Republic of Rwanda

Ministry of Health

Annual Report on HIV AND AIDS 2012-2013

RWANDA BIOMEDICAL CENTER

A Healthy People. A Wealthy Nation

ACKNOWLEDGEMENTS

The HIV annual report was developed in collaboration with various partners involved in the National Response to HIV in Rwanda.

The RBC-IHDPC-HIV&AIDS, STIs and Other Blood borne Infections Division would like to take this opportunity to thank all stakeholders who actively participated in providing the necessary information on the progress in implementing the National Strategic Plan 2009-2012 for the fiscal year July 2012-June 2013

Through the Monitoring and Evaluation Technical Working Group, the RBC-IHDPC-HIV&AIDS, STIs and Other Blood borne Infections Division collected the required information and data from MOH/RBC-IHDPC (NRL, NCBT) RBC-MPDD, CDLS, Umbrellas, EDPRS Sectors and some implementing partners.

We are very grateful for the technical support provided by different development partners to contribute to the achievements of the national HIV response during this reporting period.

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EXECUTIVE SUMMARY

The 2012-2013 National Annual Report on HIV program presents the progress in implementing the strategies and activities articulated in the National Strategic Plan on HIV and AIDS 2009-2012 (ending in June 2013), commonly referred to as the HIV NSP.

The NSP clearly articulates the progress towards set targets by planned strategies to achieve the implementation of the four year strategy. The country has made great progress during the reporting period and some of the key achievements are summarized under the three impact areas below.

Impact 1: The incidence of HIV in the general population is halved by 2012 (HIV Prevention)

In June 2013, there are 493 health facilities offering voluntary counseling and testing. The scale-up of health facilities offering VCT services contributed to the increase in the number of clients counseled and tested for HIV. There were **3,121,257** tests done in health facilities and mobile VCT from July 2012 to June 2013. The total number of HIV tests performed from 2003 up to June 2013 is **13,685,577**.

The World AIDS Day (WAD) was launched in December 2012 under the theme ***"The Role of the Intore in Stopping New HIV Infections within the Rwandan Community"***. The Intore are upstanding Rwandan citizens that act as mentors and role-models in local communities.

Specific preventive interventions have been implemented during the reporting period to reach key populations identified in the 2009-2012 HIV NSP, namely young women age 15-24 (through youth friendly centers and youth friendly corners in health facilities), female sex workers (through outreach by peer educators, reduction of household socio-economic vulnerability, adapted HIV, STI and family planning services) and other vulnerable and most at risk populations, such as people with disability (PWD), Men having sex with men (MSM), and mobile populations (fishermen, motorcyclists)

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. The revised supply chain system considers the different partners and comprises the standard operational procedures (SOP) manual, designed to provide guidance to all partners and entities involved in the supply and distribution of condoms at the different levels.

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. During this reporting period, male Circumcision services have been provided to 138,711 boys and men. Among them, ten thousands (10,000) men have been circumcised using Prepex method. 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.

By June 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. There are 445 health facilities (health center and hospitals) collecting samples (DBS) including some District Hospitals for early infant diagnosis for children born to HIV-positive mothers.

Impact 2: Morbidity and mortality among people living with HIV are significantly reduced (HIV Care and Treatment)

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. New guidelines have been elaborated and disseminated for the screening and treatment of cryptococcal infections.

Between July 2012 and June 2013, 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 from 107,938 to 123,499.

Numerous integrated training sessions were organized to improve knowledge and skills of health care providers on various topics: Implementation of D4T Phase out, Hepatitis B

Screening and vaccination, Rational use of drugs and lab commodities, Training of HIV Clinical Mentors, Implementation of Cryptococcus Infection Screening. A total of 980 (37MD and 936 Nurses and 7 social workers) from all over the country were trained on the national guidelines.

To enhance the rational use of ARV drugs, supervision visits have been conducted with aims to ensure the continual supply of drugs and reagents and the adherence to national guidelines while dispensing drugs and testing.

To improve the quality of HIV services, several strategies were implemented: active tracing of patients lost to follow up and identification of drug resistance, clinical mentorship to provide practical onsite training to health care workers, provision of adherence support through psychosocial support, integrated mental health care and nutritional support.

Impact 3: People infected and affected by HIV have the same opportunities as the general population (HIV Impact mitigation)

To develop entrepreneurship among people infected and affected by HIV, different associations were transformed into cooperatives with RRP+ support, and CHF Higa Ubeho. In the year 2012-2013 24% of RRP + member organizations have certificates of RCA (Rwanda Cooperative Agency) and 26% are still searching for the official document.

In this reporting period **15,141 individuals** from households of persons infected/affected by HIV/AIDS received food security and nutrition services from USAID Higa Ubeho 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. Nutrition services include nutritional status monitoring, cooking demonstrations, home visits, hygiene education, nutrition education and growth monitoring during activities for children under 5.

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

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.

A study has been carried out ***(Stigma and Discrimination Index Survey*)** by RBC/IHDPC in collaboration with partners which aimed at establishing the level of stigma and discrimination for the people infected and affected by HIV for better interventions.

RRP + with the support of RBC and UNWOMEN , supported the process of integrating women and youth in the organization of RRP + , to better contribute to the agenda for accelerated advancement of women , girls and gender equality in the context of HIV .

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ABBREVIATIONS

ABC	Abstinence, Be faithful and Condoms
ABS	Advanced Business Strategies
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-Natal Consultations
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
BSS	Behavioral Sentinel Surveillance
C&T	Care and Treatment
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDLS	Comité de District de Lutte contre le SIDA (District AIDS Control Committee)
UTH-B	University Teaching Hospital of Butare
UTHK	University Teaching Hospital of Kigali
CHW	Community Health Worker
CPDS	Coordinated Procurement and Distribution Systems
CSO	Civil Society Organization
HCT	HIV Counseling and Testing
DH	District Hospital
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment – Short course

EDPRS	Economic Development and Poverty Reduction Strategy
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child HIV Transmission
FBO	Faith Based Organization
FHI	Family Health International
FOSA	Formation Sanitaire (Health Facility)
FP	Family Planning
FSW	Female Sex Workers
GIPA	Greater Involvement of People living with HIV and AIDS
GSLSA	Group Saving and Loan Associations
GOR	Government of Rwanda
HBC	Home Based Care
HF	Health Facilities
HIV	Human Immunodeficiency Virus
HRT	Health Resource Tracking Tool
HSSP	Health Sector Strategic Plan
ICAP	International Center for AIDS Care and Treatment Programs
IEC	Information, Education, Communication
IGA	Income Generating Activity
IHDPC	Institute of HIV/AIDS, Disease Prevention and Control
IMCI	Integrated Management of Childhood Illnesses
M&E	Monitoring and Evaluation
MARPs	Most at Risk Population
MC	Male Circumcision
MCH	Maternal Child Health

MDG	Millennium Development Goals
MIFOTRA	Ministry of Public Services and Labor
MIGEPROF	Ministry of Gender and Family Promotion
MIJESPOC	Ministry of Youth, Sport and Cultural
MINAFET	Ministry of Foreign Affairs
MINAGRI	Ministry of Agricultural
MINALOC	Ministry of Local Government, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MINICOM	Ministry of Commerce and Industry
MINIJUST	Ministry of Justice
MININFRA	Ministry of Infrastructure
MINIYOUTH	Ministry of Youth
MoH	Minister of Health
MPDD	Medical Procurement and Distribution Division
MSM	Men who have Sex with Men
NCBT	National Center for Blood Transfusion
NCC	National Commission of Children
NGO	Non-Government Organization
NISR	National Institute of Statistics of Rwanda
NRL	National Reference Laboratory
NSP	National Strategic Plan on HIV and AIDS
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children

