REPUBLIC OF RWANDA

MINISTRY OF HEALTH

RWANDA BIOMEDICAL CENTER

A Healthy People. A Wealthy Nation

RWANDA

GLOBAL AIDS RESPONSE PROGRESS REPORT (GARPR) 2014

Rwanda Biomedical Center - March 2014

RWANDA

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Acknowledgement

Concerted efforts have been made to control the HIV epidemic in Rwanda. Over the course of carrying out interventions; policies, strategies and programmes have been improved. Rwanda continues to join fellow member countries of the United Nations in expressing the will to reverse the HIV epidemic and mitigate its effects. This continues to be done in major ways assessing the progress made towards achieving the Millenium Development Goals (MDGs) to come in just few months by 2015.

Reporting to the state of interventions being made against HIV and AIDS is a huge collective effort. This 2014 GARPR report draws upon the efforts of quarterly and annual reporting for the national HIV/AIDS report.

In the first place, I would like to acknowledge the efforts of dedicated staff in the various Government of Rwanda institutions who compile these indicators reports periodically.
To facilitate the compilation of these reports, a task team led by the Mr **Eric Remera**-HIV Division of Rwanda Bio-Medical centre working with technical staff from Rwanda Biomedical Centre and partners was constituted. We remain entirely grateful to the advice provided by specialists from our Partners, particularly **Mr. Justus Kamwesigye**-UNAIDS Rwanda.
Special thanks to members of the civil society, local and international Non-Governmental, Bilateral organizations as well as Rwandan Government institutions that participated in the completion of this report.
I would like to also acknowledge the staff in health facilities, district health teams who always put in an extra effort to deliver the data on time to facilitate the country to meet its international reporting obligations, while providing services to the population.I also thank all members of technocal working groups that reviewed and validated the content of this report. All participants are listed in the annex.

We believe that this document provides a realistic picture of Rwanda's progress in HIV response as of December 2013. I look forward to the re-shaping and improvements in the delivery of interventions as a result of the findings presented in this report.

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List of Acronyms and Abbreviations

ABASIRWA	Abanyamakuru Barwanya Sida mu Rwanda baharanira n'ubuzima (Rwanda Media network against HIV and AIDS and for health promotion)
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral (drugs)
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
BIAT	Bio Intensive Agriculture Techniques
BSS	Behavioral Surveillance Survey
CD4	Cluster Differentiation 4
CDC	U.S. Centers for Disease Control and Prevention
CDLS	Comité de District de Lutte contre le SIDA
CHW	Community Health Worker
CSE	Comprehensive Sexuality Education
DHS	Demographic and Health Survey
EDPRS 2	Economic Development and Poverty Reduction Strategy 2
EMR	Electronic Medical Recording System
EMTCT	Elimination Mother-to-child Transmission of HIV
FOSA	Formation Sanitaire (Health Facility)
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender-Based Violence
GF	Global Fund
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counseling and Testing
HF	Health Facility
HFU	Health Financing Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP III	Health Sector Strategic Plan III
ICT	Information Communication Technology
IDPD	International Day of Persons with Disabilities
IDU	Injecting Drug Users/Intravenous Drug Users
IEC	Information, Education, Communication
IGA	Income Generating Activities
IHDPC	Institute of HIV Disease Prevention and Control
IPC	Interpersonal Communication
IV	Intravenous
IYCF	Infant and Young Children Feeding
MC	Male Circumcision
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MIFOTRA	Ministère de la Fonction Publique et du Travail (Ministry of Public Service and Labor)
MINECOFIN	Ministry of Economic Planning and Finance

MPPD	Medical Procurement and Production Division
MoH	Ministry of Health
MOT	Mode of Transmission
MSM	Men who have Sex with Men
NCC	National Commission for Children
NGO	Non-Government Organization
NRL	National Reference Laboratory
NSP	National Strategic Plan
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan For AIDS Relief
PICT	Provider-initiated Counseling and Testing
PIT	Provider-initiated Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSF	Private Sector Federation
PWD	People With Disability
QMS	Quality Management System
RBC	Rwanda Biomedical Center
RCA	Rwanda Cooperative Agency
RCLS	Confessions Religieuses pour La Lutte Contre Les SIDA (Rwanda Interfaith Network against HIV and AIDS)
RRP+	Réseau Rwandais des Personnes Vivant avec le VIH (Rwanda Network of PLHIV)
RPPA	Rwanda Public Procurement Authority
SDC	Sero-Discordant Couples
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
TWG	Technical Working Group
TRAC Plus	Centre for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
UPHLS	Umbrella des Personnes Handicapées dans la Lutte contre le SIDA (Umbrella of People with Disabilities in the Fight against HIV and AIDS)
USAID	United States Agency for International Development
USG	United States Government
USPLS	Umbrella of Public Sector against HIV and AIDS
VCT	Voluntary Counseling and Testing
WAD	World AIDS Day
WHO	World Health Organization
YFC	Youth Friendly Center

I. Overview of the AIDS epidemic

Context

Rwanda is a small landlocked country in East Africa; it is bordered in the north by Uganda, south by Burundi, East by Tanzania and in the west by the Democratic Republic of Congo. It has an estimated population of 10.7 in 2011 (NISR, 2012) It has four Provinces – North, South, East, West- and Kigali City and has 30 districts.

At this same time 63.2% of the population is living on less than $1.25a day. According to EICV (integrated household living conditions survey) assessing the level and pattern of poverty in Rwanda, a marked reduction in poverty has been achieved in the last 5 years (11.8 point percent between 2005/06 and 2010/11 (from (56.7% to 44.9% living under the national poverty line). This is a significant reduction over a five year period.)

This increase in economic development has been accompanied by achievements in population health: the life expectancy at birth has increased from 41 in 1998 to 56 in 2012 (according to the Human Development Index 2013) and the total fertility rate has decreased from 6.1 in 2005 to 4.6 in 2010. (DHS, 2010) Among key indicators for child health, infant mortality has decreased from 73 per 1000 in 2005 (RDHS, 2005) to 50 per 1000 in 2010 (RDHS, 2010), and under-five mortality has decreased from 133 per 1000 to 76 per 1000 in the same years. (RDHS, 2005; RDHS, 2010) These are substantial gains in this period of time.

HIV ***prevalence***

HIV prevalence in Rwanda has remained stable since 2005 until 2010 . In the DHS with HIV testing carried out in 2005, the national prevalence was measured to be 3.0% in people between 15 and 49. (DHS, 2005) In the most recent population-based survey, the 2010 DHS, this is still the same prevalence "3%". HIV prevalence is higher among women than among men (3.7% compared to 2.2%). The highest HIV prevalence is among women aged 35-39 (7.9%) and among men aged 40-44 (7.3%). The City of Kigali, Capital of Rwanda has the highest prevalence at 7,3% while all other provinces prevalence is below 3%.

Although the HIV prevalence in the general population remains 3%, Key populations play an important role in the dynamic of HIV in Rwanda; Recent Behavioral Surveillance Survey among Female Sex workers revealed a very high prevalence at 51% nationally. This explains how HIV in Rwanda represents a mixed epidemic

The figures below highlight prevalence at different age ranges

Figure 1 Percentage of Males infected with HIV by age group, Rwanda 2005 and 2010.

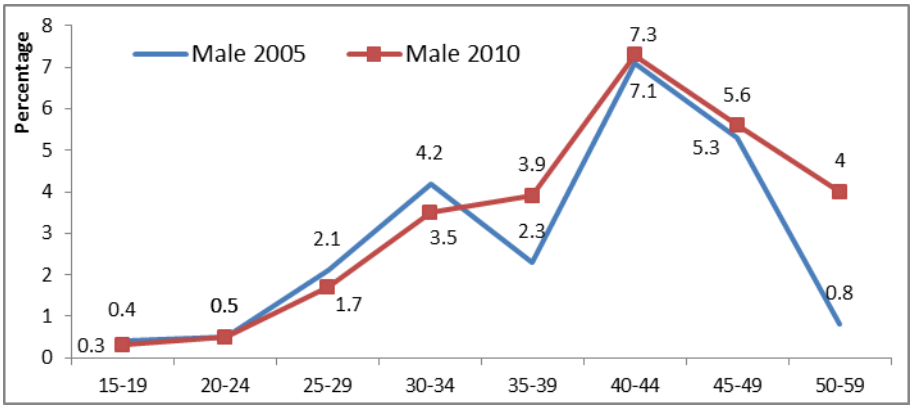
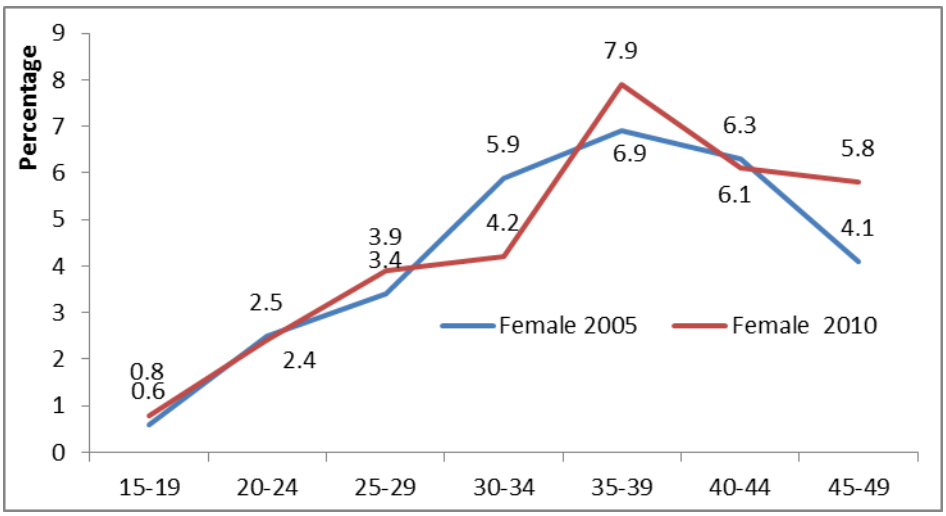


Figure 2 Percentage of Females infected with HIV by age group, Rwanda 2005 and 2010.



II. National Policy and programmatic responses to the HIV and AIDS epidemic.

Vision 2020
The Government of Rwanda's guiding development strategy; it includes six pillars describing strategies for achieving the country's long-term development objectives, among which HIV/AIDS is clearly highlighted.

Economic Development and Poverty Reduction Strategy (EDPRS) 2013-2018
The current medium-term strategy for achieving Rwanda's Vision 2020 goals. The EDPRS provides the framework for multi-sectoral action on HIV and AIDS: the strategic plan for each of seven economic sectors that have a role to play in HIV response. The EDPRS encompasses all actors working in each sector, including private ventures and communities, with each sector under the leadership of a Government Ministry.

Health Sector Strategic Plan III
The Third Rwandan Health Sector Strategic Plan (HSSP III) provides strategic guidance to the health sector for six years, between July 2012 and June 2018. HSSP III is inspired and guided by the VISION 2020, which will make Rwanda a lower-middle-income country by 2020; the Rwandan Health Policy of 2004; and the priorities set out by the Economic Development and Poverty Reduction Strategy (EDPRS 2008–2012). For HIV/AIDS, HSSP III aims to:

- Reduce new HIV infections;
- Reduce morbidity and mortality;
- Ensure equal opportunities for vulnerable groups and people living with HIV;
- Strengthen the quality management of HIV AIDS.

National Strategic Plan on HIV and AIDS (NSP 20013-2018)
The reference document for all sectors, institutions and partners involved in the fight against HIV and AIDS. The NSP sets ambitious goals for its timeframe of execution: Lowering the new infection rate by two thirds from an estimated 6,000 per year currently to 2,000 (5); Halving the number of HIV-related deaths from 5,000 to 2,500 per year (6); and Ensuring that people living with HIV (PLHIV) have the same opportunities as all others. The NSP includes indicators and targets, making it possible to track progress and follow up on commitments made. It will be evaluated both at midterm and at the end of the cycle. These evaluation will be the basis for mid-course corrections and prioritizations to reach the targets within the timeframe.

National Accelerated Plan for Women, Girls, Gender Equality and HIV (2010-2014)
Four-year strategy to accelerate actions to promote gender equality and reduce women's and girls' increased vulnerability to and risk of HIV. The plan aims to ensure that: women's and girls' equal access to HIV services is guaranteed by an evidence-informed HIV response; political commitment is matched by concrete actions and resources for women and girls; and rights of women and girls and their empowerment are protected and promoted in the context of HIV.
The National Strategic Plan for HIV 2013-2018 is closely aligned with the Economic Development and Poverty Reduction Strategy 20013-2018 (EDPRS 2) and Vision 2020. The multi-sectoral EDPRS includes the Health Sector Strategic Plan (HSSP III), on which the NSP for HIV is fully based.

III. Progress on the 2011 Political Declaration on HIV and AIDS

In 2011, Rwanda signed the United Nations General Assembly Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS. The Declaration reaffirmed country commitments to halt and reverse the spread of HIV and AIDS and set ambitious targets to be achieved by 2015. Below is a summary progress on the targets.

i. Reduce by Half, sexual transmission of HIV

Rwanda's current national HIV strategy prioritizes reducing sexual transmission and aims to halve HIV transmission by 50% by 30th June 2013. The country appears to be on track to reach the target by 2015, although no data is currently available to assess progress towards reducing new HIV infections. Since 2005, HIV prevalence in the general population has been stable at 3.0%. The country has adopted strategies to increase the availability and accessibility of condoms, develop minimum prevention packages for all key populations at higher risk of HIV infection, and promote voluntary male circumcision. Challenges to achieving the target include the limited availability of funds and human resources devoted to HIV prevention and the difficulty of promoting long-term behaviour change.

ii. Reduce transmission of HIV among people who inject drugs by 50% by 2015

Injecting drug use is not present or widely practiced in Rwanda and is not a contributing factor in HIV transmission. This target is therefore neither relevant nor a priority for Rwanda.

iii. Eliminate new HIV infections among Children

Rwanda is currently on track to meet the target on eliminating new HIV infections among children and reducing AIDS-related maternal deaths by 2015. The NSP prioritizes prevention of mother-to-child transmission of HIV and in 2012 the country adopted a new national strategy for the elimination of mother-to-child transmission. Rwanda has scaled up the availability of PMTCT services nationwide, strengthened the capacity of health care providers to provide comprehensive services, and is now promoting Option B+(ART for pregnant and breastfeeding mothers . Challenges to reaching the target include low utilization of modern family planning methods among HIV-positive women and the limited geographic coverage of facilities able to provide the full package of comprehensive PMTCT services.

iv. Increase number of People on Treatment

Rwanda is currently on track to provide universal access to lifesaving antiretroviral treatment for those in need by 2015. Rwanda has prioritized the early initiation of ARVs and ART is provided free of charge to those who are eligible. The country has also promoted task shifting of ART services to nurses. In 2013, 91% of adults and children eligible for ARVs received them. Challenges to achieving the target include financial and human resource constraints to funding and implementing new treatment guidelines for early initiation of ART and the limited geographic availability of HIV testing, counseling and treatment services.

v. Halve the number of TB related deaths among People Living with HIV

Rwanda is currently on track to reduce tuberculosis deaths in people living with HIV by 50% by 2015. The NSP 2013-2018 prioritizes the provision of TB screening and treatment for people living with HIV and aims for 80% of HIV-positive patients to be screened for TB in HIV care and treatment settings. The country implements WHO Stop TB standards including intensified TB case finding, infection control measures, and provision of Isoniazid preventive therapy to people living with HIV. Between July 2011 and June 2013, 67% of patients newly enrolled in HIV care and treatment were screened for TB 100% of those diagnosed with TB received anti-TB treatment. Challenges include limited diagnostic capacity, infection control measures, and difficulties in diagnosing extra pulmonary TB in HIV-positive people.

vi. Closing the resource gap

Closing the resource gap and ensuring sustainable financing of the national HIV response is a clear priority for Rwanda, although the country is not currently on track meet the target by 2015. Development aid to Rwanda has declined significantly in recent years, including funds for HIV. Although Rwanda has been successful in achieving the domestic funding targets of the Abuja

Declaration, it cannot meet the growing gap necessary to fund its HIV response. Rwanda is also exploring strategies to minimize costs and increase efficiency gains within the sector and plan a long term strategy to increase domestic funding for HIV program.

vii. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

Rwanda is currently on track to reach the target of eliminating gender inequalities and increasing the capacity of women and girls to protect themselves from HIV. The NSP recognizes the role of gender inequality in the spread of HIV and prioritizes the response to gender-based violence. The country also has a specific strategy on women, girls, gender equality and HIV. The HIV response has promoted women's empowerment and prevention of GBV. National laws and policies protect and promote the equal rights of women and girls and in 2012 the Rwanda adopted a new national policy and strategic plan against GBV. Sociocultural beliefs and practices that continue to promote inequality and tolerate violence are the key challenge to ensuring women and girls can protect themselves from HIV.

viii. Eliminate HIV-related restrictions on entry, stay and residence

Rwanda has achieved the target of eliminating HIV-related restrictions on entry, stay and residence, therefore this target is already met.

ix. Strengthen Integration

Rwanda is on track to meet the target to strengthen HIV service integration, which is a priority of the country's national development and HIV policies. The NSP prioritizes the linkage of HIV services, including integration within the broader health system and linking of different modes of service delivery (i.e. clinical and community-based interventions). HIV is further mainstreamed in all national economic and development strategies and across all sectors. The HIV response has promoted integration of HIV services with those for TB, STIs,viral hepatitis and in broader sexual and reproductive health and family planning service delivery. Challenges to integration include financial and human resources constraints, including continued donor support for vertical and not integrated programmes.

