

Empowered Women Build Healthy Nations



Findings from the CARE Learning Tour to Rwanda
and the Democratic Republic of the Congo

August 22-25, 2011



A woman walks to her farm in Butaro Village, Rwanda

Introduction

On this unique two-country Learning Tour, a high-level delegation, including Congressman Jim McDermott from Washington State who helped lead the trip, traveled to Rwanda and the eastern Democratic Republic of Congo (DRC) to learn about the reach and scope of U.S. investments in overseas development programs, particularly those focused on positive health outcomes for women, young girls and their families. The delegation witnessed firsthand critical issues related to overcoming global poverty including health, education, governance and gender-based violence across two very different – yet connected – country contexts.

During the trip, delegates examined the advancements of Post-Genocide Rwanda including impressive gains in maternal and child health mortality rates as well as the role that political will and good governance systems play in enabling a society to deliver lifesaving health care services to its population. In eastern DRC, delegates gained insight on the response to conflict, women’s rights and deep poverty. In both countries, participants gained an awareness of the challenges at the household, community and government levels, and were introduced to promising practices and cost-effective solutions that are saving lives, particularly through innovative programs focused on women’s empowerment.

The Learning Tour further showcased the strong partner Rwanda and the DRC have in the United States to achieve Millennium Development Goal 5: reducing maternal deaths by three-quarters and providing universal access to reproductive health by 2015. Major U.S. development initiatives – Feed the Future and the Global Health Initiative – are also being implemented in Rwanda, and the DRC is part of the Feed the Future Initiative for the East Africa region.

Participants

- **Congressman Jim McDermott** (D -WA)
- **Congressman Donald Payne** (D-NJ)
- **Congressman Steve Cohen** (D-TN)
- **Carla Koppell**
Senior Coordinator for Gender Equality & Women’s Empowerment, USAID
- **Mike Gerson**
Columnist, Washington Post
- **Toby Whitney**
Legislative Director, Congressman McDermott
- **Randy Wade**
District Director, Congressman Cohen
- **William Payne**
Deputy Chief of Staff, Essex County, New Jersey
- **Hannah Kaye**
Program Officer, The Bill & Melinda Gates Foundation
- **JoDee Winterhof**
Senior Advocacy Advisor, CARE



The delegation in Rwanda (from left to right): William Payne, Hannah Kaye, JoDee Winterhof, Congressman McDermott, Congressman Payne, Congressman Cohen, Carla Koppell, Michael Gerson, Randy Wade and Toby Whitney.

Rwanda Overview

Rwanda is a landlocked country comparable in size to the U.S. state of Maryland with nine million people. It is bordered by Uganda, Burundi, the Democratic Republic of the Congo (DRC) and Tanzania. It has a fertile and hilly terrain which gives it the title “land of a thousand hills.” Rwanda has the highest population density in continental Africa. It is also one of the least urbanized countries on the continent. While the capital Kigali has been growing at a rapid rate, 92 percent of Rwanda’s population still lives in rural areas where growth is much slower.

Rwanda has achieved tremendous progress since the devastating genocide of 1994. The Government of Rwanda developed a “Vision 2020” strategy, establishing a set of development goals aimed at transforming the country from a poor, post-conflict nation to a middle income, regional trade and investment hub in which people are healthier, educated and more prosperous. Cross-cutting areas of Vision 2020 include gender equality, environmental protection, sustainable national resource management and science, information and communications technology.

Moving forward, the country is well-positioned to become a success story of how well-planned and innovative programs can make a difference in the health of a nation and the overall positive development of a country. The sense of order in Rwanda and advancements of infrastructure and health systems are indicators of the resilience, hope and pride of the Rwandan people as well as strong political will from the country’s leadership.

Despite impressive gains, Rwanda is still among the world’s least developed countries, ranking 152 out of 182 in the United Nations Development Programs current Human Development Index. Although it is the first country in the world where women outnumber men in Parliament (occupying 45 out of 80 seats) and girls’ attendance at primary and secondary school exceeds that of boys, women are more likely to be extremely poor than men. According to recent statistics, 77 percent of Rwandese live on less than \$1.25 a day, and those living in rural areas are exceptionally poor – partly because up to 90 percent of Rwanda’s population still relies on small-scale agriculture to sustain their livelihoods. Malnutrition remains a serious problem among children.