PBF	Performance Based Financing
PCR	Polymerase Chain Reaction
PE	Peer Educators
PEP	Post Exposure Prophylaxis
PEPFAR	Presidential Emergency Plan For AIDS Relief
PIT	Provider Initiated Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child HIV Transmission
PWD	People With Disabilities
QC	Quantification Committee
RBC	Rwanda Biomedical Center
RCLS	Réseau des Confessions religieuses dans la Lutte contre le SIDA
RH	Reproductive Health
RHCC	Rwanda Health Communication Center
RNYC	Rwanda National Youth Council
RPOs	Rwanda Partners Organizations
RRP+	Réseau Rwandais des Personnes vivant avec le VIH
RWANARELA	Rwanda Network of Religious Leaders living with AIDS
SGBV	Sexual Gender Based Violence
SOP	Standard Operating Procedures
SPIU	Single Project Implementation Unit
SSF	Single Stream Funds
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendants
ToT	Training of Trainers

TS	Task Shifting
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UPHLS	Umbrella des Personnes Handicapées dans la Lutte contre le SIDA (Umbrella of people with disabilities in the fight against AIDS)
USAID	US Agency for International Development
USD	US Dollars
USG	United States Government
VCT	Voluntary Counseling and Testing
WAD	World AIDS Day
WHO	World Health Organization
YFC	Youth Friendly Center

I OVERVIEW

1. INTRODUCTION

The Annual Report on HIV and AIDS 2012-20123 captures the main achievements and progress to date in the implementation of the multi-sectoral HIV response in Rwanda, as outlined in the National Strategic Plan on HIV and AIDS 20013-2017 (NSP).

The NSP serves as the guidance document for all HIV implementers in the country, indicating key national results that should be achieved through the delivery of high quality HIV services in both health facilities and community settings. Following the Three Ones framework, the NSP clearly describes the roles and responsibilities of all actors and stakeholders in the HIV response at the international, national, and decentralized levels, indicating key strategies to guide implementation.

2. Purpose of Annual Report on HIV and AIDS 2012-2013

The report is meant to serve as the overall reference document for the HIV response in Rwanda, providing the most comprehensive data on progress in NSP implementation and achievements against NSP results and targets with the purpose of informing key stakeholders on the progress against outputs and strategies in order to reorient actions and interventions with the aim of maximizing the results of the plan and inform other planning processes.

The National Annual HIV Report also includes a financial section describing HIV expenditures for the same time period. This financial report refers to the total HIV expenditures from recent years (since the beginning of the current NSP) and compares those past expenditures to the estimation of HIV expenditures for fiscal year 2012-2013. For GOR HIV expenditures, more details are given on the main cost categories to which it contributes.

3. Organization of Annual Report on HIV and AIDS 2012-13

This National HIV Annual Report is largely focused on the progress in implementation based on the national and programmatic indicators with a small narrative summary on the description of activities and strategies.

The first part is a narrative describing progress in the implementation of key strategies by all HIV actors in the country for the reporting period. As such, the report is primarily organized according to the three Impact Results outlined in the NSP 2013-2017:

- The incidence of HIV in the general population is halved by 2012
- Morbidity and mortality among people living with HIV are reduced
- People infected and affected by HIV have the same opportunities as the general population

In the NSP, each Impact Result is further organized into outcome results, intermediate results (for the HIV Prevention Impact Result), and output results. For this report, the progress is described at a secondary level by output result under each impact result with a narrative describing the achievements of HIV actors in the country according to key strategies under each output.

The financial part of the report provides information on HIV expenditure during the reporting period with a comparison of the gap and budget projections to the expenses and actual commitment by different stakeholders. The expenditures are available by NSP categories.

At each result level, performance and success indicators have been selected as national and program level indicators with annual targets to measure progress. Impact and outcome results are higher level results obtained and measured at the population level. These changes take several years to detect through population-based surveys and other research studies, and thus are beyond the purview of this report. Nonetheless, some data are available to report against the NSP national and program-level indicators (typically divided according to the community-based and facility-based HIV response).

II HIV PREVENTION

2.1 IMPACT 1: THE INCIDENCE OF HIV IN THE GENERAL POPULATION IS HALVED BY 2012

2.1.1 Output 1.1.1.1. General Population is reached by comprehensive HIV prevention programs

This output seeks to ensure that all members of the Rwandan population are informed about HIV and STI prevention, and the existence of key services such as family planning, HIV testing and availability of condoms. During the reporting period of July 2012 to June 2013, all partners worked together to provide HIV prevention services to the general population according to the key strategies outlined in the NSP.

A. **Community sensitization for promotion of safe sexual behaviors, including HIV testing and promotion of condom use**

- **Extension and Improvement of HCT Services**

The overall HIV testing and counseling goal is to identify as many people living with HIV as early as possible after acquiring HIV infection, and link them appropriately and in a timely manner to prevention, care and treatment services. The people tested who are not infected are given appropriate counseling and are linked to appropriate prevention services. All forms of HIV testing and counseling are absolutely voluntary and adhere to the five **C's**: **C**onsent, **C**onfidentiality, **C**ounseling, **C**orrect test results and **C**onnections to care, treatment and prevention services.

HIV counseling and testing services are offered free of charge at all public health facilities recognized by the Ministry of Health of Rwanda. Accredited private clinics do also offer HIV testing to individual adults or couples at a price determined by the MOH rules and regulations.

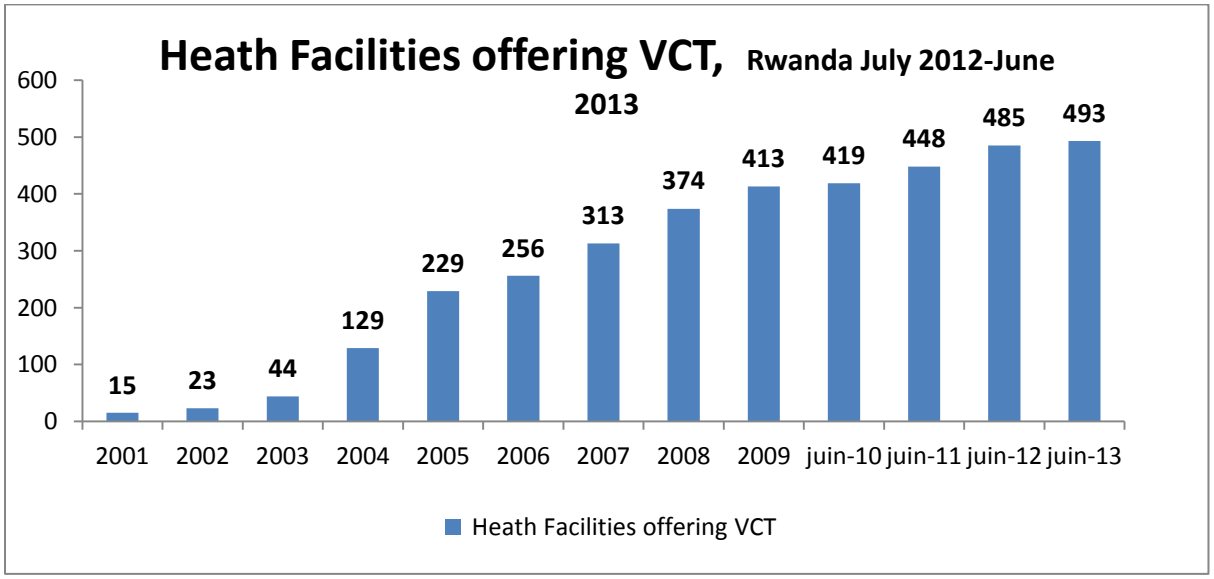
HTC services are offered to everyone who wishes to know his/her HIV status; those who come to health facilities with signs, symptoms or health conditions that could indicate the suspicion of HIV infection are advised by care providers to get tested through provider initiated testing (PIT).

The outreach HIV counseling and testing (HCT campaign) was also 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 health facilities' staff trained in HIV counseling and testing. HCT campaigns offer a valuable opportunity to overcome the challenge of geographical accessibility for hard to reach areas. Some campaigns are organized with specific target populations transmitting the HIV infection to the general population such as key populations (sex workers, mobile populations) and vulnerable groups.

During the year 2013, we introduced the WHO recommended use of finger prick blood collection method in HIV testing. With the collaboration of NRL division and clinical partners, finger prick tools (trainer's manual, provider's manual and finger prick booklet) were disseminated and training of trainers from districts hospitals countrywide has been completed.

