

Rebuilding Hope

Polyclinic of Hope Care and Treatment Project: A Holistic Approach for HIV-Positive Women Survivors of the Rwandan Genocide¹



Participants of the Polyclinic of Hope Care and Treatment Project.

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In 1994, Rwanda experienced a genocide that left 1 million dead and 3 million as refugees. Further, militia youth and military men used mass rape and sexual and gender-based violence (GBV) as weapons of war, leaving tens of thousands of women infected with HIV. When the genocide ended, many of these women were left with nothing—their husbands and children had been killed, their homes taken or burned, their communities torn apart, and their health compromised. Access to medical care and counseling was nearly non-existent immediately after the war and some women—with families, homes, and perhaps jobs just months before—slept on the street, while others found abandoned housing. These women were left to pick up the pieces, care for surviving children, and cope with the psychological trauma of loss and violence entirely on their own. Their bodies had been violated, and feeling alone in the world, they later said, had destroyed their spirits.

In 1994, soon after the genocide ended, the Rwanda Women Network (RWN; then Church World Service [CWS]) launched a gender-based violence awareness campaign, encouraging women survivors active in CWS to share their stories. Seven women survivors in Kigali came together to share their experiences of violence and loss and provide each other support. As time progressed, the number of women exchanging their experiences increased, and a space had to be rented and staffed with volunteer nurses. This space became the Polyclinic of Hope (PoH), a center established to provide women survivors with

¹An AIDSTAR-One compendium and additional case studies of programs in sub-Saharan Africa that integrate multiple PEPFAR gender strategies into their work can be found at www.aidstar-one.com/focus_areas/gender/resources/compendium_africa?tab=findings.

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PEPFAR GENDER STRATEGIES ADDRESSED BY THE POLYCLINIC OF HOPE CARE AND TREATMENT PROJECT:

- Reducing violence and coercion
- Increasing women and girls' legal protection
- Increasing women and girls' access to income and productive resources, including education.

much-needed medical care and trauma counseling. Within the first year, however, women said that they could not remain healthy even with these services because the lack of shelter and food left them ill or unable to take antiretroviral therapy (ART). They could not afford to purchase food and had no land to grow food. Being homeless also affected their morale and made it difficult for them to move on emotionally from the trauma of the genocide. These women have found it difficult to get treatment and care because of the stigma attached to both HIV and GBV, particularly in government hospitals (Amnesty International 2004).

In 1997, newly established from CWS, RWN took over PoH with the aim of addressing women's needs holistically. In addition to providing basic medical care, ART, and HIV and trauma counseling, RWN rehabilitated 150 homes from 1997 to 2000 and, in 2000, built the Village of Hope, which provided shelter for 20 women genocide survivors and their families. Today, Village of Hope includes a community center where 150 residents and 4,000 individuals in the broader community learn vocational skills and participate in other health, educational, and socioeconomic activities.² In 2005, RWN began the Care and Treatment Project (CTP), which provides a package of health and socioeconomic services for HIV-positive women survivors of the genocide and their families. RWN also added projects to raise awareness of women's human and legal rights, to provide outreach services to people living with HIV and orphans and vulnerable children, and to build community networks as a means to share lessons and best practices with other service providers.

This case study focuses on the PoH CTP located in Kigali. AIDSTAR-One staff conducted in-depth interviews with key informants at the National AIDS Control Council, the U.K. Department for International Development office in Rwanda, and the Ministry of Gender and Women in Development. They also conducted group and individual interviews with project staff and held focus group discussions with five groups of women—caregivers of orphans and vulnerable children, income generation activity participants, the “pioneers” (the initial group of PoH participants), user group members (project participants that have been selected to collect feedback from peers), and Village of Hope residents—and one group of men participating in the project.

²Village of Hope received the UN Development Programme and Joint UN Programme on HIV/AIDS 2006 Red Ribbon Award and the 2007 UN-Habitat Dubai International Award as a best practice for improving the lives of children, widows, and families affected by the genocide.