Currently the Government of Rwanda, in partnership with the United States and other international donors, is implementing equitable, efficient and pro-poor service delivery while promoting local development and good governance.



Health

Maternal and newborn health (along with health care workforce development) are key priorities reflected across all governmental policies, strategies and initiatives. According to the World Health Organization (WHO), Rwanda has made significant improvements in increasing access to family planning and decreasing the rate of maternal mortality. This progress has been possible, in part by the Rwandan Government, for increasing the number of hospitals and placing skilled health care personnel in remote areas to address maternal, newborn and reproductive health specifically. Progress has also been made to reduce the prevalence of HIV/AIDS in Rwanda.



Known as "Umuganda," every last Saturday of the month all Rwandans take part in community service activities to improve the country.

However, despite these advances in maternal and reproductive health, every year between 30,000 and 90,000 Rwandan women die or sustain injuries from complications related to pregnancy or childbirth, including obstetric fistula, according to the organization Engenderhealth. Additional statistics show that Rwanda has one of the world's worst child mortality rates – at least one in ten Rwandan children die before their fifth birthday and 42 percent of Rwandan children under five years old are malnourished. About 810,000 Rwandan children have been orphaned, in part due to the 1994 Genocide, with more than 100,000 children living in child-headed households.

According to the WHO, approximately 90 percent of Rwandans are at risk of contracting malaria and high rates of malnutrition continue to adversely affect women and children.

With a national health insurance plan that covers 92 percent of the nation, community health insurance programs known as "mutuelles" reach the poorest rural communities. Rwanda is on track to enabling sustainable growth and equitable health care. As established by the Government, Rwandans pay approximately \$3 a year for health insurance and 10 percent of their treatment costs. Recent reports show that enrollment has risen from 44 percent in 2006 to 90 percent today. As a result, maternal and newborn mortality rates have decreased over the past five years while skilled birth attendance coverage has steadily increased. Considering the mechanisms established to align, harmonize and report on achievements and gaps, Rwanda seems on track to achieve its Millennium Development Goal (MDG) targets. Improvements in maternal and newborn health are linked to the importance given to women and children and of strong leadership and community involvement.

Democratic Republic of the Congo

The DRC is the third largest country in Africa, twice the size of the U.S. state of Texas, with a population estimated at 70 million. The country has enormous potential, but years of poor governance, conflict and instability have caused it to sink close to the bottom of the United Nation's Human Development Index. Considered to be the richest country in the region for natural resources, DRC's population is among the poorest. For decades it was known for its rich geology, which includes large reserves of cobalt, copper and diamonds. The conflict that began in the DRC in 1996 has thus far cost the lives of over five million people and resulted in limited infrastructure, health service delivery and a challenging path toward sustainable development.



Under the right conditions, DRC can turn the corner towards peace and stability. It has enormous mineral wealth, unrivalled hydro power potential, rich agricultural land and is well-placed in the heart of Africa to develop trade links and attract local and foreign investment. DRC is significantly more stable than it was a decade ago, and its economy is growing. However, armed conflict and banditry, particularly in the east, provide major challenges forcing people to flee their homes. The United Nations estimates two million internally displaced camps have been constructed across the country.

Health

The DRC is off track to meet virtually all of its MDG targets. According to recent statistics, three out of five Congolese live on less than \$1.25 a day. More than a third of children are out of school and a similar proportion is malnourished. Despite a push to improve maternal and child mortality, 100 Congolese women still die every day from complications related to pregnancy and childbirth. It remains one of the worst countries to be pregnant. In addition, levels of gender-based violence are among the highest in the world, beset recently by the deadliest conflict since the end of World War II.

Despite the challenges, support from foreign governments, United Nations agencies and humanitarian aid groups has improved access to basic services and infrastructure, provided lifesaving humanitarian assistance and improved the lives and livelihoods of millions of Congolese people. But much remains to be done. For example, there is a plan to open more midwifery schools and strengthen the health care workforce as a measure to improve maternal and newborn health, but governance issues, such as lack of government funding for training health care professionals, continue to work against such efforts.

Sound economic management and better governance, combined with further investments in infrastructure and basic services, could lead to stability and prosperity in the DRC. This could, over time, yield enormous benefits for millions of poor people in the DRC itself, to its neighbors and to the broader world. Addressing political instability and governance, in particular, should be made a priority to help the DRC turn in that direction.