In order to increase the number of clients counseled 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 were done in health facilities and mobile VCT from July 2012 to June 2013.

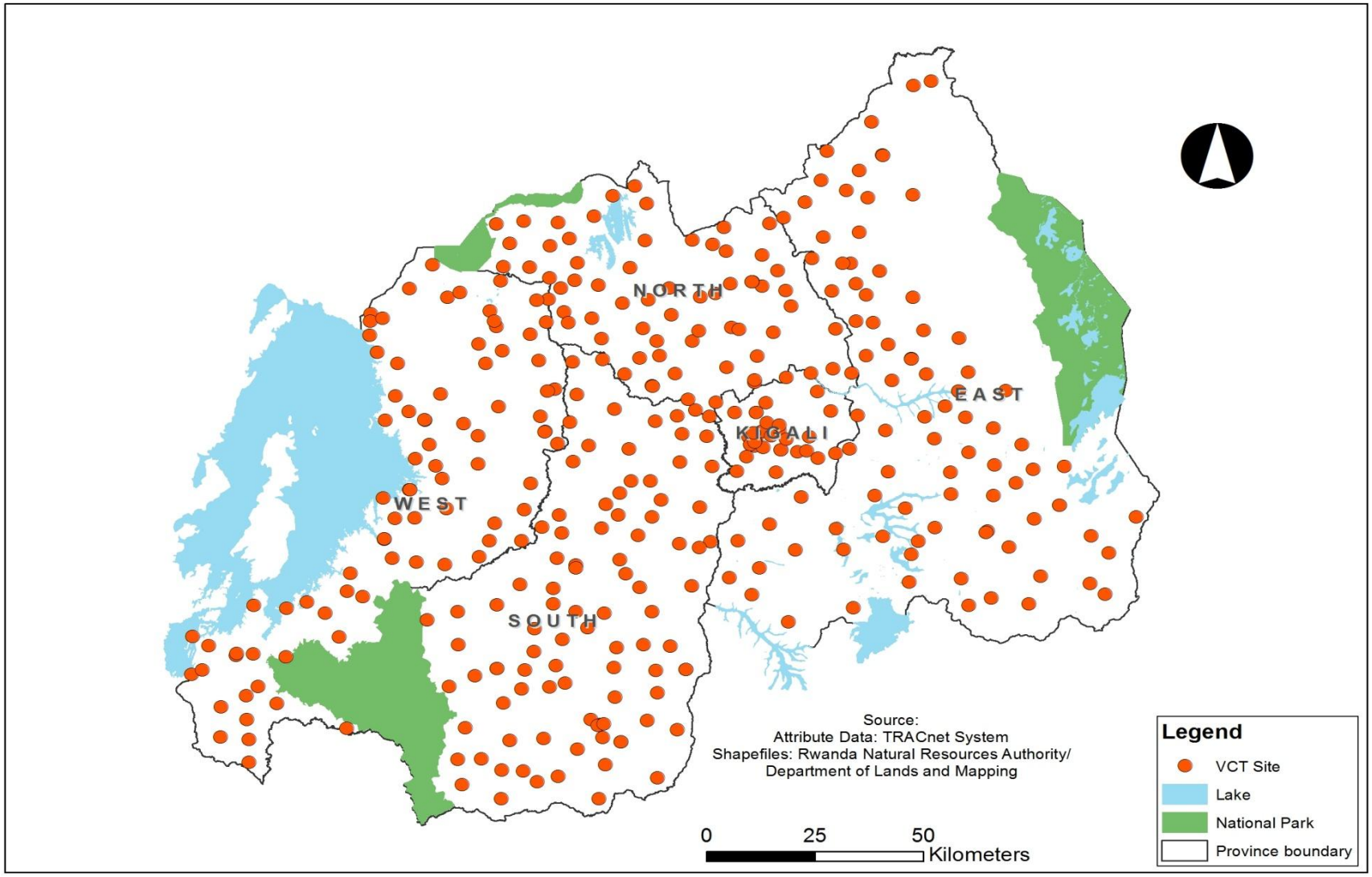
Figure 1 Trend in health facilities offering voluntary counseling and testing since 2001



Source: TRACnet, 2012-2013

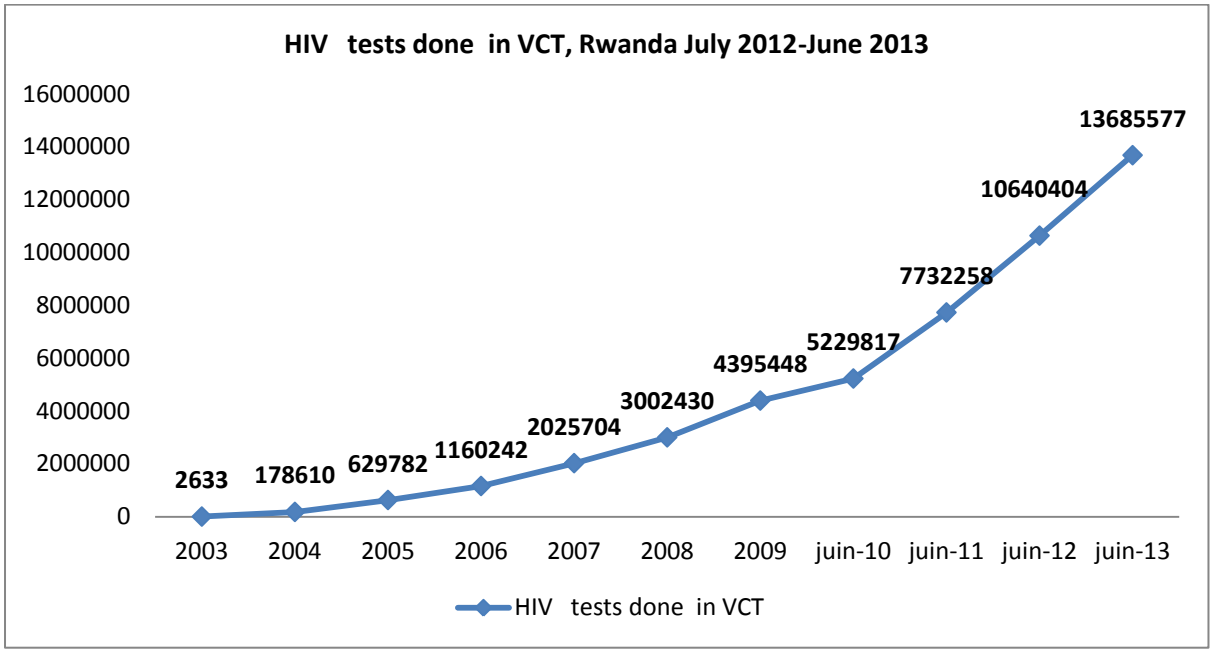
The Figure above indicates a significant increase in the number of health facilities offering VCT, from 15 in 2001 up to 493 health facilities in 2013.

Map 1HCT Coverage, Rwanda July 2012 – June 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.

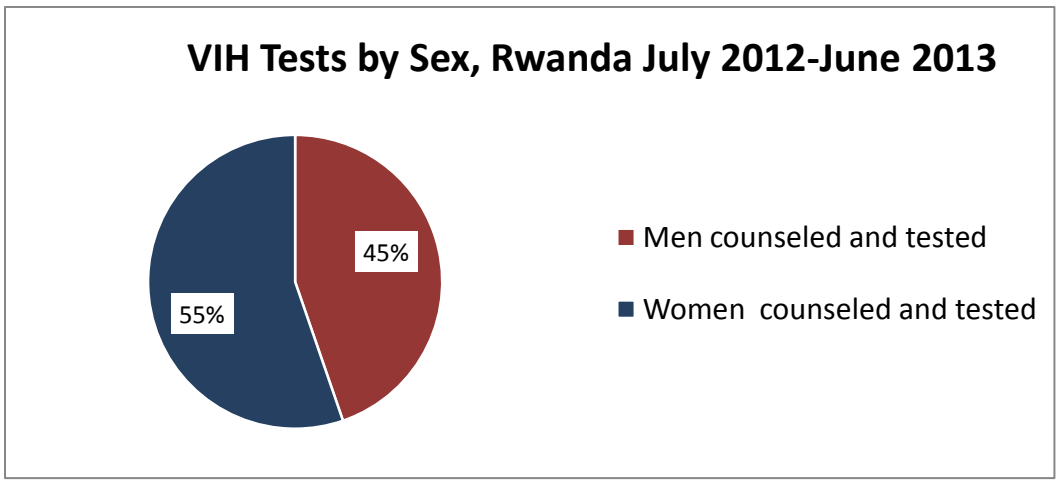
Figure 2: Cumulative number of HIV tests performed from 2003 to June 2013



Source: TRACnet, 2012-2013

The total number of HIV tests performed from 2003 up to June 2013 was 13,685,577. This number includes people tested in both health facilities (VCT&PIT) and HCT campaigns.

