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Folder Title:

Rwanda (Continued)

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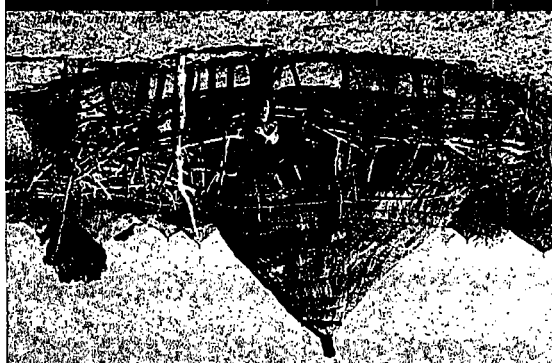
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A Suite of Practical Courses to Support Implementers of Reform

for health systems strengthening

Skills



Abt Associates
Health Policy
Training Institute



Abt Associates Health Policy
Training Institute (AAHPTI)
4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 USA
www.abt-train.org



First course to be held November 27-December 15, 2000 in Washington, DC, USA



Abt Associates is launching its Health Policy Training Institute (AAHPTI) with three course modules designed to provide developing country technical leaders with critical skills needed to strengthen health systems and implement health reform. The three-week training program will be offered by Abt Associates staff and affiliated faculty, all of whom have extensive field experience in implementing health reform. Applicants may select 2 of the 3 modules listed below. Module 1 is strongly recommended for all participants—in addition participants may select Module 2 or Module 3.

Application of Costing Tools to Health Reform (Module 1)

Course content includes basic economic analysis methods applied to the health sector, including lectures, practical problem sets, small group work, and discussions on the following topics:

- **Costing and cost analysis:** health related application of fixed, variable, and marginal costs
- **Pricing:** how the market sets prices; how prices may be set in the health sector to take into account externalities, merit goods, capitation, prepayment, and bundling of services
- **Cost-effectiveness and cost-benefit analyses:** how health sector decision makers can use these tools to assist in making better decisions
- **Price indices:** how a price index is calculated and using price indices to set health-sector prices



Resource Planning Tools and Methods (Module 2)

Course content includes resource planning methods and evidence based policymaking. The specific resource planning topics of the course are:

- Preparing resource rationalization plans to support health priorities
- Setting long-term geographic priorities for capital investments
- Managing the flow of construction project requests and using decision support tools to provide evidence to help say "Yes" and (especially) "No"
- Long-term planning for human resources requirements

The course utilizes a set of take-home software tools for facilitating the planning process. The tools require country specific data, and trainees

will be requested to provide country data for analysis during the session.

Technical Management of Reform (Module 3)

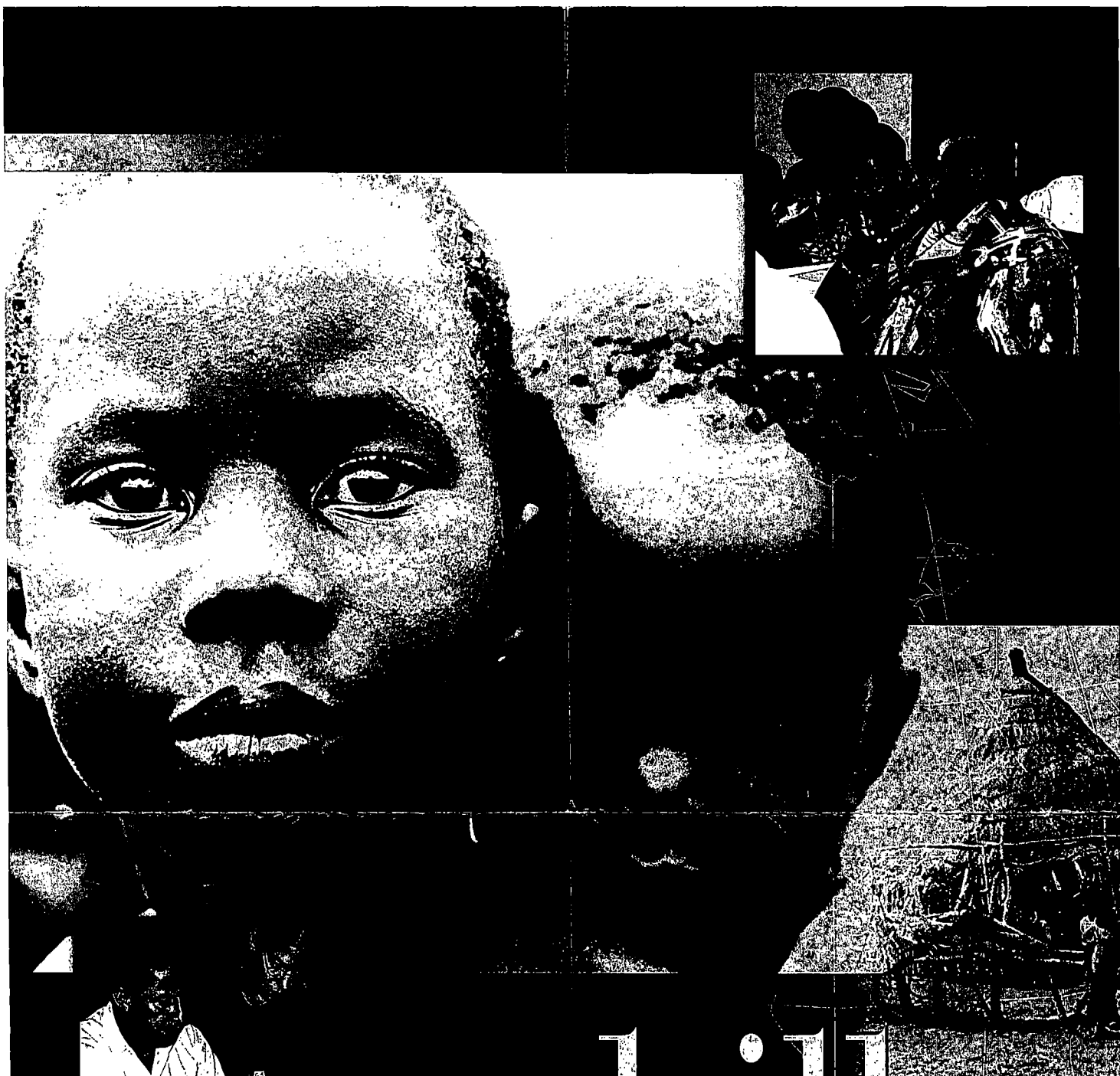
Course content includes a step-by-step, practical approach to the technical management of reforms in the health sector, using case-study materials from reforms in Middle East, Africa, Latin America, and Asia.

- **Assessing the need for reform:** how to diagnose health sector problems to design an appropriate set of reforms, including the assessment of the macropolitical environment and building political and popular support for reform
- **Planning and implementing reform:** choosing when to use pilots to test reforms and when to do phased implementation by levels of the system or geographically; how to plan a pilot test or a phased approach
- **Monitoring and evaluation of reform:** how to choose indicators of reform success and failure, methods for data collection, interpretation of results, and making mid-course corrections
- **Going to scale:** how to go from testing to full-scale reform, including getting political, technical, and financial backing to expand or replicate programs



building **skills**
for health systems strengthening

A Suite of Practical Courses to Support Implementers of Reform



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Abt Associates Inc.



AAHPTI
Abt Associates
Health Policy
Training Institute

November 27-December 15, 2000, Washington, DC, USA

Abt Associates is an employee-owned research and consulting firm. We have a multi-disciplinary international staff of more than 1,000 who use research-based methods to address social-sector and business problems. Since 1965, we have provided analysis, evaluation, design, policy advice, training, information services, and technical assistance to public-sector clients.

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Basic

facts

about

HIV/AIDS

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Health Reform and Priority Services

Summer/Fall 1999



URUBYIRUKO RW'U RWANDA TWIYEMEJE GUFATA IYAMBERE MU RUGAMBA RWO KURWANYA SIDA.

Urubyiruko rugeza ubutumwa ku rundi rubyiruko.

Rubyiruko, basore, nkumi, namwe ngimbi, reka tujye hamwe twigire inama. Dore icyago SIDA kiratwibasiye, turebere hamwe uburyo bwose bwo kuyirwanya.

SIDA ni mbi, bamwe basigaye bayita nkongwa, kuberako imunga umuntu igatuma indwara z'ibyuririzi zimukorahiraho, ikamwica urubozo n'uware umuzi atakimumenye.

Ibuka ko umuntu umwe ku icumi mu Rwanda yanduye agakoko ka SIDA. Ibuka ko hejuru ya 95% y'abantu bandura agakoko ka SIDA bakandurira mu mibonano mpuzabitsina.

Ibuka ko SIDA idutwara ubuzima kandi uziko ntakintu kiruta ubuzima.

Reka turamire ubuzima bwacu, dukurikize imwe mu mico ya basokuru yo kwifata mbere yo gushaka.

Abakobwa dukwiye gutsimbarara ku busugi bwacu. Musore nawe kwitandukanya n'ubusambanyi bizatuma wubaka urugo ruboneye.

Kunda, kandi kundwa ariko umenye ko urukundo rwiza ruzira inenge.

Abadashoboye kwifata ntibaziyahure, hari ubundi buryo bwo kwirinda, niyompamvu tubasaba ngo ntumuzibagirwe narimwe gukoresha kandi neza agakingirizo.

Niba wifuza kurushinga, ukwiye kwipimisha, maze nusanga uri muzima ufate ingamba zo kwirinda ku buryo budasubirwaho. Nusanga waranduye, ntiwihebe cyangwa ngo ukurizemo kwanduza abandi. Ukwiyeye kwifata neza kuko bishobora no kongera iminsi yawe yo kubaho. Uwanduye agakoko ka SIDA ashobora no kukamarana imyaka igera kuri 15. Icyo gihe umuntu ashobora no kugera ku bintu byinshi yifuzaga kugeraho.

Namwe mwanduye agakoko ka SIDA, cyangwa murwaye SIDA, nimufashe urubyiruko kuyirwanya. Tubasabye cyane cyane gutanga ubuhamya bw'ubwandu n'indwara ya SIDA mu gukangurira urundi rubyiruko kuyirinda.

Turamagana abantu banduye agakoko ka SIDA, bagakwiragiza mu rubyiruko kandi babizi.

Rubyiruko, nimuze tube urumuri, tube intangarugero mu myifatire yacu, tubigaragarize abo dukunda n'abadukunda, mbese nabatubona bese.

URUBYIRUKO RURABWIRA ABABYEYI N'ABAREZI

Namwe babyeyi batubwira, nimutwegere tuganire ku byerekeye ubuzima bwacu, kandi ntumugire isoni zo kutumenyesha SIDA n'ububi bwayo.

Nkuko mwatubonye izuba, nimuse-sengure, hanyuma mudusobanurire inzira zose zadukururira ubwandu bwa SIDA.

Niba mudasobanukiye, nimusobanuze hanyuma mutwigishe amazi ataragenda inkombe.

Babyeyi mugerageze gushaka uburyo bwose bwo kurinda urubyiruko kwishora mu buraya. Mushakisha uburyo bwose kugira ngo urubyiruko rwishora mu buraya kubera ubukene rushobore kugira iyindi mibereho.

Babyeyi, uwo mwari wanyu nimurinde guca munzira mbi ishobora gutuma ajya mu busambanyi.

Abarezi, kuko arimwe mubonana n'urubyiruko buri muni, mu byo mutwigisha byose muzajye mushaka umwana wo kudukangurira kwirinda icyago cya SIDA.

Nimujye mwumva inama za PNLS, n'izindi nama zihita kuri Radio zerekeranye n'ikibazo cya SIDA. Izo nama zizabagirira akamaro.

Abanduye n'abarwayi ba SIDA ntibakwiriye gutereranwa. Ni mubatere inkunga.

Urubyiruko rurabwira abayobozi ba leta n'abamadini.

Bayobozi ba Leta: Abashinzwe ku buryo bw'umwihariko umurimo w'uburezi, abagenzuzi b'amashuri, ba diregitari b'ibigo by'amashuri, tubasabye gushishikariza abo muyobora gushyira mu bikorwa gahunda yo kurwanya icyorezo cya SIDA.

Abayobozi b'urubyiruko mu nzego za Komini na segiteri n'abayobozi b'ababategarugori, mu bikorwa byanyu bya buri munsu, mujye mushishikariza urubyiruko kurwanya no kwirinda SIDA.

Abayobozi b'amadini, namwe ntimutangwe mu rugamba rwo kurwanya icyorezo cya SIDA: Mukwiye kujya hamwe mugafashanya, mugashyiraho ingamba zihamye zo kuyirwanya. Ingengo y'imari ya buri dini ikwiye kugaragaza ko SIDA ari ikibazo kitaweho. Ntimutererane amashyirahamwe ahamikiye ku madini afite ingamba zo kurwanya SIDA, ahubwo muyafashe gukomeza uwo murego.