Though rich in resources, DRC is still in great need of economic and social reconstruction, and champions for the rights of women.

Day 1: Monday, August 22 – Rwanda

Remembering the past; building a future

During a **morning roundtable discussion** in downtown Kigali, introduced by CARE Rwanda Country Director, Navaraj Gyanwali, and Reproductive Health Coordinator, Jaime Stewart, and joined by Anne Casper, the U.S. Embassy's Chargé d 'Affaires, delegates were briefed by key health and gender experts, including: the Honorable Dr. Agnes Binagwaho, Rwanda's Minister of Health; Antoinette Habinshuti, Deputy Country Director for Partners in Health; Dr. Apolline Uwayitu, Management Sciences for Health; Deguene Fall of UNICEF; and Diana Ofwona, UNIFEM Regional Director. The speakers called attention to government ownership for managing the health system, which doesn't allow for the duplication of efforts. Deguene Fall of UNICEF noted how, "There is a clear division of labor among partner organizations based on mandate and areas of comparative advantage."



Minister of Health Agnes Binagwaho (left and U.S. Charge d'Affaires, Anne Casper) address the Learning Tour delegation.

According to Minister Agnes Binagwaho, the Rwandan government is in the "driver's seat" and has demonstrated success out of the trust of its people: "The money you [the U.S. government] invested in Rwanda was wise. It has helped people to have better lives but we still have a long way to go." She added that Rwanda is on track to integrate all health sector programs, affirming that, "We are ready to cover all the country [with health care services]."

Diane Ofwona of the United Nations Agency focused on gender equity, UNIFEM, added that this is "a country with clarity in direction" that has "a policy framework articulated in partnership. Rwanda has one of the most engendered constitutions in Africa and is a model in the region for ending violence against women."

It appears that Rwanda is on the right path. However, it continues to be dependent on steady donor support from the international community; otherwise, the country may suffer significant setbacks.



Photos paint the walls of the Genocide Memorial in Kigali, Rwanda.

The first visit on the Learning Tour was to **Rwanda's Genocide Memorial** to pay respects and remember Rwanda's difficult past during the 1994 Genocide. The delegation was reminded that today, Rwanda prides itself with a new, hopeful mantra, "*One People, One Destiny.*"

The Memorial is an emotional and educational tribute to the nearly one million lives lost in the 100-day genocide. Reading firsthand accounts of the survivors, seeing pictures and video of countless victims, examining blood-stained clothing, weapons and other exhibits and walking by on-site mass burials of nearly 250,000 people, make this a unique memorial.

Each delegate placed a floral wreath on one tomb and a moment of silence was observed to reflect on the need to prevent crimes against humanity worldwide.

After the Genocide Memorial, the Learning Tour headed to **Kamonyi Village to visit an Early Childhood Development (ECD) program**, where villagers raised their thumbs and shouted *Komera Komera*, a local greeting meaning "*Be Strong Be Healthy.*"

Approximately half the children in Rwanda under age five suffer from chronic malnutrition, which results in stunted growth. Most children have traditionally been taught to work in the fields or at home rather than be encouraged to play and attend school. According to CARE's community coordinator, Joseph Ngamije, the agency has organized 84 home-based education and nutrition care groups in four of the ten districts in Musambira, with support from a U.S.-based company called Covance, where the delegation visited. Mothers rotate in pairs to look after infant children, teach proper hygiene such as hand washing and prepare and feed them porridge made from maize, soya, sorghum and sugar. When the children reach three to six years old, they move to one of five ECD centers where they learn to draw, count and play – preparing the basic building blocks for primary school. Parent-teacher associations are formed as part of this project. Parents also receive training on child rights and learn about the benefits of family planning and adequate reproductive health. This program is



A moment of silence at the Genocide Memorial to reflect on the importance of upholding human rights.



Rep. Payne (left) and his brother, William Payne, in Kamonyi Village.

currently still in the pilot phase and plans to scale-up in additional districts in the next two years across rural Rwanda.

