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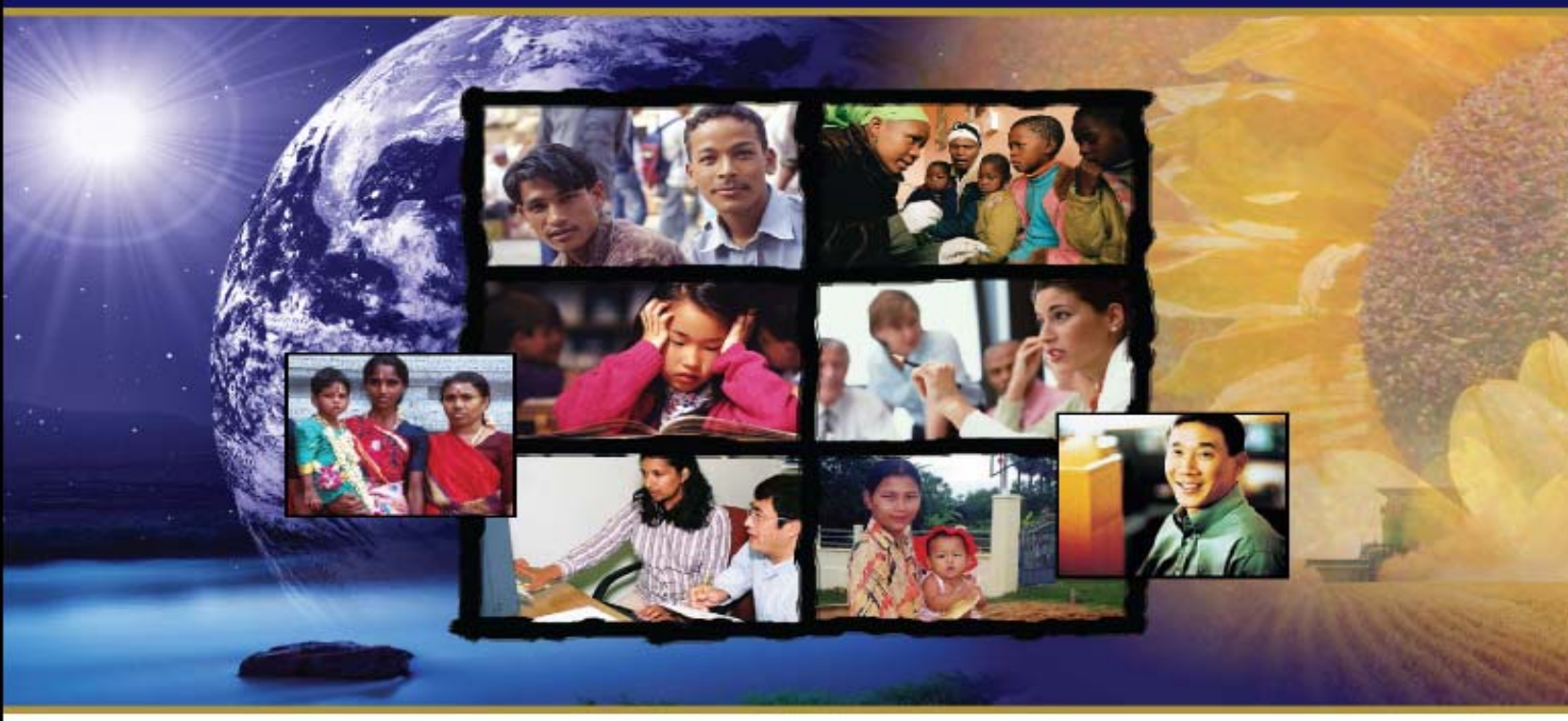
CONSTELLA GROUP

CONSTELLA FUTURES

Preparing for Microbicide Access

RWANDA COUNTRY PROFILE



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PREFACE

With funding from the European Community, the International Partnership for Microbicides (IPM) commissioned a series of country profiles that compile information on demography, HIV and health systems in countries hosting or planning to host microbicide trials. They are intended to provide basic overviews that can inform the development of more detailed policy research agendas and support future planning for the introduction of microbicides. They do not set out detailed microbicide introduction strategies or address product specific challenges.

Constella Futures was commissioned to prepare profiles for India, Nigeria, Rwanda and Tanzania. Studies were also conducted separately in South Africa and Zambia. The country profiles are available at www.ipm-microbicides.org

The recommendations made in the reports are those of the authors and do not necessarily reflect IPM's views, positions or plans.

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REPORTS IN THIS SERIES

Prepared by Constella Futures:

- India Country Profile
- Nigeria Country Profile
- Rwanda Country Profile
- Tanzania Country Profile
- Preparing for Microbicides Access: A Synthesis Report

Prepared by Jo Heslop (data are comparable to Constella Futures reports):

- South Africa Country Profile
- Zambia Country Profile

Prepared by Health and Development Africa:

- A Country Preparedness Assessment of Microbicide Access and Use in South Africa

Prepared by JHPIEGO/ Zambia:

- Microbicide Country Preparedness Assessment – Zambia: Prospective Introduction of a Microbicide to Prevent or Reduce HIV Transmission

CONTENTS

ACRONYMS

AIDS	Acquired Immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
CAMERWA	Centrale d'achat de médicaments essentiels du Rwanda
CNLS	National AIDS Control Commission
DHS	Demographic and health survey
DRC	Democratic Republic of Congo
EPI	Expanded Programme on Immunisation
EU	European Union
FGDs	Focus group discussions
FHI	Family Health International
FP	Family planning
GAHF	Government-assisted health facilities
GDP	Gross domestic product
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GFCCM	The Global Fund Country Coordinating Mechanism
GTZ	German Development Organisation
HBC	Home-based care
HIV/AIDS	Human immunodeficiency virus/ Acquired immunodeficiency syndrome
IPM	International Partnership for Microbicides
IUD	Intrauterine device
JSI	John Snow Inc.
M&E	Monitoring and evaluation
MAP	Multisectoral AIDS programme
MOH	Ministry of Health
MOU	Memorandum of understanding
MSD	Medical Stores Department
MSH	Management Sciences for Health
MWRA	Married women of reproductive age
NGOs	Non-governmental organisations
OFLAAS	African First Ladies Alliance Against AIDS
ORC	Opinion Research Corporation
OVC	Orphans and vulnerable children
PEPFAR	The President's Emergency Plan for AIDS Relief (USA)
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PRB	Population Reference Bureau
PSI	Population Services International
RSPA	Rwanda Service Provision Assessment
SEAM	Strategies for Enhancing Access to Medicines Programme
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STI	Sexually transmitted infection(s)
SWAp	Sector-wide approach(es)
TBA	Traditional birth attendant
TRAC	Treatment and research centre
TRIPS	Trade-related aspects of intellectual property rights
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	Voluntary counselling and testing of HIV
WHO	World Health Organization
WTO	World Trade Organization

EXECUTIVE SUMMARY

This report for Rwanda is one of a series of country profiles commissioned by the International Partnership for Microbicides (IPM) to build a background on which to begin to examine microbicides access at the country level. The objectives of the project are to look at country settings and begin to identify mechanisms, critical pathways and key procedures to accelerate the availability of microbicides in developing countries. The team built the profiles as desk-based research using standard data sources. In-country consultants assisted the researchers by interviewing stakeholders and filling important gaps unavailable in the grey literature.

The Republic of Rwanda is a small central-African country with a population of approximately nine million. It is a low-income country with a gross domestic product (GDP) per capita of US$207. While it is the most densely populated country in Africa, most of the population lives in rural areas. There has been a history of ethnic tension in Rwanda and this culminated in the 1994 genocide during which roughly 800,000 people were killed.

While the country continues to recover from the crisis, it is currently attracting a large amount of donor funding. The health sector, as in most of Africa, was struggling to cope before the AIDS epidemic. Considerable donor funding is now pouring into Rwanda, and Rwandans are employing these funds well.

Demographic situation. The country is still recovering from the genocide. Birth and death rates are significantly higher than the average for sub-Saharan Africa and life expectancy is 47 years. Ideal family size (about five children) is lower than total fertility (at 6.1) and there is high, unmet need for contraception.

HIV situation. Rwanda is a high-burden, low-income country facing a mature, generalised HIV epidemic. The Rwanda Demographic and Health Survey (DHS) carried out in 2005 showed an overall prevalence rate of three percent among 15–49-year-olds. The prevalence rates found in the recent population-based survey are much lower, however, than previous UNAIDS data based on sentinel surveillance in 2004, which had estimated the rate at 5.1 percent. HIV prevalence trends among pregnant women suggest a relatively stable epidemic overall and it is estimated that 190,000 people are infected with HIV. Women are more vulnerable than men and account for 57 percent of estimated infections. Incidence data are unavailable.

Health system. Rwanda adopted a health development strategy based on decentralised management and district-level care in the late 1980s. The 1994 genocide completely disrupted the system, destroying much of the infrastructure, equipment and personnel. Since

then, the Rwandan government has issued a new policy to guide reconstruction,[1] and decentralisation has now been completed in all 30 districts. However, certain health programmes that were initiated as vertical programmes continue under a vertical structure.