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TWIYEMEJE
KUZAYITSINDA**

**POROGARAMU Y'IGIHUGU
YO KURWANYA SIDA**

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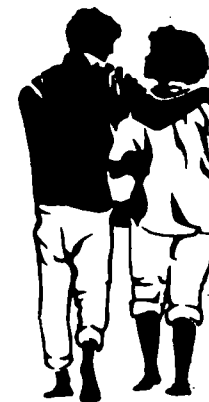
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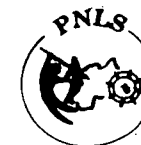
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MINISITERI Y'UBUREZI



**URUBYIRUKO RW'U RWANDA
TWIYEMEJE GUFATA IYAMBERE
MU RUGAMBA RWO KURWANYA SIDA.**





Partnerships
for Health
Reform

Pia Schneider
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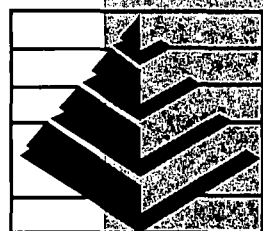
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PHR/Rwanda



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Colaboración
para la Reforma
de la Salud

Partenariats
pour la réforme
de la santé

Partnerships for Health Reform (PHR) seeks to improve people's health by enabling the health sector to provide and ensure equitable access to sustainable, quality health care services. Working in partnerships with national and local governments, communities, non-governmental organizations (NGO) and donors, PHR technical expertise supports and promotes positive changes in health policies, regulations, financing, and the quality, organization and management of health services from hospitals to clinics, across urban and rural areas, among public and private sector providers.

Colaboración para la Reforma de la Salud (PHR) aspira a mejorar la salud de las personas capacitando al sector salud para que proporcione y garantice un acceso equitativo a servicios de atención de salud sostenibles y de calidad. El caudal de conocimientos técnicos del PHR, puesto a colaborar con gobiernos nacionales y locales, comunidades, organizaciones no gubernamentales y donantes, apoya y promueve cambios positivos en las políticas, los reglamentos y el financiamiento del sector salud, así como en la calidad, la gestión y la organización de los servicios de salud, desde los hospitales hasta las clínicas, a través de zonas urbanas y rurales, entre proveedores del sector público y privado.

Le projet Partenariats pour la réforme de la santé (PHR) vise à améliorer la santé des populations en donnant au secteur sanitaire les moyens d'assurer des services de santé durables et de qualité et l'accès équitable à ces services. Travaillant en partenariat avec les administrations nationales et locales, les communautés, les organisations non gouvernementales et les bailleurs de fonds, l'expertise du projet PHR encourage et soutient des changements positifs dans les politiques et les réglementations sanitaires et dans le financement de la santé ainsi que dans la qualité, l'organisation et la gestion des services de santé depuis les hôpitaux jusqu'aux dispensaires, dans les agglomérations urbaines comme dans les zones rurales et chez les prestataires.

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July 2000



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Prepayment Scheme in Rwanda Accepts Sero-Positive Members

Nearly 11 percent of the Rwandan population is estimated to have HIV/AIDS making it one of the most important health issues facing the country. HIV/AIDS is often excluded from insurance schemes, leaving low-income sero-positive patients impoverished, financially ruined, and exposed to more health problems. Under the USAID funded global PHR Project, for the first time, a National Health Accounts framework and methodology was used to estimate sero-positive households' utilization and expenditures on health care in Rwanda.

The study found that half of the sero-positive patients interviewed were widowed, that they use up to 10 times more basic health care services compared with the general population, and that HIV seriously impairs the ability of low-income households to meet basic needs. Less than 30 percent of households interviewed were able to meet the costs of health services exclusively from their own resources. Most households resorted to multiple ways to pay for health care including receiving assistance, borrowing, and selling assets. The study suggests that AIDS causes serious curtailment in access to health care and increases the economic burden on poor households.

The majority of Rwandans still pay out-of-pocket user fees to receive health care services. Paying user fees at the time when care is needed impedes access to care for the poor as well as for 90 percent of the Rwandan population who are subsistent farmers and have cash only on a seasonal basis. Prepayment schemes solve this problem. The Rwandan Ministry of Health (MOH), in collaboration with the USAID-funded PHR Project, developed and implemented prepayment schemes in three Rwandan health districts. Since July 1999, almost 90,000 inhabitants in the these three districts became members of prepayment schemes. Preliminary findings reveal members pay on a per capita level three times as much for health care

than non-members. At the same time, members' access to care has significantly increased to one visit per capita per year compared to non-members who still report 0.2 visit per capita per year.

The prepayment scheme of the health center of Matyazo in the health district of Kabutare has decided to extend solidarity and prepayment scheme coverage to some 50 sero-positive community members. The annual premium of FRw 2,500 (\$7.80) entitles a family up to seven members to prepayment scheme membership for one year. Members benefit from all services and drugs on the essential drug list provided at the health center, ambulance transport to the district hospital and a limited benefit package at the district hospital, which includes Cesarean section, overnight stay, and physician consultation.

The *WHO Report 2000* discusses the question of how far insurance prepayments may be rated to risks, and the extent to which such premiums should be financed, including subsidies for those unable to pay. The 50 sero-positive prepayment scheme members in Matyazo benefited from a church donation, which paid for their one-year membership premium at a higher price of FRw 2,000 per sero-positive member, instead of FRw 530 for an individual that signs up in a group. The decision to accept sero-positive, high-service users in a prepayment scheme pool puts an additional financial risk on the health center. The health center is paid a monthly capitation rate - which is not risk-adjusted - by the prepayment scheme, and would therefore have all interest to apply risk selection. The health center of Matyazo is aware of the financial risk taken with accepting sero-positive patients in its prepayment scheme pool. Although sero-positive members benefited from their membership premiums being subsidized at a higher price, which will increase the health center's monthly capitation revenue, the health center will still need additional financial support

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from the government and donors to assure its financial stability.

The WHO report proposes protecting the sick and the poor by avoiding negative equity consequences in health financing and setting financial and regulatory incentives. Translated into the case of Rwandan prepayment schemes, public- and donor-funded AIDS programs should target low-income, sero-positive patients by financing their and their family's prepayment membership at a higher price. It is too early to institutionalize risk-adjusted capitation payment and health re-insurance in a

developing country like Rwanda. Therefore, positive incentives should be set to support the health centers, which take additional financial risks by accepting sero-positive members in their capitated prepayment pool. For example, public and international funds can be used to guarantee providers' financial risk created by sero-positive, low-income groups, as well as to pay prepayment scheme membership at a higher price to vulnerable population groups such as low-income, sero-positive patients, and as a result improve their access to care and protect them from impoverishment.

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The Rwandan Health Sector

Background

The Rwandan public health sector consists administratively of three levels, namely first, the central level Ministry of Health (MOH) with five directorates, second, 11 health regions and third, 40 health districts. Similarly, care is provided on three levels, with two public referral hospitals, 28 district hospitals, and 283 health centers in 1998. On average, one health center serves a population of 23,030, whereas one district hospital covers about 217,428 inhabitants. There are four referral hospitals in Rwanda of which one - King Faical Hospital in Kigali - was privatized in early 1998. The two public hospitals include the Central Hospital of Kigali (CHK) and the University Hospital in Butare (HUB). The psychiatric hospital in Ndera is church-owned. In 1998, additional specialized private sector care was publicly funded to 102 patients who were transferred abroad.

The Rwandan government has been a major provider of health services, while church-owned facilities are important partners, especially in rural areas. The role of private providers is still limited, but has been growing, mostly in urban areas. Although the Rwandan MOH in collaboration with international organizations created an extensive network of health facilities, shortage of public funds and weak management have caused drug and service prices for patients to increase and as a result patient utilization to drop. Rwanda's health information system (SIS) reported in 1998 every fourth citizen went for a primary care consultation at a health center (0.28 consultations per capita). In 1999, the MOH with the technical assistance of Partnerships for Health Reform projects (PHR), funded by USAID and administered by Abt Associates, addressed the financial barriers of the rural population when accessing health care. As a result, community-based health prepayment schemes were developed and implemented in three Rwandan health districts (so called "Mutuelles" or "mutual health organizations").

Health Status

Communicable diseases dominate Rwanda's burden of sickness and suffering, pointing to a debilitating excess burden among the poor. The 1998 annual report of the MOH shows for health centers, the majority (88%) of curative health encounters - about 2.3 million patient contacts - suffered of one of the five most frequent diagnoses including malaria, fever, intestinal diseases, respiratory infections, pneumonia and skin lesions. A population-based nutrition survey revealed almost half (43%) of the Rwandan boys and girls below 5 years were suffering from nutritional stunting. Exhibit 1 compares the Rwandans health status with their neighbors'. Rwanda's infant mortality rate of 131 per 1,000 live births in 1996 is considerably above the average for Sub-Saharan Africa (91/1,000), as well as the country's under-five mortality rate of 205 per 1,000 live births in 1996 scores highly compared to the Sub-Saharan African rate (147/1,000). Average life expectancy at birth is estimated at 49 in Rwanda in 1997, and the total fertility rate is higher (6.5 in 1996) than in Sub-Saharan Africa (5.6)¹.

¹ Republic of Rwanda. *Rwanda Development Indicators* 1999. Kigali.



Exhibit 1: Health Outcome Indicators in Rwanda compared with Sub-Saharan Region and Low Income Countries

Region / Country Year	Maternal mortality ratio per 100,000	Mortality rate under age 5 per 1,000	Infant mortality rate under age 1 per 1,000	Estimated HIV Prevalence	Life expectancy in years
Sub-Saharan Africa (97)	430	147	91	9 %	49
Low Income Econom. (97)	308	100	80	5 %	61
Rwanda (1997)	810	205	131	11 %	48.5
Rwanda (1991)	300 (1988)	150	84	n/a	46

(Source: Rwanda Development Indicators 1998, World Bank World Development Report 1993, World Health Organization Annual Report 1999, Enquête Démographique et de Santé Rwanda 1992)

HIV/AIDS

In 1997, the Ministry of Health "Programme National de Lutte contre le SIDA" (PNLS) conducted a population based sero-survey and identified approximately 11% of the adult population to be HIV-positive. HIV-prevalence in rural areas has increased since 1986 from 1.3% reaching urban levels of 10.8% in 1997. Highest prevalence rates (20%) were found among women in age groups 25-34, as well as among respondents working in the service sector (16% - 19%),² a small and economically the most productive population group. The prepayment scheme of Matyazo accepted about 50 HIV-positive members who are poor, and whose one-year premium has been subsidized. Thanks to their "Mutuelle" membership, sero-positive patients now have access to basic preventive and curative care at the health center, as well as to drugs on the essential drug list without the threat of impoverishment. Increasing incentives for health centers that do not exclude sero-positive patients would seem appropriate.

National Health Accounts (NHA)

The MOH, in collaboration with PHR, collected and evaluated utilization and financial health data to establish National Health Accounts (NHA) in Rwanda. NHA are designed to give an essential and comprehensive description of sources and flows of health money, showing where the resources come from, and how they were used in the health sector. Exhibit 2 presents first NHA results. The Rwandan health sector is at largely financed by foreign assistance, which allows total health spending in percent of GDP to reach comparable levels as in Uganda and other Sub-Saharan countries. However, the government contribution to health in terms of government overall spending (2.6%), as well as in terms of total health sources (11%) remains at a dismal level, although about half of the total health franc goes to the public sector.

² Republic of Rwanda. PNLS: *The Rwanda national HIV/STD/AIDS strategic plan. Framework for the MTEIII period 1998 to 2001*. Kigali 1998.

Exhibit 2: NHA Rwanda 1998

Total Population in 1998	7,883,000
Exchange Rate in 1998	USD 1 = FRw 317
Total GDP (nominal) estimated for 1998	FRw 631,680,000,000 (USD 1,992,681,388)
Total government expenditure and net lending in 1998	FRw 117,431,000,000 (USD 370,444,795)
Total Health Expenditures (NHA 1998)	FRw 27,049,110,452 (USD 85,328,424)
Per Capita Health Expenditure Total in 1998	FRw 3,431 USD 10.8
Public	FRw 421 USD 1.3
Private	FRw 850 USD 2.7
International Sources	FRw 2,160 USD 6.8
Total Health Expenditures as Percent of nominal GDP	4.3 %
Public	0.5 %
Private	1.1 %
International	2.7 %
Percent of total government expenditure spent on health care in 1998	2.6 %
Sources of Funds Distribution:	
Public:	11 %
Public Firms:	1 %
Private:	25 %
International:	63 %

Despite the important foreign support of 63% to the health sector, initial NHA data reveals poor access to health care and poorer health status than people living in neighboring countries. Findings conclude an inefficient allocation of health funds and emphasize the need to develop and implement essential financial management tools and information systems at all levels of the health sector.

Use of and Expenditures on Outpatient Health Care by a Group of HIV Positive Individuals in Rwanda

July 2000

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Partnerships
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Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *better informed and more participatory policy processes in health sector reform;*
- ▲ *more equitable and sustainable health financing systems;*
- ▲ *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- ▲ *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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The opinions stated in this document are solely those of the authors and do not necessarily reflect the views of USAID.

Abstract

Nearly eleven percent of the Rwandan population is estimated to have HIV/AIDS making this one of the most important health issues facing the country. To date, estimates of expenditures on HIV/AIDS in Rwanda have suffered from many shortfalls including the absence of a consistent methodology, reliance on secondary data analysis, and a lack of information on private out-of-pocket expenditures. Under the USAID funded global Partnerships for Health Reform Project, for the first time, the National Health Accounts framework and methodology is being used to estimate expenditures on HIV/AIDS in Rwanda. This methodology will address some of the shortfalls in earlier studies.