The delegation visited the home of Leoncie Dushabeyeru, a 36-year-old mother of two in Kamonyi village. The eight mothers in this home-based care group call themselves *Utunyange* (Angel). Child care is provided on weekdays between 7 a.m. and noon. Porridge is served promptly at 10 a.m. and is preceded by hand washing. CARE pays the annual health \$3 insurance fee for group members identified as “the most vulnerable.”

The ECD project has also helped socialize children with one another, engage fathers in child rearing and build mutual trust among parents. Sylvie Nyiransabimana is the group treasurer whose one-year-old daughter attends home-based care.

Twice a month she contributes 300 Rwandan francs (\$.50) for porridge. Sylvie says that, “I used to carry my baby on my back while I worked in the field. It was extremely hard. Today I don’t get tired and am more productive.” The *Utunyange* home-based care group plans to start a farming cooperative, selling produce at the local market on Fridays.



Sylvie Nyiransabimana’s children are healthy and she’s more productive because of the ECD program. She and her husband use family planning services to space out pregnancies.



Inside the Nyarubaka ECD Center. An example grassroots effort by CARE and a community to reduce malnutrition, improve education and build trust among parents.

Moving to the ECD center on the top of a hill beside a primary school, the delegation heard from Vestina Niyigena, a 23-year-old teacher who has been there for two years after being elected by the local parent association. Vestina described their daily schedule, which is posted at the entry of the classroom, and how children are learning social skills. The ECD center has a playground with a swing set and slide, which locals had never seen or used before. Vestina says that balanced meals are provided at the center and parents also help to identify malnourished children in the community and refer them to community health workers. They also conduct school clean up and beautification activities. “Parents are working together to improve the health and education of their children,” says Vestina. “Before, women weren’t allowed to leave their homes without their husband’s permission.” Seventy-nine percent of former ECD center children now attend primary school. Most are girls.

Back in Kigali, **the delegation met with Prime Minister, Bernard Makuza**, to discuss Africa-related issues and governance in Rwanda. According to Prime Minister Makuza, “It is impossible to understand this country without knowing its past. To improve life you must first respect life. This was not the case before 1994.” He added that, “Stable governance has been a good draw for investment. In this country you will get far more than elsewhere. The groundwork is laid.”

The night ended with a special **United States Agency for International Development (USAID) briefing** with the delegates on the U.S. strategy and partnerships in Rwanda, specifically focused on health, education, governance and media. In addition, the U.S. Embassy hosted a **dinner reception at the residence of Anne Casper, U.S. Chargé d’Affaires in Rwanda**, attended by governors, ministers and representatives of Rwanda along with key technical partners from USAID, U.S. Centers for Disease Control, CARE and other NGOs.



The delegation with Rwandan Prime Minister, Bernard Makuza (from left to right): Michael Gerson, Toby Whitney, JoDee Winterhof, Congressman Cohen, Congressman McDermott, Congressman Payne, Charge d’Affaires of the U.S. Embassy in Rwanda, Anne Casper, Rwandan Minister of Health, Agnes Bingawaho, Randy Wade and Hannah Kaye.

Day 2: Tuesday, August 23 – DRC

Yearning for peace, opportunity and an end to gender-based violence

An early departure from Kigali, Rwanda brought the delegation three hours west, through road construction, to the border with Goma in Eastern DRC. The delegation crossed the border into the DRC, as did close to a one million Rwandans who fled after the 1994 Genocide. The border is porous and wrought with a history of trade of consumable goods, human labor and precious minerals. Goma has been at the epicenter of ongoing local conflicts in the region and also serves as a gateway for refugees. In 2002, local residents were trapped by the fast-flowing lava from a volcanic eruption. Approximately 30 percent of Goma was destroyed. The landscape today is covered by lava rocks. More disturbingly, the region is reported to have some of the brutal accounts of gender-based violence, and access to education and basic health care services are extremely limited. Although a peace accord was signed in 2003 to end the civil war, local and frequent violent clashes erupt among various militias groups who are fighting to control access to mines. The most vulnerable members of society – specifically women and young girls – continue to bear the brunt of violence. Despite this reality, there is evidence of promising interventions that specifically support the needs of women and young girls.

Joined by U.S. Ambassador to the DRC, James Entwistle, the delegation visited a group of women who live in the outskirts of Goma. Funded by USAID, Women for Women International is working to stop rape and violence and promote opportunities for women who have been excluded from society. The one-year program includes rights awareness classes, job-skills training and emotional support. According to Huguetti Mbombo

Kabamba, Women for Women International's sub-office manager in North Kivu, "A woman who goes through the program is not the same when she started."