There is no official sector-wide approach (SWAp) in Rwanda as yet, but donors do provide the majority of money spent in Rwanda on health, and public sector spending accounts for about 57 percent of all expenditure. Approximately 70 percent of contraceptives are obtained from public sources.

Regulatory capacity. Rwanda is serious about the control and quality of medicines and is in the process of strengthening systems to monitor this. Standards for drugs and cosmetics are being developed using the Zimbabwe standards as a guide. When drugs enter the country, they are tested using World Health Organization (WHO) standards. In the case of antiretrovirals (ARVs), this analysis is carried out in South Africa.

Manufacturing. There is little manufacturing capacity in Rwanda and almost all drugs are imported. There is one government-owned facility called Laboratoire Pharmaceutique, which manufactures approximately 29 drug species, including intravenous fluids and other sterile solutions.

Procurement. Rwanda has an autonomous supply agency called the Centrale d'achat de médicaments essentiels du Rwanda (CAMERWA), which handles virtually all health products. The only exceptions are via the UN agencies, such as UNICEF. Created in 1998, CAMERWA channels everything, so that all non-UN donors and mission groups are compelled to use them (Crown Agents). There is ever increasing pressure on CAMERWA as the quantity of donor assistance in Rwanda continues to grow.

HIV programming. The Government of Rwanda demonstrates a high level of political commitment in its national response to the AIDS epidemic. The approach is multisectoral, multi-disciplinary, decentralised, and community-based, and robust frameworks are in place. Rwanda has benefited from extensive donor support to HIV/AIDS, largely as a result of the high level of commitment on the part of the government. External funding increased more than tenfold between 2003 and 2005, with PEPFAR, the Global Fund, UN agencies, and the World Bank making substantial contributions.

There has been improvement in the past five years in HIV-prevention knowledge, but not in behaviour, as unprotected sex has increased. Treatment has improved and 36 percent of people needing ARVs were receiving treatment in 2005. Eighty-five percent of districts have at least one ARV site. Rwanda is seen as one of the more successful countries with its

[1] Rwanda Service Provision Assessement (RSPA), 2001

treatment scale-up and has been one of the most successful implementers of Global Fund grants, with grants totalling US$90 million so far.

See Annex for information on institutions active in HIV and sexual reproductive health (SRH).

IMPLICATIONS FOR A FUTURE MICROBICIDE

A consultant interviewed a range of key stakeholders in Rwanda, asking them what might have an impact or influence on a future microbicide. Here are some of the results of this informed speculation.

DELIVERY CONSIDERATIONS

Microbicides would best be delivered through **multiple channels**. Suggested delivery channels and challenges for microbicide delivery would include:

Social marketing. If microbicides are registered as over-the-counter products, then social marketing is likely to be an important approach. Rwandan social marketing programmes are looking into new ways to deliver condoms. If successful, these could provide useful insights.. Even if microbicides are registered as prescription only, social marketing may still be an option for delivery. Once an initial prescription has been given and women have learned how to use a microbicide, they could obtain their re-supply through social marketing outlets.

Community-based distribution. PSI suggests the community-based distribution model might work for microbicides. As microbicide use will likely require considerable counselling in the initial stages, local women designated to distribute the method to neighbouring women can be trained to explain the product and its benefits to them. There is some experience here with a pre-packaged malaria product.

Overworked health staff in Rwanda are having trouble delivering quality healthcare services, such as much-needed sexual and reproductive health (SRH) services, as so much support is being focused on HIV. Adding another product (such as microbicides) to the mix will require consideration of health system capacity.

The **logistics system in Rwanda is in its nascent stages,** as most healthcare supplies were picked up by individual healthcare facilities in Kigali from CAMERWA. A new system will mean that it will be some time before the system is running smoothly with experienced staff. Meanwhile, frequent stock-outs of key medicines will remain common.

CAMERWA is able to carry out **long-term bulk procurement** (procuring large quantities to satisfy the national need) of medicine and medical supplies, which can bring down the unit

cost of microbicides. (Larger-scale procurement of the female condom never took place because of perceived poor up-take of the method.)

The HIV-prevention programme would be the most suitable vehicle for microbicide entry as the programme is currently well funded, although reliant on a high level of external donor financing that can be unpredictable. However, microbicides do not necessarily need to be marketed as an HIV-prevention product. Other marketing options need to be considered, e.g. personal hygiene.

HIV & SRH. There is currently a task force within Rwanda to integrate HIV/AIDS and SRH. Collaborating with individuals on this task force might be a good place to start to ascertain an idea of the path ahead. A new PSI campaign is also sending out integrated FP and HIV messages. The Global Fund is also taking integration into consideration.

Family Planning Task Force. In addition, there is a re-introduction of the Family Planning Task Force run by the Ministry of Health. Members of the task force include PSI, UNFPA, GTZ, USAID, and Columbia University. This group has been successful at coordinating the work of the public and the private sectors. Including microbicides as part of the family planning strategy could be a useful entry strategy, although this will be of secondary importance to the HIV-prevention strategy.

The Rwanda Service Provision Assessment revealed that the contraceptive method mix used by women largely mirrored what was available from health service providers. Given that the **supply chain system is under-developed**, this is most likely reflective of constrained choice (women use what they can get), rather than system responsiveness.

Female condom experience. The introduction of the female condom may provide important lessons on how to introduce a microbicide. Both the female condom and a future microbicide will be female-initiated HIV prevention methods. Both require some training on utilisation and both will be seen as more expensive than the standard (a male condom). Lessons learned from female condom branding, testing acceptability, distribution, pricing, and training on use may all be informative.

Price and availability. Many consider female condoms too expensive and difficult to find, marking key issues that will need to be addressed in establishing microbicides.

SOCIAL CONSIDERATIONS

There is a **high proportion of widows** who are particularly vulnerable to HIV infection. Special attention needs to be made to ensure that widows have access to microbicides.

Microbicides as a hygiene product. Women have a tradition of using vaginal hygiene products in Rwanda. There might be some scope for marketing microbicides as a hygiene product.

While **overall contractive use is low** (modern methods at 10 percent), injectables are more popular than the daily oral pill. This might imply that microbicide formulations that require less frequent than once-a-day application (such as a vaginal ring) may be more popular.

Dry sex is practised by some populations in Rwanda. This could conflict with microbicide use, where products have lubricating properties. Further research is required on the prevalence and consequence of such practices.

While microbicides are female-initiated, **engaging male partners** in Rwanda will be key in improving compliance with microbicide use.

STAKEHOLDER OUTREACH

The first lady is involved in fundraising for organisations of people living with HIV/AIDS (PLWHAs). She is also involved in the **African First Ladies Alliance Against AIDS** (OFLAAS) and maybe a potential microbicides advocate.

Build on good will of microbicide clinical trials. One microbicide organisation is carrying out clinical trials in Rwanda. These trials involve considerable community outreach and the building of trust within the country. If these trials are handled carefully and considerately, there will be a solid base of microbicide supporters in Rwanda.

1 INTRODUCTION

This report for Rwanda is one of a series of country profiles commissioned by the International Partnership for Microbicides (IPM) to build a background on which to begin to examine microbicide access at the country level. IPM commissioned Constella Futures in April 2006 to carry out the project, which is funded by the European Commission. The primary aim of the project is 'to accelerate access of women in less-developed countries to microbicides as soon as possible after clinical trials have demonstrated their effectiveness in preventing HIV infection'. Broadly, the objectives of the project are to look at country settings and begin to identify implications for microbicide introduction in developing countries.

This country profile for Rwanda is meant to be a resource for the microbicide community as access to microbicides becomes a reality over the next few years. The profile includes summary demographic and health information as well as an overview of the procurement, regulatory, and manufacturing situation. Finally, the profile includes institutional mapping and outlines the key players in HIV/AIDS and sexual and reproductive health (SRH). Some suggestions for microbicide planning and research in Rwanda conclude the report.

2 METHODOLOGY

The microbicides access country profiles are meant to be background documents for future microbicides research and modelling. IPM provided the outline for the Country Profile series and the outline is reflected in the table of contents for the report. The team built the profiles using standard data sources from the UN system, the Population Reference Bureau, the Demographic and Health Surveys, and the Global Fund. These data were chosen to allow comparability across countries. Additional studies and in-country data were included, if available. In-country consultants assisted the researchers by interviewing stakeholders and filling important gaps unavailable in the grey literature.

Finally, two meetings were held by the Constella Futures team: one in London including international experts, and one in Nairobi bringing together the in-country consultants. Both sets of experts provided additional information and colour, giving their opinions on best ways to provide microbicide access as well as identifying obstacles.

3 DEMOGRAPHIC INFORMATION

3.1 BASIC DEMOGRAPHIC AND SOCIO-ECONOMIC CONTEXT

TABLE 3.1 DEMOGRAPHIC DATA

Total population *(PRB, 2006)*	9,052,000
Population density per square mile *(PRB, 2006)*	890
Percentage of population living in urban areas *(PRB, 2006)*	17%
GDP per capita *(WHO, 2005)*	US$207
Human Development Index *(WHO, 2005)*	0.45 (ranked 159/177)
Percentage of population on under $2 a day *(PRB, 2006)*	84%

The Republic of Rwanda is a small central African country bordering ton Uganda, Tanzania, Burundi and the Democratic Republic of Congo (DRC). Rwanda's population is approximately nine million, with a population density of 890 people per square mile, making it the most densely populated country in Africa. The vast majority (83 percent) of the population lives in rural areas. Rwanda is a low-income country with a GDP per capita of US$207 and a Human Development Index of 0.45 (the 19th lowest ranking in the world). Almost three-quarters of the population live on less than $2 a day.

