

Overview

The HIV epidemic in Rwanda is generalised, with a prevalence of 3% in the adult population and substantial HIV burdens in key populations such as Female sex workers (FSW) and Men having sex with men. For FSW, the prevalence was estimated at 45.8% in 2015, a slight decrease compared to 51% in 2010. The first behavior and Biological Surveillance survey among Men having sex with Men (MSM) conducted in 2015 has shown a prevalence of 4%.

The 3% HIV prevalence in the adult aged 15-49 years remained stable in all the three Demography Health Surveys (DHS) consecutively (2005, 2010 and 2014/15). The later DHS showed that HIV prevalence is higher among women (3.6 %) than men (2.3%) and it revealed for the first time the HIV prevalence among children aged 0-14 years is 0.2%. HIV prevalence increases with age and is highest among women age 40-44 (8%) and men age 45-49 (9%). HIV prevalence is higher in the City of Kigali (6%) and is relatively uniform throughout the other provinces (2-3%). The recent epidemiological analyses conducted among FSWs showed the City of Kigali has the highest HIV prevalence of 55.5% and the lowest in Eastern province (34%). HIV Prevalence among youth 15-24 remains low but it shows an increase from 2010 to 2015 in the age group of 20-24. The prevalence among women 20-24 has increased from 1.8% to 2.4% and among men 20-24 from 0.5% to 1%.

The 2013-14 Rwanda AIDS Indicator and HIV Incidence Survey showed that HIV incidence in Rwanda is 0.27 per cent in general, and is higher in urban areas than rural areas. The majority of new infections occur in stable heterosexual couples (65%), followed by key populations such as female sex workers (FSW), their clients and their partners, those having casual heterosexual sex and men who have sex with men. HIV services have reached the level of near universal access:

➤ HIV testing Services (HTS) is available in 99% of health facilities. Interventions for HIV testing services will be more targeted to ensure that HIV positive people are reached. HIV testing will be also used as strategy for HIV prevention especially by helping those who are still HIV negative to sustain their HIV negative status. This is the case of adolescents and young adults who represent a big proportion of Rwanda population but with limited access to HIV testing services.

A combination strategies will be used to optimize access to HIV testing services including facility based testing, targeted community outreach to key populations in hot spots and home based testing through HIV self testing.

➤ Prevention of mother to child transmission (PMTCT) in 96% and ART services in 96% of them. Ninety-six Percent (96%) of health facilities provide a complete package of HIV services: HCT, PMTCT, ART. Roughly 98% of the health facilities in the country are offering HIV care and treatment services. More than eighty two Percent (82.6%) of people living with HIV receive ARV by December 2016.

Morbidity and mortality among people living with HIV have reduced in recent years due to the coverage of ARV, early initiation and improvements in diagnosis and treatment of opportunistic infections. Mortality has decreased by 82% in last two decades. PMTCT has almost reached

universal coverage and the number of new HIV infections occurring in the age group 0-14 years' account for less than 500/year. There is no disaggregated data on Mortality among Key populations.

COMMITMENT 1. Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

The 90-90-90 HIV global target identifies the following goals to be met by 2020: 90 percent of all HIV infected people are diagnosed, 90 percent of all diagnosed people are initiated on ARVs, and 90 percent of those on ARVs have fully suppressed viral load.

The Rwandan Ministry of Health (MoH) revised its national guidelines and introduced its “Treat All” strategy that is in line with the 2015 WHO consolidated guidelines recommending treating all HIV positive individuals as soon as possible. This strategy was launched in Rwanda on 1st July 2016. Since then, all HIV positive people are initiated on ART as soon as they test positive, beginning with those who were in pre-ART at the time.

The actual coverage is 82 percent and is used as the baseline value to measure progress during the next period 2018-2020. Therefore, major efforts are required to successfully implement the “Treat All” strategy, including increasing capacity to deal with larger patient loads, identifying new patients, and maintaining and further improving quality of services. Currently, the majority of people under treatment were detected only after symptoms had appeared (based on clinical and/or immunological eligibility criteria up to 2015). Therefore, one of the main challenges to implementing “Treat All” will be attracting people who are infected but still healthy to get tested and receive regular treatment. This challenge will be addressed through better targeting of HCT to high risk groups and people who have not yet been tested, and by improving counseling of HIV-positive people to ensure their enrollment and retention in the ART program.

COMMITMENT 2. Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

The country is aiming to continue the downtrend line of mother to child HIV transmission rate below 2 percent. This rate is in line with global EMTCT goal to eliminate new pediatric HIV infections and improve maternal, newborn, and child health and survival in the context of HIV.

