO HAD NOT BEEN RAPED. THIRTY EIGHT PERCENT OF RAPE VICTIMS WERE IN THE 12-19 YEAR AGE GROUP.

CHILDREN AND HIV/AIDS

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10. THE HIV EPIDEMIC HAS A DISPROPORTIONATE IMPACT ON CHILDREN, CAUSING HIGH MORBIDITY AND MORTALITY AMONG INFECTED CHILDREN AND ORPHANING MANY OTHERS. HIGH RATES OF MOTHER TO CHILD TRANSMISSION HAVE CAUSED RWANDA TO COUNSEL MOTHERS AGAINST BREAST-FEEDING. THIS IS A PAINFUL DECISION IN LIGHT OF THE COUNTRY=S HIGH INFANT MORTALITY RATE.

A. APPROXIMATELY 30 TO 40 PERCENT OF INFANTS BORN TO HIV-POSITIVE MOTHERS IN RWANDA AND OTHER AFRICAN COUNTRIES WILL ALSO BECOME INFECTED WITH HIV. DURING THE NEXT 16 YEARS, AIDS IS EXPECTED TO INCREASE RWANDA=S ALREADY HIGH INFANT MORTALITY RATE (130 PER 1,000 LIVE BIRTHS) BY 10 PERCENT.

B. IN 1997, 21 PERCENT OF ALL PEDIATRIC PATIENTS, AND 60 PERCENT OF THOSE WITH MALNUTRITION IN THE KIGALI CENTRAL HOSPITAL WERE HIV POSITIVE. BY THE YEAR 2000, NEARLY 60 PERCENT OF ALL RWANDAN ORPHANS WILL HAVE LOST THEIR PARENTS TO AIDS. IN 2010 THAT PERCENTAGE WILL RISE TO OVER 80 PERCENT.

YOUTH AND HIV/AIDS

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11. SIXTY PERCENT OF THE TOTAL RWANDAN POPULATION IS YOUNGER THAN 20. THE MINISTRY OF HEALTH ESTIMATES THAT THE HIV PREVALENCE RATE AMONG THE SEXUALLY ACTIVE

POPULATION UNDER AGE 20 WAS ALMOST 10 PERCENT IN 1997. THE ADOLESCENTS OF BOTH SEXES WHO HAD NOT GONE TO SCHOOL HAD HIGHER PREVALENCE RATES THAN THOSE WHO HAD ATTENDED SCHOOL. GIRLS AGED 12-14 YEARS WHO HAD NOT RECEIVED EDUCATION HAD A RATE OF 9.4 PERCENT IN CONTRAST TO 5.0 PERCENT AMONG THOSE WHO HAD ATTENDED SCHOOL. FOUR PERCENT OF RWANDANS AGED 12 TO 14 ARE ALREADY INFECTED WITH HIV. AMONG 15-19 YEAR-OLDS, HIV PREVALENCE IS ACTUALLY HIGHER IN RURAL AREAS (8.5 PERCENT) THAN IN CITIES (3.4 PERCENT). IN A POST-WAR SURVEY CONDUCTED BY UNAIDS, TWO OUT OF FIVE RAPE VICTIMS WERE TEENAGERS.

SOCIOECONOMIC AND POLITICAL EFFECTS OF HIV/AIDS

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12. THE HIV/AIDS EPIDEMIC WILL HAVE A SEVERE IMPACT ON THE ECONOMY AND SOCIETY OF A COUNTRY ALREADY OVERBURDENED WITH DEBT AND THE BITTER LEGACY OF A GENOCIDAL CIVIL WAR. IT THREATENS RWANDA'S FOOD SUPPLY, TRADE, AND FUTURE DEVELOPMENT, AS WELL AS THE HEALTH AND WELL-BEING OF ITS PEOPLE. THE ILO ESTIMATES THAT ONLY 52 PERCENT OF RWANDANS ARE ECONOMICALLY ACTIVE. AIDS WILL BE MOST PREVALENT AMONG THIS MOST PRODUCTIVE GROUP. HIV HAS POTENTIAL IMPLICATIONS FOR POLITICAL STABILITY. IN MANY INSTANCES, THE SPREAD OF HIV/AIDS IS A PART OF A CRIPPLING CYCLE AFFECTING LEADERSHIP AND GOVERNANCE. CIVIL STRIFE, REFUGEE FLOWS, URBANIZATION, AND POVERTY ALL PLAY A ROLE IN CREATING CONDITIONS CONDUCIVE TO THE RAPID SPREAD OF HIV/AIDS.

13. THE RWANDAN MILITARY DOES NOT THE CAPABILITY TO SURVEY THE ARMY FOR AN ACCURATE HIV INFECTION RATE, BUT IT WOULD LIKE TO DO PRECISELY THAT. CURRENTLY ALL MILITARY PERSONNEL THAT COME TO KANOMBE MILITARY HOSPITAL ARE TESTED FOR HIV INFECTION. THE TESTING SO FAR HAS REVEALED AN ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) INFECTION RATE IN THE MILITARY OF AN ESTIMATED 14 PERCENT. THE RWANDAN MILITARY ATTRIBUTES THIS RATE TO SEVERAL REASONS. FIRST IS THE COMMAND EMPHASIS GIVEN TO THE PROBLEM SINCE THE ARMY WAS CREATED IN 1990. COMMANDERS REGULARLY BRIEF THEIR SOLDIERS ON PREVENTION OF HIV, AND CONDOMS ARE READILY AVAILABLE IN

ALL UNITS. SECOND, A LARGE PART OF THE CURRENT ARMY HAD VERY LITTLE CONTACT WITH CIVILIAN POPULATIONS FROM 1990 THROUGH 1993. IT IS TRUE THAT SOME SENIOR COMMANDERS HAVE BECOME AIDS VICTIMS IN THE RECENT PAST, AND THERE ARE PROBABLY OTHERS WHO ARE INFECTED, HOWEVER, THIS IS NOT LIKELY TO SERIOUSLY DEGRADE COMMAND AND CONTROL OF THE ARMY, SINCE RWANDA CONTINUES TO SEND FIELD GRADE OFFICERS TO PROFESSIONAL DEVELOPMENT SCHOOLS THROUGHOUT THE WORLD, ENSURING A NUCLEUS OF WELL-TRAINED OFFICERS FOR THE FUTURE. WHATEVER THE TRUE RATE OF INFECTION IS, THE RWANDAN MILITARY HOPES TO DECREASE THE HIV INFECTION RATE IN THE FUTURE. THIS, HOWEVER, MAY BE COMPLICATED BY CURRENT EXTENDED DEPLOYMENTS OF UNITS WITHIN THE DEMOCRATIC REPUBLIC OF CONGO (DROC), AND THE RATE OF INFECTION MIGHT IN FACT INCREASE.

14. HIV/AIDS CAN DEAL A CRUSHING BLOW TO FAMILIES STRUGGLING TO SURVIVE. NEARLY ALL OF RWANDA'S POPULATION IS ENGAGED IN SUBSISTENCE AGRICULTURE. MINISTRY OF HEALTH STUDIES HAVE SHOWN THAT THE INCOME OF A FAMILY DROPS SIGNIFICANTLY WHEN ONE OR BOTH PARENTS ARE INFECTED WITH HIV. FAMILIES ARE FORCED TO SELL OR LEASE THEIR HOMES, AND SOME ARE UNABLE TO AFFORD FOOD AND OTHER NECESSITIES. IN A 1996 STUDY, 20 PERCENT OF HIV-POSITIVE PEOPLE SURVEYED REPORTED HAVING REDUCED FOOD RESOURCES. THIS PERCENTAGE IS LIKELY TO INCREASE AS MORE AND MORE HIV-POSITIVE PEOPLE DEVELOP AIDS.

15. RWANDA'S HEALTHCARE SYSTEM IS ALSO POORLY EQUIPPED TO COPE WITH THE EFFECTS OF THE EPIDEMIC. IN 1998, 2.7 PERCENT OF THE RECURRENT BUDGET (0.3 PERCENT OF THE GDP) WAS SPENT ON HEALTH. A PERCENTAGE EXPECTED TO RISE TO 4 PERCENT OF THE RECURRENT BUDGET IN 1999. FORTY-THREE PERCENT OF THE COUNTRY'S HEALTH EXPENDITURE IS FINANCED BY THE GOVERNMENT, 38 PERCENT BY EXTERNAL AID, AND 22 PERCENT BY THE GENERAL POPULATION. THE NUMBER OF HOSPITAL BEDS OCCUPIED BY PEOPLE LIVING WITH HIV/AIDS ROSE FROM 9,000 IN 1993 TO 35,600 IN 1997. THIS ACCOUNTS FOR AN ESTIMATED 50 PERCENT OF HOSPITAL CAPACITY OCCUPIED BY AIDS RELATED CASES. AS HIV/AIDS EPIDEMIC INCREASES; THE NUMBER OF PATIENTS MAY OVERWHELM THE HEALTHCARE SYSTEM LEADING TO AN INCREASE IN TOTAL NATIONAL EXPENDITURE BOTH IN ABSOLUTE TERMS AND AS A PROPORTION OF THE NATIONAL PRODUCT. THE NET EFFECT WILL BE TO INCREASE THE PRICE AND REDUCE THE AVAILABILITY OF HEALTH CARE TO

EVERYONE, WHICH WILL TEND TO AFFECT THE POOR THE MOST.

16. INTERVENTIONS-NATIONAL RESPONSE: IN 1986 RWANDA'S MINISTRY OF HEALTH CREATED A NATIONAL COMMISSION FOR AIDS AND DEVELOPED AN INTENSIVE HIV/AIDS EDUCATION CAMPAIGN IN COLLABORATION WITH THE RWANDAN RED CROSS. IN FEBRUARY 1987 THE RWANDAN GOVERNMENT, IN COOPERATION WITH THE WORLD HEALTH ORGANIZATION(WHO) GLOBAL PROGRAM ON AIDS, DEVELOPED THE FIRST MEDIUM TERM PLAN FOR THE PREVENTION AND CONTROL OF THE DISEASE. THE FIRST MEDIUM TERM PLAN (1988-1992) TARGETED BLOOD TRANSFUSION SAFETY, PREVENTIVE HEALTH EDUCATION, AND EPIDEMIOLOGICAL SURVEILLANCE. THE PROGRAM WAS WELL ESTABLISHED, WITH BOTH EXTERNAL AND INTERNAL SUPPORT. IN THE POST-CRISIS PERIOD, THE MINISTRY OF HEALTH RENEWED ITS COMMITMENT TO DECENTRALIZING THE HEALTH CARE SYSTEM, AND THE GOVERNMENT MADE HIV/AIDS PREVENTION A PRIORITY IN ALL ITS ECONOMIC AND PUBLIC INVESTMENT PROGRAMS. IN ADDITION TO PREVENTING THE SPREAD OF HIV, THE CHALLENGE FOR THE SECOND MEDIUM TERM PLAN (1993-1997) WAS TRYING TO MINIMIZE THE SOCIO-ECONOMIC IMPACT OF AIDS ON AFFECTED INDIVIDUALS AND FAMILIES. IN 1997 THE MINISTRY OF HEALTH RESTRUCTURED THE NATIONAL AIDS CONTROL PROGRAM (PNLS IN FRENCH) TO ACT SOLELY AS A COORDINATION AND RESEARCH BODY. PLANNING, RESOURCE MANAGEMENT, AND SERVICE DELIVERY ARE THE RESPONSIBILITY OF HEALTH DISTRICTS. DECENTRALIZATION OF THESE FUNCTIONS SHOULD MAKE STI AND HIV SERVICES AVAILABLE TO RURAL POPULATIONS FOR THE FIRST TIME, BUT THE AVAILABILITY AND QUALITY OF THESE SERVICES REMAINS LIMITED.

17. TODAY HIV/AIDS IS CONSIDERED A NATIONAL PRIORITY. THERE IS A STRONG COMMITMENT AT THE HIGHEST LEVELS OF GOVERNMENT, AS WELL AS THE CHURCH, TO OPENLY TALK ABOUT HIV/AIDS AS A NATIONAL TRAGEDY. RWANDA IS CURRENTLY THE HEADQUARTERS OF THE GREAT LAKES AIDS INITIATIVE (GLAI). THIS IS AN INITIATIVE TO COMBAT THE SPREAD OF HIV/AIDS ALONG THE TRADE ROUTES IN THE GREAT LAKES.

18. THE OVERALL MINISTRY OF HEALTH BUDGET RECEIVED A 23 PERCENT INCREASE IN 1998/1999. IN THE PROJECTED BUDGET FOR THE YEAR 1999/2000, AIDS AND AIDS RELATED ACTIVITIES GOT AN INCREASE OF 80 PERCENT, WITH PARTICULAR EMPHASIS ON BEHAVIOR CHANGE.

19. THE PNLS RECENTLY FINISHED ITS THREE-YEAR STRATEGIC PLAN FOR 1999-2001, AS WELL AS A NATIONAL HIV/AIDS PREVENTION AND COMMUNICATION STRATEGY.

PRIORITY AREAS OF THE NATIONAL STRATEGIC PLAN ARE TO:

A. MAINTAIN 100 PERCENT SAFE BLOOD TRANSFUSION.
B. REDUCE STI PREVALENCE AMONG THE GENERAL POPULATION AND AT-RISK GROUPS, INCLUDING THE MILITARY, TRUCK DRIVERS, AND SEX WORKERS.
C. REDUCE VULNERABILITY TO HIV AND OTHER STIS.
D. REDUCE THE NUMBER OF PEOPLE WHO DEPEND ON SEX FOR THEIR LIVELIHOOD.
E. PROVIDE VOLUNTARY COUNSELING AND TESTING SERVICES.
F. STRENGTHEN CARE AND SUPPORT SERVICES FOR PLWHA AND ORPHANS.
G. MOBILIZE AND SUPPORT NON-GOVERNMENTAL, RELIGIOUS, AND COMMUNITY-BASED ORGANIZATIONS TO IMPLEMENT HIV/AIDS AND STI ACTIVITIES.
H. REDUCE MOTHER-TO-CHILD TRANSMISSION OF HIV.