IV. Country Progress Report process and stakeholder participation

The Rwanda Biomedical Center, Institute of HIV/AIDS, Disease Prevention and Control (IHDPC) led the development of this report. The whole process engaged all relevant partners from public and civil society sectors to gather relevant contributions.
The information included is drawn from the following documents validated by the Government of Rwanda: The 4th Demographic and Health Survey, 2010; National Annual Reports on HIV & AIDS, 2011-2012, 2012-2013; Behavioural and Biological Surveillance Survey among female sex workers, 2010; Behavioural Surveillance Survey among youth, 2009, Behavioural and Biological surveillance Survey among Truck Drivers 2010, and Exploring HIV Risk among MSM in Kigali, Rwanda, 2009, and National Strategic Plan for HIV AIDS(20013-2018).

Data for the Country Progress Report indicators were collected in January - February 2014. Indicator 6.1 and the funding matrix were filled using the data from the Health Resource Tracking Tool (HRTT) additional data collection through contact with major donors. The work for indicator 6.1 was led by the Health Financing Unit in the Ministry of Health. The National Commitments and Policy instrument (NCPI) Part A was filled in a meeting held on 18th March 2014 by government institutions working in HIV AIDS. The NPI part B was filled by Civil Society organisations in a stakeholders meeting held on the 5th March 2014.

Throughout the process of developing the report, the One UN HIV theme group has been involved from planning through data collection and validation.
Rwanda's Progress Report for 2014 has been validated by the government of Rwanda, Civil Society representatives and development partners through an inclusive and open stakeholders meeting held on the 26th March 2014. The comments and suggestions raised in this meeting have been incorporated in the final report submitted.

V. Overview of Global AIDS Progress Reporting data

Indicator	Age or other disaggregation criteria	Women	Men	Indicator definition	Sources
Target 1: Halve sexual transmission of HIV by 2015					
1.1 Young people: Knowledge about HIV prevention	*overall*	52.6%	47.4%	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	RDHS 2010 (Tables 13.3.1, 13.3.2; pp180-181)
	15-19	49.3%	43.5%		
	20-24	56.3%	52.4%		
1.2 Sex before the age of 15	*overall*	3.8%	11.3%	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	RDHS 2010 (Table 13.15; p202)
	15-19	4.8%	13.3%		
	20-24	2.8%	8.8%		
1.3 Multiple sexual partnerships	*overall*	0.6%	3.9%	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	RDHS 2010 (Tables 13.8.1, 13.8.2; pp189-190)
	15-19	0.3%	0.4%		
	20-24	0.9%	3.2%		
	25-49	0.6%	5.8%		
1.4 Condom use at last sex among people with multiple sexual partnerships	*overall*	28.9%	27.5%	Percentage of women and men aged 15-49 who had more than one partner in the last 12 months who used a condom during their last sexual	RDHS 2010 (Tables 13.8.1, 13.8.2; pp189-190)

Indicator	Age or other disaggregation criteria	Women	Men	Indicator definition	Sources
				intercourse	
1.5 HIV testing in the general population	*overall*	38.6%	37.7%	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	RDHS 2010 (Tables 13.10.1, 13.10.2; pp194-195)
	15-19	27.3%	23.9%		
	20-24	47.2%	41.7%		
	25-49	39.9%	42.7%		
1.6 HIV prevalence in young people	*overall*	1.6%	0.4%	Percentage of young people aged 15-24 who are living with HIV	RDHS 2010 (Table 14.3, p211)
1.7 Sex workers: prevention programmes	*overall*	-	-	Percentage of sex workers reached with HIV prevention programmes	Data not available
	<25	-	-		
	≥25	-	-		
1.8 Sex workers: condom use	*overall*	83.2%	-	Percentage of sex workers reporting the use of a condom with their most recent client	Behavioural and Biological Surveillance Survey Among Female Sex Workers, Rwanda, 2010 (Table 6, p25)
	<25	85.3%	-		
	≥25	81.3%	-		
1.9 HIV testing in sex workers	*overall*	86.6%	-	Percentage of sex workers who received an HIV test in the past 12 months and know their results	Behavioural and Biological Surveillance Survey Among Female Sex Workers, Rwanda, 2010 (Table 11, p30)
	<25	86.4%	-		
	≥25	86.8%	-		
1.10 HIV prevalence in sex workers	*overall*	50.8%	-	Percentage of sex workers who are living with HIV	Behavioural and Biological Surveillance Survey Among Female Sex Workers, Rwanda, 2010 (Table 12, p31)
	<25	42.1%	-		
	≥25	57.7%	-		
1.11 Men who have sex with	*overall*	-	-	Percentage of men who	Data not available

Indicator	Age or other disaggregation criteria	Women	Men	Indicator definition	Sources
men: prevention programmes	*<25*	-	-	have sex with men reached with HIV prevention programmes	
	≥25	-	-		
1.12 Men who have sex with men: condom use	*overall*	-	52.3%	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Exploring HIV Risk among MSM in Kigali, Rwanda, 2009 (pp25-26)
	<25	-	-		
	≥25	-	-		
1.13 HIV testing in men who have sex with men	*overall*	-	42.4%	Percentage of men who have sex with me who received an HIV test in the past 12 months and know their results	Exploring HIV Risk among MSM in Kigali, Rwanda, 2009 (p29)
	<25	-	-		
	≥25	-	-		
1.14 HIV prevalence in men who have sex with men	*all*	-	-	Percentage of men who have sex with men who are living with HIV	Data not available
	<25	-	-		
	≥25	-	-		
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015					
2.1 People who inject drugs: prevention programmes	-	-	-	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	Data not available
2.2 People who inject drugs: condom use	-	-	-	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	Data not available

Indicator	Age or other disaggregation criteria	Women	Men	Indicator definition	Sources
2.3 People who inject drugs: safe injecting practices	-	-	-	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	Data not available
2.4 HIV testing in people who inject drugs	-	-	-	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	Data not available
2.5 HIV prevalence in people who inject drugs	-	-	-	Percentage of people who inject drugs who are living with HIV	Data not available
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths					
3.1 Prevention of mother-to-child transmission	*Any type*	92%	-	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	National Annual Report on HIV & AIDS, 2011 (pp44-45)
3.2 Early infant diagnosis	-	94%		Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Universal Access reporting, 2011
3.3 Mother-to-child transmission of HIV (modelled)	*1.8%*	na	na	Estimated percentage of child HIV infections from HIV-positive women	Nationals Strategic Plan for HIV 2013-2018

Indicator	Age or other disaggregation criteria	Women	Men	Indicator definition	Sources
				delivering in the last 12 months	
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015					
4.1 HIV treatment: antiretroviral therapy	*all*	92%		Percentage of eligible adults and children currently receiving antiretroviral therapy.	HIV & AIDS in Rwanda Epidemiologic Update, 2013; TRACnet system
	<15	60%			
	>15	95%			
4.2 Twelve-month retention on antiretroviral therapy	*all*	91.7%		Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Nationals Strategic Plan for HIV 2013-2018
	<15	na			
	>15	na			
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015					
5.1 Co-management of tuberculosis and HIV treatment	-	92.8%		Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Nationals Strategic Plan for HIV 2013-2018
Target 6: Reach a significant level of annual global expenditure (between $22 billion and $24 billion) in low- and middle-income countries					
6.1 AIDS spending	-	See funding matrix		Domestic and international AIDS spending by categories and financing sources	National Health Resources Tracking tool. Ministry of Health, 2013
Target 7: Critical enablers and synergies with development sectors					
7.1 Government HIV and AIDS policies	-	See NCPI reporting		National Commitments and Policy Instrument	NCPI

Indicator	Age or other disaggregation criteria	Women	Men	Indicator definition	Sources
				(NCPI)	
7.2 Prevalence of recent intimate partner violence	-	44.3%	-	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.	RDHS 2010 (Tables 17.7, 17.10; pp 246, 250)
10.1 Orphans' school attendance	*orphans*	83.8%	91.2%	Current school attendance among orphans and non-orphans (10-14 years old, primary school age, secondary school age)	RDHS 2010 (Table 2.13; pp27-28)
	non-orphans	96.0%	96.2%		
7.4 External economic support to the poorest households	-	-		Proportion of the poorest households who received external economic support in the last 3 months	Data not available

VI. HIV Interventions and achievements

a) Prevention

Community *sensitization for promotion of safe sexual behaviours, including HIV testing and promotion of condom use is the main stay of HIV prevention strategy.*

Extension and Improvement of HCT Services

The overall HIV testing and counselling (HTC) goal is to identify people living with HIV as ate early stage of HIV infection and enrol into care and treatment services. Peopel tested negative are encouraged to continue use prevention strategies and remain HIV-. All forms of HIV testing and counselling are absolutely voluntary and adhere to the five **C's**: **C**onsent, **C**onfidentiality, **C**ounselling, **C**orrect test results and **C**onnections to care, treatment and prevention services.

HTC services are offered free of charge at all public health accredited facilities in Rwanda . Accredited private clinics also offer HIV testing according to national norms and standards .

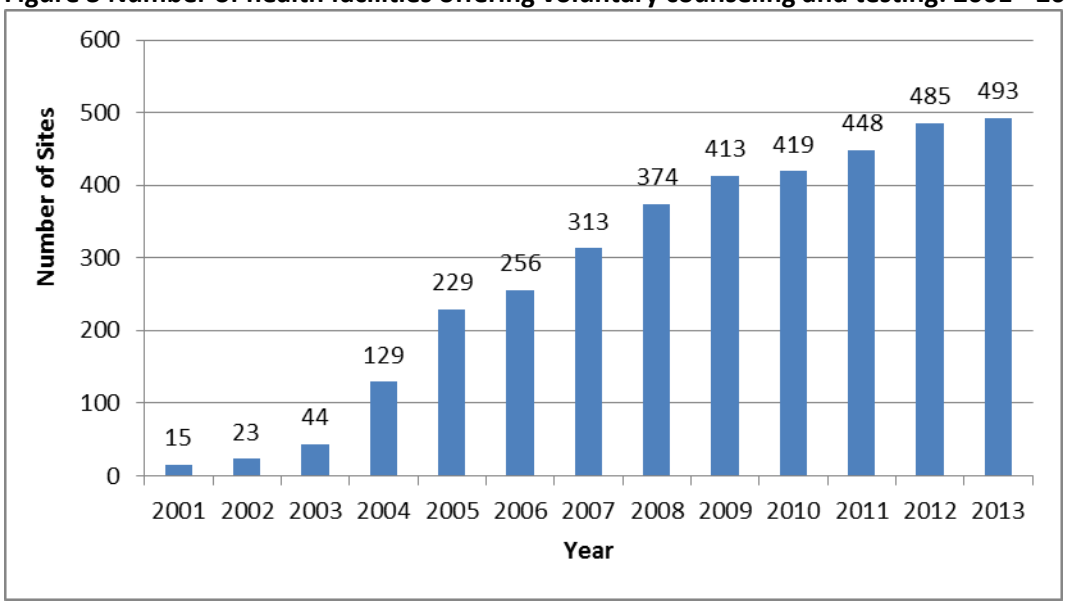
In Rwanda , both voluntary and provider initiated counselling and testing are provided.

To overcome the challenge of geographical accessibility for hard to reach areas ,outreach HCT campaigns are regurarly carried out at the community level through the collaboration and partnership with community-based organizations, the private sector, NGOs and Faith-Based Organizations with the support of trained health care providers . Currently outreach campaigns target key populations (sex workers, mobile populations, vulnerable groups) that are most at risk to transmit or to acquire HIV infection.

During the year 2013, Rwanda introduced the "finger prick" blood collection method in HIV testing as recommended by WHO . With the collaboration of National Reference Laboratory (NRL),clinical partners new finger prick method has been launched across all facilities in Rwanda.

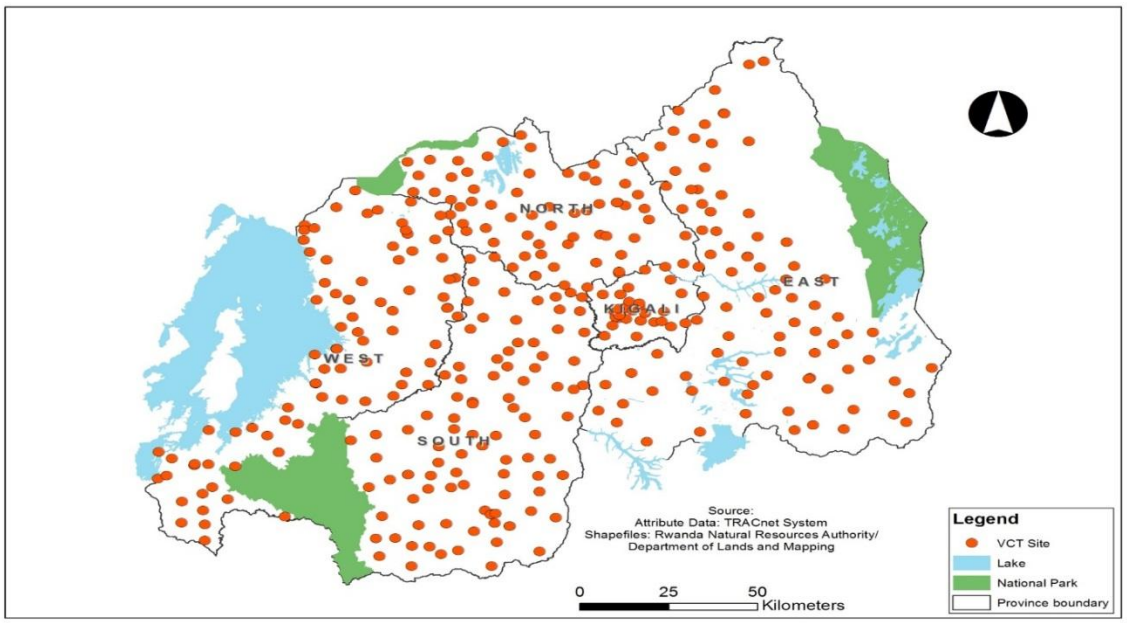
In order to increase the number of clients counselled and tested for HIV, services scale-up among health facilities was conducted to reach 493 health facilities offering HCT services and **3,121,257** tests conducted across the country from 1st July 2012 to 30th June 2013.

Figure 3 Number of health facilities offering voluntary counseling and testing: 2001 - 2013



Source: TRACnet

The Figure above indicates a significant increase in the number of health facilities offering VCT, from 15 in 2001 up to 493 health facilities in 2013.



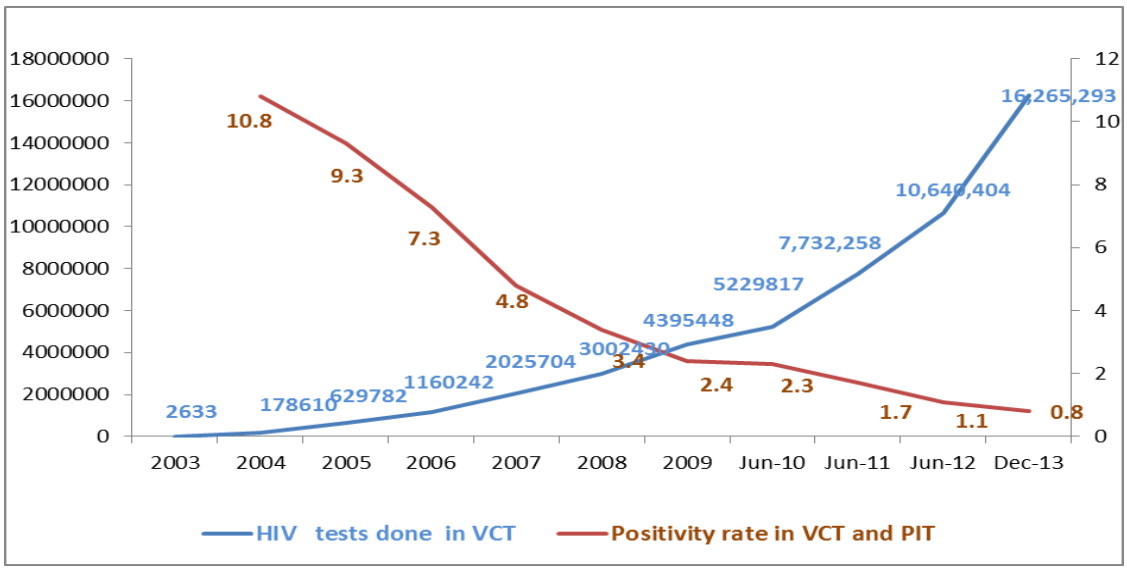
Map 1: Distribution of HCT services across the country by Dec, 2013

The increase of Health Facilities offering HCT services is also reflected in the mapping above with a good repartition of Health facilities with HCT services throughout the country.