Gender and HIV in Rwanda

Seventeen years after the 1994 genocide, Rwanda is rebuilding its infrastructure, addressing poverty, and increasing access to health and education. Women, men, and children are still coping with the effects of the genocide, including HIV. In Rwanda, the HIV prevalence is 3 percent among adults, according to the last Demographic and Health Survey in 2005, yet HIV prevalence is significantly higher among women than men, at 3.6 percent versus 2.3 percent, respectively (Institut National de la Statistique du Rwanda and ORC Macro 2006). This difference in HIV prevalence between men and women is due, in part, to the mass rape of women during the genocide. Rwandan women are also limited by gender norms and power dynamics between the sexes in negotiating safe sex both inside and outside of marriage. GBV is relatively common, with 31 percent of women reporting having experienced an act of physical violence since the age of 15, most often at the hands of a husband or partner (UN Development Fund for Women 2008). Furthermore, rape was the most frequent crime reported in the first three months of 2007 (UN General Assembly Special Session 2008).

The Rwandan government has responded to the HIV epidemic by launching a coordinated campaign for prevention, care, and treatment, with strong political leadership starting with the president. Among its successes, the government estimates that 70 percent of people in need of ART are currently on treatment. The government has also ensured that the National Strategic Plan on HIV and AIDS, 2009–2012, is aligned with Rwanda’s Economic Development and Poverty Reduction Strategy 2008–2012, in which HIV is a cross-cutting issue across all 12 sectors, and Rwanda’s Vision 2020, which described the country’s long-term development goals. In January 2009, the government established the Gender Monitoring Office, which ensures that gender is mainstreamed at all levels and that gender disaggregated data is collected.

Rwanda’s response to the HIV epidemic uses the “Three Ones” approach, with one national coordinating body (The National AIDS Control Commission [CNLS]), one national strategic plan of action, and one national monitoring and evaluation framework. CNLS, established in 2000 under the Ministry of Health, administers the strategic plan at the national level, alongside the Treatment and Research AIDS Center, which leads HIV treatment and research.

District AIDS Control Committees in each of the country’s 30 districts implement the National Strategic Plan on HIV and AIDS, 2009–2012. Civil society is organized under a number of umbrella organizations that coordinate the government and civil society responses to HIV (CNLS 2009). To ensure coordination of services between government and civil society, each District AIDS Control Committee is composed of representatives from district-level public health offices and civil society. Each district is required to offer a comprehensive package of services that include voluntary HIV testing and counseling, prevention of mother-to-child transmission, prevention and treatment of opportunistic infections, and nutrition supplements for pregnant mothers and poor individuals on their first six months of ART. Each district must also work with at least one nongovernmental organization (NGO) or civil society organization partner (Joint UN Programme on HIV/AIDS 2008). An online HIV database maps service providers and their progress at the district level (Joint UN Programme on HIV/AIDS 2008).

CNLS works with the Ministry of Gender and Women in Development, which coordinates the government’s gender activities. The National Women’s Council, established in 2003 under the Ministry of Gender and Women in Development, seeks to mobilize and build the capacity of women in communities to address their needs and meet Rwanda’s development goals, and works to link gender efforts in communities with national priorities.

In response to women's loss of property during the genocide, in 1999 women were given the right to inherit property from their parents and spouses, and male and female children were given equal inheritance rights. Women's right to own property was further strengthened in the constitution and in the 2005 Land Law. However, women's ability to benefit from these laws is constrained by their lack of knowledge of their rights, their need for legal support to claim their rights in court, and the general precedence of customary law that denies women rights that may be stipulated in formal law. Further, the laws only apply to women with legal marriage contracts and cannot be applied retroactively, which leaves out many women genocide survivors.

Rwanda has ratified numerous declarations, charters, and conventions opposing GBV. In September 2008, Rwanda passed a bill making all forms of GBV illegal, including marital rape, with penalties for each crime. While awareness of the law is high and the police and the judicial system are enforcing it effectively, violence rates within marriage continue to be high. The police department has established a gender desk in every police station to assist violence victims with police services, improve their access to medical and legal services, and raise awareness among local authorities on GBV and human rights.

The government is now addressing the specific needs of women genocide survivors by ensuring they receive health services, including ART, at government hospitals, and through the Victims of the Genocide Fund, which provides them medical insurance, financial assistance to send orphans to school, and shelter and rental assistance. Finally, the government reinstated the Gacaca Court, a community-level traditional justice system that aims to promote reconciliation and addresses crimes such as murder, bodily injury, and property damage, while those accused of planning or leading the genocide, torture, rape, or other sexual crimes are tried in the national criminal courts.

