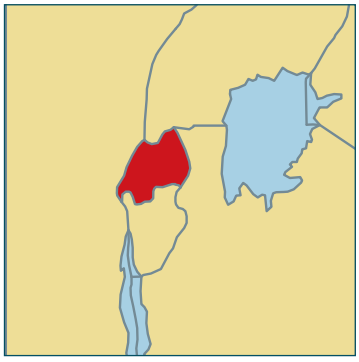
CHAPTER 5

Rwanda

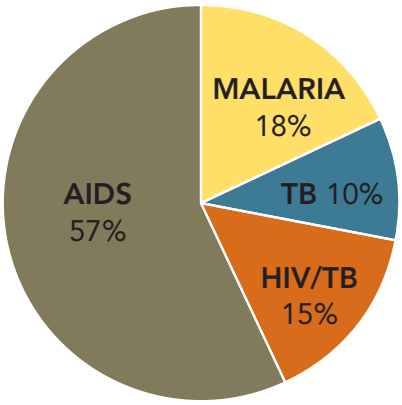
Focus on the future



Grant details

Diseases	**HIV/TB (Round 1)** **HIV/AIDS (Round 3)** **Malaria (Round 3)**
Principal recipient	Ministry of Health (Rounds 1-3)
Local fund agent	Crown Agents (Rounds 1-3)
Grant agreement signed	10/04/03 (HIV/TB, Round 1)
Total funding request	US$ 99,557,353
2-year approved funding	US$ 33,882,383
Total funds disbursed	US$ 4,251,354 (Disbursement 3, 06/03/04)

Grant profile



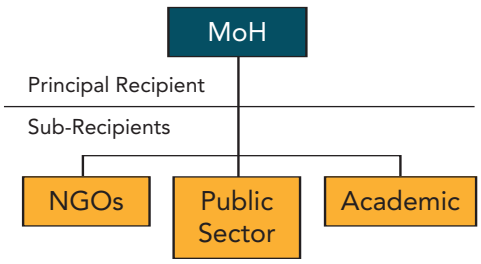
Population & health statistics

Population	8,272,456
Life expectancy	39.27 years
Number of people living with malaria	538,537
Number of people living with TB	49,469
Number of people (adults & children) living with HIV/AIDS in 2003	170,000 – 380,000
Adult (15-49) HIV prevalence in 2003	5.1%
GDP (2003)	US$ 10.11 billion
% of population below poverty line	60% (2001 estimate)
Government health spending per capita per year*	US$ 6
Global Fund investment per capita per yr.	US$ 2.41

Sources: Millennium Development Goals Database, UN Statistics, UNAIDS, WHO

* The Commission on Macroeconomics and Health projects a minimum of US$ 34 per capita per annum is needed for healthcare

Funding structure



Children have been hard hit in Rwanda. Both the 1994 genocide and the AIDS pandemic have robbed many children of their parents and other family members – and too often the promise of a safe and healthy future.

The devastating impact of HIV/AIDS in Rwanda is particularly cruel in a country still reeling from the 1994 genocide. 2004 marks the tenth anniversary in which one million Rwandans were slaughtered. In Rwanda, it is impossible to forget.

Every family in the country was affected. The crumbling remains of houses around the country bear witness to homes and families destroyed. Many survivors carry terrible physical as well as emotional scars. Hundreds of thousands of children were orphaned, and more than 100,000 children now live in child-headed households. Roadside billboards encourage people to participate in the gacaca, a modified version of the traditional court system, established to deal with the huge number of cases of genocide suspects still due to stand trial.

The impact of HIV/AIDS has some appalling similarities — and links. It is estimated that up to half a million women were raped during the genocide, and tens of thousands were infected with HIV. Many of these women have died, and many are gravely ill. Few have access to treatment. Households that took in orphans of the genocide now find themselves taking in the children of relatives and friends orphaned by AIDS. The country, which is struggling to regain a measure of economic growth after losing more than 10 percent of its population in 1994, including many from its skilled and educated workforce, faces ongoing losses to AIDS.