There has been a history of ethnic tension in Rwanda – both before and after independence from Belgium in 1962, when the majority ethnic group, the Hutus, had control. This culminated in the 1994 genocide during which roughly 800,000 people died. It also caused two million Hutu refugees to flee the country, approximately 10,000 of whom remain in the neighbouring Democratic Republic of Congo (DRC) where they have formed an extremist insurgency group. Since the genocide there has been substantial international assistance and political reforms, including Rwanda's first local elections in 1999 and the first post-genocide presidential and legislative elections in 2003; also, investment and outputs have been boosted. However, reconciliation between the two ethnic groups is complicated by the Tutsi political domination and Hutu extremist insurgency in the DRC.[2]

Kigali is the capital of Rwanda and the country was originally divided into 12 provinces. There have been decentralisation reforms, with new geographical demarcations and regrouping of the country's 30 districts into five new regions, namely: South, West, North, East, and Kigali City. Official languages are French, Kinyarwanda (a universal Bantu vernacular) and English, with Swahili also being widely used in commercial centres. The population is 57 percent Catholic, 26 percent Protestant, 11 percent Adventist and five percent Muslim. Main exports are coffee, tea, hides and tin ore. Ninety percent of the Rwandan labour force is agriculturally based.[3]

3.2 HEALTH AND FERTILITY

TABLE 3.2 HEALTH AND FERTILITY DATA

Crude birth rate	43
Crude death rate	17
Projected population increase 2006-2050	128%
Life expectancy at birth	47 years
Life expectancy at birth (male)	46 years
Life expectancy at birth (female)	48 years
Total fertility rate	6.1
Ideal family size – women *(RDHS, 2000.)*	4.9
Ideal family size – men *(RDHS, 2000.)*	4.8
Percentage of married/in union women of reproductive age (MWRA) using contraception	17%
Percentage of MWRA using modern contraception	10%
Unmet need for family planning *(PSP-One, 2005.)*	36%
Age at first marriage (women) *(DHS, 2006.)*	20.7 years
Age at first sex (women) *(DHS, 2006.)*	20.1 years

[2] CIA, 2006.
[3] Ibid

Age at first birth *(RDHS, 2000.)*	22.0 years

Source: PRB, 2006, unless otherwise stated.

Both the crude birth and death rates are significantly higher than the average for sub-Saharan Africa. The life expectancy had fallen to 44 years in 2001 from 50 years in 1990, but is now back to 47 years. It appears that AIDS could have had a large impact on this (see Section 5). The total fertility rate had been declining, but has slightly increased again in 2006 to 6.1 and is still among the highest in sub-Saharan Africa. Ideal family size is also high, at almost five children, but has also reduced significantly in recent years. Actual and ideal family sizes vary enormously with socio-economic variables; people who are younger, urban and more educated want and have smaller families. Contraceptive use is low in Rwanda, although it has increased significantly in recent years. One in six women practises family planning and one in 10 uses modern methods. This translates to a high unmet need for family planning and more than one in three women wishing to delay or terminate childbearing are not using contraception.

3.3 GENDER

TABLE 3.3 GENDER DATA

Percentage of women aged 15-24 who are literate (can write a simple sentence)	76%
Literate women as a percentage of literate men	98%
Percentage of women aged 15+ who are economically active	85%
Percentage of men aged 15+ who are economically active	87%
Percentage of women with access to newspaper, TV and radio *(RDHS, 2005)*	1.6%

Source: PRB, 2005, unless otherwise stated.

Three in four women in Rwanda are literate, which is higher than the average for East Africa. Moreover, women's literacy is on par with men, with 98 literate women to every 100 literate men. Women are also almost as economically active as men. This is not necessarily an indicator of women's empowerment, but often more a reflection of poverty levels. Just 1.6 percent of women have full access to the media.

4 HIV LEVELS AND TRENDS

TABLE 4 HIV DATA

HIV prevalence	3.1%
# of people living with HIV (adults and children)	190,000
# of children (0-14) living with HIV	27,000
# of adults (15-49) living with HIV	160,000
# of adult women living with HIV	91,000 (57%)
# of children (1-17) orphaned by AIDS	210,000

Source: UNAIDS, 2006.

Rwanda is a high-burden, low-income country facing a mature, generalised HIV epidemic. The Rwanda Demographic and Health Survey carried out in 2005 showed an overall prevalence rate of three percent among those 15–49 years old. The prevalence rates found in the recent population-based survey are much lower, however, than previous UNAIDS data based on sentinel surveillance in 2004, which had estimated the rate at 5.1 percent. HIV prevalence trends among pregnant women suggest a relatively stable epidemic overall. It is estimated that 190,000 people are infected with HIV. Women are more vulnerable than men, accounting for 57 percent of estimated infections. HIV prevalence in Rwanda is substantially higher for men and women in urban areas and for those with a secondary education.[4] There is no reliable standardised or national-level information available on HIV incidence, nor prevalence data for high-risk sub-populations. Children orphaned by AIDS are now estimated to number 210,000.

Rwandan women have sex for the first time on average at 20.1 years and marry at 20.7 years, which is older and with a smaller gap, than in many other African countries (Table 4.2).

5 HEALTH SYSTEM PROFILE

5.1 DESCRIPTION

Rwanda adopted a health development strategy based on decentralised management and district-level care in the late 1980s. The 1994 genocide completely disrupted the system, destroying much of the infrastructure, equipment and personnel. Since then the Rwandan government has issued a new policy to guide reconstruction.[5] In 2001, the Ministry of Health (MOH) carried out a Rwanda Service Provision Assessment Survey (RSPA). Some of their results are included here. (Of the four countries profiled by Constella Futures, only Rwanda had carried out a service provision survey.)

[4] RDHS, 2005
[5] RSPA, 2001

GOVERNMENT HEALTH MANAGEMENT STRUCTURES

Decentralisation has now been completed in all 30 districts. However, there are certain health programmes that were initiated as vertical programmes and continue under a vertical structure. Responsibilities are as follows:

District level. The district level consists of a district health office, district hospital and health centres. Districts operate autonomously, providing services to well-defined populations. They are responsible for the health needs of the population and for health facilities and services, including the private sector. Financial and logistic resource management is now under the responsibility of all districts.

Provincial level. The 11 provincial health offices provide supervisory and technical support and ensure adherence to policies and guidelines.

Central ministry. The central ministry develops health policy and the overall strategic and technical framework within which health services are provided. They are also responsible for monitoring operational programmes and for managing the direct referral facilities.[6]

GOVERNMENT HEALTH SERVICE DELIVERY STRUCTURES

Health centres. There are 366 health centres, each staffed by three or four nurses. There is usually one health centre for each "zone de rayonnement" (smallest administrative unit) but this is not always the case, as health centre positioning is based on geographic access, with 85 percent of the population within a 1.5-hour walk of a health facility. Each health centre covers an average of 25,000 people. There are also 10,500 health organisers seconded to health centres in Rwanda.

District hospitals. There are 33 district hospitals, each staffed by between one and four doctors and 10 to 40 nurses and covering an average of 250,000 people. District hospitals focus on referred cases but also provide the services of health centres.

National reference hospitals. There are four national hospitals that provide more specialist services and offer the highest level of service. Although these hospitals should operate almost solely on a referral basis, in practice they also carry out roles of district hospitals due to unclear delineation of responsibilities and insufficiently functioning district hospitals.[7]

[6] Ibid.
[7] GFATM, 2003, GFATM, 2005, RSPA, 2001.