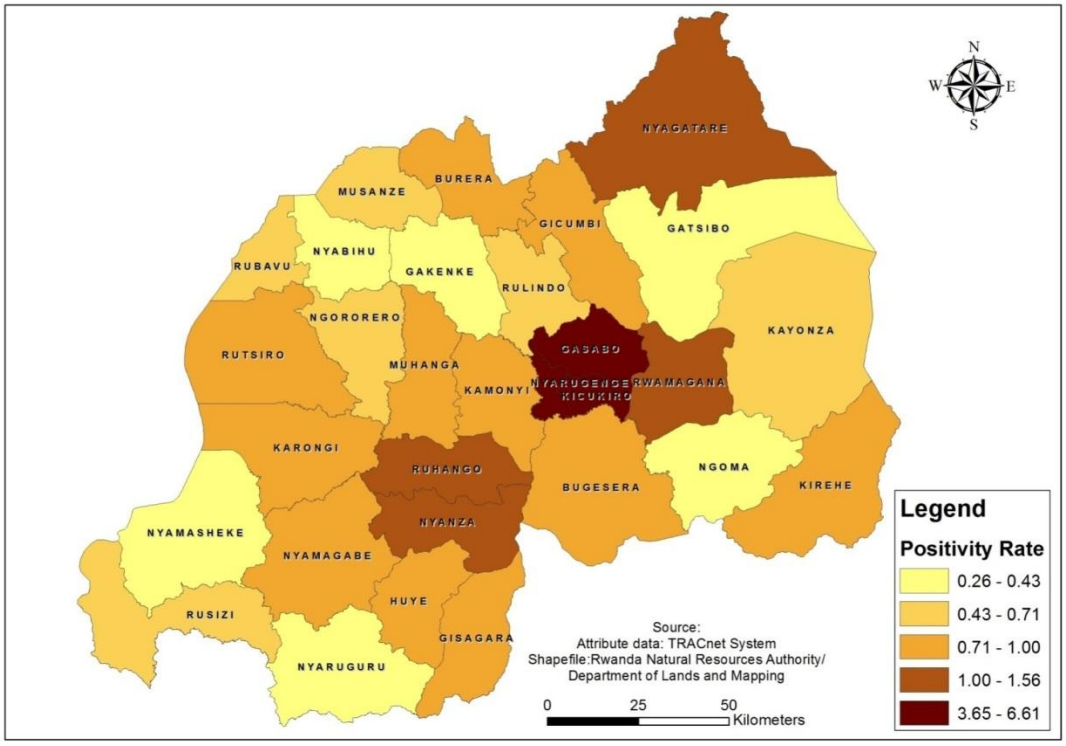
The total number of HIV tests performed from 2003 up to 2013 was 16,265,293. This number includes people tested in both health facilities (PITC) and HCT campaigns. Of the total 3, 121,257 people tested from July 2012 to June 2013, 55 % were women and 45% were men. The number of tests presented should not be reflected as number of people tested at facility level since test repeaters may contribute to this high number; there no easy mechanism to control this, however the new strategic plan for Rwanda highligths that hiv testing will be prioritized for kep populations and groups at risk of acquiring or transmitting HIV.

By end of 2013, the HIV positivity rate in testing and counseling services was 1% in women and 0.8% in men. In the last seven years, a downward trend in HIV positivity rates among clients tested in VCT services has been observed, from 10.8% in 2004 (TRAC Report 2004) to 0.8% in 2013. The HIV positivity rate is higher in Kigali City and some districts in eastern and southern provinces as indicated in the map bellow.

Figure 4 Number of tests and seropositivity, Rwanda 2003 to December 2013



Map 2 HIV Positivity Rate in Rwanda, July 2012-Dec, 2013



World AIDS Day

The World AIDS Day (WAD) is commemorated each year in Rwanda in December 2013; It was commemorated under the theme ***“"The role of Leaders in the HIV Response in Rwanda".***

The launch on December 1st was followed by HIV awareness and prevention campaign held across the country in series of commitment meetings with leaders at all levels; this exercise is still ongoing at the time on this report.

The world AIDS Day campaign in Rwanda included "the mural painting" an initiative activity of " Kurema- Kureba- Kwiga" project supporting young Positive to share their stories and memories in art works , painting mural and drawing; this activity has reached all provinces of Rwanda and very well appreciated by many people in Rwanda.

Comprehensive prevention Programs for Sex Workers

Based on defined minimum package of services for HIV prevention programs targeting sex workers; implementation of the services has been scaled up during the priod covered by this report, Female sex workers group has been evidenced by recent study findings as one of key drivers of the HIV epidemic in Rwanda with a prevalence of 51% (BSS FSW 2010) , another study conducted by the Rwanda Biomedical Center in 2012 suggested sex workers size estimation between 25,000-45,000 in Rwanda ,using participatory mapping and capture-recapture methodologies . During the current

reporting period, RBC-HIV division, in collaboration with UNFPA and Global Fund coordinated different HIV prevention interventions targeting female sex workers in order to ensure their access to comprehensive HIV services.

To this end, significant achievements were made to improve HIV services provided to female sex workers. A new Sero-behavioral survey is planned to provide most recent data on this particular group. The RBC-HIV division is expected to provide results of this survey during the course of 2015.

Coordination mechanism of key populations and M&E

The national guidelines for HIV Prevention interventions among sex workers was developed and disseminated. There are being implemented and a sustainable monitoring system was put in place so that sex workers, as key populations for HIV prevention, get optimal health and social services in line with the objectives set out in the HIV National Strategic Plan 2013-2018. As we move forward, we continuously monitor and record implementing partners' feedback from the users and a great consideration is put on areas that need revision and improvement in the future.

The coordination mechanism for Female Sex Workers is in place and is tirelessly reinforced for a sustainable effectiveness. This committee is integrated in the multidisciplinary coordinating organ for HIV and AIDS control at the District level that collaborates with other steering committees within the District. It oversees the implementation of HIV prevention intervention among FSWs by different stakeholders at the District level in relation to the National Strategic Plan for HIV control. This includes also advocacy for related policies, strategic directive and national protocols that guide the implementation in all facilities.

Outreach to sex workers through peer education programs

Continuous trainings are organized for sex workers in order to improve their comprehensive knowledge on HIV prevention. The training content includes adapted information on HIV and STIs prevention, condom use promotion, referral for HIV testing and STI diagnosis. Modules on utilization of reproductive health services, VCT and PMTCT are also covered. Discussion and mentorship on violence prevention and socio-economic self-reliance are conducted as they are inherently characterizing their daily life.

To reach active FSWs, ROADS II, USAID project facilitates the peer education activities whereby ten (10) FSW are asked to make a group and select one leader among them who will be trained as a peer

educator. It is through these groups of 10 FSWs that community HIV prevention activities are carried out on a weekly basis. These include:

- Increasing FSW knowledge on HIV/AIDS, STIs, HIV care and treatment, family planning, condom use and negotiation, GBV prevention, the effect of alcohol and other drug abuse/consumption and existing services in the country and locality, etc. This is done through peer education, IEC/BCC material distribution, etc.
- Improving positive behaviors, including reducing the number of sexual partners, consistent use of condoms, increasing the use of modern contraceptive methods, increasing the use of dual contraceptive methods, decreasing drug and alcohol abuse, as well as increasing health seeking behaviors such as STI screening and treatment, HIV C&T, GBV services, care and treatment for those who are HIV positive.
- Improving health services/product accessibility, done through active condom distribution through peer education, access to community health insurances for all FSW and their children.
- Reaching FSW partners by including condoms in the minimum package for HIV prevention for sex workers.

Reduce socio-economic vulnerability of sex workers

Through FHI 360/ROADS II project, 42 Groups Savings and Loans associations (GSLA) of FSWs were formed to introduce economic strengthening activities among FSWs as part of their HIV prevention and care and support strategy. Such activities serve as an alternative way to gain and save money towards economic sustainability and self-reliance in the future. To improve alternative income generation among FSWs, the FHI 360/ ROADS II project applied a household economic strengthening strategic framework developed to increase household resilience among vulnerable households.

The economic strategy framework is built on three pillars:

- ✓ Increase household food production through combined agriculture technologies (kitchen gardens, organic agriculture, improve household production through changes in agriculture techniques)
- ✓ Increase household incomes through Group Saving and Loan associations (GLSA) methodology,
- ✓ Increase family economic stability via market oriented production, value chain and market analysis.

Extension of HIV, STI and family planning services to sex workers

RBC /IHDPC and FHI ROADS collaborated with District hospitals, Health facilities, CDLS and FSWs to identify health facilities to be supported to provide health services to FSWs. FHI360/ROADS II provided the technical assistance to selected health centers in 5 districts(Kicukiro, Gasabo, Rubavu and Rusizi) based on HIV prevalence among FSWs.

As results, 2,310 active FSWs have been identified and are now reached by program interventions; 223 FSWs were trained as peer educators during previous years; 36 GLSA groups were formed with 835 members. All FSWs reached were referred to health centers and 1,632 (70.6%) were provided with regular STI screening, HIV testing, FP services and condom. Results showed 21.3% were HIV positive and 0.5 % were new HIV infections. During STIs screening services, it was reported that out of 1632 FSWs who attended the service, 538 were screened positive and were given facilitation for further diagnostic procedures and treatment. It is worth noting that 1,378 out of 2,310 (60%) are regular users of family planning

Other vulnerable and most at risk populations are reached with comprehensive prevention programs

People with disabilities (PWD)

In the year 2012-2013, RBC/HIV in collaboration with UPHLS coordinated different activities in prevention with main focus on HIV, STI, FP and GBV.Many documents and tools (Large print, Braille, Audio CD, Video message with sign language and Image boxes) were disseminated and distributed to people with disabilities for use on community awareness campaigns .

Capacity building of implementing partners and community was also conducted under the theme "*Barrier-Free Society, Inclusive HIV&AIDS Services: Towards Zero New HIV Infection among PWDs".*

Male Having Sex with male (**MSM)**

There is not legal barrier to offer health services to same sex sexual activities in Rwanda, and any sort of discrimination is legally prohibited .

With the support of ICAP, one of major implementing partners, community linkage of this key population to three clinical services delivery points were initiated. This enabled the creation of a friendly environment in which MSM can comfortably discuss sexuality education issues with their health care providers and access services.

Facilitation for HIV, AIDS, STIs screening and management has been availed for this population group. Hence, 70% of MSM in their respective social networks subscribed for the community health insurance as compared to 5% at the beginning of the program.

Through community interventions, MSM have been able to share education on comprehensive HIV and STIs prevention strategies during their monthly community meetings. They have also been able to access available HIV prevention and treatment services including essential reproductive health commodities like condoms and lubricants.

Service data collected routinely show that 298 MSM received HIV services. The report states that 286 attended HIV education and counseling sessions and 141 among them went through HIV voluntary counseling and testing. The positivity rate among them was 10.6% as 15 among 141 tested positive for HIV.

STI screening services are provided routinely and service data show that 14 persons were found positive for STIs among 146 who were screened. Those who screened positive for STIs were given facilitation to additional diagnostic procedures and treatment. HIV testing was coupled to STI screening services, and 9.5% among those who screened positive for STIs were also infected with HIV. Enrollment for HIV care and treatment was immediately initiated.

Prisoners

In prison 54,350 people were tested and 737 were HIV positive. This was done through VCT services with support group of peer educators; and 964 were trained on HIV and TB prevention. At entrance, 15,230 the new comers were screened for TB and among them 7 (0.007%) people were positive to TB. The number of people living with HIV in prison is 2,935 among them 2,160 (74%) are on ART to offer some of the services like PMTCT have been reinforced.

Truck drivers

The Truck drivers Surveillance Survey have been conducted; data collection was carried out in stop over point of truck drivers. The data from this study will be available in 2014. Interventions targeting truck drivers also continue to be implemented in all stop over points.

Other Most at Risk Population

a. Fishermen

The NSP 2009-2012 had identified fishermen as a key population for HIV and AIDS in Rwanda. RBC in collaboration with the key partners and stakeholders in fighting against the HIV embarked on planning for special HIV/AIDS programs targeting fishermen at the District and community level.

As part of the WAD 2012 campaign, RBC/IHDP/HIV Division conducted a campaign for fishermen and all the persons interacting with them (fish sellers and clients) aimed at raising their awareness

on prevention of HIV new infections. The followed guidance from a mapping activity conducted in 2010-2011.

As a result, 3,146 fishermen attended HIV prevention educational sessions conducted by technical experts from RBC/IHDPC/HIV Division and implementing partners in support to key populations. The campaign included also a HTC outreach service whereby 197 persons received HIV counselling and testing. Among them, 10 were found HIV positive (5%).

Availability of and access to Male and female condoms

Unlike the preceding years where most efforts were invested in the promotion of condom use to increase demand and build awareness around condoms, this reporting period was devoted to one other major component of supply. This was informed by the increase in demand following campaigns and the availability of condoms for distribution during the preceding years. Utilization data showed the increase in the use of condom at last sex among different population groups and the general population at large, but with some challenges of availability and access to all population groups.

Social marketing to improve condom accessibility

The MoH through RBC-IHDPC and implementing partners ensured availability of condoms free of charge in all public health facilities and in the community through community health workers. In partnership and support of the social marketing sector, the rapid sales outlets were created in order to increase availability and accessibility of condoms for the population.
These activities are in continuity of initiatives implemented in the country in recent years.

Among the results of these efforts, the 2010 RDHS reported that 85.6% and 90.7% of young women and men respectively aged 15-24 knew a source for condoms, increased from the previously reported 37% and 73% in women and men respectively. Results from the recent 2010 BSS show that condom use at last sexual intercourse has increased among both the youth aged 15-24 (43%) and CSWs (83%)as compared to previous 2000 and 2006 surveys. While 80% of female sex workers used condoms at last sex with a client, the proportion for consistent condom use with a paying sexual partner in the month preceding the survey rose from 28% in 2006 to 33% in 2010.

Health facilities together with all the other service delivery points have been able to distribute 11,996,756 condoms during the reporting period.

Different small organized community groups including associations, cooperatives, Anti AIDS Clubs in schools, youth centers, NGOs, peer groups etc involved in HIV prevention contribute to distribute

condoms to members especially since potential users in these groups often easily interact for other purposes, creating a bigger window for accessing condoms.

Following demand by HIV prevention programs among MSM in Rwanda, RBC/MPPD with the support of ICAP procured personal lubricants important for maximizing the protective effect of condoms in this risk group. Based on estimates for condoms needs among MSM, estimates for lubricants have also been included on the lists for essential commodities for HIV prevention in the NSP and quantified accordingly. With support from our implementing partners, resources are being mobilized for their procurement.

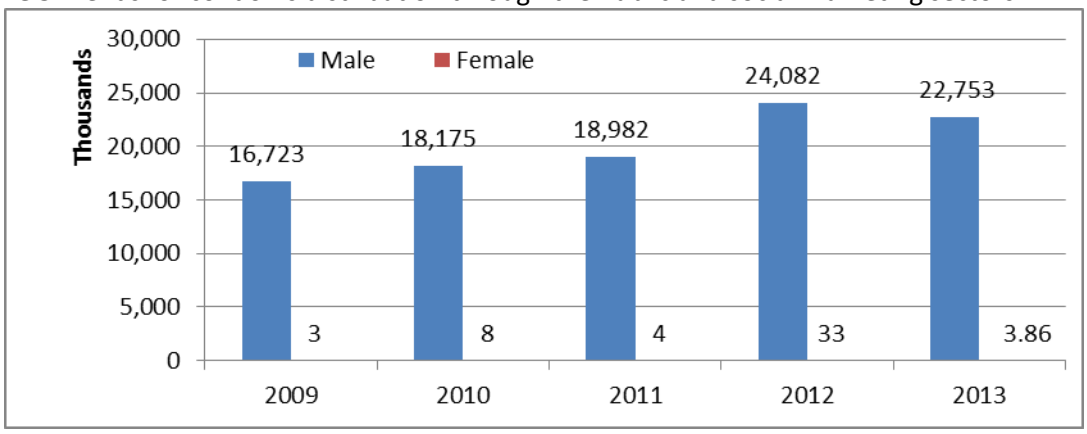
MoH is continuously advocating and promoting the creation of secondary health posts that complement Catholic based health facilities in the promotion of modern family planning contraceptives, including condoms. All health facilities governed by Catholic Church do currently have a secondary health post.

The integration of services in the health service delivery points evolved as a major boost to the uptake and access to condoms. This allows having condom dispensing box in every clinical service, easing access for service users.

The private sector in the country emerged as a strong partner in the promotion of health programs. We engaged several activities in partnership with private sector entities or companies involved in the distribution of first moving consumer commodities. This includes a support to RBC/MPPD in extending access to condoms through distribution of condoms in private sector's distribution network, especially targeting people in places of exposure to high risk sex like bars and hotels.

Results from the study on the acceptability and utilization of the female condom showed that specific population groups identified the use of a female condom as an empowerment tool for women. Therefore, this is taken as a window for targeted promotion and distribution among this population group.

Figure 5 Trends for condoms distribution through the Public and social marketing sectors



Source: RBC/MPPD and SHF-Rwanda distributions data

Distribution of condoms in recent years has been increasing but with a slight decrease in the fiscal year 2012-2013. Nevertheless, it is worthy to note that distribution in the Public sector has been steadily increasing. 11,996,756 condoms were distributed through the public sector distribution mechanism and 10,760,411 through the social marketing sector. This could be explained by the unwavering efforts of strengthening the supply chain system for the public sector and the development of the standard operational procedures manual for the supply of condoms in the public sector which is progressively disseminated in different forum.