About 400 women between the ages of 18-45 are currently enrolled in classes. Half are rape survivors. The women meet in groups of 25 twice a month for two-hour sessions. They purposefully take it slow to safeguard comfort levels. A men's leadership program was also started as a means to foster support and encourage women's participation.



Inside the Women for Women International Education Center.



Congressman McDermott and Carla Koppell listen to Marie's story.

Sitting in a dimly lit room, women raised their hands when asked to write numbers on the blackboard, demonstrating how they've learned to count. They've learned how to do calculations, which helps them with buying and selling goods, but they still don't know how to read and write. The estimated cost for literacy training is \$27 per woman. One participant, Marie (named changed for protection reasons), volunteered to tell us her story. Marie is a rape survivor whose baby died during the delivery. The rape also left her infected with HIV and shunned from her community. "Joining the program has changed my life and helped me regain my dignity," she says.

Life in several parts of Eastern DRC often means fleeing from place to place, trying to stay one-step ahead of violent militia groups, who often use sexual violence as a weapon. While accurate statistics are challenging to corroborate in the DRC, a recent study in The American Journal of Public Health (June 2011) estimates that nearly two million women have been raped in the DRC, with women victimized at a rate of nearly one every minute.

The delegation traveled next to the United Nations Refugee Agency, and Norwegian Refugee Council-managed **Mugunga III camp for internally displaced people**. The 2,239 people living on this black lava-rock hilltop yearn for peace and stability and to return home. Unfortunately, these refugees are not able to return home. According to Ousseni Compaore, a UNHCR camp coordinator there are gaps in health, education and water and sanitation, "The situation is really worrying. People are without a home. Funding is down. The needs remain great."

In late 2010 there was a marked increase in the number of rapes when women and young girls ventured outside the camp to collect firewood for cooking. Over a three month period, 50 attacks were reported. One mother, Diane (name changed for protection reasons), has lived in Mugunga III camp for over two years. She's from a small village in Rutshuru territory, a three-hour drive



Ambassador James Entwistle and the delegation are briefed at the Mugunga III IDP camp.



A young woman carries briquettes to her family in the Mugunga III IDP camp.

away. Her family fled after shooting started and young girls were dragged into the bushes to be raped. “We can’t return home,” says Diane bluntly, struggling to contain her emotions. “The men who attacked our village are now living in our homes and farming our sugar cane.”

Diane and other camp women now use a wooden hand press to make donut-shaped fuel briquettes out of sawdust, paper and mud so that they no longer have to forage for firewood. About 24 briquettes are used to cook a pot of beans. The women sell briquettes in packs of 450 for \$8. Since they started cooking with briquettes there has only been one reported rape case

among women and girls in the camp. Moving forward, the women in Mugunga III need support for socio-economic and income-generation projects, but more importantly, they want the international community to know they have suffered enough.

The country’s governance problems and increasing violence in the East are closely linked. Local residents claim that as the DRC national elections approach in November 2011 it will be critical that the Congolese people themselves hold their leaders accountable at the ballot box and that proper election monitoring takes place.

Day 3: Wednesday, August 24 – DRC

It takes a village, and good governance

Lake Kivu is one of the great lakes in East Africa around which widespread armed conflict has occurred since the mid-1990s. On this day, the delegation drove through a dusty, bumpy road – passing men on bicycles who were hauling charcoal to the market – to meet with members of **Bweremana Village**, supported by Heal Africa. The village cooperative president, Victorine Kikiri, beats her drum with a stick, leading a group of 85 women and scores of children through a maze of thatched-roof homes to greet the delegation. The women have banded together to improve their reproductive health and promote family planning services in their village. They call their solidarity group *Meme Mere* (We’re all Mothers).



Two women from the motherhood solidarity cooperative in Bweremana Village.

According to Florentin Lonena, a Heal Africa community supervisor, women pay \$10 for a normal hospital delivery and over \$60 if they require a cesarean section. A prenatal consultation costs a dollar. The cooperative enabled life-saving services for the women of Bweremana. On a hillside plot overlooking their village the *Meme Mere* women farm cabbage, eggplant, carrots, cassava and sweet potatoes. A portion of their profits from selling produce (for example, a head of cabbage sells for 20 cents locally and 50 cents in

Goma) goes into a social fund that group members can access in times of emergency. The payback amount is usually 30 percent of the total borrowed.