DONOR SUPPORT
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20. MANY MULTILATERAL AND BILATERAL DONORS ARE ACTIVELY ENGAGED IN HIV/AIDS PROGRAMS IN RWANDA (SEE BELOW). TO REDUCE HIV TRANSMISSION, USAID HAS BEEN WORKING COLLABORATIVELY WITH UNAIDS, WHO, UNICEF, AND THE BELGIUM COOPERATION. DUE TO THE TRANSITION FROM EMERGENCY TO DEVELOPMENT IN RWANDA AND THE MULTITUDE OF ACTORS IN THE HEALTH SECTOR, CLEAR AND COMPLETE DATA ARE DIFFICULT TO OBTAIN. THE MINISTRY OF HEALTH AND DONORS ARE MAKING A CONCERTED EFFORT TO IMPROVE COORDINATION AND JOINT PLANNING WITHIN A COMMON FRAMEWORK. HOWEVER, ESTIMATED SUPPORT FROM THE DONOR COMMUNITY FOR THE NATIONAL STRATEGY IN 1996-97 WAS USD 10.8 MILLION. OF THAT, THE U.S. CONTRIBUTED USD 3 MILLION.

A. BILATERAL ORGANIZATIONS CONTRIBUTIONS: USAID HAS SUPPORTED HIV/AIDS ACTIVITIES SINCE 1993. USAID/RWANDA WAS THE FIRST BILATERAL MISSION TO RESUME DEVELOPMENT PROGRAMMING IN THE COUNTRY IN 1994, THROUGH FAMILY HEALTH INTERNATIONAL AIDS CONTROL AND PREVENTION (AIDSCAP) PROJECT. PROMPT USAID ASSISTANCE IN THE HEALTH SECTOR MADE IT POSSIBLE TO RE-ESTABLISH THE NATIONAL HIV/AIDS PROGRAM AND LAUNCH HIV AND STI PREVENTION, EDUCATION, AND SOCIAL MARKETING ACTIVITIES THROUGHOUT THE COUNTRY IN THE POST-WAR PERIOD. IN MARCH

1997, USAID INITIATED A TRANSITION PLAN IN WHICH EMERGENCY RELIEF WAS SCALED DOWN AND DEVELOPMENT ASSISTANCE FOCUSED ON REBUILDING CAPACITY IN THE HEALTH, JUSTICE, AND AGRICULTURAL SECTORS. USD 2.2 MILLION WAS DEDICATED TO HIV/AIDS ACTIVITIES IN FY 1997, AND USD 2 MILLION IN 1998. USAID'S FY1999 BUDGET FOR HIV/AIDS ACTIVITIES IS USD 3 MILLION. USAID/RWANDA IS WORKING TO INCREASE THE USE OF HEALTH SERVICES AND CHANGE BEHAVIOR RELATED TO HIV/AIDS, STIS, AND MATERNAL-CHILD HEALTH. MAJOR USAID COOPERATING AGENCIES INCLUDE FAMILY HEALTH INTERNATIONAL, CARE, AND POPULATION SERVICES INTERNATIONAL. HIV/AIDS ACTIVITIES IN THE MISSIONS INTEGRATED PLAN FOR 1997-1999 INCLUDE: TECHNICAL ASSISTANCE TO REGIONAL AND DISTRICT MEDICAL TEAMS TO PLAN AND MANAGE THE INTEGRATION OF HIV/AIDS AND STI SERVICES INTO EXISTING HEALTH SERVICES; DEVELOPMENT OF TOOLS, METHODOLOGIES AND MATERIALS TO IMPROVE THE QUALITY OF SERVICES; TRAINING OF HEALTH WORKERS, COUNSELORS, LOCAL LEADERS, AND HIV/AIDS EDUCATORS; SUPPORT FOR REGIONAL ASSISTANCE TO LOCAL PROGRAMS, INCLUDING COMMUNITY-BASED EDUCATION AND AWARENESS RAISING; CONTINUED SUPPORT TO A NON-GOVERNMENTAL ORGANIZATION (NGO) TO DEVELOP A SUSTAINABLE MODEL FOR PEER EDUCATION IN ONE REGION THAT WILL BE REPLICABLE IN OTHER REGIONS; AND FUNDING PROGRAMS THROUGH CHURCH ORGANIZATIONS WITHIN THE COUNTRY TO EDUCATE YOUNG CHILDREN AND THE YOUTH IN THE PREVENTION OF HIV/AIDS. IN COLLABORATION WITH THE WORLD BANK AND THE MINISTRY OF HEALTH (MOH), USAID/RWANDA ESTABLISHED A LOCAL NON-PROFIT NGO CENTER MANAGED BY RWANDANS. THE SERVICES OF THE CENTER WILL INCLUDE DESIGN AND PRODUCTION OF EDUCATION MATERIALS TO PREVENT THE SPREAD OF HIV/AIDS.

B. UN AGENCIES, COORDINATED BY UNAIDS, PROVIDE THE MAJORITY OF ALL FINANCIAL ASSISTANCE. SUPPORT FROM UNAIDS COSPONSORS IN 1996-97 TOTALED NEARLY USD 23 MILLION WITH THE WORLD BANK PROVIDING THREE FOURTHS OF THIS AMOUNT THROUGH ITS OVERALL HEALTH SECTOR REFORM. A PROJECT FUNDED BY THE WORLD BANK AND INTERNATIONAL MONETARY FUND AIMS TO IMPROVE THE EFFICIENCY OF THE NATIONAL PRIVATE HEALTH SYSTEM AND EXPAND USE OF HEALTH SERVICES, INCLUDING THOSE IN SUPPORT OF NATIONAL POPULATION AND NUTRITION STRATEGIES.

C. OTHER GOVERNMENT SPONSORED INTERVENTIONS NGOS ALSO

RECEIVE FUNDING FROM A VARIETY OF SOURCES AND CONDUCT MOST OF HIV/AIDS PREVENTION AND CARE ACTIVITIES IN RWANDA.

21. IN APRIL THIS YEAR, THE RWANDAN GOVERNMENT STARTED A PROGRAM OF ANTI-VIRAL TRIPLE THERAPY FOR PATIENTS WITH AIDS. THE GOVERNMENT IMPORTS THE MEDICINES AND THE PATIENTS PAY FOR IT. TREATMENT COSTS $475.00 PER MONTH. ONLY 140 WEALTHY RWANDANS ARE FOLLOWING THIS THERAPY. PATIENTS ARE KEPT ON AIDS MEDICATION AS LONG AS THEY REMAIN ALIVE.

22. THROUGH AN UNICEF SPONSORED PROJECT, PREGNANT WOMEN ARE GIVEN AZT AT NO CHARGE IN ORDER TO REDUCE VERTICAL TRANSMISSION TO THE UNBORN CHILD. THE MINISTRY OF HEALTH HAS EXPRESSED INTEREST IN INITIATING OTHER PREVENTIVE THERAPY AT THE TIME OF LABOR, FOLLOWING ENCOURAGING TRIAL RESULTS IN UGANDA. USAID AND OTHER ORGANIZATIONS ARE CURRENTLY EXAMINING THE COMPLICATED ISSUES SURROUNDING SUCH DRUG THERAPY AND ARE PREPARING APPROPRIATE POLICIES.

THE FUTURE
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23. ALTHOUGH AIDS AWARENESS IN RWANDA HAS BEEN SLOWER TO DEVELOP THAN IN SOME COUNTRIES IN THE REGION, IT IS NOT TOO LATE FOR AN EFFECTIVE RESPONSE TO THE HIV/AIDS EPIDEMIC IN RWANDA. USAID IS CURRENTLY PROVIDING LEADERSHIP ROLE IN ITS SUPPORT TO THE RWANDAN MINISTRY OF HEALTH IN THE FIGHT AGAINST HIV/AIDS. ALSO NGOS, CHURCHES, WOMEN'S GROUPS, BUSINESSES, MICRO-ENTERPRISE, AND COMMUNITY GROUPS HAVE SHOWN THAT THEY CAN PLAY AN IMPORTANT ROLE IN HIV PREVENTION AND CARE.

WORLD AIDS DAY OBSERVANCES IN RWANDA
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24. EVENTS MARKING WORLD AIDS DAY IN RWANDA TARGETED ADOLESCENTS AND YOUNG PEOPLE UNDER THE AGE OF 25 AND ENCOURGAGED THEM TO SPEAK OUT ABOUT HIV/AIDS AND TO EDUCATE THEMSELVES AND OTHERS TO HELP STOP ITS SPREAD. T-SHIRTS AND BANNERS WITH THE SLOGAN," NIYEMEJE KWIRINDA SIDA, NKENEYE KUBAHO! I AM COMMITTED TO PROTECTING MYSELF AGAINEST AIDS, I WANT TO LIVE!" WERE

DISTRIBUTED THROUGHOUT THE COUNTRY TO GROUPS PARTICIPATING IN THE DAY'S EVENTS.

IN KIGALI, THOUSANDS OF YOUNG PEOPLE MARCHED IN THE NATIONAL STADIUM IN THE PRESENCE OF GOVERNMENT MINISTRIES, MEMBERS OF PARLIAMENT, DIPLOMATS, MEMBERS OF THE INTERNATIONAL COMMUNITY AND GENERAL PUBLIC. THE GUEST SPEAKER WAS THE WIFE OF THE VICE PRESIDENT. IN HER SPEECH, SHE CALLED ON PARENTS, TEACHERS AND RELIGIOUS LEADERS TO BREAK THE CULTURAL BARRIERS AND START TALKING OPENLY TO THEIR CHILDREN ABOUT SEXUALITY, CONDOM USE AND OTHER SAFE SEXUAL PRACTICES BECAUSE NOT DOING SO WOULD BE A DISERVICE TO THE COUNTRY'S FUTURE GENERATIONS.

THE HIGHLIGHT OF THE CEREMONY WAS MARKED BY A DECLARATION BY THE NATIONAL YOUTH COUNCIL, "WE THE RWANDAN YOUTHS GATHERED HERE BEFORE YOU AND THE RWANDAN PEOPLE, HEREBY SWEAR IN THE NAME OF GOD, THAT THROUGH OUR ELECTED COUNCILS, WE SHALL USE OUR POWER TO LISTEN AND TO LEARN TO PROTECT OURSELVES, OUR FRIENDS AND OTHER RWANDANS AGAINST HIV/AIDS BECAUSE ALL TOGETHER, WE NEED TO LIVE. WE SHALL HELP TO ADVOCATE FOR CARE OF THOSE WHO ARE INFECTED AND THOSE WHO ARE ORPHANED AND WIDOWED BY HIV/AIDS. WE ARE DETERMINED TO WORK WITH THE COUNTRY'S LEADERSHIP THROUGH A MULTI-SECTORAL APPROACH, TO SUPPORT DIFFERENT PROGRAMS AND STRATEGIES AIMED AT ERADICATING THE AIDS VIRUS IN OUR SOCIETY".

SPEECHES BY POLITICAL LEADERS CLEARLY REFLECT THE FACT THAT AIDS IS NOW WIDELY ACCEPTED AS NOT ONLY A CATASTROPHIC HEALTH PROBLEM BUT AS A VERY REAL CONSTRAINT TO DEVELOPMENT. WITH ADDITIONAL FINANCIAL AND TECHNICAL ASSISTANCE, THESE GROUPS COULD BE MOBILIZED TO EXPAND PROVEN INTERVENTIONS ON A NATIONAL SCALE.

25. LONG-TERM GOVERNMENT POLICY SHOULD ADDRESS THE UNDERLYING CAUSES OF HEALTH PROBLEMS, INCLUDING INADEQUATE HOUSING, SANITATION, WATER, AND NUTRITION. MEASURES ARE NEEDED TO ENSURE A SAFE AND SUFFICIENT BLOOD SUPPLY. LEGISLATION AND ENFORCEMENT ARE REQUIRED TO PROTECT THE HUMAN RIGHTS OF PERSONS LIVING WITH HIV/AIDS. RWANDA NEEDS TRAINING, TECHNICAL ASSISTANCE, AND RESOURCES IN ORDER TO MEET THE INCREASING DEMAND FOR VOLUNTARY HIV COUNSELING AND TESTING.

26. THE WHITE HOUSE HAS ANNOUNCED A NEW PRESIDENTIAL AIDS IN AFRICA INITIATIVE, " LIFE (LEADERSHIP AND INVESTMENT IN FIGHTING AN EPIDEMIC)" WHICH WILL PROVIDE AN ADDITIONAL DOLS 100 MILLION FOR AIDS PREVENTION AND CARE PROGRAMS IN THE CONTINENT. THE RWANDAN MINISTRY OF HEALTH HAS PREVIOUSLY SOLICITED USAID ASSISTANCE FOR A NUMBER OF PRIORITY INITIATIVES FOR WHICH SUFFICIENT FUNDS WERE UNAVAILABLE. THE USAID MISSION HAS THEREFORE PREPARED AN OUTLINE OF SUPPLEMENTAL HIV/AIDS PROGRAM ACTIVITIES IT PROPOSES TO UNDERTAKE WHEN LIFE FUNDS ARE MADE AVAILABLE TO RWANDA. (THIS PROGRAM WILL BE DESCRIBED IN A SEPTEL). GIVEN RWANDA'S STRATEGIC IMPORTANCE AND IMPACT ON SECURITY IN THE REGION, ITS HIGH HIV PREVALENCE, AND ITS FIRM COMMITMENT TO COMBAT AIDS AT THE HIGHEST POLITICAL LEVELS, THE POST ANTICIPATES THAT RWANDA WILL FIGURE PROMINENTLY IN THE ALLOCATION OF LIFE RESOURCES. STAPLES#######

RWANDA AND HIV/AIDS

Country Profile

Rwanda is the most densely populated country in Africa. More than 90 percent of the population live in rural areas. Rwanda is also one of the poorest countries on the continent, with a gross domestic product (GDP) per capita of $250.

At the end of 1996, Rwanda's external debt stood at $1.1 billion, or 83 percent of the GDP. High debt service is affecting the country's ability to devote resources to health care. The post-genocide government, now in its fifth year of rule, is still struggling to rebuild a civil society, reintegrate hundreds of thousands of recently returned refugees, ensure food security, and provide basic public services. Extreme poverty, ethnic tensions and loss of human resources due to death and detention have multiplied Rwanda's development challenges. The World Bank estimates that Rwanda's GNP was more than halved in this decade, from $373 in 1990 to $179 in 1996.

The civil war completely destroyed Rwanda's extensive network of health centers and hospitals. Since the end of the war in July 1994, the government has received financial and technical support from the international community to rebuild its health infrastructure.