Fighting HIV/AIDS is therefore truly a matter of national survival for Rwanda — for individuals, families, communities and the country as a whole. With up to 380,000 people currently living with HIV — many of whom do not know they have been infected — and an estimated 36,000 people in need of antiretroviral (ARV) treatment — Rwanda has an enormous task ahead of it.

And the country is rebuilding itself. The gacaca court system is beginning its third phase and will continue for some time to come. The Gisozi Genocide Memorial, a museum and garden built over large tombs containing the remains of 250,000 genocide victims, opened in April. Government-sponsored conferences are held for young people to talk about the genocide and to ensure that the country never forgets, yet continues to heal.

The government is also committed to reducing the country's reliance on foreign aid by looking for new economic opportunities. Fresh kilometers of paved road are added every day and new construction abounds in the capital of Kigali.

"Maybe because of the genocide, we want to run," says Dr Chantal Kabagabo, Director General of Health and Social Affairs in the Office of the President. "We want to do everything as fast as possible, to rebuild, and to do it for ourselves."

Large painted billboards on the streets of Kigali remind people of the risk of HIV/AIDS, warning people against casual sex and encouraging them to get tested. More difficult to see is the steadily expanding infrastructure for diagnosing and treating HIV/AIDS throughout

the country. Rwanda's Round One grant from the Global Fund was awarded to a proposal for integrated voluntary counseling and testing services, worth up to US$ 15 million over five years, with US$ 8.4 million committed for the first two years. The goal of the program is to expand comprehensive testing services for HIV/AIDS to all of Rwanda's health districts and to introduce ARV treatment in several centers. Funding will also cover preventive education campaigns targeting the country's young people, who make up about half of the population.

INTEGRATED VOLUNTARY COUNSELING AND TESTING

VCT Integré (VCTI), or Integrated Voluntary Counseling and Testing, is really a kind of "VCT Plus", going beyond simply testing people for HIV. It includes voluntary counseling and testing, prevention of mother-to-child transmission of HIV as part of antenatal services, diagnosis and treatment of opportunistic infections and sexually transmitted diseases, consistent referral of patients to and from tuberculosis clinics, and home-based care and support for people living with HIV/AIDS and their families.

VCTI was conceived as an important first step in strengthening a broad-based response to HIV/AIDS around the country. By gradually extending access to comprehensive HIV testing services to three health centers in each of Rwanda's 39 health districts, these services will become available in 117 health centers and in all regions, even if not in every village. And by working not only with government players but also with civil society organizations, the reach to different sectors of society will be wider and deeper.

While a component of the Round One grant is for the expansion of ARV treatment in two major reference hospitals, the biggest component is for the scale-up of VCTI. However, the roll-out of VCTI will also complement the World Bank's MAP project, which in 2004 will bring ARV treatment to some of the first districts where VCTI is being implemented. Following that, Rwanda's Round Three grant from the Global Fund, signed in June 2004, has a huge component for the expansion of access to ARVs around the country. These various grants and programs will help to ensure that Rwanda has affordable testing and treatment for HIV/AIDS available in all health districts by the end of the third year of its program in 2006.

"When we thought of writing the VCTI proposal, we thought we should really increase access to treatment for people in communities," says Dr Chantal. "We wanted not only to work within health systems but with the wider community — youth groups, associations of people living with HIV/AIDS."

Health animators play a key role in VCTI, raising the awareness of community members on disease prevention, diagnosis and treatment. They are volunteers who visit households to promote available health services and provide basic preventive education, forming an important link between health centers and the community. With the introduction of VCTI, one of their jobs is to ensure that people know about new services and to encourage them to get tested.

