



We believe in life before death

Baseline Study of HIV & AIDS in Rwanda

Final Report

Prepared by:



March 07, 2007

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
APELAS	Rwanda Business Coalition against HIV/AIDS (<i>Association du Prive et Para-etatique dans la Lutte Contre le VIH / SIDA</i>)
ARDHO	Rwandan Association for the Defense of Human Rights
ARV	Antiretroviral Drugs / Therapy
AVEGA	Association des Veuves du Genocides
CA	Christian Aid
CDC	Centres for Disease Control
CDLS	District Aids Control Commission
CHAMP	Community HIV/AIDS Mobilisation Program
CHFI	Cooperative Housing Foundation International
CHUK	Central University Hospital, Kigali
CLADHO	<i>Collectif des ligues et associations de defense des droits de l'homme au Rwanda</i>
CNLS	<i>Commission Nationale de Lutte Contre Le SIDA</i> (National National Aids Control Commission)
CRA	Centre for Resource Analysis Limited
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EER	Eglise Episcopale Au Rwanda (Anglican Church of Rwanda)
FBOs	Faith-Based Organisations
FHI	Family Health International
GDP	Gross Domestic Product
GOR	Government of Rwanda
HIV	Human Immunodeficiency Virus
MAP	Multisectoral AIDS Project.
MDGs	Millennium Development Goals
MINECOFIN	Ministry of Finance and Economic Planning
MoH	Ministry of Health
NCS	National Census Service
NRL	National Reference Laboratory
NWC	National Women's Council
NYC	National Youth Council
NISR	National Institute of Statistics of Rwanda
OVCs	Orphans and Other Vulnerable Children
PACFA	Protection of Families against HIV/AIDS
PEER	Province of the Anglican Church of Rwanda
PEPFAR	President's Emergency Plan for AIDS Relief
PHR	Partners for Health Reform
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International

RBA	Rights-Based Approach
RDHS II, III	Rwanda Demographic and Health Surveys Round II, III
RRP+	Rwandan Network of People Living with HIV/AIDS
TB	Tuberculosis
TBA	Traditional Birth Attendants
TRAC	Treatment Research Aids Centre
UEBR	Union of the Baptist Church in Rwanda
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund.
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

Table of Contents

ACRONYMS AND ABBREVIATIONS	1
ACKNOWLEDGEMENTS	5
Executive Summary	6
1.0 INTRODUCTION	11
1.1 Background	11
1.2 Overview of Christian Aid and its Intervention in HIV/AIDS	12
1.3 The Baseline Study – Rationale and Objectives	13
1.4 Methodology Used.....	13
1.5 Study Limitations.....	14
2.0 COUNTRY CONTEXT.....	15
2.1 Geographical and Biophysical features	15
2.2 Political and Governance Context	15
2.3 Population and Demography.....	16
2.4 Socioeconomic, livelihoods and Poverty Situation	17
2.5 Gender and Cultural Context	19
3.0 SITUATION ANALYSIS OF HIV/AIDS IN RWANDA.....	21
3.1 Status and Trends in Prevalence and Distribution of the Pandemic	21
3.2 Main ways of transmission/spread.....	26
3.3 Knowledge and Behavioural change issues.....	28
3.4. Status of Treatment, Care, and Support	30
4.0 IMPACT OF HIV/AIDS ON THE POPULATION AND ECONOMY	32
4.1 Impact on the Macro Economy	32
4.2 Impact on the Micro-economy.....	33
4.3 Impact on health and health care systems.....	34
4.4 Impact on Education	35
4.5 Social security and vulnerability (orphans, widows).....	35
4.6 Impact on Women and Gender	36
4.7 Impact of HIV/AIDS on Human Rights	36
5.0 RESPONSE INTERVENTIONS TO COMBAT HIV/AIDS IN RWANDA	38
5.0 General.....	38
5.1 Major Actors/Stakeholders and Coordination Framework	38
5.2 Policy Interventions by Government	40
5.2.1 Major Aids-related Policy Initiatives and their Impact.....	40
5.2.2 Voluntary Counselling and Testing (VCT).....	41
5.2.3 Prevention of Mother-to Child-Transmission	43
5.3 Programme/Project interventions by Civil Society and other Actors	43
5.3.1 Response by Faith-based organisations	43
5.4 Response by Christian Aid and Partners.....	44
5.4.1 Shyira Diocese:	45
5.4.2 Kigeme Diocese	46
5.4.3 Byumba Diocese	47
5.4.4 Kigali Diocese.....	47
5.4.5 Union of the Baptist Church in Rwanda (UEBR).....	48
5.4.6 BARAKABAHO	49
5.4.7 CLADHO.....	49
5.4.7 AVEGA.....	50
5.4.8 ARDHO	50
5.5 Resource Mobilization and Utilisation in the HIV/AIDS Sector.....	51

5.6. Synthesis of the Main Achievements in Combating HIV/AIDS	52
6.0 ACHIEVEMENTS MADE AND EMERGING ISSUES.....	54
6.2 Programme development and Financing Issues.....	54
6.2.1. Prevention.	54
6.2.2 HIV/AIDS Programs Monitoring, Surveys and Research:	60
6.2.3 Treatment, Care and Support:	61
6.3 Institutional Partnerships and Sectoral Coordination Issues.....	65
7.0 MAJOR GAPS, CONSTRAINTS AND CHALLENGES	66
7.1 Major Gaps and Areas not sufficiently covered	66
7.2 Major Constraints and Challenges	68
8.0 CONCLUSIONS AND RECOMMENDATIONS.	75
8.1 Major Conclusions and key messages	75
8.2 Recommendations.....	77
List of References	84
Annexes.....	86

ACKNOWLEDGEMENTS

Christian Aid Rwanda takes the privilege to thank all stakeholders who facilitated the current baseline study of HIV&AIDS in Rwanda.

We are particularly grateful to Centre for Resource Analysis Limited (CRA) for leading the process and for facilitating the baseline study throughout the process.

We also thank all the participants to the validation workshop held in Kigali on February 20, 2006, whose inputs have enriched the final report.

We are thankful to the stakeholders in Kigali for sparing their useful time, during the busy period of elaborating the National Economic Development and Poverty Reduction Strategy (EDPRS), to give the consulting team audience and provide useful information, without which this report might have been difficult to prepare.

We express our utmost gratitude to the local people, local government leaders, religious leaders and district-based development workers in the fight against HIV&AIDS, particularly in the areas visited during fieldwork, for committing their time and volunteering information through interviews and discussions. It is this first hand information that formed the basis of the analysis and recommendations reflected in this report. Without their genuine participation in the discussions, the quality of this report might have been low. The recommendations made in this report, of which their inputs have sufficiently been considered, will be considered in the Christian Aid's and its partners' Programming strategy to improve their wellbeing.

***Christian Aid Rwanda
Country Manager
Tel. +250 0252 587228
B.P. 2829 Kigali***

Executive Summary

General Introduction

HIV/AIDS is one of the world's most disastrous calamities of the 20th century. In just about a quarter century of its discovery, HIV/AIDS has killed more than 20 million people, mostly productive women and men, making it a major roadblock to poverty reduction and development. Sub-Saharan Africa, where Rwanda is situated, has a disproportionate share of the AIDS pandemic and its impacts – home to about two-thirds of people living with HIV/AIDS and four-fifths of AIDS orphans. And in 2005, about 86% of AIDS related deaths in 2005 were in Sub-Saharan Africa.

Rwanda is among Sub-Saharan African countries that have been hit most by the HIV/AIDS pandemic, particularly due to high levels of poverty and the 1990s civil war and genocide. AIDS orphans account for more than 2%. But there has been significant progress in fighting the pandemic. The Demographic and Health Survey (DHS) 2005 estimated the national HIV/AIDS prevalence at 3%, which represented a decline from about 5.1% in 2003 and about 12.8% in 1998. This represents a remarkably positive trend from 5.1% in 2003 (UNAIDS 2004) and the 1997 estimates that put seroprevalence at between 11% and 12.8%. HIV/AIDS prevalence in Rwanda varies among socio-demographic categories (e.g. age groups, social status, education levels), location (urban/rural) and occupation (farm/non-farm, formal/informal sector, employed/unemployed), among other factors. More women than men are infected (2.3% for males, 3.6% for females). HIV/AIDS prevalence is also higher among urban than rural populations (7.3% in urban and 2.2% in rural areas).

In the fight against HIV/AIDS, Rwanda's political commitment at the highest level has been a key factor – with both the President and First lady personally involved in HIV/AIDS campaigns, and has been enormous support of bilateral and multilateral development partners. The partners have been involved in advocacy, funding, coordination, monitoring, and evaluation.

In Rwanda, like elsewhere in the world, civil society has been and remains at the forefront of prevention, care, and support, particularly among the most vulnerable and hard-to-reach populations (UNAIDS 2006). International civil society organizations, among others, Christian Aid, have campaigned and mobilised resources, in different fronts, for the rights of people infected with and affected by HIV/AIDS to access drugs and other forms of support, protection from discrimination and stigmatization, and mobilized resources to address poverty, gender violence, and forms of human rights violation that perpetuate the spread of HIV/AIDS.

Despite the recognition of the magnitude and significant health, economic, social, and psychological consequences of HIV/AIDS, and the increasing attention and resources

devoted to the fight against HIV/AIDS, few evidence-based answers are available to answer questions related to those with the greatest need of assistance, the most effective interventions, and the most appropriate approaches in the different settings in fighting the pandemic. Most often, donors, policy makers, and program managers have been forced to make decisions regarding allocation of scarce resources for people infected and affected by HIV/AIDS using little evidence about who are in most need of assistance, and what type of interventions would be most effective in helping them.

The Baseline Study – Rationale and Objectives

The rationale for commissioning this baseline study was to generate fairly comprehensive and reliable data on the status and trends of HIV/AIDS in Rwanda, on the basis of which Christian Aid will develop a consortium programme to support its partners. This report presents the findings of the baseline study commissioned by Christian Aid, Rwanda, as part of its programme development to support partners in the HIV/AIDS portfolio. It maps the country profile, highlights the global picture of HIV/AIDS in the country, including trends, distribution of the pandemic, the knowledge and behavioural issues, impact of the HIV/AIDS pandemic on macro and micro-economy, health, household, demography, and vulnerable groups. It also points out the response by Government, civil society, Christian Aid partners in general and specifically its work in Rwanda and resource mobilization and utilization systems.

Methodology Used

The methodology used in the study was a combination of participatory and rapid assessment techniques of literature review; interviews and in-depth discussions; and direct observations. Subject matter literature was reviewed from documents by CNLS, TRAC, NISR, MoH, and UNAIDS, among others, and we held interviews and discussions in Byumba, Butare, Ruhengeri, and Kigeme.

Key findings:

- In general, a policy environment has been created that promotes equity in access to care and support, and promotes integrated and multi-sectoral approach to HIV/AIDS control and prevention.*
- There also appears to be adequate funding for HIV/AIDS activities over the medium to long term, through the Millennium Development Commitments and the GoR's prioritization of HIV/AIDS.*
- Strong and effective mechanisms for coordination of programming; monitoring and follow-up, to reach all infected and affected people, and to ensure coherence and synergy in program design and implementation are lacking*

Major Gaps

- *Building institutional capacity among local partners; management systems for projects and programmes; financial and accounting; nutritional support and income generating projects for HIV/AIDS infected and affected persons; home-based care for HIV/AIDS patients; trauma and psycho-social counselling; HIV/AIDS and human rights issues; special interest and at-risk-groups; and provision of HIV/AIDS health care services beyond sensitization and VCT*
- *Among CA partners weaknesses include: limited or no follow-up of project activities, either due to few staff or lack of clear monitoring systems; limited coordination of activities, resulting in duplication, confusion and waste of time and resources; limited funding largely due to weak resource mobilisation and absorption capacities; little attention paid to issues of power relations in households, reproductive rights and domestic violence; and income generating activities have been supported with no adequate mechanisms to develop capacity for their conceptualization and management.*

Major Challenges

- *Extreme poverty and vulnerability among most Rwandans increases susceptibility to HIV/AIDS infection, exacerbates the effects of the pandemic, and pose serious challenges to intervention agencies;*
- *Socio-cultural barriers especially those that place women in a position of powerlessness and voicelessness, and limit communication about HIV/AIDS, remains a serious challenge to HIV/AIDS prevention and control;*
- *Declining social cohesion and responsiveness, and socio-cultural barriers which undermine efforts to fight HIV/AIDS*
- *For most partners, particularly the churches, HIV/AIDS is but a small component of the many programmes they are handling.*
- *Weak organizational capacity at grassroots levels.*
- *Lack of motivation among health service providers*
- *Behavioural change interventions are insufficient and/or inappropriate*
- *Lack of predictable and sustainable funding tend to limit programming of local civil society interventions;*
- *Coordination of programming and operations undermine the ability to develop synergy and realisation of effective results at local level. It should, nonetheless, be appreciated that many institutional mechanisms for coordination are emerging (e.g. Clusters, focal points and networks at national and district level) even though they are yet to be effective.*

Major conclusions

Rwanda's HIV/AIDS prevalence and associated effects were exacerbated by the civil strife and genocide of the early 1990s. The achievements made in reducing the infection (or prevalence) rates and other effects (deaths, socioeconomic impacts,..) since then are, arguably, enormous – HIV/AIDS prevalence rates presently stand at around 3%

from more than 10% in 1998. Combined efforts and commitment of the GoR and non state actors, particularly donors and civil society, coupled with the determination and resilience of the Rwandan population, explain, to a large measure, the positive results. The Rwandan political leadership is firmly focused on the fight against HIV/AIDS- A country review of the progress on MDGs also show that HIV/AIDS, gender and education are some of the few areas where Rwanda is highly likely to achieve the MDG targets.

The main observations that need to be considered in any planned intervention are:

- *The face of HIV/AIDS in Rwanda has changed progressively over the last one decade – from a perception of purely health/ medical problem associated with evil to a recognised national socioeconomic, cultural and political disaster requiring multi-sectoral interventions. Stigmatization and beliefs about HIV/AIDS are declining, and the Rwandan society is, on the whole, increasingly positive and passionate about sero-positive members of society. Nonetheless, there are still elements of stigmatisation, although more of perception than real. The fact that many members of society are reluctant to take HIV/AIDS tests and some PLWHA still fear to come out in the open, could, in part explain this.*
- *HIV/AIDS in Rwanda manifests spatial/ geographical variability (with marked differences between rural and urban areas), engendered, and like most of sub-Saharan Africa, associated more with poor and vulnerable groups.*
- *Yet, these differentials, particularly the gender dimension of the pandemic, including domestic violence and reproductive health and rights of women, has not received sufficient attention; many HIV/AIDS service organizations face severe constraints of funding and there exist no interventions in many areas perceived as being geographically remote;*
- *HIV/AIDS programming is increasingly following a multi-sectoral approach (i.e. Behavioural change, VCT, PMTCT, ART, IGAs...); FBOs and other locally institutionalized organizations have potential to create impact but need to be strengthened;*

Major Recommendations

- *There is need for partners to review the strategy and intensify mobilization and sensitization, and support of communities to respond to VCT.*
- *CA partners need to involve and train local leaders and community based health care workers, cell and sector coordinators, law enforcement officers, and health animators so that they can help mobilise the communities and become change agents.*
- *Strengthen partners' institutional and human resource capacity for HIV/AIDS programming, knowledge management, and learning.*
- *Empower partners with adequate resources to ensure that all areas, especially rural, are reached with the messages, care, and support to prepare and appropriately respond to the pandemic.*

- *Youth must not be thought for but empowered to be at the forefront of HIV/AIDS prevention and control.*
- *Expand partnerships and strengthen collaboration with other actors to improve service delivery particularly for people infected with or affected by HIV/AIDS.*
- *There is need for rights-based advocacy to expand coverage and improve efficiency of VCT and other health care services, with a focus on enhancing access by PLWHA.*
- *Integrate women's rights issues into the HIV/AIDS interventions.*
- *CA partners should consider increasing provision of psycho-social support, visiting, and counselling PLWHA and families affected by HIV/AIDS;*
- *Behavioural change communication (BCC) messages and strategies used to match with reality to include preventive measures that promote prevention (or protection) of sexually active people e.g. through condom use (other than the current AB only); stepping stones and other life skills training.*
- *Design multi-objective and holistic packages to include social mitigation; prevention, treatment and care e.g. where patients are assisted to access not only ARVs but also food to enable them have good nutrition and a well balanced diet.*

1.0 INTRODUCTION

1.1 Background

HIV/AIDS is one of the world's most disastrous calamities of the 20th century threatening to reverse the achievements made in human development especially in developing countries. Since the first cases were identified in 1981, HIV/AIDS has killed more than 20 million people. In 2000, the World Bank declared AIDS a development crisis because of the devastating impact it was having on per capita income of the worst hit countries. In June 2001, a Declaration of Commitment on HIV/AIDS was signed by 189 Heads of State at the UN General Assembly Special Session on HIV/AIDS (UNGASS). This signified recognition by world leaders that HIV/AIDS was a global disaster, requiring greater commitments especially in helping the poor countries where the pandemic was escalating.

Global estimates (UNAIDS 2006) indicate that about 40 million people were living with HIV/AIDS in 2005, reflecting an increase from about 37.8 million people in 2003 (UNAIDS 2004). Out of the 40 million people living with HIV/AIDS, 44% are women and about 2.3 million are children (i.e. under 15 years).

The impact of the pandemic on children is even more worrying. An estimated 700,000 children were newly infected with HIV in 2005, while about 570,000 children died due to AIDS-related complications (UNAIDS 2006). To a large measure, the problem is due to limited attention. For instance, fewer than 5% of the HIV positive children receive treatment, and about one million children who have lost parents to AIDS go without care or support.

Sub-Saharan Africa remains the most affected region accounting for about two-thirds (64%) of the total number of people living with HIV/AIDS, and home to 79% of all AIDS orphans. In addition, 86% of AIDS related deaths in 2005 were in Sub-Saharan Africa, implying that the region has a disproportionate share of the AIDS pandemic and requires global attention and new commitments. To a large extent, the AIDS pandemic has affected Sub-Saharan Africa most because there has been slow progress in introducing effective and sustainable measures for prevention, care, and treatment of people infected with and affected by HIV/AIDS (UNAIDS 2004).

In Rwanda, the first AIDS cases were identified at the Central Hospital of Kigali (CHK) in 1983. Since then, it has spread widely, affecting both urban and rural populations. The strife of the 1990s and the ensuing genocide of 1994 played a key role in the escalation of the HIV/AIDS pandemic. Out of an estimated 250,000 women who were raped and survived the genocide, at least 175,000 were reported

to have been infected with HIV (Lenoir 2004), many of whom have since died. AIDS orphans account for more than 2% of the population, and HIV/AIDS is next to malaria as the leading cause of mortality in Rwanda (MoH 2004). Table 1 below presents the Rwanda situation in relation to Sub-Saharan and global HIV/AIDS status, with respect to selected key indicators.

Table 1: Selected HIV/AIDS Status indicators for Rwanda, SSA, and Global

HIV/AIDS Indicator	Global	Sub-Saharan Africa	Rwanda
Estimated # of PLWHA	38,600,000	24,700,000	190,000
New Infections		3,200,000	
Deaths from HIV/AIDS	2,800,000	2,400,000	21,000
Orphans due to HIV/AIDS	15,200,000	12,000,000	210,000

Source: UNAIDS 2006. *Report of the Global Aids Epidemic*

In the fight against HIV/AIDS, civil society has been and remains at the forefront of prevention, care, and support, particularly among the most vulnerable and hard-to-reach populations (UNAIDS 2006). International civil society organizations (CSOs), among others, Christian Aid, have campaigned tirelessly, in different fronts, for the rights of people infected with and affected by HIV/AIDS to access drugs and other forms of support, protection from discrimination and stigmatization, and mobilized resources to address poverty, gender violence, and forms of human rights violation that perpetuate the spread of HIV/AIDS. The results are impressive – increased international funding for HIV/AIDS, tremendous reduction in the cost of anti-retroviral drugs (ARVs), and bringing dignity to people infected with or affected by HIV/AIDS.

1.2 Overview of Christian Aid and its Intervention in HIV/AIDS

Christian Aid (CA) is a UK charity founded in 1945, by more than 40 protestant churches of the UK and Ireland. Its work is inspired by Christian values, and strongly believes that every person has a right to a full and decent life. Presently, CA is working with churches and civil society organisations in more than 50 countries of the World, including Rwanda where it has been working since 1963. Like most international agencies, CA does not intervene directly, but works through partnerships with national and local organisations, providing technical and financial support to enable them reach and impact the target groups at the lowest level.

In Rwanda, CA supports 12 partners¹ including churches and other faith-based organisations, who are working to improve the poor people's lives through different interventions. CA focuses on the following sectors: Livelihoods security; good

¹ Christian Aid partners in Rwanda include: AVEGA, AVP, ARDHO, CLADHO, CPR, EER SHYIRA, EER BYUMBA, EER KIGALI, EER KIGEME, BARAKABAHO, RWARRI and UEBR.

governance; economic and social rights; HIV/AIDS; and deals with gender and capacity building as cross cutting issues, where emphasis is to encourage local stakeholders to actively participate in issues that affect them. In working to improve the livelihoods of the poor, CA follows a rights-based approach and partnership building, where it aims to strengthen the capacity of local civil society to advocate and influence the policies that affect their lives.

In the HIV/AIDS sector, CA has worked with BARAKABAHO, CLADHO, ARDHO, and the Anglican Dioceses of Byumba, Kigeme, Kigali, and Shyira. In addition, CA has worked with the Union of the Baptist Church in Rwanda (UEBR) and organised groups for vulnerable groups notably Association of the Genocide Widows (AVEGA).

1.3 The Baseline Study – Rationale and Objectives

The rationale for commissioning this baseline study was to generate fairly comprehensive and reliable data on the status and trends of HIV/AIDS in Rwanda, on the basis of which Christian Aid will develop a consortium programme to support its partners. This report presents the findings of the baseline study commissioned by Christian Aid, Rwanda, as part of its programme development to support partners in the HIV/AIDS portfolio. In accordance with the Terms of Reference (TORs), it attempts to map the country profile, highlight the global picture of HIV/AIDS in the country, including trends, distribution of the pandemic, the knowledge and behavioural issues, impact of the HIV/AIDS pandemic on macro and micro-economy, health, households, demography, and vulnerable groups. It also points out the responses by Government, civil society, Christian Aid partners in general and specifically its work in Rwanda and resource mobilization and utilization systems. Assessing impact and monitoring progress in implementation require partners to have clear baseline information and this does not exist.

1.4 Methodology Used

The methodology used in the study was a combination of participatory and rapid assessment techniques:

(a) Literature review: a number of documents were reviewed – annual reports, strategic plans, guidelines and tracking study reports from CNLS and TRAC, action plans and progress reports from partners, statistical abstracts and global HIV/AIDS status from UNAIDS, DHS reports from the National Institute of Statistics of Rwanda (NISR), and research reports from various authors. Also reviewed were GoR policy statements on poverty, HIV/AIDS, orphans and vulnerable children (OVCs), health care delivery, gender and domestic violence, and others. A list of

documents reviewed is attached at the end of the report. In identifying documents, the websites of key stakeholder institutions, particularly CNLS, MoH, NISR, and UNAIDS were particularly useful. A complementary matrix format was used as both analytical tool and to obtain data from organisations.

(b) *Interviews and in-depth discussions* were held with representatives of target institutions and organisations in Kigali and in selected provinces. In the field (outside Kigali), visits were conducted over 3 days (one day in each province/district) in Byumba, Ruhengeri (Shyira Diocese), Butare, and Kigeme (Nyamagabe district). Stakeholders interviewed in the 4 areas visited were mainly partners of Christian Aid, in addition to CDLS, local government officials and selected NGOs actively involved in HIV/AIDS work, essentially Caritas, health care providers, and some beneficiaries of the programs (mostly members of the Network of People living with HIV/AIDS (PLWHA)) and clients of the voluntary counselling and testing (VCT) services. The list of persons met is attached at the end of the report.

(c) *Direct Observations* – In Byumba and Kigeme, the team visited some projects of PLWHA supported by CA partners, and visited health care facilities where VCT services were offered.

1.5 Study Limitations

Besides the mishaps that delayed the start-up and the team's own judgemental problems, the main limitations were the following:

- difficulties in fixing appointments, which often became too bureaucratic, with some not being honoured;
- difficulties with obtaining documentation – HIV/AIDS information is very scattered among actors, and some respondents (actually most) were unwilling to provide documentation related to reports, except a few brochures which had very little information;
- Language difficulties – we had not anticipated that most documents would be in French, so we did not make provision for expertise in French.
- Most field-based respondents did not have anything written at all, so we relied on verbal information provided in interviews, which were short of facts and figures.
- Finally, and more problematic was the wide discrepancies between the multiple sources. We overcame this problem by triangulating as many sources as we could, and tracing the ultimate principal source.