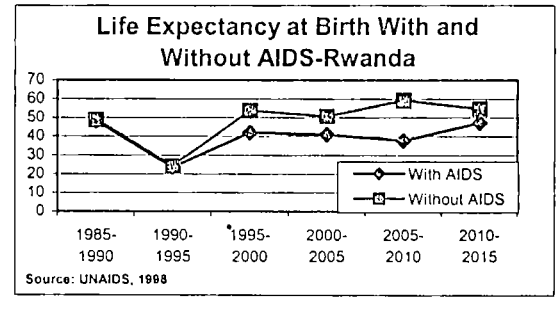
Overall health in Rwanda remains poor, with only 27 percent of Rwandans living within a one-hour walk of a health center. Infectious diseases—malaria, respiratory infections, HIV/AIDS and other sexually transmitted infections (STIs), and diarrhea—were the predominant cause of morbidity and mortality in 1998.

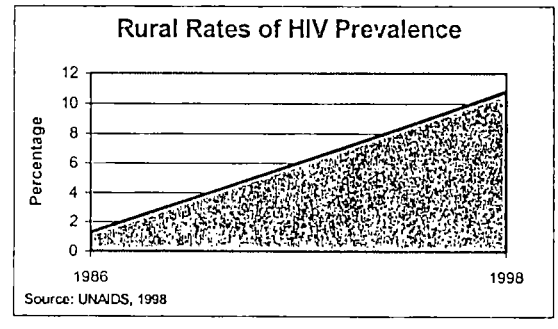
Rwanda is currently designing and implementing a comprehensive model of health reform. USAID is working with the Rwandan government to improve stability and increase human and physical capacity so that Rwanda can initiate effective sectoral reforms, implement major structural adjustment, and attract significant private sector investments.

HIV/AIDS in Rwanda

The Joint United Nations Programme on AIDS (UNAIDS) reports that Rwanda is already one of the nine African countries most severely affected by the epidemic:

- More than 370,000 Rwandans—almost 13 percent of the adult population—are living with HIV. About 180,000 of them have developed AIDS.
- HIV prevalence rates in urban areas range from 32 percent in low-risk groups to 56 percent in high-risk groups. Rural rates range from 10 percent in low-risk groups to 11 percent in high-risk groups.
- AIDS claimed 36,000 lives in 1997.
- AIDS is one of the three leading causes of death in Rwanda. By 2005, the crude death rate will be 40 percent higher due to AIDS than it was in 1990.
- Life expectancy has been reduced from 54 to 42 years as a result of AIDS.





- Data correlating HIV and TB in Rwanda are dated, but indicate rates ranging from 50% to nearly 95% of TB patients infected with HIV.

According to the Ministry of Health, the underlying causes of the epidemic are the economic crisis; high rates of multiple sex partners; the early onset of sexual activity; the presence of STIs; the availability of commercial sex; and resistance to talking about sex and using condoms.

Before the political turmoil of the mid-1990s, more studies had been conducted to understand the HIV epidemic in Rwanda than in most developing countries. The pattern of infection was a familiar one: high rates (more than 27 percent of pregnant women infected) in urban areas, but far lower rates (just over 1 percent) in the rural areas that were home to the bulk of the population.

The political turmoil in recent years changed the shape of the epidemic. A 1997 survey indicated that the gap between rural and urban HIV prevalence rates was closing. Rural rates soared from 1.3 percent in 1986 to nearly 11 percent in 1998.

Much of this shift in the epidemic can be ascribed to the huge population movements during and after the years of ethnic conflict. Nearly three-quarters of 4,700 Rwandans surveyed in 1997 had lived elsewhere in the preceding three years. Refugees who spent those years in countries with relatively strong prevention programs had lower rates of HIV infection than those who stayed in Rwanda. People who had lived in Rwandan refugee camps, however, endured overcrowding, violence, poverty, and despair—conditions that often led to rape or consensual but unprotected sex.

The social structure within the country has also changed in ways that threaten to exacerbate the HIV/AIDS epidemic. The war broke down social taboos against promiscuity, and the constant threat of violence has made it difficult to convince people of the severity of a disease that takes years to develop. Remaining members of decimated families search for companionship and opportunities to start new families. In some communities, the pre-colonial tradition of polygamy is being revived as many women who lost their husbands and sons in the fighting now share men in order to have more children.

HIV/AIDS and Women

- In 1997, 30 percent of pregnant women in urban Kigali antenatal clinics and 15% in other regions tested positive for HIV, compared to 10 percent in rural clinics
- Young women of childbearing age (15 to 24) are more likely to be infected than males in the same age group.
- Women with histories of STDs (genital sores) are much more likely to be HIV positive, 26%, than those with no such history, at only 10 percent seropositive.
- While 95% of prostitutes know the risks of HIV transmission, only 50% use condoms, due to objections of their customers.
- Seventy six percent of prostitutes tested are HIV positive.

In Rwanda, as in many other countries, women's low social and economic status, combined with greater biological susceptibility to HIV, put them at greater risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound this vulnerability.

Urban women are at much greater risk of HIV than rural. This trend is more consistent across age groups for women than for men.

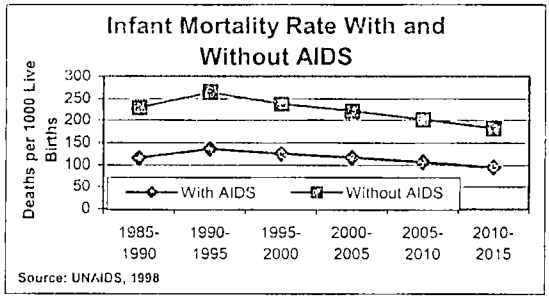
"When men are told they are HIV-positive," says Dr. Maria Neira, a UN volunteer who was a physician for the local and expatriate community of the United Nations system in Kigali, "some get very angry and deliberately sleep with as many women as they can to contaminate them."

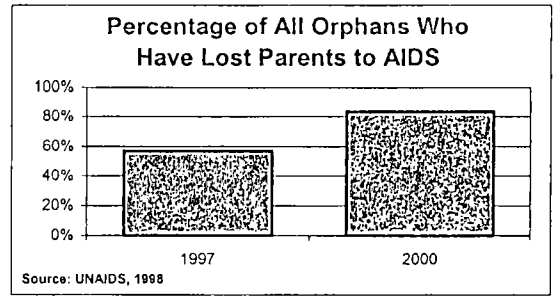
Rape—inside or outside refugee camps—has no doubt played a part in spreading the virus in Rwanda. Some 3.2 percent of women surveyed by UNAIDS after the war reported being raped—over half of them during the conflict itself. Rape was used as a weapon and means of humiliation of women during the 1994 conflict. Women who reported rape were three times as likely to have suffered from genital sores and other symptoms of the STIs that increase the efficiency of HIV transmission. Seventeen percent of the women who had been raped were HIV-positive, compared with 11 percent of those who had not been raped. Thirty eight percent of rape victims were in the 12-19 year age group.

Children and HIV/AIDS

The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality among infected children and orphaning many others. High rates of mother to child transmission have caused Rwanda to counsel mothers against breast-feeding. This is a painful decision in light of the country's high infant mortality rate.

- Approximately 30 to 40 percent of infants born to HIV-positive mothers in Rwanda and other African countries will also become infected with HIV.
- During the next 16 years, AIDS is expected to increase Rwanda's already high infant mortality rate (130 per 1,000 live births) by 10 percent.
- In 1997, 21% of all pediatric patients, and 60% of those with malnutrition in the Kigali Central Hospital were HIV positive.
- At the end of 1997, there were 94,000 AIDS orphans living in Rwanda.
- By the year 2000, nearly 60 percent of all Rwandan orphans will have lost their parents to AIDS. In 2010 that percentage will rise to over 80 percent.





Youth and HIV/AIDS

Sixty percent of the total Rwandan population is younger than 20. The Ministry of Health estimates that the HIV prevalence rate among the sexually active population under age 20 was almost 10 percent in 1997.

The adolescents of both sexes who had not gone to school had higher prevalence rates than those who had attended school. Girls aged 12-14 years who had not received education had a rate of 9.4% in contrast to 5.0% among those who had attended school.

- Four percent of Rwandans ages 12 to 14 are already infected with HIV.
- Among 15- to 19- year-olds, HIV prevalence is actually higher in rural areas (8.5 percent) than in cities (3.4 percent).
- In a post-war survey conducted by UNAIDS, two out of five rape victims were teenagers.

Socioeconomic and political Effects of HIV/AIDS

The HIV/AIDS epidemic will have a severe impact on the economy and society of a country already overburdened with debt and the bitter legacy of a genocidal civil war. It threatens Rwanda's food supply, trade, and future development, as well as the health and well-being of its people. The ILO estimates that only 52% of Rwandans are economically active. AIDS will be most prevalent among this most productive group.

HIV has potential for implications for political stability. In many instances, the spread of HIV/AIDS is a part of a crippling cycle affecting leadership and governance. Civil strife, refugee flows, urbanization, and poverty all play a role in creating conditions conducive to the rapid spread of HIV/AIDS.

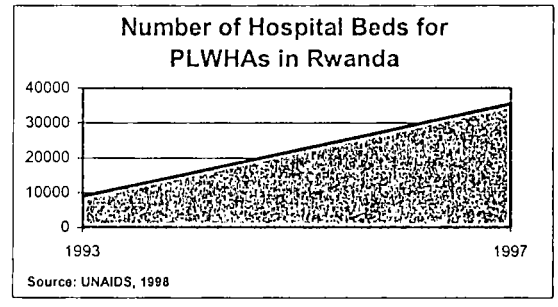
The high HIV/AIDS infection rates in the military personnel of the country including officers as well as enlisted personnel, will result in national security threats as military command structures are diminished and depleted by the disease. A 1998 UNAIDS report entitled "AIDS and Military" states that military HIV infection rates in the country are three to four times higher than in the civilian population. A strong correlation found between rank and prevalence rates indicated that as the disease progresses, the military will suffer from debilitated leadership and inability to meet military needs and commitments. The Rwandan military is currently developing a three-year action plan to combat AIDS in collaboration with the Ministry of Health.

HIV/AIDS can deal a crushing blow to families struggling to survive. Nearly all of Rwanda's population is engaged in subsistence agriculture, yet with the limited land per family in this densely populated country, more than half of these households do not produce enough for their families. Chronic malnutrition has become endemic. One USAID-supported study found that about 30 percent of children in several age groups were either moderately or severely malnourished.

Ministry of Health studies have shown that the income of a family drops significantly when one or both parents are infected with HIV. Families are forced to sell or lease their homes, and some are unable to afford food and other necessities. In a 1996 study, 20 percent of HIV-positive people surveyed reported having reduced food resources. This percentage is like to increase as more and more HIV-positive people develop AIDS.

Rwanda's healthcare system is also poorly equipped to cope with the effects of the epidemic. In 1998, 2.7 percent of the recurrent budget (0.3 percent of the GDP) was spent on health—a percentage expected to rise to 4 percent of the recurrent budget in 1999. Forty-three percent of the country's health expenditure is financed by the government, 38 percent by external aid, and 22 percent by the general population.

The number of hospital beds occupied by people living with HIV/AIDS (PLWHA) rose from 9,000 in 1993 to 35,600 in 1997. This accounts for an estimated 50% of hospital capacity



occupied by AIDs related cases.

As HIV/AIDS epidemic increases, the number of patients will overwhelm the healthcare systems leading to an increase in total national expenditure both in absolute terms and as a proportion of the national product. The net effect will be to increase the price and reduce the availability of health care to everyone, which will tend to affect the poor the most.

Interventions

National Response

In 1986 Rwanda's Ministry of Health created a National Commission for AIDS and developed an intensive HIV/AIDS education campaign in collaboration with the Rwandan Red Cross.

In February 1987 the Rwandan government, in cooperation with the World Health Organization's (WHO) Global Programme on AIDS, developed the First Medium Term plan (MPTI) for the prevention and control of the disease. The First Medium Term Plan (1988-1992) targeted blood transfusion safety, preventive health education, and epidemiological surveillance. The program was well established, with both external and internal support.

In the post-crisis period, the Ministry of Health renewed its commitment to decentralizing the health care system, and the government made HIV/AIDS prevention a priority in all its economic and public investment programs. In addition to preventing HIV, the challenge for the Second Medium Term Plan (1993-1997) was trying to minimize the socioeconomic impact of AIDS on affected individuals and families.

In 1997 the Ministry of Health restructured the Programme National de Lutte Contre le SIDA (PNLS) to act solely as a coordination and research body. Planning, resource management, and service delivery are the responsibility of health districts. Decentralization of these functions should make STI and HIV services available to rural populations for the first time, but the availability and quality of these services remains limited.

Today HIV/AIDS is considered a national priority. There is a strong commitment at the highest levels of government, as well as the church, to openly talk about HIV/AIDS as a national tragedy.

The overall Ministry of Health budget received a 23 percent increase in 1999, with a particular emphasis on HIV/AIDS. The PNLS recently finished its three-year strategic plan for 1999-2001, as well as a national HIV/AIDS prevention and communication strategy. Priority areas of the national strategic plan are to:

- Maintain 100 percent safe blood transfusion.
- Reduce STI prevalence among the general population and at-risk groups, including the military, truck drivers, and sex workers.
- Reduce vulnerability to HIV and other STIs.
- Reduce the number of people who depend on sex for their livelihood.
- Provide voluntary counseling and testing (VCT) services.
- Strengthen care and support services for PLWHA and orphans.
- Mobilize and support nongovernmental, religious, and community-based organizations to implement HIV/AIDS and STI activities.
- Reduce mother-to-child transmission of HIV.

Donors

Many multilateral and bilateral donors are actively engaged in HIV/AIDS programs in Rwanda (see next page). To reduce HIV transmission, USAID has been working collaboratively with UNAIDS, WHO, UNICEF, and the Belgium Cooperation.