This paper presents key findings from a survey of three hundred and fifty HIV positive individuals who were either enrolled in a HIV/AIDS support group or sought care at four selected health facilities. The study examines their socio-demographic status, their use of and expenditures on health services, and how these expenditures were financed. On average individuals in the sample had been HIV positive for 4.52 years. For both males and females the most important reason for getting tested was that the individual was either sick or had symptoms that made them think that they might be HIV positive. Following this it was either their partner or another individual in the household having HIV. A key finding from this study was that HIV seriously impairs the ability of households to meet basic needs.

For the entire sample the annual per capita rate of health service utilization translated to 10.92 outpatient visits. This compares with a per capita use rate of 0.29 outpatient visits for the general population in 1998. However, significant differences emerged in use rates according to gender, marital status, income, and place of residence. Similar differences also emerged in terms of the level of expenditures on health services.

A key finding of this study is that less than thirty percent of households were able to meet the costs of health services exclusively from their own resources. Most households resorted to multiple ways to pay for health care including receiving assistance, borrowing, and selling assets. Sixty-six percent of households received some kind of assistance, 18% had to borrow money to pay for care, and 5% had to sell assets.

The study findings highlight the need for more systematic research to better understand the impact of HIV/AIDS on households. At a minimum, the findings highlight gender, income, and place of residence inequities in the use and expenditures on health services as well as the ability to mobilize non-household resources to pay for care. Clearly, policy interventions are required to address these inequities. Rwanda is one of the few countries that has developed and implemented a clearly articulated policy for dealing with the AIDS epidemic. However, given the current state of the economy, level of health expenditures, and reliance on donors for funding health costs it is difficult to see the government being able to mobilize significant new resources to pay for expenditures on treatment for this population. Alternatively, the government should strengthen and expand its efforts to prevent the spread of this disease, and finance access to basic care for low-income groups.

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1. Introduction

The Partnerships for Health Reform (PHR) Project, is USAID's global flagship project on health sector reform and systems strengthening. Through PHR, USAID aims to improve health policy and health system capacity and increase public and private sector resources for priority health services in developing countries. PHR seeks to improve people's health by improving health system performance to increase the use of high-quality sustainable priority health services. Currently, the PHR project is working with HIV/AIDS Division of USAID to gather specific information on how global HIV/AIDS interventions are financed and managed.

PHR was specifically asked by USAID to collect data on the sources and uses of funding for HIV/AIDS services in Rwanda. Earlier studies to estimate HIV expenditures in Rwanda have been undertaken (i.e. Emberg, G., et al., Shepard, D. 1998, UNAIDS); however, the accuracy of these estimates is challenged by 1) a lack of a consistent methodology; 2) the reliance on secondary data analysis; 3) a focus on public expenditures; and 4) a lack of information on private out-of-pocket expenditures. PHR has suggested that the NHA framework, which is a method for gathering national health financing and expenditure data from both the public and private health sub-sectors, including consumers, could be a more accurate tool to estimate expenditures on HIV. Because NHA tracks all expenditure flows across a health system, and links the sources of funds to service providers and to ultimate uses of the funds, NHA can answer questions of: Who pays? How much? For what? The flow of funds that NHA depicts is critical to policymakers who seek to identify health system problems and opportunities for improvement, to develop and select the best resource allocation strategy, and to monitor impact and adjust policies. In the fall of 1999, the PHR project in collaboration with the Rwandan MOH and WHO, developed a methodology to capture accurate estimates on the sources and uses of funding for HIV/AIDS in Rwanda using the National Health Accounts (NHA) framework.

The National Health Accounts exercise in Rwanda has four objectives: 1) to first develop a methodology to collect HIV disease specific and program specific expenditures; 2) to test the methodology through data collection and analysis; 3) to integrate the results from the HIV data collection into the overall framework of NHA; and 4) to build the capacity of in-country nationals to replicate the NHA exercise. Ultimately it is hoped that as a result of this activity, the MOH will be equipped to better understand and track sources of funding and expenditures on health and HIV/AIDS and that the results of the NHA study could lead to improved resource allocation decisions.

Because the NHA model strives to show public, private and out-of-pocket expenditures on health services, surveys designed to collect primary data from the different levels of programming were conducted. These surveys were also developed by PHR, in collaboration with the MOH and took place in hospitals, pharmaceutical companies, NGOs, etc.

Presented in this paper, are the findings from the outpatient survey on the use of and expenditures on health care by a sample of HIV positive individuals. The findings from this survey serve two important purposes: 1) to provide a snapshot of health expenditures at the household level that will add perspective to the overall picture of health expenditures on HIV in Rwanda; and 2) to add to the small body of literature that examines the impact of HIV on households (Over, M., et al., 1998, Bechu, N, 1998, Janjaroen, S.W., 1998, Kongsin, S., 2000). Included in the paper will be descriptions of the sample, in terms of socio-demographics, how HIV has affected the quality of life

for HIV positive individuals, where and by whom treatment was sought, per capita utilization rates, and how this care was financed.

1.1 Background on Rwanda

Rwanda, located in Sub-Saharan Africa, has a population of nearly eight million people, half of which is below the age of 20 (Republique Rwandaise. 1996). Rwanda is a low-income country, with a per capita GDP in 1998 of \$252, which is well below the 1990 level of \$270. Nearly three-fourths of the population lives below the poverty line, and according to the World Bank, the number of poor households jumped sharply from 1993 to 1997; today more households are living further below the poverty line than before the genocide in 1994 (World Bank. 1998. Rwanda Poverty Note).

Despite the GDP growth rate of 9.6% in 1998, Rwanda's average annual growth projections are slowing to 6.8% for 1999 to 2003 (World Bank, 1999. Rwanda at a Glance). Since the war in 1994, external resource inflows have contributed to the limited recovery of Rwanda's economic growth, rather than the recovery of productive capacity. Despite these advances, Rwanda faces a bleak economic future as its' external and domestic debt rose rapidly from just under \$400 million in 1985 to about \$1 billion in 1996, and to \$1.4 billion in total debt stocks (including arrears) by the end of 1998, equivalent to 72% of GDP.

Approximately 90% of Rwandans are active in the agriculture, the most labor intensive and least productive sector. The agriculture sector produces nearly one-third (37%) of the country's GDP; with coffee and tea remaining the principal export crops. However, in Rwanda most agricultural production is still subsistence agriculture, primarily for household or community consumption. Industry and manufacturing constitute about 23% of GDP and employ 2% of the population; comparatively, 7% of the labor force works in the service sector producing 43% of GDP in 1998.

In terms of health care, the per capita amount spent by the Government of Rwanda has dropped significantly since before the genocide in 1994. In 1998, the Rwandan government spent on a per capita basis \$6.80 on debt service and \$1.30 on health. This amount represents a fall in the real terms from the pre-war target level of \$4.5 on health care (World Bank. 1999. World Development Indicators). Table 1 below, shows how Rwanda's public health spending as a share of total government expenditures remained at a low level of 2.6% of total government expenditures. NHA 1998 data reveals, that 63% of the Rwandan health sector is financed by international organizations, 25% by private households, and 12% by the Rwandan government.

Table 1: Summary Statistics NHA Rwanda 1998

Total Population in 1998	7,883,000
Exchange Rate in 1998	USD 1 = FRw 317
Total GDP (nominal) estimated for 1998	USD 1,992,681,388
Total government expenditure and net lending	USD 370,444,795
Total Health Expenditures (NHA 1998)	USD 85,328,424
Per Capita Health Expenditure Total in 1998:	USD 10.8
Public	USD 1.3
Private	USD 2.7
International Sources	USD 6.8

Total Health Expenditures as Percent of GDP :	4.3 %
Public	0.5 %
Private	1.1 %
International	2.7 %
Percent government total expenditure spent on health in 1998	2.6 %
Sources of Funds Distribution in 1998:	
Public:	11 %
Public Firms:	1 %
Private:	25 %
International:	63 %

1.2 HIV/AIDS in Rwanda

Sub-Saharan Africa has less than 10% of the world's population but it accounts for 80% of AIDS deaths, 70% of new infections, 95% of the world's AIDS orphans, and 90% of children with AIDS or with HIV infections (Bloom, D. E. 1999). In Rwanda, the first AIDS cases were identified in 1983. In 1997, the Ministry of Health's National Program for the Control of AIDS (PNLS) conducted a population based sero-survey and identified approximately 11% of the adult population to be HIV-positive. Prevalence rates for both rural and urban areas were also included. In rural areas, the prevalence rate has increased since 1986 from 1.3% to 10.8% in 1997, rivaling rates found in urban areas. The highest prevalence rates (20%) were found among women in age groups 25-34, and among respondents working in the service sector (16% - 19%), and that females were up to two times more likely to be infected than men. The survey pointed to the reality that the economically productive population in Rwanda is and will continue to be impacted by the virus.

Despite the assumption that knowledge of HIV is estimated to be high due to widespread IEC campaigns, significant behavior change is not documented and condom use remains low. The same study reports that 70% of commercial sex workers (CSW) tested sero-positive and only 10% of them practiced protected sex, with clients determining the use or non-use of condoms. Rural and urban areas report a relatively high prevalence of STIs, indicating that STIs and HIV are widespread in the country; and according to PNLS, individuals with a history of STIs, were two to three times more likely to be infected with the virus than those without previous infections. Also contributing to the spread of the virus, is the continued practice of wife inheritance and wife sharing among siblings in parts of rural Rwanda.

Community studies also conducted in Rwanda revealed that AIDS is highly stigmatized; in a survey it was found that 60% of the respondents refused to associate with a person who has AIDS (Republique Rwandaise. PNLS. 1998).

1.3 The Government's Response to the HIV/AIDS Crisis

Rwanda is one of the few countries that has developed and implemented a clearly articulated policy for dealing with the AIDS epidemic. In collaboration with its partners, the Ministry of Health (MOH) and PNLS redefined Rwanda's HIV/STD/AIDS strategy in 1997 and a multi-sectoral approach was selected for the national guiding policy. In terms of actual programming, the Rwandan PNLS focuses its efforts on co-ordination, monitoring, and evaluation of HIV prevention, resource

mobilization, and surveillance, while health regions are tasked with implementing preventive activities (Republique Rwandaise. PNLS. 1998).

Unfortunately, the success of this strategy is challenged by the gross lack of voluntary testing and adequate counseling in the country. HIV testing is being done only somewhat systematically in two public tertiary hospitals in Kigali and in Butare. Based on physician interviews and review of patient records at the Central Hospital of Kigali (CHK) it is estimated that 60% of the patients hospitalized in the internal medicine department are sero-positive. According to the hospital, patients are not generally screened for the virus, and those who are and do test positive are very likely not to be informed about their health status because of the lack of follow-up and stigmatization of the disease. In the same respect, district hospitals or health centers generally do not screen for the virus; given there is no adequate follow-up for the patient. Clearly, the decision not to test individuals, or to inform individuals who have been tested of their HIV status, raises many ethical questions, and limits the government's ability to control the epidemic.

1.4 Methodology of Data Collection

In 1998 the Partnerships for Health Reform Project in collaboration with the MOH and WHO initiated the first National Health Accounts for Rwanda, and in the fall of 1999 the HIV/AIDS component was integrated into NHA activity. In an effort to capture data on out-of-pocket expenditures on health services the researchers embarked on a survey to examine both the utilization of, and expenditures on outpatient health services by 350 households that reported at least one sero-positive individual.

A first version of the household questionnaire developed by the researchers was presented to the NHA steering committee, which consists of representatives from the Ministry of Health, the Minister of Finance, the Rwandan National Bank, and donors, and is presided by the Secretary General of the MOH. The questionnaire was modified after receiving inputs and additional questions from the National AIDS program (PNLS), UNAIDS Kigali and AIDSMARK/PSI. The questionnaire was then pre-tested by social workers on 20 patients at CRIS, an HIV meeting and counseling center in Kigali.

The questionnaires were addressed to HIV positive individuals who were informed about their health status. Interviews were conducted in four health facilities, namely at the Central Hospital of Kigali, an outpatient health center of Bilyogo in Kigali, a consultation center in Kigali (CRIS), and at the AIDS association in Butare. Interviews were conducted by social assistants who worked at one of the four facilities, and who had known the patient over a period of time and have established a personal relationship with the patient. PHR's analyst supervised the data collection process.

Table 2: Household Survey Collection Sites

Collection Site	Description	Interviewers	Number of questionnaires
CHK	Central hospital of Kigali. Only few patients were informed about the diagnostic, thus the small number of questionnaires.	6 social assistants	12
Bilyogo	Health center in Kigali offering an AIDS service with currently more than 600 HIV patients and their families. Supported and headed by Spanish nuns.	4 social assistants	193
CRIS	Rwandan Information Center on AIDS (Center for pre- and post-test counseling)	4 social assistants	40
AIDS Association in Butare	Christian association in Butare headed by an Italian nun. Counts about 180 members, all sero-positive. Members benefit from limited financial support for basic food, clothing and primary health care.	3 social assistants	105

1.5 Study Objectives

This study is the first attempt to analyze the use of health services, expenditures and how these services are financed by HIV positive individuals. Results of the survey will be integrated into the National Health Accounts framework, and will be used to estimate out-of-pocket expenditures by HIV positive individuals. It is also hoped that findings assembled will add to the small body of evidence on household level expenditures by those who have HIV/AIDS; and will inform public policy to deal with the AIDS epidemic in Rwanda.