2.0 COUNTRY CONTEXT

2.1 Geographical and Biophysical features

Rwanda is mountainous landlocked central African country situated between 1° 4' and 2° 51' South and 28° 53' East. It covers a total land surface area of 26,388 Sq Km, which inhabits about 8.1 million people (as of the Census 2002). It shares its northern border with the Republic of Uganda, Tanzania in the east, the Democratic Republic of Congo (DRC) in the West, and Burundi in the South. The country stands at an average altitude of 1,700 metres but the terrain is diverse with the highest ranges in the North Western being above 4,000 metres, and the lowest in the Eastern plains at below 800 metres above mean sea level. The moderate tropical montane climate affords Rwandan farmers 2 crop seasons. Average rainfall is around 1,500 mm in the north and west, while in the east it averages 900 mm.

2.2 Political and Governance Context

Rwanda is a post-conflict country, having emerged from a destructive civil war of the 1990s that culminated into massive genocide in 1994. Whilst the country has made great strides in restoring the state structures and resuscitating the socioeconomic fabric, challenges still remain.

Administratively, the country is divided into 5 provinces (including Kigali city), 30 districts, 416 sectors, 2,148 cells and 14,975 *Imidugudu*. All political positions in the local government system are now elected up to district level. The province has only a coordinating role and it is a deconcentrated tier of the central government. The lowest administrative unit, the *Umudugudu*, comprises about 50 households.

It is to be recalled that the country has just emerged from a long legacy of highly centralised governance, where decision making was top-down. The highly centralised system that had been perpetuated from pre-colonial times effectively disenfranchised the population by excluding them from participating in making decisions that affected them, alienated the leaders from the led, and created a situation of total dependency where people depended on the central government, had unquestionable royalty absolute fear of leaders. The consequence of many years of such a legacy was the 1994 genocide that decimated up to one million people. In 2000, however, the Government of Rwanda (GoR) adopted a decentralisation policy where political power, administrative responsibilities, and resources were progressively transferred to lower levels essentially district and sector levels. Enormous achievements have, in this regard, been achieved, especially in empowering local people to elect their own leaders, thereby exercising their right to

choose how they should be governed; in facilitating community development through popular people's participation in planning and decision making; and involving women, youth and other interest groups that had been excluded from decision making. Subsequently, decentralisation now provides a governance framework for all development interventions including HIV/AIDS. The centre of development planning has effectively shifted from Central Government (Ministerial level) to district and lower levels, where development needs are identified through community development committees (CDCs).

Despite the democratisation process where people have power to elect their own leaders, local leaders still hold a lot of influence, often limitless fear and respect, and in most provinces, district mayors down to cell coordinators, are regarded as icons of authority, so much so that where local leaders lack vision and charisma, development has been markedly slow compared to areas which had creative and visionary leaders (CRA/MINALOC/World Bank 2005).

With regard to women's participation in political governance and decision making, there has been increased recognition of the historical role of women especially in the post-genocide reconstruction, which, through education and international campaign to mainstream women in development, has led to gender-sensitive legislation, policy and programming. To-date, women are actively involved in politics at all levels, even-though their involvement at the local level is still low. Gender equality in Rwanda is guaranteed by the National Constitution 2003 and various legislations such as the Family Protection law that bar married men from marrying other wives and guarantees the rights of women and children to property. To ensure full women emancipation, a national gender policy and strategy has been formulated to guide mainstreaming gender across government and all spheres of life.

Political leadership is very important in the fight against HIV/AIDS, and Rwanda has provided a good example. The President and First Lady have been at the forefront of the war on HIV/AIDS, as has been the entire political leadership at the ministerial level.

2.3 Population and Demography

The August 2002 Population and Housing Census, put Rwanda's population at 8,128,553 persons, of whom 3,879,448 (47.7%) were male and 4,249,105 (52.3%) were female (NCS, 2005). The population has nearly quadrupled in the last 4 decades from approximately 2.6 million people in 1960 to approximately 8.1 million in 2002 (MINITERE, 2003). Table 2 below shows the population distribution by province and rural/urban categories.

Table 2: Population distribution by province and urban/ rural residence

Province/ city	Urban		Rural		Total
	Population	%	Population	%	
Kigali city	603,049	100	0	0	603,049
Kigali Ngali	51,693	6.5	737,637	93.5	789,330
Gitarama	137,995	16.1	718,493	83.9	856,488
Butare	137,334	18.9	588,580	81.1	725,914
Gikongoro	32,427	6.6	457,302	93.4	489,729
Cyangugu	59,070	9.7	548,425	90.3	607,495
Kibuye	46,640	9.9	422,376	90.1	469,016
Gisenyi	67,766	7.8	796,611	92.2	864,377
Ruhengeri	71,511	8.0	819,987	92.0	891,498
Byumba	66,268	9.4	641,518	90.6	707,786
Umutara	8,437	2.0	413,186	98.0	421,623
Kibungo	90,414	12.9	611,834	87.1	702,248
National	1,372,604	16.9	6,755,949	83.1	8,128,553

Source: MINECOFIN/NCS, Feb. 2004: *Census 2002 in Brief*

The key demographic characteristics of Rwanda's population, in the context of HIV/AIDS, include the following:

- *A young population* - some 5,546,015 persons (68 %) were under 25 years in 2002, 81% under 35 years (NCS 2005) and only 3% older than 65 years;
- *High population densities* - 378 persons per sq. km of habitable surface area, and a growth rate of about 3% (NCS 2005), one of the highest growth rates in sub-Saharan Africa.
- *Predominantly rural*- urban population only constitutes about 17%, with the rest being rural.
- *More female than male* - females outnumber males by 4% (i.e. female: male = 52: 48);
- *Skewed spatial population distribution* – besides urban areas, north and north-western provinces (which have high fertility levels and high agricultural production potentials) are more densely populated than south and eastern dry plains which are mainly inhabited by pastoral communities;
- *About 24% of the population are in school* (MoH 2005) and this, coupled with the fact that the population is generally young, imply high dependency levels.

These socio-demographic characteristics affect the quality of life and influence the knowledge of the population about, and their ability to protect themselves from HIV/AIDS.

2.4 Socioeconomic, livelihoods and Poverty Situation

Rwanda was ranked 159th on the UN Human Development Index (HDI) ranking for 2004 and 2005 out of 177, and is thus among the poorest countries in the world. The

1994 genocide made the rising poverty situation worse – the proportion of absolute poor increased from 48% in 1990 to 78% in 1994, a situation associated with a record decline in gross domestic product (GDP) of 50%. This period has also been associated with high population density; high prevalence of HIV/AIDS; and severe environmental degradation.

Real gross domestic product (GDP) in 2003 was approximately US \$250 per capita. Agriculture is the mainstay of the economy, providing employment to more than 80% of the population (MINECOFIN 2005). In 2003, agriculture contributed 41% to GDP, accounted for 48% of total exports and 89% of total employment (MoH 2004). A lot of progress has been made since 1994 but the challenges remain. Poverty situation is still severe, with 60% of the population living below the poverty line (under US\$ 1). In terms of livelihoods, the economy is largely agrarian, with about 90% dependant on agriculture mostly characterised by smallholder subsistence farmers.

In terms of social development indicators, there is generally low level of education, low access to health care and high levels of unemployment.

Literacy and education: About 60% of the population know how to read and write, with literacy levels being higher among men than women. The net schooling at the primary level for the population segment aged 8 – 13 years is 67.9%. It is slightly higher among the females especially in the urban areas. At the secondary level, the rate corresponding to the 13 – 19 year segment is 39.6%, again with higher rates for females in urban areas. Schooling rates are lowest at the university level of education (10.6%) (NCS 2005).

Since 2003, when the GoR declared fee-free primary education, the net enrolment rates in primary schools have increased tremendously and currently stand at 92% (MINECOFIN 2006). Gender disparities in primary enrolment have been closed, and in fact, there are more girls than boys (slightly over 50%). Retention in school, however, remains a big challenge, considering that dropout rates stand at 16%. High levels of vulnerability and poverty, ignorance of parents, low quality due to imbalance between facilities and pupils, have been pointed out as the underlying factors for low retention in school.

In terms of health care, the public sector is the most dominant provider of health care services in Rwanda, and access to public health care is through enrolment in mutual health insurance scheme² (locally known as *mutuelles des sante*) for local people, and RAMA (Association of Rwandese Health Assurance) mainly for people employed in the formal sector (e.g. salaried employees). Coverage of mutual health

² Households pay annual subscription for their members to access health care including medical consultations and basic drugs. This, however, excludes chronic illnesses such as HIV/AIDS.

insurance is very low, averaging 30% nationally, and as low as 9 - 10% in some provinces (MoH 2005), implying that access to health coverage among the population is very low. Unaffordability due to poverty, poor quality of service delivery, physical barriers like distance to health centres, and low awareness have been pointed out as the main reasons for low coverage. Indeed, statistics show that the patient to doctor ratio is 50,000:1 and patient nurse ratio at 3,900:1 which are very low in relation to the basic standards set by the World Health Organisation (WHO). There are emerging policy responses, however, to step-up coverage of mutual health insurance, including massive population sensitisation and improving the quality of health care.

Rwanda continues to face serious challenges of high HIV/AIDS prevalence. But considering the socioeconomic and political challenges that the country has faced, especially the genocide of 1994, Rwanda's situation is unique, and needs extraordinary efforts to successfully fight the pandemic. Poverty and HIV/AIDS in Rwanda are inextricably linked with poverty undermining efforts to prevent HIV/AIDS and vice versa. Indeed, efforts to control HIV/AIDS, through intensive awareness-raising and support programmes, continue to be hindered by the high levels of poverty, illiteracy and unemployment, among others, underscoring the need to step up the efforts from multi-sectoral perspectives.

2.5 Gender and Cultural Context

Traditionally, Rwanda has been a patrilineal society where men dominated all spheres of life. Women's role was restricted to domestic work – looking after the family and cultivating food. Women's rights to property such as land were restricted although the traditional values guaranteed their protection within family setup. However, the socio-political and economic transformation has influenced this, even though it is still, by and large, a male dominated society. The 1994 genocide shifted the demographic balance between females and males, resulting in a sex ratio of 91.3 males for every 100 females. It also had a significant impact on the gender roles in the Rwandan society, as it catapulted women into what were hitherto men's roles. More than one-third (about 35%) of households are headed by women (including 22% households headed by widows), largely as a result of the war, genocide and ensuing HIV/AIDS in which more men than women have perished. Largely as a result of this responsibility, Rwandan women are now actively involved in economic activities, most of them in agriculture and informal sector where they engage in petty trade.

The Rwandan culture is rich and diverse, and is expressed in music (songs, folktales,), a common language with rich vocabulary, medicine, dressing and a host of traditional beliefs, rules and norms. In the modernising society, some cultural values and beliefs have a positive role to play in the development process, including

fight against HIV/AIDS, while others can and have had detrimental impacts. Traditional music, for instance, is being used, with remarkable success, to diffuse the message on the dangers of HIV/AIDS among youth and adult people³, can be a useful tool in raising awareness. Yet other cultural norms such as those that inhibit dialogue between parents and children, that undermine the status of women or violate their rights such as arranged marriages, can be dangerous to development. In other aspects, traditional medicine is widely used in Rwanda, and, according to MoH (2005), sick people are as likely to consult a traditional healer as modern health care providers, a situation that underscores their influence on people's health. In recognition of the role they play and the influence they have on communities, the GoR, through its Institute for Scientific Research (IRST) has been trying to organise them into associations, to find a way of developing indigenous knowledge in medicine. Traditional Birth Attendants (TBAs) play a particularly crucial role in maternal and reproductive health of Rwandan women, as more women were assisted to deliver by TBAs than qualified health professionals.

Despite the rich traditions, the majority of the population profess the Christian faith (93.4%) about half (49.5%) of whom are Catholics and 27.2% protestant/Anglican. Muslims constitute a very small proportion (1.8%) of the population and are mainly in Kigali city. Religious leaders, perhaps more than government leaders, command a lot of respect and wield a lot of influence among Rwandan communities.

In general, the Rwandan socio-economic, political and socio-cultural landscape, in which development, including the fight against HIV/AIDS, takes place, is dynamic and fast changing. The current status and trends of HIV/AIDS prevalence are discussed in the proceeding chapter 3.

³ For instance, while launching the UNICEF supported "UNITE FOR CHILDREN, UNITE AGAINST AIDS" programme, President Paul Kagame, quoted a traditional Rwandan song '*Impinja Ntzigapfe*' to emphasize that children should not die as a result of AIDS, and added that certain strengths inherent in Rwandan culture can help in the fight.

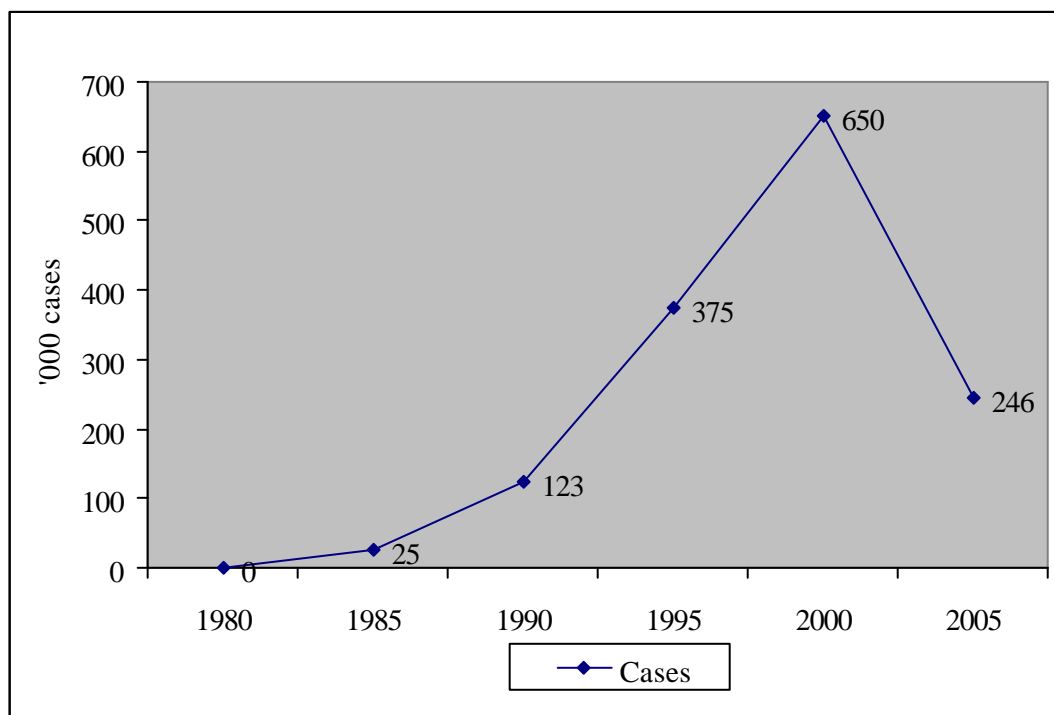
3.0 SITUATION ANALYSIS OF HIV/AIDS IN RWANDA

3.1 Status and Trends in Prevalence and Distribution of the Pandemic

The Demographic and Health Survey (DHS 2005) estimates put the national HIV/AIDS prevalence at 3%, with large variations in sexes (2.3% among males, 3.6% among females) and location (7.3% in urban and 2.2% in rural areas). This represents a remarkably positive trend from 5.1% in 2003 (UNAIDS 2004) and the 1997 estimates that put seroprevalence at between 11% and 12.8%. Estimates in 2002 by UNAIDS and the GoR put prevalence rates at 8.9% and 13.5% respectively, among the working population. Nearly 50% of seropositive individuals were women and 13% were children under 15 years of age (PHR*plus*, 2004). UNAIDS (2004) estimated 49,000 AIDS-related deaths in 2002, although it was difficult to verify because few patients were being tested for HIV.

The statistics on prevalence has generally shown a positive trend up to 2000, after which there is a marked decline (see figure 1).

Figure 1: Trends in HIV/AIDS Prevalence in Rwanda



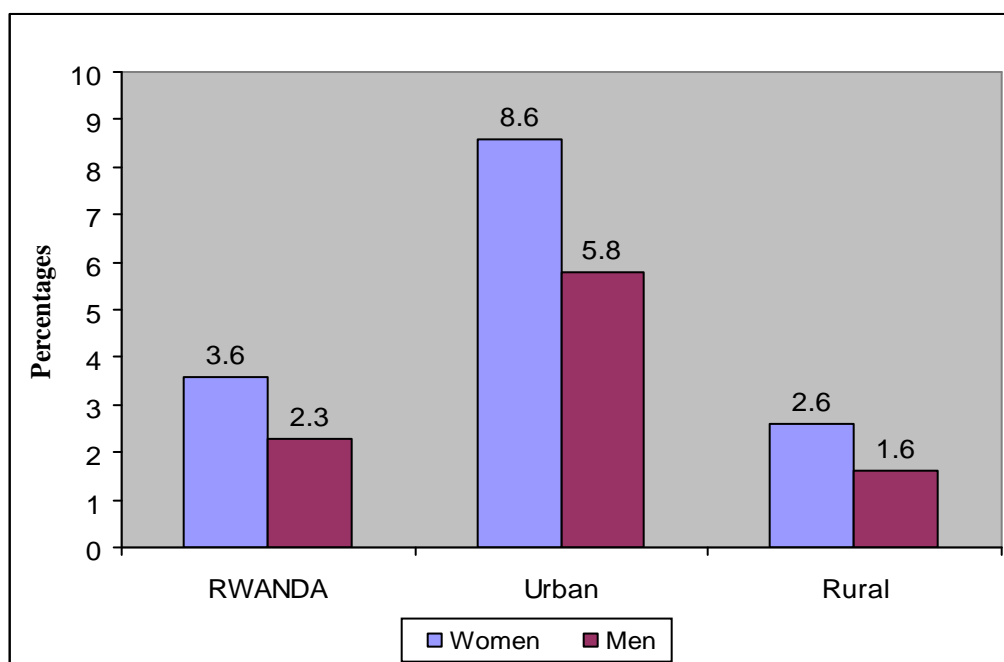
Source: UNDP/GoR. MDGs Status Report for 2003 and CNLS, 2005.

HIV/AIDS prevalence in Rwanda varies among socio-demographic categories (e.g. age groups, social status, education levels), location (urban/rural) and occupation (farm/non farm, formal/informal sector, employed/unemployed), among other factors.

1. Prevalence by Urban-Rural location and Gender

As indicated earlier, urban areas have far higher prevalence rates than rural areas. Desegregation of data according to gender shows that more women than men are infected, and this cuts across rural and urban settings as shown in figure 2 below.

Figure 2: HIV Prevalence by Urban-rural Locations and Gender



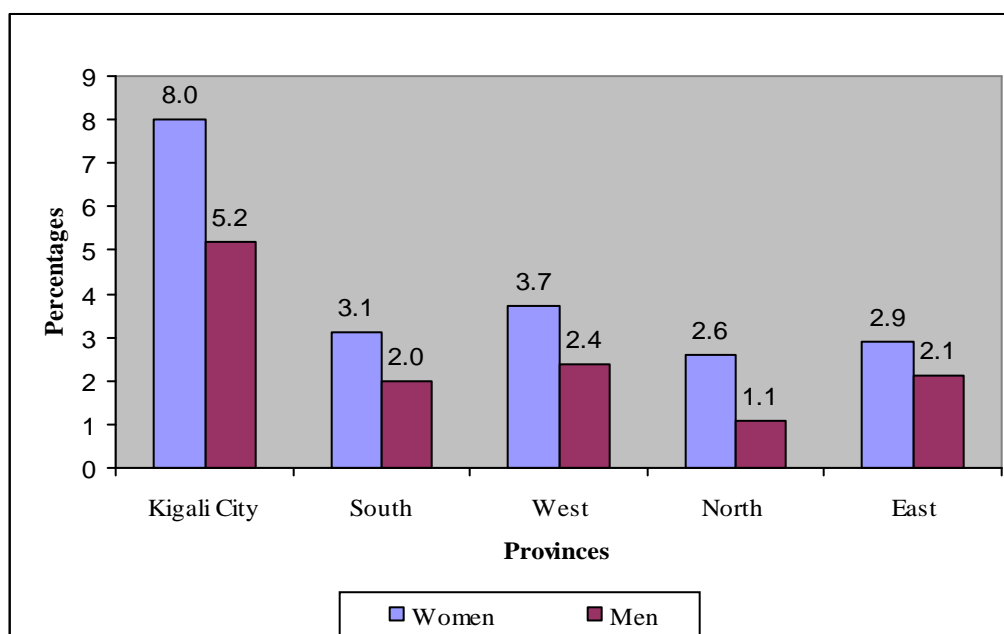
Data Source: DHS 2005 (July 2006).

High levels of mobility, lifestyles and exposure to risk factors for HIV/AIDS infection (e.g. influence of peer pressure, information,) in urban areas, have been pointed out as some of the main causes of higher prevalence rates than rural areas.

2. Spatial distribution/prevalence by region

HIV/AIDS prevalence rate for Kigali city is disproportionately much higher than other provinces (more than twice the national rates and the next highest province). In all provinces, prevalence rates among women are significantly higher than among men. Kigali city and Western Province have higher prevalence rates than the national average. Figure 3 below shows the HIV/AIDS prevalence by province.

Figure 3: HIV/AIDS Prevalence by region



Data Source: DHS 2005 (July 2006).

The relatively high incidences of HIV/AIDS in the western province are largely attributed to poverty and the effects of the prolonged insurgency of the late 1990s that led to displacements. For instance, high incidences of street children and prostitution in Rubavu, Karongi and Rusizi districts, fuelled by the strategic location near the border with the DRC, have been blamed as key factors for HIV/AIDS infection. In other areas, although the prevalence rates are comparatively lower, the risk factors exist including refugee camps in the south, overcrowding and idleness in grouped settlements, new communities and cultural values perceptions towards sex (inheritance, men dominance over sexual relations...).

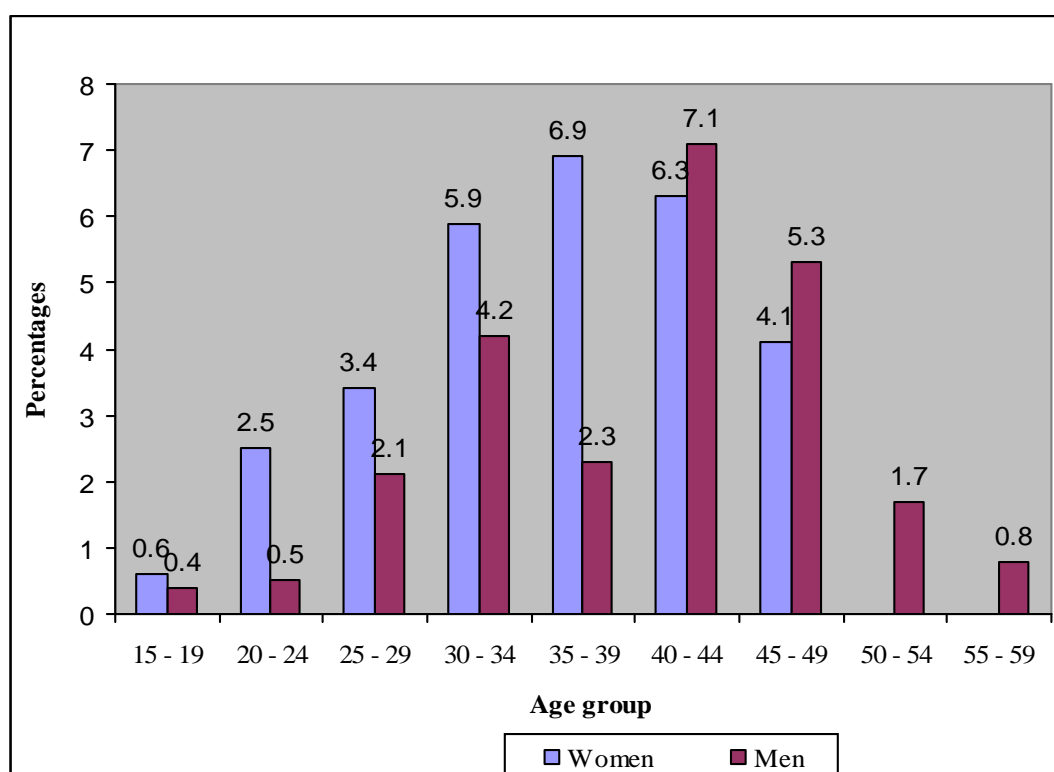
3. Social-demographic (prevalence by age groups)

According to the DHS 2005, women within the age group 30-39 years and men in the age bracket 40-49 years have the highest rates of HIV/AIDS infection. While the causal factors have yet to be explicitly explored, women currently in their thirties were adolescents and young women who were vulnerable during the war and genocide of the 1990s, a number of whom were massively raped. Today, they have got married, leading to further spread since many of them did not take HIV/AIDS tests prior to getting married. HIV tests only became a mandatory requirement for couples intending to get married recently (generally after 2002). It should be noted, however, that the HIV/AIDS test is not a legal requirement, but is an enforceable requirement by religious leaders and local authorities, of those intending to marry (officially).