Organization	Amount US$ 1996-97
Germany (period covered unknown)	4,700,000
USAID	3,000,000
Luxembourg	1,300,000
EU	1,000,000
Belgium	800,000
Total	**10,800,000**

Bilateral organizations' contributions

USAID has supported HIV/AIDS activities since 1993. USAID/Rwanda was the first bilateral mission to resume development programming in the country in 1994, through Family Health International's AIDS Control and Prevention (AIDSCAP) Project. Prompt USAID assistance in the health sector made it possible to re-establish the national HIV/AIDS program and launch HIV and STI prevention, education, and social marketing activities throughout the country in the post-war period. In March 1997, USAID initiated a transition plan in which emergency relief was scaled down and development assistance focused on rebuilding capacity in the health, justice, and agricultural sectors. One million dollars was dedicated to HIV/AIDS activities in FY 1997. USAID's FY1999 budget for HIV/AIDS activities is $3,000,000.

USAID/Rwanda is working to increase the use of health services and change behaviors related to HIV/AIDS, STIs, and maternal-child health. HIV/AIDS activities in the mission's integrated plan for 1997-1999 include:

1. Technical assistance to regional and district medical teams to plan and manage the integration of HIV/AIDS and STI services into existing health services.
2. Development of tools, methodologies and materials to improve the quality of services.
3. Training.
4. Support for regional assistance to local programs, including community-based education and awareness raising.
5. Continued support to a nongovernmental organization (NGO) to develop a sustainable model for peer education in one region that will be replicable in other regions.
6. Funding programs through church organizations within the country to educate young children and the youth in the prevention of HIV/AIDS.
7. The USAID AIDSMARK in collaboration with the World Bank and the Ministry of Health (MOH) are helping to establish a local non-profit NGO managed by Rwandans. (The Rwanda Center for Health Communications) The services of the center will be design and production of education materials to prevent the spread of HIV/AIDS.

UNAIDS has a coordinating theme group based in Rwanda. The group, chaired by WHO, includes representatives from UNDP, UNICEF, UNFPA, the World Bank, and UNESCO and the Director of the PNLS. Support from UNAIDS cosponsors in 1996-97 included:

Organization	Amount US$ 1996-97
World Bank	18,600,000 *(June 1996-July 1998)*
UNFPA	2,100,000
UNICEF	1,500,000
UNAIDS	100,000
UNDP	609,000 *(96 only)*
WHO	41,000 *(96 only)*
Total	**22,950,000**

The World Bank has not made any direct loans for HIV/AIDS to the Rwandan government. However, the World Bank, in collaboration with the International Monetary Fund, has been one of the major donors for overall health sector reform. A project funded by these two organizations aims to (a) improve the efficiency of the national private health system and (b) expand use of health services, including those in support of national population and nutrition strategies.

Rwanda is currently the headquarters of the Great Lakes AIDS Initiative (GLAI) . This is an initiative combat the spread of HIV/AIDS along the trade routes in the Great Lakes.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies include Family Health International, CARE, and Population Services International. NGOs also receive funding from a variety of sources and conduct most of HIV/AIDS prevention and care activities in Rwanda.

- In April this year, the Rwandan government started a program of anti-viral triple therapy for patients with AIDS. The government imports the medicines and the patients pay for it. Treatment costs RWF 180,000 per month ($475.00) for the triple drug therapy. The annual income per capita for an average Rwandan is $210.00. This option is therefore beyond the means of all but a tiny fraction of the population. At present, only 140 wealthy Rwandans are following this therapy. Patients are kept on AIDS medication as long as they remain alive.

- Through a UNICEF sponsored project, pregnant women are given AZT at no charge in order to prevent vertical transmission to the unborn child. The Ministry of Health has expressed interest in initiating other preventive therapy at the time of labor, following encouraging trial results in Uganda.

FHI's IMPACT Project is providing capacity building in regions in the area of STI management, and assisting in the coordination of local NGOs working in the area of HIV/AIDS prevention.

Challenges

Major constraints to HIV/AIDS control in Rwanda include:

- *More immediate threats.* In the wake of the constant threat of violence and in the midst of a daily struggle to subsist, it is difficult to convince people to care about a disease that takes years to develop.
- *Inability to discuss and distribute condoms.* Although the church has accepted the responsibility to speak against HIV/AIDS to their flock, it is reluctant to support programs that distribute condoms.
- *Impact on women.* The importance of Rwandan women as the main source of family stability and nutrition makes them especially vulnerable to economic pressure to trade sex for money or food. The situation is compounded by the fact that, there is a large number of widows of the 1994 genocide who engage in having multiple sexual partners in order to find social security and to replace their dead children.
- *Lack of literacy.* Although universal use of the language *kinyarwanda* eliminates some of the communication difficulties encountered in other countries containing many ethnic groups, illiteracy is a major constraint to HIV/AIDS education. Almost three-fourths of the country's women and more than half the men are estimated to be illiterate.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Rwanda:

- Household food security is essential if Rwanda is to achieve peace and stability. Without it, people will continue to struggle over a fragile resource base, and conflict will continue.
- Long-term government policy should address the underlying causes of health problems, including inadequate housing, sanitation, water, and nutrition.
- Measures are needed to ensure a safe and sufficient blood supply.
- Legislation and enforcement are required to protect the human rights of PLWHA.
- Rwanda needs training, technical assistance, and resources in order to meet the increasing demand for voluntary HIV counseling and testing.

The Future

It is not too late for an effective response to the HIV/AIDS epidemic in Rwanda. The USAID is currently providing leadership role in its support to the Rwandan ministry of health in the fight against HIV/AIDS. Also NGOs churches, women's groups, businesses, microenterprise, and community groups have shown that they can play an important role in HIV prevention and care. With additional financial and technical assistance, these groups could be mobilized to expand proven interventions on national scale.

Important Links and Contacts

1. UNAIDS CPO
2. PNLS

U.S. Agency for International Development

Population, Health and Nutrition Programs
HIV/AIDS Division

1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Implementing AIDS Prevention and Care (IMPACT) Project

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703)-516 9779
Fax: (703) 516-9781
URL: www.fhi.org

April 1999

The Economic Impact of AIDS in Rwanda

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

LABOR FORCE STATISTICS		
	Economically Active Labor Force: 1989	
Sector	Aged 14 years & over	%
AGRICULTURE		
Agriculture, hunting, forestry and fishing	2,832,558	90.1
INDUSTRY		
Mining and quarrying industries	4,692	0.15
Manufacturing industries	45,088	1.4
SERVICES		
Electricity, gas and water	2,561	0.08
Construction	38,237	1.2
Trade, restaurants and hotels	80,026	2.5
Transport, storage and communications	7,332	0.23
Finance, insurance, real estate and business services	3,128	0.1
Community, social and personal services	12,021	0.4
Activities not adequately defined	9,413	0.3
TOTAL EMPLOYED	**3,143,056**	**100.0**

Rwanda's economy is heavily reliant on agriculture, with over 90% of the population employed in that sector, mostly at the subsistence level. The main food crops are plantains, sweet potatoes, cassava, and dry beans. The main export crop is coffee, which accounted for 75% of total export earnings in 1995. Although only 1.4% of the population is employed in manufacturing, this sector accounted for 15.2% of GDP in 1995, producing beverages and tobacco, food products, and basic consumer products. The country has suffered from ethnic tensions, its landlocked geographic position, and its vulnerability to droughts and a drop in world coffee prices.[1]

[1] Europa World Year Book 1998, Volume 2 (1998) Europa Publications Limited (1998).

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from Rwanda to illustrate these impacts.

Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

- An early study examining the needs of HIV-positive women in Kigali found that very little support existed for them. Assistance was needed for housing and employment, and once AIDS developed, for childcare, food, and funeral services. Over two-thirds of the women did not expect their partners to take care of them when AIDS developed, and three-quarters of them did not expect help from their extended family. The authors predict that the childcare needs necessary once AIDS developed would not be met by the extended family.[2]

- Refugee camps became an oasis for Rwandans in Tanzania and Zaire in 1994. Women in particular were found to be vulnerable to high risk behavior in these camps, as many became single heads of households, and had no one to turn to for advice.[3]

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries

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[2] Keogh, P, C Almedal, S Allen, C Muhawenimana, J Tice, S Hulley (1989) "Evaluation of the social services needs of HIV+ women enrolled in a cohort study in Kigali, Rwanda," Int Conf AIDS; 5:822 (abstract no. T.E.O.3).

[3] Wondergem, P, C Vogel, B Brady, (1995) "Rwandan refugee women – their life, health and sexuality." HIV Infect Women Conf P68 (abstract AIDS/95921973); and Mabasi, M, GL Wenbo, and N Nzila (1996) "Evaluation of HIV infection progression risk in area refugees at north-east region of Zaire." Int Conf AIDS; 11(1):381 (abstract no. Tu.C.2674).

where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops. Thus, AIDS could affect the production of cash crops as well as food crops.

- An early, prospective study for Rwanda classified the agricultural systems there into five different types, according to how vulnerable each is to labor supply interruptions. The most vulnerable system was found to be in the Volcanic Highlands, because seasonal demand for labor varied tremendously. Small nuclear families were also found to be more vulnerable than extended families in all of the systems. By the year 2000, it was anticipated that as many as 25% of households would be affected.[4]

Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

[4] Gillespie, S (1989) Potential impact of AIDS on farming systems: a case-study from Rwanda. Land Use Policy 6:301-12.

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

    - In 1990, the average hospitalization costs for an AIDS-related episode was US$196. The average hospital stay for AIDS patients was twice that of non-AIDS patients, or 25 days compared to 12 days. On average, lifetime costs consisted of 1.66 hospitalizations and a total cost of US$358. Total costs paid for AIDS patients in 1990 were US$0.6 million, or 4.6% of the public sector health budget. It was anticipated that, in 1994, these costs would increase to consume 11.4% of the public sector health budget.[5]

- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

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[5] Shepard, DS, RN Bail, A Bucyendore. (1992) "Costs of AIDS Care in Rwanda." Inf Conf AIDS; 8(2):D471 (abstract no. PoD 5505).

- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

- **Military.** Military personnel are particularly vulnerable to HIV/AIDS as they spend most of their time away from their families. Many use commercial sex workers on a regular basis. When they return to their families, the virus is spread.

    - In Rwanda in 1994, it was estimated that as many as 65% of the soldiers in the military were HIV positive.[6]

Macrocconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small.

There are several mechanisms by which AIDS affects macroeconomic performance.

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.

- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

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[6] "Did HIV Contribute to the Breakdown of Society in Rwanda?" AIDS Analysis Africa, 1994.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

The incidence of HIV in Rwanda increases with income levels. In 1987, a study found that women whose partners had higher income levels and worked in higher-skilled occupations, were more likely to be HIV-positive that women whose partners were not as successful. Women whose partners were farmers had an HIV prevalence rate of 9 percent, while the rate for those whose partners were in the private sector of the government was over 30 percent. The impact on the macroeconomy will be more pronounced as the lack of skilled people becomes more and more prevalent.[7]

What Can Be Done?

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives

[7] IFPRI (1996) "Study Shows AIDS Slowing Economic Growth in Africa," http://www.cgiar.org/IFPRI/pressrel/061796.htm.

for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

- In 1994, the AIDS Control and Prevention Project worked with CARE International to establish an HIV prevention program in refugee camps, after genocidal civil war began in Rwanda. Refugees are particularly vulnerable to the spread of HIV, due to the difficult economic conditions in the camps. Over 1.5 million condoms were distributed in the first 12 months of the project.[8]

- A joint program between the Ministry of Social Affairs and Caritas Rwanda has placed children who have been orphaned or whose parents can no longer care for them. Although the first choice for placement is family members, sometimes foster families or group homes are provided. These efforts are financed by the program, with an annual cost of approximately US$392 per child. These costs include payments to the caretakers and school fees for each child.[9]

- A program to train Rwandans to provide care at home was instituted by the Red Cross. Volunteers were trained by the Red Cross in simple nursing care skills, and then returned to the villages to visit and train families there. Interviews with 24 of the families six months later found the volunteers to be effective in transferring these skills, and in providing psychological support to the families.[10]

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS.

A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an

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[8] Benjamin, JA. (1996) "AIDS Prevention for Refugees: The Case of Rwandans in Tanzania," AIDSCAP Electronic Library (Family Health International/The AIDS Control and Prevention Project, Durham, North Carolina).

[9] UNICEF. 1994. "Action for Children Affected by AIDS: Programme profiles and lessons learned." Joint WHO/UNICEF document. New York, NY: December 1994.

[10] Schietinger, H, C Almedal, BN Marianne, RK Jacqueline, BL Ravn. (1993) "Teaching Rwandan families to care for people with AIDS at home," Hosp Journal; 9(1):33-53.

appropriate share of national and international donor resources to fund important programs.