5.2 ANNUAL EXPENDITURE

TABLE 5.2 HEALTH EXPENDITURE DATA

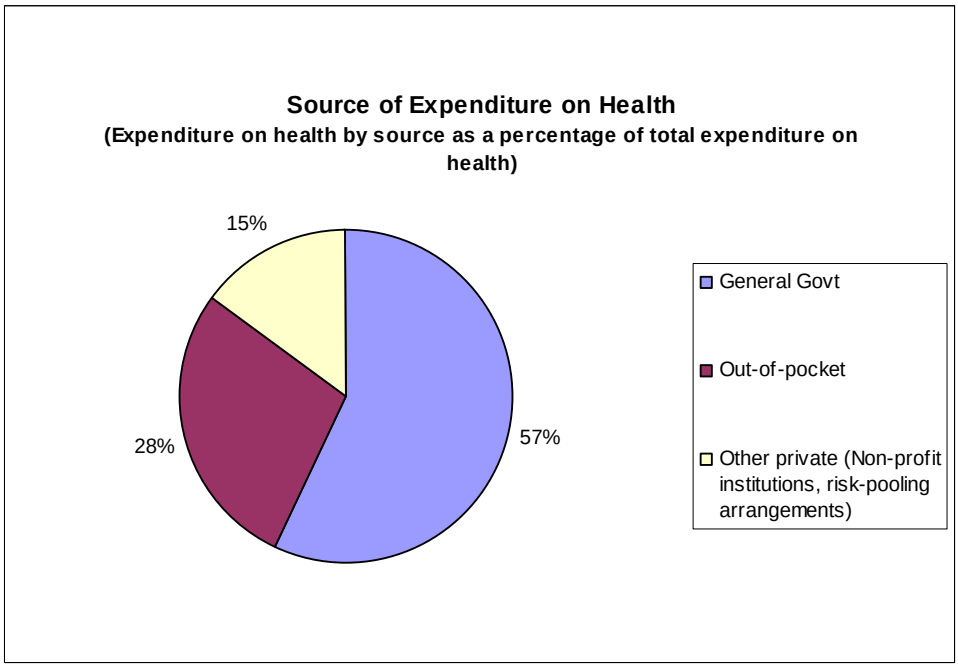
Total annual expenditure on health	US$99.6 million
Per capita expenditure on health	US$11
Percentage of government budget spent on healthcare	13.4%
Total expenditure on health as a percentage of GDP *(PSP-One, 2005).*	6%

Source: WHO, 2005, unless otherwise stated.

Rwandans spend almost $100 million on health, or $11 per capita. The government spends 13.4 percent of its budget on health, showing a strong commitment.

While the state covers over half of health spending, a good proportion is paid for by the general public out-of-pocket (see Figure 5.2).

FIGURE 5.2



Source: PSP-One, 2005.

5.3 PROPORTION OF DONOR FUNDING

TABLE 5.3 ESTIMATED HEALTH FUNDING SOURCES IN FINANCIAL YEAR 2002/03

Funding source	Amount per capita (USD) per annum	Total (USD) per annum
Government of Rwanda	3	27,156,000
Donors	7	63,364,000
TOTAL	**10**	**90,520,000**
User fees	Unknown	Unknown

Source: GFATM, 2005.

Rwanda benefits from strong external support to its health sector (see Table 5.3). However, the $10 per capita expenditure translates to $1.65 at the health centre level and user fees are heavily relied on at this level (quantifiable data are not accessible). This is considered a major barrier to access in Rwanda.[8] A sector-wide approach has not yet been officially established in Rwanda.[9]

5.4 PUBLIC/NOT-FOR-PROFIT/PRIVATE MIX

Health facilities run by religious and non-profit organisations make up a substantial proportion of health facilities in Rwanda. In 2001, 40 percent of secondary facilities were run by non-profits.[10] These government-assisted health facilities (GAHFs) are fully integrated into the public health system with the government providing support services to all facilities and staff, irrespective of their resources (such as in-service staff training, participation in district management teams and signing of agreements to follow MOH policies).

Since 1995, the private medical sector has grown considerably and continues to grow. In 1999, there were 329 private health facilities in Rwanda, with more than 50 percent of them located in or near Kigali. They have hospitalisation facilities and most provide specialist services, such as physiotherapy or gastrology. The number of private pharmacies in the country increased from 300 in 1999 to 405 in 2001.[11]

Traditional medicine is widely used in Rwanda, with sick people being as likely to consult a traditional practitioner as modern healthcare providers, depending on the nature of their problem. The MOH is trying to form traditional practitioners into associations, but few were functioning in 2001. Traditional birth attendants (TBA) are also widely used and the MOH has

[8] GFATM, 2005.
[9] GFATM, 2005.
[10] RSPA, 2001.
[11] Ibid

trained and equipped 1,800 TBAs in four pilot districts since 2001. This will be expanded if the evaluation is positive.[12]

PUBLIC/PRIVATE MIX FOR FAMILY PLANNING

Public sources dominate, providing seven tenths of family planning. The private and non-profit sectors play a smaller but significant part in service delivery, providing almost a quarter of contraceptives (see Figure 5.4.2).

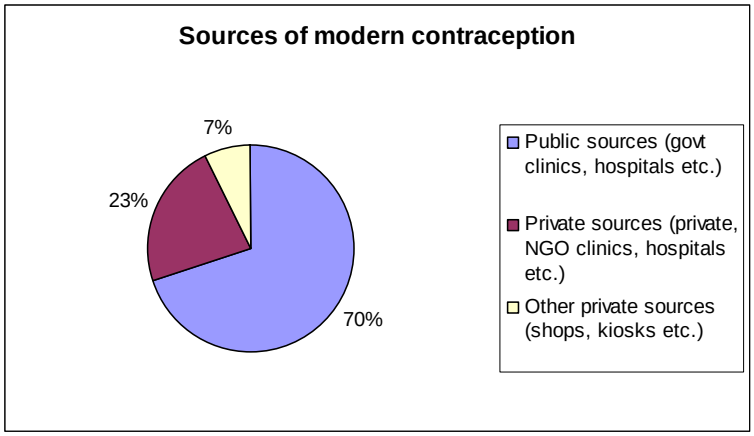


Figure 5.4.2
Source: PRB, 2002.

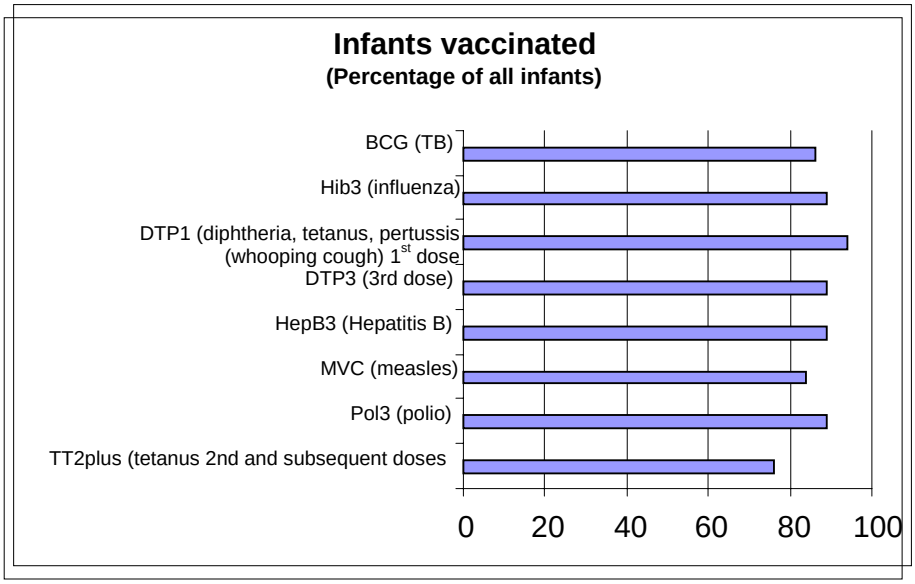
5.5 KEY HEALTH INTERVENTIONS

5.5.1 KEY VACCINES

The Government of Rwanda, following WHO recommendations, has had an expanded programme on immunisation (EPI) in place for several years. Figure 5.5.1 shows Rwanda's immunisation coverage. This is relatively high in comparison with surrounding countries and would be higher if immunisation were improved in urban areas, particularly in Kigali, where coverage is significantly lower. Immunisation coverage has remained steady in recent years.[13]

[12] Ibid
[13] RDHS, 2005.

FIGURE 5.5.1



Source: UNICEF, 2006.
TT vaccination is for pregnant women (not infants).

5.5.2 CONTRACEPTIVE COVERAGE

Data for 2002 show that modern contraceptive use has been relatively low in Rwanda, compared to neighbouring countries. (NOTE: 2006 estimates show a higher contraceptive prevalence rate of 10 percent for modern methods. These 2002 data are used to show method-mix data unavailable for more recent years.) Injectable contraceptives are the most common method, followed by the pill. Traditional methods have been more popular than modern ones. Preliminary results of the 2005 DHS show overall modern contraceptive use to have doubled in the last five years to 10 percent, with the most pronounced increase in the rural areas. Use of traditional methods has also slightly decreased.

Recent announcements from the Rwandan president imply a new push to revive the family planning programme in the wake of Rwanda's high birth rate and the prospect of quick population doubling time (by 2030). It is too soon to say whether this new thrust, funded by the US, will make a big difference in strengthening the reproductive health programme. (Kinzer, 11 Feb. 2007).

TABLE 5.5.2.1 CONTRACEPTIVE METHOD MIX, 2002
(Selected methods, married/in union women of reproductive age, 15-49)

Modern methods	Pill	1.0%
	Injection	1.9%
	Condom	0.4%
	Female sterilisation	0.8%
	Male sterilisation	0.0%
	Other modern methods	0.2%
	Total	**4.3%**
Traditional methods	**Total**	**8.9%**
No method	**Total**	**86.8%**

Source: PRB, 2002.

5.5.3 ESSENTIAL MEDICINES

Since 1995, the national health policy has recommended using generic essential medications, distributed to health units in the country through an independent non-profit purchasing supply house, CAMERWA, and a network of district pharmacies. The list of essential medicines is revised regularly, and is based on the main causes of mortality and morbidity in the country and standards of evidence established in the most recent pathology reports.[14] Data on the availability of general essential medicines are not available.