The fact that most of the women in this age bracket are married and the tendency of younger women getting married to relatively older men than themselves could be a contributing factor to the high infection rates among men between 40 – 49 years.

From the age of 40 years, more men than women are infected. After 40 years, most women are reaching menopause and are less sexually active. In general, young women (15 – 40 years) are more infected due to a number of cultural, social, and economic factors. Women are culturally expected to be submissive and are given a subordinate position compared to men. This partly explains why they are most often easily coerced/ pressured into sex or/ and early marriages, less educated than men, and relatively given fewer opportunities. Although the reasons have not yet been explicitly known, there is a marked difference between infected women and men in the age group 35 – 39 years (2.3% of men and 6.9% of women). For 15 – 49 year olds, women are 1.5 times more infected than men (M: 2.3%, F: 3.6%), with the gap even wider among the youth in 15-24 year age group (M: 0.5%, F: 2.5%). Figure 4 and table 6 below illustrate HIV/AIDS prevalence rates by age group and rural-urban distribution.

Figure 4: HIV/AIDS prevalence by age groups



Source: DHS III, 2005

Table 6: HIV/AIDS Prevalence by Age group and Rural –Urban Distribution

Age group	Rural	Urban
15 – 19	3.0%	6.5%
20 – 24	2.4%	7.0%
25 – 29	2.9%	8.4%
30 – 34	4.7%	10.8%
35 – 49	2.3%	5.2%

Source: TRAC 2002

According to TRAC 2002, single women and those separated from their partners had significantly higher rates (15.4% & 11.9% respectively) than women in other categories, though the sample of single/separated categories was relatively small. Cohabiting women were reported to have lower HIV prevalence than married women (3.1% & 6.0% respectively) because the former are better placed to negotiate for protected sex than married women. HIV prevalence was reported to increase with the level of education, with a peak of 8.0% among women who reported having attended secondary school.

Analysis of prevalence by occupation on the other hand, showed that rates were lower among women involved in farming as their primary occupation (4.4%), and highest among women involved in small-scale business (12.5%). These are only followed by homemakers at 9.7%. HIV prevalence was also reported to be higher among women with 2 – 3 pregnancies (6.2%) than among those with more than 5 pregnancies (3.6%).

Table 7: Prevalence rates

Indicator	Proportion/Number
National prevalence	2.3% Men
	3.6% Women
	2.2% Rural 7.3% Urban
Infected men	1.6% Rural 5.8% Urban
Infected women	2.6% Rural 8.6% Urban
Infected children (0 – 14 yrs)	22,000
HIV Mother to child transmission rate	10.3% (with medical intervention) 25 – 40% (without medical intervention)
HIV+ pregnant women (exposed children) per year	11,412 Rural 6,617 Urban
HIV+ newborn per year (with no medical intervention)	2,853 Rural 1,654 Urban
HIV+ newborn per year with medical intervention)	1,175 Rural 681 Urban
HIV orphans	160,000
Total infected and affected children	200,000

Source: CNLS Report, June 2005

3.2 Main ways of transmission/spread

According to UNAIDS (2006), HIV in Rwanda is spread primarily through heterosexual contact (75%) and mother-to-child transmission (20%). Only 20% of births occur in maternities; the rest take place at home, often assisted by traditional birth attendants, where there are few safety precautions, and the risk of transmission between the “mid-wife” (TBA), mother, and child are very high. Indeed, according to the DHS 2005, 61% of births were not assisted by trained personnel, 43% were assisted by traditional, untrained mid-wives, while 17% had no assistance at all.

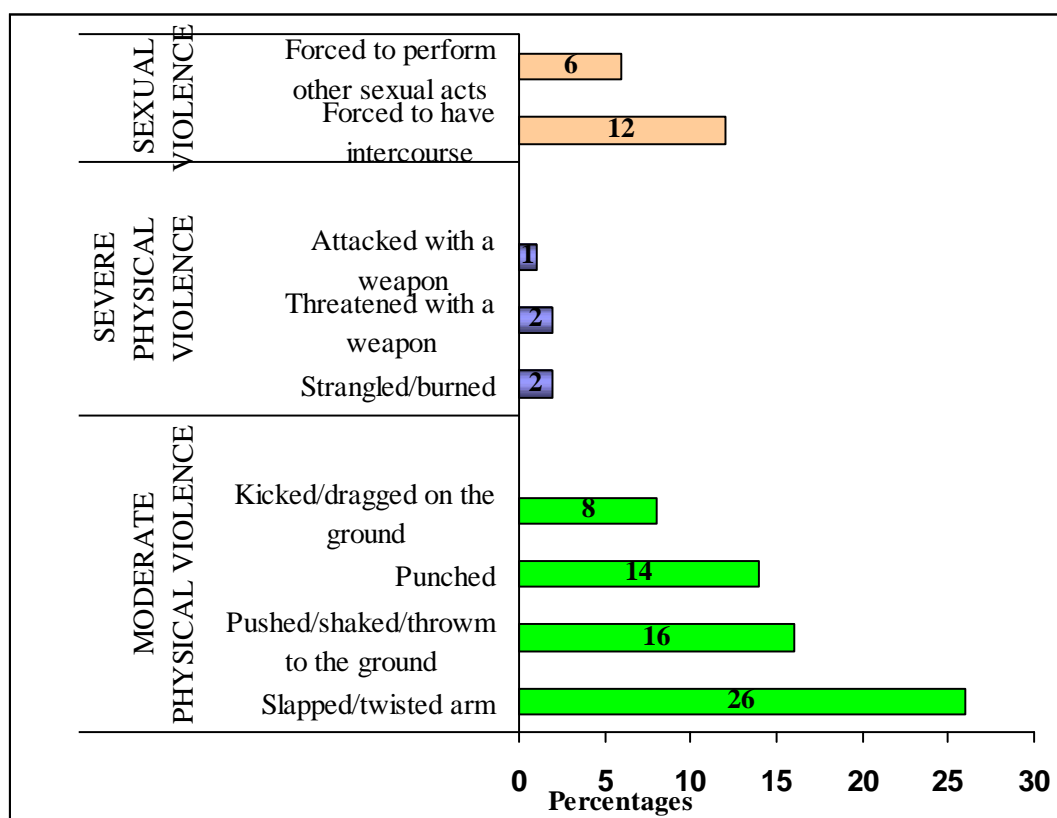
HIV infection spread rapidly during the genocide, due in part to widespread rape. According to UNAIDS, half of the 3.2% of women in Rwanda who reported being raped during the genocide are now HIV positive. The refugee camps in the immediate post-genocide period were squalid, violent, and crowded leading to further unsafe sex. Since the war, many women and girls, including those widowed or orphaned by war have been forced into prostitution. According to a report by amfAR AIDS Research, June 2005, in Rwanda, where rape was used as a form of ethnic cleansing during the 1994 genocide, it was estimated that of the 250,000 women who were raped and still alive, 70% are HIV infected.

There is emerging evidence connecting the spread of HIV and gender-based violence, particularly among young women. Experience of violence and controlling behaviour from male partners are associated with increased risk of HIV infection among women. Rape - the most extreme version of forced sex – occurs in many different settings and situations including intimate relationships, schools, health-care facilities, refugee camps, and during periods of armed conflict. Most young women’s first sex encounter is often coerced, and such coercion is often viewed as a routine and part of the relationship. Gender-based violence can take the form of physical, sexual, and psychological abuse by a person with whom the victim has had an intimate relationship or by a stranger. Physical abuse can take the form of hitting, slapping, punching, or kicking. Psychological abuse includes belittling, humiliating, and intimidating an individual, while sexual abuse includes rape within marriage or dating relationships, rape by strangers, unwanted sexual advances or harassment, forced marriages, denial of the rights to use of contraceptives or other measures to protect against sexually transmitted diseases and HIV/AIDS, forced prostitution and trafficking of people for sexual exploitation.

In Rwanda, nearly one third (31%) of the women have suffered from physical domestic violence since 15 years of age (DHS III, 2005). In 47% of the cases, the perpetrator of these acts was the husband or partner. More than one third of the women have suffered acts of spousal abuse through physical, sexual, or emotional

abuse more frequently and on repeated basis. 10% of the women have suffered abuse while they were pregnant, and 17% of women in broken marriages suffered from acts of violence during a pregnancy. Figure 5 below illustrates the different forms and levels of domestic violence experienced by women in Rwanda.

Figure 5: Rwanda women's experiences with domestic violence



Source: DHS III, 2005.

Domestic violence may increase a woman's risk for HIV infection through forced or coercive sex in a number of ways:

- ⇒ The physiology of the genital tract makes women – especially young ones – inherently more susceptible to the HIV infection than men. Women are twice as likely to acquire HIV from men during sexual intercourse than vice-versa (amfAR, 2005)
- ⇒ Forced or violent intercourse can cause abrasions and cuts, which facilitate entry of HIV through mucosa.
- ⇒ Forced sex limits a woman's ability to successfully negotiate prevention behaviours such as use of condoms.

Psychological factors that increase a woman's vulnerability to both sexual abuse and HIV infection include age, alcohol or drug consumption, previous history of abuse, number of sex partners, and involvement in sex work, education level, and socioeconomic status. Studies link a history of childhood sexual abuse to an increase in HIV risk-taking behaviour, including drug abuse, having a male at risk for HIV, having multiple partners, and exchanging sex for drugs, money, or shelter.

There are thousands of orphans, many of whom are being raised by family members, neighbours, and strangers. Unaccompanied children, particularly orphans, are highly vulnerable to sexual abuse and being pressed into survival sex, and commonly have high infection rates.

Other factors accounting for the spread of the pandemic include high rates of sexually transmitted infections, low availability and use of condoms, early onset of sexual activity, and limited public awareness of the disease. Tuberculosis is also a major health problem in Rwanda; between 40% - 60% of HIV patients are cross infected with TB. High-risk populations in Rwanda were identified to include sex workers and their clients, orphans, prisoners, commercial drivers, and transportation workers.

3.3 Knowledge and Behavioural change issues

There has been an increase in knowledge about the HIV/AIDS pandemic (spread, prevention, treatment) among the general population and stigmatisation of PLWHA has reduced to some extent. Most people are aware that HIV/AIDS is mainly transmitted through sex and from mother to child either at birth or through breast feeding. They are also aware that it can be prevented through abstinence, being faithful (for married couples), and using condoms during sexual intercourse. PLWHAs that belong to active supportive associations have more accurate knowledge about HIV/AIDS than those who do not. They are aware of activities that weaken them physically, such as drinking alcoholic beverages and the necessity for having a balanced diet. They have a basic understanding of opportunistic infections.

Support organisations in the fight against HIV/AIDS have used a multi-faceted approach involving lobbying and advocacy, sensitisation of communities, care and treatment, training, material and financial support. In communicating the messages about HIV/AIDS, use has been made of the media, music, drama, games, associations, peer educators, and income generating activities. Most people now have a more than good knowledge on where and how to access VCT services, PMTCT services, ARVs, condoms, and other services. Comprehensive knowledge

among youth on different prevention methods has increased from 22% in 2002 to 52% in 2005 (CNLS, 2006). However, behaviour change remains a barrier and communication messages are often conflicting, especially for the youth. Unprotected sex has increased for both sexes (10% - 15% among females and 42% to 48% among males) and the use of condoms among males dropped from 55% to 41% (CNLS, 2006).

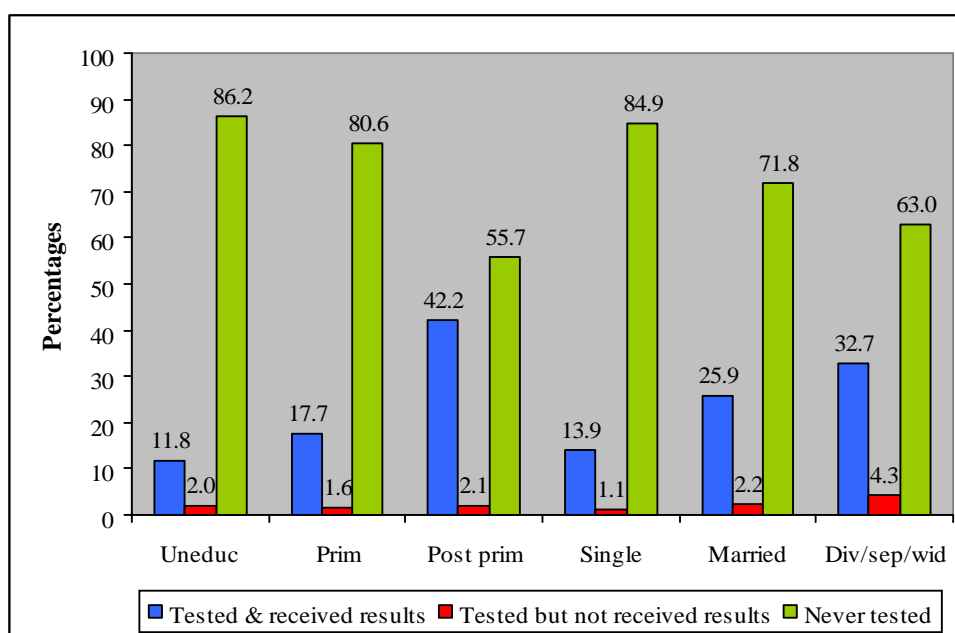
The recent survey (DHS III) observed that although 94% of all mothers received prenatal care from trained personnel, the number of visits made remains below WHO standards. Only 13% complied with the standards by attending at least four counselled prenatal visits. During these visits, the majority of prenatal tests were conducted but only 6% of the women were informed of signs of complications in their pregnancies. 70% of the births occur at home, while 40% women in the richest quintile and 32% of those with at least a secondary-level education gave birth at home, leading to increased risks of mother-to-child transmission.

Despite the marked decline in stigmatisation around HIV/AIDS, it still remains considerable, although it is now more of perceptions than real. In addition, the level of societal support for people infected with/affected by the virus continues to decline due to widespread poverty and breakdown of social cohesion among communities (families). PLWHA wait a long time to get tested for HIV, many suspecting their seropositive status for years and rarely come out to declare their status. The risks associated with disclosure of HIV infection deter many PLWHA from revealing their HIV status. Some PLWHA choose not to disclose their status for fear of abandonment, rejection, discrimination, violence, upsetting family members, accusations of infidelity from their partners, families, communities, while others still believe that their persistent illnesses are caused by bewitchment. However, the fear of abandonment is often justified by some people who still believe they can contract HIV by sheer proximity to HIV-infected people.

For many PLWHA, majority of whom already live in poor conditions, upon confirming their positive serostatus, a cycle is triggered in which their initial impoverishment becomes worse. Physical deterioration, inadequate medical care, poor nutrition, loss of hope and constant fear of death, etc, tend to worsen their situation. Although the majority of PLWHA in Rwanda are aware of the need to have a well balanced diet, the lack of access to food or lack of money to purchase it makes presents a form of death sentence for them. Yet quite a number of some PLWHA, particularly men, are driven into or continue to take alcohol, as part of the strategy for stress and pain relief. Notwithstanding the known and often warned of negative effects, alcohol and tobacco are believed to play important social role in managing psycho-social problems among PLWHA, even though temporary.

Due to fear or being stigmatised, many people fear to test or confirm their sero-status despite apparent increase in awareness and knowledge about HIV/AIDS. Figure 6 below shows the status of HIV/AIDS testing in Rwanda, by social category (level of education and marital status). It should be observed that between 57.8% and 88.2% of the population do not know their sero-status, and this raises serious concerns for the prevention and control efforts.

Figure 6: HIV/AIDS testing by level of education and marital status



Source: DHS III, 2005

Positive attitude change among religious leaders and their congregations

Perhaps the most significant impact that was mentioned in all the 4 areas visited was the change in attitude, among religious leaders, towards HIV/AIDS victims (infected and affected). It was reported, in all dioceses visited, that the training and sensitisation provided to religious leaders and church workers has assisted to change their stigmatising attitudes and segregation towards PLWHA. *“Before we were trained, we would look at PLWHA as sinners and unworthy people, not fit to be in God’s house. They were not allowed to get into choirs, or get to the pulpit to read a scripture, yet that’s where they rightly belong. Now, we embrace them, counsel them, and warmly support them. Most of them have come back to church”* testified an Anglican Priest in EER Byumba.

3.4. Status of Treatment, Care, and Support

Of the 906,000 sero-positive Rwandans as at the end of 2002, 154,000 (i.e. 17%) were estimated to urgently require antiretroviral therapy (ART). However, by mid June 2003, only about 900 (i.e. less than 1%) were receiving ART, and by August

2005 the number of HIV/AIDS patients accessing care and treatment numbered only 13,881 adults and 1,054 children, who were receiving ARV in 67 sites. By the end of 2005, the number of people accessing ARVs was 19,058 (17,615 adults and 1,443 children). These figures imply that despite the interventions in scaling up access to HIV/AIDS treatment and care, the proportion of HIV/AIDS patients accessing ART remains very small.

As noted in section 3.1, mother-to-child-transmission is the second major mean of HIV/AIDS transmission, accounting for 20% of all infections. In 120 health facilities, 119,869 women received PMTCTs and 80% of them were tested; the prevalence rate was 7%. With regard to women who had received Niverapine, the total was 4,414 at the end of September 2005. Figures issued by TRAC indicated that 199 sites had PMTCT program.

Estimates from food relief agencies in Rwanda suggest that 50% of PLWHA require some form of food assistance. For many patients, access to food remains problematic, as they may be unable to travel to a distribution site. The EU and WHO have jointly supported a major effort to ensure safety of the blood supply, thereby reducing transfusion-associated infections. However, the lack of resources for universal precautions remains a concern in health facilities.

4.0 IMPACT OF HIV/AIDS ON THE POPULATION AND ECONOMY

4.1 Impact on the Macro Economy

The HIV/AIDS pandemic in Rwanda affects all segments of the population, threatening the development and prosperity of the nation. The impact of HIV/AIDS in Rwanda has been and continues to be disastrous, in all spheres of life. The agricultural sector, which is the mainstay of the economy, and which relies on labour, has been the most affected by the pandemic. According to Bolinger and Stover (1999) and MINECOFIN (2005), the main impacts of HIV/AIDS on Rwanda's economy are reflected in:

- (a) *Loss of the labour supply* – the country loses productive young men and women at an unprecedented rate, resulting in decline in production and food security. With regard to the elite professionals, the impacts of the pandemic are even more devastating. The health sector alone incurs man power losses of about 1% per year, while in education sector, the massive loss of the few teachers, has resulted in massive costs in recruiting expert teachers from neighbouring countries, notably Kenya and the DRC.
- (b) *Direct costs of illnesses and deaths* – direct costs include expenditures for medical care, drugs, and funeral expenses.
- (c) *Indirect costs* – lost time during illnesses, recruitment and training costs to replace workers, care of orphans, etc;
- (d) *Diversion of investment resources to finance HIV/AIDS associated illnesses.* Personal investments decline and this has an effect on domestic resource mobilisation and investment. In 2000, it was estimated that per capita expenditure on health was about US \$ 12.70 of which 10% was spent on HIV/AIDS (USAID/PHR 2000). Since then, however, the proportion spent of expenditure on HIV/AIDS has more than quadrupled, particularly with the stepping up of efforts for prevention, treatment and care.

The impact of HIV/AIDS on the macro economy of Rwanda can thus be summarised as follows:

- *Reduction in the number of workers available* – most of the dead are in their productive years, it has a devastating effect on the economy. It is difficult to get experienced personnel and even young workers with limited experience are only coming up as the new higher education institutions start sending their graduates to the market. In the agricultural sector, unskilled labour has not been spared – agricultural production in many households affected by

HIV/AIDS is low and in some instances, it has come to a halt – only children are left; the older ones are too sick to cultivate.

- *A shortage of workers leads to higher wages and poor performance*, which increases the cost of production. For food production, certainly there has been a visible impact. The other issue is, replacing experienced workers with young inexperienced ones reduced the productivity or slows down production. As a result, the country's competitiveness is at a disadvantage because experienced and skilled personnel have to be imported from elsewhere.
- Inevitably, this is associated with low international competitiveness, unfavourable labour market for investments, reduced government revenue and personal savings. This could have contributed to the apparent high cost of living.

There is, however, need for detailed study of the impact of HIV/AIDS on the macroeconomic situation, to generate information tools that can be used for advocacy and resource mobilisation, as well as to inform policy strategies for mainstreaming HIV/AIDS in the different sectors.

4.2 Impact on the Micro-economy

HIV/AIDS and malaria pose the greatest health and economic burden on Rwandan households (MoH 2006). At household level, its impact is further exacerbated by poverty (particularly worsening socioeconomic conditions), which combine with socio-cultural and epidemiological variables to influence its prevalence (SSRC 2004 in IDRC and CRDI, March 2006).

At the household level, there is depletion of the family's material capital, increase in the number of dependants for the survivors, the reduction or loss of manpower, the increase in the drop-out rate, the reduction of working hours per day, etc. According to the UNAIDS Report, 2004, Sub-Saharan African countries will have lost at least one fifth of their farm labourers by 2015.

Impact on food security: HIV/AIDS creates significant economic stress on households and communities that affects both nutritional status and long-term food security, social and economic welfare, and access to sufficient food for a healthy and productive life. In all the areas visited during the field survey, PLWHA complained that some of them are too weak to cultivate even if they had land, a situation that has affected their health. In Kigeme, it was reported (by Health care givers and some NGO officials) that some PLWHA were reluctant to take on or continue anti-retroviral treatment (ART) because they feared the drugs would weaken them further if they didn't get enough food. Households lose not only the

income and food production of sick individuals but also the economic contributions of family members who care for them.

Impact on household economy

Illness and death bring substantial expenses – including medical care, funerals, and care and education of orphaned children – that take resources away from household's budget for basics such as food, clothing, and school fees. USAID/PHR (2000) estimated that 93% of expenses of Aids Treatment were incurred by households through out-of-pocket payments, excluding what they spend on pharmaceuticals and other related materials purchased at independent pharmacies and shops, and according to MoH (2005), the figures have declined to 54%. However, considering that more than 60% of the population is below the poverty line (MINECOFIN 2005, MoH 2005), this underscores the huge financial burden that HIV/AIDS has put on household incomes and welfare. The impact of this is felt in the reduced ability of households to meet basic needs.

But perhaps the most significant impact is felt in agricultural production and food security. In former Gikongoro province (Kigeme zone) illness and death were blamed for food shortage in HIV/AIDS affected households, some PLWHA who were mobilised and supported to grow own food could not because they were too weak to cultivate, and depend on food handouts.

Impact on people infected/affected by HIV/AIDS

The impact of HIV/AIDS on people infected with and affected by HIV/AIDS, is even more devastating. In terms of health care, MoH (2005) estimated that PLWHA spend 4.6 times more than the general population for inpatient care and 4.1 times for outpatient care. This is an additional burden considering that PLWHA are more likely to fall sick because of opportunistic infections, yet they and their attendants suffer inconveniences of being less productive (if they work at all), a situation that further reduces their ability to earn.

4.3 Impact on health and health care systems

AIDS was reported to be the sixth cause of admission and the second cause of death in Kigeme hospital (Personal Interviews with Personnel). In Kigeme zone, where HIV/AIDS prevalence was reported to be about 6% (even then disputed as grossly underestimated), the already weak health service delivery has been overstretched. The health centres are crowded and about half of the beds are occupied by HIV/AIDS patients. The place is stinking and Health Workers were reported to be stressed (Personal Interviews with stakeholders during field work). Moreover, Kigeme hospital has only one permanent nurse and a doctor who is a general practitioner, supported by few medical workers who come on a visit - basis that is

unreliable. With respect to human resources in Rwanda, annual losses within the active labour force in the health sector are estimated at 1% (Ricardo Bitran, et al 2003), which is very high considering the scarcity of trained health professionals in Rwanda.

4.4 Impact on Education

HIV/AIDS has, unequivocally led to increased morbidity and mortality among young adults in many parts of Sub-Saharan Africa. Although all sectors of society have been affected, the impact on the education sector has been devastating (both teachers and students). The clearest quantifiable impact of HIV/AIDS on teachers is the level of in-service mortality. Actual and past impacts have been measured mostly through school-based surveys, educational personnel records, and HIV/AIDS prevalence rates among teachers and students.

HIV/AIDS is a real threat to the education sector with a cumulative negative impact at the local and national levels. It affects education in three key areas, namely;

- Demand for education decreases because children (especially girls) drop out of school to care for sick parents, cannot meet the costs of schooling or the children themselves are sick and frequently out of school.
- Supply of education deteriorates due to ailing teachers.
- Quality and management of education deteriorates due to absenteeism of both ailing teachers and school administrators.