1.6 Data Limitations

Data collection for this activity was constrained by two key factors: 1) only few health facilities provide HIV testing and identify their sero-positive patients; and 2) certain facilities do not inform patients about their status. For example, at the time of collection (January 2000), the CHK reported, no HIV test has been done during the prior four months (Sept - Dec 1999), limiting the number of eligible patients interviewed to twelve. Generally, health centers and hospitals reasoned that because there is no follow-up treatment such as counseling or improved access to symptomatic treatment, patients would not need to be tested. Health facilities which provide HIV tests are often part of a research study on the subject (e.g. some health centers in district of Byumba), but are not part of an ongoing testing and counseling.

Thus, the sample of individuals in this study would not represent the universe of those who have HIV for the following reasons: 1) the sample has a selection bias, because the participants in the study have been tested and are aware of their HIV status; 2) as it will be shown in the paper, the majority of individuals were tested because they thought they were infected, or because they were experiencing symptoms of HIV, versus finding out their status during the course of a routine testing.

2. Results of Analysis

2.1 Sample Characteristics

Table 3 provides the socio-demographic characteristics of the sample. There were 348 individuals who were HIV positive. Of these 85% were females; 69% were from urban areas; and less than 8% had secondary education or higher. The high percentage of females in the sample probably means that they were more likely to enroll at facilities as well as seek care and counseling. Similarly, the high proportion of urban residents likely reflects the fact those facilities and institutions that provide counseling and treatment tend to be urban based. Given the age distribution of the sample we decided to collapse the age groups into the four categories shown in the table. Over 73% of the sample were between the ages of twenty-six and forty-five; half were widowed and only 13% were married. As will be seen later the high proportion of widowed individuals puts an increased strain on their ability to pay for health services. We used the household expenditures to create expenditure quintiles and these are used as proxies for income. The median household expenditure of the sample was higher than that of the general population.

Table 3: Sample Characteristics

Category	Females (n=293)	Males (n=53)	Total Sample (n=348)
Place of Residence			
Urban	77.9%	15.9%	69.0%
Rural	22.1	85.0	31.0
Age Groups			
Less than 25	7.5	0.0	6.4
26-35	46.4	26.4	43.4
36-45	38.9	45.3	39.9
46 and Older	7.2	28.3	10.4
Marital Status			
Single	19.5	24.5	20.3
Married	8.0	43.0	13.0
Widowed	54.0	25.0	50.0
Divorced/Separated	4.0	6.0	5.0
Co-habitant	14.0	2.0	12.0
Education Level			
Primary	75.8	66.7	75.8
Post Primary	17.0	27.3	17.0
Secondary and Higher	7.3	6.1	7.3

Note: Education Level shown only for those who reported having gone to school.

Table 4 shows that there were 4.5 persons on average in the sample households. A little over 8% were one or two individual households, 45% had between three and five individuals, 34% had between six and eight individuals, and the remaining 12% had nine individuals or more. In twenty-six percent of these households there was at least one person other than the respondent who was HIV positive.

Table 4: Percentage Distribution of Households by Number of People

Number of People	Percent
Up to 2 Persons	8.4%
3-5 Persons	44.7
6-8 Persons	34.3
9 or more Persons	11.7
Average Number Per Household	4.5
Households with at least one other person with HIV	26%

2.2 Diagnosis of HIV

Table 5 shows that on average individuals in the sample had been HIV positive for 4.52 years. This is higher for females (4.63 years) than males (3.96 years). Forty-one percent of females and 32% of males had been HIV positive for five years or more.

Table 5: Percent Distribution of Sample by Number of Years since Diagnosis

Category	Percent Distribution		
	Females	Males	Total
< 1 year	3%	9%	4%
1-2 years	16%	25%	18%
2-3 years	9%	8%	9%
3-4 years	10%	17%	11%
4-5 years	17%	8%	16%
5-6 years	7%	0%	6%
6-7 years	9%	6%	9%
> 7 years	25%	26%	26%
Total	100%	100%	100%
Mean	4.63 years	3.96 years	4.52 years

The researchers are interested in knowing the reasons that prompted these individuals to get tested (Table 6). Clearly, for both males and females the most important reason for getting tested was that the individual was either sick or had symptoms that made them think that they might be HIV positive. Following this, it was either their partner or another individual in the household having HIV. Routine pre-natal tests and other tests leading to a HIV positive diagnosis was given as a reason by a small proportion of the sample.

Table 6: Reason for Getting Tested (Percent)

Category	Percent Distribution		
	Females	Males	Total
Had Symptoms	25%	41%	30%
Was Sick	44%	68%	53%
HIV in household	8%	6%	8%
Partner had HIV	22%	19%	24%
Pre-natal test	6%	0%	6%
Blood test	5%	9%	6%
Other Reasons	3%	0%	3%
Total	113%	145%	130%

Note: Sum adds to more than 100% because multiple reasons given

2.3 Impact of HIV on Quality of Life

One finding that became evident from the survey was that HIV seriously impairs the ability of households to meet basic needs. Table 7 shows that 73% of households were either unable to or meet with difficulty the food needs of the household. The corresponding percentages for other categories of basic needs are 57% for housing, 86% for education, and 82% for clothing. While longitudinal studies will be required to better understand the longer-term economic impact of HIV on households these findings do indicate that these are probably quite severe.

Table 7: Ability to Meet Basic Needs of Household

Category	Very Well	Well	With Difficulty	Unable
Food	6.4%	20.4%	55.8%	17.4%
Housing	9.8%	32.4%	34.6%	23.2%
Education	2.9%	11.6%	44.9%	40.6%
Clothing	1.7%	15.9%	62.6%	19.7%

Tables 8, shows the impact of HIV on the ability of the respondent to work. Table 9 shows the number of days of work missed in the past two weeks. While Table 8 indicates that 67% of the respondents reported that HIV had no impact on their ability to work, 56% reported that they had lost or missed at least one day of work in the past two weeks due to ill-health. On average, respondents missed 4.8 days of work in the previous two weeks due to ill health. Nearly 35% of the respondents had missed at least one week of work with 20% reporting that they could not work at all in the past two weeks.

Table 8: Impact of HIV on Ability to Work

Category	Percent
No effect	67%
Affected ability for < 3mths	18%
Affected ability for >3mths	15%

Table 9: Number of Days of Work Missed in Past Two Weeks

Number of Days	Percent
0	43.9%
1	1.7%
2	4.2%
3	5.9%
4	3.0%
5	4.6%
6	1.7%
7	10.1%
9	0.4%
10	2.5%
11	0.4%
12	1.3%
14	20.3%
Average Number of Days Lost	4.8 days

2.4 Location Of Facility And How These Were Reached

Table 10 shows that the vast majority of respondents used facilities that were in their community. This could be both a reflection of the manner in which the sample was drawn as well as the fact that individuals in rural areas might live too far away and might not be able to pay to travel to urban centers for treatment.

Table 10: Location of Facility

Category	Percent
In the Community	85%
Outside the Community	15

The observations made earlier are reinforced by the fact that the primary reason for choosing a facility was the distance from home. Reputation and the cost of care were other key factors that influenced that choice of facility.

Table 11: Reason for Choosing Facility

Category	Percent
Condition Not Improved	2%
Distance from home	33
Cost of Care	11
Reputation	17
Employer Required	3
Specialty of Care	2
Referred	3
Others	28

Table 12: How Facility Was Reached

Category	Percent
Walked	62%
Bicycle	1
Bus or Taxi	31
Friend Gave Ride	2
By Car	3
Others	1

2.5 Utilization of Outpatient Health Services

Table 13 shows that fifty-five percent of the respondents reported at least one health-related visit to a facility in the past month. Thirty-percent had one visit, 14% had two visits, and the remaining 11% had three visits.

Table 13: Percent Distribution of Sample by Number of Visits

Number of Visits	Number of Persons	Percent
0	156	45%
1	105	30%
2	47	14%
3	40	11%
Total	348	100%

The visits in the past month were transformed into annual per capita use rates and these are presented in Table 14. For the entire sample the annual per capita use rate translated to 10.92 outpatient visits. This compares with a per capita use rate of 0.29 outpatient visit for the general population in health centers (MOH Health Information System, 1998). Some interesting findings emerge from these results. While women formed a greater proportion of the sample, males used more health services per capita than females. Those living in urban areas used over ten times the number of visits as those in rural areas reflecting probably both the lack of access as well as the inability to pay

for the latter. Those who were married used more health care than the widowed. The lowest use rates were for those who were either single or divorced. This could reflect both health status as well as ability to pay. Not surprisingly, those in the highest expenditure quintile (5) had twice as many visits per capita as compared with those in the lowest expenditure quintile (1). Similarly, the lowest level of health care use was found among those who had only primary education. While these findings cannot be generalized to the entire population that is HIV positive it is clear that once individuals who are HIV positive decide to enroll with a health facility or counseling center they become high users of health care services.

Table 14: Annual Per Capita Use Rate for Outpatient Visits

Category	Males	Females	Total Sample
Total Sample	12.68	10.61	10.92
Place of Residence			
Urban	13.06	34.89	26.45
Rural	6.00	2.34	2.45
Age Groups			
Less than 25	0.00	7.64	7.64
26-35	17.14	10.07	10.73
36-45	12.00	11.68	11.74
46 and older	9.60	11.43	10.67
Marital Status			
Single	11.08	6.83	7.61
Married	15.13	12.52	13.83
Widowed	11.08	11.54	11.51
Divorced/Separated	8.00	8.31	8.25
Co-Habitant	12.00	12.00	12.00
Expenditure Quintiles			
Quintile 1	4.00	8.63	8.19
Quintile 2	21.60	10.76	11.62
Quintile 3	9.33	8.89	8.95
Quintile 4	14.67	10.59	11.20
Quintile 5	18.86	15.75	16.45
Level of Education			
Primary	11.45	11.14	11.18
Post Primary	29.33	20.14	22.38
Secondary and Higher	18.00	15.60	17.00

2.6 Expenditures on Outpatient Health Services

Table 16 shows that annual per capita health expenditures by the respondents in the sample was \$63 which constituted a significant proportion of total household expenditures, and was considerably above the average household per capita health expenditure of \$2.7 as reported in Table 1. Looking at the pattern on expenditures we see that not only do males use more health services per capita they

also spend 2.6 times as much as females. Those living in urban areas spent nearly three times per capita as those living in rural areas. Individuals in the highest expenditure quintile spent over thirteen times that spent by individuals in the lowest expenditure quintile and those who were married spend three times as much per capita as those who were widowed. Thus, as with male utilization, those living in urban areas, those with higher incomes, and the married spent much more on a per capita basis for health services when ill.

Table 16: Annual Per Capita Expenditures (Rwandan Francs) in 1999. (Exchange Rate USD 1 = FRw 350)

	Total FRw Per Capita	USD
Total Sample	22,175	63
Gender		
Females	17,724	51
Males	46,780	134
Place of Residence		-
Urban	15,821	45
Rural	5,384	15
Expenditure Quintiles	FRw	USD
Quintile 1	6,302	18
Quintile 2	5,645	16
Quintile 3	10,287	29
Quintile 4	13,379	38
Quintile 5	84,813	242
Age Groups		
Less than 25	17,534	50
26-35	17,960	51
36-45	27,145	78
46 and older	22,527	64
Marital Status		
Single	11,961	34
Married	63,735	182
Widowed	20,998	60
Divorced/Separated	4,950	14
Co-Habitant	4,013	11
Level of Education		
Primary	22,980	66
Post Primary	77,092	220
Secondary and Higher	53,640	153

Table 17 disaggregates health expenditures by type of service. For all categories the expenditures on medicine accounted for the largest percentage of expenditures (61 %). This was

followed by consultation fees (13 %) and then by investigations (6 %). Transportation costs accounted for less than 5 percent of expenditures for both urban and rural residents.