TABLE 5.5.3 AVAILABILITY OF FAMILY PLANNING SERVICES

(Percentage of facilities offering temporary methods of contraception, permanent methods of contraception and the rhythm method, by type of facility and operating authority).

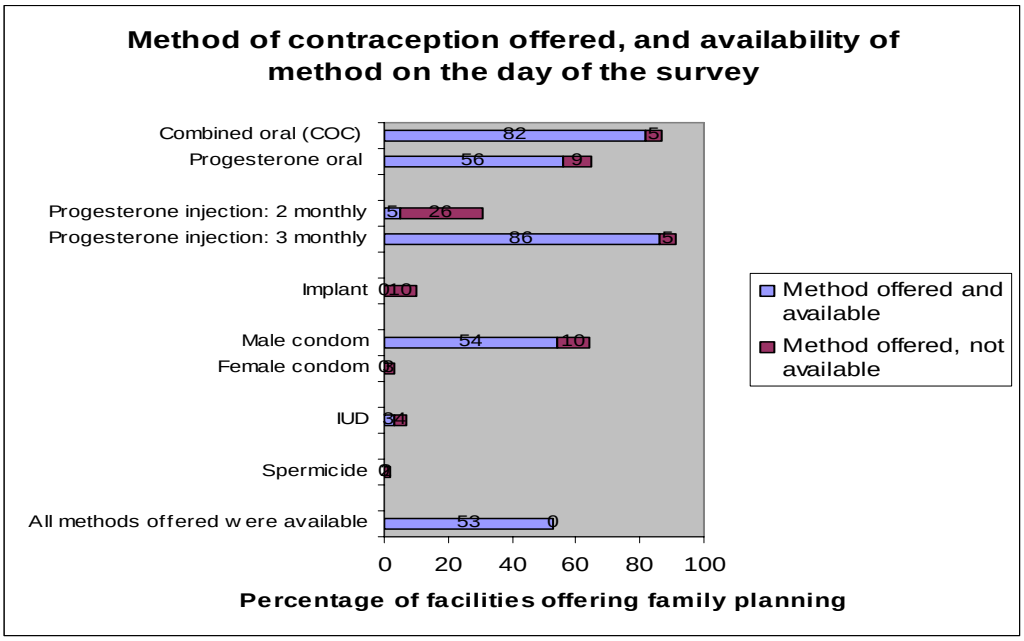
Percentage of facilities offering:	Temporary clinical methods of contraception	Permanent methods of contraception	Rhythm method
Type of facility			
Hospital	44	41	24
Health centre	75	0	26
Dispensary	80	0	11
Operating authority			
Public	86	5	23
GAHF	42	9	27
TOTAL	71	6	24

Source: RSPA, 2001

[14] RSPA, 2001.

The Rwanda Service Provision Assessment assessed contraceptive availability in health facilities. Seven out of 10 facilities in Rwanda offer temporary methods of contraception, with health centres and dispensaries being much more likely to offer these services than hospitals. Government-run facilities are more than twice as likely to offer these services as those run by religious and non-profit organisations (see Table 5.5.3). The most available contraceptives were the three-month injectable and the combined oral contraceptive (see Figure 5.5.3). Condoms were available in just over half of facilities and female condoms in none. For other methods, there was very limited availability or none at all; however, implants and intrauterine devices (IUDs) are primarily offered at hospitals. These data roughly mirror that of the contraceptive method mix, suggesting that contraceptive use is largely influenced by availability at health service providers. Figure 5.5.3 also shows that the supply is not reliable, as only 53 percent of facilities had all methods available.

FIGURE 5.5.3



Source: RSPA, 2001.

The RSPA also found that:

- Storage conditions for contraceptives were inadequate in 14 percent of facilities.
- Expired contraceptives, including condoms, were found in 15 percent of facilities.
- Only 45 percent of facilities had defined conditions for quality storage and stock management systems for contraceptive methods. Public facilities were consistently stronger than GAHFs in this aspect.

The results of the Rwanda Service Provision Assessment for microbicides give some indication of the ability of the health system to stock and distribute microbicides. While modern methods of family planning are not practised by more than 10 percent of Rwandans

of reproductive age, family planning is already in demand and the health system is covering only a proportion of the need.

6 REGULATORY CAPACITY

Rwanda is committed to the control of the quality of medicines and is in the process of creating its own systems (Crown Agents). The regulation of drugs and cosmetics in Rwanda is overseen by:

- The MOH's Task Force for Pharmacy
- The Bureau of Standards
- The Laboratoire Pharmaceutique (occasionally)

Normally, regulation is done for idrugs, icosmetics and food. A representative from the Laboratoire Pharmaceutique sits in the MOH's Task Force for Pharmacy (TRAC, Labophar).

Rwanda is developing quality standards for drugs and cosmetics using the Zimbabwe standards as a guide. They are also working with the Management Sciences for Health (MSH) Rational Pharmaceutical Management Plus (RPM Plus) Programme and are supported by PEPFAR. The system is in transition.

According to the director of TRAC, when drugs arrive in the country, they are tested for quality and standards by both the MOH's Task Force for Pharmacy and the Bureau of Standards. However, the two regulatory bodies have not in the past been coordinated and harmonised in carrying out the task. Currently, harmonisation is taking place to avoid duplication and waste of resources. Sometimes, the MOH sends drugs to Laboratoire Pharmaceutique for analysis, and have so far been satisfied by their results and services. The Laboratoire Pharmaceutique is hoping that in future, WHO will assist in having the MOH include them as a regulatory body, for they have the capacity. Rwandan officials feel that if all the quality control is carried out in Rwanda, it will save time.

When drug consignments come into the country (ARVs, for example), they are checked to ensure they meet the standards of WHO. Then a sample is kept aside for full analysis in cases where quality is suspect, or for future detailed analysis. The detailed analysis for ARVs is currently being carried out in South Africa (TRAC).

Crown Agents (procurement agents for the Global Fund) say that there are no current official requirements for regulatory approval in Rwanda, although MSH is trying to introduce them. There are not yet registration processes or requirements for over-the-counter approval.

As Rwanda has had no regulatory process of its own in the past, they have relied on external regulation requirements such as WHO or the EU. (N.B. If these are not available, UK approval

would be seriously considered, according to Crown Agents.) Microbicides would probably be prescription-only in the first instance. Rwanda is a signatory to the William J. Clinton Foundation preferential pricing arrangements and this has quality controls built in. As these systems are in a state of flux, this will have to be monitored carefully if working in Rwanda.

Fast track for AIDS products. There is currently no fast-track process for ARVs, which are regulated the same way as normal drugs. ARVs are generally generics and are imported from India. Customs clears these in three to four days. The Bureau of Standards and WHO test them; some are sent to South Africa for quality control checks). This whole process takes about six months. There are plans in the future to have ARVs delivered directly to CAMERWA, thereby shortening the process.

7 Local Manufacturing Capacity

There is little manufacturing capacity in Rwanda and almost all drugs in use are imported. There is one government-owned facility called Laboratoire Pharmaceutique, which is currently the only manufacturing company in Rwanda and is manufacturing 29 drug species. They have been manufacturing since 1982. According to the head of the manufacturing arm of Laboratoire Pharmaceutique, plans for a project to manufacture ARVs locally are underway and they are making a choice whether to use technology from India or Brazil. The facility manufactures intravenous fluids and other sterile solutions but it is clear that the business needs substantial foreign investment to advance further. Laboratoire Pharmaceutique is facing financial constraints in meeting the manufacturing demand for drugs in the country (Crown Agents).

The Belgian Technical Company is supporting Laboratoire Pharmaceutique by rehabilitating the production unit. A Canadian/Belgian company, Proparies, has also approached the government of Rwanda to establish a local manufacturing company for malaria, tuberculosis and ARV drugs.

8 Procurement Systems

Rwanda has an autonomous supply agency (ASA) called the Centrale d'achat de médicaments essentiels du Rwanda (CAMERWA) that handles virtually all health products. (The only exceptions are via the UN agencies such as UNICEF.) Created in 1998, CAMERWA channels everything, so that all non-UN donors and mission groups are compelled to use it (Crown Agents). CAMERWA's mission is to assure the procurement and distribution of essential drugs, medical consumables and equipment of least cost to all health establishments. All procedures for importation are handled by CAMERWA on behalf of the MOH. There are no taxes or clearance charges imposed on health commodities and there are no different requirements for medical or consumer products. As a result of the increased bulk

ordering, CAMERWA has been able to reduce country-wide prices. They are a non-profit agency and only mark up drugs and commodities to cover their own costs.

According to Crown Agents, CAMERWA has a wide supplier base as well as a sound procurement manual. It has established good working relationships with all of the major pharmaceutical companies.

CAMERWA is a member of the African Association of the Central Merchandising for Drugs, a useful association for interagency collaboration. Rwanda does not recognise any patent laws or restrictions at this time. As a member of the World Trade Organisation (WTO) with least-developed country status, the country is exempt until 2016 from providing patent protection under the Trade-Related Intellectual Property Rights (TRIPS) agreement (Crown Agents).