According to Kinghorn et al (2003), an estimated 2,500 teachers shall die of AIDS during this decade, and revealed that annual deaths caused by AIDS among teachers would increase from just over 100 in 2002 to 250 deaths by 2015. This is too much a gap to bear for a sector which was severely affected by the 1994 genocide, and which has the burden of delivering quality education under the Education for all (EFA) policy.

4.5 Social security and vulnerability (orphans, widows)

Rwanda has one of the highest proportions of orphans in sub-Saharan Africa. According to UNICEF (2006), an estimated 52% of the Rwandan population is below 18 years and about 30% (1,264,063) are orphans and vulnerable children (OVCs). While these are attributed to multiple factors including the 1994 genocide, war, and HIV/AIDS, about 160,000 have been orphaned because of HIV/AIDS. Kinghorn et al (2003) projected that the number of orphans aged between 0 – 16 years, who have lost their mothers due to AIDS would increase from 64,000 in 2003

to 208,000 by the year 2015. It was also revealed that almost 10% of children in the upper section of primary and lower section of secondary school would be orphaned by HIV/AIDS during the 10 years to come (2003 – 2013).

This situation places a heavy burden on the traditional safety nets of communities to cater for the rights of children affected by HIV/AIDS. As a result, the level of child vulnerability is high – some 7,000 children live on the streets, and 100,096 children are living in child-headed households with no parental care. But in terms of social vulnerability, increased numbers of orphans and widows increases escalates the level of poverty, as men (and adults generally) are the main bread winners for the family. Widows lose social protection, while children lack parental care and social protection.

4.6 Impact on Women and Gender

Women and girls have been the most affected by HIV/AIDS in Rwanda, and this partly stems from the massive rape during the genocide, where, according to Nduwimana (2004), rape was used as a weapon of war against women aged 13 to 65. In addition, the comparatively higher risks that young women face compared to men and boys have worsened their situation.

According to the DHS 2005, the prevalence among 20-24 year olds is five times higher for young women (at 2.5%) than for young men (0.5%). UNICEF (2006) argues that these discrepancies are due to the fact that girls are more affected by poverty, low literacy, and lack of necessary life skills for positive behavioural change compared to boys (DHS 2005).

Perhaps the most significant impact of HIV/AIDS on women and gender issues is the change in role of women – more than one-third of households are headed by women, and women now have assumed roles and responsibilities previously handled by men. It was also reported that women are more involved in VCT than men. Moreover, when couples are discordant, women take care of the positive men, but when a woman is positive and the man is negative, the woman is sent away from the home. Men marry and when they learn that they are positive, generally they do not tell their wives and take drugs without informing their wives.

4.7 Impact of HIV/AIDS on Human Rights

The HIV/AIDS pandemic is not just a public health issue; HIV/AIDS presents an obstacle to all human rights, for example, the right to education, the right to work and the right to safety and protection from abuse and violence. The stigma attached to HIV/AIDS stifles education and knowledge, as well as access to health care.

Many Christians were reportedly traumatized and rejected in churches because of the hostile reception from religious leaders and fellow Christians. Women are most affected – Young widows have to endure forced sexual unions with inlaws in order to remain part of the family or risk losing their husbands’ estates (Amnesty International 2004). Children’s rights to material, shelter and emotional needs, later on education have, for many, been shuttered by the disorientation of families, break down of the social cohesion that obliged communities to look after the children “as their own”. Despite the fee-free primary education, many children of school going age remain out, and those orphaned by HIV/AIDS are most affected. Finally, children’s freedom to play and share with other children have been infringed as many have to take care of their sick parents or fulltime household heads when their parents are dead. Child-headed households are a common phenomenon in Rwanda but mostly in the Western province.

5.0 RESPONSE INTERVENTIONS TO COMBAT HIV/AIDS IN RWANDA

5.0 General

Rwanda's national response to the HIV/AIDS pandemic is reflected in the national strategic framework with the following components (CNLS, Feb.2006):

- ⇒ strengthening preventive measures against HIV/AIDS transmission;
- ⇒ adopting the response interventions to the evolving socioeconomic and health conditions by using surveillance and research results;
- ⇒ improving HIV/AIDS related treatment for persons infected and affected by HIV/AIDS
- ⇒ Increasing the knowledge and capacity to take appropriate action to prevent the spread of HIV/AIDS.

5.1 Major Actors/Stakeholders and Coordination Framework

The GoR and partners' seriousness on strengthening coordination in HIV/AIDS can be reflected in the establishment of the National Aids Control Commission (abbreviated in French as CNLS) in 2001, under The Presidential Decree No. 02/01 of 16/3/2001. Among its tasks, CNLS provides a legal and institutional framework for defining the implementation, monitoring, and evaluation of the National Policy on HIV/AIDS. In addition, multiple coordinating bodies have also been created, enabling the country to respond to the multiple challenges associated with the fight against HIV/AIDS.

The HIV/AIDS coordination framework evolved in 1999 when a national Programme for Control and Prevention of HIV/AIDS was formulated in the Ministry of Health. Because of the multi-sectoral nature of the HIV/AIDS pandemic and the importance that the GoR attached to the fight against HIV/AIDS, the HIV/AIDS control programme was transferred to the Office of the President and constituted into CNLS, which is a more structured and permanent body, that has since been the overall coordinating body for HIV/AIDS control and prevention, with structures at district level i.e. District Aids Control Commission (CDLS).

The national strategy for coordination of HIV/AIDS control and prevention activities is mainly through umbrella organisations. Presently, CNLS works with 9 umbrella organisations in the execution of its coordination functions, as follows:

- National Women's Council – coordinates all activities related to gender and HIV/AIDS, and related vulnerable groups;

- National Youth Council – coordinates youth activities in HIV/AIDS
- People living with HIV/AIDS (PLWHA) – coordinates all activities relating to people infected with and affected by HIV/AIDS.
- NGOs forum – brings together all NGOs working in the HIV/AIDS sector
- Private sector HIV/AIDS cluster (APELAS)
- Network of Religious Organisations i.e. Inter-faith HIV/AIDS network.
- Umbrella organisation for Journalists (ABASIRWA) – a fairly recent umbrella just about one year old, it is yet to do anything tangible.
- Umbrella for People with Disabilities – has also just recently been formed to coordinate and advance the interests and issues of people with disabilities.
- Public sector umbrella – that coordinates the activities of various public sector agencies and ministries.

The structure and composition of these coordination structures, their present level of functioning and the challenges they face, is presented in a matrix format in Annex 1. However, as most of the umbrella structures are relatively new, they are yet to become operationally effective.

Ministries and public sector agencies: Since 2002, there is a Minister of State specifically in-charge of HIV/AIDS and other Epidemics. The Ministry of health sets the policy agenda, and has put in place a specialised centre for AIDS treatment and research (TRAC). The Ministry of health also provides policy guidance in mainstreaming HIV/AIDS in other sector ministries and line Government agencies.

Local Authorities: The National Decentralization policy provided a framework for coordinating the National AIDS Program since it calls upon the actors – not only at the central level but also at the decentralized level – to deal more efficiently with the HIV/AIDS problem starting from the grassroots level. HIV/AIDS activities should be integrated into the districts’ strategic plans and based on the needs of the population.

Development Partners: The Partners of NACC in the fight against HIV/AIDS are the umbrella groups, government organizations, and NGOs as well as institutions of bilateral and multilateral cooperation. However, all partners should register themselves with the NACC and be given a certificate of approval before launching their activities.

Response from the Private Sector: The involvement of the private sector in the fight against HIV/AIDS has been intensified, whereby some companies have developed schemes for prevention, care and treatment of their staff. BRALIRWA, a leading manufacturer of soft and alcoholic drinks, led the private sector in initiating a policy to assist its HIV/AIDS infected employees to access Anti-retroviral therapy

(ART), and also put in place mechanisms to protect workers from stigmatisation, provide information on protection against HIV/AIDS.

5.2 Policy Interventions by Government

5.2.1 Major Aids-related Policy Initiatives and their Impact

A number of policies have been put in place and actively pursued to address specific HIV/AIDS issues. Although most are fairly recent, these policies have yielded commendable results. Key HIV/AIDS related strategies and policies include:

- The National Health Policy – enlists HIV/AIDS as an epidemic and gives it a priority in the sector strategies and plans;
- National Policy on Nutrition;
- The National Policy on HIV/AIDS in the education sector;
- The National Policy for AIDS in professional circles;
- The National Policy on Care and Treatment;
- The National Policy on OVCs – which identifies 16 categories of OVCs and outline strategies for caring and assisting them;
- The National Policy on VCT for HIV/AIDS
- The National Prevention Plan;
- The Strategic Framework of TRAC;
- The National Communication Strategy for Behaviour Change (CBC);
- The strategic framework for the fight against discrimination, and stigmatization of persons living with HIV/AIDS.

The OVC policy developed in 2003 resulted in increased attention to infants. Perhaps one of the most outstanding impacts of the HIV/AIDS related policies is the ongoing integration of HIV/AIDS into sector strategies, plans and budgets, which would ensure systematic and sustainable mechanisms for HIV/AIDS prevention and control.

The President of the Republic and the First lady are personally dedicated to the cause, demonstrated through numerous interventions such as PACFA. The government in general has demonstrated initiative by establishing the coordinating structure for the multi-sectoral response (CNLS); strengthening the capacity of the Treatment and Research AIDS Centre and Laboratory Services; and ensuring a positive environment for partners to contribute to efforts of reducing the impact of HIV/AIDS on the population.

The National Strategic Plan for 2005 – 2009 HIV/AIDS Control is structured upon five axes:

- i. Reinforce measures of prevention of HIV/AIDS transmission;
- ii. Assure that the national response to HIV/AIDS is adopted by Rwanda's evolving social economic and health conditions by using surveillance and research;
- iii. Improve HIV/AIDS related treatment for persons infected and affected by HIV/AIDS;
- iv. Reduce the detrimental effects of HIV/AIDS on Rwanda's micro and macro socio economic conditions;
- v. Coordinate the multi-sectoral response to increase cost-effectiveness.

The decentralization process in Rwanda further provides more opportunities for community involvement in all aspects of national development including efforts to fight the HIV/AIDS pandemic.

5.2.2 Voluntary Counselling and Testing (VCT)

As an approach to strengthen effective prevention and treatment of HIV/AIDS infected persons, the GoR established the Centre for Treatment and Research in HIV/AIDS, as a specialised semi-autonomous institution handling epidemiological aspects of the AIDS pandemic. TRAC has collaborated with international agencies and institutions in conducting research and monitoring the clinical aspects of the HIV/AIDS spread, prevention, treatment and control. It is in this respect that a number of counselling and testing centres have been gradually established, with support from different development partners. Table 7 below shows the numbers of sites by (former) province and health district as of mid 2005.

Table 7: Number and Distribution of VCT Sites in Rwanda (As of June 2005).

Province	Health District	# of VCT sites	Notes/ Observations	
Butare	Kabutare	7	Two of the sites became operational in 2002, two in 2004 and 3 in 2005. Four of these are supported by Global Fund. Others by MAP, Trocaire & PSI.	
	Kibirizi	4		
	Nyanza	3		
Byumba	Byumba	5		
	Gakoma	4		
	Muhura	2		
	Ngarama	2		
Cyangugu	Bushenge	2		
	Gihundwe	3		
	Kibogora	2		
	Mibirizi	3		
Gikongoro	Kaduha	1		
	Kigeme	4		
	Munini	1		
Gisenyi	Gisenyi	7		
	Kabaya	2		
	Muhororo	4		
	Shyira	1		
Gitarama	Gitwe	1		
	Kabgayi	7		Nearly all supported by USAID/Impact.
	Remera-Rukoma	2		
Kibungo	Kibungo	4	All set up under Global Fund in 2005	
	Kirehe	3		
	Rwamagana	6		
	Rwinkwavu	4		
Kibuye	Kibuye	5		
	Kirinda	3		
	Mugonero	2		
	Murunda	3		
Kigali/Ngali	Bugesera	3		
	Kigali-Kabuga	8		
	Ruli	5		
	Rutongo	3		
Ruhengeri	Gatonde	3	With exception of one, all others in Ruhengeri were set up & operationally supported by Global Fund	
	Gitare	3		
	Nemba	3		
	Ruhengeri	4		
Umutara	Gahini	4		
	Kiziguro	3		
	Nyagatare	7		
Kigali City	Muhima	22	Includes one private initiative by BRALIRWA in 2001.	
Total		165		

Source: TRAC Databases (2005).

Note: With the exception of one site set up in 1997 at TRAC, and a few in 2000, most sites set up in 2004 and 2005, with Global Fund and MAP implementation were effected. It should also be noted that there are geographical disparities in the distribution of sites with Gikongoro least served. Part of the problem is inadequate health care facilities.

5.2.3 Prevention of Mother-to Child-Transmission

Some groups of TBAs have received HIV/AIDS training and use delivery kits that reduce the likelihood of HIV transmission during delivery, but these practices are not widespread. Outreach to and training of TBAs in both safe delivery practices and universal precaution is still lacking. Rwanda has one of the highest maternal mortality rates in the world. Infant formula for sero-positive mothers has not generally been available in Rwanda. Both the cost of formula and lack of an available clean water supply in some areas have been barriers to widespread use of formula. The stigma associated with HIV has been a disincentive to pursue formula options as mothers who do not breastfeed their children may fear being identified as having HIV/AIDS.

5.3 Programme/Project interventions by Civil Society and other Actors

Rwanda benefits from support of its partners in the fight against HIV/AIDS, particularly bilateral and multilateral cooperation that include the cluster of donors and the UN thematic group on HIV/AIDS. This sector is involved in advocacy, funding, coordination, monitoring, and evaluation. Moreover, considerable support from various technical work groups within the field of prevention, support to OVCs, and research is received. More specifically, interventions have been made by United States, United Kingdom, Belgium, France, Italy, Germany, World Bank/MAP, Global Fund, UNDP, UNICEF, WFP, UNFPA, WHO, USAID/PEPFAR, and ADB.

The main Civil Society Organisations (CSOs) working in the fight against HIV/AIDS in Rwanda include Family Health International (FHI), Cooperative Housing Foundation International (CHF), Community HIV/AIDS Mobilisation Programme (CHAMP), MSF Belgium, Columbia University, Clinton Foundation, Christian Aid, World Vision, Action Aid, CARE, ADRA, John Hopkins University, World Relief, Luxemburg Development, Social Impact, Catholic Relief Service (CRS), Caritas, and EGPAF. These have worked in partnership with a number of local CSOs and umbrella groups such as those for religious institutions, youths, PLWHA, journalists, and NGO forum. *(Please refer to Annex 3 for the matrix of CSO's, their areas of intervention, coverage, source of funding, partners, achievements, and challenges)*

5.3.1 Response by Faith-based organisations

Faith-based organisations (FBOs) in Rwanda play a crucial role in the socio-economic, spiritual and political development of the country, and religious leaders

influence almost all aspects of the population. The realisation that HIV/AIDS is a multi-faceted pandemic, requiring not just medical but socio-cultural, economic and spiritual interventions, prompted the GoR to bring religious leaders on board, as evidenced among others, by the CNLS board chair held by one of the religious leaders. FBOs (which include churches, mosques and affiliated organisations) have been providing care and income generating activities support to poor and vulnerable groups. However, the main interventions have been undertaken with support from the World Bank funded Multi-sectoral Aids Project (MAP) and the UNDP/CNLS project, which have enabled them to:

- *establish a network* where representatives of different faiths meet and exchange views on HIV/AIDS, including prevention and control approaches. As a result of this regular exchange of ideas, the hitherto huge gap in perceptions and beliefs is reported to have narrowed;
- *mobilise, sensitise people and provide material support* to the people infected and/ or affected by HIV/AIDS. About 70% of the churches and mosques, now collect funds, food, clothes and other materials, during masses and worship gatherings, at least once a month, and then passed on to the helpless HIV/AIDS affected people (CNLS 2006a). Health care support includes payment of subscription fees for mutual health insurance and treatment, while in education support includes school fees and scholastic materials.
- *Develop materials and conduct training* in facts and basic issues, as well as counselling on HIV/AIDS for religious leaders, workers and community leaders, to empower and support others. This has resulted in reduction of stigma around HIV/AIDS victims.
- As some of the main service providers in health, education, and in some areas, community development, active involvement of religious institutions has enabled HIV/AIDS interventions to reach many communities – FBO founded schools are now involved in sensitising and disseminating information on HIV/AIDS, and more than 60% of the health care facilities providing PMTCT-VCT and some ART, are under religious organisations (CNLS 2006a).
- *Empowerment of religious leaders to inspire others*. More than 400 Muslim leaders (Imams), for instance, have undergone HIV/AIDS testing, and this has encouraged their followers to visit VCT sites and take tests.

5.4 Response by Christian Aid and Partners

More broadly, CA interventions in HIV/AIDS include:

- Health care services (Prevention and reproductive health services)
- Treatment, care, and support
- Financial and material support to people infected and affected by HIV/AIDS

CA does not intervene directly, but works through partnerships with local organisations, providing technical and financial support to enable them reach and impact the target groups at the lowest level. Currently, CA's local partners in the area in HIV/AIDS interventions include:

- Anglican Dioceses of Byumba, Kigeme, Kigali, and Shyira
- Union of the Baptist Church in Rwanda (UEBR)
- BARAKABAHO
- CLADHO
- ARDHO and
- Association of the Genocide Widows (AVEGA).

5.4.1 Shyira Diocese:

Works with Mother's Union, Father's Union, and through support from PSI, has constructed Dushishoze Center with activities focusing on youth reproductive health. The Center is equipped with a VCT laboratory. Shyira diocese covers the former provinces of Ruhengeri, Kibuye, and Gishenyi.

(a) *Prevention*

- Provision of VCT services to youths between 15 – 24 years (at the Center & mobile services)
- Testing for STIs.
- Center is equipped with youth attractive systems focused on films, games (basketball, volleyball...)
- Hold sensitisation and information sharing meetings with youths who visit the Center and counsels those intending to marry/get married
- In collaboration with the local authorities, the diocese organises film sessions in trading centres (especially those that are distant from the Center) where HIV/AIDS related messages are delivered.
- Trains peer teachers in order to extend its activities. Works in collaboration with all churches based in the area, the National Youth council, and the schools.

(b) *Treatment, care, and support*

- The Center does not provide health care. Instead it refers people in need to the hospital in the area.
- Each parish initiated an association for PLWHA

- Eight HIV+ people come to the diocese every Wednesday for prayer. They are grouped in Benibyiringiro association.
- Diocese has limited activities in spiritual and psychological care.
- They do not provide nutritional care for PLWHA

5.4.2 Kigeme Diocese

Kigeme Diocese HIV/AIDS Programme is made up of Mother's Union, Rural Development, Integrated Food Security Programme and Education Departments. Also gets financial support from Compassion International and FHI.

(a) Prevention

- Information, Education, and Communication (IEC).
- Carried out debates within communities where people were sensitised about HIV/AIDS and how to fight it.
- Targeted the entire population in the area estimated at 489,729 people (Census, 2002)
- Emphasis was put on abstinence and faithfulness among the married people
- Sensitisation is made through existing programmes.
- Educating the youth in primary schools and their teachers about HIV/AIDS with testimonies provided by PLWA.
- Sensitisation was done in 16 schools in 2006.

(b) Treatment, care, and support

- Diocese does advocacy work in Nyamagabe and Nyaruguru focussing on access to health (*mutuelles de sante*), care, and food.
- VCT services are offered through Kigeme hospital. Extended VCT services to neglected areas with support from Rotary Club international
- Provision of PMTCT services to expectant mothers
- HIV+ people are organised into associations
- Currently have 27 associations of PLWHA consisting of 832 people (field data collected, Oct. 2006)
- Provision of ARVs. Drugs are distributed to 668 people in Gikongoro district
- Counselling services are provided once a week at the hospital.
- Prayers are held and people are given lessons on HIV/AIDS after prayers.

(c) Financial and/or material support

- Pays fees for OVC and children of PLWHA that go to school

- Helps collection and analysis of projects by PLWHA before they are submitted to MAP for funding
- Four associations of PLWHA are involved in credit and savings cooperative scheme
- Seven associations of PLWHA benefited from livestock distribution. By Oct. 2006, 381 livestock (goats & sheep) had been given out.
- Provided loans to women associations in the area.

5.4.3 Byumba Diocese

The HIV/AIDS programme in Byumba targets widows, couples, youth, orphans, PLWHA, women leaders, and church leaders

(a) *Prevention*

- Sensitisation programs to leaders at the parish level (women, youth,...) and catechists.
- Pastors are trained on HIV/AIDS while they attend biblical training, and a total of 428 people had benefited by September 2006
- Sensitisation is done through athletic competitions, anti-AIDS clubs and students' camps during holidays, as well as through the food security and widows' programme.
- Provision of mobile VCT services – this is provided on demand. Once at least 200 people register for VCT, a request is made and mobile VCT services are provided.

(b) *Care and support*

- Scholarships have been provided to 203 orphans, mostly targeting those orphaned by HIV/AIDS;
- Provision of socio-psychological care to 1,143 PLWHA organised in 23 associations.

5.4.4 Kigali Diocese

The program works in Bugesera district, south of Kigali city. The main activities are mobilisation and VCT services but also include care and support. VCT services have been supported by Geneva Global and World Relief.

(a) *Prevention*

- Awareness about HIV/AIDS is created through outreach, information, education, and communication.

- VCT services. Target was 5,000 people but 3,594 people have already benefited from VCT services
- Church leaders and VCT mobilisers organise the awareness campaigns
- Some PLWHA have been assisted in getting ART.

5.4.5 Union of the Baptist Church in Rwanda (UEBR)

UEBR is a countrywide church but covers only 7 parishes in HIV/AIDS intervention; Kigali, Ruhengeri, Ruhuha, Mukoma, Nyananga, Butare, and Hakwa UEBR Parishes. Its interventions in HIV/AIDS are coordinated by UEBR Health Center but there are parish committees in charge of HIV/AIDS. Its work is in awareness, VCT, and care and support. More often, priority is given to UEBR church followers. Currently, the number of beneficiaries is 502, with 79% being women and 27% of the women supported being HIV+

(a) *Prevention*

- Pastors responsible for parishes were trained in HIV/AIDS. 8 couples (pastors and their wives) were trained
- Spread messages through church member meetings
- Had an introduction to stepping stones for four days
- Provision of VCT services

(b) *Treatment, care and support*

- PLWHA formed associations at the parish level
- They deal in petty trading
- Pastors organise home visits and advise people infected/affected by HIV/AIDS.
- 200 HIV+ people are supported.
- Provide moral and psychological support to PLWHA
- Drug distribution among target beneficiaries focuses on the entire family rather than an individual

(c) *Financial and/or material support*

- Provided soft loans to start own projects in business, agriculture, and livestock
- They oblige the beneficiaries to set aside some funds to guarantee and be used as security to access bank loans.

5.4.6 BARAKABAHO

BARAKABAHO's main activities in HIV/AIDS focus on awareness through stepping stones training, and care and support, mainly to PLWHA through income generating activities, and assisting OVCs with education (tuition, school materials,..). BARAKABAHO is not directly involved in execution of field activities but works by assisting people organised in smaller organisations. Target beneficiaries include orphans, widows, child headed families and the very poor. It covers the eastern province in the districts of Kayonza and Rwamagana.

(a) *Prevention*

- Advocacy
- Supporting VCT services by providing transport money for the poor to go for VCT;

(b) *Financial and/or material support*

- Provided stepping stones training in collaboration with CA and Anglicord to foster families and child headed households in Kibungo/Muhazi, Nyanza and Ruhango.
- 407 people have so far benefited from the training
- Supports income generating activities (goats, cows, pigs, restaurants, sewing workshops, petty trading, and mill projects
- Builds associations' capacity in project management
- Provision of formal education scholarships to OVCs. 80 OVC have so far benefited
- Vocational training which has benefited 100 youth to date
- Health insurance, with 200 beneficiaries

5.4.7 CLADHO

CLADHO (*Collectif des ligues et associations de defense des droits de l' homme au Rwanda*) is an umbrella organisation established in March 1993 by four associations (the Association for the Defence of Individual Rights and Public Liberties (ADL); Rwandese Association for Defence of Human Rights (ARDHO); Association of Peace Volunteers (AVP); Rwandese League for Promotion and Defence of Human Rights (LIPRODHOR) and later Association for Promotion of the Union by Social Justice (KANYARWANDA)).

CLADHO mainly focuses on advocacy and capacity building of its members in areas of human rights, education and communication, resource mobilisation and support. With support of Christian Aid, CLADHO undertook stepping stones

training during October 28th – December 9th, 2005 for its members. Some 40 people (with equal number of women and men) benefited from this training, and were expected to help mobilise and facilitate attitude change in the communities.