The Polyclinic of Hope Care and Treatment Project's Approach

PoH CTP uses a holistic, comprehensive approach to address the various needs of women GBV survivors. The project recognizes that women's experiences as a result of the genocide include violence, trauma, poverty, ill health, and poor nutrition. It also recognizes that a range of health and socioeconomic factors serve as barriers to HIV prevention, care, and treatment. Therefore, the project provides a package of services to meet the multiple and interlinked needs of women and their families. It has also been designed to identify needs on an ongoing basis through formal participant feedback and informal feedback from



Polyclinic of Hope pharmacist preparing drug therapy.

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project staff as they implement support groups, workshops, and other services. As new needs are identified, the project adapts its activities to include new components.

CTP uses a family-centered approach, recognizing that the health and well-being of family members strongly influence that of women. The project therefore provides health and social services to women's husbands and children. This approach is in accordance with Rwandan policy that recommends a family-centered approach to HIV care.

Development and Implementation

With funding from the U.K. Department for International Development and the UN Voluntary Fund for Victims of Torture, and in partnership with the Imbutu Foundation and the Survivors Fund,³ CTP is implemented in four areas where high rates of mass rape occurred during the genocide: the PoH in Kigali, the Village of Hope in Gasabo District, and centers in Bugesera District in Eastern Province and Huye District in Southern Province. CTP has other implementing partners including the Association des Veuves du Génocide (Agahozo) and Solace Ministries. This case study focuses on the PoH CTP.

CTP was developed with three goals for HIV-positive women genocide survivors and their families: 1) to provide quality HIV care and treatment, 2) to strengthen community-based care and develop income generation activities, and 3) to ensure access to government services and participation in community programs. These goals simultaneously address women's immediate needs—for example, through clinic-based health services and home-based care—and their long-term needs—by

transferring skills and responsibility to community-based caregivers and government facilities to provide health services, and to women and their families to earn income. In this way, CTP aims to transform HIV-positive women genocide survivors into change agents who can help other women, participate in income generation activities, lead support groups, and take on other empowering roles. The project's broader aim is to reduce overall HIV prevalence, mortality rates, and opportunistic infection rates among women genocide survivors and their families (Elliott and Mbithi 2008).

The PoH CTP employs a doctor, three nurses/ pharmacists, a counselor, a social worker, and an income generation officer. Each participant is assessed on intake and is directed to relevant staff to help address her specific needs. When new needs are identified or emergency needs arise post-intake, PoH CTP's holistic approach allows for staff to nimbly address these needs, whether it involves arranging for ambulatory transport of participants to urgent care clinics or providing a hardship allowance to those participants who have been turned away from their homes. If staff members are unable to address these needs, staff will then refer participants to other service providers.

PoH CTP's health services include voluntary HIV testing and counseling, trauma counseling, ART services, basic medical care, medical referral services, and outreach via mobile visits. Individual and group counseling sessions for women living with HIV cover topics such as prevention of mother-to-child transmission, prevention for positives, treatment options, and drug adherence. Trauma counseling sessions cover issues such as anger and fear management, fear of dying, and positive living. PoH CTP provides food supplements to very poor participants in their first six months of ART. The project monitors participants on ART to ensure they are accessing services and adhering to medications. It strengthens community-based care by providing health and counseling outreach via mobile units, as

³Formerly in partnership with the Prevention and Care for Families against AIDS, an initiative of Rwanda's First Lady and the Survivor's Fund.

PROJECT INNOVATIONS

- Flexibility to add on project components in response to participants' needs
- Project components targeted to meet women's most urgent and basic needs
- Strong recognition of connections among violence, HIV infection, poverty, nutrition and basic health, and legal and human rights
- Capitalizes on peer support as crucial for post-conflict and violence recovery
- Strong link between clinic-based services and social services
- Family-centered approach to HIV care provides treatment and support to sexual partners and children
- Victims advocating for change.

well as helping caregivers monitor patients and responding to alerts on ill patients.

In response to an external review that found that it needed to strengthen its community-based services and income-generating activities, in June 2008, PoH CTP increased efforts to provide income generation support to CTP participants (Elliott and Mbithi 2008). Women are encouraged to form groups of seven to nine individuals, develop proposals for an income-generation activity, and secure commitment from local authorities before submitting the proposal to RWN. RWN provides groups with business training and monitors each group's business. The PoH CTP income generation officer facilitates vocational skills training and provides start-up funds. Income generation activities include cosmetic stalls, clothing and shoe shops, tailoring, animal husbandry, and selling of food items.