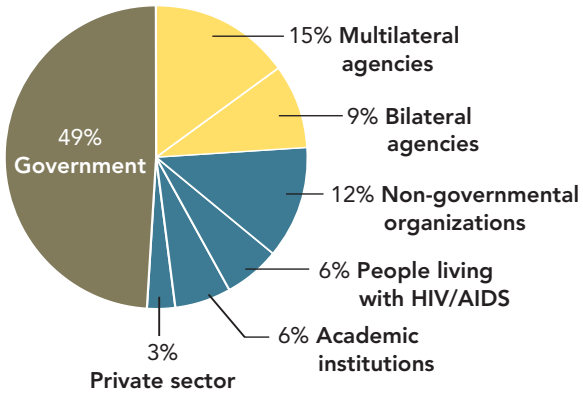
VCTI is being rolled out in six waves, district by district. The first-wave districts and health centers were chosen on the basis that they had at least one component in place already, usually voluntary counseling and testing or prevention of mother-to-child transmission. While approximately 60 percent of the health centers in Rwanda are government-run facilities and 40 percent are church-run agrées (private, not-for-profit clinics), the private facilities serve approximately 60 percent of the population. Therefore, it was also important to select both public and private health centers in all regions.

The Rukara Health Center in Umutara, a region northeast of Kigali, was part of the second wave of VCTI sites. It opened its brand-new brick building for VCT services in April 2004. Rukara now has four new consultation rooms

Grant progress against milestones

- **1,586 people living with HIV/AIDS began antiretroviral treatment, more than doubling the target for the first year**
- **38 health centers around the country began offering integrated voluntary counseling and testing services, including treatment for opportunistic infections**
- **7 hospitals were set up (4) or enhanced (3) for the distribution of antiretroviral treatment for people living with HIV/AIDS**
- **394 youth peer educators were trained in HIV prevention**
- **167 service providers for integrated VCT services were trained in TB treatment**
- **8,709 first-time VCT clients were served at integrated VCT centers**

CCM composition



The Global Fund and the World Bank — working together to increase access to treatment

In Kigali, the Global Fund-financed VCTI project and the World Bank-financed Multi-country AIDS Program, or MAP, share not just their offices but also a project management unit, overseen by the country's National AIDS Control Commission.

The unit has two management teams, one for each project, which have created a formal Collaboration Committee that meets regularly to share information and identify opportunities for cooperation.

"The teams work together," says Blaise Karibushi, coordinator of the VCTI project management team. "Their programs are complementary. VCTI and MAP are also doing joint drug procurement."

While VCTI is expanding voluntary counseling and testing services in the health centers of all health districts and ARV treatment to some of the central hospitals, MAP will bring ARV treatment to a total of 12 district hospitals.

In rolling out VCTI, some of the first and second wave sites were identified based on the districts selected by the MAP project. By the time treatment is available through MAP, testing will already have been underway in those areas and waiting lists for treatment prepared. The joint planning will also ensure that some people tested at VCTI sites in 2004 will have access to ARVs well before the end of the year. Rwanda's Round Three grant contains a strong ARV scale-up component, and it will further complement VCTI and MAP coverage when it begins implementation later this year.

and a pharmacy with storage space. On-site testing facilities mean that only samples requiring confirmation testing need to go to the central lab in Kigali. The staff of one doctor and three nurses has all undergone training in the capital, and they plan to hire a fourth nurse soon to help relieve some of the workload. VCT is offered three days per week and prevention of mother-to-child transmission (PMTCT) services are offered twice a week. On a Wednesday, when PMTCT services are offered, the spacious waiting room is filled with women waiting for the group counseling that comes before individual sessions. After agreeing to a test, the women will only have to wait for one hour to receive their results.

The first two waves have now launched, and though renovations are still ongoing in some sites, the first of these have been operational since November 2003. The third wave had its site evaluations in June 2004 followed by contracting, renovations and new construction. New and existing staff started training in June, and the sites will be operational by September. By the end of April 2004, 38 health centers in 15 districts had implemented VCTI. Roll-out will be complete by May 2006.