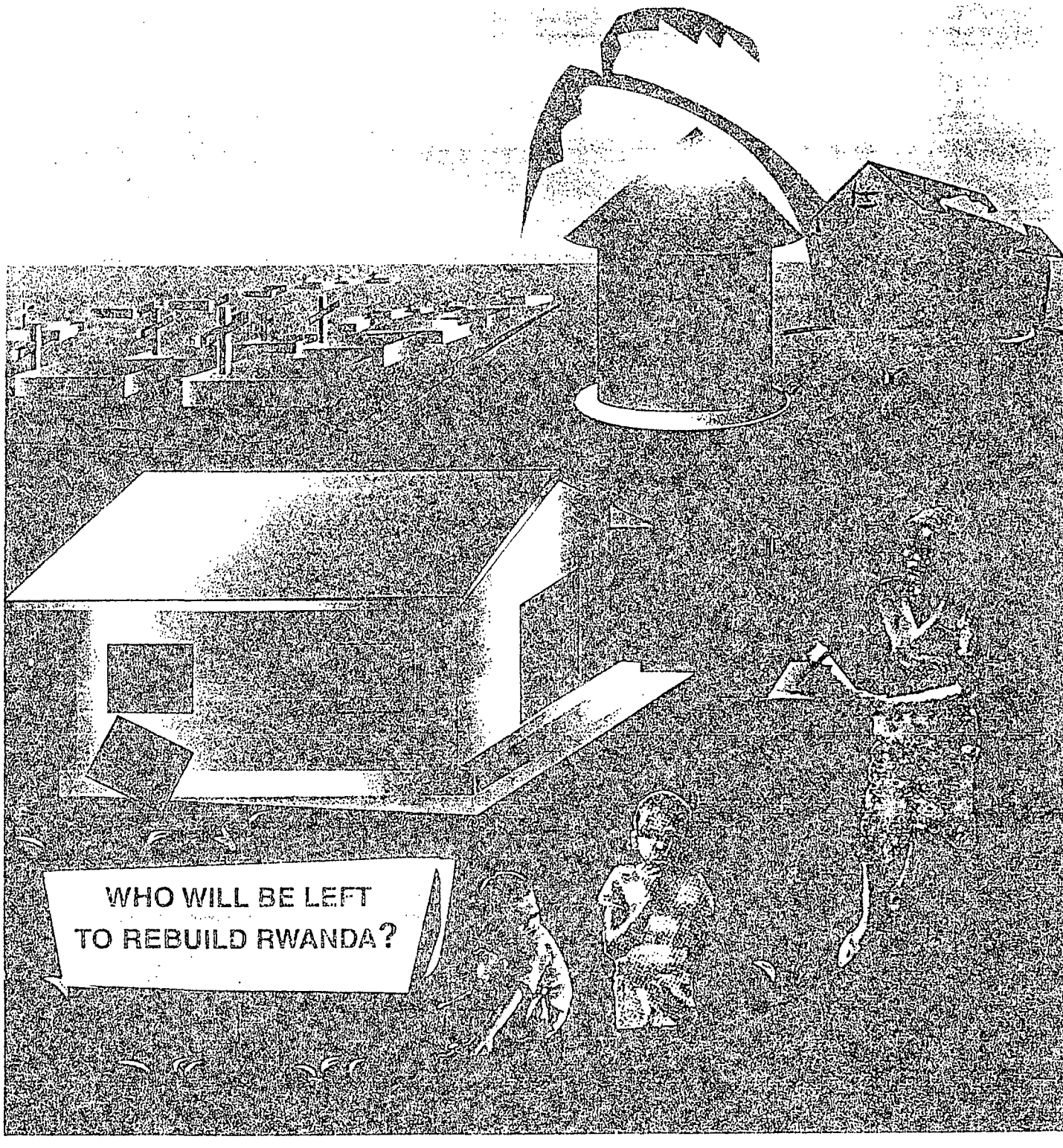
Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

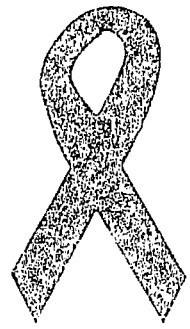
U.S. Based
Institutional Interventions

Rwanda

Organization	Intervention																
	Advoc.	BCI	Care/S	Training	Cond.	SM	Eval.	HR	IEC	MTCT	Research	Policy	STD	VCT	Orphan	TB	Other
Cooperating Agencies																	
FHI/IMPACT		X		X			X		X		X	X	X				Capacity building
PSI					X	X			X				X				
HVO/NGOs																	
American Refugee Committee																	
CARE		X		X	X	X	X		X			X	X		X		
World Relief	X	X		X					X			X			X		
Doctors Without Borders		X	X	X					X								
Salvation Army			X		X				X						X		

HIV/AIDS IN RWANDA: A NATIONAL CATASTROPHY





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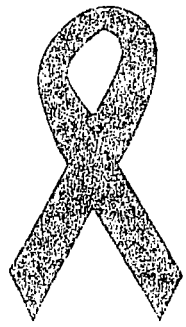
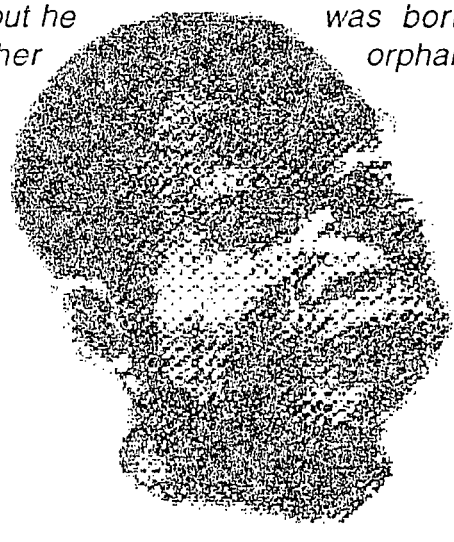


Every number in this report has a face...

Marie was 17 years old when she married. She had a baby right away, and another one 3 years later. The second one was sickly and died before his first birthday. Soon after, her husband became ill with tuberculosis. He went to the doctor for medicines, which he took for 6 months. After he had been well for early a year, he began having diarrhea and weight loss. Marie again became pregnant, but her husband died before the baby was born.

When she found out that her husband had died of AIDS, she asked the doctor many questions about the illnesses and how it was spread. It surprised her that people could have a silent virus that could make them sick after many years. She realized her husband might have become infected before they were married. She had never had sex except with her husband, nor had she ever received a blood transfusion, so she knew that she could not have given the infection to her husband. She wondered if he gave her the virus, and if that was why their second baby died.

Marie and her child went back to her village to live with her mother. She was afraid for the baby she was carrying, but he was born healthy. Marie died 4 months later leaving another orphan in Rwanda.



This is a daily tragedy in Rwanda adding to the severe consequences of the 1994 genocide

How can you help build a healthy and productive Rwandan society?

Political will & action. Although political leaders have started speaking out about HIV/AIDS, stigma and discrimination against infected people exists and needs to be targeted as a major constraint. A strong political commitment to the fight against HIV/AIDS is crucial.

Countries that have shown the most success, such as Uganda and Thailand, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to HIV/AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multisectoral approach by making it clear that the fight against HIV/AIDS is a national priority. Third, it signals to individuals and community organizations involved in HIV/AIDS interventions that their efforts are appreciated and valued. Finally, it ensures that the interventions will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for government in the fight against HIV/AIDS is to ensure an open and supportive environment for effective programs. Legislation and enforcement are required to protect the human rights of People Living With HIV/AIDS (PLWHAs). The Government of Rwanda needs to make HIV/AIDS a national priority, not to consider it simply as a health or social problem. By stimulating and supporting a broad multisectoral approach that includes all segments of society, with a special emphasis on the youth and the rural areas, the Government of Rwanda can create the conditions in which prevention, care and treatment can succeed and protect the country's future development prospects.

RWANDA & HIV/AIDS
HERE ARE THE FACTS

We are approaching the year 2000. How many Rwandans live with HIV now?

Almost every family in Rwanda knows or has seen someone dying of AIDS. According to the Joint United Nations Programme on AIDS (UNAIDS), Rwanda is already one of the nine African countries most severely affected by the epidemic. In 1997, it was estimated that 11% of the adult population was HIV infected, meaning that almost 370,000 people were living with HIV infection. The HIV epidemic is spreading rapidly throughout the country. For example, in 1986 the HIV prevalence rate in rural areas was 1.3%, but by 1997 the rate increased to 10.8%.

At least 150 people contract HIV each day. It is estimated that 55,560 new cases of HIV had occurred in 1998 in Rwanda. AIDS is one of the three leading causes of death in Rwanda. By 2005, the crude death rate will be 40% higher due to AIDS than it was in 1990.

The most productive generation will be lost. The 15-49 year old is most affected by AIDS. Approximately 25% of young adults in the urban areas in Rwanda are HIV infected or one person out of four people you meet on the street of Kigali is HIV infected.

Alarming new infection rates. The 1997 population based sero-survey found an HIV prevalence of 4.1% among 12-14 year old children.

Invest hope in our children. Sixty percent of the total Rwandan population is younger than 20 years old. The HIV epidemic has a disproportionate impact on children causing high morbidity and mortality among infected children, and orphaning many others. Children born to HIV-positive mothers have a 25-30% chance of being positive themselves. In 1997, 21% of all pediatric patients, and 60% of those with malnutrition in the Kigali Central Hospital were HIV positive. In the absence of rigorous preventive measures, infant mortality rates will be 25% higher than they would have been in the absence of AIDS.

By the year 2000, nearly 60% of all Rwandan orphans will have lost their parents due to AIDS. In 2010, that percentage will rise to over 80% without vigorous interventions.

Young adults who have not gone to school have higher prevalence rates than those who have attended school. Girls 12-14 years old who have not received education have a rate of 9.4% in contrast to 5.0% among those who have attended school. Four percent of Rwandans ages 12 to 14 are already infected with HIV. Among 15 to 19 year olds, HIV prevalence is higher in rural areas (8.5 %) than in cities (3.4 %).

Our mothers, sisters & daughters. In 1997, 25-30% of pregnant women in urban Kigali antenatal clinics and 15% in other regions tested positive for HIV, compared to 10% in rural clinics. Young women of childbearing age (15 to 24) are more likely to be infected than men in the same age group. Women with histories of sexually transmitted diseases are 26% more likely to be HIV positive than women with no such history, at 10% seropositive. While 95% of commercial sex workers know the risks of HIV transmission, only 50% use condoms, due to objections of their customers. Approximately 75% of commercial sex workers are HIV positive.

In Rwanda, as in many other countries, women's low social and economic status, combined with greater biological susceptibility to contracting HIV, put them at greater risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound this vulnerability. Urban women are at much greater risk of HIV than rural women. This trend is more consistent across age groups for women than for men.

Violence destroys futures. Rape inside and outside refugee camps has played a part in spreading the HIV virus in Rwanda. Some 2.2% of women surveyed by the PNLS after the war reported being raped. Women who reported rape were three times as likely to have suffered from sexually transmitted infections. Seventeen percent of the women who had been raped were HIV positive, compared with 11% of those who had not been raped. Thirty-eight percent of rape victims were in the 12-19 year age group.

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Decreased life expectancy. The impact of AIDS is complex and its consequences are severe for a country, which is rebuilding its society after genocide. AIDS affects the individual, the community, and the nation emotionally and economically. How do you rebuild a nation when the United Nations estimates the life expectancy for a Rwandan is 49 years old? If adequate measures against HIV/AIDS are not in place in Rwanda within 5 years, the life expectancy could fall to 35 years. We will be moving backwards after advances in maternal and child health, vaccination programs, and nutritional status.

AIDS has penetrated all socio-economic classes and all geographic locations in Rwanda. The overall prevalence in the rural areas is slowly approaching rates in the urban areas - educated and non-educated, young and old, rich and poor are all contracting HIV.

What is the impact of HIV/AIDS on Rwandan society?

Daily life is disrupted. As the epidemic increases in the community, traditional habits and beliefs are challenged and a level of uncertainty is created. The family budget for food or other events is shortened by the care of an AIDS relative. Funerals have become a common thing in the daily life of Rwandan people. The death of a parent due to AIDS puts the family in deeper poverty. Agricultural practice is also altered as labor availability changes with the death of family members.

Due to the combination of AIDS and a high birth rate, the dependency ratio (the number of children and elderly to producers) will increase. The increased dependency ratio will complicate preparation of the next generation for life as adults in Rwanda. Children will be caring for children as the epidemic increases.

Besides the tragic effects of genocide, many families are in desperation because of AIDS — parents are burying their children and children are burying their parents. The future of the Rwanda family, community, and nation is in jeopardy.

HIV/AIDS overwhelms health care system. The health system is overloaded with AIDS cases particularly in the internal medicine and pediatric departments. It was estimated that 60% of hospital beds in internal medicine at CHK are occupied by AIDS patients, and 80% of deaths occurring in the same hospital are AIDS related.

Workforce capacity is diminishing. HIV/AIDS is affecting the workforce in the private and public sector. There is an increased loss of trained personnel due to HIV/AIDS morbidity and mortality. The 1997 serosurvey showed that 17% of managers, administrators and professionals; and 19% of traders and businesspersons are HIV infected.

HIV/AIDS is one disease that renders people sick and weak for many years. This impacts productivity in the workforce not only for the person who is sick for several years, but also for the family members and friends who take care of the ill individual.

Expensive for society. It is difficult to determine the total costs associated with HIV/AIDS. There are costs made by HIV individuals, families and friends that are not documented. There are hospital and outpatient costs, loss of earnings due to illness and premature deaths, productivity losses arising from absenteeism, labor turnover, expenses allocated to HIV/AIDS control which could have been used for other activities, etc. The bottom line is that HIV/AIDS expenses are extremely high and will continue to drain the resources in Rwanda. The upcoming socioeconomic study will provide more details by the end of the year.

What are we doing now?

History of HIV/AIDS national response. In 1987, the National AIDS Control Programme (PNLS) was established under the Ministry of Health and Social Affairs. In February 1987, the Rwandan government, in cooperation with the WHO Global Programme on AIDS, developed the First Medium Term plan (MPTI) for the prevention and control of the HIV/AIDS. The First Medium Term Plan (1988-1992) targeted blood transfusion safety, preventive health education, and epidemiological surveillance. The program was well established, with both external and internal support. One year later, a National Commission for AIDS was created and an intensive HIV/AIDS education campaign was developed in collaboration with the Rwandan Red Cross.

The Ministry of Health renewed its commitment to decentralizing the health care system, and the government made HIV/AIDS prevention a priority in all its economic and public investment programs. In addition to preventing HIV, the challenge for the Second Medium Term Plan (1993-1997) was trying to minimize the socioeconomic impact of HIV/AIDS on affected individuals and families, but this Medium Term Plan was poorly implemented because of the war and the genocide.

In 1997, the Ministry of Health restructured the Programme National de Lutte Contre le SIDA (PNLS) to act solely as a coordination body. Planning, resource management, and service delivery are the responsibility of health districts. This restructuring resulted in the decentralization of HIV/AIDS activities at region and districts levels in order to make sexually transmitted infections (STIs) and HIV/AIDS services more available to rural populations, even if the availability and quality of these services still need to be improved.

The multisectoral fight against AIDS has also been boosted since 1997, resulting in more and more involvement of the non-health sectors. Local partners have included religious organizations, youth groups, women's groups, armed forces, schools, NGOs, local authorities, and the media.

Who is involved?

Partners involved. Many multilateral and bilateral donors are actively engaged in HIV/AIDS programs in Rwanda.

Belgian Cooperation. Supports HIV surveillance; and the National Referral Laboratory for Retroviral Infections.

German Cooperation. Supports condom social marketing and accessibility, and the Butare health district's HIV/AIDS activities.

Government of Luxembourg. Supports the National AIDS Control Programme, the National Referral Laboratory for Retrovirus Infections, the Rwanda Center for Health Communications, the National Blood Transfusion Program, and the Rwandan AIDS Information Center.

UNAIDS. Coordinates the HIV/AIDS theme group based in Rwanda. The group, currently chaired by UNICEF, includes Representatives from UNDP, WHO, UNFPA, the World Bank, and UNESCO. This group will soon grow to include other organizations and sectors.