Table 17: Percentage Distribution of Expenditures by Type of Service

	Fees	Medicine	X-Rays	Lab-Test	Transport	Others	Total
Total Sample	13%	61%	6%	6%	4%	10%	100%
Gender							
Females	14%	65%	8%	7%	4%	3%	100%
Males	11%	52%	3%	5%	4%	24%	100%
Place of Residence							
Urban	14%	55%	4%	3%	5%	20%	100%
Rural	13%	61%	4%	16%	5%	0%	100%
Exp. Quintiles							
Quintile 1	15%	63%	3%	13%	5%	0%	100%
Quintile 2	23%	47%	4%	11%	4%	10%	100%
Quintile 3	10%	65%	9%	5%	11%	0%	100%
Quintile 4	12%	50%	12%	19%	7%	1%	100%
Quintile 5	12%	62%	6%	4%	3%	13%	100%
Age Groups							
Less than 25	24%	72%	0%	3%	0%	0%	100%
26-35	18%	59%	6%	9%	6%	3%	100%
36-45	9%	57%	7%	4%	4%	18%	100%
46 and older	8%	77%	6%	7%	1%	1%	100%
Marital Status							
Single	20%	54%	4%	9%	9%	3%	100%
Married	15%	50%	7%	4%	3%	21%	100%
Widowed	9%	72%	6%	7%	4%	2%	100%
Divorced/Separated	45%	0%	32%	0%	23%	0%	100%
Co-Habitant	10%	58%	1%	6%	4%	21%	100%
Level of Education							
Primary	10%	68%	9%	8%	4%	2%	100%
Post Primary	16%	53%	3%	4%	1%	22%	100%
Secondary and Higher	10%	66%	8%	9%	11%	0%	100%

2.7 How Health Expenditures Are Financed

A very important research question that we tried to answer in this survey was how these households financed health care expenditures. Table 18 shows that a very small proportion of households were able to meet the costs of health services exclusively from their own resources. Most households resorted to multiple ways to pay for health care including receiving assistance, borrowing, and selling assets. Sixty-six percent of households received some kind of assistance, 18% had to

borrow money to pay for care, and 5% had to sell assets. The high proportion of households that reported receiving assistance reflects community and church support systems that exist in Rwanda. In the absence of these the impact of health expenditures would have been even more catastrophic for these families.

Table 18: Sources of Financing for Health Expenditures

Category	Percent
Received Assistance	66%
Borrowed	18%
Sold Assets	5%

Table 19 shows the source of assistance. Only 28% of households reported that they needed no assistance. The church was the single largest source of assistance followed by family and friends. At least for this sample of respondents the role of non-governmental agencies, international organizations, and health insurance in meeting the costs of health care was negligible.

Table 19: Source of Assistance

Category	Percent
Family/Friend	11.8%
Employer	3.8%
Church	16.2%
International Organization	0.5%
NGO	0.3%
Health Insurance	0.8%
Other private sources	38.7%
No Assistance	27.9%
Total	100.0%

Those who reported having borrowed (18%) were asked from whom they had done so. Sixty-four percent reported that they had received a loan from a friend or neighbor, 16% reported having borrowed from family, 7% had borrowed from banks, 5% from various non-governmental organizations, and the remaining 9% from other sources. Once again the family, friends, and community are the primary source of support.

Table 20: From Whom Borrowed

	Percent
Family	16%
Friend or Neighbor	64%
Bank	7%
NGOs	5%
Others	9%
Total	100%

Table 21 compares with the cost per visit and how this was financed. For the sample of respondents we noticed that while the cost of the visit was FRw 2,030 the individual received from assistance, borrowing, and sale of assets amounted to FRw 14,163. This key finding combined with other results from the analysis would lead one to hypothesize that HIV seriously impaired the ability of the respondent to meet the basic needs of the household. Hence, not only had they to either seek assistance, borrow, or sell assets to meet the cost of care but they also had to use these resources to meet the other needs of the household. Quite clearly the large difference that we observed in this survey calls for a much more detailed study to better understand how HIV affects households.

Table 21: Average Cost Per Visit, Average Amount of Assistance Provided per Visit, Average Amount Borrowed per Visit, and Average Sale of Assets per Visit

	Average Cost per Visit	Average Amount of Assistance Provided per Visit	Average Amount Borrowed per Visit	Average Sale of Assets per Visit
Total Sample	\$6.40	\$21.32	\$20.03	\$3.32
Gender				
Females	\$5.27	\$18.97	\$21.04	\$1.13
Males	\$11.64	\$32.22	\$15.35	\$3.80
Residence				
Urban	\$4.85	\$4.70	\$3.64	\$0.26
Rural	\$2.12	\$2.47	-	\$0.08
Income				
Quintile 1	\$2.43	\$3.02	\$0.01	\$
Quintile 2	\$1.53	\$2.29	\$0.29	\$
Quintile 3	\$3.62	\$9.65	\$0.70	\$0.50
Quintile 4	\$3.96	\$6.40	\$4.84	\$1.18
Quintile 5	\$16.26	\$65.88	\$70.43	\$11.26
Age Groups				
Up to age 25	\$7.24	\$6.26	0.0	\$-
26-35	\$5028	\$18.75	\$12.75	\$0.20
35-45	\$7.35	\$3.01	\$31.33	\$0.74
46 and older	\$6.85	\$2.58	\$12.17	\$0.74
Marital Status				
Single	\$4.89	\$3.63	\$0.26	\$-
Married	\$14.86	\$71.58	\$53.12	\$16.43
Widowed	\$5.79	\$14.95	\$21.25	\$1.08
Divorced	\$1.89	\$4.97	\$	\$
Co-Habitant	\$1.08	\$6.68	\$0.45	\$
Education				
Primary	\$7.76	\$22.95	\$25.89	\$8.28
Post Primary	\$15.95	\$40.03	\$37.79	\$1.34
Secondary and Higher	\$17.98	\$78.15	\$63.09	\$-

3. Conclusions

In Rwanda, as in other countries, HIV/AIDS is not only a health problem but has strong social and economic dimensions, and is competing for limited resources with other urgent health care demands such as malaria, diarrhea, respiratory infections. The findings from this study seem to indicate that females might be more likely to enroll at facilities, as well as seek care and counseling. On average individuals in the sample had been HIV positive for 4.52 years. This is higher for females (4.63 years) than males (3.96 years). For both males and females the most important reason for getting tested was that the individual was either sick or had symptoms that made them think that they might be HIV positive. Following this it was either their partner or another individual in the household having HIV. Routine pre-natal tests and other tests leading to a HIV positive diagnosis was given as a reason by a small proportion of the sample. These findings confirm our earlier observations that routine testing for HIV is not common and given the stigma attached with this condition even when tests show the person to be sero-positive these findings are not communicated.

A key finding from this study was that HIV seriously impairs the ability of households to meet basic needs. Nearly three-quarters of the households either were unable to or met with difficulty the food needs of the household. In the same respect most of the household could not meet other basic need. Findings indicate that 57% households could not meet their basic need for housing, 86% did not meet basic education needs, and 82% of those indicated that they could not cover all of their basic clothing needs. Also, on average, respondents missed 4.8 days of work due to ill health in the past two weeks. Nearly 35% of the respondents had missed at least one week of work with 20% reporting that they could not work at all in the past two weeks. While longitudinal studies will be required to better understand the longer-term economic impact of HIV on households these findings do indicate that these are probably quite severe.

While these findings cannot be generalized to the entire population that is HIV positive it is clear that once individuals who are HIV positive decide to enroll with a health facility or counseling center they become high users of health care services. For the entire sample the annual per capita use rate translated to 10.92 visits. This compares with a per capita use rate of 0.29 outpatient visits for the general population in 1998. However, significant differences emerged in use rates by different characteristics. While women formed a greater proportion of the sample males used more health services per capita than females. Those living in urban areas used over ten times the number of visits as those in rural areas reflecting the more limited access as well as limited income among rural respondents. Those who were married used more health care than the widowed and those in the highest expenditure quintile had twice as many visits per capita as those in the lowest expenditure quintile.

Looking at the pattern on expenditures we see that not only do males use more health services per capita they also spend 2.6 times as much as females. Those living in urban areas spent nearly three times per capita as those living in rural areas. Individuals in the highest expenditure quintile spent over thirteen times that spent by individuals in the lowest expenditure quintile and those who were married spent three times as much per capita as those who were widowed.

A key finding of this study is that less than thirty percent of households were able to meet the costs of health services exclusively from their own resources. Most households resorted to multiple ways to pay for health care including receiving assistance, borrowing, and selling assets. Sixty-six

percent of households received some kind of assistance, 18% had to borrow money to pay for care, and 5% had to sell assets. The high proportion of households that reported receiving assistance reflects community and church support systems that exist in Rwanda. In the absence of these the impact of health expenditures would have been even more catastrophic for these families.

The study findings highlight the need for more systematic research to better understand the impact of HIV/AIDS on households. At a minimum, the findings highlight gender, income, and place of residence inequities in the use and expenditures on health services as well as the ability to mobilize non-household resources to pay for care. Clearly, policy interventions are required to address these inequities. Rwanda is one of the few countries that has developed and implemented a clearly articulated policy for dealing with the AIDS epidemic. However, given the current state of the economy, level of health expenditures, and reliance on donors for funding health costs it is difficult to see the government being able to mobilize significant new resources to pay for treating health treatment for this population. The government should strengthen and expand its efforts to prevent the spread of this disease, and finance access to basic care for low-income groups.

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Partnerships
for Health
Reform

Piloting Prepayment Schemes in Rwanda

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University Research Corporation

Piloting Prepayment Schemes in Rwanda

Pia Schneider and Miriam Schneidman

Introduction

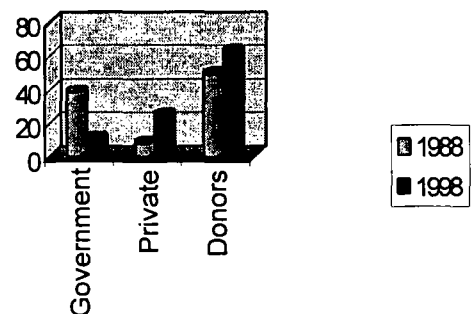
Growing concerns over rising poverty and the sharp drop in demand for health services during the post-genocide period motivated the Rwandan government to seek innovative ways to assure access to quality health care. With international donors announcing plans to scale back their assistance in the late 90s, Ministry of Health (MOH) officials decided to look for local, alternative methods of financing health care. To this end, authorities launched an innovative prepayment scheme in three of the country's 40 health districts. This article describes briefly the context in which the reform was initiated, the main features of this innovative scheme, and the preliminary results. Finally, it summarizes lessons learned which might be of relevance to other countries in sub-Saharan Africa that are facing stringent financial constraints, worsening poverty levels, and poor utilization of health services.



Background

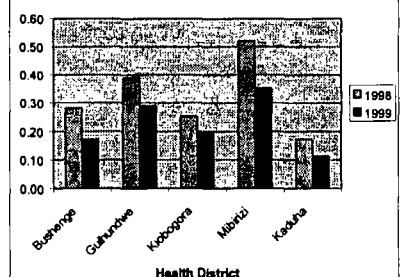
With a per capita GDP of US\$253 Rwanda ranks amongst the poorest countries in the world. From 1993 to 1997 there was a sharp rise in poverty, with the proportion of households falling below the poverty line increasing from 53 to 70 percent. Over 90 percent of the population engages in subsistence agriculture, which is the least productive sector. The health sector is characterized by heavy dependence on external aid (Exhibit 1) with the country receiving close to US\$7.0 per capita for health. During the last decade the government's share of the overall contribution to health plummeted to a historical low (i.e. less than 12 percent of total health funds) with households and donors assuming an increasing and unsustainable financial burden.

Exhibit 1: Sources of Health Funds



Rwanda has a long standing tradition of charging user fees for health services and drugs. However, during the humanitarian phase after the 1994 genocide primary health care was provided free of charge in most health facilities. In 1996, the MOH re-introduced user fees, which had a discernible detrimental impact on utilization. By 1999, utilization of primary health care services dropped to a national average of .25 annual consultations per capita. Even districts benefiting

Exhibit 2: Rate of Utilization of Curative Services, by Health District



from donor-funded investments experienced a drop in utilization rates (Exhibit 2), emphasizing that investments in strengthening the service delivery system are important but not sufficient. Governments need to also focus on the factors influencing the demand for health care (e.g. high opportunity cost; perceived poor quality of care; limited purchasing power; seasonal variations in cash income).

The population recognized the need for solidarity health care mechanisms and a number of spontaneous but isolated mutual health funds emerged throughout Rwanda. With technical assistance and financial support from the Partnerships for Health Reform project, funded by USAID and administered by Abt Associates, the MOH launched a major pilot scheme in 1999 which was expected to provide the elements for nationwide replication.

The MOH spearheaded the design of the scheme and encouraged a *highly participatory process*. A steering committee, headed by the Director of Health Care and including government and civil society representatives from the central and regional levels, was established to coordinate the activities. Key stakeholders from the communities met in a series of district workshops and community gatherings to agree upon the organizational and management features and the modalities for its implementation. Proposals stemming from these meetings were shared with the central steering committee, which provided feedback and advice to the districts.

A series of focus group sessions was also organized to seek the views and attitudes of the local population. Participants expressed concerns about their deteriorating financial access to health services, the poor quality of care, and their strong interest in participating in trustworthy mutual health organizations. They also acknowledged their lack of experience in organizing themselves in associations or mutual help organizations. These sessions were followed up with several sensitization and awareness campaigns using radio spots, newspaper articles, and community meetings with local political and church authorities, where the population was informed about the introduction of the scheme.

Rationale & Objectives

The overriding goal of the pre-payment scheme (PPS) is to improve equity in access to quality health care for the rural population. The scheme was also expected to provide incentives for providers to raise the quality and efficiency of service delivery and to foster local participation in its design and management, thereby empowering communities to take responsibility for their health care. The PPS was based on the premise that even the poor are willing to pay for health care. Nevertheless, they need a mechanism for pooling risks and for addressing seasonal fluctuations in revenues associated with a subsistence economy.