NEW ACCESS TO TREATMENT IN RWANDA

Rwanda's original plan was to put about 1,500 people on ARVs by the end of the second year of the VCTI project in 2005 and 2,000 by May 2006. In January 2004, with VCTI roll-out making great progress and a Round Three grant around the corner to further increase access to ARV treatment, Rwanda decided to accelerate the pace of ARV scale-up with Round One funding. By April 2004, more than 2,000 people had been put on ARVs at sites in Kigali and Butare, and each site was adding about 100 more people every month.

In terms of paying for the drugs, if the patient's household income is less than US$ 85 per month, they receive the drugs free of charge. A medical team considers patients' dossiers and their eligibility for free treatment. Dr Innocent Nyaruhirira, Minister of State for HIV/AIDS, believes this form of case-by-case decision-making increases the responsibility of patients in terms of their compliance with prescribed drug regimens.

"This makes it an agreement between the person and the national and international communities," says Dr Innocent. "This understanding is important for adherence. They must practice safe sex and take the drugs as prescribed. It's a moral contract."

Dr Appoline Uwayitu, Assistant Director at the Centre Hospitalier Universitaire de Kigali (Kigali Central Hospital or CHK), explains, "We have a selection committee for ARV patients here at the hospital. In addition to meeting the criteria in terms of cell count and so on, they must be able to provide an address for themselves and also the name and address of a second person so that we have a means of following them up."

The courtyard in the middle of CHK is small but pleasant with benches and shady areas, and people chat quietly as they wait. The VCT Center is nearby and bustles with activity as people wait for counseling, testing, results or treatment. There are few consultation rooms, and all are full.

The Center offers VCT services twice a week and on alternate days has a clinic with counseling, testing and treatment for pregnant women. The Center also provides prophylactic treatment, dispenses ARVs and gives food assistance to people on ARVs who do not have enough to eat, including corn, soy, sorghum, rice, sugar and milk.

"Things have improved greatly since the drugs arrived," says Sister Marie-Josée Malibori, in charge of the

Ruhengeri, northern Rwanda, bordering Congo and Uganda, and close to the Virunga chain of volcanic mountains.

voluntary counseling and testing program at the hospital. "Stigma is dropping amongst these people. It is very encouraging for us as health workers to see the difference. People who came in with extremely low CD4 counts now have better health and can find jobs. We can see the improvement.

"Compliance is good, but we watch for missed appointments because this can be a sign they have stopped taking their drugs. When people feel better after about two months, this can happen. We give them counseling not only before and after testing, but also before and during ARV treatment."

The VCT Center will soon move into new premises at the hospital, currently under construction. The new space will have a dispensary and provide more space for consulting and counseling.

PROCURING ANTIRETROVIRALS

CAMERWA is Rwanda's government-established but independent, non-profit procurement agency for the health sector. Public and private sector clinics and hospitals as well as programs run by non-governmental organizations and multilateral agencies get all medicines and health-related commodities here.

Before Global Fund grant-financed programs began in Rwanda, CAMERWA had never ordered drugs and supplies on as large a scale as it does now. With no model for antiretroviral drug procurement, Rwanda based its first procurement plan on that of neighboring Burundi. Physical space in the Kigali warehouse is now at a premium as boxes of antiretrovirals and other medicines crowd test kits, syringes and other equipment on the shelves.

"We will be ordering even more ARVs with Global Fund money and also for MAP [the World Bank's ARV treatment project]. And when the [Global Fund Round Three] malaria program begins, we will be ordering ten times as many bed nets as that," says Dr Ernest Rwagasana, the director of CAMERWA, waving at a corner of the warehouse full of insecticide-treated bed nets. "You can see how much space they take up."