Kanyare Sabasaba, 34, is a mother of 10 children, eight of whom are alive today. The last delivery nearly cost Kanyare her life. Hemorrhaging at an ill-equipped health post, Victorine stopped a passing truck and paid the driver to take Kanyare six miles to the district hospital. Successfully treated, she also had a tubal ligation because of her high risk. Victorine, 50, considers the women in her group as “daughters.” She stayed with Kanyare. Other group members walked to the hospital to visit. Out of the 85 women in the *Meme Mere* solidarity group, 20 have used the social fund to cover hospital fees.



The safe motherhood solidarity cooperative in Bweremana Village pools funds to pay hospital delivery fees.



Mothers helping mothers: Kanyare Sabasaba says she owes her life to Victorine Kikiri for getting her to the hospital.

Access to and demand for reproductive health services is high. According to country statistics, nearly half of Congolese women have a child by age 19 – and the average mother bears six children. Women become pregnant too soon and continue having children for too long; they deliver prematurely or beyond gestational age; and they have too many children spaced too close together which doesn’t give their bodies time to recover from their previous pregnancy – increasing the risk for maternal and newborn deaths. Kanyare didn’t know about birth spacing and contraception use before. “If I knew about family planning then I would have used it,” she says. Heal Africa trains women’s group leaders like Victorine to promote family planning in their

villages as well as educate and garner the support from influential local religious leaders.

On the road back to Goma, the delegation visits the **Kirotshe District Hospital**, where local residents are treated in emergencies. This government-supported hospital has only four doctors for 350,000 people. Dr. Martin Mwamba, gave the delegates a tour of the facility and explained that “villages are poor and this hospital is poor but we do our best. To treat people properly requires more means. It requires collaboration with U.S. hospitals, exchange visits with doctors and building the capacity of community health workers.”

Consequently, as the delegation departed, a group of men approached the hospital carrying an improvised wicker hammock stretcher with bamboo hand rails, on which an exhausted 27-year-old mother of four in labor was being carried in. According to the husband, “the baby won’t come out.” The case was too complex for staff at their local health post so they were referred to the hospital. After a five-hour trek over a mountain from a village with



Dr. Martin and Congressman McDermott walk through the maternity ward at the Kirotshe District Hospital.

no road, they finally arrived. Dr. Martin was called into action, serving as a reminder that DRC lack of health facilities and trained health workers are major barriers to saving lives of women and their children.



Mike Gerson, Ambassador James Entwistle and Sara Rasmussen-Tall of USAID discuss U.S. assistance efforts in the DRC.

In Goma later that day, **U.S. Ambassador James Entwistle** and local USAID staff held a lunch briefing on

U.S. strategy in the DRC. According to Ambassador Entwistle: “We want to make sure that what happened here in the late 1990s and early 2000s will never happen again. The United States is committed and confident that problems can be solved and that we can help make a difference.” He added that, “The transition from emergency to development assistance doesn’t work without community participation. It’s about building local capacities.”



A woman in labor arrives to the Kirotshe Hospital on a hammock stretcher after a five-hour trek from her village.

The delegation next headed to **Heal Africa Hospital** in Goma, which serves a growing number of the urban poor in the city. The delegation was greeted by Dr. Kasereka “Jo” Lusi, Heal Africa co-founder and orthopedic surgeon. Heal Africa is a partner in the five-year *Ushindi* project, along with CARE, Save the Children, the American Bar Association, among others. *Ushindi* is Swahili for “victory” or “to overcome.” The project, funded by USAID and others, brings integrated medical, legal, psychosocial and economic support services to survivors of gender based violence in nine health zones in eastern DRC.



Dr. Jo Lusi highlights the needs of women and girls who come to the Heal Africa Hospital for treatment.



Women at the Heal Africa Hospital in Goma are not only treated for fistulas and counseled for sexual violence but also learn new skills and about their rights.