UNDP. Supports studies on the socio-economic impact of the HIV epidemic; evaluation of NGO and association roles; and a workshop on HIV and development.

UNFPA. Funds reproductive health in adolescents; voluntary testing and counseling (until 1999).

UNICEF. Supports sensitization activities for youth (in- and out-of-school); prevention of mother-to-child transmission of HIV infection; and supports to multisectoral committees at the prefecture level.

USAID. Provides technical assistance to regional and district medical teams to integrate STI/HIV/AIDS into existing health services; develops tools, methodologies and materials to improve the research capacity of the MOH; conducts studies on health care finance and the impact of HIV/AIDS on the society; supports peer education in Gitaram; funds religious organizations to educate youth in the prevention of HIV/AIDS; and supports the Rwanda Center for Health Communications to build local research & evaluation strategies, Internet library services, health resources and HIV/AIDS documentation, graphic design, video & audio production, and training.

WHO. Provides technical support to the program.

World Bank. Supports PNLS; HIV surveillance studies; supports local associations; supports the decentralization process; and funds information and education activities

Where are we going?

New Developments. Since 1997, the Government of Rwanda decided to have a budget line to support the National AIDS Control Programme and the budget has slightly been increased in 1999. The Government also provides support for staff salaries and program overhead. The Ministry of Health, in collaboration with other sectors, is currently working on a project to restructure and strengthen the coordination role of the National AIDS programme and establish the National AIDS Commission (CNLS), which will be given three mandates:

- Be an open forum for ideas exchange for the fight against HIV/AIDS
- Be a consultative forum for HIV/AIDS policies
- Be a forum for multisectoral mobilization

In addition, care for people suffering from sexually transmitted infections (STIs) and HIV/AIDS has been made a priority. Since January 1999, antiretroviral drug treatment for People Living With HIV/AIDS (PLWHAs) has been introduced in Rwanda. The Ministry of Health is doing whatever possible to cut down the costs of this treatment so that more people have access.

Since the mother-to-child transmission is the second means of HIV transmission in the country, a program aimed at reducing the risk of transmission to the newborn has been put into place April 1999.

HIV/AIDS voluntary testing and counseling has been established in some areas of the country and the demand is increasing every day. Programs are currently being develop in order to increase testing and counseling centers in each district by the end of 2001.

An initiative to combat the spread of HIV/AIDS in the region called the Great Lakes Initiative on AIDS (GLIA) was established in March 1998 with the Health Ministers from Burundi, D.R. Congo, Kenya, Rwanda, and Tanzania. The GLIA was officially launched at the headquarters in Kigali on April 1999 with the Director of UNAIDS, Dr. Peter Piot, and Health Ministers from neighboring countries.

What is the new national strategy?

The PNLS, in collaboration with other sectors and organizations,recently finished its three-year Multisectoral Strategic Plan for 1999-2001, and a national HIV/AIDS prevention and communication strategy. Priority areas of the national strategic plan are to:

- Maintain 100% safe blood transfusion.
- Reduce STI prevalence among the general population and at-risk groups including the military truck drivers, and commercial sex workers.
- Reduce vulnerability to HIV and other STIs.
- Reduce vulnerability to STI/HIV infection among school youth.
- Reduce the number of people who economically depend on sex for their livelihood.
- Increase the availability of voluntary counseling and testing (VCT) services.
- Strengthen care and support services for People Living With HIV/AIDS (PLWHA) and orphans.
- Mobilize and support nongovernmental, religious, and community-based organizations to implement HIV/AIDS and STI activities.
- Reduce mother-to-child transmission of HIV.
- Strengthen the coordination role of the National AIDS Control Programme.
- Promote cultural norms, values, practices, and religious beliefs that reduce risk fo HIV transmission.
- Provide care and support for unaccompanied children.
- Maintain and improve capacity to generate and share quantitative and qualitative data on STI/HIV/AIDS infections.

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USAID

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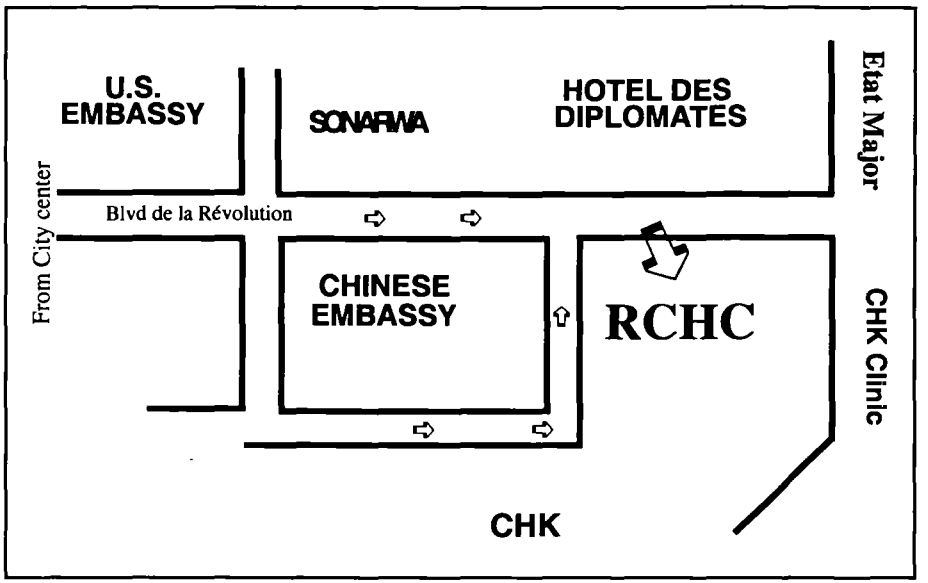

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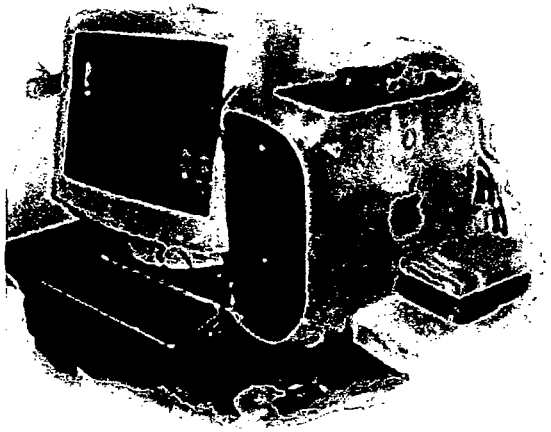

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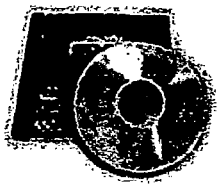

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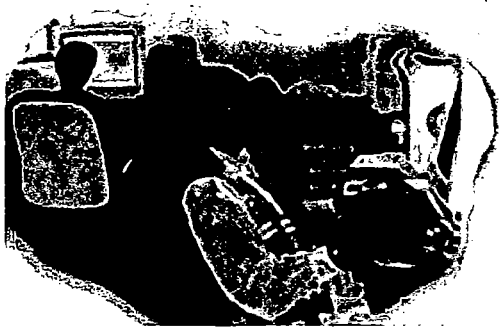
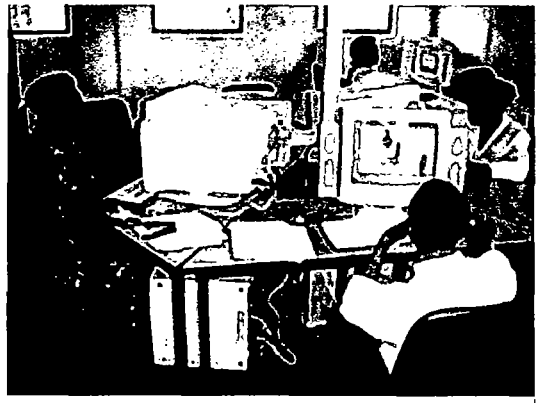


HEALTH RESEARCH LIBRARY AND DOCUMENTATION CENTER

HIV/AIDS documentation center

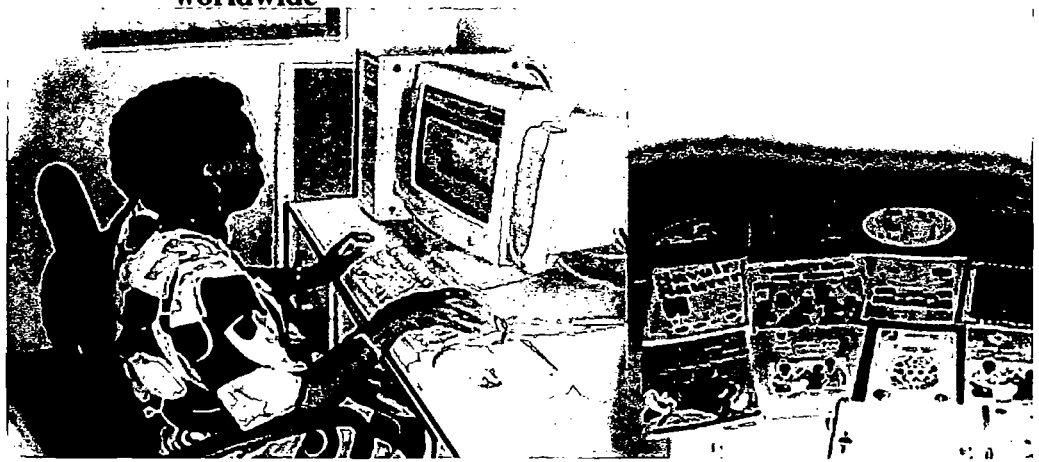
- Rwanda health reports
- Centralized cateloging for IEC materials
- Training curricula & materials

Public access



Virtual health library

- Electronic working groups
- Medline
- Popline
- Access to other resources worldwide



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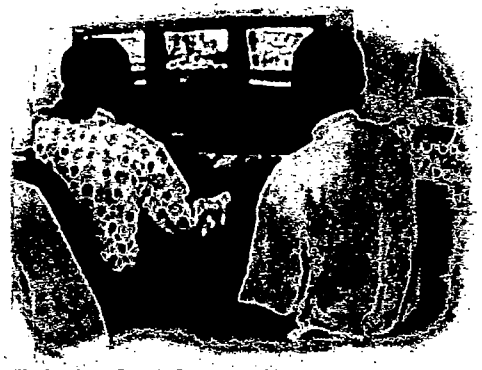

Digital video editing with the MAC G3

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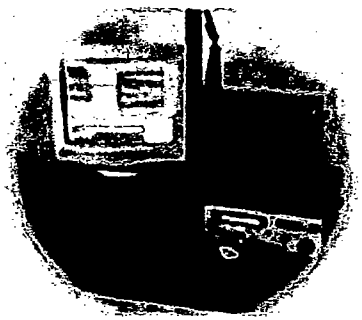
- **audio mixer with 8 channels.**



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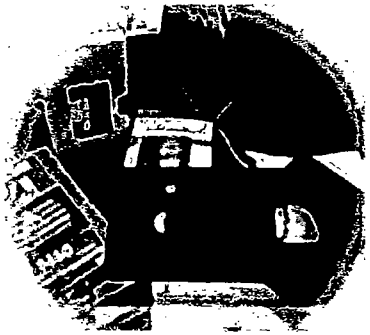

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- **video mixer**

AUDIO PRODUCTION

Editing with special sound effects

- **Sound editing on AvidXpress MAC G3**
- **Recording on 16 channels**

Recording

- **radio programs**
- **voice-overs**
- **music composition**

Digital recording on Dat cassettes

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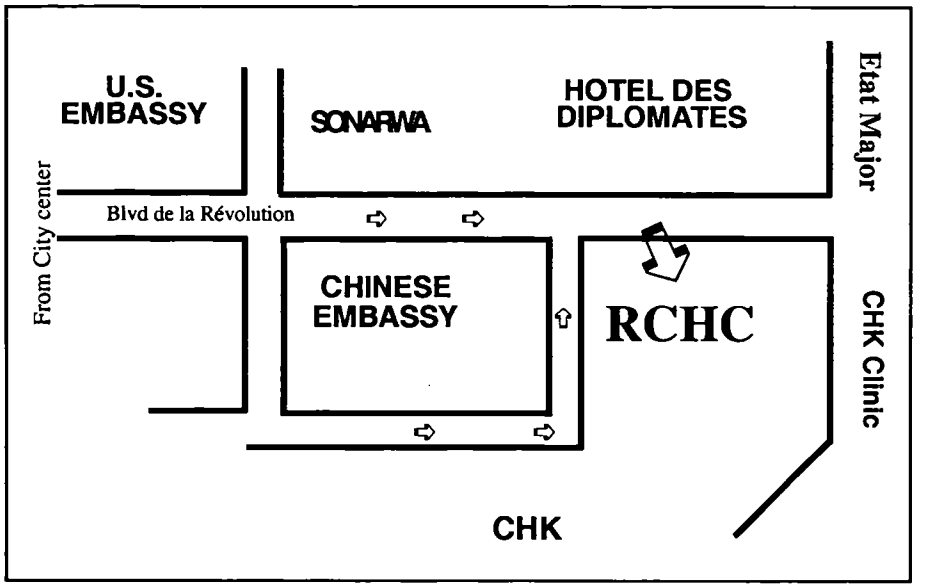

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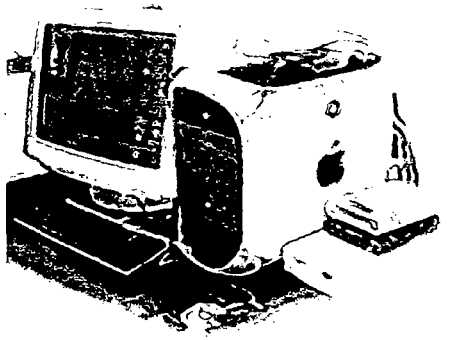

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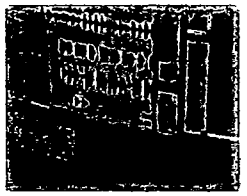