Key Features

The main features of the pilot and control districts selected by the committee are presented below (Exhibit 3). Participating districts were selected based on the following criteria: *commitment* of the population and of local authorities; availability of a *functioning district hospital* with a network of health centers; and some *prior experience* in implementing PPS.

Exhibit 3: Health Centers in Pilot and Control Districts, 1998

Indicators	Pilot Districts			Control Districts		Rwanda
	Byumba	Kabgayi	Kabutare	Bugasera	Kibungo	
District population	429,367	368,020	262,160	262,465	265,313	7,883,000
Average population per health center	21,468	21,648	16,385	18,748	26,531	23,887
Number of health centers	20	17	16	14	10	330
Per capita consultations	0.5	0.5	0.7	0.6	0.3	0.3

Each health center is partnering with a PPS, which is headed by an executive bureau of five volunteers, which are elected by the local population. The *management structures* selected by the districts differed with two opting for joint management with the health facility while Kabutare chose their PPS to be autonomously managed by the population. The *benefit package* for PPS members in each district, which was defined by community representatives, is summarized in Exhibit 4. By paying an annual premium of Rwf 2,500 per family (US\$6.80 equivalent) at time of enrollment, members are entitled, after a one-month waiting period, to a basic health care package covering all services and drugs provided in their 'preferred' health center, ambulance transfer to the district hospital, and a limited package at the district hospital.¹ Members pay a 100 Rwf (US\$.27 equivalent) co-payment at each health center visit. Hospital services are covered for PPS members only if referred by their preferred health centers, which play a gatekeeper function to discourage inappropriate use of hospital facilities.

Exhibit 4: Health Center and Hospital Benefit Packages

Package	Kabutare	Byumba	Kabgayi
Health Center	<i>Services covered during first contact:</i> - Preventive and basic curative care by nurses - Drugs on essential drug list - Hospitalization at health center - Ambulance transfer to district hospital	Same as Kabutare	Same as Kabutare
District Hospital	<i>Covered with health center referral:</i> - Consultation with physician - Overnight stay - Cesarean-Section	Same as Kabutare	<i>Covered with health center referral, full treatment per episode:</i> - Cesarean-Section - Pediatric cases (<5 years) - Malaria (>5 years)

The three PPSs opted for a *capitation method* for paying primary care providers, particularly as there was a consensus that the traditional fee-for-service method would be too cumbersome administratively and might provide undesirable incentives to over treat. Hence, *risk pooling* for the health center package took place in the catchment area of each health facility with providers receiving a monthly capitation payment for each member whereas hospital risks were

¹ Premium rates were set by taking into account existing user fees and by assuming that utilization rates would increase by 25 percent compared to baseline levels.

pooled at the district level. Hospitals were to be paid a negotiated per episode payment for cesarean sections, malaria, and pediatric cases, and a fee-for-service rate for physician consultations and overnight stay. Each PPS bureau was to forward one tenth of its monthly disbursements to the district PPS federations for the reimbursement of the district hospitals.

Preliminary Results

The one-year performance of the PPS is being monitored and evaluated under a quasi-experimental design. Qualitative and quantitative data are gathered from households, patients, service providers, and scheme managers. Routine data are collected for longitudinal comparison over a 2-year period, one year before and one year after the launch of prepayment schemes.

Overall, the preliminary results are promising. Prepayment scheme members have better access to health care than non-members. They seek care earlier, need fewer drugs and contribute on a per capita basis about three times more than non-members. The pre-payment scheme appears to be a viable tool for improving financial autonomy of health centers with relatively low fixed costs, high membership levels and moderate use by scheme members.

Membership Enrollment During the past eleven months more than 83,000 Rwandans signed up in the three pilot districts, reflecting on average about 7.5 percent of the total population of these districts.² Out of the total membership, some 3,000 indigents (e.g. widows, orphans, HIV infected persons) were signed up and had their premiums paid by religious authorities, showing how such schemes can be used to subsidize the poor. Although the overall growth in enrollment compares favorably with mutual health experiences in other parts of sub-Saharan Africa³, this result fell short of the government's ambitious first year target of 30 percent. Enrollment growth was influenced by competing claims on family expenditures (e.g. school fees, local taxes) and by the ad hoc nature of the flow of subsidies received from others (e.g. religious authorities). The weakest enrollment was during months when rural households do not have any cash available (March - April).

Key factors explaining enrollment performance include the *organizational expertise* and *leadership* of PPS executive bureaus. The PPS with the highest enrollment rates had *prior experience* with mutual health funds, linked up with health centers with *qualified personnel* and established *strong partnerships* with NGO-run facilities. While all PPS executive bureaus initially experienced organizational problems and volunteer turnover this led to re-elections, and ultimately to stronger bureaus with enhanced credibility and higher enrollment levels. Anecdotal evidence also suggested that membership was influenced by the degree of trust and solidarity in these communities.

² Of these members, roughly 46,000 lived in Byumba (10 percent of population), about 17,000 in Kabutare (6 percent of population), and a little more than 20,000 in Kabgayi (5.5 percent of population).

³ For example, a similar scheme in Tanzania enrolled some 2500 households during the first year of operation and another one in Benin had only 15,000 beneficiaries after seven years of operation.

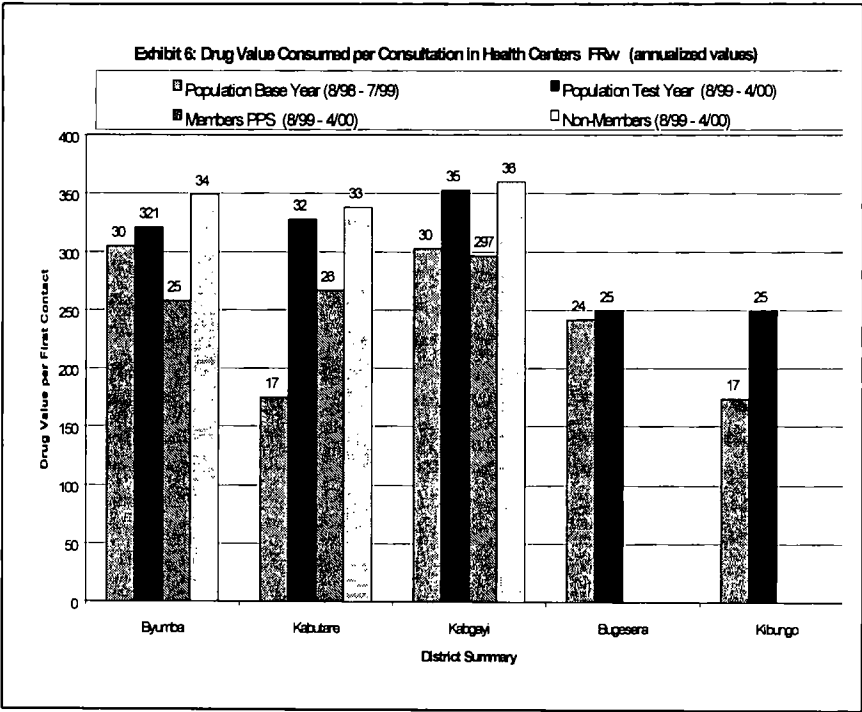
Utilization of Health Care While utilization rates declined across the board in all pilot districts, new case consultations for PPS members were up to seven times higher than for non-PPS members. On average, PPS members visited health centers more often, reporting annualized rates of about 1.2 new case consultations in Byumba, 1.5 consultations in Kabutare, and roughly 1.6 in Kabgayi (Exhibit 5). By contrast, annual consultation rates for non-members hovered at only .2 per capita in the pilot and control districts. It is clear that the goal of increasing financial access has been attained.

Exhibit 5: Average First Contact Consultation Rates in Health Centers Before and After Introduction of PPS

Annual Consultations per Person	Pilot Districts			Control Districts	
	Byumba	Kabutare	Kabgayi	Bugesera	Kibungo
Population Base Year (8/98-7/99)	0.24	0.47	0.32	0.27	0.19
Population Test Year (8/99-4/00)	0.21	0.33	0.29	0.23	0.20
PPS Members (8/99-4/00)	1.18	1.54	1.57	NA	NA
Non-Members (8/99-4/00)	0.16	0.29	0.26	NA	NA

Quality of Health Care Several health centers introduced qualitative improvements in the management and supervision of health services. For example, Byumba replaced the auxiliary personnel who were heading its health centers with trained nurses. This had a positive impact on membership rates that doubled within a three-month period. The frequency and quality of supervision has also been strengthened in many health centers. Priority is given to discussing specific quality of care issues, strengthening data collection, and improving use of standard treatment protocols.

Using limited resources in a rational way contributes to improving the quality of care. Efficiently provided care would be expected to minimize the value of drugs consumed per consultation since conditions would be diagnosed earlier, before heavy medication is required. Compared to the year before the launch of the PPS, the value of drug consumption in all districts has increased for non-members. By contrast, the drug value per consultation for members decreased in Byumba, remained the same in Kabgayi, and increased in



Kabutare but not as high as for non-members (Exhibit 6). Health center personnel reported that PPS members seek care earlier and need fewer drugs than non-members.

Resource Mobilization and Cost Recovery

Prepayment schemes show the potential to improve mobilization of local resources for primary health care. Exhibit 7 shows clearly that members report per capita contributions three times as high as non-members. Prepayment schemes helped to increase the per capita contribution of the total population in the districts of Kabutare and Kabgayi, whereas the overall decline in Byumba was only partly softened by members' higher contribution.

Exhibit 7: Average Per Capita Financial Contribution in Health Centers Before (8/98 - 7/99) and After Introduction of PPS (8/99 - 4/00) (annualized in RF)

Annual Per Capita Contribution	Pilot Districts			Control Districts	
	Byumba	Kabutare	Kabgayi	Bugesera	Kibungo
Population Base Year (8/98 - 7/99)	156	165	179	174	129
Population Test Year (8/99 - 4/00)	137	185	190	150	148
Members PPS (8/99 - 4/00)	491	573	535	NA	NA
Non-Members (8/99 - 4/00)	121	174	182	NA	NA

The general decline in consultations, however, has left many health centers with workloads below capacity and declining revenues. Health centers which continued depending heavily on non members' fee-for-service payments have been unable to adjust their fixed cost structure, and thus experienced a decline in overall cost recovery levels. Generally, the degree to which health centers could improve their cost recovery ratio, depended on their productivity, and the extent to which PPS members used health care services.

Lessons Learned

A number of important lessons have been generated in the initial year of these pilot schemes.

- *First, the schemes have demonstrated the willingness to prepay for care of an important segment of this low-income population if certain conditions were fulfilled.* These include: high quality of care, financial trustworthiness of scheme managers, strong degree of community solidarity, and the "right" incentives (e.g. affordable premiums and co-payments). The success of these schemes is also driven by high level political support, strong leadership, and technical support for their design and implementation.
- *Second, the Rwanda experience has also shown that such schemes can be effectively used as a mechanism for targeting subsidies to the poor.* For example, governments and donors could assume financial responsibility for membership of vulnerable groups by paying higher premiums, thereby providing incentives to providers to accept higher-cost patients.
- *Third, the introduction of the PPS has had some positive secondary effects.* Amongst these we can cite greater local participation and empowerment of communities in the health care marketplace. Schemes with large membership pools have become important interest groups in these communities. In a post-genocide society where the social fabric was seriously

destroyed, the introduction of the mutual health schemes has the potential to rebuild trust and democratic processes.

- *Fourth, the introduction of the schemes has the potential to assure regularity of funding for health facilities, thereby contributing to quality and efficiency improvements.* As the Rwanda experience has shown this will depend on sustained membership growth, a critical mass in membership levels, and discouraging over-use of health services.
- *Finally, while the schemes emerged as a response to the limitations of existing health care financing strategies, they should not be seen as a justification for government disengagement.* In low-income countries there will be continuing need to broaden the tax base to assure minimal levels of public financing of health care.

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Spotlight

Prepayment Programs in Rwanda: More than 12,000 Members in Two Months

UPDATE: On Sunday, September 26, the MOH in Rwanda broadcast a weekly national two hour radio program on PHR-sponsored prepayment schemes in Butare, Kabgavi, and Byumba. In the studio, presenting information on prepayment schemes and responding to questions, were the minister of health and high-level government representatives, together with the president of the federation of prepayment schemes in Byumba. Citizens from all of Rwanda were given the opportunity to call and ask questions.

Rwandans currently contribute to the financing of their health care costs through user fees. While this may appear to be a straightforward system—you pay for health care only if and when you need it—it has several drawbacks: Even low fees may prevent the poor from seeking care when they truly need it. This is especially a problem for certain socioeconomic groups, such as farmers who have “extra” cash only on a seasonal basis, or low-wage workers who are not paid when they are too sick to work. Also, only those who seek care contribute towards the cost of health care; this denies ongoing financial resources to a health care system or group.

Prepayment schemes address these problems. Under prepayment, individuals or households pay a premium into a health care fund on a regular basis, usually annually, semi-annually, or even monthly. Payment of the premium entitles the individual or household to seek health care services in a defined benefits package, for a given period of time, without additional payment. Contributions from persons who do not fall ill help to cross-subsidize the care of those who do.