The Heal Africa hospital employs seven medical specialists and 12 generalists, and holds 155 beds and various wards for women and children. Their team provides free counseling and medical assistance to survivors of sexual violence as well as trains women with income-generating skills, like sewing. The hospital delivers, on average, six babies a day and conducts 280 obstetric fistula repairs a year – a debilitating yet preventable medical condition which results from poor medical care during childbirth. The medical staff also provides services to prevent mother-to-child transmission of HIV and trains nurses and traditional midwives new skills to improve safe childbirth and delivery techniques. The facility also helps survivors of sexual

violence take legal action in courts. According to Dr. Lusi nearly, half the gender based violence cases they treat at the hospital are adolescent girls. Since 2006, there have been 200 perpetrators convicted for gender based violence through the American Bar Association's mobile court.

Dr. Lusi is a champion of maternal and family health. As a former Senator in the transitional government, he authored Article 15 in the 2005 Congolese Constitution, condemning rape and sexual violence against women, punishable by law as a crime against humanity. It was clear from our time in the DRC that, while laws and a national strategy for combating gender based violence are good starting points, more work is needed with civil authorities to ensure the protection of all women as well as community sensitization activities to overcome negative social attitudes toward women.

The night ended with the U.S. Embassy hosting an informal dinner reception, attended by representatives of DRC local government along with key technical partners from USAID, UNICEF, CARE and other NGO organizations. The reception was launched with a special performance by Vodacom Superstar winner, DRC's own American idol, Innocent Bulame.

Day 4: Thursday, August 25 – Rwanda

Community health workers save lives

The final project site on the Learning Tour was the **Partners in Health (PIH) program in Butaro Village** near the border with Uganda in Rwanda as the delegation departed from the DRC. Lush terraced hillsides, sustenance farming and a panoramic view of Lake Burera dominate the one-hour drive from the nearest paved road. Sitting outside a health center and separate family planning post, the delegation learned about the role community health workers play in reducing maternal and newborn deaths through home visits and referrals. One such health worker, Marie Nahimbazwe sits next to Immaciela Nyirambarushimana, a 35-year-old mother of six, nursing the twins she delivered on June 24.



Community health worker Marie Nahimbazwe conducts home visits to monitor the health of expectant mothers and children under age 5.



Carla Koppell with Immaciela and one of her twins delivered at Butaro Hospital.

Women like Marie use the rapid SMS on her government-provided cell phone to communicate with the health center when an emergency referral is needed for a woman experiencing a pregnancy or childbirth-related complication. In the past year, Marie used her cell phone to hail emergency transport, helping save the lives of two mothers with unexpected complications. When asked if there's anything she needs to do her job better, Marie says "a pair of boots" to wear during her home visits when it rains and gets muddy. There are two community health workers for every 100 homes in this area.

During one home visit, Marie introduced Immaciela who was just two months into her pregnancy. At first Marie didn't realize Immaciela was having twins. The "baby" was positioned horizontal instead of vertical. She feared Immaciela would miscarry so she brought her to the health center and closely monitored her progress until she delivered by caesarean section at the nearby hospital. Immaciela says she had waited five years before getting pregnant, receiving quarterly Depo-Provera injections free of charge at the family planning post. There are 7,080 women of reproductive age in Butaro sector and 2,250 of them use some form of modern contraception.

According to Immaciela, "The health care system worked for me. Now we are working hard to keep this hospital. We suffered for a long time and now don't want to waste this gift."

Walking up the road from the health center the delegates had a first look at the newly constructed **Butaro Hospital**. In a joint venture with the William J. Clinton Foundation and Rwanda's Ministry of Health, the Boston-based Partners in Health (founded by Dr. Paul Farmer) built the first hospital in this remote district. Using traditional building techniques, materials and employing a locally trained labor force of 3,500 people, it opened its doors on January 24, 2011 after two years of construction. The district hospital serves over 400,000 people and rests on the same breezy mountaintop once occupied by a military camp. The Army was relocated to make way for what many consider Rwanda's top priority: health care.



The delegation visits the Butaro District Hospital.



Butaro Hospital sends a message that high quality medical care can and must be delivered to the rural poor in Africa.