Figure 3: Distribution of People tested by sex, June 2011- July 2012

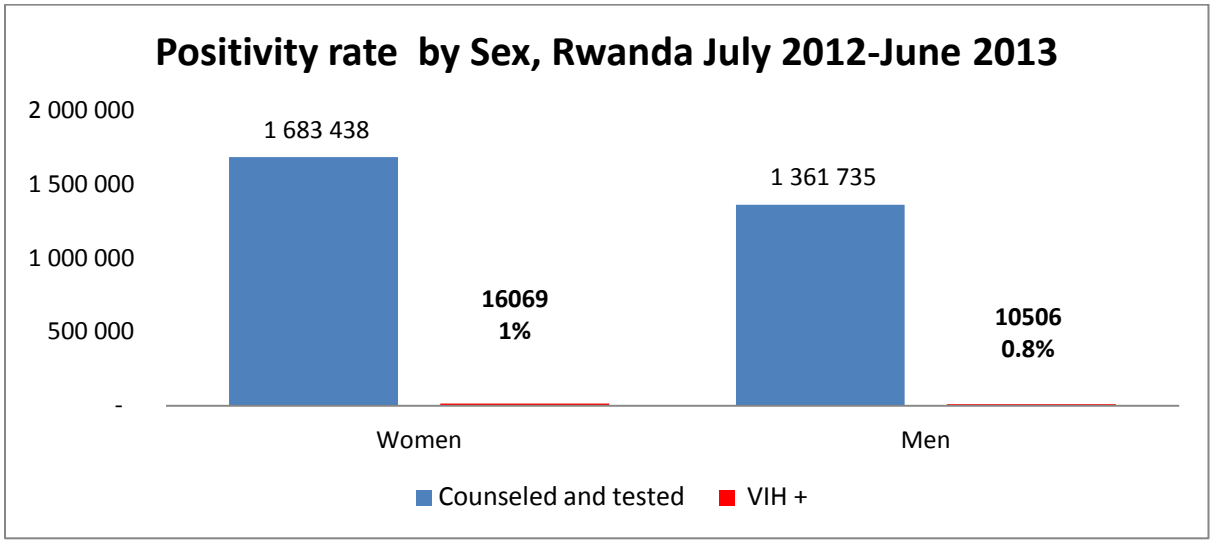


Source: TRACnet, 2012-2013

Of the total 3, 121,257 people tested from July 2012 to June 2013, 55 % were women and 45% were men.

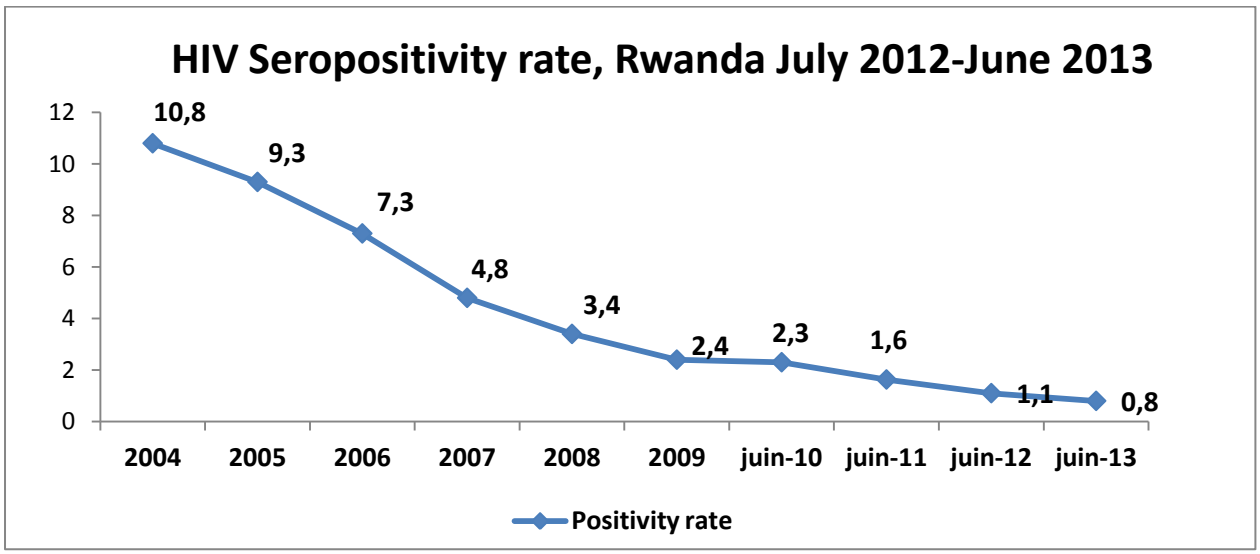
For the reporting period (July 2012- June 2013), the HIV prevalence was 1% in women and 0.8% in men)

Figure 4: Positivity Rate by Sex



Source: TRACnet 2012-2013

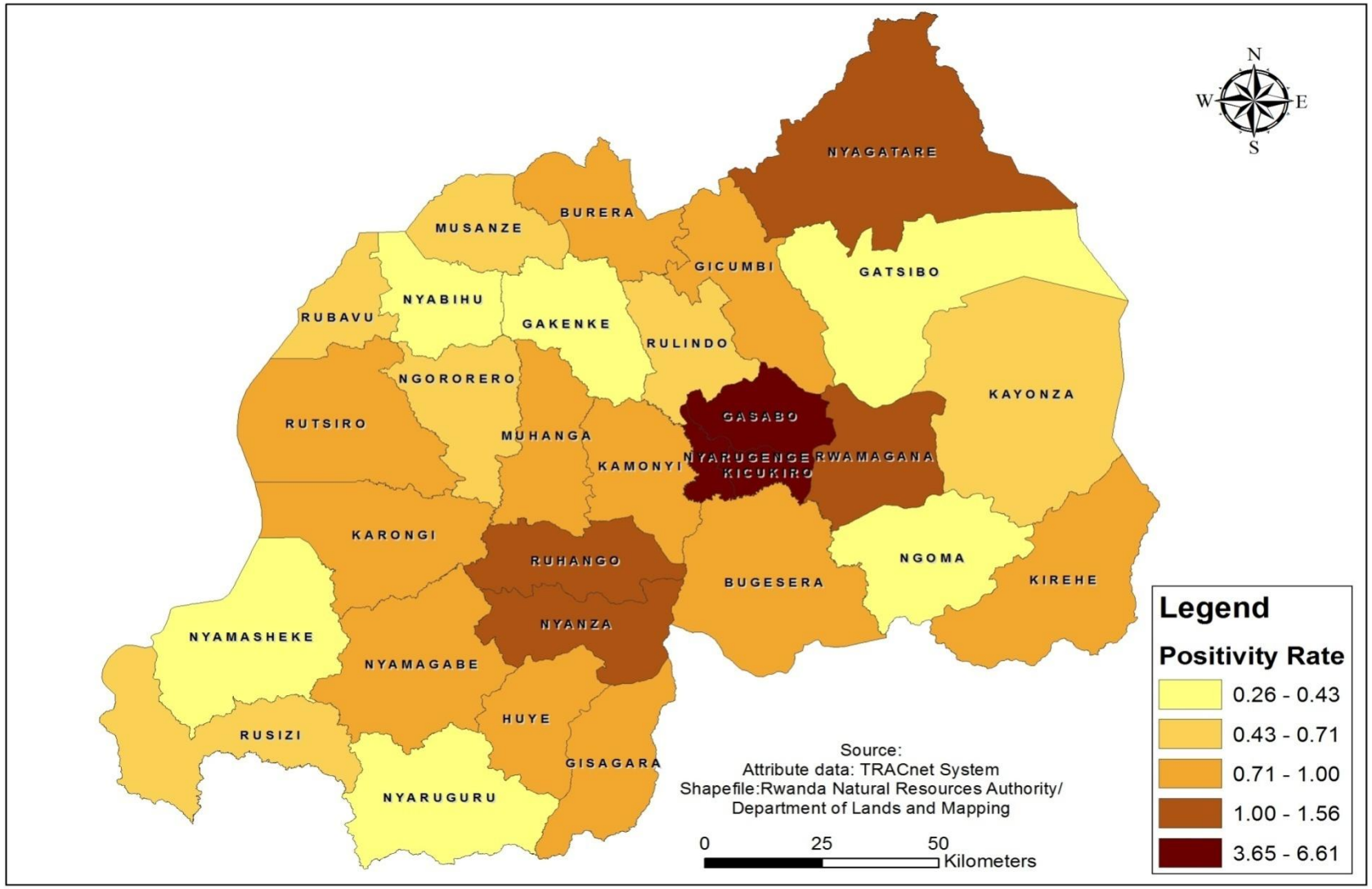
Figure 5: Seropositivity rate among people tested for HIV from 2004 to June 2013