Increased access to circumcision for Newborn boys, adolescents and adults

According to the 2010 Rwanda Demographic and Health Survey (DHS), Male Circumcision prevalence is 15% and HIV prevalence in the Rwandan population, aged 15-49 years is 3%. Since 2008, Male Circumcision program has been added to the existing HIV prevention interventions. Voluntary Medical Male Circumcision (VMMC) has been acknowledged as a key prevention strategy in the 2013-2018 National Strategic Plan of HIV.

To coordinate Voluntary Medical male Circumcision (VMMC) activities in the country and use efficiently available resources, the Ministry of Health (MoH) and the Rwanda Bio Medical center decided to use non-surgical procedure using PrePex device for all adult men. Surgical male circumcision will be only reserved to those who are not eligible for PrePex device and young men aged less than 18 years old.

In order to increase the prevalence of circumcision in the population, VMMC is being promoted for adult males. Although circumcision of newborn boys will not contribute to the immediate result of reduced sexual transmission of HIV, it is nonetheless an important long-term strategy for reducing susceptibility to HIV infection in the Rwandan population. Both strategies are being simultaneously implemented in the country.

Progress in Male circumcision service delivery

In the context of availing Male Circumcision services country wide, at least 2 health care workers per health facility have been trained on VMMC techniques using surgical methods and up to now 450 health facilities are routinely providing these services.

Initially VMMC surgical kits have been provided to all trained sites and now the provision is done based on the request from each health facility. The supply of these kits has been integrated in the national supply chain of medicines, laboratory reagents and medical consumables.

By in the period January 2012 to December 2013, male Circumcision services were provided to 200,216 boys and men.

Innovations to accelerate and sustain delivery of services

Trials of the PrePex device for non-surgical MC were conducted in Rwanda using the WHO Evaluation Framework of Adult Male Circumcision Devices. Rwanda has completed the roadmap, validating the safety, efficacy, acceptability and superiority (over dorsal slit, on both time and safety) of PrePex. Country roll out is ongoing

Increased availability and accessibility of PMTCT services

Expansion of integrated PMTCT services in all health facilities and ensure national coverage

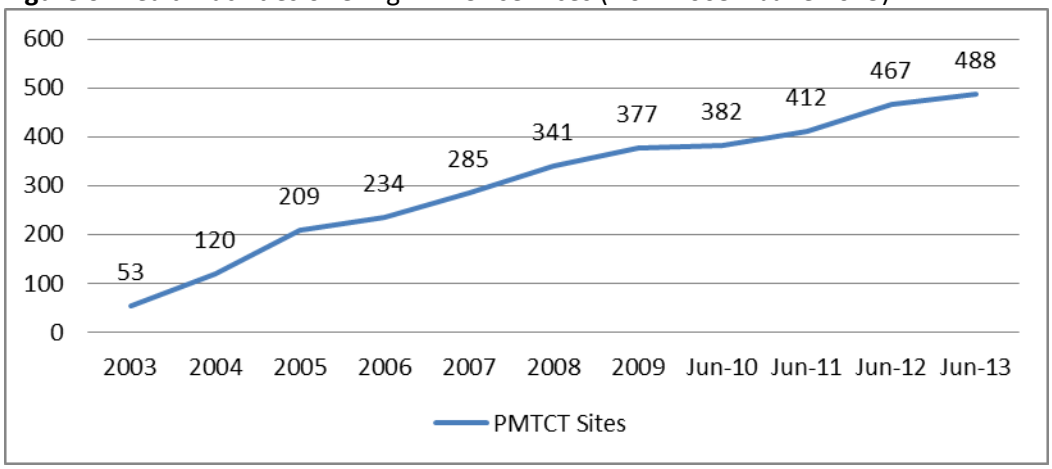
PMTCT activities are integrated at the Health Facilities (HF) level into Maternal and Child health (MCH) services. Activities of PMTCT program in Rwanda include:

- scaling up Health Facilities offering PMTCT services with a focus to provide technical support to private health facilities for offering PMTCT services,
- increasing the number of pregnant women receiving PMTCT services,
- providing ARV prophylaxis to pregnant women in need,
- ensuring adequate maternity and infant follow-up in post natal services,
- following discordant couples and
- increasing the utilization of Family Planning services.

By December 2013, 488 HF were offering PMTCT services, an increase of 5% from the previous year's 467 Health Facilities. This means that 97 % of Health facilities (Hospitals and Health centers) are offering PMTCT services. All health facilities (health center and hospitals) are collecting samples

(DBS) including some District Hospitals for early infant diagnosis for children born to HIV-positive mothers. In order to complement the Rwanda National Reference Laboratory (NRL), a second laboratory center was set up in the southern province to process and analyze HIV DNA PCR testing. This has solved the turnaround time for facilities waiting PCR and VL results

Figure 6: Health facilities offering PMTCT services (from 2003 – June 2013)

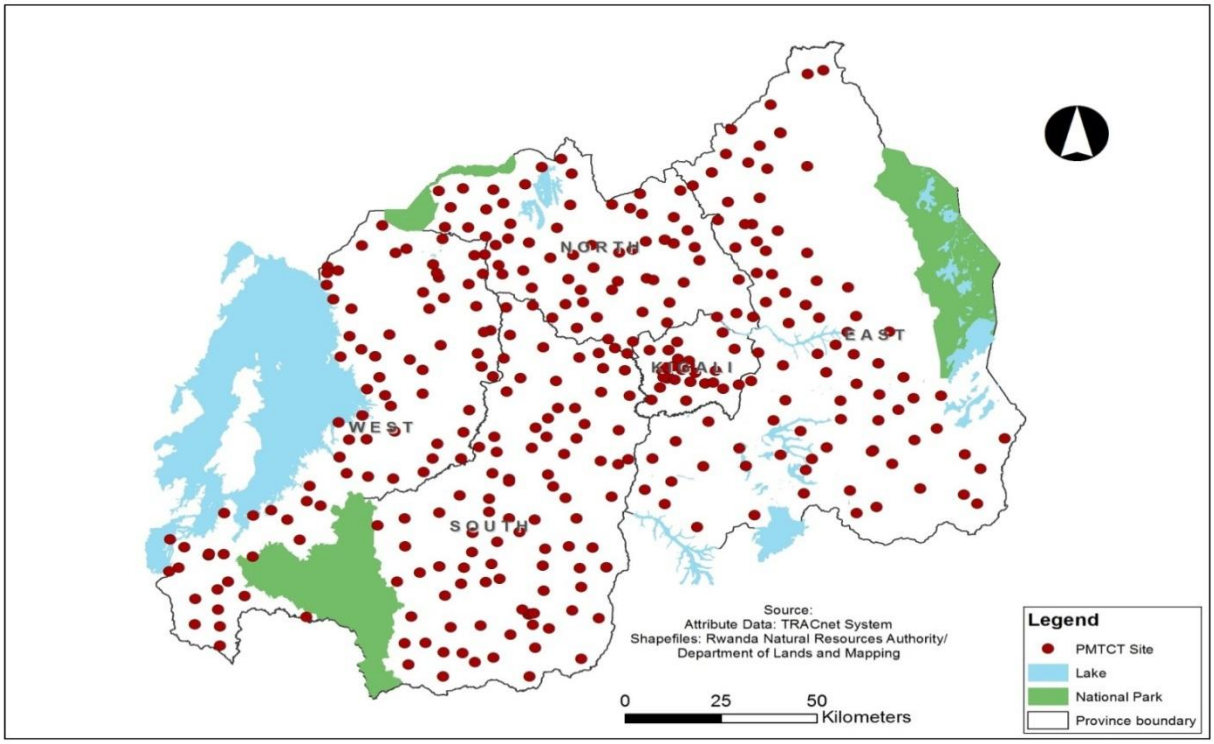


Source: TRACnet, 2012-2013

The implementation of PMTCT program is guided by the national EMTCT strategy 2011-2015, which aims to reduce new HIV infection in children to less than 2% by 2015 and to contribute to the improvement of maternal health and infant survival by providing quality integrated maternal and child health services to fight against HIV/AIDS. The national scale up plan is aligned with the global recommendations for comprehensive PMTCT programming and incorporates the four essential components of PMTCT namely:

- Prong 1: primary prevention of HIV among women (15-49 years);
- Prong 2: prevention of unintended pregnancy among HIV positive women;
- Prong 3: prevention of HIV transmission from mother to child;
- Prong 4: provision of care and treatment to HIV infected women, children and their families.

Map 3: PMTCT Geographic Coverage, Rwanda July 2012 –Dec, 2013



Strengthening integration of PMTCT services in existing health facilities

PMTCT services are integrated in existing MCH services in Health facilities: HIV testing is offered during ANC and in maternity to pregnant women who don't know their status, and those who are HIV + are offered ART for life. Their babies are also enrolled for follow up. During immunization visits, HIV exposed infants are identified and sent for PCR and other appropriate follow up. It is an additional opportunity to capture mothers who may not come for ANC visit and deliver at home, but fortunately come to the facility for the baby immunization. If they are living with HIV, they are then enrolled in care and treatment, as well as their babies.

ANC attendance by pregnant women

At the time of ANC, the package of service provided to HIV positive pregnant woman includes:

- Pre & Post-test HIV counseling
- Blood draw for CD4 same day after post counseling
- Appointment for CD4 results
- Partner testing
- Hemoglobin testing
- WHO HIV clinical classification
- Enrolment into care and treatment

- Initiation of ART
- Counselling about infant feeding
- Counselling on FP and safer sex

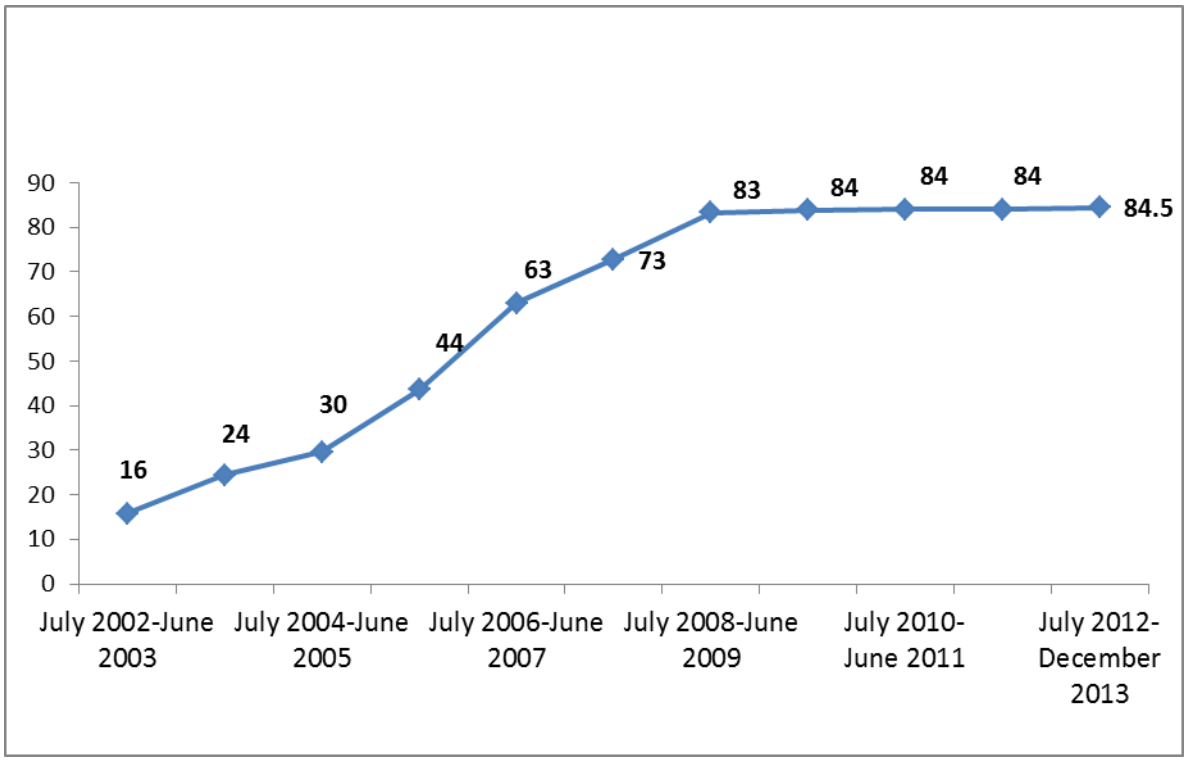
Male uptake and family approach for PMTCT

Following the Government's initiative to encourage male partners of pregnant women attending ANC visits to be counseled and tested for HIV, an increased proportion of male partners have been counseled and tested over the years.

The importance of male spousal involvement in the prevention of mother-to-child transmission programs is important to maintain family health and adherence to human immunodeficiency virus (HIV) treatment and prevention regimens. Furthermore, it allows both partners to fulfill equitably their parental responsibilities. With the political commitment and support from community systems, it is encouraging to witness this progressive improvement of male engagement in PMTCT activities as it is the direct outcome of activities implemented at the community level.

Figure 10 indicates the trend of the HIV male partners testing in PMTCT program since 2002. 16% male partners of pregnant women were counseled and tested between July 2002 and June 2003 and this increased fivefold to 85% in 2013.

Figure 7: Proportion of male partners counseled and tested for HIV in PMTCT, Rwanda, July 2002-December 2013



Source: TRACnet, 2011-2013

Map 4 Male uptake of HIV testing in PMTCT in ANC, Rwanda July 2012-June 2013

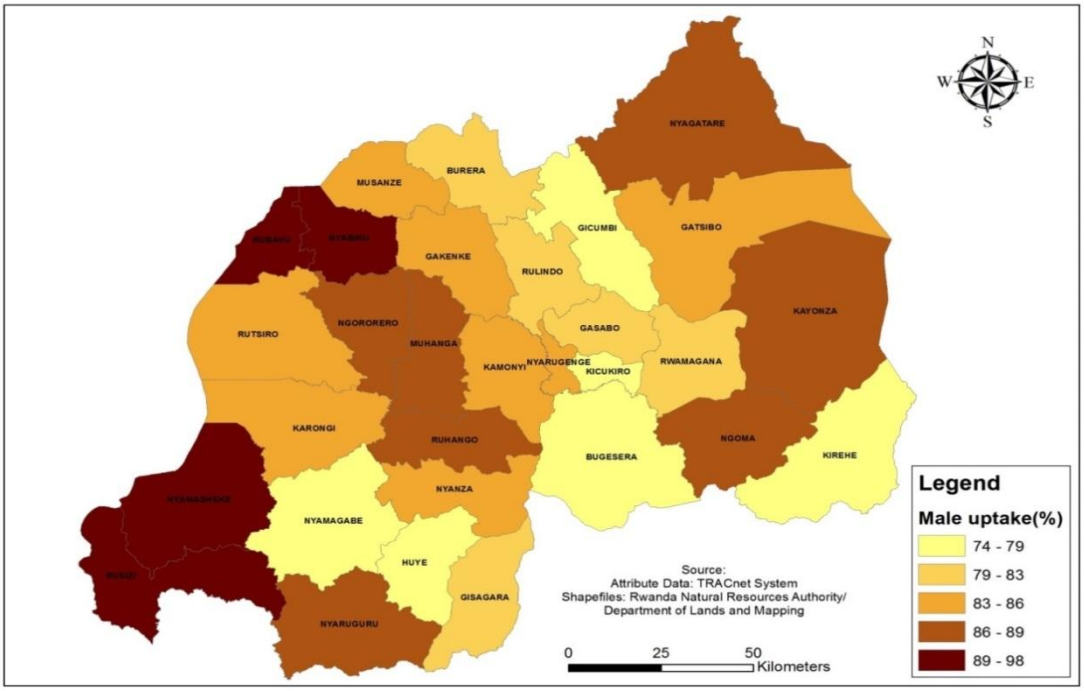
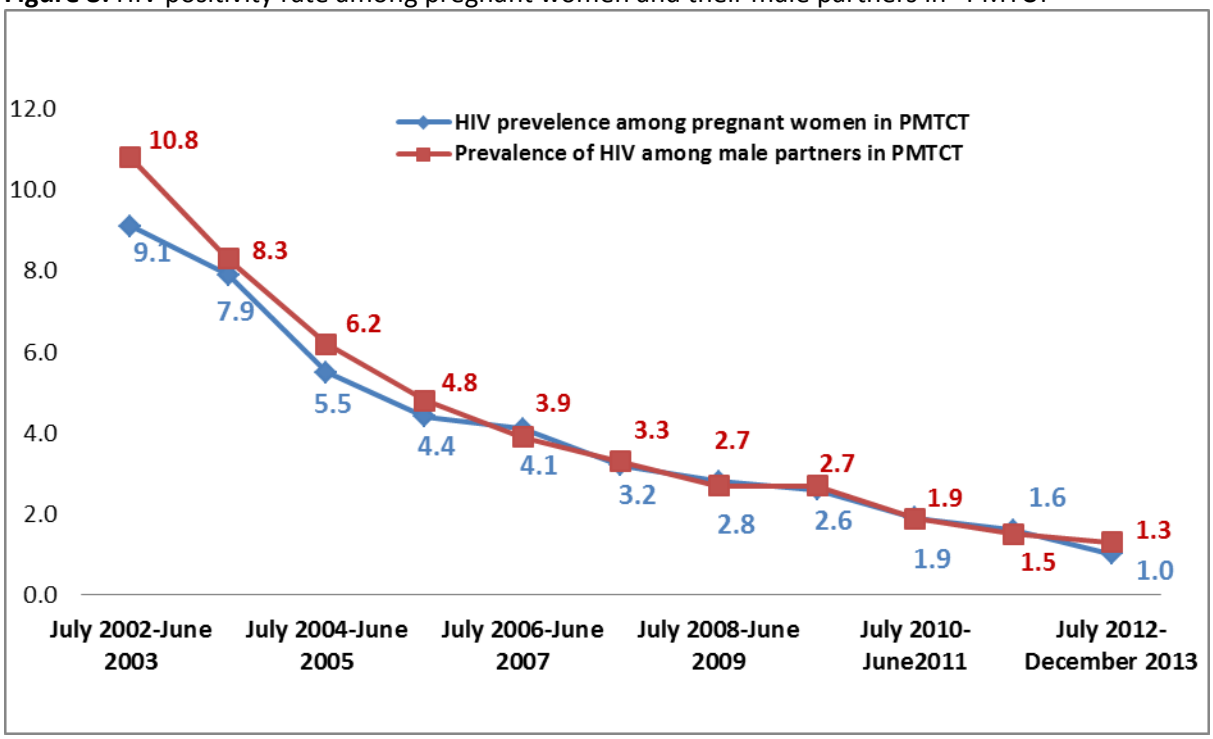


Figure 8: HIV positivity rate among pregnant women and their male partners in PMTCT



Source: TRACnet, 2012-2013

The Figure 9 indicates HIV positivity rates of pregnant women attending ANC and their male partners and shows the progressive decrease in these rates between July 2002 and Dec, 2013.