In the first half of 1999, the Rwanda Ministry of Health, in collaboration with PHR and community members from three districts, developed a prepayment scheme. Its objectives are to improve access to and quality of health care; engage community members in program administration; and strengthen management capability in health centers and districts. On July 1, prepayment pilot programs were introduced in the three districts, management committees were constituted, and contracts were signed with health care facilities. The programs were publicized on national radio theater broadcasts. By September 1, more than 12,000 Rwandans—1.3 percent of the



Prepayment scheme members, Rwanda

population of the three districts—had enrolled in the programs.

While each district program has unique aspects, the three programs share certain features: All members join by paying an annual premium. Each district offers care at 15 to 20 health centers and one hospital. The

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	X	X				Capacity building
PSI		X		X	X	X			X	X		X	X				

PVOs/NGOs

CARE		X		X	X	X	X		X		X	X	X		X		
World Relief	X	X		X					X		X				X		
Doctors Without Borders		X	X	X					X		X						
Salvation Army		X	X	X	X				X		X				X		

KEY:	Advoc.	Advocacy	MTCT	Mother to Child Transmission activities
	BCI	Behavior Change Intervention	Research	HIV/AIDS research activities
	Care/S	Care & Support Activities	Policy	Policy monitoring or development
	Training	HIV/AIDS training programs	STD	STD services or drug distribution
	Cond.	Condom Distribution	VCT	Voluntary counseling and testing
	SM	Social Marketing	Orphan	AIDS orphan activities
	Eval.	Evaluation of several projects	TB	TB control
	HR	Human Rights activities	Other	(i.e. blood supply, etc.).
	IEC	Information, education, communication activities		

RWANDA AND HIV/AIDS

Key Talking Points

Rwanda is among the nine African countries hardest hit by the HIV/AIDS epidemic:

- About 13 percent of the adult population are infected with HIV.
- HIV prevalence rates range from 11 to 56 percent among high-risk groups.
- More than 370,000 Rwandans are living with HIV—180,000 of them with AIDS.

AIDS Deaths AIDS is one of three leading causes of death in Rwanda. It claimed 36,000 lives in 1997 and has already reduced life expectancy from 54 to 42 years.

Women and HIV/AIDS In 1997, 30 percent of pregnant women in urban Kigali antenatal clinics and 15 percent in other regions tested positive for HIV. A post-war survey found that many women had been raped, and that victims of rape were more likely to be infected with HIV.

Youth and HIV/AIDS In 1997 the estimated HIV prevalence among the sexually active population younger than 20 was almost 10 percent. Four percent of Rwandans ages 12 to 14 are already infected with HIV.

Children and HIV/AIDS Over the next 16 years, AIDS is expected to increase Rwanda's already high infant mortality rate of 130 deaths per 1,000 live births by 10 percent. At the end of 1997, Rwanda had 94,000 AIDS orphans.

Reconstruction and Development The HIV/AIDS epidemic will have a severe social and economic impact on a country already overburdened with debt and the bitter legacy of a genocidal civil war. Families struggling to survive will lose food and income as adults become too ill to work. Government services will be unable to meet the increasing need for care and support. And the loss of so many productive workers will slow efforts to rebuild and develop Rwanda's economy.

USAID was the first bilateral mission to resume programs in Rwanda in 1995. This prompt assistance made it possible to quickly launch HIV prevention activities throughout the country. USAID dedicated \$1 million in FY 1997 to HIV/AIDS activities.

National Response HIV/AIDS is now considered a national priority. The government's health budget was increased by 23 percent in 1999, with an emphasis on HIV/AIDS. The national AIDS program has developed a strategic plan for 1999-2001 and a national HIV/AIDS prevention and communication strategy.

Despite this progress, Rwanda faces formidable challenges in responding to the epidemic. More immediate threats to health, including violence and inadequate access to housing, clean water, sanitation, and nutrition, make people more vulnerable to HIV and more fatalistic about their risk of infection. Continuing ethnic conflicts keep urgently needed health workers and HIV prevention programs out of war zones, and religious resistance makes it difficult to promote condom use.



U.S. Agency for
International Development
Population, Health and Nutrition
Programs
HIV/AIDS Division

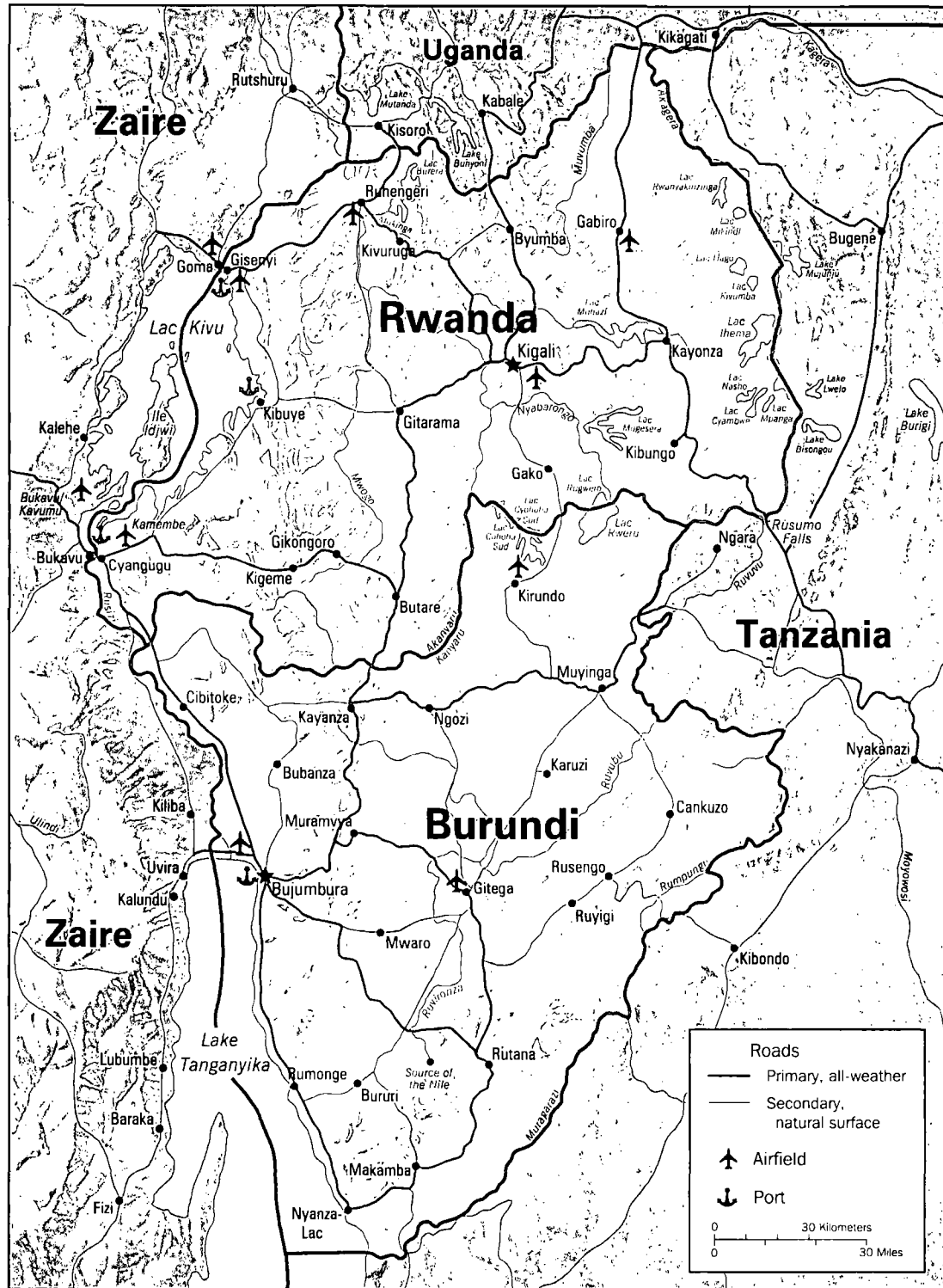
1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
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Implementing AIDS Prevention
and Care (IMPACT) Project

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516-9779
Fax: (703) 516-9781
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Rwanda and Burundi





Christian Barratt <chbarratt@usaid.gov>

08/25/2000 07:47:00 AM

Please respond to chbarratt@usaid.gov

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: Rwanda DHS data on the hoof -

Hi everyone -

Last Friday I got my hands on the first regional "dose" of data from the Rwanda demographic and Health Survey (DHS), currently in the field. They are completely covering one region at a time, then proceeding to the next one while data entry is done in Kigali. This will permit us to have complete regional data sets as each fieldwork is done in each region.

Last weekend I was fooling around with the first set, from the Prefecture of the City of Kigali (population around 700,000) and made a short report for the Minister and other donors. Pretty basic, but wanted it to be easily digestible. I'll think of adding a few more tables for the next one. Recall that Rwanda is 90% rural, so this is as good as it will get as far as education or infrastructure dependent indicators...

They are entering and editing the data from the next 3 regions now, so I'll be making a similar installment about every 10 days until all 11 regions are finished. I'm holding off for another 24 hours to sending this around Kigali to give my friends at ONAPO, the local survey partner, to distribute under their name. I wanted them to get some good press from this.

ciao.cb



- DHS COMMENTS PVK.DOC



- MIXGRAPH PVK.DOC



- PVK COVER.DOC



- PVK PROJECTIONS.XLS

Impact of Genocide on AIDS in Rwanda.

The genocide and civil war in Rwanda has had a profound effect on the AIDS epidemic in the country. Massive movements of people, targeted violence against women, and the sheer numbers of family members massacred have radically altered the demographics of sexual behavior in the country. Large numbers of health workers were killed and infrastructure destroyed. These changes have placed large numbers of Rwanda's most vulnerable at high risk of HIV and crippled its ability to respond effectively to the epidemic on its own.

The genocide and war of 1994 caused nearly the entire Rwandan population to be displaced from one place to another. More than 3 million people became refugees in Congo and Tanzania. Populations from urban areas, where HIV prevalence was traditionally much higher than in rural areas, mixed with those from rural settings, causing an abrupt infusion of more risky cultural and sexual norms to traditional rural practices. A country-wide sero-survey showed that HIV prevalence in rural areas was less than 1.8% in 1987, but jumped to more than 10% after the genocide.

In 1996, after two years in refugee camps, there was a sudden human wave of more than 2.5 million of these former refugees returning to their homes. At the same time, more than 1.5 million "old case refugees" (who had fled ethnic conflicts in 1959) were returning from Uganda, Tanzania, Burundi, and Congo. In some of these areas, HIV prevalence rates were more than 30% and the likelihood of returning to Rwanda with HIV was high. This massive return of people changed the profile of HIV/AIDS in Rwanda.

Rape was used as a weapon of violence and humiliation against Tutsi women during the genocide, similar to the practice during the conflicts in the former Yugoslavia. Women were specifically targeted in radio messages before the genocide, and HIV infection was a clear objective, according to survivor reports. Men known to be infected with HIV were encouraged to rape and sexually torture Tutsi women. A 1999 report of rape among genocide survivors by AVEGA, a Rwandan Women's Organization, showed that roughly one third of the over 900 survivors interviewed had been infected with HIV during the genocide. A United Nations report on the situation of human rights in Rwanda found that "rape was the rule and its absence the exception". Available statistics estimate the number of women raped during the genocide between 250,000 and 500,000.

The number of children of the war ("children of hate") is estimated by the National Population Office at between 2,000 and 5,000. Health workers report that some women have abandoned their children or committed infanticide, while others have decided to keep them. Some of these children were born with HIV and place a lingering heavy financial and psychological burden on their families.

Young girls were often forced to become "wives" of their attackers, and in some cases become sexually active at very young ages. These young girls were put at considerable risk of HIV infection.

Some (Rwandan) leaders in Rwandan refugee camps campaigned against condom use in order to increase their ethnic group's birth rate. A study by Care International in 1996, in Benako camp in Tanzania, (home to 250,000 refugees) showed that condom use fell from 12% to 5% in parallel with refugee leaders' encouragement of young men to impregnate as many women as possible to replenish their population. These politically motivated strategies placed large groups of displaced and vulnerable women at high risk of HIV and other STDs.

Following the genocide, large numbers of women and girls suddenly found themselves without the social and economic protection of husbands and fathers. Exact numbers are not known, but many women have been forced to turn to the commercial sex trade to survive in Rwanda. Latest estimates of HIV prevalence among commercial sex workers are around 76%. The genocide also produced 85,000 child-headed households, roughly half of which are headed by girls. These girls are also at high risk of being trapped into selling sex to survive.

Large numbers of health workers were killed during the genocide, and health infrastructure destroyed. Rwanda was left without the capacity to provide basic health services, much less AIDS education and guidance on safe sexual behavior. As the most devastating change in the epidemic following the horrors of the genocide, many Rwandans still view AIDS as merely something which might kill them far in the future, while they struggle to survive today.

REPUBLIC OF RWANDA
Ministry of Health
National AIDS Control Programme

HIV / AIDS

IN RWANDA

**A National Disaster that
requires multisectorial
involvement**

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.