Source: TRACnet, 2012-2013

In the last seven years, the HIV/AIDS, STIs and Other Blood Borne Infections Division has registered a downward trend in HIV positivity rates among clients tested in VCT services, from 10.8% in 2004 (TRAC Report 2004) to 0.8% reported positivity rate at the end of June 2013. The HIV positivity rate is higher in Kigali City, Nyagatare, Rwamagana, Ruhango and Nyanza Districts as indicated in the map bellow.

Map 2HIV Positivity Rate in Rwanda, July 2012-June2013



- **HCT campaigns**

HCT campaigns contribute widely in facilitating access to service for some groups of the population whose utilization is lower than targeted. HCT campaigns targets include key populations playing an important role in HIV spread to the general population, such as sex workers and mobile populations and population residing in hard to reach areas, where the utilization of HCT services in health facilities in compromised by the long distance to walk from home to the facility.

Among them, let us note Fishermen sensitization and HCT campaigns conducted in Rubavu, Karongi and Rusizi (along Kivu Lake). The distribution and sensitization of the population for regular use of condom is among key components of such campaigns. It has been a good opportunity to facilitate the population's access to condom.

- **Provision of specific counseling services for people with disabilities**

In collaboration with the Umbrella of people with disabilities in the fight against HIV/AIDS, comprehensive HIV educational tools have been designed, multiplied and disseminated to health facilities and specialized centers for people living with disabilities. They include posters, training manuals, visual and audio CDs as well as Braille documents. Refresher trainings of trainers as well as trainings of providers were conducted in order to ensure meeting specific needs of this population group.

- **World AIDS Day**

The World AIDS Day (WAD) is commemorated each year in Rwanda, and it was launched in December 2012 under the theme ***"The Role of the Intore in Stopping New HIV Infections within the Rwandan Community"***. The Intore are upstanding Rwandan citizens that act as mentors and role-models in local communities, providing "cultural values that should characterize the model Rwandan citizen".

The launch on December 1st was followed by HIV awareness and prevention campaign held all over the country during 3 months. It emphasized on programming and prioritization of HIV control activities among key populations, such as sex workers, truck drivers and men in uniform.

- **Outreach Campaigns**

The outreach campaigns were conducted in order to complement the provision of HIV services to people living in remote and hard to reach areas. Such campaigns were also conducted for population groups with special needs in HIV prevention and those considered as key in the transmission chain of HIV infection among the general population.

2.1.2 Output 1.1.1.2. Women aged 15-24 are at reduced risk of HIV Infection

The scale up of HIV services provided in Youth Friendly Centers has been coupled with the introduction of Youth Friendly Corners in health facilities. A comprehensive service package meant for adolescents has been adopted and the implementation has been launched both in youth friendly corners in health facilities and youth friendly centers. This followed training of healthcare providers and peer educators, and dissemination of IEC materials adapted to adolescents education.

Youth mobilization campaigns have been conducted in all districts of the country to increase adolescent comprehensive knowledge on HIV prevention. Radio live talks and secondary schools benefited a talk given by an HIV and STIs prevention expert.

2.1.3 Output 1.1.1.3 Sex Workers are reached by comprehensive prevention Programs

Female sex workers group has been evidenced by recent study findings as one of key drivers of the HIV epidemic in Rwanda. During the current reporting period, RBC-IHDPC 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. These activities are scaled up in all districts country wide. After completion of female sex workers' population size estimation, the need to tackle the quality of services evolved. To ensure appropriateness and completeness of interventions, the minimum package of services provided to sex workers was developed and validated to guide health care providers.

To this end, significant achievements were made to improve HIV services provided to female sex workers.

A. 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 2009-2012. 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.

B. 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 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. They 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. This is done through active condom distribution through peer education, paying *mutuelle de santé* for all FSW and their children.
- Reaching FSW partners by including condoms in the minimum package for HIV prevention for sex workers.

C. 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.

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

Under RBC /IHDPC coordination, FHI ROADS as a major implementing partner in this area collaborated with District hospitals, Health facilities, CDLS and FSWs to identify which health facility will be supported to provide health services to FSWs. FHI 360/ROADS II provided the following technical assistance to selected health centers in 5 districts(Kicukiro, Gasabo, Rubavu and Rusizi) based on HIV prevalence among FSWs:

- Training of health providers in STI screening and treatment using the national guidelines,
- Provision of adequate equipment (such as gynecologic tables, lamps, national guidelines, STI screening and treatment algorithms),
- Provision of iPADs for electronic data management and the training of health providers and data managers in the use of iPADs.
- Provision of adequate IEC/BCC materials.

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%) are provided with regular STI screening, HIV testing, FP services and condom provision.

In this group, they have all been given a chance to get counseled and tested for HIV. Results showed that 8 among them, (0.5 %) were newly HIV infected. This brings out the total number of HIV infected FSWs at 494 in the group of 2,310 (21.3%).

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

In partnership with various counterparts in support for female sex workers such as Faith Victory Association (FVA), a local NGO, the following have been achieved:

- Advocacy activities to ensure the Female Sex Workers are adequately protected from violence and discrimination, whereby 845 Law enforcement authorities participated;
- Participatory assessments and mapping exercises were conducted and helped to map 1927 sex workers;
- 1032 female sex workers were trained in peer education, covering HIV and STIs, cooperatives and life skills violence and rights and referral for HIV testing and STIs at District and local level;
- 554911 male and female condoms were availed to FSWs and their clients;
- 379 Female Sex Workers were involved in defining and conducting related activities on advocacy;

- 8716 Female Sex Workers participated in sex workers-friendly events covering HIV and STIs, condom negotiation skills, life skills and referral for HIV testing and STIs diagnosis, violence, reproductive health services VCT and PMTCT;
- 3529 Female Sex Workers participated in discussion meetings between Female Sex Workers on themes such as health, well-being, and violence and rights.

2.1.4 Output 1.1.1.4 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; during this period many documents and tools were disseminated and distributed to people with disabilities.