For the last few years, CAMERWA has begun to undertake basket purchasing. This system allows the undertaking of procurement twice a year and the needs of all are fed into a centralised point along with their timelines. CAMERWA manages this process, with assistance from the Pharmacy Board, the William J. Clinton Foundation and MSH. This transparent system results in benefits of scale-maximising pricing advantages, shipping opportunities, and facilitates the efficient distribution of products upon arrival. It also minimises documentation and avoids the need for expensive emergency procurement. Stock-outs are no longer considered to be such a problem (Crown Agents). The various donors (USAID, the Global Fund, KfW, DFID, the World Bank among others) seem happy with the way that CAMERWA performs, according to Crown Agents.

Coordination between CAMERWA and the Laboratoire Pharmaceutique could be improved. The lack of a procurement/business plan from CAMERWA makes it difficult for Laboratoire Pharmaceutique to plan manufacturing based on long-term forecasting and a memorandum of understanding for drug production would help the Laboratoire Pharmaceutique make more certain manufacturing plans (Labophar).

According to Crown Agents, Rwanda continues to have human resource problems in the public sector as many good people are lured away by NGOs and other external programmes. CAMERWA has hired new personnel as a result of the increase in procurement for Rwanda, including a new pharmacist who will work with the Treatment and Research AIDS Centre on quality control issues (Crown Agents).

Finally, there is ever increasing pressure on CAMERWA as the quantity of donor assistance in Rwanda continues to grow. As donors continue to scale up, CAMERWA will continue to need some help in managing this growth.

The lack of reliable information from the regions means that CAMERWA does not always have the accurate statistics it requires on the country's supply needs.

CAMERWA has, up until now, had its central medical stores in Kigali and all health facilities have had to pick up their medicines there. With all the new donor activity, CAMERWA is currently decentralising distribution to the district level and eight district medical stores have been set up to distribute medical supplies to all regions in the country. The future plan is to establish a district drug and medical store in each of the 30 districts in the country. This new system could benefit the eventual distribution of microbicides once it is firmly in place according to the health officials. (MSH, with funding from PEPFAR, is providing technical assistance to regions which should ultimately result in a stronger procurement and drug management system.)

9 HIV PROGRAMMING

9.1 LEVEL OF POLITICAL COMMITMENT

The level of effort in the national response to HIV/AIDS is substantial. WHO describes political commitment to fight the HIV/AIDS epidemic as high. The approach is multisectoral, multi-disciplinary, decentralised and community-based. Robust frameworks are in place, including the following:

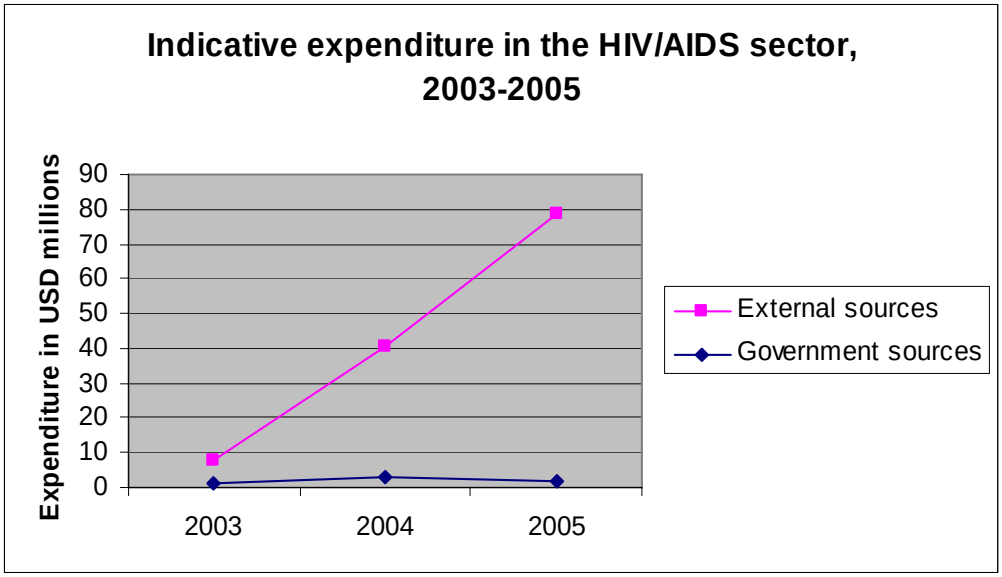
- The National HIV/AIDS Control Commission (CNLS) was established under the Office of the President in 2001;
- A National Strategic Plan for HIV/AIDS for 2002-2006 was released in 2002. It addresses prevention, care and treatment of HIV/AIDS. A mid-term review in 2004 resulted in revision of the framework and a national policy on HIV/AIDS, both of which were waiting legislative adoption in early 2006;
- Policy statements have been developed for OVC (2003-4), ART (2004), HIV/AIDS in the workplace, and condoms (2005), and a national HIV/AIDS policy document encompassing all policies was drafted in 2005;
- A National Health Sector Strategic Plan for HIV/AIDS 2002-2009 has also been developed to guide the health sector's response;
- There is a Minister of State for AIDS, TB and Malaria within the Ministry of Health;
- A national plan for monitoring and evaluation of the national response is being developed;[15] [16]
- The First Lady's Office created the impetus for the organisation "African First Ladies Alliance Against AIDS" (OFLAAS), which manages the project "Prevention and Care of Families Against HIV/AIDS" focusing on PMTCT. Ms. Kagame is also involved in fundraising for organisations of people living with HIV/AIDS.[17]

[15] WHO, 2005
[16] CNLS, 2006
[17] GFATM, 2005.

9.2 FUNDING FOR HIV/AIDS

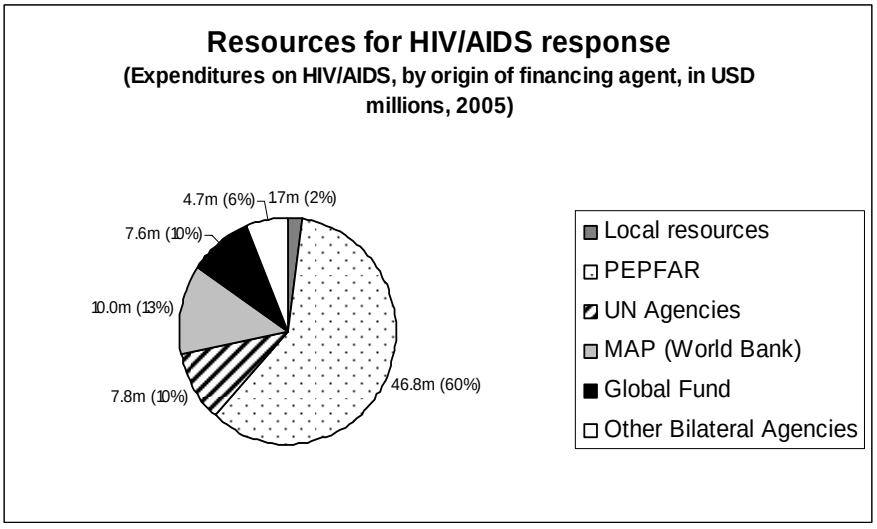
Rwanda has benefited from extensive donor support to HIV/AIDS, largely as a result of the high level of commitment on the part of the government. External funding increased more than tenfold between 2003 and 2005 (see Figure 9.2.1). PEPFAR accounted for the majority of funding, and the Global Fund, UN Agencies and the World Bank were substantial contributors. External funding accounted for 98 percent of the US$78.5m HIV/AIDS expenditure in 2005 (see Figure 9.2.2).

FIGURE 9.2.1



Source: CNLS, 2006.

FIGURE 9.2.2



Source: CNLS, 2006.

9.3 COVERAGE OF HIV/AIDS INTERVENTIONS

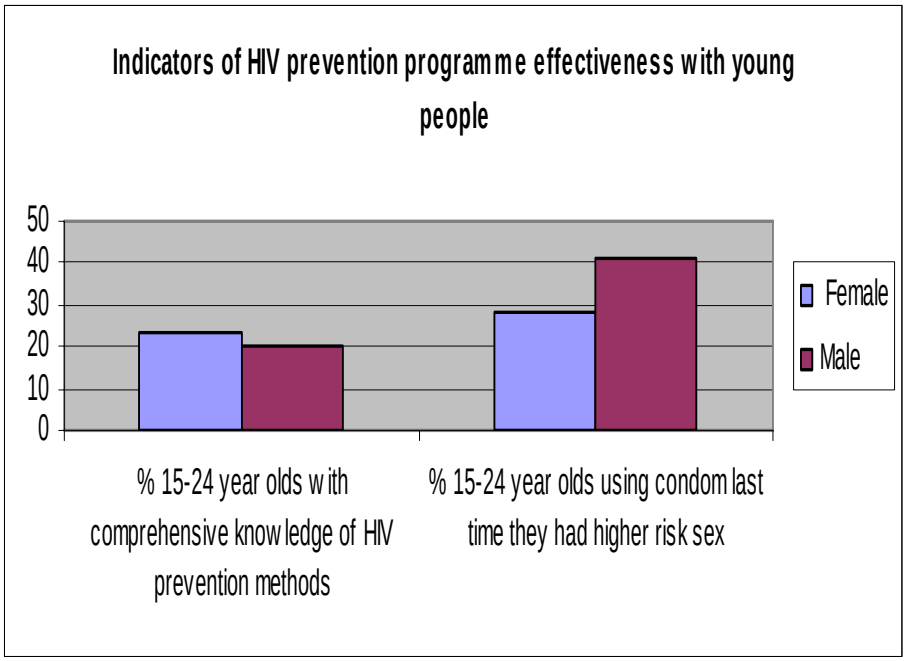
Prevention knowledge and coverage

While knowledge of safe sex behaviour has increased between 2000 and 2005, the levels of unprotected sex have increased for both males and females. Condom use among males has actually fallen significantly, from 55 percent in 2000 to 41 percent in 2005. UNAIDS claim that conflicting communication messages are confusing young people (UNAIDS, 2006). The current national plan for universal access proposes to address this issue.