5.4.7 AVEGA

AVEGA-AGAHOZO, is a non-profit organisation established in 1995, by 50 widows who are genocide survivors. AVEGA promotes self-fulfilment and self-reliance of widows and other women through many programs, ranging from social networking, skills training for employability and self employment, support home construction to peer counselling. Expanding greatly since its founding, AVEGA has spread its outreach over all of Rwanda. It's supported by UK based Survivors Fund, Christian Aid, PACFA (protection of families against HIV/AIDS) and other partners. In the context of rights, AVEGA has been supported by the Survivors' Fund to strengthen advocacy and scale-up legal representation for widows. Through this support, AVEGA is also involved in promoting peace and reconciliation and raising awareness about the reality of genocide, mobilising and facilitating members to participate in *gacaca*.

In the area of HIV/AIDS, AVEGA has been instrumental in helping widows and other women get medical support for opportunistic diseases and counselling to prepare families for the ravages of HIV, as well as home-based care. Members have also been assisted in micro-finance and skills training in income generation.

The challenges are, however, enormous – sero-positive women are frequently single mothers who need assistance with housing, food, schooling of children and access to medical treatment for opportunistic infections. The social assistance that AVEGA extends to them (mostly grants for food, hospitalization expenses, and assistance with funeral arrangements, repairing homes or schooling children living with HIV, etc) are not adequate.

5.4.8 ARDHO

ARDHO (Rwandan Association for the Defence of Human Rights) is a human rights organisation involved in research, advocacy and networking for the defence of human rights in Rwanda. With network chapters in all provinces, ARDHO collects and distributes information on the state of human rights and acts as a voice for the protection of human rights. It also trains teachers, students and other target groups to influence change in monitoring and observance of human rights, including access to HIV/AIDS treatment by infected vulnerable groups such as widows and children.

5.5 Resource Mobilization and Utilisation in the HIV/AIDS Sector

In Rwanda, HIV/AIDS is one of the most well funded programmes in the poverty reduction and development strategy. Financing HIV/AIDS prevention and control has increased dramatically in the last 5 years, partly because of the global commitments (within the framework of the MDGs) and the GoR steadfast commitment to fight the pandemic. Assessment of expenditures on HIV/AIDS shows that financial resources have increased from about US \$ 4.3 million in 2000 to US \$ 7.7 million in 2003, US \$ 40.3 million in 2004 and to US \$ 78.5 million in 2005 (UNAIDS 2006). This has been largely due to high level commitment on the part of the GoR. In the last UNGASS report, it was estimated that from a base of U.S. \$ 6.7 million in 2002, U.S. \$ 102 million was mobilized in 2003 and 2004. For 2005 alone, resources amounted to U.S. \$ 78.5 million, and the levels of support are expected to remain high until the end of 2009, when the PEPFAR programme comes to an end. The increase in resources has shown clear benefits, with remarkable successes in the number of people on antiretroviral drugs (19,058 in Dec. 2005: 8,355 in Dec. 2004; 4,189 in Dec. 2003) and number of clients reached on mother-to-child transmission. Table 3 below shows the expenditure patterns in 2004 and 2005. Overall, throughput was doubled in 2005 due to intensive efforts by the main partners (PEPFAR, Global Fund, and the World Bank).

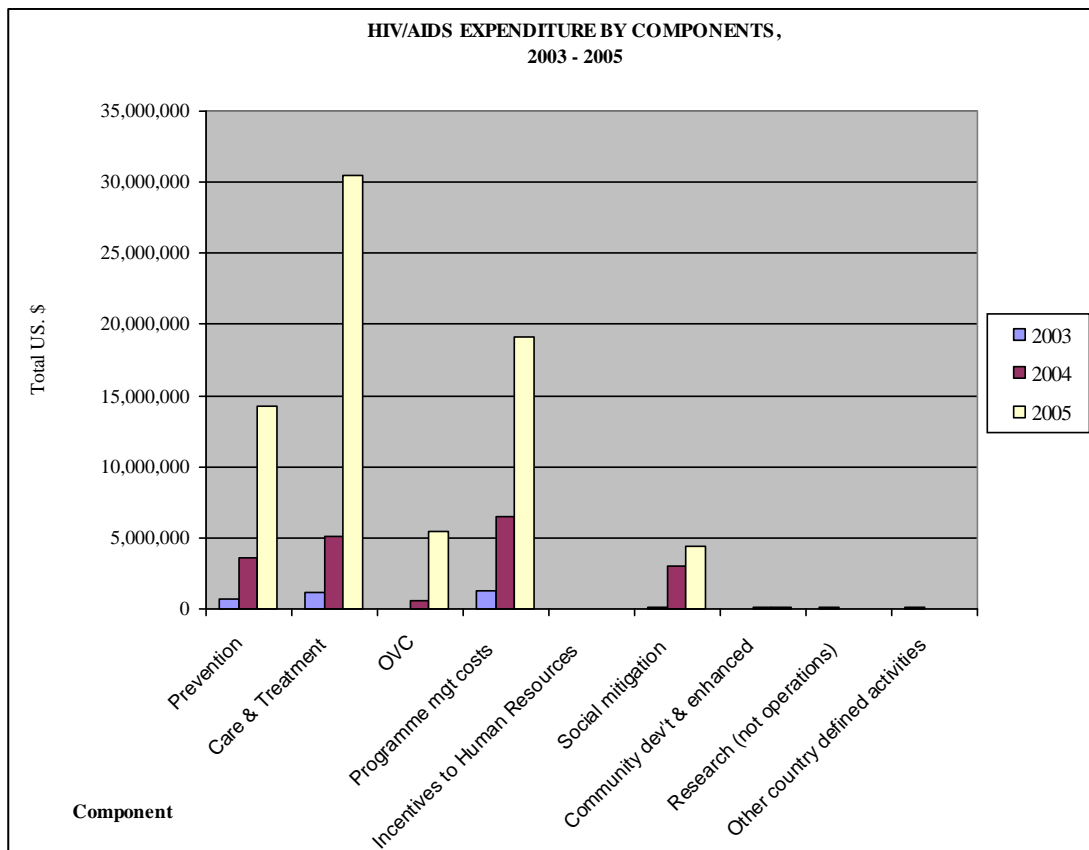
Table 7: Indicative Expenditure (in US Dollars) in the HIV/AIDS Sector, 2003 – 2005.

Source of Funding	Total Amounts (US\$)		
	2003	2004	2005
Government spending	1,324,112	2,733,159	1,705,474
USA – PEPFAR	-	15,696,394	46,817,474
Global Fund	932,160	6,452,330	7,597,300
World Bank/MAP	767,040	5,122,799	9,960,387
UN System	555,073	4,259,113	7,772,545
CNLS/UNDP Project	234,473	392,907	414,595
UNICEF	-	999,473	1,329,261
WFP	-	2,216,733	4,427,658
UNFPA	320,600	480,500	702,500
WHO	-	431,250	431,250
Other UN	-	169,500	467,282
Other Bi/Multilateral donors ⁴	4,130,000	5,590,000	4,690,000
Belgium	490,000	580,000	660,000
France	-	810,000	630,000
Italy	280,000	-	-
Germany	1,020,000	1,080,000	-
United Kingdom	2,340,000	2,350,000	2,810,000
African Development Bank	-	770,000	590,000
Total⁵	7,708,385	40,285,045	78,543,180

Source: Reporting to UNGASS: Dec. 2005.

⁴ Multilateral donor support reported was obtained through the CEPEX Donor Matrix reports.

⁵ Expenditures were not uniformly reported from development partners. The reported figures are largely the funds mobilized and not necessarily actually spent. UN expenditures reported here are actually budgets allocated; there is need to conduct the tracking of resources spent on specific HIV/AIDS programmes to be able to establish actual expenditure.



Data Source: CNLS February 2006.

5.6. Synthesis of the Main Achievements in Combating HIV/AIDS

As discussed in various sections in this chapter, Rwanda has registered impressive results in combating HIV/AIDS from around 13.7% in 2002 to 3% by 2005 (MINECOFIN/APR 2006, DHS 2005). UNAIDS (2006), estimates that between 2003 and 2005 alone, the number of people living with HIV/AIDS are estimated to have declined from about 220,000 to 190,000 (i.e. 13.6%), and death due to AIDS from 25,000 in 2003 to 21,000 in 2005 which is a remarkable progress. A summary of the key achievements are outlined thus:

- the cost of antiretroviral therapy (ARVs) declined from Frw 400,000 per month in 1998 to Frw 30,000 in 2003, and by 2005, ARVs were free at all health care centres
- increase in the number of VCT sites from 130 in 2004 to 217 in 2005 including introduction of mobile VCT services.
- stepping up prevention measures – number of sites offering PMTCT increased from nothing in 1998 to 56 in 2003 and to 150 by 2005.
- Strengthening institutional capacity for coordination, policy and treatment services – as reflected in the establishment of the National AIDS Control Commission (CNLS), Centre for Treatment and Research on HIV/AIDS

(TRAC), and large scale multi-sector programmes such as the World Bank funded MAP.

- There has been more focus on children – not only in prevention but also in treatment. Although only 10% of the children in need of ARVs had access them in 2005, ⁶Rwanda was among the 7 countries (including Botswana, Cape Verde, the Dominican Republic, Jamaica, Namibia and Thailand) that provided ARVs to at least 20% of the children that need them. While this is still modest, it, nevertheless, represents significant achievement.

⁶ Rwanda and the Global Fund. http://www.theglobalfund.org/programs/news_summary.

6.0 ACHIEVEMENTS MADE AND EMERGING ISSUES

Policy interventions: Since 2001, the GoR has enacted a number of policies and developed several strategies for prevention and mitigation of HIV/AIDS. As a result, the policy environment is observed to be increasingly pro-poor and vulnerable, who are comparatively more affected by the HIV/AIDS pandemic.

A number of intervention agencies, mostly funded by the USAID Non-governmental organizations provide food to approximately about 29,000 children affected by HIV/AIDS are, as of 2006, receiving food aid, HIV/AIDS education, counselling, home-based care, vocational training, payment of school fees, and assistance to help households earn more income (especially those headed by PLWHA or children). While it is expected that food assistance can improve the ability of households to care for children affected by HIV/AIDS.

6.2 Programme development and Financing Issues

Major achievements in HIV/AIDS in Rwanda can broadly be classified under:

- i. Prevention;
- ii. HIV/AIDS Programs monitoring, survey, and research;
- iii. Treatment, care and support; and
- iv. Poverty reduction and support to vulnerable groups.

6.2.1. Prevention.

The revised strategy for 2005 – 2009 seeks to prevent the spread of HIV/AIDS through four main approaches: behaviour change among targeted groups; behaviour change among healthcare providers; medical prophylaxis; and an enabling cultural environment. In particular there is greater attention to the youth, to individual responsibility to break the chain of transmission, and to quality and equity in healthcare delivery.

1. Prevention among the youth: In Rwanda, there is high level commitment and support to youth programmes. More emphasis is being put on the youth because 67% of the total population is under 24 years. There are an estimated 250,000 orphans and vulnerable children aged below 18 years (Census, 2002). Most youth in the bracket 15–24 years, however, do not have comprehensive knowledge about prevention of HIV/AIDS. In 2002, 22% of the youth had comprehensive knowledge about transmission of HIV (22% among females and 20% among males).

Preliminary figures for 2005 indicate that females improved in comprehensive knowledge (43% compared to 13% for males).

The National Youth Council (NYC) played a key role, through its decentralized structures, to implement prevention campaigns among the youth. Through financial support from MAP, the Global Fund and UNICEF/PACFA, the NYC managed to mobilize 120,000 youth throughout the country to go for VCT among who 100,000 accepted to be tested (CNLS 2005). As part of this mobilisation, about 700 cartons of condoms were distributed in schools, higher institutions of learning, and universities through the youth Anti-AIDS clubs.

2. Life skills for the youth: In 2004, 10,000 copies of the first teacher's guide for civic education (for grades 4 – 6) in both English and French were printed and distributed nationwide. A review of the national primary school curriculum was started in 2005, to integrate HIV/AIDS programmes to include more on anti-AIDS clubs and other youth organized activities. These activities are reflected in the increased indicative budget of 2004 – 2005 from U.S. \$ 77,000 in 2004 to U.S. \$ 1,550,000 in 2005 by UNICEF alone.

3. Prevention through individual responsibility: In 2005, Rwanda national AIDS campaign message under the global theme “Stop AIDS: Keep the promise, was individual responsibility to break the chain of transmission. These individual responsibilities revolve around knowing one's status, and having the necessary knowledge and capacity to take appropriate action to prevent the spread of HIV. The 2005 world AIDS day was a success story. It was organized and coincided with a monthly community work for the end of November. It took place in all the provinces under a joint supervision of a cabinet minister, member of CNLS commission, and a CNLS staff. Strong messages around the status of HIV/AIDS in Rwanda, and prevention strategies were channelled on that day. Another important event of the day was the provision of monetary support of Rwf. 5,000,000 to micro-projects to benefit the selected group of the OVC in each province.

Radio programmes, aired every week on separate days by CNLS, MINEDUC, and Health Unlimited – URANANA - have had impact to regulation of individual responsibility and behaviour change towards risk sex. The “*Treat Every Child as Your Own Campaign*” which was launched by the OPDAS/PACFA in collaboration with CNLS and UNICEF in 2005 responded to this call.

4. Voluntary Counselling and Testing: The evolution of VCT sites has been remarkable and may be found throughout the country. The response to accepting HIV testing is increasing, even though a large percentage of the population have not yet tested. Currently, 100% of all pregnant women who attend ANC clinics are

tested. Greater attention has been put to promoting HIV testing among the youth, married couples, and for families.

According to the DHS 2005, out of 5,837 women and 4,548 men sampled, 97% of women and 95% of men voluntarily agreed to give blood samples. Increased accessibility to anti-retroviral drugs (ARVs) and intensive awareness about the importance of knowing one's sero-status have been contributed to this positive response because of the visible hope and dignity that ART has restored for PLWHA. In some areas, particularly rural areas, financial incentives have played a part - Financial support in terms of refund of costs associated with HIV testing (mostly transport) is provided, where by an individual is given a coupon to present to the VCT center, and transportation was mainly provided by MAP (a total of 169,380 of whom over 100,000 were youth, for a total amount of Rwf. 300,216,991). At the end of 2005, the Global Fund had supported 122 operational VCT sites throughout the country, which have enabled some 257,380 people to access VCT services. This contrasts greatly with only 68,912 VCT clients registered in 2004. PEPFAR supported 141,467 individuals for the period October 2004 to September 2005.

The three above-mentioned agencies continue to support capacity building through training, provision of additional human resources, equipment and other logistical support, among others. Specific pre and post programmes targeted women survivors of the genocide, through their association, AVEGA AGAHOZO, by financial support from the Belgium Embassy and the Survivors Fund (U.K) SURF from which 220 members benefited out of the Rwf. 5,292,290. However, the increase in the acceptance to testing has to be matched with an increase in the quality and number of human resources to provide care and treatment, which remains a key challenge.

5. *Treatment of sexually transmitted diseases:* To reduce the risk of HIV/AIDS transmission, it is important to treat and contain the spread of sexually transmitted diseases. Between 2002 and 2004, the reported number of STI cases increased (22,465, 27,369, and 36,936 respectively). There were modest changes among the STI reported, but not to the extent of reported increased reporting observed for HIV/AIDS. The observed increase in reporting for HIV/AIDS may be due to several factors: real increase in availability of services, increased reporting, increased demand for accountability or demonstration of results in the HIV/AIDS sector given the large resource in flows, among others.

Table 8: Reported sexually transmitted diseases, 2002 – 2004

	2002	2003	2004
Conjunctivitis	601	911	972
Urethritis	8,436	9,185	11,436
HIV/AIDS	4,167	6,598	12,741
Genital Ulcer Women	4,580	4,936	5,883
Genital Ulcer Men	4,681	5,739	5,904

Source: CNLS Annual Report, Dec. 2005

In 2000, RDHS-II reported that among respondents aged 15 – 49, 32% (27% among males and 36% among females) reported symptoms suggestive of STIs in the last 12 months and sought care at a service provider with a personnel trained in STI care (i.e. from a clinic, hospital or private doctor). However, it is noted that it is not known if the care provider was specifically trained in STI care. The RDHS-III data shows that over all, 50% (49% females and 52% males) sought care from a service provider. This is a positive trend that can be useful for intervention in the prevention of HIV/AIDS.

6. Prevention of mother-to-child transmission (PMTCT): The GOR put in place a PMTCT programme in 2001, initially covering 6 (out of 12) provinces, and by 2004, it covered all provinces and health districts (MINECOFIN 2004a). The number of sites offering PMTCT services increased from 56 in 2003 to 120 in 2004 and 150 in 2005 (TRAC, 2005). As a result of this initiative, a cumulative of 138,000 pregnant women had accessed PMTCT services as at end of Oct. 2005. This could have contributed significantly to the reduction in the number of children living with HIV/AIDS from 30,000 in 2003 to approximately 27,000 in 2005 reported by UNAIDS (2006).

Table 9: Trends in Coverage of PMTCT Programme

	Spectrum estimation for total population 15 - 49 ⁷		PMTCT Programme monitoring data								
			ANC		TESTED		HIV+		NVP		Activities Covered.
	Pregnant women	HIV+	#	%	#	%	#	%	#	%	
2001	355,554	18,949	13,146	4	11,478	87	1,782	16	952	53	5.0
2002	363,128	19,587	42,869	12	34,944	82	3,107	9	1,547	50	7.9
2003	368,926	20,138	50,575	14	41,856	83	3,505	8	2,866	82	14.2
2004	373,382	20,596	119,496	32	95,475	80	6,405	7	4,141	65	20.1
2005 ⁸	377,000	20,735	198,234	53	178,054	90	8,632	5	5,756	67	27.8

Source: CNLS Annual Report Dec. 2005.

Table 9 shows that both promotion of HIV positive women attending ANC who received prophylaxis, and the actual coverage of pregnant women in need of ARV prophylaxis have been increasing steadily. In 2004, 65% of all HIV positive pregnant women attending ANC received NVP, and in 2005, this increased slightly to 67%.

⁷ Grey-shaded cells are estimates and extrapolations

⁸ 2005 data: ANC attendance RDHS-III, Number on NVP – TRAC, Dec. 2005

It is observed that the scaling-up of the PMTCT services has largely depended on the financial assistance from multiple partners who put more emphasis on the expansion of PMTCT sites to increase accessibility:

Table 10: Donor Support to PMTCT Services

Funding Agency	Number of Sites
Global Fund	122
MAP	1
UNICEF	16
WHO	5
AVSI	1
Concern	1
MDM	1
MSF Belgium	2
EPR	1
Total	150

Source: TRAC, 2006

7. Condom accessibility and utilisation: In a recent national study⁹ of male condom accessibility, about 12% of respondents thought married men could easily get them, and about only 2% thought married women or single women could buy them (male condoms). The cost of condoms was not perceived as a barrier. In addition, 88% urban compared to 45% of rural respondents knew of a place near their home where they could obtain a condom. Between 25% and 30% of the respondents thought anyone who needed condoms, could get them. While this suggests relatively high levels of awareness about and accessibility to condoms, their utilisation is still low, and, among males, UNAIDS (2006) reported that condom use has declined from 55% in 2000 to 41% in 2005. A number of issues are deduced about the current access to and use of condoms:

- there are marked differences in knowledge and perceptions between urban and rural people. In the study highlighted above, urban dwellers were more comfortable speaking with their friends about condoms than rural areas (78% urban vs. 60% rural respondents);
- stigma related to HIV/AIDS is a big influence to the use of condoms especially in rural areas. It is even more difficult for married and older people to buy condoms even where they are available and affordable. Some 53% of respondents thought they could be considered promiscuous, while 51% were ashamed to be seen buying a condom, and 41% thought that rumours about condoms discourage use.
- in rural areas, condoms are generally perceived to be used outside the confines of marriage.

In general, however, it was noted that even though traditional negative practices were reported to be major barriers, condoms have not been adequately accessible to

⁹ See CNLS Annual Report 2005. February 2006.

the population. In Rwanda, PSI (Population Services International) and UNFPA (United Nations Fund for Population Activities) are the leading agencies in condom marketing and distribution (CNLS 2006). PSI mainly follows the social marketing for change approach which targets the young and middle aged people, while UNFPA markets condoms in the framework of family planning and reproductive health programs.

CNLS in collaboration with partners developed a National Condom Policy and its operational plan to guide the agencies that intervene in the area of ensuring access and use of condom in the country (2005) but this has yet to be operationalised.

8. Sexual debut: RDHS-II (MoH 2000) reported that the median age at first sex was 20.8 years (Female 20.8, Male 20.6). RDHS-III (2005) found that this was 19 years for females, and 18 years for males, an apparent drop for both sexes. It is noted that this information is based on a population of people aged 15 and above, and could therefore be higher if the sample included all sexually active persons below the age of 15 years. The finding in RDHS-III that 82% of respondents (82.8% females; 81.2% males) aged 15-24 reported having sexual debut before the age of 15, provides a different view, and emphasizes the need to target youth more vigorously at earlier ages.

9. Higher risk sex and condom use among youth: In 2000, a total of 26% (10% females and 42% males) aged 15-24 self-reported having higher risk sexual behaviour¹⁰ (RDHS-II). These reports have increased to 45% among females and 62% among males according to preliminary findings from RDHS-III. Preliminary estimates of condom use from the RDHS-III conducted in 2005 suggest that 40% of females, compared to 69% of males used condoms during their last sexual encounters. While this level of use is an increase over levels reported in 2000 (39% total; 23% females, 55% males), condom use among this population will need to rise to meet the increased report of higher risk sex trend if abstinence does not increase.

10. Injection safety and management of medical waste: The Government is taking steps to improve injection safety and management of medical waste. Since mid 2004, when a baseline survey was carried out, two districts (Nyagatare and Rwamagana) were selected as pilots to improve medical waste management and injection safety. In 2005, the programme was expanded to six other districts: Gahini, Kiziguro, Kabutare, Gakoma, Nyanza and Kibilizi. The programme will reach national coverage by 2007. A national policy on injection safety and prevention of nosocomial infections and the management of medical waste is under development.

¹⁰ The proportion of respondents who had sex with a non-marital , non-cohabiting partner in the past 12 months

11. Blood safety: Measures have been taken to safeguard blood supplies for transfusion. The National Reference Laboratory (NRL) has a policy to carry out external quality controls on 10% of all negative test and 10% of all positive tests. In 2005, a total of 37,893 blood units were collected (of which 60% were collected from Kigali City). This was 31.7% increase when compared to 28,777 blood units collected in 2004. The blood transfusion programme planned to conduct training in health facilities on blood transfusion and quality control during 2006. Other plan was putting in place a notification system of serological results and referral of seropositive data to the VCT sites in health facilities.

6.2.2 HIV/AIDS Programs Monitoring, Surveys and Research:

Monitoring the epidemic: From 2004, there has been an influx of M&E technical support from key HIV/AIDS partners. This group has joined forces with the local M&E expertise to form a Technical Working Group which has been active for the major M&E activities undertaken in 2004 and 2005 with respect to HIV/AIDS. CNLS has improved the monitoring of programme efforts nationally, with a new comprehensive reporting format to be adopted by all partners in the HIV/AIDS sector. Service delivery was mapped and partner activities will be better monitored based on signed agreements. The Treatment and Research AIDS Center (TRAC) has operationalised a system, TRACNet, which is an integrated management tool to provide information rapidly on the epidemic, to monitor patients on ARV, and to monitor procurement and stock of ARVs. With the developed data collection tools and data flows, as from 2006 all the non medical programs implementing agencies will submit, quarterly, their progress reports to the CDLS, and the CDLS will compile these reports and submit to the CNLS. All medical indicators will be collected by the TRAC and the NRL.

Surveys and Research: The new strategic framework has placed emphasis on evidence-based programming and the use of research to guide decisions. As earlier mentioned, the CNLS created in September 2005, a national HIV/AIDS research committee with a mandate to scrutinize and approve research protocols from all the agencies intending to conduct research/surveys in all the domains of HIV and AIDS. This committee is broad in composition and draws members from the CNLS, TRAC, UN Systems, HIV/AIDS Umbrella Organizations, Research Institutions, the National Institute of Statistics, and Universities. The internal regulations of the committee allow participation of any other agency or individuals whom the committee may deem appropriate in the cause of the agenda.

The challenge that still remains is the great need to exchange information and share a common database on existing policies, strategies, and interventions related to HIV/AIDS among the various stakeholders.

6.2.3 Treatment, Care and Support:

The Government of Rwanda has made steady progress in provision of care, treatment, and support to people infected and affected by HIV/AIDS. The national strategic orientation in this domain is three-fold: increase access to high quality care and treatment at health facilities; increase access to high quality care and treatment within the community level; and assure that HIV/AIDS-related care and treatment is sustainable. According to TRACNet records, 2,728 individuals received care and support, with 2,143 individuals provided with general HIV related palliative care/basic health care and support as per the national policy.