The major achievements are:

- 2350 copies of the adapted training manual on disability and HIV&AIDS on Kinyarwanda , French and English version in Braille were developed and distributed to persons with visual impairments/blind;
- Avail adapted IEC tools to various types of disabilities including: Large print, Braille, Audio CD, Video message with sign language and Image boxes are being distributed to trained trainers, peer educators, groups and centers of PWDs, for use in the community awareness campaigns;

Capacity building of implementing partners and community

- Training of Healthcare professionals on HIV management among people with disabilities:169 health facilities were reached during this reporting period;
- Training of peer educators on HIV&AIDS and disability:341 people were trained on HIV/AIDs and disability

International Day of Persons with Disabilities (IDPD) campaign

In line with their contribution in the fight against HIV/AIDS among people with disabilities, International Day of Persons with disabilities (IDPD) marked a three months campaign

aiming at sensitizing people with disabilities for individual responsibility in the fight against HIV/AIDS. The theme of the campaign was "*Barrier-Free Society, Inclusive HIV&AIDS Services: Towards Zero New HIV Infection among PWDs".* Four selected districts hosted the campaign (Gasabo, Rusizi, Nyanza and Gicumbi Districts) and compiled reports from the four districts show that over 2000 PWDs were reached during these campaigns.

In total, over 99 associations and cooperatives organized outreach campaigns among their members and catchment areas from April to Mid June 2013 where 5456 people with disabilities were provided with HIV prevention messages. A disability friendly voluntary counseling and testing was conducted and 3226 persons had an opportunity to know their HIV status and get professional HIV counseling.

MSM

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.

Major achievements

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.

Other Most at Risk Population

a. Fishermen

The NSP 2009-2012 identified fishermen as a key population for HIV and AIDS in Rwanda. RBC/IHDPC/HIV, AIDS, STIs and OBBIs Division, in collaboration with the key partners and stakeholders in fighting against the HIV new infections, has therefore 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 has planned a campaign for fishermen and all the persons interacting with them (fish sellers, clients and neighbors) aiming to raise their awareness on prevention of HIV new infections. The planning followed guidance from a mapping activity conducted in 2010-2011.

Reports from different districts showed that 3146 fishermen attended HIV prevention educational sessions. The later were conducted by technical experts from RBC/IHDPC/HIV Division and implementing partners in support to key populations. Drama shows were used to attract and entertain people while spreading simultaneously HIV prevention messages. 1048 educational and promotional materials were provided through fishermen cooperatives as well as 22000 condoms distributed during the campaign. A stock of condoms was given to each fishermen cooperative in order to ensure continuous access.

The campaign included also a HCT outreach service whereby 197 persons had HIV counseling and testing. Among them, 10 were found HIV positive (5%).

b. Motorcyclists

This group has formed a federation named “FERWACOTAMO.” One of the federation objectives is providing their members and their families with updated knowledge and promotion of healthy behaviors on prevention of HIV infections and other STIs.

During this reporting period, with the support from FHI-ROADS, different meetings were conducted with the aim of providing HIV prevention and health promotion messages. 13.276 peoples mainly motorcyclists and their family members attended these educational meetings.

C. Prisoners

In prison 54350 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, 15230 the new comers were screened TB and among them 7 people were positive to TB. .

The number of people living with HIV in prison is 2935 among them 2160 were under ART.

D. Truck drivers

The major achievements during the period were categorized in two components:

1478 truck drivers were reached in clinics; 431 reached in community through the outreach programs; and among them the HIV testing done 28 were HIV positive.
At national level, the Truck drivers Surveillance Survey have been conducted; data collection was carried out in stop over point of truck drivers. The sites such as MAGERWA Gikondo, SDV transmit, MAGERWA Runda, MAGERWA Shyorongi, Akanyaru, RusiziII, CIMERWA Buagarama, Kabuye Kobil depot, Gastata Engen depot, Rusumo and Gatuna were targeted for this survey.

Umbrella coordinating bodies of HIV response

In the year 2012-2013, RBC/IHDPC worked hard to achieve the objective of strengthening the coordination structures for the fight against HIV and AIDS and among them "Umbrella organizations". This involves improving the coordination mechanisms to fulfill their mission and supporting umbrellas in various activities related to their action plans.

RBC-IHDPC organized several meetings with the umbrellas in order to share the best practices in the fight against AIDS. 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.

2.1.5 Output 1.1.1.7. Male and female condoms are available and accessible for all populations

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.

To better address this challenge, the progressive follow up for the implementation of the National condoms supply chain system that was started in 2012 following the midterm review of the National strategic plan on HIV and AIDS, was finalized in early 2013. The revised supply chain system considers the different partners and comprises the standard operational procedures (SOP) manual, designed to provide guidance to all partners and entities involved in the supply and distribution of condoms at the different levels. The ongoing dissemination of the SOPs involved a number of activities including:

- A workshop at the central level targeting Directors of District hospitals, Directors of District pharmacies and Coordinators of HIV and AIDS programs at the District level. It aims at ensuring their support in the dissemination and implementation of the procedures within their respective service catchment areas.
- Dissemination workshops at the District level targeting managers of health facilities, CSOs and NGOs and other partners involved in the supply and distribution of condoms at the district level.

To further strengthen the supply component of condom programming, increasing access to condoms especially for key population groups has been set as one of the key targets for 2018 in the new NSP. This will be achieved through improving the community based network for condom distribution and prioritizing availability for youth and key populations.

Promotion of condom use as one of the main HIV prevention methods has featured among key components of all HIV and AIDS comprehensive sensitization sessions about HIV/AIDS and STI's prevention.

- **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.

Though faced with the challenge of availability in some places especially in the hard to reach rural areas, condoms use and distribution have steadily been growing over the years and the RBC/MPPD has started the implementation of the active distribution system for all essential medical products and medicines including condoms to address challenges of availability in all health facilities. 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 are ready 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

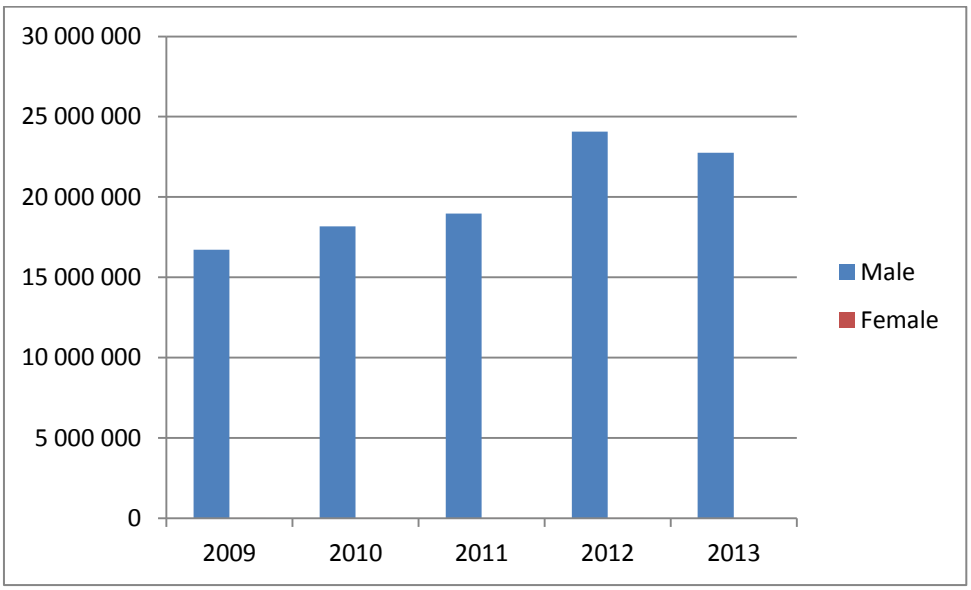
contraceptives, including condoms. All health facilities governed by Catholic Church do currently have a secondary health post.

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 6 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.

2.1.6 Output 1.1.2.1. Newborn boys, adolescents and adults have increased access to circumcision

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 National Strategic Plan of HIV management 2013-2018.

To coordinate Voluntary Medical male Circumcision (VMMC) activities in the country and use efficiently available resources, the Ministry of Health (MoH) has 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 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.

During this reporting period, male Circumcision services have been provided to 138,711 boys and men. Among them, ten thousands (10,000) men have been circumcised using Prepex method.

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.

In order to accelerate the increase male circumcision prevalence, IHDPC-HIV division in collaboration with district hospitals organized VMMC campaigns conducted over weekends.