Increase delivery by pregnant women at health facilities

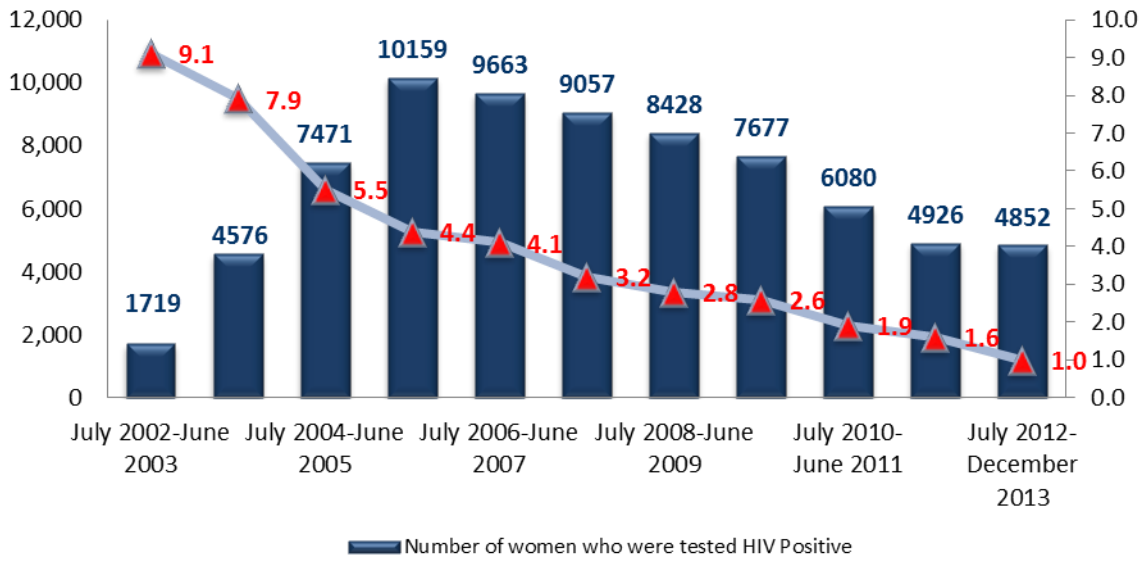
The community health system linked to health facilities supported by the strong involvement of local leaders multiplies efforts to sensitize women towards improved maternal and child health. This includes a systematic use of antenatal care and delivery at health facility. We are progressively following a positive trend of women living with HIV who deliver in health facilities, coupled with a decrease of those delivering home. During this reporting period, 316 women living with HIV delivered home compared to 371 reported for the previous year, representing a decrease of 15%.

Access and Utilization of a PMTCT Program.

Routine testing and counseling for HIV during pregnancy (at least at first ANC)

The number of pregnant women with unknown HIV status attending ANC from July 2012 to Dec, 2013 was 333,742. Among them, 326,328 (97, 7%) were counseled and tested for HIV and received their results; 4926 (1.0%) tested HIV positive (Figure 12).

Figure 9: Figure 10: HIV testing in pregnant women and HIV positivity rate in PMTCT (From July 2002-December 2013).



Source: **TRACnet, 2002-2013**

The Figure above indicates the number of pregnant women who tested HIV positive in PMTCT and HIV prevalence over the last 8 years. The HIV positivity rate for pregnant women tested at ANC reduced from 9.1% in 2003 to 1.0% in June 2013.

Increased percentage of HIV+ pregnant women receiving ART as prophylaxis in PMTCT setting

A more effective regimen of ARVs used in PMTCT was introduced in 2005. In accordance with the November 2009 WHO recommendations for PMTCT, a new PMTCT protocol was approved by the Ministry of Health in June 2010 and Rwanda chose HAART (Tenofovir based/regimen) for all HIV positive pregnant women from 14 weeks of gestation up to the end of breast-feeding (weaning). The implementation of this new protocol started in November 2010 and was revised in 2011 to allow HIV positive pregnant women to be provided with ART for life. In 2013, the new WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection were approved and initial phases of implementation were launched, including training of providers on new protocol and updating follow up tools.

Increased case-finding and follow-up of HIV+ pregnant women who initiated PMTCT

Peer educators and community health workers support health care workers in tracing those with difficulties in respect of follow up appointment, and support is provided to prevent their loss to follow up. The follow up of women in PMTCT is facilitated by health care providers detailed records

at health facilities including the appointments for follow up, and for women who are missing their appointments, home visits are immediately organized to trace them.

b) Care, Treatment and Support

Introduction.

Rwanda has made significant progress in the provision of treatment, care and support services. All progress made were towards reduction of morbidity and mortality due to HIV/AIDS by preventing, early diagnosis and appropriate treatment of opportunistic infections(OIs) as well as early antiretroviral treatment(ART) and follow up of PLHIV.

All these achievement have been possible due to high geographic coverage in terms of HFs and universal access to treatment by treating the majority of PLHIV in need of treatment. The number of health facilities offering care and treatment services to people living with HIV increased from 430 to 465. With the increase in number of health facilities offering care and treatment services, the number of patients on treatment has also increased.

Since August 2013, Rwanda started the process to update the national HIV prevention and management protocol according to 2013 WHO recommendations. Key changes considered in Rwanda are: treatment as prevention for key population(FSW and MSM); test and treat for specific group such as: TB/HIV co infection, HBV/HIV co infection and HCV/HIV co infection; initiation of treatment with threshold of CD4 greater or equal 500 as well as option B+ for PMTCT. This new protocol will be implemented at health facility level starting July 2014.

People living with HIV and tuberculosis receive appropriate treatment for TB

A. Increase case finding and diagnosis of TB in people living with HIV

HIV/TB collaborative activities have been strengthened by continuing training of health care providers and health managers to improve TB case finding and reporting among HIV+ patients
Training of health care provider and on site mentorship have been intensified to strengthen active TB screening in all PLHIV on treatment and not yet on treatment. Those on treatment con –infected to continue their ARVs and start anti TB treatment and those not yet on treatment to initiate the ART and the anti TB treatment without waiting for any other criteria. Evaluation meetings with HCP at DHs are being conducted on quarterly basis for close monitoring and support to decentralized levels.

b. Cryptococcal Infections screening program among PLVIH

An active screening of cryptococcal infection is one of strategy to reduce morbidity and mortality due to OIs. The National Guideline for comprehensive care of people living with HIV in Rwanda, put in place new recommendations regarding screening and treatment of Cryptococcal infections.

Increased Coverage of facilities offering ART

Increase *the availability and coverage of ART at health facility level*

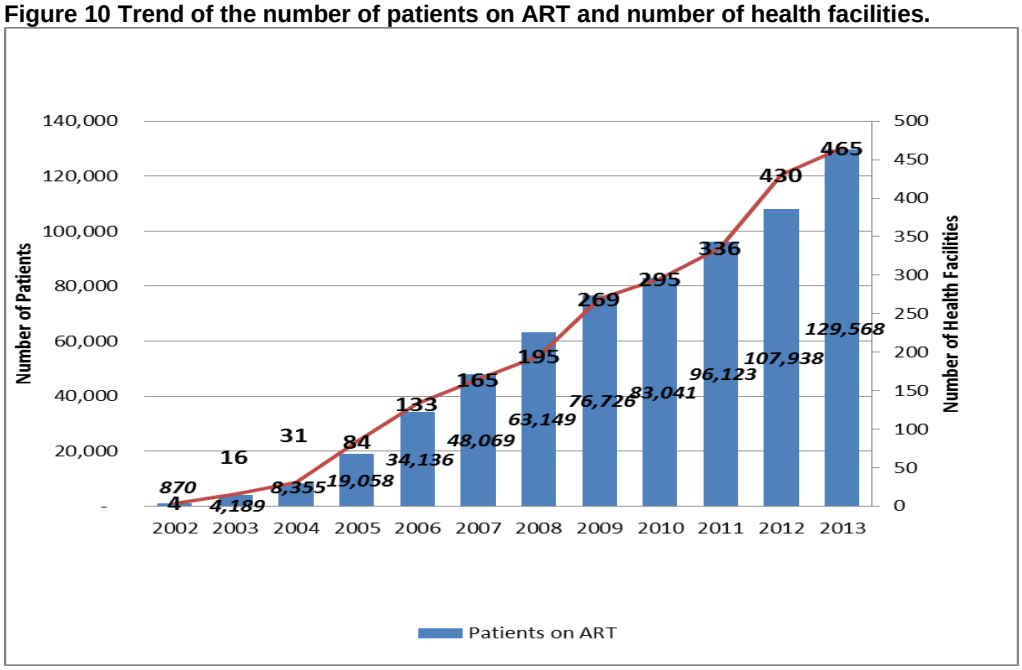
Rwanda vision for care and treatment is to optimize care and treatment to all people living with HIV in need. Now, 91% of cases in need receive care and treatment services. The target is to maximize

access to all PLWA by improvement of linkage between testing and care and treatment as well as community outreach.

By the end of June 2012, 430 health facilities were offering care and treatment services to people living with HIV. By end of June 2013, 465 health facilities were offering care and treatment services. As the number of health facilities offering care and treatment services increase, the number of patients on treatment has increased also from 107,938 to 123,499.

In 2013, 3rd line regimen was added to the national ART guidelines, and 22 patients are now receiving it.

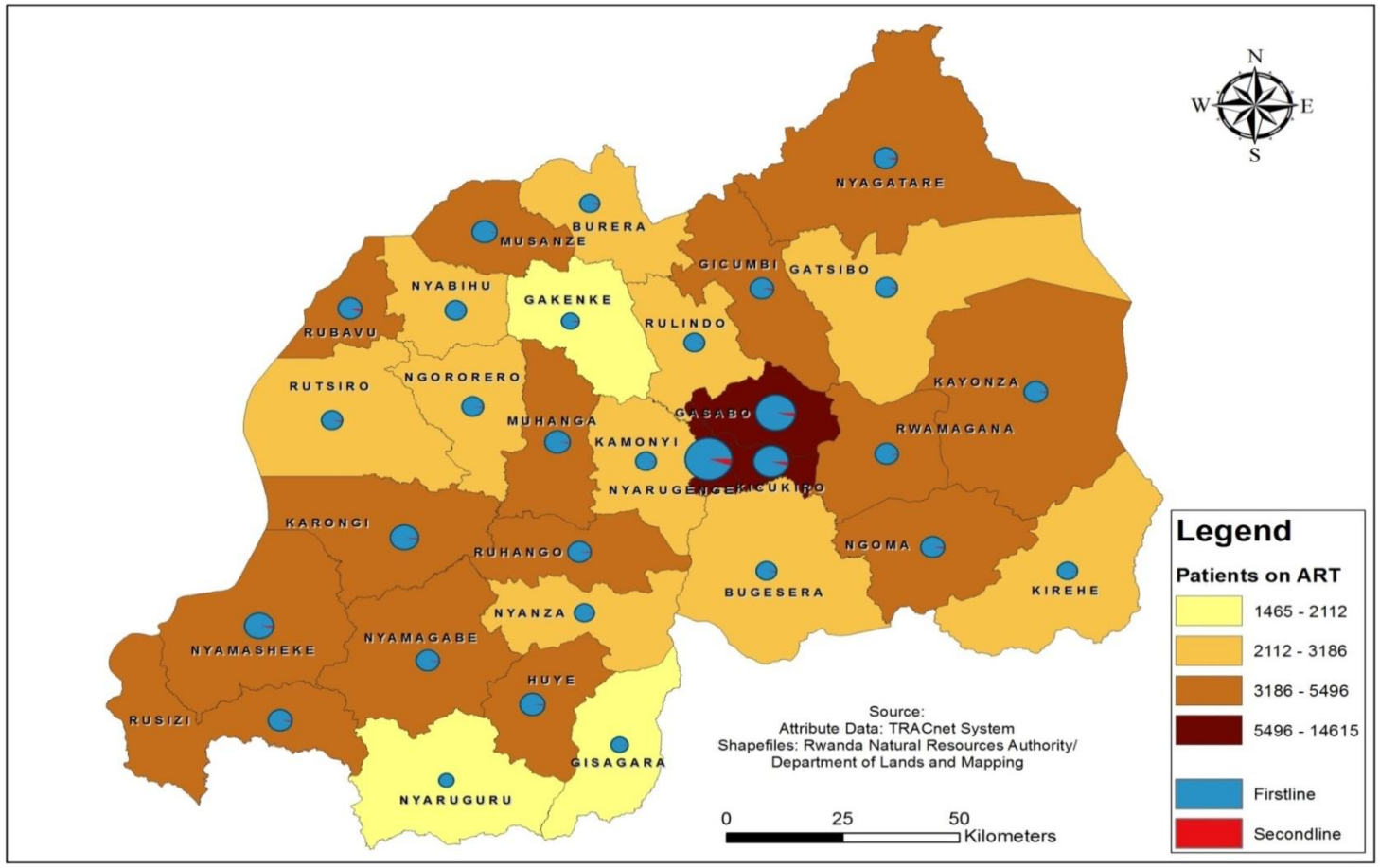
Figure 10 Trend of the number of patients on ART and number of health facilities.



Source: TRAC net, 2012-2013

Map5. Patients on ART, Rwanda-June2013

The map above indicates that the high number of patients on ART and the high proportion of patients on second line are located in Kigali city.



HIV /AIDS commodities Supply Chain

The availability of HIV/AIDS commodities is a key prerequisite to ensure the continual HIV/AIDS program scale up and disease control. The forecast and quantification of commodities needs are conducted every year, the stock status at both national and site levels are monitored on monthly basis through CPDS (Coordinated Procurement and Distribution System) mechanism. Quantification committee (QC) meetings were scheduled and a number of recommendations were made to maintain the stock in desired quantities, to minimize losses and expiries, as well as to avoid stock outs.

Quantification of HIV health commodities

Every Year, the forecast and quantification of commodities needs are conducted. The scope of this quantification was to review the previous quantification exercise and to provide 24-months forecast of ARV needs for the ART and PMTCT program for the period of July 1st, 2013 to June 31st, 2015 and developed a procurement plan for ARV quantities to be procured for the period of July 2013 to June 2014. The quantification exercise also determines the funding requirements and identifies the source of funding of HIV related commodities needs.

Monitoring of HIV related commodities consumption

The stock of HIV related commodities were closely monitored in collaboration with the Medical Procurement and Distribution Division (MPDD) and other involved partners through the CPDS mechanism. Recommendations were made to maintain the stock in desired quantities, to minimize losses and expiries, as well as to avoid stock outs.

Supervisions on rational HIV drug use

The rational use of drugs is a key for the successful of the long term treatment like antiretroviral therapy. This means to get the right medicines, in right quantity, in right conditions, for the right person, at the right time and at the right cost. In this purpose, supervision at some health facilities have been conducted with aims to ensure the continual supply of drugs and reagents, the adherence on the national guidelines while dispensing drugs and testing. Posters for ARVs side effects and dosage have been developed to improve rational use of ARVs. We have conducted the site visit to all ART sites countrywide with objectives to Increase the use of paediatric fixed dose combination and opportunistic infections drugs and we did the distribution of these medicines and to reinforce the proper LMIS reporting. An Assessment on the integration of District Pharmacies in the management of HIV health related commodities with the perspective to improve the management of ARV commodities and to solve problems of stock out of those commodities.

Training of Trainers in HIV,STIs and OBBI Services:

Training of Healthcare Providers on Comprehensive Management of HIV

From April to June 2013, RBC/HIV Division in collaboration with district hospitals organized a series of integrated trainings of providers countrywide with focus on following areas:

- Implementation of D4T Phase out in Rwanda
- Implementation of Hepatitis B Screening and vaccination
- Salvage therapy and Genotyping
- Rational use of drugs and lab commodities
- Training of HIV Clinical Mentors
- Implementation of Cryptococcus Infection Screening

During this training, a total of 980 (37MD and 936 Nurses and 7 social workers) from all over the country were trained on the national guidelines and received certificates of completion.