Didi Bertrand Farmer and Partners in Health Country Director, Dr. Peter Drobac, provided background on the hospital's innovative structure. It was conceived by a team of architects from Harvard University's Graduate School of Design to specifically halt the spread of airborne infectious diseases, such as tuberculosis. It is also the base from which the district's health system has been rebuilt. Inside the hospital there are open verandas running the lengths of the four buildings with large fans that constantly circulate fresh air through vents just below the high ceilings. Color-coded interior walls show illiterate visitors where to go. Dr. Drobac says that, "A 5.8 million dollar state-of-the-art investment has become a catalyst for change in this district."

Networking to 15 health centers and village health workers, the hospital will serve as a medical teaching facility. In addition, the government built a hydro-electric dam in tandem with hospital construction, providing a source of power and clean water, over time, to a region where it didn't exist before. New homes have sprung up on hillsides throughout the valley as families gravitate to the hospital – a sign of growing community development.

According to PIH, today 90 percent of women in the district deliver either at this hospital or in the smaller health centers, rather than risk a home delivery. As more health workers are trained and community awareness increases, Dr. Drobac hopes to soon reach 100 percent coverage. Meanwhile, community health workers note that family planning is progressively being integrated into the culture, contributing to poverty alleviation and reduction in maternal and newborn deaths. The Butaro hospital is proof positive of what is possible in solidarity-based partnerships between a government, organizations and donors.

Later in the day in Kigali, the delegation was greeted by a special group of Rwandan Women Parliamentarians and members of White Ribbon Alliance Rwanda before departing for the U.S. The delegates heard directly from the Parliamentarians concerning their views on the state of gender equality in the country and how programs are implemented - reaffirming the positive work we've seen in a country that has, through good governance and partnership, progressively transitioned from emergency to development.

Conclusion

Any successful society is gauged by the status of its women, their ability to access health care and the success of their children growing up properly nourished and educated. Ensuring the security and welfare of women and children is one of the most basic commitments we can make to humanity. It's also one of the biggest problems yet to be fulfilled in many poor countries. This is a pressing need we can all make a priority.

Over four days, the Learning Tour delegation visited two countries with very different contexts but which have a shared history and geographic proximity. In villages and hospitals the delegation met extraordinary women, men and children in communities across Rwanda and the DRC.

In Rwanda, strong political will, good governance and zero tolerance for corruption has helped enable a society in which poor people, particularly women and children, can lead healthy, productive lives. In contrast in the DRC, constant insecurity and disregard for human rights undermines development in dramatic ways.

Over the long term, accountable leadership for health and social reform in Rwanda should continue to be fully supported. It is a country ready to scale up proven, cost-effective programs. In the DRC, the international community has a role to promote security, representative government and continue efforts in support of the plight of women to overcome gender biases that underpin gender based violence.



Women observe the maternal health discussions in Bweremana Village.

Policy Recommendations

Support U.S. Investments: As part of a strong International Affairs Budget, U.S. investments in Maternal and Child Health (MCH) help fund programs that deliver life-saving services to mothers and children. That's why it is vital, even during trying financial times when difficult decisions must be made about allocation of funds, to support an International Affairs budget that is as robust as possible. Within the International Affairs Budget, specific support for the MCH account is critical. This account funds high-impact, low-cost interventions that directly impact the world's most vulnerable, and help to create healthier families and stronger communities.

Arm health workers: There is a dire need to train more community health workers, and subsequently, increase incentives to pay and retain them. The focus should be on quality over quantity. Although Rwanda, for example, is priming to scale up their health system, little difference will be made if there is not enough trained and adequately paid health care providers to meet the demand.

Advance the status of women: Although health system reform in developing countries is critical, we must address some of the underlying issues that keep women trapped in the cycle of poverty and poor health, including gender inequities. For example, empowering women as change agents, and engaging men and boys and power brokers, can lead to improvements in the health and equity of women, and increase their participation in their communities.

Promote good governance: In order to support healthy societies, we must promote accountability and governance activities in both countries, and ensure participation from both men and women.



The CARE Learning Tours program introduces policymakers and other influential individuals to the importance of U.S. investments, particularly as it relates to family health outcomes for women and girls. The goal is to utilize these individuals in ongoing advocacy efforts and help inform recommendations for a long-term U.S. strategic approach toward these issues.

We are deeply grateful to the many individuals who generously gave of their time to make this visit to Rwanda and DRC a success. CARE specifically thanks the Bill and Melinda Gates Foundation for its generous financial support to the Learning Tours.

If you are interested in CARE's Learning Tours program, please contact:

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