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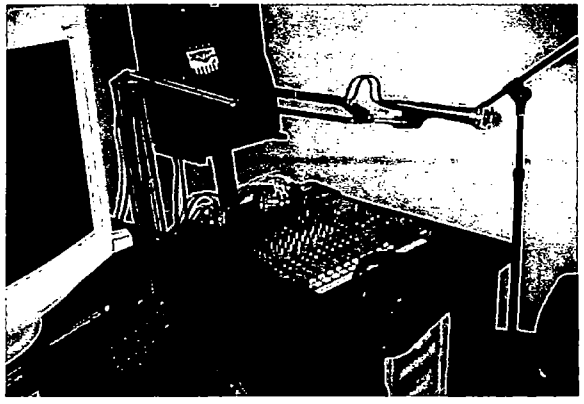

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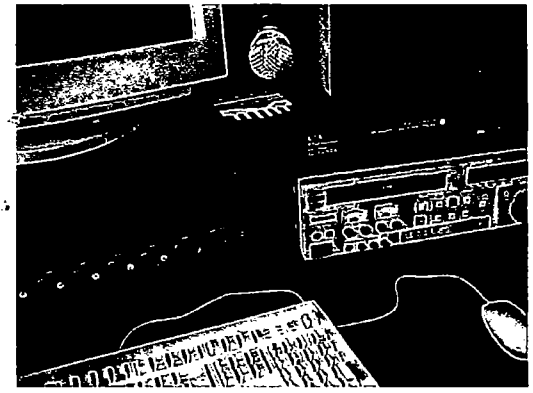

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Image and sound editing with special effects

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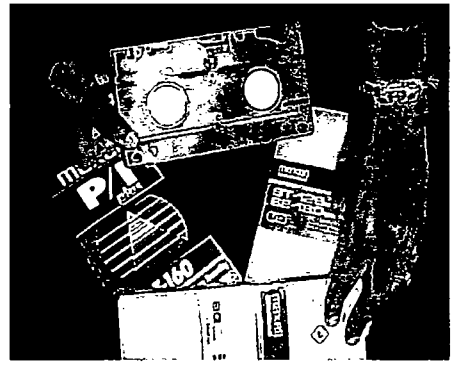

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.e\ switcher
.video mixer

GENOCIDE SITES TO VISIT

NYANZA GENOCIDE MEMORIAL CEMETERY

Located at Nyanza, Kicukiro some 15 minutes away from city center, this site is a memorial cemetery where thousands of genocide victims where buried. It is characterized by hundred of crosses laid on a hill where there is a central tiled tomb in which there are remains of Ignace RUHATANA a well known human rights activist who was killed during the genocide and was the chairman of the *KANYARWANDA* a local human rights association.
Mid-April 1994 when the UNAMIR force(UN Peacekeeping Force in Rwanda) pulled out of the technical school of Kicukiro, more than 5,000 attempted to escape the threat posed by the *Interahamwe* militia and ex-government forces but could not go far and most of them were brutally massacred around the Nyanza hill.
This cemetery has been visited by Secretary of State, Madeleine Albright and Ambassador Richard Holbrooke.

NTARAMA CHURCH GENOCIDE SITE

Situated 28 km South east of Kigali towards the Burundi border in the Bugesera region you pass one of the longest wet upland valleys in Rwanda. The River Nyabarongo meanders in the valley. This site, formerly a Catholic church is located past the *Peace Village Nelson Mandela* a new resettlement (about 50 minutes from Kigali).
Approximately 5,000 people were killed in and around the church. Remains of those who were killed bear fresh evidence of the brutal and expedient methods the *Interahamwe* militia carried out mass killings. The site consists of a church building where remains of some 300 people are laid with all their household effects. Outside the church is a temporary shelter built to expose skulls and bones with marks of bullets, clubs, machetes, spears, axes and other traditional or tailored weapons where wreaths are laid. Some remains can be seen in the priest's office and in the Sunday school buildings. Buildings were severely damaged by grenades as the *Interahamwe* militia and ex-government forces attempted to force a way through the church and managed to kill everybody inside.
It was a tradition for Rwandans to take refuge inside the churches whenever a conflict would arise for safety but this time well planned and organized massacres did not permit refuge.
Killings took place around April 15, 1994 but the RPF soldiers arrived a month later on May 14, 1994 and found all people dead, said Nsabimana Marc, the site's watch person. Thus remains could not be protected from dogs and other animals for one month.

NYAMATA CHURCH GENOCIDE SITE

This site is located in Nyamata town, 30 km away from Kigali and 10 minutes down the road from Ntarama in Kanzenze commune. In 1992, Tonio Locatelli an Italian volunteer was killed by Presidential Guards for having denounced on international radio networks the massacres of Tutsi in the Bugesera region committed by the government-presumably after an order issued by Bourgmaster Rwambuka to kill thousands of Tutsi who were hiding inside the church. This campaign started

following the RPF invasion in 1990. She died as a martyr but saved many people's lives. After 1994 genocide and massacres, an estimated 25,000 people are buried outside the church but at least 1,000 people were killed inside the church.
Stains of blood can be easily seen on the altar cloth, walls and roof and grenade blasts pork the galvanized roofing sheets. An underground platform made of glass has been built where bones, skulls are exposed. The remains of MUKANDORE Annonciata are buried in a casket with all the evidence of a brutal murder and rape. She was 28 years when she was brutally assassinated by *Interahamwe* militia with a stick thrust up inside her genitals. She was thrown in a 30 meter-deep pit where approximately 1,000 other bodies were rotting. Her body though remained intact despite the fact it was found in a pit said Rwema Epimaque, the site's watch person.

REPUBLIC OF RWANDA
MINISTRY OF HEALTH

THE BLOOD PROGRAMME

1. Date of start: 1976

2. Situation in January 2000

a) Structures:

Blood Transfusion Centres (BTC)
- Kigali: National BTC
- Butare: Regional BTC
- Ruhengeri: Regional BTC

Blood storages (Transfusion posts)
- Rwamagana (for East hospitals)
- Cyangugu (for South-West hospitals)
- Kibuye (to be implemented soon)

Equipments
- Laboratories: equipments for the main analysis are available
- Collection Vehicles: 3 (one is very old)
- Recruitment: 2 (one is very old: 260000 Km)
- The 2 need to be replaced soon

Personnel
- 1 Medical Officer
- 1 Administrator
- 1 Donor Recruitment Officer
- 24 Technologists
- 23 other personnel (drivers, secretaries, hygiene,etc...)
- Lack: 8 technologists

BUDGET:
- Running costs only: 420.000 USD
- Sources: MOH: 50%
- The remaining must be found ~~in~~ from Donators

ACTIVITIES IN 1998, 1999

1. Donor recruitment:

Status: 100% volunteer, non renumerated
- Nationwide and made through Rwanda Red Cross network
- Targeted groups:
  - rural: 50%
  - schools: 45%
  - urban: 5%

Number of Blood donors:
- estimation: 12.000
- 50-60% repeat donors

Number of blood units collected:

1997: 19872 units
1998: 19782 Units
1999: 19422 units

That quantity is supposed to cover all the transfusion needs in the country (19000 -20000 per year).

2. Laboratory: routine analysis

Blood grouping
Cross-matching
Diseases screening:
HIV 1/2: 1,5%
HBs: 2,8%
HCV: 3,5%
Syphilis: 0,7%

Peremption: 0,9%
Overall discarded units (non consumed because of differents reasons): 14%
Units available for transfusion: 85-86%

3. Hospitals supply

The system is organized as below:

*Hospitals near BTCs request for each patient in BTC: cross-matching are done in the BTC

*Hospitals far from BTCs: receive a quantity of blood for 1 or 2 weeks and the necessary: transfusion sets, blood group serums

* Hospitals too far from BTCs: are supplied from blood storages in Rwamagana, Cyangugu and nextly, Kibuye.

4. Transfused Patients:

Each year: 12000 to 15000 personns are transfused
60% are children below 5 years
Causes of transfusion:
Malaria and malaria associated diseases: 75%
Obstétrical and surgery and others: 25%
Mean Nb of units per patient: 1,2 unit

5. Conculusions

The Blood Programme is well working in Rwanda
The pool of donors give enough blood for the country
The transfusion team has enough experience
The necessary analysis are made to ensure transfusion safety
The Ministry of Health and local Administration give support to the programme

6. PROBLEMS

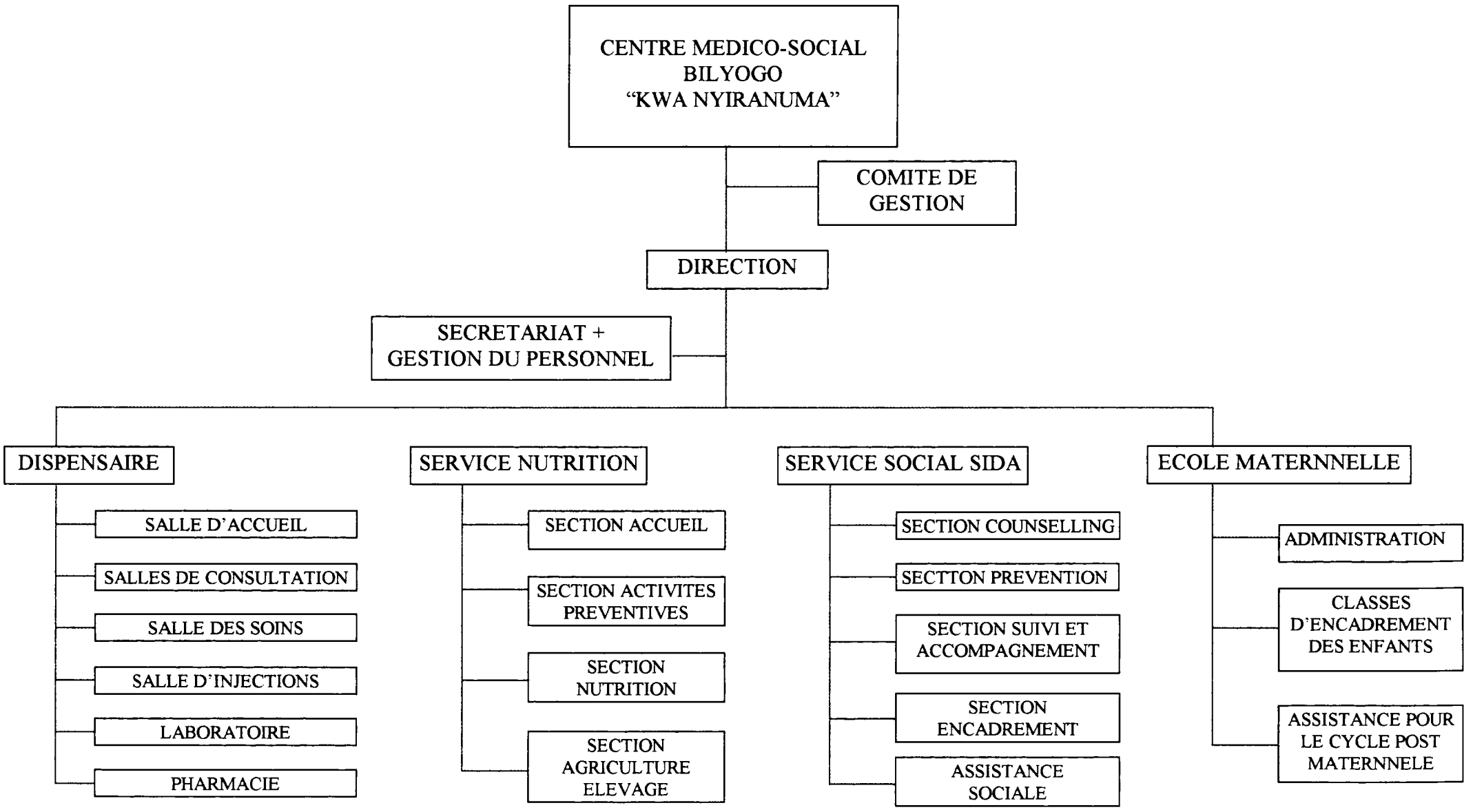
Available budget is not enough
Instability of personnel
Collection Véhicles (some are tired)
Training (the main personnel is new)
Lack of place in Butare BTC

7. Perspectives:

Computerization in Kigali (next months)
Implementation of Quality assurance (4 next years

2. STRUCTURE DU CMS BILYOGO

2.1. ORGANIGRAMME DU CENTRE MEDICO-SOCIAL BILYOGO "KWA NYIRANUMA"



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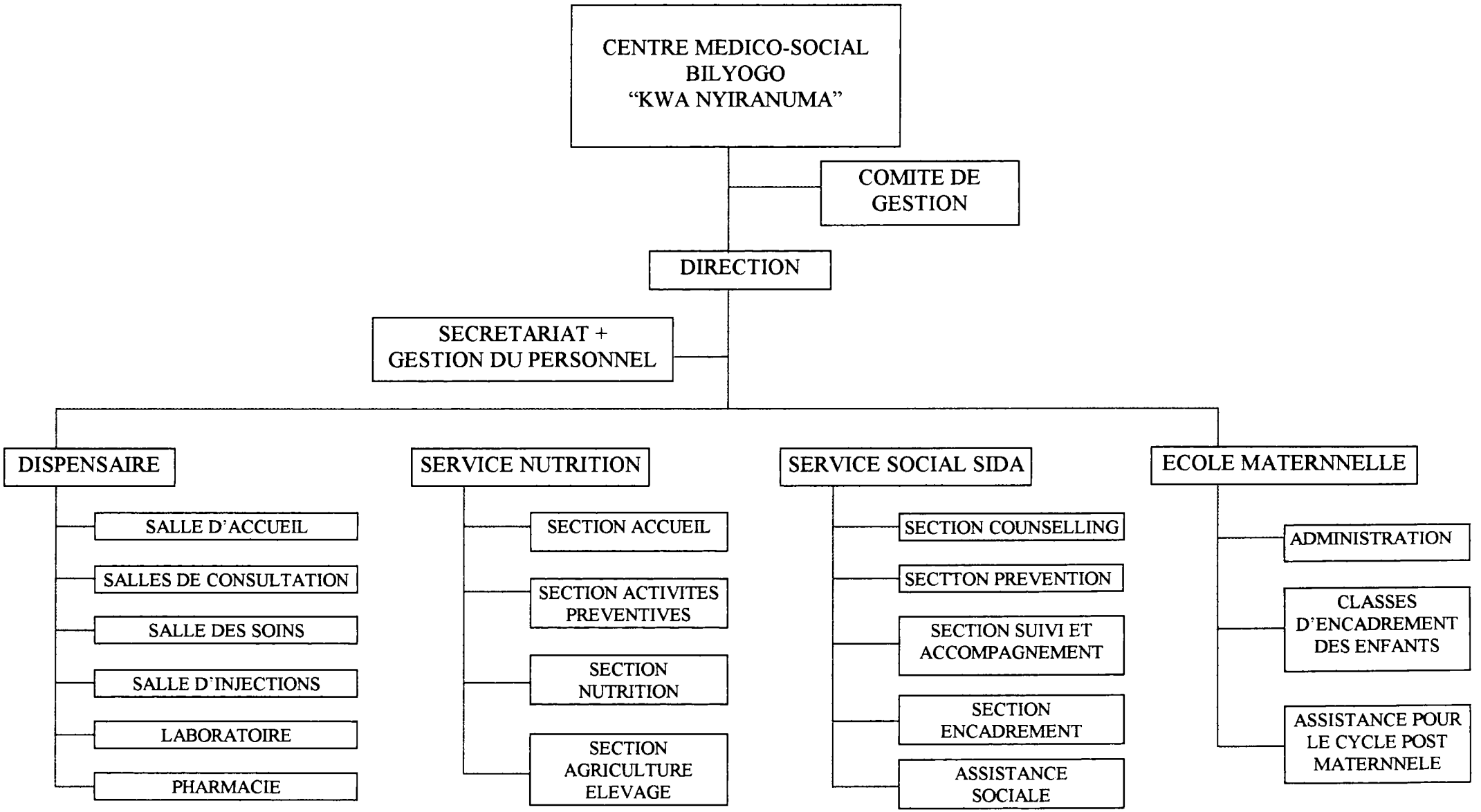

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FAX COVER SHEET

TO: THE WHITE HOUSE
FOR: MS. SANDY THURMAN

FAX NUMBER: 202-456-2438

FROM: Dick Goldman FAX NUMBER: 250-74735

SUBJECT: ARTICLE IN THE NEW TIMES, RWANDAN PAPER.