Training of Trainers in HIV Services

With Rwanda's continued focus on capacity building for clinicians around the country, the skill of training facilitation for the nation's infectious disease leaders becomes increasingly important.
In that context, RBC/HIV Division in collaboration with Partners In Health (PIH) conducted a series of training of trainers (TOT) countrywide, teaching participants about participatory training methodologies appropriate for adults and applying them to training activities about topics related to HIV care including task shifting, viral hepatitis, STIs prevention and management

Training of Healthcare Providers on Hepatitis B Screening and Vaccination

Hepatitis B Vaccination

For the prevention of hepatitis B infection, all staff from health sector, and health care providers and their families received three doses of Hep B vaccine since April 2013..

Quality standards for ART are maintained

Strengthen the M&E system to identify and trace patients lost to follow up

An assessment was done to analyze key factors of patients lost to follow up between testing and Care and treatment services; among identified factors, there is a big number of clients comparing to

the capacity of health facilities. Again, the distance between testing site and care and treatment services is another important factor of lost to follow up.

Other important studies were initiated to monitor effectiveness of ART drugs and care and treatment quality improvement:

- Evaluation of transmitted HIV drug resistance among clients aged between 15-21 years attending voluntary counseling and testing services in Kigali
- Early Warning Indicators in sentinel sites
- HIV drug resistance presence among patients on art treatment and related program factors in Rwanda in 2013": Longitudinal study

Clinical mentorship

Clinical mentorship established in health sector especially in RBC/HIV Division, is a program of practical onsite training and clinical consultation that promotes ongoing health professional development to get sustainable high-quality clinical care outcomes. Mentoring is seen as part of the continuum of education required to create competent health care providers. 30 clinical mentors (14 Medical Doctors and 16 nurses) were trained by international teams of infectious diseases specialits to equip them with skills needed to bring to lower level of mentorship cascade.

PLHIV receive adherence support at FOSAS and in community

Adherence has been always a concerning area for comprehensive care and treatment of people living with HIV/AIDS. In this area, emphasis has been put on adherence through integrated mentorships where health care providers have been initiated to systematic adherence assessment using both objective and subjective methods.

Psychosocial support and community support palliative care for People living with HIV including

Facility and communitybased Adherence support

In addition to health facility based services, community approach was initiated to involve community health worker in the follow up and adherence preparation of patients infected by HIV. In year 2012-2013, a lot of emphasis was put on integration of HIV in a community health guideline.

Integration of psychosocial support and mental health in routine follow up of the HIV patients

Since poor mental health was identified as a barrier to care for HIV-positive patients and a cause of poor outcomes for care and treatment services, HIV Division has been scaling up the integration of Mental Health and HIV in all hospitals in the country. Lessons learned show that patients in routine

care need enhanced comprehensive care and treatment including psychiatric services. This excise is done through systemic screening of mental problems using standardized tools.

Nutritional support for People living with HIV.

Malnutrition and HIV/AIDS acts symbiotically and create a vicious cycle that weakens the immune system. The good nutrition can improve the health and quality of life of people living with HIV. The nutritional support for PLHIV is an integral part of a comprehensive response to HIV/AIDS within all ART services and done according to national recommendations. In order to fight against malnutrition among PLHIV, different activities are done in this area such as:

- Capacity building of Health care providers on Nutritional care and support focusing on Nutritional counseling and assessment
- The continuous care and support of moderate and severe malnutrition among PLHIV
- Harmonization of food and nutritional support for eligible PLHIV in needs
- Development of nutritional tools : Three algorithms were developed:
    - Nutritional management of HIV+ adults,
    - Management of malnutrition of children infected by HIV
    - Nutritional counseling on Infant and Young Children Feeding (IYCF) in HIV context.

c) Impact Mitigation

Creation of Employment Opportunities for Infected and Affected Persons (Including Child Household Heads)

To develop entrepreneurship among people infected and affected by HIV, different associations were transformed into cooperatives with the network of people living with HIV (RRP+) support and partners intervening in the domain (CHF HigaUbeho) . Training and ongoing technical support was provided to assist associations of PLWHA to acquire cooperative status. This training covered business plans development for these cooperatives.

During fiscal year 2012-2013, the Network of People Living with HIV and AIDS (RRP+) has registered new cooperatives from associations supported by the Global Fund ,CARITAS Rwanda empowered associations and cooperatives of people living with HIV revolving credit and 575 PLHHIV received health insurance cards

Improve Food Security for PLHA.

In this reporting period **15,141 individuals** from households of persons infected/affected by HIV/AIDS received food security and nutrition services from USAID HigaUbeho Program. Among them 3,484 adults (2,699 women and 785 men) and 11,657 children under 5 (5,745 girls and 5,912 boys) received nutrition services.

Food security services included: training on Bio Intensive Agriculture Techniques (BIAT), mushroom production techniques, small livestock keeping and seeds to use in their households when adopting the new techniques (BIAT). Furthermore, the beneficiaries also received bio-fortified crops (orange flesh sweet potato rich in vitamin A, Iron fortified beans, maize rich in proteins) and small livestock provided which will later be shared among farmer field schools members.

Nutrition services include nutritional status monitoring, cooking demonstrations, home visits, hygiene education, nutrition education and growth monitoring during activities for children under 5. They are provided during the monthly Positive Deviance Hearth (PDH) group session and during home visits. During the monthly PDH sessions, participants help the household where they met to install a kitchen garden, a tippy tap, and clean the house and it's surrounding.

A study has been carried out to evaluate the Social-Economic Impact of Income Generating Activities (IGAs) funded by Global Fund via Cooperatives to the lives of cooperative members. The findings from the study will be available in 2014.

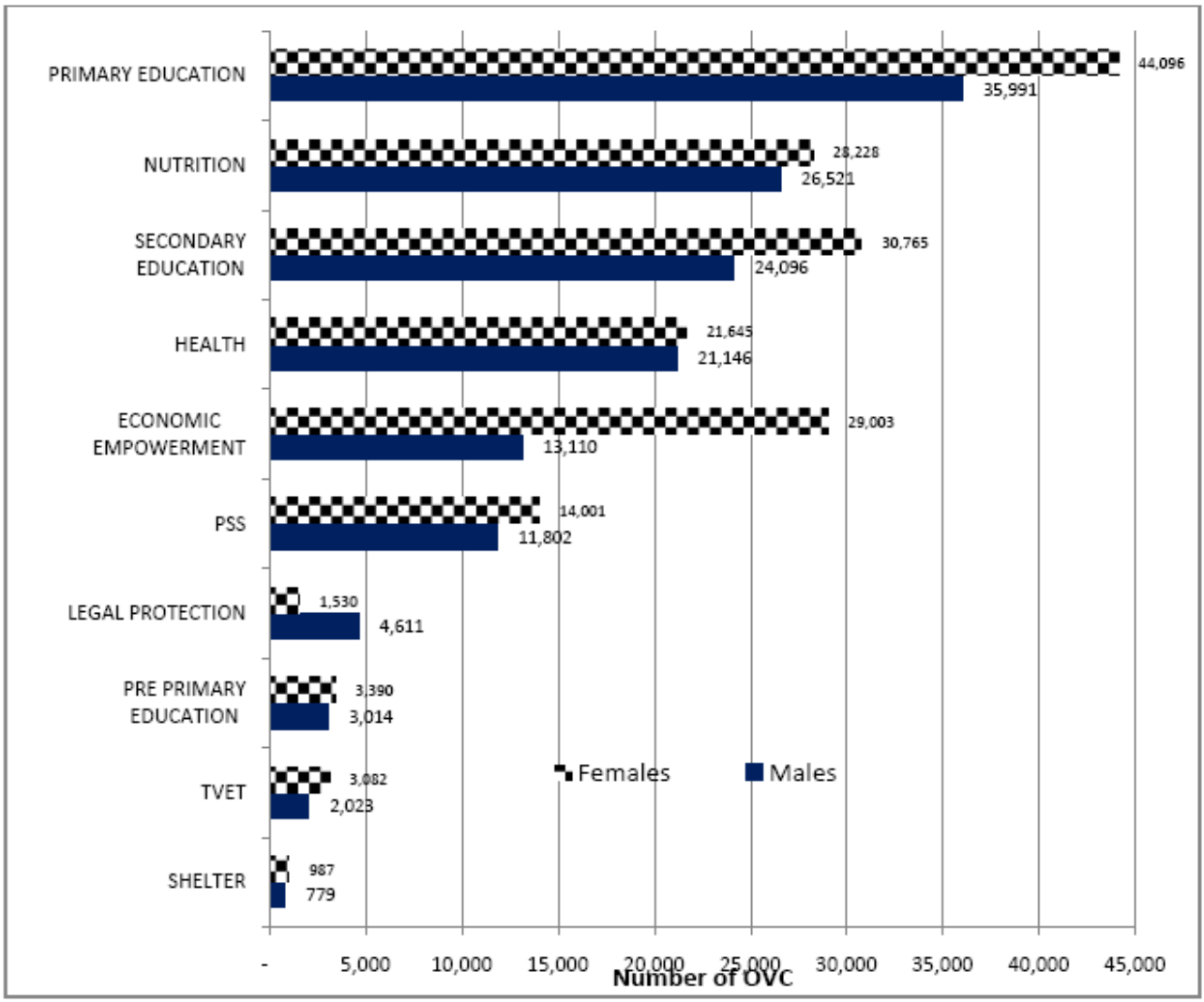
Sensitization on the cultivation of gardens and preparing a healthy and balanced diet (RNA : improved nutritional rehabilitation Foyer) at Bulera district 80 % of the 250 households visited PLHAs have gardens at home and know how to prepare comprehensive food, thus reducing the level of malnutrition among people living with HIV.

Management, Coordination and Transparency of OVC Program

At the end of every quarter, organizations intervening in the promotion and protection of children's rights are expected to provide a report showing the support given to children especially the orphans and other vulnerable children (OVC). It is from these reports that National Commission for Children (NCC) can gauge the total number of children supported in the different categories of services and also to identify the active organizations in the different areas of intervention.

By end of June 2013 total number of 24 organizations intervening in OVC program reported to NCC the different numbers of OVC served as summarized in the table below.

Figure 11. OVC service provision



At District level, a staff in charge of OVC was recruited and coordination meetings are organized on quarterly basis and quarterly reports from Districts sent to National Commission for Children (NCC). NCC also organizes partner meetings on semi-annual basis with a regular follow up organized quarterly.

The identification of OVC for education and other support (like Secondary school fees and start up kits, Primary education, Housing support, Nutrition, Protection, Health, Psychosocial support) is continuously done. The criteria's for the selection of OVC are known to all partners and is done from the grass roots level.

Through the coordination of the National Commission for Children, different partners (NGOs, UN Agencies)provided support to OVC on different components among others they include the minimum package (Secondary school fees and Start up kits, Primary education, Housing support, Nutrition, Protection, Health, Psychosocial support).

Accessibility and utilization of Legal Aid Services by Infected and Affected by HIV

For the awareness of PLHIV and OVC on their rights, RRP+ and other partners have carried out sensitization sessions on the rights of people living with HIV.

Regarding legal education for lawyers on rights of PLHA and OVC, different manual will be used in the training of trainers for each district in the person of Deputy Mayor for Social Affairs, The petition charged at the sector level, lawyers in the districts, the responsible for the legal support service (MAJ), and basic courts representatives.

These representatives are the main entrance for the legal support institutions fighting the stigma and discrimination in the community addressed to the PLWHA. The sessions of trainings have been conducted in different districts in the country. RRP+ also partners institutions like HAGURUKA to provided legal assistance for person living with HIV and AIDS in some judicial cases.

VII. Coordination of the HIV response

In the year 2012-2013, RBC- HIV Division continued to play the role of strengthening the coordination structures for the fight against HIV and AIDS including "Umbrella organizations". Technical working groups and coordination meetings were conducted in a comrehenive and participatory manner. . Umbrellas were offered technical and financial support, beneficiaries include RRP+, NGO forum, ABASIRWA, UPHLS, RCLS, Public and Private Sector Federation. RBC-IHDPC ensured that all strategic plans of the umbrella organizations, operational plans, and action plans were aligned to the National HIV and AIDS Strategic plan. These umbrellas report to RBC their coordination activities including ideas and recommendations of their respective beneficiaries in order to inform effective planning and programming.

For the capacity building of Umbrellas as the coordination structures of community activities in the fight against HIV and AIDS, RBC/IHDPC has continuously supported them to build an improved and solid structure. This helps to efficiently coordinate HIV activities at their level and conduct different trainings based on their expressed needs. The focus on management of their umbrellas and familiarizing with national monitoring and evaluation tools have been cited among core needs to be regularly addressed.

In addition, different trainings targeting mainly private and public sector HIV focal persons were conducted on HIV work place programs. In collaboration with ILO and RBC, the public sector umbrella has initiated and launched a tripartite forum that will act as coordinating body for the work place programs in public, private and Civil society sector.

Public and private sectors, in collaboration with RBC, have mobilized funds for the coordination of HIV prevention activities in work places from The International Labor Organization and UNICEF.

For the public institutions, different coordination activities were carried out such as the development of HIV and AIDS annual action plan 2012-2013 (MIFOTRA and Private sector, CSO sector) aligned to National Strategic Plan for HIV management 2009-2012.

MIFOTRA and RBC-IHDPC trained HIV focal persons from RCLS and RRP+ on M&E, transformational leadership and CSO. Training on skills improvement in planning and M&E was conducted for the CSO umbrella coordinators at the district level for RCLS and RRP+.

Civil Society Umbrella organizations in collaboration with RBC and UNAIDS developed a CSO WEBSITE that resulted from the mapping exercise that was conducted for all CSO umbrellas and will be updated on a regular basis by selected umbrella focal person.

VIII. Major challenges and remedial actions

a) Progress made on key challenges reported in 2012

Knowledge and protective behaviours, especially in high risk groups

The has been reported in previous progress report , where knowledge on prevention was still low among truck drivers ; to further mitigate this gap, the Rwanda Bio-medical center and partners has organised special trainings and outreach programs targetting the same groups , a study is at end stage to inform if the knowledge has really improved.

Flat-lining HIV prevalence in youth, with significant difference between boys and girls

The particular vulnerabilities of young girls, combined with increased difference in the HIV prevalence in young girls compared to young boys, represent a challenge requiring ongoing monitoring and actions., This remain a challenge for the national HIV program although different campaigns and programs have been launched including suggar dadies and sugar mamies prevention campaigns, this will continue to be adressed as a priority in the new Strategic Plan

High HIV prevalence in female sex workers

As recent studies show, HIV prevalence is 51% among sex workers, indicating a need to address the HIV prevention and care needs of this population. Sex worker targeted prevention programs and condom use by clients are major challenges faced by current HIV interventions. Kep groups are particular in the new country strategy, especially recent guidelines suggest a test and treat for sex workers which is expected to reduce new HIV infections among the key groups but also benefit general population

Social support and nutritional services to PLWHA

People living with HIV in Rwanda receive anti-retroviral therapy free of charge when clinically indicated, but social support and nutritional services are not accessed as desired. New nutrition guidelines definied criteria for accesssing support and now has been planned accordingly

Delayed disbursement of donor support

The government implementation of HIV programs has faced delays due to the time between funding commitments and disbursement of funds from government partners. Annual planning is hampered by lag times of several months between commitment of funds and those funds being available for the implementer. This has been solved with regular talks and joint plannig as well as implementation

Remedial actions planned for achievement of agreed targets

Rwanda has recently initiated a new strategic plan 2013-2018, although the target ate set high and ambitious, there is a strong commitment to achieve more with few resources buidling on value for money and effieciencies.

b) Current Challenges in the HIV response

Donor funding continue to decrease at high speed

The country is facing a rapid decrease in external resources , the government of Rwanda is putting in all efforts to takeover , however the reduction trend from external resources may affect targets set by country to reduce by 75% new HIV infections, reduce by 50% AIDS related deaths, and reach zero stigma and discriminations for people infected and affected by HIV

HIV prevalence of HIV among key populations

The HIV prevalence in Rwanda is 3% at general population level, however the epidemic situation is very complex, key groups represent major drivers of the epidemic, the latest study suggested that 51% of female sex workers in Rwanda are HIV infected; although the new NSP put an emphasis on key populations, it will take efforts and time to reduce the high transmission of HIV bridged with core transmitters.

IX. Support from the country's development partners

Key support

Rwanda is a country of highly skilled health and public health practitioners, also benefitting from the financial and technical support of development partners. The two majority funders of the HIV response are the Global Fund and PEPFAR, and in addition to those, a number of international foundations and organisations, bilateral agencies and the UN are supporting the process of policy and program development.

Actions needed by the development partners

The development partners must sustain their support for HIV prevention, care and treatment, social support and mitigation in Rwanda, and commit to working with the Government in setting and achieving targets in the National Strategic Plan 2013-2018. To better support the Government, development partners should continue joint planning and coordination and continue to report budgeting and spending as well as submitting annual plans and reports. This facilitates Government planning and monitoring of the use of development partners' resources.

Nationally and internationally, the development partners should continue to harmonise reporting requests to minimize the burden of reporting and maximize the time spent supporting beneficiaries. In Rwanda a common monitoring and evaluation system managed by RBC-HIV Division and a Health Recourse Tracking Tool managed by the Health Financing Unit in the Ministry of Health provide the environment to streamline these processes. Development partners should fully engage with such tools for their own reporting needs.