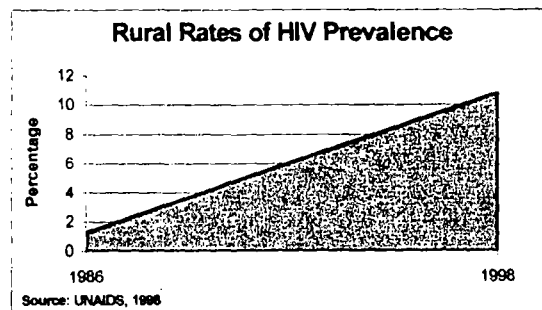
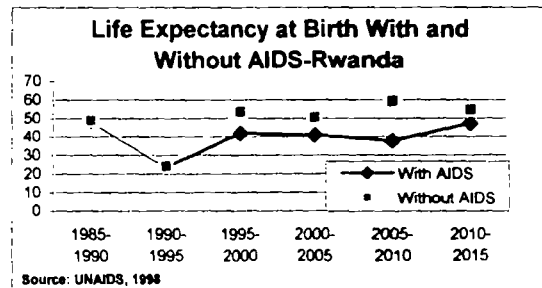
Overall health in Rwanda remains poor, with only 27 percent of Rwandans living within a one-hour walk of a health center. Infectious diseases—malaria, respiratory infections, HIV/AIDS and other sexually transmitted infections (STIs), and diarrhea—were the predominant cause of morbidity and mortality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

HIV/AIDS EPIDEMIOLOGICAL PROFILE

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 400,000 Rwandans—almost 11 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 30 percent in low-risk groups (prenatal care attendants) to 61 percent in high-risk groups (sexually transmitted infections patients). 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.

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- Life expectancy has been reduced from 54 to 42 years as a result of AIDS.
- Data correlating HIV and Tuberculosis (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 high prevalence of Sexually Transmitted Infections; the availability of commercial sex; and resistance to talking openly 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 .

The war and genocide 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.

HIV/AIDS and Women

- In 1997, 25-30 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 Sexually Transmitted Diseases) are much more likely to be HIV positive (26%) , than those with no such history, at only 10 percent seropositive.

Much of this shift in the epidemic can be attributed to the huge population movements during and after war and genocide. Nearly three-quarters of 4,700 Rwandans surveyed in 1997 had lived elsewhere in the preceding three years. The study found that 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 suffered from these political problems. The war also 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.

- 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

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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.

Rape—inside or outside refugee camps—has no doubt played a part in spreading the virus in Rwanda. Some 2.2 percent of women surveyed by PNLs 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 Sexually Transmitted Infections 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.

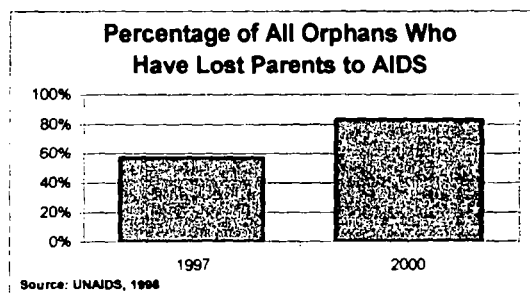
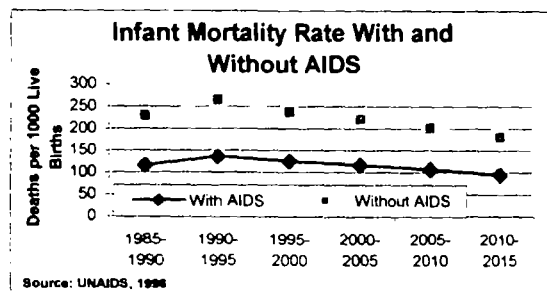
Children and HIV/AIDS

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 are going to bring 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 due 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 PNLS, two out of five rape victims were teenagers.

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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 consequences of the genocide which has tremendously impacted on the economically active segment of the population. 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 including officers as well as enlisted personnel, may 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 sub-saharian africa countries 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.

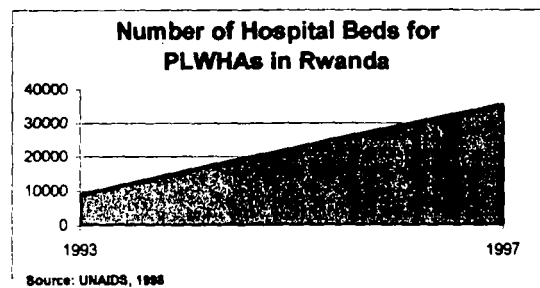
The Rwandan military is currently developing a three-year action plan to combat AIDS in collaboration with the Ministry of Health's National AIDS Control Programme (PNLS)

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 our 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.

Rwanda's healthcare system is also poorly equipped to cope with the burden 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. In CHK, more than 60% of hospital beds (internal medicine and pediatrics services) are occupied by PLWHA patients.

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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 1987, the National AIDS Control Programme (PNLS) was set up under the Ministry of Health and Social Affairs.

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.

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.

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, 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 of the Programme resulted in decentralisation of HIV/AIDS activities at region and districts levels in order to make Sexually Transmitted Infections and HIV services more available to rural populations even if the availability and quality of these services still need to be improved.

The multisectoriality for the fight against AIDS has also been boosted since 1997, resulting in more and more involvement of non health sectors in the fight against HIV/AIDS. (political leaders; education; Youth in and out of school; church; media, etc...) Multisectorial committees for the fight against AIDS (church, youth, women, armed forces, education, NGOs, local authorities, media ...) have been established in all the prefectures and are beginning to be set up at the commune level.

The Ministry of Health, in collaboration with other sectors are currently working on a project to restructure the National AIDS Commission, 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 multisectorial mobilisation

In addition to prevention programmes carried out by many actors on the field, patient care has also been a priority : care for people suffering from Sexually transmitted Infections and care for People Living With HIV/AIDS.

Since the mother-to-child transmission is the second means of HIV transmission in the country, a programme aimed at reducing the

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risk of transmission to the newborn has already been put in place since April 1999.

Since January 1999, modern treatment for PLWHA using Antiretroviral drugs has been introduced in RWANDA and the Ministry of Health is doing whatever possible to cut down the costs of this treatment so that more and more people have access to it.

HIV/AIDS Voluntary Testing and Counselling has been availed in some cities of the country and the demand is increasing every day. Programmes are currently being developed in order to avail at least one testing and counselling center per district by the end of 2001.

The Rwanda is currently the headquarters of the Great Lakes Initiative on AIDS (GLIA). This initiative to combat the spread of HIV/AIDS in the region was set up in 1998 in Kampala, following a Health Ministers meeting held in Kigali in August 1997. The GLIA was officially launched in Kigali in April 1999.

Today HIV/AIDS is considered a national priority. There is an emerging strong commitment at the highest levels of

government, as well as the church, to openly talk about HIV/AIDS as a national tragedy.

The PNLS recently finished its three-year multisectorial 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.
- Increase the availability of 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.
- Strengthen the coordination role of the national AIDS Control Programme

Challenges /Constraints

Major constraints to HIV/AIDS control in Rwanda include:

- 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.
- Limited access to 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.
- Measures are needed to ensure a safe and sufficient blood supply.
- Legislation and enforcement are required to protect the human rights of People Living With HIV/AIDS and to also regulate a number of high risk practices
- Although political leaders have started speaking out about HIV/AIDS, stigma and discrimination against infected people is still there and need to be targetted as a major constraint
- Prevention efforts don't prevent infected people to become sick and the burden on the health services goes beyond the capacity to respond. The Government will need more NGOs and community organisations involvement in order to teackle this challenge.

The Future

It is not too late for an effective response to the HIV/AIDS epidemic in Rwanda. NGOs churches, women's groups, youth'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.

The success in RWANDA will depend on how much efforts will have been put on programmes targetting the youth and on the programmes which will be designed to

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prevent further spread of the epidemics in the rural areas.

A strong political commitment to the fight against 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 multisectorial approach by making it clear that the fight against AIDS is a national priority. Third it signals to individuals and community organisations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the programmes 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 AIDS is to ensure open and supportive environment for effective programs. The Government of RWANDA need to make AIDS a national priority, not to consider it as health/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 mitigation programs can succeed and protect the country's future development prospects.



INTERNATIONAL
au RWANDA

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INTERNATIONAL AU RWANDA

MEMORANDUM

A : Sandy Thurman
DE : Uwe Korus
OBJET : F.Y.I

DATE : 13/01/00

Dear Ms Thurman,

Many thanks for your visit.
Please find enclosed a concept paper on
CARE Rwanda's HIV/AIDS Program Evolution.

Best Regards

Advocacy and Institutional Development for Protection of Unaccompanied Children and Child-Headed Households against HIV/AIDS in Rwanda) - CARE International in Rwanda's HIV/AIDS Programme Evolution and Success in Preventing and Reducing the Implications of STDs/HIV

Introduction

One of the major tragic outcomes of the 1994 genocide and its aftermath was a huge number of children who either lost their parents or were separated from them for one reason or another. In 1999 over 5,000 unaccompanied children are still living in registered centers. While tremendous success has been achieved to reduce 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 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, 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 of 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 of infections in rural areas from 1.3% in 1986, to 10.8% in 1997.

CARE's Response

CARE has adopted and implemented a multi-tiered strategy to address the issues of HIV/AIDS that have evolved over the past five years 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 the country in its successful efforts in HIV/AIDS prevention and education, widened the scope of work to include a project focusing on protecting children from HIV/AIDS, and more recently, focusing even more on children-headed households and orphans. As the program has evolved, building on successes and lessons learned in the context of post-genocide Rwanda, the CO recently was 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 AIDS/HIV prevention program to expand countrywide, while incorporating capacity strengthening 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 to be, and later confirmed, 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) and establish 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 that the peer educators trained by CARE be integrated into the government cadre of Health Animateurs.

Phase II in turn 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 with 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 for Protection of Unaccompanied Children and Child-Headed Households against HIV/AIDS Project

Throughout CARE Rwanda's work both before and post-genocide, the Country Office has developed a reputation as the leader in HIV/AIDS prevention work in the country. Concurrently, CARE Rwanda has continued to develop 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 for advocacy 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. The project 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 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, to establish sustainable services to such groups over time. This ground-breaking approach to more traditional work 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 East Africa and Middle East Country Directors, Regional Management, and CARE USA's office of the Senior Vice President, the issue of HIV/AIDS as a continued problem of unprecedented scale in the East Africa region was raised. WHO figures also support this fear, as it is estimated that about 50 - 60 per cent of HIV infections in Africa are from East Africa, an area that accounts for only 15 per cent of the total population of sub-Saharan Africa. AIDS is said to be the leading cause of death in countries such as Uganda and Tanzania. It is indeed 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, wider-reaching social implications of the AIDS pandemic on effected 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 accompany and build on the experience of country offices like CARE Rwanda working for the promotion of 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 where CARE works to mitigate the social, psychological and economic impact of HIV/AIDS on poor communities otherwise condemned to lose many of their members and thus the achievements of development work of at least two generations. This working group is comprised of members from Country Offices, CARE's South and West Africa RMU, and CARE USA's Health and Population Unit. The group is mandated to devise a strategy that builds on CARE's existing work being carried out in COs, looking closely at Rwanda's model and lessons learned. Other research results from other agencies/partners will be reviewed, and CARE reproductive health programs for youth in countries such as Kenya, Tanzania and Uganda will explore prevention in their program area. There is also notable IEC work being carried out with the youth and general public within the region.

The Way Forward

AIDS/HIV Prevention and Child Advocacy

Lessons learned and information sharing 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 are core elements to Rwanda's strategy, concurrent with advocacy and action in their HIV/AIDS prevention projects, all steering towards a unified goal. In the region and in Africa as a whole, CARE will establish and implement appropriate messages, methodologies and strategies to keep the issue of HIV/AIDS high on the agenda of the 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 millenium.

THE WHITE HOUSE
WASHINGTON

October 30, 2000

Lieutenant Annebaut Ufiteyezu
P.O. Box 3019
Kigali, Rwanda

Dear Lieutenant Ufiteyezu:

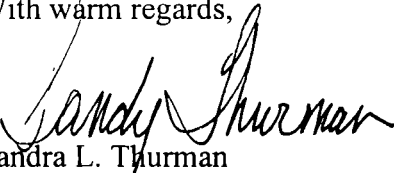
Please accept my very belated thanks for all of your wonderful support during my recent visit to Rwanda. In addition to having a wonderful time the visit was very productive. While the trips across the country and meetings with officials were very impressive, I must admit that our outing to see the gorillas was my favorite part of the trip. I can't remember the last time I was that excited about going anywhere!

I realize that you do this sort of thing all the time and are quite accustomed to the long hours, but you must have been completely exhausted by the time I left. I certainly was! However, I just wanted to tell you that you made the trip much less tiring by your constant and gracious support.

Please express my gratitude to all of your colleagues as well. You guys do a great job!

I hope to see you again the next time I am in Rwanda.

With warm regards,

A handwritten signature in black ink, appearing to read "Sandra L. Thurman". The signature is fluid and cursive, with a large initial "S" and "T".

Sandra L. Thurman
Presidential Envoy for AIDS Cooperation, and
Director, Office of National AIDS Policy