Rwanda to benefit from US funding on Aids

By Safari Gaspard

The Rwanda government is scheduled to benefit from a 100 million US dollar aid to Africa for the fiscal year 2000. This was revealed recently by the Director for National Aids policy office in the White House, Ms. Sandra Thurman.

Speaking to guests at Rwanda health communications centre, Ms. Thurman pledged further United States commitment to the fight against HIV in Africa.

"It is not about Africa, it is about the rest of the world. Aids is not just a health issue, it is an economic, security and stability issue", she said.

It is expected that the money will be allocated to HIV prevention programmes, like the procurement of Protector condoms and the promotion of their use, Aids awareness, treatment for the prevention of mother to child HIV transmission and HIV testing strategies.

It is pertinent to note that recently the United States Vice President, Al Gore described Aids as a global aggressor which, in Africa, was as much a security crisis as a humanitarian one.

Other countries slated to benefit from the funding are Ethiopia, Kenya, Malawi, Mozambique, Uganda, Tanzania, Namibia, Senegal, Zambia, Nigeria and South Africa. Ms Thurman said that these countries were selected by the United States Congress on the basis of their political commitment to the fight against the epidemic, and the level and severity of their HIV status in comparison to other African countries.

Sharing Ideas: The Minister of Health, Dr. Ezechias Rwabuhihi, (left) shares ideas with the Director, White House office of National Aids policy, Ms. Thurman Sandra

In 1998 alone, 2.5 million people died of the deadly epidemic worldwide, 2 million of them, that is about 80% were from Africa, and ever since the epidemic came to international recognition, 13.9 million people have already died of the disease.

In Rwanda, 150,000 people have already died of the epidemic, 60,000 are Aids orphans and 400,000 are believed to have been infected so far.

Sixty percent of the total Rwandan population is younger than 20. The Ministry of Health estimates that the H.I.V prevalence rate among the sexually active population under age 20 was almost 10 percent in 1997.

According to the Ministry of Health, the underlying causes of the epidemic are the economic crisis, high rates of multiple sex partners; the early onset of sexual activity, the availability of commercial sex and resistance to talking openly about sex, and

informed Ms. Thurman that HIV and Aids control in Rwanda is hampered by limited resources and the difficulty to convince people to care about a disease that takes years to develop.

Ms. Thurman assured the listeners that the United States government was committed to reducing the stigma of the disease and to care for children orphaned by Aids. She said that when a single disease threatens every thing from economic strength to peace keeping, we clearly face a security threat of the greatest magnitude, adding that fighting the disease should be part of a new security agenda.

Speaking at the same occasion, the Minister of Health Dr. Ezechias Rwabuhihi firmed government's commitment to the fight against Aids.

The United States government has already donated 2 million US$ to the Rwandan government but by the time we went to press, it was not yet clear who the exact beneficiaries of the aid would be.

Ms Sandra Thurman's delegation included, Michael Skokwitz, a clinical phycologist, Thomas Clinton Niblock, deputy director o economic policy staff for th bureau of African Affairs, M Mary Fisher, founder, Famil

Biruta tipped for Speaker

From Page 1

vice-presidency, while the post of Parliamentary Sec-

retary General in the Ministry of Agriculture, Livestock and Forestry, Drocelle Mugorewera from

tioned one of its members of Parliament, Hon. Ntiruhungwa Jean de Dieu, for a ministerial post to replace Biruta. Ntiruhungwa, who hails from Ruhengeri, replaced the former MP, Maniraguha Jacques, who was kicked out of the party

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Presenting a paper on the HIV Status in Rwanda, Dr. Ntaganira Innocent, the Director for the National Aids Control Programme, (PNLS), informed Ms. Thurman that HIV Aids c o in Rwanda is hampered by limited resources and the difficulty to convince people to care about a disease that takes years to develop.

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Biruta tipped for Speaker

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vice-presidency, while the post of Parliamentary Sec-

[illegible] Secretary General in the Ministry of Agriculture, Livestock and Forestry, Drocelle Mugorewera from the Christian Democrats PDC) (Sometimes known as Central Democrats).

The sources continue that high level consultations were in session the whole of

tioned one of its members of Parliament, Hon. Ntiruhungwa Jean de Dieu, for a ministerial post to replace Biruta. Ntiruhungwa, who hails from Ruhengeri, replaced the former MP, Maniraguha Jacques, who was kicked out of the party by its president, the current Prime Minister, Pierre Celestin Rwigema, after a protracted p struggle.

It is also believed that some MPs in many parties

TO: CHERYL BAUERLE.

ADDRESSING HIV/AIDS IN RWANDA

Introduction

One of the tragic outcomes of the 1994 genocide and its aftermath was the huge number of children who either lost their parents or were separated from them. In 1999, over 5,000 unaccompanied children were still living in registered centers. While tremendous success has been achieved in reducing the number of children in institutions, a growing number of AIDS orphans, some of whom are HIV positive, are rapidly replacing them. The capacity of families to continue to absorb AIDS orphans, as done in many African countries, is limited: most Rwandan families have already adopted orphans from the genocide. Integration of additional children into families will be difficult to achieve, especially those children who are HIV positive.

Concurrently, an estimated 85,000 households are headed by children or adolescents, mostly female, who have suffered some form of trauma and are extremely vulnerable without family members to provide guidance and act as positive role models. Young girls heading these households are often forced to prostitute themselves to provide to the families in their care, thus exposing themselves to HIV infection.

The HIV sero-prevalance rates in both rural and urban areas in Rwanda are increasing. The National AIDS Control Programme (PNLS) conducted a population-based survey in 1997 that showed an overall prevalence of 11.1%. The prevalence rate in the youngest age group (12-14 years) of 4.1% indicates a high proportion of new infections. According to the above survey, there is an increase in infections in rural areas from 1.3% in 1986, to 10.8% in 1997.

CARE's Response

Over the past five years, CARE has adopted and implemented a multi-tiered strategy to address the issues surrounding HIV/AIDS that have evolved in both pre-and post-war Rwanda. For the first three-and-a-half years, CARE Rwanda's work in the HIV/AIDS sector focused on HIV/AIDS prevention in one of the eleven administrative regions of Rwanda, targeting adults and youth of reproductive age. Recently, CARE Rwanda, having established itself as a leader in successful HIV/AIDS prevention and education efforts in the country, widened its scope of work to include a project focusing on protecting children from HIV/AIDS. This project emphasizes the needs of child-headed households and orphans. As the program has evolved, building on successes and lessons learned in the context of post-genocide Rwanda, CARE Rwanda was recently awarded funding for their innovative "AID For Children Against HIV/AIDS" project. This new project, supported by CARE USA's Africa Fund, allows CARE Rwanda's HIV/AIDS prevention program to expand countrywide, while incorporating capacity building and advocacy approaches for children's rights.

The Evolution

CARE Rwanda's Work in HIV/AIDS prevention in Post-War Rwanda

In September 1995, with funding from AIDSCAP, the World AIDS Foundation and UNICEF, CARE initiated Phase 1 of its post-genocide HIV prevention project. The project was developed to address what was then believed, and later confirmed, to be a dramatic increase in HIV infection rates in rural Rwanda following the 1994 conflict. The first phase of the project was

designed to address the rapid increase and other aspects of high-risk sexual behavior and their consequences for HIV transmission. Emphasis was placed on the design, testing and production of information, education and communication (IEC) tools and the establishment of a cadre of peer educators to raise awareness and disseminate messages concerning risky behavior and HIV/AIDS transmission. Main lessons learned in the first phase included the need for increased collaboration with the Government of Rwanda's Région Sanitaire, and the need for peer educators trained by CARE to be integrated into the government cadre of Health Animateurs.

Phase II of the project emphasized STD prevention and the link between untreated STDs and HIV transmission by building a cadre of community-based health volunteers to educate at-risk populations about STD/AIDS prevention. The project also increased the number of STDs appropriately diagnosed and treated at health facilities and focused community education on the linkage between untreated STDs and increased risk of HIV transmission. Throughout both phases, the project consistently concentrated on increasing condom use by the target population. In its fifth year, CARE Rwanda is focusing on sustainability (including maintenance and quality control), further strengthening the capacity of the Région Sanitaire to manage its system of Animateurs to provide peer education for the population, and building more comprehensive reproductive health services.

The Advocacy and Institutional Development (AID) for Children against HIV/AIDS Project

Throughout CARE Rwanda's work both pre-and post-genocide, the Country Office has developed a reputation as the leader in HIV/AIDS prevention work in the country. CARE Rwanda has developed its internal capacity to build advocacy into its programming interventions around several critical policies and issues that have significant impact on Rwanda's population. These range from land tenure and the controversial government policy of "villagization", to the need to protect the rights of extremely vulnerable populations vis-à-vis HIV/AIDS.

In September 1999, building on their USAID-funded "Protecting Children from AIDS" project, CARE Rwanda received support from CARE USA's Africa Fund to support a complementary, innovative project titled "Advocacy and Institutional Development (AID) for Children Against AIDS". The two-year project incorporates advocacy for institutional and community-based strategies to meet the needs and rights of children with respect to protection against STDs, in general, and HIV, in particular. It also aims to improve the care and counseling available to HIV positive individuals living amongst unaccompanied children in centers and orphanages and child-headed households. CARE Rwanda is focusing on building the capacity of organizations working with unaccompanied children in institutions and child-headed households to enhance the basic life skills of these children and to build social safety nets that provide for the special needs of these children, especially those who are HIV positive. Its objective is to ensure sustainable services to such groups over time. This ground-breaking approach in the HIV/AIDS sector is built on five years of on-the-ground experience and analysis in Rwanda's post-war society, and is viewed as a flagship program for CARE in the field of HIV/AIDS.

Regional Initiatives: Increasing Momentum

During recent discussions at the regional level--among CARE's East Africa and Middle East (EA/ME) Country Directors, Regional Management Unit (RMU), and CARE USA's Office of the

Senior Vice President–the issue of HIV/AIDS as a problem of unprecedented scale in the East Africa region was raised as a major concern. WHO statistics-- which estimate that about 50 - 60 percent of HIV infections in Africa are from East Africa, an area that accounts for only 15 percent of the total population of sub-Saharan Africa--support this concern. AIDS is said to be the leading cause of death in countries such as Uganda and Tanzania. It is becoming increasingly clear, particularly in East Africa, that HIV/AIDS is having a devastating socioeconomic and political impact.

As has been noted in Rwanda, the impact acutely effects children, youth and poorer communities where health facilities are inadequately resourced and organized to cope with the epidemic. Further, broader-reaching social implications of the AIDS pandemic on affected communities are not adequately addressed. For example, in situations when a member of the family is taken by the disease, all family members are in turn marked by the negative socio-cultural stigmas associated with the virus. Many of these families and individuals fall through the cracks of service provision and social care. The economic and political instability within the region is only adding to the increased spread of the virus.

To increase momentum around this ever-urgent issue, CARE's EA/ME Regional Management Unit has established a working group to build on the experience of country offices like CARE Rwanda that promote the rights of people, in particular children, living with HIV/AIDS. Moreover, the working group will explore instituting similar multi-tiered approaches in other countries in which CARE works to mitigate the social, psychological and economic impact of HIV/AIDS on poor communities; these communities are otherwise condemned to lose many of their members and, thus, the achievements of development efforts of at least two generations. This working group is comprised of representatives of country offices, the EA/ME RMU, the South and West Africa RMU, and the Health and Population Unit. The group is mandated to devise a strategy that builds the existing work being carried out in COs, looking closely at Rwanda's model and lessons learned. Research results from other agencies/partners will also be reviewed, as will the prevention components of CARE's reproductive health programs for youth in countries such as Kenya, Tanzania and Uganda. The group will also review the notable IEC work being carried out with youth and the general public within the region.

The Way Forward

AIDS/HIV Prevention and Child Advocacy

Sharing information on lessons learned will be an essential component of CARE Rwanda's work as they continue to build on their experience to date, and take on the multiple levels of issues and far-reaching implications of the virus in Rwanda's communities. Strengthening civil society by building institutional capacity of the government and rights-based organizations, and pursuing advocacy and action in their HIV/AIDS prevention projects are the core elements of CARE Rwanda's strategy. In the region, and in Africa as a whole, CARE will develop and execute appropriate messages, methodologies and strategies to keep the issue of HIV/AIDS high on the agenda of international and national communities. For CARE in Africa, HIV/AIDS prevention and mitigation of the far-reaching social and cultural implications on youth will be a top priority in the new millennium.

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