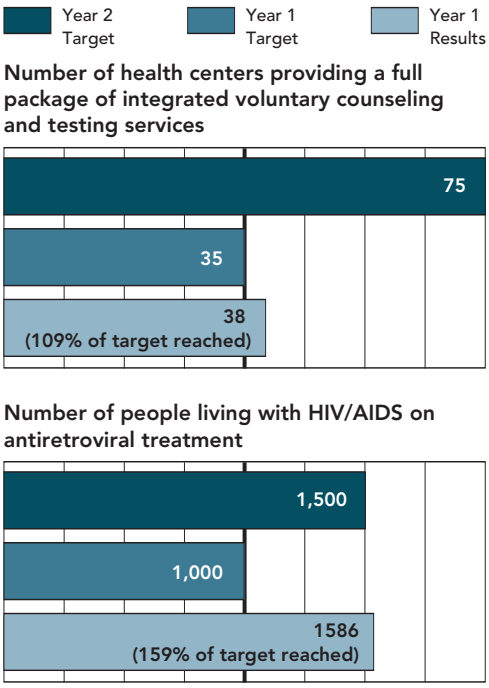
CAMERWA is now talking about expanding the warehouse and has already begun to rent additional cold storage space from the Ministry of Health. They are also planning to decentralize distribution by the end of the year, explains Dr Rwagasana.

"New warehouses will be completed in each region in 2004, and the Kigali warehouse will become the supply center. This will be more efficient," he says. "Right now, each district clinic must come to collect its supplies here in Kigali. Sometimes it is difficult for them to do this or it takes a lot of time. Sometimes they can run out of stock."

One of the key challenges the country faces for ensuring consistent stocks of the necessary drugs and other supplies is a relatively weak supply chain infrastructure. A lack of reliable information from the regions means that CAMERWA does not always have accurate statistics on the country's supplies and future needs. Management Sciences for Health (a private, non-profit organization),

Key indicators

HIV/AIDS



funded by the United States President's Emergency Plan for AIDS Relief, is going to provide training in the regions and work with health districts to implement systems to manage stocks and better calculate district needs. The requirements of scaled up testing and treatment programs throughout the country will ultimately result in a stronger procurement and drug management system in Rwanda.

CAMERWA has hired new personnel as a result of the increase in procurement for Rwanda, including a new pharmacist who will work with the country's Treatment and Research AIDS Center on quality control issues. As a result of greatly increased bulk ordering, CAMERWA has already been able to reduce prices for the whole country because as a non-profit agency, they mark up drugs and commodities only enough to cover their costs.

CHALLENGES

Implementation of the VCTI program is linked to Rwanda's process of decentralizing its health system, giving greater powers to the districts and health centers. Currently, the Project Management Unit in Kigali interacts with every site directly. With the gradual increase in staff and management capacity at the district level, this will lessen — an important goal, given that the end result in 2005 will be 117 centers implementing VCTI.

Another challenge is quality control at the level of the health centers after years of underfunding in the health sector and insufficient skill and staffing levels. As in many African countries, and more than many due to the genocide, Rwanda faces a shortage of skilled healthcare workers — doctors, nurses, lab technicians, caregivers — particularly those trained to administer ARV treatment and those willing to work in far-flung, rural villages. The country also has under-equipped laboratories and a limited ability to conduct the tests needed to determine whether a patient should start on ARVs. "The speed of training people to provide ARVs is definitely a concern," says Dr Innocent. "The availability of well-equipped labs is another. Prices have decreased for ARVs, but lab reagents are still expensive."

With the drop in drug prices, and financing for ARVs coming from Global Fund grants and the World Bank's MAP project, one of the main obstacles to treatment in Rwanda — the cost — has begun to lessen. However, building the systems for determining when people should start on ARVs, administering treatment and following up is all new.

"For years the delay in getting people on ARVs was dealing with the donors and resource mobilization, all the talk and the bureaucracy and no action," says Dr Innocent. "Now we're dealing with practicalities on the ground and how to actually go about distributing ARVs. There are many contradictions [in the medical advice for] putting someone on ARVs."

In 2003, Rwanda finalized national criteria for putting people on ARV treatment and created a system for determining who would get the drugs at a time when the amount of treatment available was limited.