Over all, 595 HIV-infected individuals (diagnosed with TB who then tested positive for HIV) received clinical prophylaxis and/or treatment for TB at sites directly supported by the national TB program. PNILT benefited from institutional capacity building and national training support through technical assistance from Columbia and the CDC as well as logistics support through the MSH/RPM. The number of people in need of treatment by end 2005, according to WHO 3 by 5 Report 2005, was 39,000. The number of people on ARV has considerably increased over years from 3,206 in 2003 to 8,991 in 2004 doubling to 19,058 (1,443 Children and 17,615 adults) in 2005 and 32,859 by end of November 2006 (TRAC Reports, Dec.2005 & Dec 2006). This is very close to 3 by 5 achievements, considering the new DHS results. It is also important to note that out of about 30,000 adults on ARVs as of end of 2006, about half were women, suggesting improved access for women.

To ensure access to treatment and to ARV by the poor, the Government released a Ministerial Decree establishing guidelines for the distribution of ARVs in 2004. Among other articles, this Decree is to provide ARV free to poor (vulnerable) affected persons and a token amount of money on a sliding scale in family approach to ensure that women and children are not left out. This Decree followed successful negotiations between Government and pharmaceutical companies to reduce the cost of ARV from approximately \$400 to \$100 in 2003. In 2005, the average monthly cost of ARV at the Kigali University Referral Hospital (CHUK) reduced further from 34,000 Rwf (\$63) to 10,000 Rwf (\$18) per month. In addition, the government has continued to provide support to initiated common basket for procurement of ARVs from CAMERWA.

A total of 19,058 patients were on ARV treatment by December 2005, with disproportionately more adults than children accessing antiretroviral drugs (only 8% of the drugs benefited children compared to 92% for adults). This disproportionate access underscores the need to re-focus interventions on the young segment of the infected population. It should also be emphasised that children aged below 14 years

compose 44% of the general population (according the Population and Housing Census 2002). There are, however, signs of increasing recognition of this need, as evidenced by the first National Paediatric conference on HIV/AIDS held in June 2005, which also recommended increased diagnosis for children, as well as the recent policy on OVCs. Global Fund and MAP projects provide most of the financing (54%) for the ARVs provided.

However, it is important to note the challenges that still remain in regard to care and treatment. Although ARVs are provided free of charge, there still exist circumstances that make accessibility difficult for a number of PLWHA:

- The provision of a token amount of money to the infected/affected families to ensure that women and children are not left out may not be sustainable. These are donor-supported programmes (particularly by MAP) that have definite timeframes. This initiative may not be sustained after the programmes come to an end.
- It is required that in order to access free ARVs, patients must enrol into an association of PLWHA. Due to the stigmatisation that still surrounds HIV/AIDS, a number of people are reluctant to declare their status, even to as few people as their immediate family members. Thus, they do not register and miss out on the treatment.
- Due to fear of stigmatisation, most PLWHA prefer to get treatment from mobile VCT units than from the conventional health facilities. Patients assume and therefore get the confidence that the mobile unit health providers are more qualified, experienced, and less known to them. They feel more comfortable accessing services from mobile units.
- Because ARVs are now provided free of charge, health care facilities are overwhelmed by the number of patients received at the health facilities, which have not been matched with corresponding increases in the numbers and facilitation of health care providers. Faced with such challenges, the few service providers available choose either to pay more attention to HIV/AIDS patients or distribute their efforts among patients of different ailments. However, since there is no motivation for the health care providers, less attention is paid to HIV/AIDS sufferers, resulting in long waiting queues, and many patients going back without being attended to. Consequently, they lose courage and may stop coming to health facilities altogether.
- HIV/AIDS infected children are rarely targeted as a specific priority group. They are often lost in the general group of PLWHA.
- The national approach on comprehensive treatment, care, and support is rather family oriented, and thus street children (families) are not catered for.
- While national policies and strategies (especially on health, HIV/AIDS, and OVC) comprehensively address the issue of treatment, care and support, it is

obvious that implementation, coordination and monitoring (by CNLS and TRAC) need to be reinforced.

Quality of services and scaling up of human resources: The Treatment Research AIDS Center, TRAC, in collaboration with partners developed national protocols for HIV/AIDS care and treatment, and subsequently conducted a number of training to service providers at facility levels. More clinicians and health service delivery facilities are increasingly tracking individual patients to maintain proper treatment regimen. With this development also, is a concurrent effort to monitor drug stocks and have an early warning system for stock outs.

The scaling up efforts of care and treatment services requires resources if quality and equity in service delivery are to be maintained. The greatest challenge today is that of the numbers and quality of human resources available. In 2005, there were 4.2 doctors working fulltime, supported by 1.3 doctors working part-time, 61.6 clinical officers, 43.9 enrolled nurses and 6 laboratory technicians per 100,000 people. For the medium term, the national plan is to decrease the staff at central level, and to increase the capacity of the available human resource to be more efficient at sub-national levels. For example, Government has recently decided to release all medical doctors who were working in the public services on duties other than provision of care and treatment and to re-allocate them in health facilities all over the country. Partners have already taken steps to meet these training needs. It was estimated that about half of all (health) districts had received training for managing opportunistic infections, and for HIV/AIDS and counselling. A standardized training package is under formulation, and will be used to guide capacity building efforts. The challenge will be to meet these needs in a timely and sustained manner.

Despite the efforts above, the challenges of insufficient health service providers and the limited skills among them still remain predominant.

Care and support to people living with HIV/AIDS: The National Umbrella of PLWA, RRP+, created in 2003 has continued to mobilize efforts to support the associations of people living with HIV/AIDS, totalling more than 800 by December 2005. The burden of HIV/AIDS on families is high. The challenge is to create a division of labour that allows PLWHA to receive palliative care that includes family members that are able, without seriously affecting the economic output by these supportive family members.

The RRP+ in collaboration and financial support of FHI/IMPACT launched from September 2004 to October 2005 implemented a home-based care programme. The components of the programme involved trained home-based care volunteers,

financial support to associations of PLWA, procurement of HBC kits, and supporting PLWA to access community medical scheme (*mutuelle de santé*).

Poverty reduction and support to vulnerable groups:

Strategies to fight HIV/AIDS recognize a link existing between poverty reduction and AIDS and vice versa, because AIDS is an aggravating factor or cause of poverty, and combined effect of poverty and disparities of incomes on social interactions, including sexual relations, levels of vulnerability and risky behaviours related to the infection of HIV and AIDS. In the year 2005, HIV/AIDS related poverty reduction programs were largely implemented through provision of financial assistance to fund small income generating activities, particularly to benefit PLWA and women groups. The MAP, CNLS/UNDP, BAD projects, and PEPFAR (CARE International) were the main source of this support. The MAP project granted financial support to 550 micro projects with a total amount of Rwf. 3,144,820,392 through 84 granting organizations. Figures for 2004 and 2005 show that there financing remarkably increased by 65.6% at the level of granting organizations and 77.4% at the level of micro projects.

The CNLS/UNDP project financing to the micro project registered progress in the year 2005, in terms of the number of beneficiaries and amount disbursed. A total of 44 projects received funds worth Rwf. 42,590,573 in 2005 compared to 37 micro projects financed in the year 2004. This was an increase of 15.9%. The number of beneficiaries was 27,402 in 2005. This figure registered an increase of 33.3% above 17,500 beneficiaries in 2004. The project covered 14 Districts out of 42 Districts targeted by the project in 2004, and the number increased to 21 districts in 2005. The CNLS/PNUD project gives special ascent to gender dimension in its strategies to support small income generating projects.

The CNLS/BAD project started in October 2005, specifically to support small income generating initiatives from the community based organizations. In two months of its existence, the project managed to finance 24 projects out of 60 projects which submitted their requests. The amount of funds disbursed to the organization in the first phase payment, amounted to 60 percent of all the funds which would eventually be provided to the listed beneficiaries. The promotion of income generating activities will continue. More resource mobilization is required from donors because of increasing demand from different vulnerable groups.

Support of vulnerable poor families to access community medical scheme: The Umbrella of people living with HIV/AIDS, RRP+ has collaborated with the local authorities to objectively identify the neediest poor household from the associations of PLWA who need to be supported financially to access medical care through the *mutuelles de santé*. There were 221 associations of the PLWA with 5,093

households that had received funding to the tune of Rwf. 20,952,400 by January 2006.

Support to the Orphans and vulnerable Children (OVC): The interventions made to support the OVCs are developed from the OVC policy which was developed by MIGEPROF in collaboration with the CNLS and UNICEF at the end of 2004. The OVC policy defines mechanisms for socio-economic support of the estimated 1,264,000 children below 18 identified in the 2002 General Population Census as orphans. This estimate represents about 30% of children, one of the highest in the world, with breakdown by type as follows: - Maternal orphans (170,000), Paternal orphans (799,000), Double orphans (183,000), and don't know (112,000).

In recent past, most of the HIV/AIDS implementers have shown interest in supporting OVCs, with support activities ranging from provision of food, training for income generating activities for household heads, and payment of school fees and provision of scholastic materials. MAP, PEPFAR and the Global Fund were reported to be the main funding sources for OVCs. In 2004, MAP reportedly assisted 6,945 OVCs, and the total number had accumulated to 25,365 by end of 2005. Of this figure, 19,122 benefited from direct payment of school fees, 856 benefited from vocational training and 5,386 benefited from provision of scholastic materials. This area of support was worth Rwf. 1,125,435,580, constituting 53% of all the funds that the project disbursed.

Supporting the vulnerable households to access mutual health insurance (*mutuelle de sante*) is another component which benefits the OVC. Of the 28,519 households who were given the cards, 7,539 were OVC school children. According to PEPFAR report covering the period of Oct 2004 to Sept 2005, a total of 26,682 OVC benefited from school fees and payment of community health insurance scheme. This support was channelled through CRS, AFRICARE, CARE International, World Relief, and SWAA Rwanda to mention some agencies. With the commencement of CHAMP programmes, increased support in this domain was expected.

6.3 Institutional Partnerships and Sectoral Coordination Issues

The recognition, across the public, private and civil society spectrum, that the disastrous effects of the HIV/AIDS pandemic transcend sectors, was one of the main achievements. To date, a number of sectoral policies, strategies and programmes, include HIV/AIDS. In the civil society, HIV/AIDS mainstreaming has long taken root. What is lacking is the translation of such commitments from pledge statements on paper into real actions.

7.0 MAJOR GAPS, CONSTRAINTS AND CHALLENGES

7.1 Major Gaps and Areas not sufficiently covered

In general, a policy environment has been created that promotes equity in access to care and support, and promotes integrated and multi-sectoral approach to HIV/AIDS control and prevention. There also appears to be adequate funding for HIV/AIDS activities over the medium to long term, thanks to the Millennium Development Commitments and the GoR's prioritisation of HIV/AIDS. What is clearly lacking, however, are strong and effective mechanisms for coordination of programming; monitoring and follow-up, to reach all affected people, and to ensure coherence and synergy in program design and implementation. The main gaps in programming and interventions identified by this study include:

1. Institutional Capacity for programming, knowledge management and learning: although monitoring and evaluation, follow-up and learning are critical to program sustainability and impact, it's still weak in the HIV/AIDS sector, as evidenced by duplication, different but often contradictory information sources, over-concentration of intervention in some areas at the expense of others, etc. As a response, CNLS has developed a reporting framework but this is fairly recent and yet to be operationalised. It is hoped that new reporting structure will serve as a basis for partner organisations to develop more robust monitoring and evaluation systems.

Management systems for projects and programmes, financial and accounting, monitoring, evaluation and reporting, follow-up and advocacy for local communities are lacking especially among churches and FBOs, which have strong and permanent networks at all levels.

2. Nutritional support remains a very small component of care and support for HIV/AIDS infected and affected persons, yet good nutrition is considered a key aspect of improving and sustaining health for PLWHA. In Byumba, Kigeme and Shyira, stakeholders and PLWHA themselves reported that PLWHAs had been trained and were aware of the importance of having balanced diet and knew how to prepare it. However, most PLWHA are too poor to afford even basic food, while some of those with access to land were too weak to cultivate. They depended on food aid handouts by the projects and relief agencies, which are too little and not consistent. Failure to address the nutritional problems may have negative implications for the treatment and care of PLWHA. For instance, it was reported in Kigeme, that some PLWHA are reluctant to register for or continue with ART without adequate food because they argued that the drugs were too strong for them, increased their appetite and yet they had no means of satisfying it.

3. Home-based care for HIV/AIDS patients and indeed for people infected with or affected by HIV/AIDS is emerging as a key aspect of care and support. However, the current support does not adequately cover home-based care, as it entails, for most partners (churches) visits to PLWHA and not medical and psycho-social support at home, of which most AIDS patients are in desperate need.

4. HIV/AIDS has increased trauma and psycho-social problems for especially vulnerable groups such as orphans, widows, genocide survivors and extremely poor people, whose situation was worsened by the genocide or civil disturbances (such as in former Gisenyi or Gikongoro/ Kigeme zones). However, very few partners are offering psycho-social support including trauma counselling. Most partners offer spiritual counselling (Kigeme, Byumba, and Shyira Dioceses) but not trauma and related needs of PLWHA.

5. Food support and income generating projects are essential part of the HIV/AIDS support interventions. Nutritional problems were mentioned in all the areas visited among the main worries of PLWHA. In Kigeme, some female PLWHA were reported to engage in sex with relatively wealthy men to get food and basic necessities. Yet these aspects are not adequately covered. Food aid is a very small component of the CA partners' interventions. In addition, income generating projects, which involve micro-credit support, are generally small – loans given are small and there is little training of beneficiaries in micro-credit. It is also important to identify appropriate projects which the PLWHA can manage. For instance, in Kigeme and Byumba, it was reported that PLWHA were organised into groups which help each other in farming but many complained that they were too weak to cultivate.

In Byumba and UEBR Butare, beneficiaries were given some credit without sufficient orientation and training, and they misused the funds, without undertaking any tangible projects. With some training, beneficiaries in Byumba were later able to put in place some projects. In Gikongoro, a recent evaluation of HIV/AIDS related project by Medical Missionaries of Mary (MMM) also found out that youth groups and PLWHA groups were given small micro-credit funds without clear orientation and they misused it perceiving it to be a grant. Part of the problem is that such micro-projects are supported in the context of relief and many project managers in the partners' interventions have not had sufficient training e.g. in projects identification micro-credit, follow-up, etc.

6. HIV/AIDS and human rights issues including domestic violence, right to be in school, right to decent shelter, etc, have not been adequately addressed. The faith-based organizations which have wider and longer term relationships with the target communities (such as the churches) are best placed to advance these interventions.

7. Special interest and at-risk-groups such as youth have not been adequately covered despite the opportunity provided by youth membership in the CDLS and their involvement in community activities. Youth have unique emotional, psycho-social and material needs, all of which influence how they respond to development interventions. These needs also vary according to youth categories – e.g. in-school youth, out-of-school youth, girl-youth, those with family responsibilities, etc. Some partners (such as Shyira Diocese) have, with support from Population Services International (PSI), established youth centres and support programmes such as Centre Dushishoze in Shyira and Butare. However, not all youth are involved. Even those who are attracted (e.g. by the films or sports activities) hear the messages about HIV/AIDS but are reluctant to take up HIV tests and make informed decisions on how to protect themselves about AIDS. Moreover, many of the main intervention strategies such as through mothers and fathers' unions do not appeal to youth.

With regard to CA partners involved in HIV/AIDS (those visited in Kigali, Kigeme, Byumba, Butare and Shyira), a number of weaknesses were observed:

- Very often there is limited or no follow-up of project activities, partly because project personnel are few and working on a whole range of activities. Partly, however, the problem of monitoring and follow-up is due to lack of clear systems for project management including documentation;
- there is limited coordination of activities, resulting in duplication, confusion and waste of time and resources;
- there is limited funding, partly a result of lack of technical capacity to conceptualize and prepare projects for resource mobilization;
- institutional capacity (lack of information systems, skilled personnel,..) is weak and require capacity building support;
- little attention has been paid to issues of power relations in households (how much voice women and children have, how they express themselves), reproductive rights and domestic violence, even though with a good focus on ensuring that they receive support e.g. access to ART by genocide widows and orphans.
- little focus on livelihoods and rights issues, which are often the underlying problems that provide fertile ground for HIV/AIDS to spread.
- Income generating activities have tended to be supported with no adequate mechanisms to develop capacity for their conceptualization and management. This raises concerns for appropriateness and sustainability.

7.2 Major Constraints and Challenges

Although remarkable progress has been made in reducing the prevalence of HIV/AIDS and access to treatment and care (according to DHS 2005), a number of constraints and challenges exist, that threaten to undermine the HIV/AIDS cause.

1. Extreme poverty and vulnerability: most stakeholders met are concerned that poverty and vulnerability is the most pressing challenge undermining efforts to fight HIV/AIDS. Poor and vulnerable individual households and communities are difficult to reach, tend to respond slowly to interventions, and cannot afford the basics of life even when they have access to information, anti-retroviral psycho-social support. It also complicates programming and resource mobilisation. In Kigeme, Butare, Byumba, Shyira and Kigali, nearly all stakeholders met during the baseline study, expressed frustration that they were overwhelmed by the multiple needs of their program beneficiaries. *“Supporting a child who is an orphan, has no food, no where to sleep, no clothing, and needs school fees are extremely difficult, even to provide basics. It requires a lot of funding”* Lamented programme officials at BARAKABAHO.

The other challenge related to this is that there are too many vulnerable men, women and children affected by HIV/AIDS, and with the little resources and organisational capacity that characterise such agencies, they face difficulties in selecting people to support, and are compelled to spread the few resources among many beneficiaries at the expense of efficacy and impact.

3. Declining social cohesion and responsiveness: While community initiatives such as home-based care are being supported and have in many instances proved to work, their success remains hinged on the community’s cohesion and social ability to take on responsibilities of looking after the sick. Incidences have been reported where AIDS patients could not be taken to health centres for treatment simply because they failed to raise money as little as Fr 200 to hire patient carriers (Ingobyi) or motivate able bodied men to carry them. In these circumstances, it may be difficult to get volunteers to look after the patients under home-based care, or to adopt orphans.

4. Socio-cultural barriers undermine efforts to fight HIV/AIDS: Rwandan women are culturally submissive to their husbands (NPA 2006). They tend to remain silent and are not expected to “make noise” even when their rights are violated. Sex is still a taboo and even church leaders are reluctant to talk about it; the gap in communication between adults and young people is still wide and undermine any opportunity to exchange ideas or to impart values and information to young people.

5. Inadequate access to health care support including VCT:

Thus, despite the increased access to VCT services, they are still inadequate. In Byumba only 6 VCT centres exist in the diocese. Partly as a result, VCT services at health centres visited tended to be restricted to a maximum of 30 clients per day, and many people are disappointed when they are turned away after walking tens of kilometres in the hills to seek such services. Quite a number do not return, while others opt for the mobile VCT services. Moreover, mobile VCT do not charge fees, as opposed to the health centres where clients/patients pay Frw 100 consultation fees. A combination of these factors tends to increase the pressure on both the health centre based and mobile VCT services, resulting in further disappointment. Mobile VCT services appear to be popular compared to health centre based because of a number of reasons:

- they are free and no consultations paid as in some health centres;
- quality was perceived to be higher than at local health centres since the health care providers come from Kigali (TRAC) where the facilities were presumed to be of better quality;
- external VCT providers were presumed to guarantee confidentiality, as the testing and handling of results is done by people completely unfamiliar to them.

The main message from this is that – testing is associated with stigmatisation; there appears to be some concerns of mistrust about the professional behaviours of some health care providers conducting testing; and inadequate counselling.

The pressure on mobile VCT services, which most people appear to prefer, has made them more crowded and capacity-strained. The following are some key observations on awareness and access to HIV/AIDS services:

- ✧ *Tendency to concentrate in easy to reach areas* – it was reported that most NGOs tend to avoid areas perceived to be remote or hard to reach (such as deep rural areas) and tend to concentrate around the highways. This has widened the gap in knowledge and empowerment between “accessible” and “hard-to-reach” areas, yet it is where most poor people live.
- ✧ *Behavioural change Communication* – comprehensive knowledge of HIV/AIDS among pregnant women attending anti-natal is 100%. Among the youth, it has increased from 22% in 2000 to 52% in 2005.
- ✧ *Poverty and vulnerability* – working with OVCs, widows and elderly.
- ✧ *Inadequate services*: an estimated 22,000 infants are born to HIV positive patients annually in Rwanda, but PMTCT services are only available in half of the 400 health facilities in the country, implying that many new births are at risk of infection during birth and breast feeding.

Partly as a result of inadequate facilities, there is imbalance distribution of HIV/AIDS treatment: As of 2005, Kigali city had more sites providing ARVs than other provinces. And about 49% of HIV/AIDS patients accessed ARVs in Kigali based facilities. Equally, 53% of children on ART were in Kigali City. What this implies is that the farther way from Kigali the patients were, the less likely they were to access ART, yet most of the HIV/AIDS patients outside Kigali (mostly in rural areas) are poor.

6. For most partners, particularly the churches, HIV/AIDS is but a small component of the many programmes they are handling. As a result, clear institutional structures that can design, monitor and evaluate specific HIV/AIDS projects appear to be lacking. Few staff and budgets are allocated to HIV/AIDS activities, yet the areas covered are very wide.

7. Lack of motivation among health service providers: A combination of too much work load due to many patients, fewer staff, stressful work environment and low pay, health workers in all the zones visited (and nationally) have low morale and motivation. In these circumstances, VCT services being free at health centres and hospitals are not given priority, and tend to be inefficient, as evidenced in many crowds witnessed in most health centres.

8. Weak organisational capacity at grassroots levels.

Many youth groups have formed AIDS prevention and control associations (Club Anti-SIDA) but most of them are dormant or tend to collapse almost as soon as they are formed. From the interviews held with local stakeholders, the underlying constraints with such organisations include:

- lack of organisational and technical capacity for management and resource mobilisation. As a result, they lack funding and become dormant;
- are initiated by youth many of whom are household heads or have economic responsibilities which take them away from such community commitments to better paying jobs;
- youth who are active in founding and managing the Anti-AIDS clubs generally tend to be mobile in search of economic opportunities elsewhere – usually after the age 17-19 years.
- Sometimes such organisations collapse when active members are married off away from the community.
- There is limited coherence and coordination, as most Clubs tend to be shaped and operate within the framework of the funding or support agency, especially those attached to different denominations.

Weak absorption capacity – the paradox about increasing resources that does not reflect corresponding impact on the pandemic, is partly a result of lack of absorption capacity. It was reported by many stakeholders at national level that a lot of resources are not utilised, while lower level organisations felt the funding cycles were too short, and with stringent conditions. “*Sometimes a funding agency tells you to do a project in a totally different activity from what you are doing*”, a statement echoed by officials met in at least 2 organisations.

9. Behavioural change interventions are insufficient and/ or inappropriate:

Despite increased awareness and knowledge resulting from multi-media and multi-strategy communication interventions, awareness about HIV/AIDS and positive response to such messages remain low:

- risky behaviours (essentially unprotected sex) were reported to be on the increase. For instance, adults reporting unprotected sex with non regular partners increased from 10% to 15% among females and from 42% to 48% among males, while condom use declined from 55% in 2000 to 41% in 2005 (DHS 2005). In the EER Kigeme Diocese zone, some PLWHA returned to active unprotected sex work when their health got better, a situation that could increase new infections.
- stigmatisation and fear are still high in some areas. In Kigeme Diocese, many men were reported to be reluctant to take HIV tests, reasoning that having women tested was enough, implying that the incidence of discordant couples was not known to them.

10. Predictable and sustainable funding is lacking. Although there appears to be a lot of funding in the HIV/AIDS sector, funding was reported to be inadequate and unreliable. Part of the problem is engineered by the short term nature of funding and technical support.

11. Coordination of programming and operations remains a serious challenge:

Although many coordination mechanisms (including networks from national to district level) exist and more appeared to be emerging, inadequate coordination remains a serious challenge. The main problems in this regard relate to

- Institutional, logistical and human resource capacity constraints. The HIV/AIDS NGOs forum for instance, has only 3 personnel, while the Inter-faith HIV/AIDS prevention Network has only 4 staff including the coordinator.
- Funding - The NGOs forum has been restricted by CNLS from mobilising funds and only relies on CNLS which funding was reported to be grossly inadequate and unreliable; it has only 3 technical staff (Coordinator, Programmes Officer and Executive Secretary) all of whom are based at the

head office. These are too few to effectively undertake coordination work outside the office. Moreover, compliance of members with regard to submission of regular reports and attendance of meetings and payment of subscription fees is low, making the NGOs Forum a lame duck.

- Membership is involuntary, whereby CSOs are compelled by CNLS to belong to Resistance. Disagreements between “members” and the forum are common and subscription is still low.
- Although the principal role of the NGO forum is coordination, there is no vote (or budget) for the coordination function indicating that their coordination role is, most often in name.

As a result of these constraints, it was noted, that most action plans are never executed.