Where they are not able to provide services, PoH CTP refers participants to government services and community programs to ensure it is meeting its long-term objective of transferring services to sustainable government-employed service providers. These include government health facilities for basic medical care, paralegals and the Gacaca for legal and genocide-related justice issues, and police for incidents of violence. PoH CTP works with other PoH projects to ensure comprehensive and/or complementary services. For example, PoH participants that are not survivors of the 1994 genocide but are living with or affected by HIV are supported by the Community HIV/AIDS Mobilization Project, another project that builds capacity of civil society groups to support, treat, and care for those living with and affected by HIV.

In addition to CTP, PoH engages in a variety of other activities, including those concerning legal rights specific to property and inheritance, and advocacy and networking. For example, CTP caregivers participate, alongside community members and government administrators, in trainings in inheritance and property rights offered by RWN and nine local partners. RWN developed a paralegal program to provide legal assistance for women, to provide additional training to paralegals to represent clients and mediate in the Gacaca process, and to train community members on women's legal rights pertaining to inheritance, property, constitutional rights, and violence. RWN is also affiliated with local, regional, and international partners to build its own and its partners' institutional capacity by sharing lessons learned and best practices in community mobilization, home-based care, and property and inheritance rights,



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Income generation activity participants at a shared cosmetics stall.

and currently works with more than 40 partner groups including community-based organizations, associations, and cooperatives.

What Worked Well

The PoH CTP project has had a significant impact on women's health. Monitoring data show that beneficiaries' health has improved and that those receiving ART have increased CD4 counts. In interviews for this case study, women in "user groups" that the PoH established to provide project feedback said that opportunistic infections have decreased since PoH began.

According to the clinic's income generation officer and PoH CTP participants, individuals who participate in the income generation activities are healthier than those who do not because these participants now can afford food, medicine, and

shelter. Although the income generation component of PoH CTP had only been in operation for eight months at the time of interview, 21 groups of approximately eight women each had formed and were active in small-scale farming, animal husbandry, and trade. The income generation officer noted that participants have already benefited significantly from the project by taking care of urgent needs. Participants as well as the PoH CTP counselor noted that through income generation activities, peers (fellow participants) have been able to pay rent and/or school fees, refurbish houses and purchase food, clothes, and mobile phones. With financial security, women also are experiencing an attitudinal/psychological change, according to the income generation officer, and are reconnecting with the community and feel they are regaining control over their lives. "They see that their future is bright," she explained.

Project participants said that although other programs provide assistance to women genocide survivors and people living with HIV, PoH is the only one to provide comprehensive services that address the range of needs of HIV-positive women genocide survivors. PoH CTP participants said that the project coordinates with the Victims of the Genocide Fund in identifying genocide survivors and linking them with assistance, and with various NGO and government service providers, to ensure individuals receive comprehensive services that are not duplicated elsewhere.

Another strength of PoH CTP is that it builds sustainability into project activities using multiple avenues. The income generation activities, for example, decrease participants' dependency on PoH and other service providers. As one income generation activity participant said, "I can go to the garden and now grow something for the home. Before I had nothing to do with my land. I had no hope."

Participants also shared their knowledge with others in the community, increasing project reach. For

EVALUATION

A program review of the PoH CTP conducted in 2009 found that more participants are accessing ART than ever and that the CTP has strengthened its offering of care and treatment services to survivors and their families (Bellis, Gahongayire, and Ntuzinda 2009). Clinic participants also reported that the center makes an effort to provide them with services that are not stigmatizing (and did not draw attention to the patient's status as a genocide survivor), and offers a wider range of services than those offered in government clinics.

example, women said they are educating their children about HIV prevention, caregiving, and positive living. PoH caregivers said they try to encourage family members to care for sick kin. They also are educating community members about HIV and addressing HIV-related stigma and discrimination.

According to focus group participants, PoH CTP is utilizing a participatory approach through community user groups that monitor the quality of the clinic's services. These user groups consist of *ijisho mboni*, or "watching eyes," peers who are nominated by fellow participants because of their ability to keep secrets and represent their concerns. By advocating on the community's behalf, the user groups ensure women receive all the services they need.

PoH CTP trains women on their legal rights, including inheritance and property rights. This has a tremendous impact on their sense of empowerment and self-worth. As one woman explained, "...Now I am a leader...I am now an advocate for women. When we have problems, we write [them] down and now know to go to the local authority." Women also have renewed hope of returning to the homes and land they had lost during the war.