"The government made a decision to make ARVs universally accessible, not just available to those who could pay for them. Since quantities are currently limited, they are going to those who most need them, regardless of income levels," explains Dr Innocent. "VCT services are 200 Rwandan francs [about US 35¢] for those who can afford to pay the fee and free for those who can't. A committee determines who gets ARVs, using new national guidelines and decides on payment schedule based on a three-tiered system according to income."

One challenge in making these services universally accessible is that they may not address the specific needs of all groups. The most glaring example is the large numbers of women who were raped during the genocide.

"Victims of genocide, women and girls who were victims of rape, many say they are not getting what they need. They are a special group. They are still traumatized," says Dr Chantal Kabagabo, Director General of Health and Social Affairs in the Office of the President. "They may not always want to go where others are and to use the regular VCT services. They may need particular services."

Dr Chantal says that this is a question being looked at by her office and others, including AVEGA, the Association of Genocide Widows in Rwanda. One option is to make AVEGA a sub-recipient for additional, specialized services with current or future grants. Another is to work through the First Lady's organization, Prevention and Care of Families Against HIV/AIDS. While AVEGA is currently providing ARV treatment for a very small number of women, there is no comprehensive program in place to address their particular needs for diagnosis and treatment.

Home-based care for people living with HIV/AIDS

One of the many components of Rwanda's integrated plan for diagnosis and treatment is home-based care for people living with HIV/AIDS and their families, an initiative led by a Rwandan NGO, the National Association for Supporting People Living with HIV/AIDS (ANSP+). Based on a set of guidelines produced by the national association, the 164 member associations of ANSP+ around the country are being trained in home-based care and supplied with kits and, in some cases, food packages for individuals and families in their areas.

Levels of cooperation between health centers and local associations of people living with HIV/AIDS (PLWHAs) vary widely. ANSP+ finds that their links to private health care centers, run by faith-based organizations, are stronger than those to public health care facilities. The private health care centers are often more likely to refer patients to the local PLWHA association for support and to work with the groups when a patient could benefit from home visits or food aid.

This is changing with the VCTI project, which aims to ensure comprehensive levels of cooperation and cross-referrals between health centers and local PLWHA associations. A meeting is planned between ANSP+, the heads of each health district, association leaders and volunteers to build relationships and ensure they are working together effectively.

To date, 50 percent of health centers with integrated VCT services have home-based care in the surrounding communities. In addition, 255 people living with HIV/AIDS have been trained to provide home-based care.

LOOKING AHEAD

Political commitment to fight the three diseases is high in Rwanda at all levels, and support from President Paul Kagame is strong. "The Ministry of State for HIV/AIDS reports directly to the President," says Dr Innocent. "Funding — national as well as international — has increased. The First Lady is particularly committed to programs for women and children through her own organization, and she also sits on the steering committee of the Organization of African First Ladies Fighting HIV/AIDS."

While Rwanda is only at the beginning stages of a comprehensive, nationwide response to HIV/AIDS, there is a strong sense of confidence among health officials and program implementers that the country can succeed in making a measurable impact against the disease.

"Some donors don't believe we can do what needs to be done. What is important to note is that people are dying. This enables us to provide treatment and access to treatment. You don't need a lot to save people's lives. You need to give the drugs safely, give them in safe conditions, and after that you can build what needs to be built while these people are alive," says Dr Agnès Binagwaho of the National AIDS Control Commission of Rwanda. "This is the reason for the Global Fund's success: you are open to what we really need, and we can do what we decide we need to do."

If implementation of VCTI and ARV scale-up continue at the current pace, Rwanda will see significant access to diagnosis and treatment in every district by 2006, and possibly ahead of schedule. Expansion of the national malaria program will begin later this year, funded by a Round Three grant worth US$ 13 million over the first two years and aiming to reduce overall malaria-related illness by 25 percent and child mortality linked to malaria by over 50 percent in three years.

Concludes Dr Agnès, "We need donors to support basket funding, to let us do what we need to do. And if we don't perform, then let them take the money away."