12. Inadequate programming

- In EER Byumba, associations of PLWHA were provided with short term loans to undertake income generating projects but most of them misused or diverted the funds and hardly any serious projects were undertaken, and no one repaid the loan. The low compliance and response was reported to be resulting from inadequate mobilization and training and the perception that the loans provided were a gift from God, which could not be repaid to the church. As a response, a change of strategy where beneficiaries were sensitized and retrained and provided with additional funding, was reported to have resulted into improved performance.
- Inadequate support provided to target beneficiaries, partly because of the overwhelming numbers and inadequate resources.

Eroded social capital where communities were disoriented by the genocide and continue to afflict community cohesion: this might undermine the current efforts to apply community based approaches, as an approach to establish safety nets for vulnerable communities. Many households, organizations, etc, supporting widows, OVCs and others affected by HIV/AIDS are overstretched because of the overwhelming numbers. In Kigeme, Byumba, and Butare, it was reported that one of the biggest challenges faced by intervening agencies is how to select the poorest and among the poorest children. Because very often local intervention agencies have little resources to reach out to all, many deserving children have been left out. Initiatives such as Home-based care (HBC), foster families, etc, may not work well if there are no volunteers and no incentives to attract more support organizations, to support the big number of expected cases.

Inadequate training activities: Most training and sensitization activities provided have been inadequate. For instance, life-skills training packages such as Stepping stones, have been applauded in fighting HIV/AIDS, particularly through promotion

of *gender equity, inter-generational respect* and *solidarity with PLWHA*, as well as observance of human rights. This, however, can only be achieved if the training is systematic, well targeted and consistent. The stepping stones training undertaken by UEBR, Barakabaho and other partners was too short to have impact. The officials talked to also admitted that the training was undertaken over a 4-day period, which was too short to create impact.

8.0 CONCLUSIONS AND RECOMMENDATIONS.

8.1 Major Conclusions and key messages

A combination of firm political consistent of the GoR, overwhelming and consistent support of development partners (essentially donors and civil society), together with resilience and determination of the Rwandan population, by and large, account for the impressive positive results in bringing down the HIV/AIDS prevalence from more than 12% in 1998, 5.1% in 2003 to just about 3% in 2005. In fact, according to the recent country review (see UNDP/ MINECOFIN 2004), HIV/AIDS, is, besides gender equality and education, one of the few areas in which Rwanda is firmly on track to reach the millennium development goals (MDGs) commitments.

The main observations that need to be considered in any planned intervention are:

1. The face of HIV/AIDS in Rwanda has changed progressively over the last one decade – stigmatisation and beliefs about HIV/AIDS are declining, and many people infected and/or affected by HIV/AIDS in Rwanda are now confident, and coming out to join associations. However, the socioeconomic and socio-cultural factors that increase vulnerability to HIV/AIDS mostly poverty, cultural values and attitudes, are still at play, and undermine efforts to fight the pandemic.

2. The *nature and distribution of HIV/AIDS in Rwanda is spatial* (manifests and affects the populations differently in rural and urban areas). Although rural areas have consistently registered much lower HIV/AIDS prevalence rates than urban areas, there is need for caution – stigmatisation of HIV/AIDS sufferers is still considerably high. Even though much of it is reported to be more of self perceptions than real, many people are reluctant to join associations for PLWHA for fear of being exposed. In general, HIV/AIDS stigmatisation in Rwanda is generally linked to the many myths and perceptions around the pandemic, which are only slowly changing.

3. *Some incentives are helping to break barriers* and could yield good results if scaled-up: the support to PLWHA in form of food, ART including home-based care and counselling, among others, has motivated many people who would otherwise have opted to suffer quietly, to come out.

4. *There is a tendency for intervening agencies (mainly local partners) to ignore remote areas.* In Kigeme, a concern was raised that most (actually nearly all) local organisations in HIV/AIDS tend to concentrate on areas along the main road, with remote areas left out. It is hoped that the CDLS will assist to iron out the imbalances through strict monitoring and vetoing of activities by implementing agencies.

5 Although HIV/AIDS manifests gender differences and affect women and men differently, *the gender dimension of the pandemic, including domestic violence and reproductive health and rights of women, have not received sufficient attention in intervention programmes.* Some CA partners, for instance, raised the issue of alcoholism that leads to battering of women by their husbands, forcing them into sex and rape of women but there were no interventions specifically addressing such issues.

6 Despite the fact that HIV/AIDS is among the most heavily funded sectors in Rwanda, especially since 2003, many HIV/AIDS service organisations face severe constraints of inadequate and unreliable funding, and many parts of Rwanda, especially those perceived to be remote, have received no interventions.

7. HIV/AIDS programming is increasingly following a multi-sectoral approach; nonetheless a lot more still needs to be done. Besides expanded VCT services, intensified behavioural change communication activities, and expanding access to antiretroviral therapy, a number of programmes are providing a comprehensive package addressing prevention and control as well as mitigation of the effects of the HIV/AIDS scourge.

8. Faith based organisations (in particular, churches) and other locally institutionalised organisations, have potential to create impact, as they have established formal and informal networks where they can reach all categories of people. EER, the Baptist church and the Catholic Church, for instance, have youth, mothers, fathers union ministries, support to needy groups, while others even have singles, professionals, and other groupings. If supported, they can reach out to and impact people even in hard-to-reach areas.

9. Institutional coordination in the HIV/AIDS prevention and control has improved significantly since 2000, with the establishment of CNLS in the Office of the President, and more recently, the decentralisation of the HIV/AIDS coordination. The umbrella organisations and networks' approach has enormous potential but needs to be strengthened, by, among others, building formal systems to enable it serve its members, and sensitising member organisations about its advantages. At the local level, there is need to work with and strengthen CDLS, as a mechanism that improve operational coordination at grassroot levels. In particular, CA partners need to be aware of and work through this system.

10. Multi-sectoral actions must be reinforced at the community level to support the reduction to exposition to diseases and changes in behaviours of the population and health services among the poor. Rwanda may not considerably reduce the prevalence of transmissible diseases, malnutrition, HIV/AIDS, fertility and sanitary

inequities without strengthening the coordination of multi-sectoral interventions at the community level, without improving behaviours in terms of health, etc. And, CA and partners can play an influential role in this regard, especially considering that many of them such as the churches are already involved in multisectoral programs in health, production, social and community development.

8.2 Recommendations

The main (generic) recommendations made include:

1. There is need for partners to review the strategy and intensify mobilisation and sensitisation and support of communities to respond to VCT.

As earlier indicated (DHS 2005, Christian Aid report, and field survey), response to HIV testing (under VCT and other initiatives) remain low, and the fact that many Rwandans have not tested to know their sero-status is worrying. It is recommended that Christian Aid and partners consider reviewing the strategy to intensify their campaigns to encourage more people, especially youth (in and out of school) and married couples to take HIV tests. Specific aspects that need to be improved include:

- *step-up information* – knowing the advantages of being aware about one’s sero-status is good, but the decision to take the test is rather difficult. Intensifying the mobilisation and campaigns to highlight the advantages of testing, can assist many people to take decisions about HIV/AIDS testing. Publicising such advantages, such as ability to protect oneself, or quickly enrol for free treatment, could help undecided people who fear the unknown to come out and take the test.
- *counselling*- to empower clients to be prepared to handle the post-test situation irrespective of the outcome of the tests, there is need to step up professional counselling. Pastors and Peer Educators need intensive training to equip them with advanced skills to effectively counsel and communicate with clients, especially those with many social complications.
- *expanding peer education and support* - targeting schools (primary and secondary school) pupils, teachers, communities and local leaders. Support should not only cover comprehensive training but also include tooling and logistical facilitation that will enable the AIDS peer workers to perform their work more effectively. Facilitation should include booklets on myths and facts and information on HIV/AIDS, prevention and control; bicycles to facilitate movement, and incentives such as T-shirts, umbrellas and recognition of services e.g. Certificates.

2. Strengthen partners' institutional and human resource capacity for HIV/AIDS programming, knowledge management and learning.

All CA partners reported that they had difficulties in monitoring and follow-up of their work. For most churches, however, HIV/AIDS is not distinct but embedded in other programmes. Partly as a result, it is given low specific attention in personnel and budgetary allocations, and there are no specific institutional systems such as monitoring and evaluation and follow-up for it. In Shyira Diocese, for instance, which covers a vast area, pastors who are assigned HIV/AIDS work have limited time to effectively undertake HIV/AIDS work, and in all Dioceses, including UEBR Butare, they reported that budgetary constraints cannot allow them to recruit sufficient personnel, yet these institutions are strategically positioned to create impact. Other organisations such as BARAKABAHO generally face similar institutional capacity problems even though their area of coverage is low. It is recommended that a comprehensive partners' capacity building program be designed for CA partners to enable them step up HIV/AIDS program design, execution, follow-up and reporting, and this will entail supporting them to:

- (i) create portfolio for HIV/AIDS or upscale the position of HIV/AIDS within their programs;
- (ii) develop technical capacity to identify and design specific well targeted programmes in more holistic ways taking into consideration the diversity of their target groups. This will enable them be able to mobilise resources from other national and international programmes such as MAP, PEPFAR, and others;
- (iii) set-up institutional systems and procedures that will enable them effectively monitor, follow-up and report on their HIV/AIDS interventions, as well share information and network with other actors;
- (iv) recruit, train and retain competent personnel in essential areas such as HIV/AIDS and psycho-social counselling and support, domestic conflict resolution, monitoring and evaluation, communication, financial management and accountability, among others. It should be emphasised that the new M&E and reporting formats developed by CNLS will require that partners have formal M&E systems as well as basic competences in M&E.

3. There is need to rethink the HIV/AIDS prevention and control strategy for rural areas to prepare and respond appropriately to the HIV/AIDS pandemic. In this regard, emphasis should be put on:

- i. empowering partners with adequate resources to ensuring that all areas are reached with the messages, care and support. Although statistics show that rural areas have lower prevalence rates, they are least prepared to respond to the pandemic should the rates increase. To encourage intervening agencies to reach areas perceived to be remote or hard-to-reach, Christian Aid (or

other financing agencies) should provide in-built incentives to target the disadvantaged areas;

- ii. secondly, there is need to revisit the strategy from a more provisioning approach (where partners offer hand-outs of food to PLWHA, school fees for orphans and material support) to a more rights-based strategy to influence local Government policies (to ensure that disadvantaged children are catered for in the budgets and that food relief for AIDS patients is included in the humanitarian support of agencies like WFP/MINALOC, to ensure that PLWHA are given special incentives in micro-finance and other services, and to influence change in the communities towards improved care, support and respect for PLWHA.
- iii. Play an active role in enhancing accountability and rigorous monitoring of service providers – so as to ensure better targeting of resources to areas where need is most felt, and encourage local NGOs and other intervening agencies to reach all grassroots levels¹¹. In this way, most of CA partners such as Churches and other FBOs need to be strengthened and equipped to amplify the voice of the people affected by and infected with HIV/AIDS. It is this approach that will promote openness and direct confrontation of stigma.

4. Review the strategy for youth participation to enhance targeting of youth issues and their participation in HIV/AIDS prevention and control.

The main message here is that youth must not be thought for but be at the forefront of HIV/AIDS prevention and control. Various studies have shown that youth participation in reproductive health and HIV/AIDS programs helps young people to develop confidence, change attitudes, and establish more meaningful relationships with adults and to make positive decisions about their lives (UN Inter-Agency Group on Young People's Development and Protection). Youth in Rwanda need information, opportunities to develop skills to avoid risks, and to negotiate safe sex, access to condoms and youth-friendly services. Most specifically for the CA partners, the current strategies should entail a clear structuring of youth into interest and issues categories. They can be reached through:

(a) *In-school youth* – collaborating with schools to mobilise them into drama groups, training core leaders and teachers, and influencing the schools to provide them with facilities and other forms of support to learn and impact anti-aids messages to follow youth. During holidays, regular youth camps can be organised (especially for secondary and tertiary institutions) and work with youth leaders to speak and take lead in such camps.

¹¹ In Kigeme and Byumba, local authorities & other stakeholders met lamented about NGOs which come from Kigali and photograph “beneficiaries” and go back with little tangible results. The few who are doing commendable work were reportedly concentrating around the main roads, ignoring areas considered or perceived to be remote. In this respect, empowering local stakeholders to hold such intervening agencies accountable might increase effectiveness and efficiency of such programs.

(b) *Out-of-school youth* – need to be supported in counselling (e.g. about early marriages); income generating projects (targeting youth in poor households or those with family responsibilities such as orphans), skills development and life skills for girl-youth.

5. Expand partnerships and strengthen collaboration with other actors to improve service delivery particularly for people infected with or affected by HIV/AIDS. Such partnerships could include:

- *partnership with public and private health care providers* – e.g. Centre Dushishoze in Shyira Diocese which has no health care facilities need to collaborate with the Hospital or Health Centres to enable its clients receive VCT, ART and other services, and are effectively followed up;
- *partnership with relief aid providers* (e.g. World Vision, World Food Program, International care and relief and MINALOC) can improve better targeting or reaching PLWHA with food and other basic items, which would otherwise not be covered in the partner’s already constrained programs;
- *partnership or collaborative arrangements with schools, social centres and local leaders*, can facilitate dissemination of HIV/AIDS messages or access to target groups in such areas. Especially in schools, collaborating with school authorities can assist to develop more convenient programs for target school populations (pupils, teachers and other workers), while local authorities can arrange to get messages delivered or time arranged for HIV/AIDS campaigns during community activities as appropriate such as Umuganda, Gacaca sessions, etc.
- *Partnership and support to community based groups and care givers* – e.g. TBAs, leadership of formal and informal associations and opinion leaders. Training TBAs in safe delivery of mothers and provision of basic kits can help increase knowledge of prevention and reduce HIV transmission through birth.

6. There is need for rights-based advocacy to expand coverage and improve efficiency of VCT and other health care services, with a focus on enhancing access by PLWHA:

Access to health is a fundamental human right of every Rwandan enshrined in the National Constitution 2003, but enjoyment of such rights is hampered by physical barriers and financial affordability. PLWHA, particularly poor ones, suffer double jeopardy. In Kigeme and Shyira Dioceses, for instance, only one centre (Kigeme and Ruhengeri Hospitals respectively), were reported to offer CD4 tests (Kigeme hospital in Kigeme Diocese, Ruhengeri Hospital in Shyira Diocese), which are too far away from where PLWHA live, yet such tests are a requirement for one to access ART. Even though ART services are free, the costs involved in accessing

ART are more than transport but includes food and upkeep especially if one is hospitalized (e.g. when one is given drugs). Moreover, PLWHA have to pay for treatment of opportunistic infections, which are usually very costly. To enable poor people access the free VCT and antiretroviral therapy (ART/ARV) services provided, mechanisms are needed to expand their access to basic health care. While some projects have paid mutual health insurance costs for PLWHA and provided additional support, it is mainly in form of hand-outs which may not be sustainable. There is need for strong advocacy to remove such barriers, and, for the CA partners, it could entail:

- engaging Government and other service providers be responsible for costs of mutual health insurance for very poor people and those infected with and affected by HIV/AIDS;
- stepping up advocacy to improve expand health facilities in under-served areas like Kigeme, Byumba, Ruhengeri and others, to bring services closer to where PLHWA live;
- advocating for expansion of mobile VCT services and mobile medical services (that can enable PLWHAs to reach all geographically remote areas where health centres hardly reach;
- advocating for special care for PLWHA in health care
- mobilising resources to support Government efforts especially since some like the church are already involved in health care delivery.
- Advocate for specific facilities and care for HIV/AIDS patients in public and private health care centres, to eliminate stigmatization and improve care for HIV/AIDS patients. Churches and FBOs like Shyira which are influential can engage and support GoR to create or designate specific areas for HIV/AIDS patients and train health care staff to be sensitive to and compassionate about the needs of HIV/AIDS patients.

It should be recalled that intervention agencies have put in a lot of effort in sensitizing people to respond to VCT, and that efficient and effective VCT services will help to retain present clients, who will also assist to recruit new clients. But it could result in a backlash if the crowds that flock health centres are not addressed, and continue to be frustrated by long delays. How can someone who is not sick keep walking long distances to health centres for HIV tests?

7. Integrate women's rights issues into the HIV/AIDS interventions

Domestic violence, abuse of child and women's rights such as rape, wife-battering, child abuse, etc, have generally not been sufficiently addressed. Yet cases of women being forced to have sex in marriage, children being forced to streets due to domestic violence and ending up vulnerable to HIV/AIDS, are mentioned even by partners. There is need to empower partners to:

- clearly analyse the links between HIV/AIDS and domestic violence in homes, and explore underlying causes like poverty, alcoholism, and psycho-social problems; and
- develop programmes to identify and sensitise the culprits (who are usually men) and victims (usually women) and support them through life skills; and
- advocate for and work with local authorities and community leaders to monitor and enforce observance of women and child rights.
- empower women to break the silence which usually make their situation worse.

8. Strengthen care and support, particularly for PLWHA and OVCs, and home-based care for AIDS patients

In a situation where family and socio-cultural bonds have been disoriented, the church and community based organisations remain the most viable and sometimes the only available institutions to foster social networks and support. While CA partners are involved in providing psycho-social support, visiting and counselling PLWHA and families affected by HIV/AIDS, it's still limited. Part of the problem is the fact that most partners have too few personnel for the vast areas covered. Secondly, the interventions do not cover all aspects of social care – for instance support to OVCs in all areas visited does not cover all affected children, in some areas only covering infected children. None of the partners is involved in providing home-based social and medical care for AIDS patients, yet health centres are too far from them. In this regard, there is need for CA partners to:

- develop programmes to support OVCs, to ensure that all affected children (infected and affected, in family or out of family) receive the care and material support they need. The churches can, for instance mobilise funds locally and from donors, to take children to school;
- be supported to mobilise and train community members (can identify volunteers) to help support PLWHA especially AIDS patients. Home based care givers can be easily mobilised by the church from among their congregations, given the respect and follow-up they have. But they need to be supported to train volunteer care givers in medical, psycho-social support. They also need resources to provide materials and incentives to facilitate volunteer home-based care givers.
- Support mobilisation of communities to become responsive and care for people affected by HIV/AIDS. Families can be requested and counselled to take responsibilities of foster-care for children or elderly who are left by dead relatives, and to guide and support children in house-hold headed families.

9. There is need to review the behavioural change Communication (BCC) messages and strategies used to match with reality. The present emphasis on

“abstinence” and/or be “faithful” (i.e. the AB) for which most funding exists (39% of HIV/AIDS funding is currently from PEPFAR that strictly focuses on AB), should be complemented by other preventive measures that promote prevention (or protection) of sexually active people e.g. through condom use; stepping stones and other life skills training.

10. There is need for support interventions to be multi-objective and holistic: In areas where there are few intervening agencies to complement CA partners’ efforts, there is need to review the strategy to cover all essential aspects. This implies a program package that includes social mitigation, prevention, treatment and care e.g. where patients are assisted to access not only ARVs but also food to enable them have good nutrition and a well balanced diet; they are sensitised not to engage in risky behaviours but are also assisted to start income generating activities or gain skills to enable them engage in productive activities. It should be emphasized that good nutrition with a well balanced and adequate diet (either obtained through food assistance or growing own food) can play an important role in decreasing risk behaviours that can expose an individual to HIV/AIDS, providing care and support to those it affects, and mitigating its impact on these communities (USAID 2005).

11. There is need to work with and train local leaders in HIV/AIDS issues. CA partners need to involve and train local leaders and community based health care workers – cell and sector coordinators, law enforcement officers, health animators (Abajyanama b’ubuzima, and community development committee (CDC) members, so that they can help mobilise the communities and become change agents.

12. There is opportunity for the local coordinating mechanisms to work, In particular, CA partners need to be supported to participate more actively in the CDLS in which they are represented, to influence the district local governments and other local actors to prioritise HIV/AIDS in their plans and budgets.

List of References

Bolinger L and J. Stover. 1999. Economic Impact of HIV/AIDS in Rwanda. The Futures Group International.

CNLS/ GoR April 2006. Annual Report of Activities in Fighting HIV/AIDS in Rwanda for the year 2005.

http://www.ekklesia.co.uk/content/news_syndication. March 2004. Christian Aid urges rethink on Rwanda

CNLS/UNAIDS. 2006. Rwanda: Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS).

CNLS 2006a. Some Good Practices in HIV/AIDS Prevention and Control. Kigali. www.cnls.gov.rw

CRA/MINALOC/World Bank 2005. Decentralisation and Service Delivery in Rwanda: Assessment of the Impact, Prospects and Challenges. August 2005. .

FONDATION Barakabaho, March 2006. Rapport Annuel 2005.

Kinghorn,A., B.N. Kgosidintsi, G. Schierhout, F. Gatete, G. Bwandinga and J. Rugeiyamu. 2003. Assessment of the Impact of HIV/AIDS on the Education Sector in Rwanda. Ministry of Education, Science, Technology and Scientific Research. Education Sector Support Programme. CfBT/Stoas.

Kornfield. R., S. Babalola, D. Awasum and B. Quenum-Renaud. February 2006. Living with AIDS in Rwanda: A Study in Three Provinces. John Hopkins University Centre for Communication Programs.

Lenoir, G. 2004. Rwandan Women Survive Genocide, Rape and HIV. Africa Priority network. www.peaceworkmagazine.org/pwork

MINECOFIN 2006. Rwanda Poverty Reduction Strategy Evaluation Report (2002-2005).

MINECOFIN, 2004a. Poverty Reduction Strategy. Annual Progress Report June 2003-June 2004.

MINITERE, 2003. National Environment Protection and Management Policy for Rwanda.

MoH 2004. Government of Rwanda. Health Sector Policy. September 2004.

MoH 2005. Rwanda National Health Accounts 2002. March 2005.

MoH 2006. National Behavioural Change Communication Policy for the Health Sector. Kigali, December 2006.

Nduwimana, F. 2004. The Right Survive: Sexual Violence, Women and HIV/AIDS. Rights and Democracy. <http://www.dd-rd.ca/english/commdoc/publications/women/hivAIDSviolEn1.htm>

NPA (Norwegian People's Aid), 2006. Evaluation Mission for Norwegian People's Aid (NPA) Programme in Rwanda in 2005. Support to Local Partners. Final Report, May 2006.

PHR*plus*, 2004. Partners for Health Reform*plus*. Fact Sheet on HIV/AIDS in Rwanda. April 2004.

Ricardo Bitran, et al. 2003. The Impact of HIV/AIDS on Rwanda's Health sector.

Rwanda Business Coalition (APELAS) Profile. May 2006. <http://www.weforum.org/pdf/GHI/Rwanda.pdf>

TRAC Reports 2004, 2005 & 2006. www.tracrwanda.org

UNAIDS AIDS Epidemic Update, December 2005.

UNAIDS 2006. Global AIDS Epidemic Update, December 2005. [www.unaids.org/pub/GlobalReport 2006](http://www.unaids.org/pub/GlobalReport/2006).

USAID/PHR. 2000. Financing HIV/AIDS: Results from Rwanda's National Health Accounts. November 2000.