X. Financing for the National HIV response

a) Funding source for HIV Expenditures in Rwanda FY 2011/12 & FY 2012/13

The spending on HIV for FY 2011/12 was collected from Health Resource Tracking tool (HRT) where all health sector actors (Government institutions and Development Partners) are required to report on annual basis their expenditures for the previous fiscal year and the Budget for the current fiscal year.

The data used for the spending of FY 2012/13 was not collected from HRT due to the ongoing process of revising the tool in time of producing this report. This revision will make it more user friendly and flexible on both data reporters and administrators sides. These data was collected from the main funding sources especially from SPIU (for GF), USAID and UN agency (One UN) while the data for International NGOs and other bilateral agencies we used the estimations from their budgets reported into HRT.

b) Public and External funding source for HIV

FY 2011/12, total HIV spending was USD 234.6 million in Rwanda, USD 17.7 million (7.6 percent of the total HIV spending and 16 percent of the total Government spending on Health) came from public funding while USD 216.8 million (92.4 percent of the total HIV spending and 58 percent of the external spending on Health) came from external funding. This total spending doesn't include OOP and the contribution of private sector.
Among external funding, Global Fund for AIDS, TB and Malaria represent a big proportion in HIV spending followed by USG, International NGOs and UN Agencies with 48.8%, 39.3%, 2.8% and 1.8% of the total HIV spending respectively.

Bilateral Organizations rather than USG included the Government of Luxembourg and Swiss Development Cooperation with USD 405,802 and USD 66,482 respectively represent 0.2 percent out of the total HIV spending then other multilateral agency rather than GF and UN Agencies included only the World Bank with the contribution of USD 23,500 (0.01 percent of the total HIV spending).

In FY 2012/13, total HIV spending was USD 243.6 million, 4 percent of increase from the previous FY spending. The Public contribution represents 8.2 percent of the total funding (17% of the total Government spending on Health) while external contribution represents 91.8 percent of the total funding of HIV spending.
Global Fund for AIDS, TB and Malaria made the largest contribution among all external funds with USD 133.3 million (54.7 percent of the total HIV spending), the latter increased by 14 percent from the previous FY spending followed by the United States Government (USG) with USD 84.4 million representing 34.6 percent of the total HIV spending (a decrease of 9 percent of the previous FY spending).

Figure 12 Funding for HIV/AIDS in 2011 and 2012

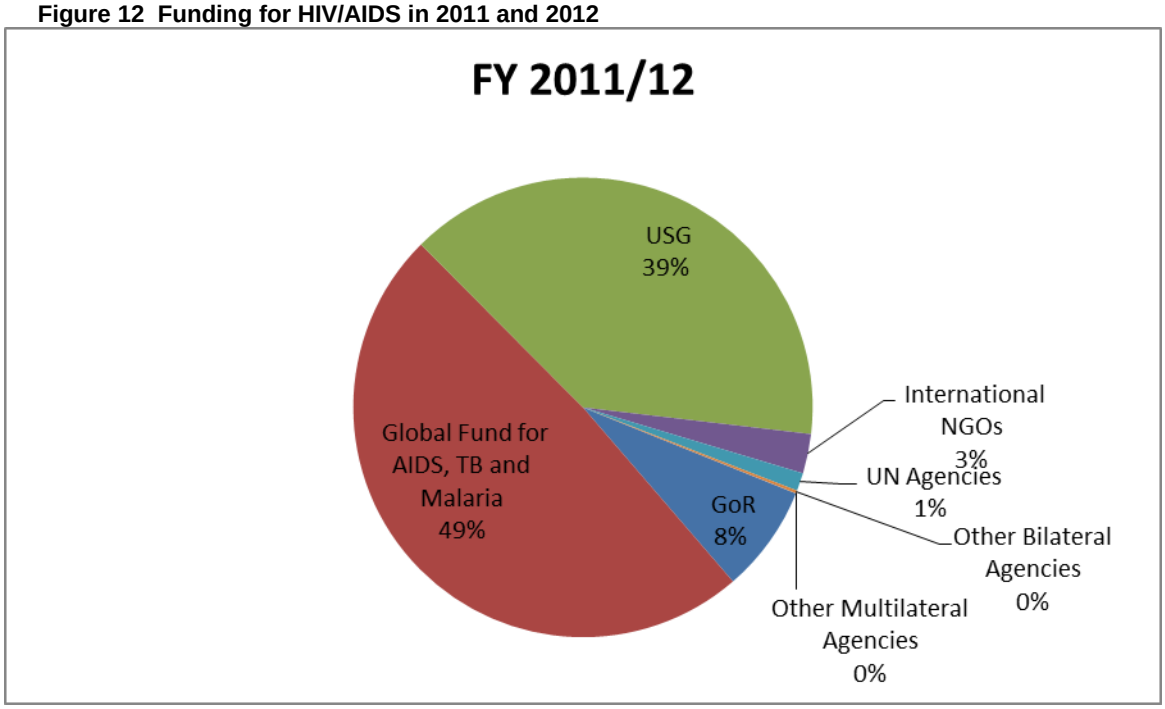
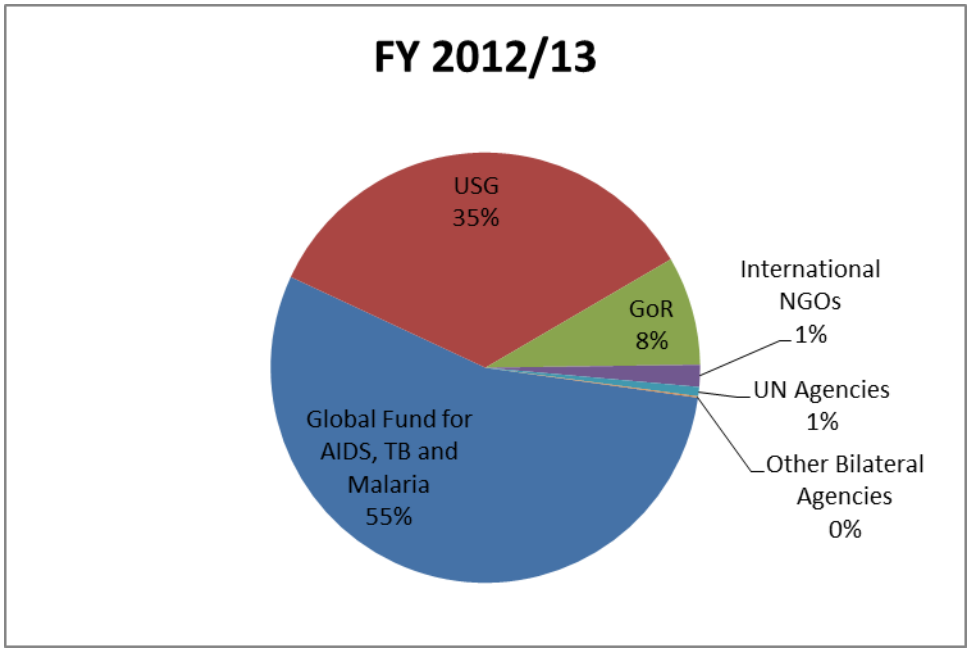


Figure 13 Funding for HIV/AIDS in 2012 and 2013



XI. Monitoring and evaluation environment

An overview of the current monitoring and evaluation (M&E) system

As the government of Rwanda continues to implement and scale up comprehensive HIV prevention, care and support interventions for its population, it is becoming increasingly crucial to develop a strong evidence base for planning and programming purposes. This includes understanding the dynamics of the HIV epidemic, including the sub-groups and other determinants driving the transmission of new infections; and gathering objective evidence on interventions that effectively and efficiently contribute to achieving the national targets of preventing new infections and improving the quality of life of people living with HIV.

The development of this M&E Plan adhered to the guiding principles of functional M&E systems proposed by the international community, and employed a participatory process engaging all HIV M&E Stakeholders at both the national and district levels. RBC In collaboration with partners organized a workshop in June 2013 to assess the functioning of the national M&E system. The RBC used two assessment tools: the M&E Systems Strengthening Tool (MESST) and the MERG's draft assessment tool for the 12 components of a functional national M&E system.

M&E Systems in Rwanda

The M&E system, and thus the M&E Plan, has several purposes and was developed by employing various strategies guided by overarching principles. In order to ensure that all essential components were included in the final M&E plan, it was decided to organize the M&E system around the twelve essential components of a functional M&E system, which outlines a comprehensive framework incorporating all M&E related tasks.

Rwanda has a large array of M&E systems for the health sector in general. These are in the process of being coordinated through a national M&E database, to allow collection of all data sources in one tool. HIV Data are divided into clinical (facility based) and a non-clinical (community based) components. The development of this M&E system and capacity building for its use are integral parts of the NSP 2013-2018.

Community-based M&E

Data collection and reporting is carried out at the decentralised level by the coordinator of the CDLS. 11 indicators have been selected; districts report on these quarterly . The data is coordinated centrally through HMIS, and analysed at the national level by M&E analysts in RBC. The 11 selected indicators correspond to data needs for follow-up of the NSP 2013-2018.

Facility-based M&E

Rwanda has employed web-based system (TRACnet) Since 2004. It primarily utilizes phone and internet connections to allow health facilities to report monthly on ART, PMTCT and VC, as well as male circumcision and discordant couples modules added in 2011. Around 450 health facilities report into TRACnet every month. District level agencies and implementing partners can access the data for program implementation monitoring. On the national level, M&E analysts compile the data, check quality and provide feedback, sharing it for research, using it for reporting purposes and for program monitoring and evaluation.

An electronic medical record (EMR) for patient medical charting is also functional in around 300 facilities. There is a plan to scale up the EMR system ion all facilities offering HIV services . In the beginning of 2012 approximately 20 district hospitals and only 120 health facilities had implemented the new EMR.

The national HIV M&E system experience the challenges:

- Shortage of human resources to collect and report the HIV data. This has been remedied by training of many regular training of data managers and health providers on the use of TRACnet system
- Data use is not yet sufficient at district level.

XII. National Commitments and Policy Instrument (NCPI)

The NCPI measures progress in the development and implementation of national-level HIV and AIDS policies, strategies and laws. This represents the framework within which the national response is anchored.

National AIDS Strategic Plan

The NSP 2013-2018 is the third HIV and AIDS intervention strategic plan being implemented in Rwanda. It follows the 2008-2012 strategic plan. The NSP reflects a strong evidence base and focuses on results. It aims at Lowering the new infection rate by two thirds, halving the number of HIV-related deaths, and ensuring that people living with HIV (PLHIV) have the same opportunities as all others.

The NSP addresses issues of key populations and vulnerable groups. These include men who have sex with men, sex workers, mobile populations, persons in uniform, young people, women and girls and people with disabilities. Key settings such as prisons, schools and workplaces are also taken into account. Cross cutting issues related to human rights protection, stigma and discrimination, gender inequality, poverty and involvement of people living with HIV (PLHIV) feature prominently in the NSP. In addition to highlighting the vulnerabilities of these groups, the NSP outlines specific strategies such as creating public awareness of stigma and discrimination and the legal barriers that prevent key populations from accessing and utilising services appropriately.

The multi-sector integration of HIV in the wider national development agenda is ensured by the identification of HIV as a cross-cutting issue within the Second Economic Development and Poverty Reduction Strategy (EDPRS 2). Each sector within EDPRS has specific HIV mainstreaming strategies and targets. Given the multi-sectorial nature of the NSP, it covers sectors such as education, health, labour, military, transport, gender, young people, agriculture, finance and social welfare. All of these have earmarked budgets.

The NSP has an operational plan for the period July 2013 to June 2015, commonly known as the HIV Consolidated Operational Plan. This operational plan has clear programme goals, clear targets and milestones, detailed costs for each programmatic area and an indication of funding sources.

The overall rating of strategy planning efforts in Rwanda's HIV programmes in 2013 has remained at 9 out of 10, the same level as 2011. It was at 10 out of 10 in 2007 and 2009.

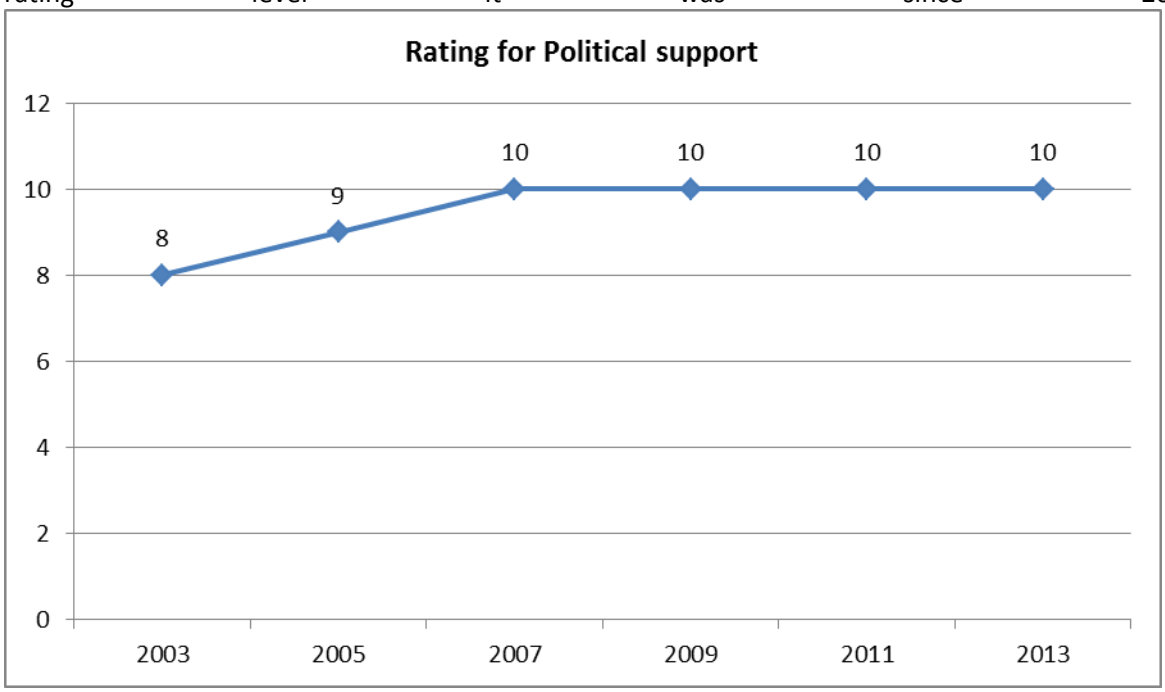
Political Support and Leadership

The government has demonstrated a significant level of support for the national HIV response. The government has called for more ambitious targets towards eliminating mother to child transmission of HIV.

The national health budget for 2013/2014 demonstrates increased government funding for the HIV/AIDS programs. The Government officials continue to be involved in activities that demonstrate their commitment to the national HIV/AIDS response. The First Lady launched the national plan for elimination of mother to child transmission. The Prime Minister officiated the opening of the East Africa Health Research Conference held in Rwanda. The Minister for Health officiated the World AIDS day commemoration.

Despite these successes, challenges still remain with regard to sustainability of the national HIV response given the overwhelming donor dependence as well as the lack of sufficient local resources. The NSP reflects the need to develop sustainable financing mechanisms. The GoR is also committed to enhancing domestic financing of the response and involvement of private sector.

The overall rating for political support for HIV and AIDS programmes in 2013 stands at 10. The same rating level it was since 2007.



Civil Society Involvement

The contribution of civil society to strengthening political commitment of top leaders and national strategy/policy formulations has been high. Civil society has also participated in the development of key documents such as the NSP 2013-2018.

A diversity of civil society representatives were involved in the development of the NSP 2013-2018, and the gender assessment of the National response to HIV. The Civil society also continued to be part of CCM and participated in several coordination meetings with PEPFAR. CSOs also provided inputs to the First Lady's speech for the replenishment of the Global Fund in Washington DC.

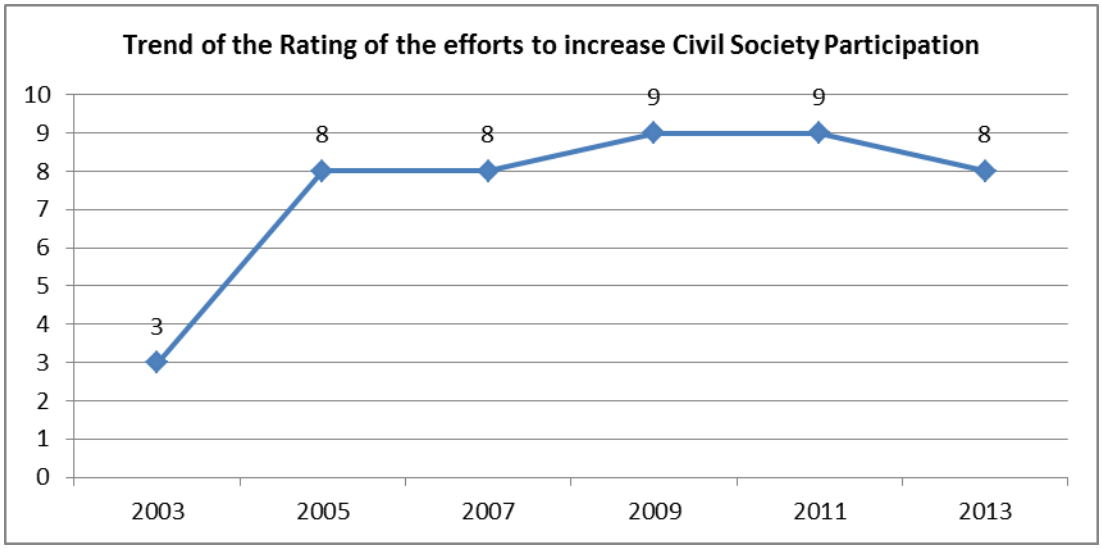
Although resources are being reduced, international organizations continue to provide technical support and guidance to national NGOs especially for the use of evidence in programming and resources mobilization, development of tools, conducting studies to develop generate evidence (stigma index, mapping exercise for CSOs interventions). For example in March 2012 UNAIDS trained CSOs staff in evidence-based planning and reporting. UN Women provided support to RRP+ for the creation the Youth and Gender into the Network of RRP+, UNICEF has provided support to the

Interfaith Network for the dissemination of the sermon guide on HIV and Maternal and Child health linking Safe motherhood and Bible and the Qor'an. Christian Aid has supported the interfaith network of Rwanda to implement the SAVE model for the HIV response. Support has also been provided to CSOs to align they strategic plans to the NSP, support has also been provided to local NGOs to attend international fora for experience sharing, learning and networking

The major challenges in civil society involvement include the funding environment. Due the reduction of the Global Fund funding, there has been a reduction of 67% in the number of CSOs sub-recipient of GF grants (from 90 to 30), which is likely to have negative impact on the coverage of CSOs interventions. There has also been significant reduction of donor-international NGOs that have closed their offices in Rwanda and others moved out of the health sector.