Women trained in rights conduct theater performances in remote areas on their experiences during the genocide, how to reconcile with perpetrators, and how to use the Gacaca process. A woman described the value of this training: "PoH is better because they teach us about our rights, about the laws...They've really helped us rebuild ourselves." Another woman added, "Most of us have no education. But we know the laws. We know our rights."

One of the seven women who originally came together for support shortly after the genocide sums up her experience this way: "We didn't know any of the people at PoH. We started with seven women. We met at PoH. We started sharing ideas. But all we could do was cry and then go back home...The initial thing they did for us was they gave us shelter, clothes, blankets, cooking pots. They really recreated us."

Lessons Learned

Women genocide survivors who participate in PoH CTP said that the project is successful in large part because staff treat women, particularly women living with HIV, with compassion. "In other services, there is no heart in the care you receive. Here there is

heart,” explained one participant. Women said that this treatment created a reputation for the clinic that spread by word of mouth and drew other women to it.

PoH CTP provides two key components—counseling and support groups—that are critical for post-conflict settings and recovery from violence, according to project participants. HIV programs in such settings particularly must provide these services because HIV is directly connected to experiences of rape and violence for many of these women. Participants said that the project helped them gain perspective on their own situation as they met others who had similar, or worse, problems. Sharing their experiences, progress, lessons, and successes gives them hope.

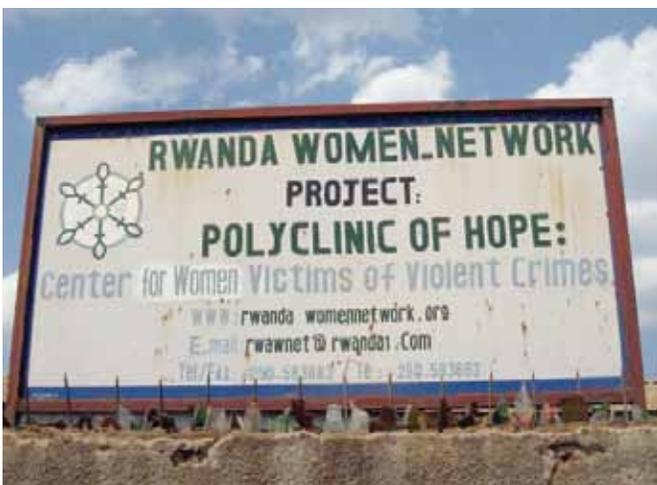
As the project developed, it became clear that food and shelter are still key basic needs that women are struggling to meet. Women interviewed repeatedly said that these two needs were barriers to other services at PoH CTP, as women need adequate nutrition to benefit from ART.

Project staff reported that a holistic approach to addressing HIV takes time. Staff must seek continual feedback from project participants to identify new needs, and these must be integrated into the current package of services in the context of resource and staff limitations. At the same time, the project must

be flexible enough to quickly respond to newly identified needs.

A key lesson of PoH CTP is the value of building successful partnerships with government and other service providers. Prior to the project, women survivors were reluctant to go to government clinics, particularly for HIV services. According to the 2008 review of CTP, “The stigma associated with HIV and their status as survivors seem to [be] the main barriers to service use. It was reported that at government services they may actually meet persons who raped them and that they were not treated with respect” (Elliott and Mbithi 2008). The review notes that in some cases, participants are sending their family members to government facilities but are not accessing them themselves, which poses a problem in providing effective family care.

While many still hesitate to use government services, some women interviewed for this case study noted that they are increasingly feeling welcomed in government hospitals, and they attribute this change to coordination between PoH and the hospital, the reputation of PoH in the community, and PoH’s sensitization work with government staff. They reported that they believe affiliation with PoH increases the likelihood of receiving better treatment because of PoH’s relationship with hospital staff. This bodes well for the project’s sustainability. PoH expects to partner with the Ministry of Health to transform its medical services into a government-standard clinic to ensure continued service availability for women genocide survivors and their participation in outreach programming that builds their capacity. Toward that end, some clinic staff have been mentored by the government health system in order to continue service provision. However, PoH will continue to provide psychosocial care, its core area of expertise, to clinic visitors. Further training of government staff in providing a welcoming environment and addressing HIV-related stigma and discrimination could further increase women’s willingness to use government hospitals.