The PMTCT program was initiated in the country and then was progressively scaled up to achieve 97.7 percent geographic coverage. As the PMTCT program achieved positive and significant outcomes related to service availability, the EMTCT strategy emphasizes re-orientation and re-organization of existing program activities. This strategy aims to continue scale-up of PMTCT service, upgrade quality, and improve access to, and utilization of, maternal, newborn and child health services at both the national and district levels. The scale-up will mainly focus on integrating PMTCT services in new public and private health facilities. In the last 3 years, the HIV Mother to Child Transmission has been stable to 1.8% .

COMMITMENT 3. Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

Rwanda is committed to ensure that clinical preventive services and condoms are available, accessible and affordable. These services have to be provided at the highest quality possible without discrimination, especially to key populations.

Specific attention will be paid to addressing barriers that key populations encounter when accessing preventive health services. Health care providers will be trained on friendly services provision to key populations, in particular FSW and MSM. These friendly services will include HTS at health facility level and in the community through outreach, family planning and reproductive healthcare, STI screening, and treatment.

COMMITMENT 4. Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

Following the findings of the 2013 gender assessment of Rwanda's national HIV response, the promotion of gender equity remains a priority orientation of the HIV response.

Despite many efforts undertaken to strengthen gender equality, girls and women are especially vulnerable to HIV due to multiple factors including, but not limited to: strict gender norms that promote unequal power relations, traditional attitudes towards sex and sexuality that limit access to information and services, limited educational attainment, economic vulnerability and dependence on men, and limited decision-making power in relationships.

Providing access to legal services for SGBV victims and integrating SGBV messages into existing communication channels are important. Effort will be put into reinforcing linkages and referral systems between the community, police authorities, and health services for comprehensive care of survivors. One-stop centers will be strengthened and SGBV services will be integrated into existing health services at each health facility. Special legal, psychological, and care packages will be provided to the most vulnerable groups, such as children, young girls, and others facing SGBV at community levels.

COMMITMENT 5. Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

Global initiatives such as “Adolescent ALL IN” that focuses on adolescent and young adult interventions for HIV prevention, care and treatment, and sexual reproductive health are being initiated in Rwanda. “Adolescent ALL IN” is a platform aiming to drive better results for adolescents (aged 10-19 years) and young adults (aged 20-24 years) through critical changes in programs and policy. It seeks to engage adolescents and unite actors across sectors to accelerate reduction in new HIV infections as well as improving the sexual and reproductive health of adolescents.

In order to enhance primary prevention, youth sensitization will be reinforced and provided through peers. Anti-AIDS clubs, peer educator systems, youth corners and youth friendly centres (YFCs) will be working through a more effective and monitorable system. This system will target adolescents and young adults both in and out of schools. Pre-nuptial testing and counselling will be reinforced and will cover all components of primary prevention beyond its current limitation to HTS in several facilities. Vulnerable young girls and young FSW will be specifically targeted. Furthermore, emphasis will be put on young boys who represent around 36 percent of female sex workers’ clients as per 2015 behaviour and biological surveillance survey of FSW.

Moreover the prevention of unintended pregnancies among women living with HIV and AIDS will continuously be supported to reduce unmet need for family planning. The availability of condoms for dual protection will be ensured and will always be coupled with counselling for consistent and correct utilization.

COMMITMENT 6. Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020

Despite the existence of a conducive legal environment for the HIV response, gaps still exist, most notably in terms of funding available, access to services and social protection for vulnerable groups.

There are two main channels through which support has been provided to PLHIV to improve their economic status: (1) strengthening cooperatives for better access to credit and implementing income-generating activities and (2) agricultural technical support to improve food security of households infected and affected by HIV.

The National Children Council is the national institution in charge of coordinating Most Vulnerable Children interventions and it has established a minimum package of services for MVC including the following elements: health services, nutrition support, education support, shelter support, and social protection by community volunteers, psychosocial support by peer educators, and socio-economic support. Among those services, educational support is the component with the largest budget. This budget includes providing scholastic material in line with the government policy of twelve years of basic education to all and school fees for children in vocational schools.

The provision of these services is implemented by a large number of civil society organizations (national and international) and will be guided by national guidelines for the MVC selection criteria and by a comprehensive national database to monitor all interventions for MVC support.

COMMITMENT 7. Ensure that at least 30% of all service delivery is community-led by 2020

During the last decades Rwanda has invested in a strong decentralized system and Rwanda has created an enabling environment for Rwandan civil society to function properly. As a matter of fact the decentralized system is providing a legal framework for greater local participation in decision-making and CSOs are fully supported to provide HIV services that complement the clinical service provide in public health facilities.