The provision of VMMC during weekends was accelerated in the country using both surgical and non-surgical method (Busogo Agriculture College, Wawa youth center, Shyira and Murunda DHs) and is in process in other districts hospitals.
In collaboration with RDF/Medical Battalion and JPIEGO we conducted big Male circumcision campaigns covering Eastern province(Bugesera,Gatsibo and Nyagatare districts) and Western province(Ngororero and Karongi Districts)and this campaign remains in progress in south province(Nyamagabe District) and Western Province (Rusizi District) and we intend to cover all districts.

MC indicators are constantly monitored and reported monthly through a web base reporting system (Tracnet) and in Perfomance Based Financing (PBF) system.
Currently the national program is planning the roll out of MC using Prepex method to all health facilities, this roll out will start by training of 2 health care workers from 9 District Hospitals. Lessons learned from the current RMH PrePex MC program will be used to inform the roll out of PrePex MC to other facilities across the country. Trainings will be led by Rwanda Military Hospital as prepex center of excellence. During this first phase we target to circumcise 35,000 men using Prepex method.

Even though there is good implementation in MC, there is a need to increase MC equipment and supplies at health facility level.

2.1.7 Output 1.2.1.1. Increased availability and accessibility of PMTCT services

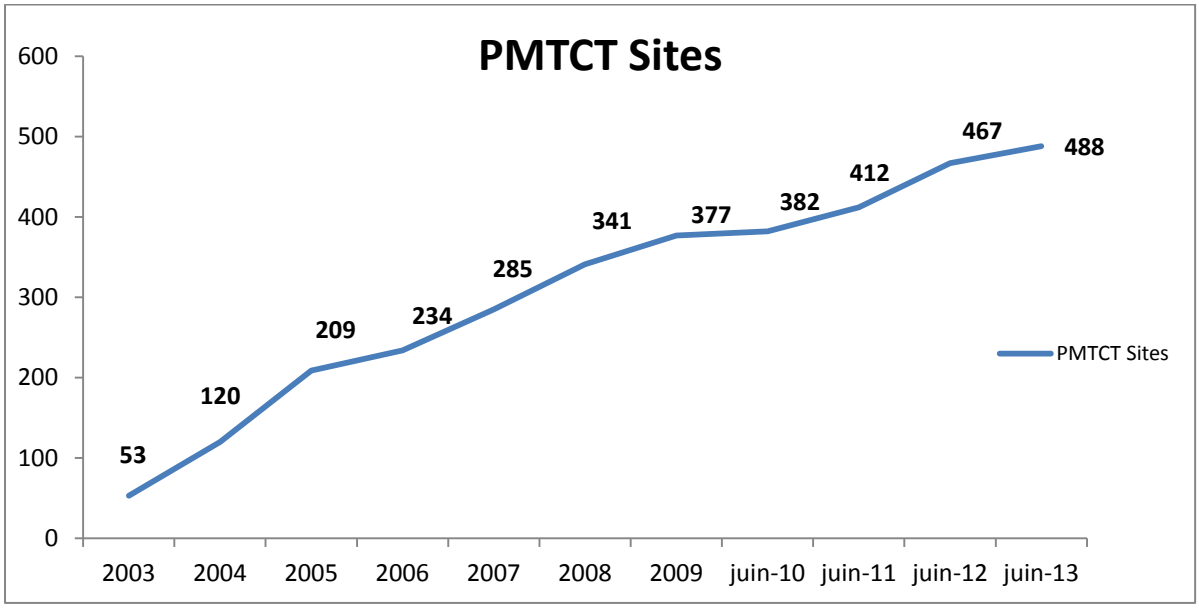
Expansion of integrated PMTCT services in all health facilities and ensure national coverage

PMTCT activities are integrated at the Health Facilities (HF) level into Maternal and Child health (MCH) services. Activities done in various services of PMTCT program between July 2012 and June 2013 included:

- 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 June 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. We have got an additional laboratory center that processes and analyzes these samples using PCR, in addition to the Rwanda National Reference Laboratory (NRL). The second laboratory center is located in the southern province, easing logistic issues for health facilities located in southern and western provinces.

Figure 7: Health facilities offering PMTCT services (from 2003 – June 2013)



Source: TRACnet, 2012-2013

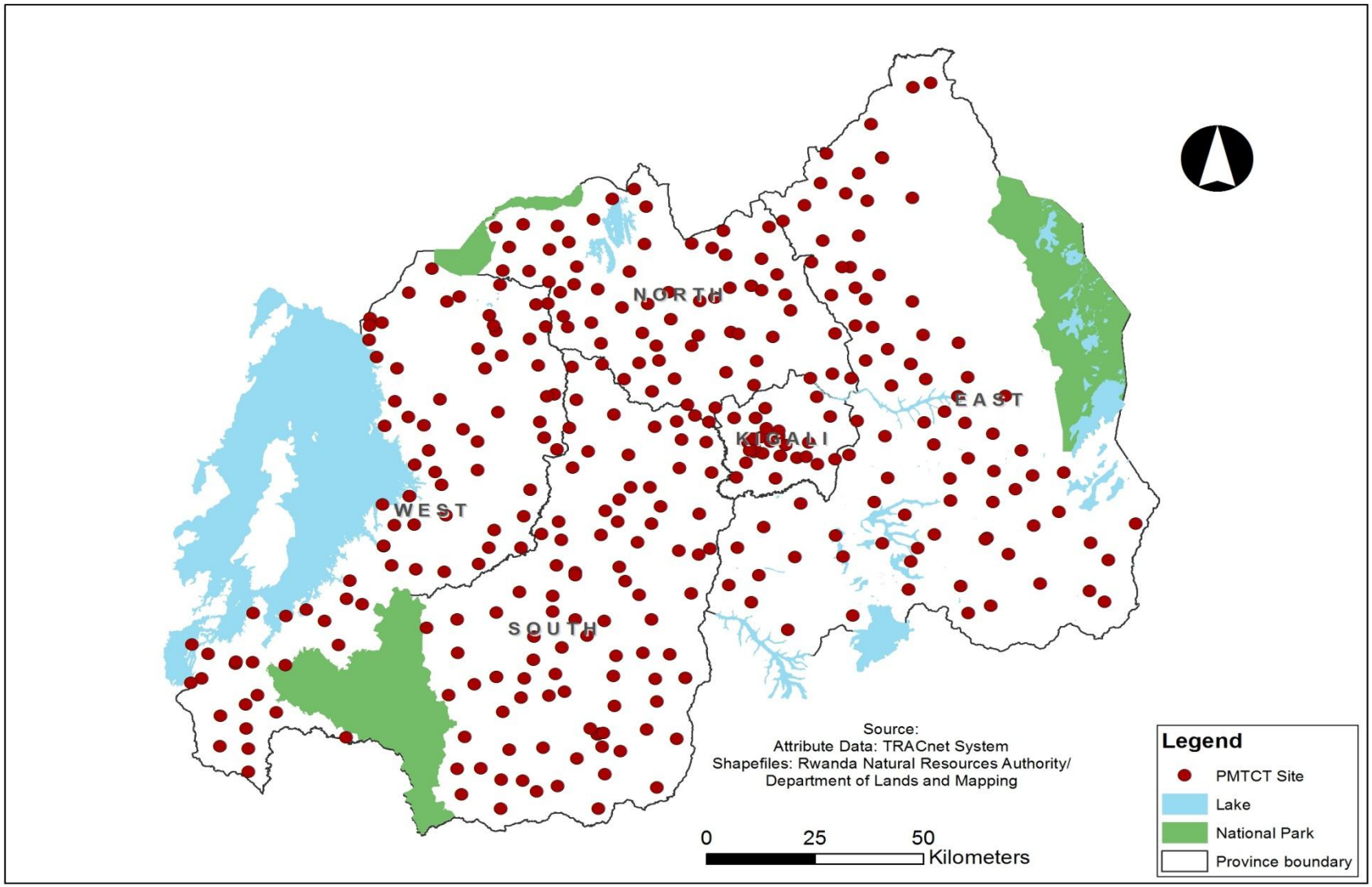
The implementation of PMTCT program is guided by the national PMTCT scale up plan 2007 - 2012 which aims to contributing to the improvement of maternal health and infant survival by providing quality integrated maternal and child health services to fight against HIV/AIDS. The national scale up plan is 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.