In 2000, knowledge of HIV prevention (ability to correctly identify condom use and limiting sex to one uninfected partner as major ways of preventing the sexual transmission of HIV, ability to correct two of the most common misconceptions about HIV and knowing that a healthy-looking person can transmit HIV) was 23 percent for young women and 20 percent for men (see Figure 9.3.1). However, the 2005 DHS found knowledge levels to have increased to 51 percent for females and 54 percent for males, indicating a significant improvement in effective HIV prevention and education in the last five years.[18] Forty percent of young men 15-24 years old reported using a condom for their last act of high-risk sex. Less than 30 percent of young women reported the same.

FIGURE 9.3.1

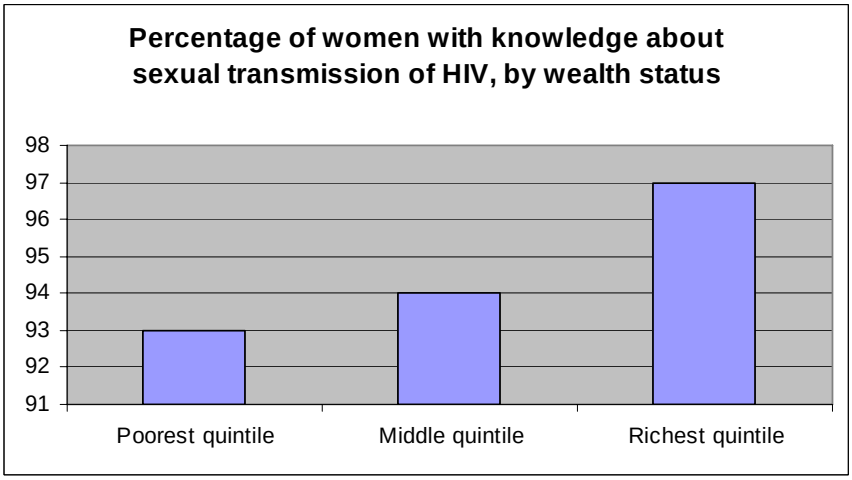
[18] CNLS, 2006.



Source: WHO, 2005.

Although Figure 9.3.2 illustrates how poverty is a barrier to HIV prevention, the differences are much less pronounced than in other countries.

FIGURE 9.3.2 (Source: PRB, 2004)



Services for voluntary counselling, testing and prevention of mother-to-child transmission have been expanding rapidly in recent years, from 50 in total at the end of 2003 to 223 VCT and 197 PMTCT sites by September 2005, covering all districts in the country.[19] The number of people accessing voluntary counselling has also been rising – up to 250,000 in 2005 according to WHO, but to 640,000 in the same period according to CNLS (UNGASS report).

[19] WHO, 2005.

Currently, 100 percent of pregnant women who attend antenatal Care (ANC) facilities are tested.[20]

TABLE 9.3.2 USE OF HEALTH SERVICES FOR HIV PREVENTION

# of VCT sites	223
# of VCT sites per 1,000,000 population	25.6
# of people tested at VCT sites (cumulative)	250,000
# of sites providing PMTCT services	197
Percentage of HIV+ pregnant women receiving PMTCT (UNAIDS, 2006)	9.4%

Source: WHO, 2005.

Clinical trials for microbicides

Project Ubuzima has been developed as an IPM clinical trial site. Located in Kigali, it is being used for a Phase I and II dapivirine gel safely trial (TMC120), among other planned trials. In addition, Project Ubuzima has assisted in setting up a community advisory group and community outreach activities.

Care coverage

Care is difficult to measure as most care in Africa takes place in the home and there are few figures available.

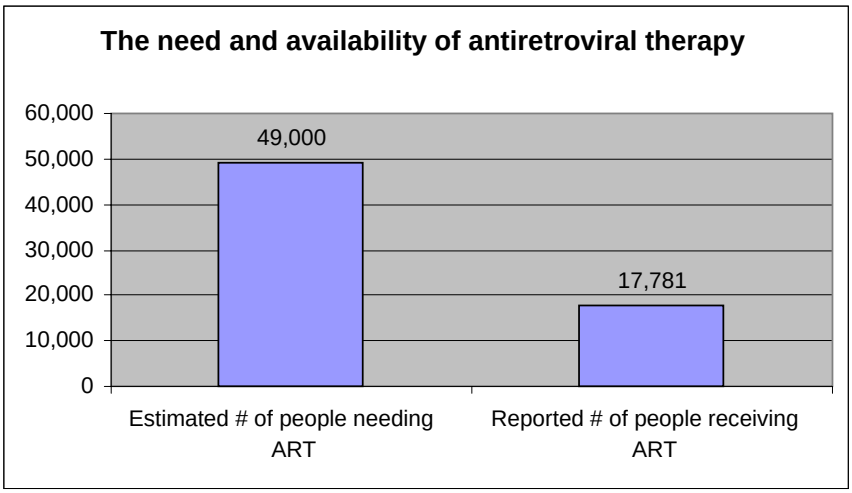
Treatment coverage

The number of centres providing ARVs increased from 16 at the end of 2003 to 76 as at September 2005, with 85 percent of districts having access to at least one ART site.[21] Thirty-six percent of people in need of ARVs were receiving it as of 2005 (see Figure 9.3.3), which is a very high proportion compared to neighbouring countries.

In 2004, the government released a ministerial decree establishing guidelines for distribution of ARVs. It allows for free access to ARVs for poor, vulnerable affected persons and a token payment on a sliding scale based on family wealth. It is also continuing to provide support to initiate a common basket for procurement of ARVs from CAMERWA.[22]

[20] CNLS, 2006.
[21] WHO, 2005.
[22] CNLS, 2006.

FIGURE 9.3.3



Source: WHO, 2005.

9.4 SCALE-UP PLANS

3-BY-5 INITIATIVE

Rwanda has been one of the more successful countries with its treatment scale-up – at the end of 2005 it was approaching WHO's target of 50 percent ART coverage. ARV scale-up has been possible with support from the Global Fund as well as other donors.

GLOBAL FUND

Rwanda has been one of the most successful implementers of Global Fund grants, with six grants totalling US$90.9 million approved so far. The Global Fund attributes this to strong commitment and collaboration by the Government of Rwanda, the country coordinating mechanism and civil society. Rwanda's first grant was evaluated in 2005 and achieved over 100 percent success rate in all 11 indicators. The focus of funding for the fifth round of Global Funds is:

- Funding of health insurance schemes for the very poor and people living with HIV/AIDS (PLWHA), and co-funding of schemes for the rest of the rural poor in six out of 12 provinces.
- Increasing health service quality through an extensive training package.

Previous Global Funding has focused on:

- Improving access to quality care for PLWHA through decentralising treatment deliverance and patient monitoring.
- Increasing access to voluntary counselling and testing (VCT) and improving integration and linkage with other services.

Rwanda also receives support from PEPFAR for a comprehensive HIV/AIDS prevention, treatment and care programme and a $10 million loan from the World Bank's Multi-Country HIV/AIDS Programme for Africa for scaling up treatment.

9.5 SOCIAL MARKETING

Major socially marketed condoms in Rwanda include:

Organisation	Product	Details
Population Services International	"Prudence Plus" – male condom	Prudence Plus introduced 1996.

Sources: PSI, 2006

PSI and UNFPA are the leading agencies in condom marketing and distribution. A study carried out in 2005 found that knowledge of where to get a condom or how much one cost were not perceived to be a barrier to condom use, but concluded that existing barriers are more related to stigma about HIV/AIDS and condoms in general. Fifty-three percent thought they would be considered promiscuous and 51 percent were ashamed to be seen buying a condom, with men finding it easier to purchase them than women. While 25-30 percent thought that single and sexually promiscuous people could get condoms, only 12 percent thought that married men could get them and two percent thought married women could.[23]

There are conflicting data on female condoms. The UNGASS report says that the female condom has only recently been introduced, while UNFPA data reveal a steady increase in female condom use from 1997 to 2002 (to 29,000 per year).

Condom procurement and clearance are now carried out by PSI for the public sector and by JSI for the private sector and are supported by PEPFAR.

10 IMPLICATIONS FOR A FUTURE MICROBICIDE

A consultant interviewed a range of key stakeholders in Rwanda, asking them what might have an impact or influence on a future microbicide. Here are some of the results of this informed speculation.