Among the new community led initiatives planned in the NSP 2018-2020 for HIV it should be outlined the innovative community based approach through peer education that is a necessary condition to implement the Differentiated Service Delivery Model (DSDM) and support the treat all strategy.

Peer education will be established to provide moral and psychological support to patients, promote adherence to treatment, and refer patients to a clinic when needed. Peer education will contribute to reducing time spent at frequent clinical visits. From a health system perspective, reducing clinic contact for clinically stable ART patients and instead focusing resources toward managing sick patients with complex clinical problems is a key objective. This shift has the potential to reduce staff workload and improve quality of care. From a HIV social impact mitigation perspective, the peer education approach will play a key role in improving referrals and linkages between the community and health facilities.

Community support through peer education will contribute to the strengthening of the Rwandan healthcare system by improving efficiency and quality of services, and this strategy is a priority to deliver quality care in the context of high coverage of treatment and DSDM

COMMITMENT 8. Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

Despite the steadily increase of domestic HIV funding, the successful implementation of the HIV AIDS response in Rwanda continues to depend to a large extent on the decreasing support of Rwanda's development partners. The development partners include official donors, local and international NGOs, civil society, and the private sector.

The commitment to a sustainable HIV response is a priority for Rwanda. The Government of Rwanda has committed to continually increasing the health sector budget to ensure better lives for Rwandans and has prioritized access to health care for all to save lives of Rwandans. Tremendous investment has been made in strengthening the health system, including developing a health insurance scheme, investing in human resources, and investing in infrastructure as a strong foundation for all health programs.

Rwanda endorsed the resolutions of an international conference on health financing that was held in Rwanda in 2016 (WHO, 2016). The main strategy adopted from this conference was to mobilize domestic resources through innovative health financing strategies. Rwanda has instigated different community health interventions and prioritized an integrated health services provision as one of the strategies to ensure sustainability of health system.

COMMITMENT 9. Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights

Despite the strong results achieved by Rwanda over the past decades in addressing the HIV epidemic, issues of stigma and discrimination relating to the HIV epidemic are still persistent. Great strides have been taken to ensure geographic and financial accessibility to health and HIV services to all citizens, yet some marginalized groups still experience barriers to accessing appropriate and adapted services.

Regarding the involvement of PLHIV in the planning and management of the HIV program, the Rwandan network of PLHIV (RRP+) plays an important role in advocacy and representation in all the decision-making bodies for the HIV response. RRP+ is also involved in interventions for economic empowerment of PLHIV (through cooperative formation and strengthening) and in addressing stigma and discrimination related to HIV. The RRP+ will continue to play a prominent and active role at the national and decentralized levels in the implementation of this plan.

COMMITMENT 10. Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

As HIV progressively becomes a chronic disease, it needs to be better integrated into the general system of healthcare provision, particularly health programs with strong linkages to HIV interventions, including sexual and reproductive health, nutrition, mental healthcare, screening and management for NCDs. On top of the historical integration of Nutrition, Family planning and Sexual and reproductive Health new innovative approach are being implemented in Rwanda.

Integration of mental health and HIV is an identified strategy to improve quality of care of patients with HIV and mental health problems. Through mental health screening for PLHIV, all patients identified with mental health problems will be treated and supported. Further, HIV prevention measures for people with mental disorders will be established. Provider-initiated testing (PIT) and HIV adapted prevention education will be provided to clients with mental health problems.

As HIV is a chronic disease that has related chronic disease coinfections/comorbidities a multidisciplinary approach is required to establish a people centered systems. A first element of integration is related to the palliative care program that is required for patient support through end of life when needed. Palliative care will be provided to patients at either a health facility or within the community depending on patient status and national recommendations. A second element of integration is the screening for cervical cancer that will become part of the systematic

OI screening for PLHIV. This screening practice will be included in the regular training and refresher courses for healthcare providers.

A key focus of integration of service is related to Hepatitis B and C. According to National Viral Hepatitis guidelines, screening for HBV and Hepatitis C virus (HCV) by testing for HBsAg and HCVAb should be performed at the first antenatal visit or other delivery setting for every pregnancy, regardless of previous Hepatitis B vaccination or previous negative HBsAg tests. Vaccination against Hepatitis B virus will be recommended for pregnant women who screen negative for the virus. Additionally, those women who screen positive will be counselled and referred for care and treatment.