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Polyclinic of Hope Kigali entrance.

Challenges

Programmatic gaps: Despite its goal to provide comprehensive services, PoH CTP staff and participants identified specific challenges and gaps. Project staff note that the limited space in the clinic is a barrier for providing comprehensive services and responding to newly identified needs. The tight space is also inadequate to accommodate the growing number of participants and compromises patient rights such as confidentiality.

The project requires further support in addressing legal rights, shelter, and income generation activities. For example, project staff reported that lack of access to lawyers forces dependence on paralegals and volunteers for legal aid and education. “It is one of the concerns we have as an institution; and it is a concern of the women [in our project],” reported one staff member. Women also repeatedly cited shelter as an ongoing urgent need. Additionally, according to a review of the overall CTP project (across three clinics), the income generation component of the project is not yet fully developed and as a result, many participants are still dependent on the project for food assistance than had been planned (Elliott and Mbithi 2008). A particular challenge is the absence of technical skills for income generation, including project selection, design, and development of business plans (Elliott and Mbithi 2008).

PoH CTP staff reported gaps in reaching both the broader community and select target groups. For example, the project targets activities to HIV-positive women genocide survivors primarily and does not work to sensitize the broader community on HIV, including HIV-related stigma and discrimination. This affects uptake of services after participants leave the clinic, as they may be discouraged upon hearing messages stigmatizing HIV in the community. Additionally, older women who have lost children and have no one to care

for them are particularly vulnerable to illness and hunger and require additional assistance, and a new generation of orphaned young girls are at risk of willingly or unwillingly engaging in unsafe sex.

Need to target men: While other government and NGO clinics addressing HIV work with couples, PoH only targets women. As a result, PoH is not known as a place where men can seek services, though some men attend HIV prevention support groups and community activities to raise awareness such as PoH theater performances. “Men don’t participate because organizations target women. Women then sensitize men [about participating] but men won’t come because they feel like these are women’s services,” explained one male participant at the Village of Hope.

Men interviewed for this case study said that the main issues they face are HIV, unemployment, and trauma from the genocide. Men have access to health services including ART, HIV counseling, and trauma counseling at government and NGO clinics, yet tend to avoid health clinics; engaging them in health programs and positive health behavior is still a challenge. The caregivers interviewed for this study reported that few men are caregivers themselves, as they feel that caregiving is a woman’s task. One woman reported, “We entered deep into the villages, as volunteers, as caregivers, to help women and children. Even the men, we tried to approach them. But they weren’t easy to approach. They complicated the problem—they have a culture of dominating women.” Further, many men refuse to use condoms and some believe women bring HIV into the family, according to some PoH caregivers. Currently, PoH CTP does not have strategies for involving men and its activities do not address harmful male norms or behaviors. However, male involvement could help alleviate women’s caregiving burden, help women better negotiate safer sex at home, and support women in reducing levels of physical violence and GBV.

Future Programming

According to recommendations in a 2008 program review, PoH CTP needs to re-examine its exit strategies, including training clinic staff to transfer PoH clinic-based services to the government. The review also recommends more attention to income generation, including involving the families of women genocide survivors in income generation to ensure sustained change in women's lives (Elliott and Mbithi 2008).

The funding for PoH CTP ended in March 2010, after which the Ministry of Health began overseeing the medical portion of activities to ensure participants' continued access to ART and other health services. RWN is currently seeking funding to continue the psychosocial care components of the project, including HIV counseling, trauma counseling, food supplementation, home-based care, and the income generation program.

Project staff also reported that an extended PoH CTP would seek to engage men, recognizing that their experiences in the genocide have left them with many of the challenges experienced by women and that women will benefit if men are supported.

Lastly, RWN has initiated CTP project activities, under the auspices of PoH replication, in other conflict-affected countries, including Burundi, the Democratic Republic of Congo, Eritrea, Ethiopia, and Sudan by training local NGOs in the application of the PoH model. ■

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RESOURCES

Integrating Multiple PEPFAR Gender Strategies to Improve HIV Interventions: Recommendations from Five Case Studies of Programs in Africa: www.aidstar-one.com/gender_africa_case_studies_recommendations

Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa. Polyclinic of Hope Care and Treatment Project (p. 108): www.aidstar-one.com/sites/default/files/Gender_compendium_Final.pdf

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