DELIVERY

Microbicides would best be delivered through **multiple channels**. Suggested delivery channels and delivery challenges include:

[23] CNLS, 2006.

- **Social marketing**. If microbicides are registered as over-the-counter products, then social marketing is likely to be an important approach. Rwandan social marketing programmes are looking into new ways to deliver condoms. This could provide useful insights. Even if microbicides are registered as prescription only, social marketing may still be an option for delivery. Once an initial prescription has been given and women have learned how to use a microbicide, they could obtain their re-supply through social marketing outlets.

- **Community-based distribution**. PSI suggests the community-based distribution model might work for microbicides. As microbicide use will likely require considerable counselling in the initial stages, local women designated to distribute the method to neighbouring women can be trained to explain the product and its benefits to them. There is some experience here with a pre-packaged malaria product.

- **Overworked health staff** in Rwanda are having trouble delivering quality healthcare services, such as much needed sexual and reproductive health (SRH) services, as so much support is being focused on HIV. Adding another product (such as microbicides) to the mix will require consideration of health system capacity.

- The **logistics system in Rwanda is in its nascent stages,** as most healthcare supplies were picked up by individual healthcare facilities in Kigali from CAMERWA. A new system will mean that there will be some time before the system is running smoothly with experienced staff. Meanwhile, frequent stock-outs of key medicines will remain common.

- CAMERWA is able to carry out **long-term bulk procurement** (procuring large quantities to satisfy the national need) of medicine and medical supplies. This can bring down the unit cost of microbicides.

- **The HIV prevention programme** would be the most suitable vehicle for microbicide entry as the programme is currently well funded. However, microbicides do not necessarily need to be marketed as HIV-preventions product. Other marketing strategies need to be considered, e.g. personal hygiene.

- **HIV & SRH.** There is currently a task force within Rwanda to integrate HIV/AIDS and SRH. Talking to some of the individuals on this task force might be a good place to start to get an idea of the path ahead. A new PSI campaign is also sending out integrated FP and HIV messages. The Global Fund is also taking integration into consideration.

- **Family Planning Task Force**. In addition, there is a re-introduction of the Family Planning Task Force run by the Ministry of Health. Members of the task force include PSI, UNFPA, GTZ, USAID and Columbia University. This group has been successful at coordinating the work of the public and the private sectors. Including microbicides as part of the family planning strategy could be a useful entry strategy, although this will be of secondary importance to the HIV-prevention strategy.

- The Rwanda Service Provision Assessment revealed that the contraceptive method mix used by women largely mirrored what was available from health service providers. Given that **the supply chain system is under-developed**, this is most likely reflective of constrained choice (women use what they can get), rather than system responsiveness.

- **Female condom experience**. The introduction of the female condom may provide important lessons on how to introduce a microbicide. Both the female condom and a future microbicide will be female-initiated HIV prevention methods. Both require some training on utilisation and both will be seen as more expensive than the standard (a male condom). Lessons learned from the female condom branding, testing acceptability, distribution, pricing, and training on use may all be informative.

- **Price and availability**. Many consider female condoms too expensive and difficult to find, marking key issues that will need to be addressed in establishing microbicides.

SOCIAL CONSIDERATIONS

- There is a **high proportion of widows** who are particularly vulnerable to HIV infection. Special attention needs to be made to ensure that widows have access to microbicides.

- **Microbicides as a hygiene product**. Women have a tradition of using vaginal hygiene products in Rwanda. There might be some scope for marketing microbicides as a hygiene product.

- While overall contractive use is low (modern methods at 10 percent), **injectables are more popular** than the daily oral pill. This might imply that microbicide formulations that need to be applied less frequently than once a day, such as a vaginal ring, may be more popular.

- **Dry sex** is practised by some populations in Rwanda. This could conflict with microbicide use, where products have lubricating properties. Further research is required on the prevalence and consequence of such practices.

- While microbicides are female-initiated, **engaging male partners** in Rwanda will be key in improving compliance with microbicide use.

STAKEHOLDER OUTREACH

- The first lady is involved in fundraising for organisations of People Living With HIV/AIDS (PLWHAs). She is also involved in the **African First Ladies Alliance Against AIDS** (OFLAAS) and may be a potential microbicides advocate.

- **Build on good will of microbicide clinical trials**. One microbicide organisation is carrying out clinical trials in Rwanda. These trials involve considerable community outreach and the building of trust within the country. If these trials are handled carefully and considerately, there will be a solid base of microbicide supporters in Rwanda.

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ANNEX – SUMMARY INSTITUTIONAL MAPPING

HIV & SEXUAL AND REPRODUCTIVE HEALTH

This section includes summary information on key agencies working in HIV/AIDS and Sexual and Reproductive Health (SRH). This includes key responsibilities, main programmes and influences, and names and contact information.

KEY AGENCIES WORKING IN HIV AND SEXUAL AND REPRODUCTIVE HEALTH

	Organisation	Responsibilities/activities	Names and contacts
Government agencies	Ministry of Health – Ministry of AIDS, TB and Malaria	Coordinating the multisectoral aspects relating to the fight against HIV/AIDS.	Dr. Ben Eliphaz Karenzi _ Secretary General, sgsante@rwanda1.com
	National HIV/AIDS Control Commission (CNLS) (NACC in French)	Sets the broad national strategic and multisectoral guidelines and coordinates the operations of provincial and district committees, monitors the epidemic. Global Fund and PEPFAR works through CNLS.	Dr. Agnes Binangwaho – Executive Secretary, abinangwaho@yahoo.com
	Treatment and Research Centre (TRAC)	Provides guidance on technical aspects of HIV including coordination, training, accreditation and supervision of accredited sites, leads on operational research.	Dr. Anita Assimwe – Director General, anitaa@tracrwanda.org
	CAMERWA	Autonomous body responsible for drug procurement and supply chain management for the public sector.	Ernest Gasana – Director, camerwa@terracom.com

Bilateral Donors and Foundations	USAID	Support for ARV, PMTCT at public health centres, training healthcare personnel in clinical management of HIV, expanding VCT, strengthening laboratory equipment to monitor people on ARVs.	John L. Dunlop – Health Officer, jdunlop@usaid.gov
	Luxembourg	Support for managing opportunistic infections and strengthening laboratory facilities.	Dr. Anne Pascal Henry, int107@rwanda1.com
	Belgium	Support for development of the health system.	Dr. Walli Van Doren – Technical Assistant, wallivandoren@rwanda1.com
	William J. Clinton Foundation	Drug procurement.	
	DFID	Capacity-building of civil society, condom promotion.	
	Italy	VCT, PMTCT, STD surveillance – two provinces (via WHO).	
Multilateral agencies	UNICEF	Supports PMTCT programmes at public health centres, awareness raising among youth and psychosocial support to PLHA.	Dr. Jane Muita – Project Officer, jmuita@unicef.org
	WHO	Normative guidance on the national response, including support for training of health workers, decentralising the provision of HIV/AIDS services and strengthening the health system.	Dr. Nsue Milang – Resident Representative, who@rwanda1.com

	UNAIDS	Technical support to CNLS, including civil society coordination bodies, M&E, Global Fund and MAP applications.	Dr. Dirk Van Hove – Country Coordinator, dirk.vanhove@undp.org
	UNDP	Strengthening national coordination (CNLS) and support structures to NGOs in six provinces.	Alain Noudehou – resident representative, alain.noudehou@undp.org
	World Bank - MAP	Central institutional support, care and treatment in three provinces via district hospitals.	
	UNFPA	Increase access to SRH services, improving the population database and its capacity for planning, increasing community participation, contraceptive commodity logistics in three provinces.	
NGOs	Médecins sans Frontières (MSF)	ART programme, expansion of VCT.	
	FHI	Supporting the expansion of services in PMTCT.	
	ANSP+	National Support Association for People Living with HIV/AIDS – coordinate the participation of people living with HIV/AIDS.	Vincent Bayingana, vinbay2002@yahoo.fr
	Rwandan Network of People Living with HIV/AIDS	Coordinate the participation of people living with HIV/AIDS.	
	Association des veuves du génocide	Activities to provide HBC and support at a pilot site.	

	PSI	Condom social marketing.	Julia Sobrevilla – Resident Representative, jsobrev@rwanda1.com
	Association rwandaise pour le bien-être familial (ARBEF)	IPPF affiliate – family planning services, youth centres, VCT, integration of FP and HIV services, maternal health.	Executive Director: Dr. Laurien Nyabienda Boulevard de Nyabugogo Tel.: +250 517138 / 572828 Fax: +250 572 828 Email: arbef@rwanda1.com
	IMPACT	Training and supervision of STDs in 5 provinces and Kigali plus VCT, OI, PMTCT.	
	Catholic Relief Services	Capacity-building to organisations supporting OVC and nutritional support.	
	Africare	Youth centre, VCT, awareness-raising, HBC in two provinces.	
	JSI	Contraceptive logistics training, including condoms.	
Research	IATEC	Project Ubuzima, IPM clinical trials for microbicides Phase I and II.	
	IAVI	Project Francisco – clinical trials on HIV vaccine.	

Source: GFATM, 2003; GFATM, 2005; WHO, 2005; UNAIDS, 2004.