Annexes

Annex 1. Matrix of Coordination framework (Umbrella organizations)

Coordination framework/Organization	Areas of intervention / scope of operation	Structure & Membership	Remarks/ observations
1. CNLS & CDLS	Overall statutory body responsible for coordination of HIV/AIDS prevention and control activities in the country. Works through Umbrella organization. Also coordinates the umbrella for public sector activities.	Is decentralized to district level (CDLS/DACC). CDLS. The CDLS is a six-member committee comprising of representatives from the district local authorities (Exec Secretary & Directors for Education, Planning, and Health & Social Affairs), Representative of PLWHA, religious organizations and a technical person from CNLS.	Coordination through umbrellas is appropriate but most umbrellas are new, requiring a lot of capacity building support.
2. Network of Persons Living with HIV/AIDS (RRP+)	Coordinates all activities relating to PLWHA nationally, and is a link between CNLS and PLWHAs. Have provincial coordination offices in all provinces.	Established in 2003, RRP+ is an apex network bringing together more than 800 local & grassroots based associations of PLWHA.	Vibrant network with strong advocacy and capacity building support for PLWHA. However, still yet to provide adequate support and to reach all areas.
3. Forum of NGOs involved in HIV/AIDS	Operates country-wide, and is a coordination body for NGOs operating in HIV/AIDS. Receives quarterly reports from member organizations, merges then and submits to CNLS. Coordinates & approved work plans of members, but does very little M&E work	Statutory, all NGOs involved in HIV/AIDS in Rwanda are members. However, currently it has 106 local & international NGOs. Organizationally, it has a committee of six including President & Vice President; and 4 secretaries i.e. - Secretary for Planning & Coordination; Follow-up & Evaluation; Financial Management; Communication & Capacity Building.	Small Secretariat, and due to financial constraints, is unable to do regular M&E and follow-up of members' activities. - Mainly relies on CNLS funding, as member subscriptions are rarely forthcoming or adequate.
Réseau des confessions religieuses Engage dans le Lutte Contre le Sida (RCLS Rwanda).	Established in 2003 and operationalised in 2004, to develop a united and harmonious approach to fight against HIV/Aids among religious groups. RCLS' roles are to: -coordinate all religious denominations in the fight against HIV/Aids. -It acts as a watch dog for the observance of CNLS' programmes. -It gives proper advice on what can be done and approve of	Comprised of Representatives of 5 denominations i.e.: Le C.E.P.R-conference Episcopal des eveques au Rwanda (Catholic Church); A.E.R-Alliance evangelique au Rwanda (30 Evangelization groups in Rwanda); Le P.E.E.R- Province de l'Eglise Episcopale au Rwanda (Anglican Church); Le C.P.R-Conseil protestant au	Submits reports to CNLS every semester on their activities, and copy to different stakeholders & partners. RCLS is a real umbrella because it is not involved in implementation of any field activity, but rather coordinates.

	each activity each beneficiary is going to carry out. - They give recommendations to member organizations so that they can be funded by interested international NGOs or any interested stake holder.	Rwanda (composed of l'ADPR,l'EPR, l'U.E.B.E.R, AEER,etc.) ; L'A.M.U.R- Muslims' Association.	
4. Rwanda Business Coalition Against HIV/AIDS/ <i>Association du Prive et Para-etatique dans la Lutte Contre le VIH / SIDA</i> (APELAS)	Coordinates activities in the private sector & parastatals. Provides technical assistance to members to elaborate HIV/AIDS action plans, as a way of mainstreaming HIV/AIDS into business sector, as well as training VCT & advocacy services.	Membership includes some 22 parastatals, 14 employee federations & other private companies, mostly large & medium enterprises. Has 6 fulltime employees including a Coordinator, 2 Counselors and an Accountant.	Has mainstreamed HIV/AIDS in the workplace through mobilization and advocacy. However, its purely funded by MAP and no own resources, raising concerns for sustainability. Also constrained by in adequate staff and no clear framework binding members.
National Youth Council (NYC)	Coordinates activities of youth structures.	Has a network running down to village levels. A parallel structure linked to Local Government council by a position of Coordinator being automatic member of the Local Government council at sector & district level.	NYC is under-funded and has limited institutional capacity to mobilize and support youth. There is limited activity at sub-national level and almost dormant levels below the district. Yet its national network that reaches grassroots make it potentially strong channel through which to reach the youth with BCC messages.
National Women's Council (NWC)	Coordinates activities related to gender and HIV/AIDS under the NWC.	Structure & functioning very much like youth.	
Forum for Journalists interested in HIV/AIDS (ABASIRWA)			Recently established and yet to become active.
Association of Persons with Disabilities			Just recently formed (less than one month by the time of the study)

Annex 2: Matrix Summary of HIV/AIDS interventions by Thematic Area and Actors

	Thematic Area	Specific activities/ interventions	Main actors
1	Prevention, care, and treatment	<p>CHAMP has five main activities and currently operates in 20 districts:</p> <ul style="list-style-type: none"> • Behavioural change communications including behavioural change programmes on abstinence and use of condoms as a means of prevention. These programmes are done through theatre, through media as radio soaps. • Home-based care programmes. Strengthening the capacity of households and members of communities. Provision of socio-psycho-counselling and socio-economic support (22,600 beneficiaries). Training is provided to local counsellors and community-based volunteers supporting HIV/AIDS activities. About 4,200 have been trained in all the 20 districts. • Helping OVC especially those that are household heads. Provision of vocational training, payment of school fees, and provision of scholastic materials (18,900 beneficiaries). • Capacity building including training, supportive teaching, strategic planning, management, and leadership. • Monitoring and evaluation 	<p>USAID/PEPFAR's plans are implemented by Cooperative Housing Foundation International (CHFI) under the Community HIV/AIDS Mobilisation Programme (CHAMP)</p> <p>CHFI is the leading organisation working with 14 partners including: CRS, John Hopkins University, Social Impact, CARE, and World Relief. National partners include: Caritas – Rwanda, Rwanda Network of people living with HIV/AIDS, SWAA – Rwanda, Profemme/Twese Hamwe, Rwanda Women's Network, PAMASOR, Urunana Trait d'union, Icyuzuzo, and WE-ACTx-Rwanda.</p>
		<ul style="list-style-type: none"> • Priority is given to medical care with nutrition support to people taking ARVs 	MSF Belgium
		<ul style="list-style-type: none"> • Intervene through technical and material support to medical centres for VCT, PCR, PMTCT, and ARV services 	Columbia University
		<ul style="list-style-type: none"> • Medical care • Negotiating low prices for ARVs • Purchase of ARVs • Children under 5 years are among their priorities. 	Clinton Foundation
		<ul style="list-style-type: none"> • Support through medical, education, psycho-socio, and IGAs 	Action Aid
		<ul style="list-style-type: none"> • Sensitisation against HIV/AIDS • Educational support • Child mentoring • IGAs • Home care support 	CARE
		<ul style="list-style-type: none"> • Provision of nutrition support to PLWHA • Educational support to chronically ill children 	ADRA
		<ul style="list-style-type: none"> • Technical and financial assistance (training and incentives) for PMTCT programs • Medical care • Nutritional support to infected/affected children and their mothers 	Luxemburg Development
		<ul style="list-style-type: none"> • Intervention for children in PMTCT programs 	EGPAF
		<ul style="list-style-type: none"> • Umbrella organisation of PLWHA • Coordinates and monitors associations of PLWHA • Provides home-based care in 	RRP+ with support from the Global Fund, MAP, and FHI

		<ul style="list-style-type: none"> • collaboration with volunteers • Enrols patients into the mutuelle de sante • IGA is provided to associations in all the provinces. (There were 755 such associations by June 2005) • Schooling, nutrition and micro finance is provided to PLWHA in Kigali City, Kigali-Ngali, Kibungo, and Ruhengere provinces 	
2	Coordination, monitoring, and evaluation	HIV/AIDS policy and strategy to address treatment, care, and support of PLWHA, OVC, widows, and families.	CNLS, TRAC
		Umbrella of CNLS that coordinates all activities of faith-based organisations against HIV/AIDS. It includes AMUR, AER, PEER, CEPR, and CPR Interventions by FBOs are cross cutting.	RCLS
		<p>National Women Council coordinates interventions by women associations.</p> <ul style="list-style-type: none"> • Advocacy for empowerment and economic support • Identification of vulnerable groups (i.e. women, children, and OVC) • Vaccination, reproductive health, and enrolment into mutuelle de sante • IGA support • Microfinance in all districts • Sensitisation on VCT, PMTCT, and nutrition • Educational support and • Professional training. 	CNF
		<p>The National Youth Council</p> <ul style="list-style-type: none"> • Sensitisation of the youth against HIV/AIDS through training of peer educators • Housing support to HIV/AIDS affected families and • Economic support (micro projects) through youth associations 	CNJR
		Coordinates interventions by NGOs into the fight against HIV/AIDS.	NGO's Forum

Annex 3: Matrix of intervention by Civil Society Organisations

Intervening Agency	Area of intervention & main activities	Target beneficiaries	Geographical coverage	Partners & funding sources	Major achievements	Major Constraints & Challenges
FHI	Health Care provision (VCT, PMTCT, Preventive Therapy and ARVs)	General population, regnant women & their partners, and PLWHA	Districts of Bugesera, Gakenke, Kamonyi, Nyanza Kicukiro, Muhanga, Ngoma, Nyamagabe, Nyamasheke, , Nyarugenge, Nyaruguru & Ruhango.	USAID		Funding buy USAID ends on 30 th Sept. 2007 Fear to go for VCT Stigma Nutritional care ended on 31 Dec 2006
	Prevention & advocacy (BCC - Behavioural Communication Change)	Youth (15 – 24 years)	Bugesera, Burera, Gakenke Gasabo,Gatsibo, Gicumbi Kamonyi, Karongi, Kayonza Kicukiro, Kirehe, Muhanga Nyagatare, Nyamasheke, Nyanza, Ruhango, Rulindo' Rutsiro, Rwamagana	Catholic Diocese/Zone pastorale of Byumba, Kibuye, Kabgayi & Nyundo; and Kigali Catholic Archdiocese		Sex is perceived to be taboo. There is fear to talk about sex and to voluntarily go for HIV tests Youth are curious about sex and want to experiment. Pornographic material displayed on websites that are regularly browsed by the youth.
CARITAS Byumba	Prevention (PEER Education for the youth organized in ant-AIDS clubs where they practice songs, drama and plays aimed at reducing the spread of HIV).	Sensitized in three groups; 15 – 25 years, youths in High School and Catechists	Former Byumba province	CARITAS International; Diocese of Byumba	Increased knowledge about Aids prevention, causes and venereal diseases (STDs), reproductive health, etc Acceptance to go for VCT. Anti-Aids clubs have been set up Organized local farmers into associations to fight poverty and assist their members. Created a spirit of volunteerism among the youth	Cultural prejudices - girls playing football are looked at as harlots, as impossible people etc and thus taken as failures Teaching people to use condoms is partly looked as luring people into playing sex. The PEER educators are voluntary workers and thus are not reliable due to lack of motivation. Some get married in distant places while other move to other places for better paying jobs. Some of these PEER educators are heads of families and need money to run their families. They even need more training and diversification in their activities. FHI which sponsored football activities has stopped the supply of balls thus halting the initiative.

RCLS – Rwanda	<p>Coordinates all religious denominations in the fight against HIV/AIDS</p> <p>Acts as a watchdog for CNLS activities</p> <p>Recommends member organisations foe</p>	Faith-based organisations among the different denominations.	<p>Countrywide.</p> <p>However, they have so far covered 15 districts in the western and northern provinces.</p>	UNICEF, UNDP, USAID, CNLS, UNFPA...	<ul style="list-style-type: none"> • Attitude change among religious leaders, resulting into a common understanding about HIV/AIDS; • Secured funding for training some of the member denominations e.g. Moslems were trained for 2 weeks • Increased turn up for VCT; • Organised PLWHAs into associations funded by churches and other NGOs. ANERELA was set up in 2005. 	<p>Funding is a problem since they are not engaged tangible field activity.</p> <p>Monitoring and evaluation of field activities by member organisations is difficult to limited finance and staff. They have only 4 members of staff.</p>
NGO Forum for HIV/AIDS	<p>Brings together all NGOs working in the fight against HIV/AIDS throughout the country</p> <p>Reviews action plans of all member organisations before approval</p> <p>Coordinates activities of all NGOS in HIV/AIDS (they help in planning, supervision...)</p>	All NGOs intervening in HIV/AIDS in the country.	Countrywide	ONUSIDA, UNFPA, RRP+, APELAS, EANASSO, KANKO, MAP	<p>Streamlined interventions by the different NGOs</p> <p>Has carried out advocacy on behalf of NGOs to prospective funders.</p> <p>Has helped members develop consistent long term plans.</p>	<ul style="list-style-type: none"> • Funding still remains a problem since donors prefer to fund activities that have a direct impact on the people • Resistance from some member organisations. Others do not even approve of the existence of the forum. • Since membership is obligatory, this leads to conflicts between the forum and some of its members. • Small budget limits follow up and evaluation of member organisations • Forum has only 3 staff members who are too few compared to the vast area covered. • Difficult in harmonising reports from member organisations. Sometimes member organisations undertake activities without seeking prior approval from the forum.
CDLS - Ruhengeri	CDLS is the representative of CNLS at district level. They are involved in coordination and monitoring	NGOs intervening in HIV/AIDS	Ruhengeri district	RRP+, NYC, and NWC	Started in July 2006 and has not achieved much to write about yet.	<p>- There is duplication of activities, as NGOs plan their activities independently without coordination – no due regard about who else is involved in similar activities. Some NGOs reportedly falsify information in reports to their donors about activities that were never carried out and areas never covered.</p> <p>- There is need to ensure that donors work directly with local authorities in order to know the activities to be undertaken and their level of funding;</p> <p>- Tendency by some NGOs to determine where and how to intervene without consulting local communities need to be controlled, and community needs assessment be a basis for intervention.</p>
Community Programme Coordination Unit (CPCU)	<p>Organising coordination meetings between the WFP and partner institutions</p> <p>Ensure that WFP activities are in line with</p>	PLWHA... , pregnant women, OVCs	Countrywide. Works with different Ministries including MoH	MINISANTE, MSF – Belgium, PACFA, Intra Health, EGPAF and other UN Agencies	<p>- Increased support for prevention and treatment of HIV/AIDS available to PLWHA, refugees...</p> <p>- HIV/AIDS sensitisation to those participating in food for work activities through anti-AIDS campaigns and in schools that</p>	<p>Sometimes food for distribution is insufficient</p> <p>GoR has to look for other donors to supplement food supplied by WFP</p>

	<p>priorities and orientations of the GoR</p> <p>WFP works with PLWHA to improve their livelihood through support and training, IGAs, support to pregnant women and their children, provision of food supplements and ART</p>				<p>participate in the school feeding programme.</p> <p>- WFP Rwanda got a grant of US \$ 20,000 to make HIV/AIDS part of the comprehensive food security and vulnerability assessment. This is expected to provide the much needed baseline to measure the impact of HIV/AIDS activities;</p> <p>- WFP has covered 250 nutrition centres across the country since 1995;</p> <p>- As of end of 2006, some 104 institutions were receiving food assistance on regular basis, with about 18,000 beneficiaries every month.</p>	
--	---	--	--	--	---	--

CHRISTIAN AID PARTNERS WORKING IN HIV/AIDS

EER Shyira	<p>Health care services (VCT services, Reproductive health services, training, treatment of STDs, post trauma counselling, and PMTCT)</p> <p>Other services (adult education, mobile cinema, and Food aid)</p>	<p>Youth (15 – 24 years), teenagers, parents to pass on the knowledge to their children, traumatized people, and pregnant women</p> <p>Adults, PLWHA, and visits to parishes and markets and sensitize about HIV/AIDS</p>	Former provinces of Ruhengeri, Gisenyi and Kibuye	PSI, World Relief	<p>- Have offered VCT services to 4,500 people (Jan. – Oct 2006); excluding those handled by Shyira hospital.</p> <p>- Sensitized over 7,500 people through mobile cinema over Aug. 2005 – Oct 2006.</p> <p>- Over 13,200 youth who came to the center were sensitized on HIV/Aids while 70 youth were taught counselling techniques.</p> <p>- Over 153 youth peer educators benefited from the training in 2006.</p> <p>- Have trained 90 youth married couples.</p> <p>- Establishment of a youth center for reproductive health</p> <p>- Helped establish 50 PLWHA associations in all the parishes of Ruhengeri, Gisenyi and Kibuye</p> <p>- Trained 75 youths in studio skills, hotel catering, ICT, mechanics, driving and hair dressing and cutting.</p>	<ul style="list-style-type: none"> • Supervision of all the three former provinces which make up the Diocese of Shyira seemingly hard as the diocese has other programs to handle as well. • The peer educators need some kind of motivation. They are not even visited to see what they are doing. • The pastors were trained in offering moral support to the PLWHA in their different associations, but these PLWHAs need more than just moral support. • They need food to eat and start income generating activities. • The youth and PLWHA have many project proposals but are lacking finances to implement the projects. • VCT services are not yet accessible by all • Many of the associations of PLWHA are either dormant or less active.
UEBR	Health care provision (Sensitizing people on	PLWHA	Operates in 7 churches of Butare, Nyananga (Butare), Hakwa	Compassion International , Care	<p>- Improved standards of PLWHA, started business, improved feeding & paid school fees for their</p>	<ul style="list-style-type: none"> • Limited financial resources • Lack of personnel and skills to prepare project documents. There is no coherent programme

	HIV/AIDS, support and counselling, VCT and ARVs		(Butare), Mukoma (Gitarama), Ruhuha (Kigali), UEBR-Kigali & Ruhengeri.	International, and FHI	children. - PLWHAs can now get money for transport from their micro projects and go for treatment. - Stigmatization has reduced. - PLWHAs do access ARVs. - Benefits 502 people. 79% women	monitoring • Discriminates against people who do not belong to their church • There is a feeling of despair among some PLWHA that they are already sick and about to die anyway. Changing their attitude may not be easy. • Discriminates against people who do not belong to the UEBR church.
EER Kigeme	HIV/AIDS prevention through sensitization programs with emphasis on the promotion of abstinence and faithfulness, VCT services Support to PLWHAs PMTCT services School fees for the helpless children and children of the PLWHA who go to school. Counselling services They act as ambassadors to the PLWHA associations Seed money/capital to start IGAs ARVs	Married couples, PLWHA, and Pregnant mothers Information, Education and communication targets the entire population in the area (489,729 people)	Gikongoro district	Mother's Union USAID, Johantter Fund, Other partners in this area include FHI, Caritas, World Vision, Compassion International, Africare, World Relief, Red Cross International	- Between 2003 – 2005, some 1,500 people undertook VCT and 252 women for PMTCT; - Set up 27 associations of PLWHA containing 832 people (as of 30 th Oct. 2006). - Helped in the fight against poverty among the vulnerable people which in turn reduces the risk of HIV/AIDS - PLWHA associations were given Goats, cows and sheep. - In total 381goats and sheep (worth 4,572,000) have already been distributed while soft loans have been provided to women associations. - They have three teachers who move all over the country teaching children in primary schools about HIV Aids. - Started with 42 EER Primary schools and then later covered other 45 other primary schools belonging to other denominations and government in the country. - So far 16 primary schools have been sensitized on HIV prevention in 2006 (with 1,772,248frw) including; Kizi, Kibeho, Rususa, Rwamiko, Rubona, Gorwe, Mirabyo, Giseke, Gisizi, Nyamyumba, Muganza, Nyarumba, Kamana, Gahurizo, Gitwe and Ruramba primary schools. - Distribution of ARVs by Kigeme hospital since 30 th October 2006. Drugs are distributed to 668 people in the Ex-Gikongoro province. - Four associations of PLWHA are	- For the PLWHA there is only one hospital-Kigeme. Patients move for than 50 km to the hospital for routine check ups and treatment. - Long waiting periods for taking blood samples, tests and treatment - The hospital does not have facilities for such patients and even then patients are sometimes too poor to afford food for themselves. - A number of vulnerable HIV+ women engage in survival sex (mainly with rich men) as a survival strategy, leading to further spread of the disease. - Food aid to the poor and helpless people is limited to a few people especially those by the road side who are easily accessible by donor agencies leaving those deep in the villages to starve. - Out of the 27 associations of PLWHA, only one association has benefited from the food aid given by Bethany organizations that distributes food to the poor people in the area.. - Access to medical treatment still remains a challenge to the local people. Even though some of the helpless people have had their Mituelle paid for them, they still find it very hard to afford the 10% charged on the drugs the hospital does on have. This means that some patients end up dying due to lack of the 10% of the cost of the drug outside the hospital. - Finding scholastic materials for the un infected children of the PLWHA is still a problem as most donors tend to emphasize on helping those children who are infected leaving out those who are not and yet their parents are sometimes too poor to help themselves and their children - Most NGOs only intervene along the roadsides, neglecting distant areas.

					involved in credit and cooperative scheme. One association manages a grain mill; - Supports 20 AIDS orphaned child headed households.	
BARAKABAHO	<p>Advocacy, income generating activities, support for VCT and education</p> <p>They focus on awareness through stepping stones.</p> <p>They do not intervene directly but rather work with organised local associations</p>	Orphans, widows and the very poor in communities	Eastern Province in the districts of Kayonza and Ramagana, Karongi, Ruhango, Nyanza, and MVK	<p>UNICEF, CNLS/MAP, CHAMP, ORAF, CNEC, ANGLICORD, RDT</p> <p>Other partners: Care International, Caritas, Africare, Rwanda Women Network, CDC and RP+</p>	<p>Stepping stones training provided to foster families and child headed households.</p> <p>407 people so far given stepping stones training.</p> <p>Support and training has given for income generating activities including giving out goats, pigs, cows...</p> <p>Paying school fees, transport and provision of scholastic materials. 40 scholarships have been given to OVCs</p> <p>Vocational training has been provided to 100 youth, while health insurance has been given to 200 people</p> <p>Construction and renovation of people's homes.</p> <p>Provided piped water to communities</p> <p>Helped in establishment of youth clubs for basket ball and volley ball and through these clubs, a message on HIV/AIDS is passed.</p>	<p>They mainly work with the vulnerable and the very poorest whose multiple needs are difficult to satisfy.</p> <p>Limited financial resources.</p> <p>The associations they work with lack personnel and skill for project management</p> <p>They lack VCT services. After sensitisation, people can not easily access VCT services. They have to walk very long distances</p> <p>Institution support is unreliable. They do not have permanent funding for their staff which makes project follow up and evaluation difficult.</p> <p>They do not have long term programmes due to the short term nature of financial support they get.</p>
EER Byumba	<p>Sensitization programs through parish leaders</p> <p>Mobile VCT services</p> <p>Training in IGAs</p>	Parish priests, youth leaders, women associations and PLWHA	Former Byumba Province (i.e. districts of Gicumbi, Rulindo, Gakenke, Rushaki, Burera, Gatsibo, and Nyagatare. However, only a few areas are covered in Rulindo, Gakenke, Burera, and Gatsabo. Only Gicumbi	<p>Trinity church U.S.A (contract expired in April 2006)</p> <p>Nowegian Church Aid</p> <p>PECR, PEER, MAP</p>	<p>People have knowledge about HIV/AIDS</p> <p>Stigmatization of PLWHA is decreasing</p> <p>Number of people going for VCT has increased</p> <p>Have organised PLWHA into</p>	<p>Mobile VCT services provided by TRAC are overwhelmed by big turn up. Some people go back without testing</p> <p>Other VCT service providers charge Frw 100 making people reluctant to access VCT services</p> <p>Limited financial resources. Most people have been sensitized but need has now arisen to offer more services.</p>

			is covered entirely		<p>associations</p> <p>Couples are obliged to go for HIV tests before being married</p> <p>Scholarships have been given to 203 orphans</p> <p>Socio-psychological care is given to 23 associations of 1,143 PLWHA</p>	<p>Widespread poverty and shortage of food especially among the PLWHA</p> <p>Behaviour change about HIV/AIDS especially among expectant mothers who are reluctant to go for PMTCT services.</p> <p>Due to high default rates, the diocese stopped giving soft loans. Most income generating activities got grounded.</p>
EER Kigali	VCT- Mobilisation and HIV/AIDS awareness through outreach, information, education and communication		Bugesera district	Geneva Global, World Relief	<p>5,000 people were targeted. 3,594 people have already benefited from the VCT services</p> <p>80% of the population are aware about HIV/AIDS</p> <p>Some PLWHA were assisted to access ART</p> <p>3,814 people went for VCT</p>	<p>Accessibility of VCT services still remains a problem</p> <p>Effective nutrition care for PLWHA</p> <p>Poverty reduction in relation to HIV/AIDS treatment, care, and support</p>
CLADHO	Stepping stones. Organized a workshop				<p>20 male and 20 female attended the workshop</p>	<p>Behaviour change</p> <p>Limited financial resources</p>

Appendix 1: List of Persons Met

	Names	Title	Organisation
1	Afurika Flugence	Monitoring and Evaluation Officer	CNLS
2	Olivier	Documentation Centre	CNLS
3	Munyura Pierre	Deputy Director	CHAMP/ CHF International
4	Dr. Nizeyimana Vianney	Deputy Director/ TRAC/ MoH Epidemiology	TRAC/ MoH
5	Michel	Social Protection Unit/ WFP Coordination	MINALOC
6	Andre Gihanza	Program Officer	RRP+ Kigali
7	Dr. Shumbussho Fabienne	Deputy Director	FHI, Rwanda Office
8	Venant	Program Manager/ HIV/AIDS	Christian Aid- Rwanda
9			
10	Mujawimana Aurelie	Administration	Réseau des Confessions Religieuses Engage dans le Lutte Contre le Sida (RCLS)
11	Damascene	Programme Officer	NGO Forum For HIV/Aids
12	Angelique	Administration	“
13	NZEYIMANA J M V	Acting Coordinator	FONDATION BARAKAGAHO
14	Mwumvaneza Sebastien,	Head of HIV/AIDS Program	EER Byumba Diocese
15	Bukadusenge Peninah,	Head, Dep't of Family & Women Affairs	“
16	Oscar Hatangimbabazi	Head, Youth HIV/AIDS Prevention Program	CARITAS Byumba
17	Mashavu Jean Baptiste	Overall Head of Health, Development & Disaster Preparedness Program	“
18	Rev. Ngedahimana Emmanuel	Project Coordinator, HIV/Aids Project	EER, Kigeme Diocese
19	Mukunzi Jean de Dieu	Coordinator/ HIV/AIDS Program	EER Shyira Diocese
20	Munana Charles,	Coordinator of RRP+	Ruhengeri.
21	Kamana Damascent	Technical Assistant	CDLS, Ruhengeri/
22	Mukeshimana Donatila	Diocesan Secretary	Union of Baptist churches in Rwanda, Butare Diocese
23	Gumiriza Emmanuel	Chief Accountant	“
24	Souleymane	Child Protection Programme	UNICEF , Rwanda
25	Pacifique	Monitoring & Evaluation Officer	“