As a result of the significant reduction in funding, many NGOs have closed. The remaining NGOs had to take on activities that were carried-out by NGOs who dropped-out. Also lack of capacity of CSOs to effectively coordinate the interventions within their constituencies continues to be a challenge and with increased workload for the remaining organizations, the lack of capacity will affect their effectiveness. With lack of the multiple sources of funding, a slight reduction in the funding source has far reaching effects on the operations of the CSOs.

Efforts to increase civil society participation in 2013 are rated at 8. This is a reduction from the score of 9 reported in 2011. The trend of efforts to increase civil Society participation has remained high since 2006.

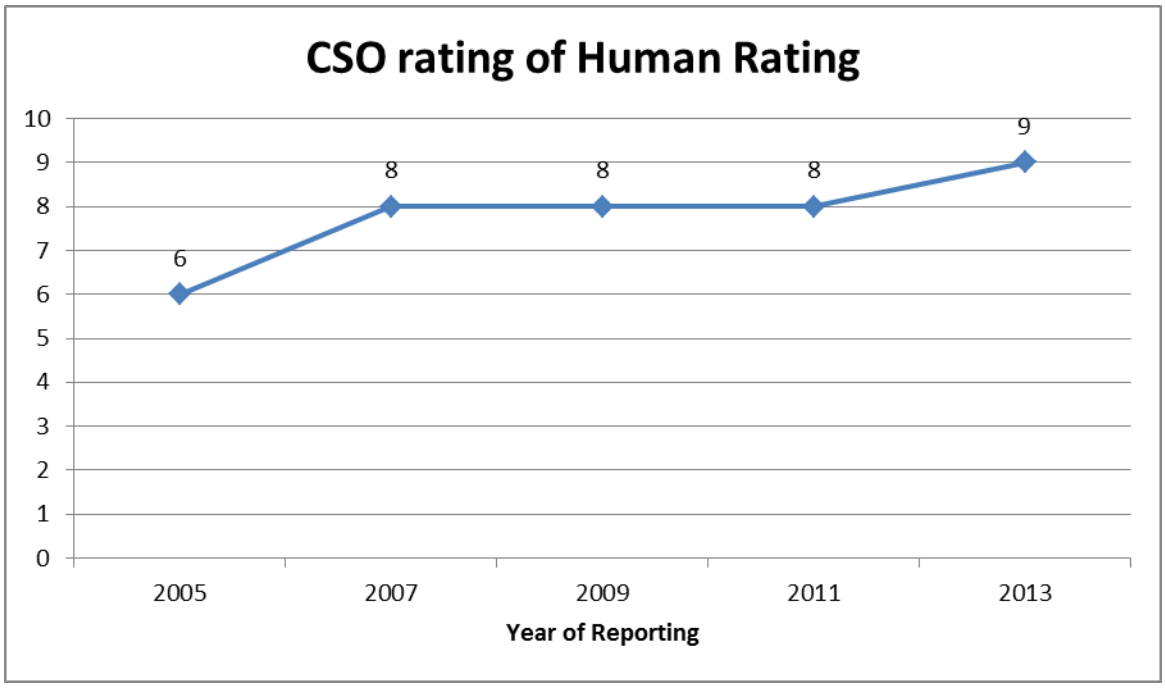


Human Rights

The Constitution of Rwanda, the law regulation labour in Rwanda (N° 13/2009 of 27/05/2009) prohibits discrimination within certain contexts. These are general laws with no specific reference to HIV and AIDS. With regard to the laws to reduce violence against women, the long awaited Anti Gender Based Violence Act was enacted in 2011. It outlaws gender-based violence which is defined broadly to include physical, sexual, economic and psychological violence. Among other things, it obligates the government to create shelters for victims of violence. Read with the Penal Code, the Act criminalises wilful HIV transmission. This is due to the fact that the Act defines Sexual Abuse to include "the engagement of another person in sexual contact, whether married or not, which includes sexual conduct that abuses, humiliates ore degrades the other person or otherwise violates another person's sexual integrity, or sexual contact by a person aware of being infected with HIV or any other sexually transmitted infection with another person without that other person being given prior information of the infection". Overall, the enactment of the Anti-Gender Based Violence Act is

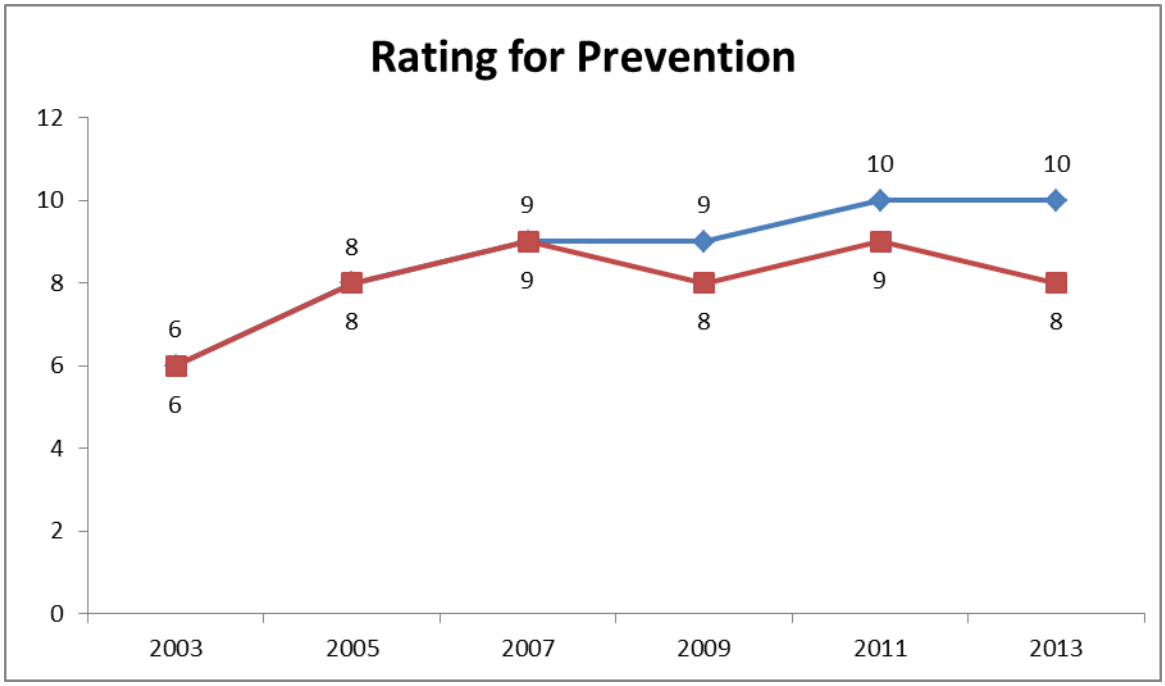
one of the major achievements in terms of legal reform. The implementation of the Act will contribute to reducing violence against women which often increases vulnerability to infection.

There are no laws that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups. These are however laws that criminalise sex work and use of drugs (including injection drug use). The illegality of sex work has however not hindered HIV prevention programs targeting this group. No information is available about the existence of people who inject drugs in Rwanda. Rehabilitation programs exist for all individuals convicted of drug use. HIV prevention program with in the rehabilitation program does not specifically target drug users.



Prevention

The National Strategy for the Prevention on HIV and STIs of 2009 has four main focus areas. These are prevention of sexual transmission of HIV and STIs, prevention of mother to child transmission of HIV, counselling and testing and prevention of HIV in health care settings. In addition, the key drivers of HIV in Rwanda have been identified through the Mode of Transmission (MoT) model. The strategies for prevention are revised and updated to be more consistent with new developments and technology. Male circumcision using prepex is being rolled out in the country. The NSP also acknowledges the importance of information, education and communication in HIV prevention.
One of the major achievements has been the scale up of male circumcision. More resources are required to scale up other prevention interventions.
The overall rating by government officials for efforts in the implementation of prevention is 10 out of 10. This is the same level as 2011. The Civil society rating for prevention is lower than the one of Government.



Treatment Care and Support

Addressing HIV treatment, care and support are key components of the NSP 2013-2018. According to the NSP, priority interventions in this area include increasing access and enrolment on antiretroviral therapy, providing treatment for TB/HIV co-infection and community and home-based palliative care. There has been a lot of progress in the area of treatment including more people being able to access ART, the adoption of the test and treat strategy for discordant couples, sex workers, and the adoption of the new WHO treatment guidelines and the availability of treatment for prisoners. Some challenges still remain with regard to Pre-ART care, treatment for opportunistic infections and adherence.

The overall rating of efforts in the implementation of HIV treatment, care and support groups is 9.

With regard to OVC, the major achievement has been the development of OVC standards of care. The NSP focuses on strategic needs of OVC such as protecting their human rights and ensuring access to adequate food, shelter, education and health services, and protection from abuse. The major challenges noted are the continuous increase in OVC, poor data collection and lack of national OVC database.

The CSO rating of efforts in the implementation of HIV treatment, care and support groups is 9 compared to 10 for 2011 and 8 for 2009. This is at the same level as the government officials rating.

Monitoring and Evaluation

There is a national monitoring and evaluation plan for as part of the Operational plan 2013-205. As with the NSP, this is coordinated by the RBC through its Monitoring and Evaluation Units. All key partners have aligned and harmonised their monitoring and evaluation with the national system.

CSOs are members of the Monitoring and Evaluation Technical Working Group at RBC. Apart from attending meetings for this Group, very few CSOs are involved in monitoring and evaluating the interventions.

The overall rating of HIV-related monitoring and evaluation is * compared to * and * in 2009 and 2007 respectively.

In conclusion, there is a good policy and strategy framework for interventions against HIV and AIDS in Rwanda. The challenge remains that of ensuring effective and comprehensive implementation. More political will is required to mobilise resources for the response as well as deal with some of the challenges such as the needs of key populations at high risk of infection. The legal framework and mechanisms for ensuring the protection of rights needs need to be strengthened in order to protect the rights of people living with and affected by HIV and AIDS. A strengthened and well-coordinated civil society sector is also critical to the success of the HIV and AIDS interventions in Rwanda.

Annex 1: Government Officials that completed he National Commitments and Policy Instrument

ORGANIZATION	NAMES	POSITION	SECTION RESPONDED TO					
			A.I	A.II	A.III	A.IV	A.V	A.VI
CDLS Gasabo	Bana Emma-Marie	CDLS coordinator	YES	YES	YES	YES	YES	YES
MIFOTRA	Ndizeye Jean Baptist	USPLS Executive Secreatry	YES	YES	YES	YES	YES	YES
RBC IHDPC	Mutamuliza Florida	In Charge of Sectors	YES	YES	YES	YES	YES	YES
RBC IHDPC	Hidura Jean Pierre	Technical Coordinator - HIV Decentralization	YES	YES	YES	YES	YES	YES
CDLS Kicukiro	Mukaranzi N. Clotilde	CDLS Coordinator	YES	YES	YES	YES	YES	YES
Ministry of Education (MINEDUC)	Rosine Bigirimana	HIV Project Manager	YES	YES	YES	YES	YES	YES
National Children Comission	Musabeyezu J. Damascene	M&E	YES	YES	YES	YES	YES	YES
National Human Rights Commission (NHRC)	Semani Ignace		YES	YES	YES	YES	YES	YES
Ministry for Internal Affairs (MININTER)	Dr. Gahima Innocent	Health Coordinator in Prisons	YES	YES	YES	YES	YES	YES
Ministry of Defence	Sebagabo Marcellin	HIV Focal point	YES	YES	YES	YES	YES	YES
RBC IHDPC	Gakunzi Sebaziga	Social Impact Mitigation Director	YES	YES	YES	YES	YES	YES
RBC IHDPC	Karangwa Chaste		YES	YES	YES	YES	YES	YES
RBC IHDPC	Remera Eric	M&E	YES	YES	YES	YES	YES	YES

Annex 2 : Participants in the Civil Society Completion of the NCPI

Names	Tittle	Organization	Respondent to Sections				
			Civil Society Involvement	Political support and leadership	Human rights	Prevention	Treatment, care and support
Badini Helene	Program Adviser	UNAIDS		Yes		Yes	
Bahati Innocent	Executive Secretary	ABASIRWA	Yes	Yes			
Bizimana Justin	Legal Representative	Amahoro Organization		Yes	Yes		
Burangwahe Omar	Coordinator	ACPLRWA		Yes			Yes
Dufitumukiza Canut	Executive Secretary	RNGOF	Yes	Yes			
Haganza James	M&E Officer	RNGOF		Yes	Yes		
Havugimana Cassien	Director	HDI		Yes		Yes	
Hirwa Triphine	Program Coordinator	ARBEF		Yes		Yes	
Iyamuremye Eric	President	RRRA		Yes	Yes		
Kagaba Aflodis	Executive Director	HDI		Yes			Yes
Kagabo Jean Bosco	Global Fund Coordinator	World Vision	Yes	Yes			
Kayumba Aime	Executive Director	KHA		Yes		Yes	
Madina Mutagoma	M&E Coordinator	RRP+	Yes	Yes			
Manzi Gloria	Prevention Associate	CDC		Yes		Yes	
Martin -Achard Nicolas	Child protection Specialist.	UNICEF		Yes			Yes
Mbabazi Pio	Peer Educator	ANSP+		Yes	Yes		
Muhayimpundu Grace	Country Director	CHABHA		Yes		Yes	
Muhimpindu M. Rose		HDI		Yes	Yes		
Mukandayisenga Madine	Executive Director	HOCA Rwanda	Yes	Yes			
Mukashyaka Geraldine	President	Vivre-Plus		Yes			Yes
Munderere Elyse I	Project Manager	FRSLHRw		Yes			Yes
Muragijerurema Viateur	DAF	Kigali Hope Association		Yes			Yes
Murebwayire Jeanne	District Coordinator	RCLS		Yes		Yes	
Muriisa Grace	HIV/Health Specialist	UNICEF		Yes			Yes
Murwanashyaka Evariste	Program Manager	AFEDEC	Yes	Yes			
Musangwa Eugenie Toussaint	Peer Educator	ANSP+		Yes	Yes		
Musore Innocent		Voice of Community		Yes		Yes	
Ndabaramiye Rwema J. Pierre	Legal Representative	CHRD		Yes	Yes		
Ndengeyinka William	Program Manager	GLIHD		Yes	Yes		
Nizeyimana Isabelle	Coordinator	R.C. Sangwa Vivre		Yes			Yes
Nkundimana Sylve	RRP+ Kicukiro	RRP+		Yes	Yes		
Ntwali Andrew	HIV CCP	UNFPA		Yes		Yes	

Names	Tittle	Organization	Respondent to Sections				
			Civil Society Involvement	Political support and leadership	Human rights	Prevention	Treatment, care and support
Rugema Jean Damascene	District Coordinator	RCLS		Yes			Yes
Ruturwa Dieudonne	Partnership Advisor	UNAIDS	Yes	Yes			
Sebagabo Christophe	Administrative Officer	Action for Health Integrated Development (AHID)		Yes			Yes
Shema Celestin	Program Manager	Prison Fellowship Rwanda		Yes		Yes	
Singirankabo Ignace	Executive Secretary	RCLS		Yes		Yes	
Sssenfuka James	RH Specialist	UNFPA		Yes		Yes	
Umuhire Nora	Program Development Manager	SFH		Yes		Yes	
Umutoniwamana Laurance	M&E Research	ANSP		Yes	Yes		
Uwamwezi Pauline	Secretaire Generale	HOCA Rwanda		Yes	Yes		
Uwayezu Andre	President- RRP+ Gasabo	RRP+		Yes	Yes		
Uwingabire Alphonsine	District Coordinator	UPHLS		Yes		Yes	
Uwitonze JMV	Project Officer	RDM		Yes	Yes		

Annex 3 : Attendance To The GARPR-2014 Rwanda Validation Meeting Of 26th March 2014

N0	NAMES	INSTITUTION	EMAIL
1	Andrew K. NTWALI	UNFPA	ntwali@unfpa.org
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