The current comprehensive PMTCT service package includes:

- HIV education,
- HCT for pregnant women (and their partners) in ANC and maternity settings,
- Provision of ARV drugs for the mother (lifelong treatment) and the exposed infant.
- Co-trimoxazole prophylaxis for infants and pregnant women,
- Early infant diagnosis (HIV testing at 6 week), HIV testing at 9 and 18 months,
- Counseling on infant feeding and family planning (FP) counseling

Map 3PMTCT Coverage, Rwanda July 2012 - June 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:

1. Pre & Post-test HIV counseling
2. Blood draw for CD4 same day after post counseling
3. Appointment for CD4 results
4. Partner testing
5. Hemoglobin testing
6. WHO HIV clinical classification
7. Enrolment into care and treatment
8. Initiation of ART
9. Counselling about infant feeding
10. Counselling on FP and safer sex

ANC is the major portal for PMTCT recruitment to follow up. Even though the higher proportion of PMTCT clients are recruited in ANC, statistics below show that the utilization of this services did not yet reach 100%. The recruitment goes on in maternity at the time of delivery and during post natal follow up, especially at the time of infant immunization.

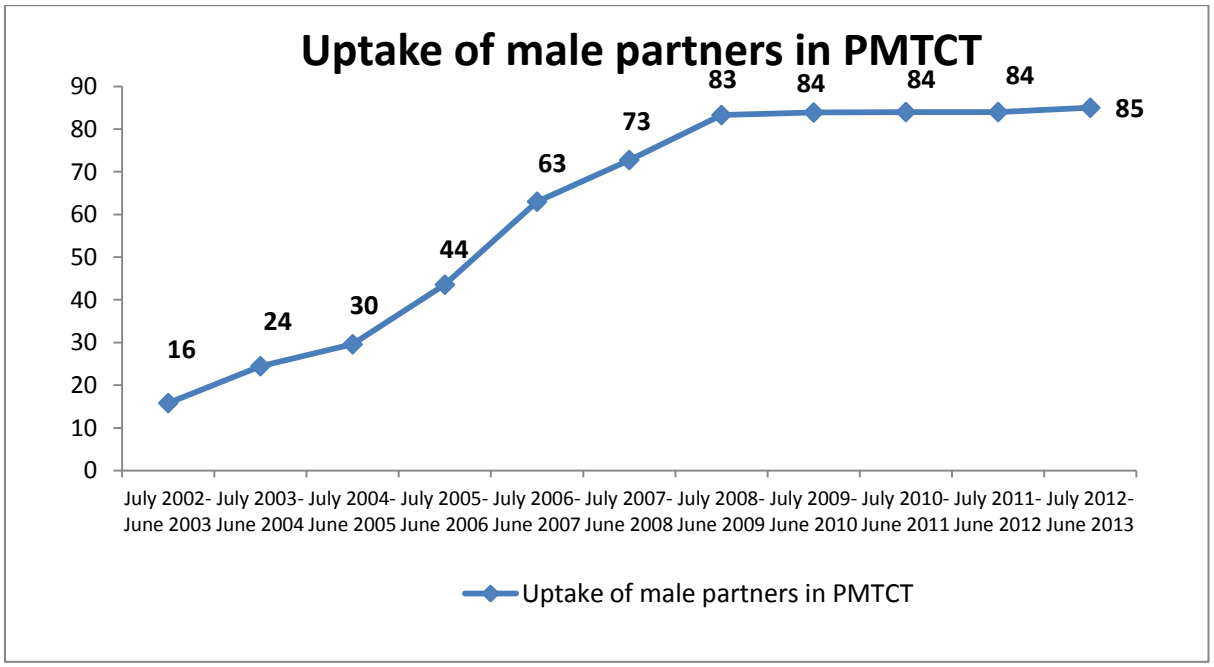
Male uptake and family approach for PMTCT

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% during the report period.

Figure 8: Proportion of male partners counseled and tested for HIV in PMTCT, Rwanda, July 2002-June 2013



Source: TRACnet, 2011-2012

Map 4 Male uptake in ANC, Rwanda July 2012-June 2013

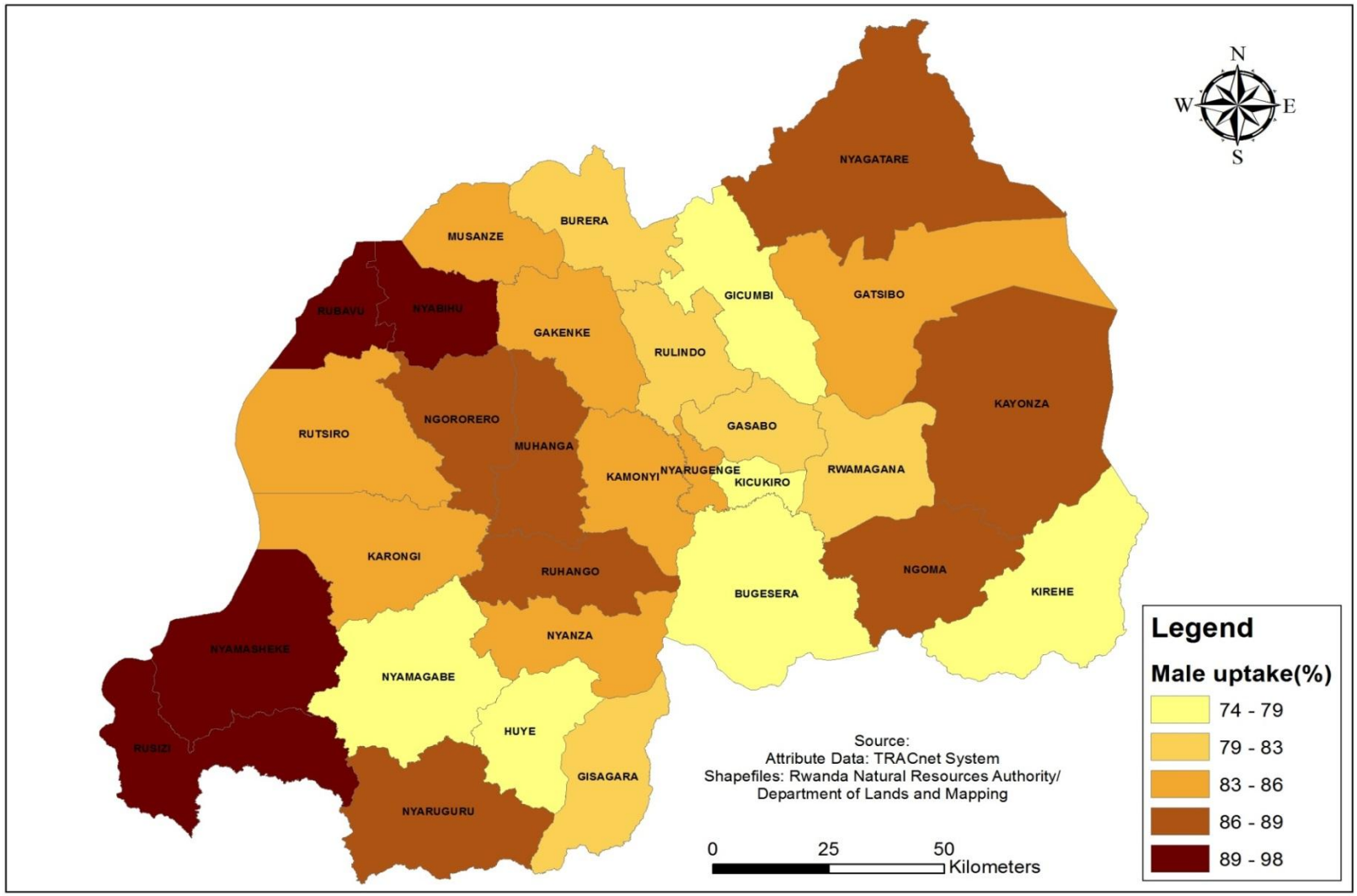
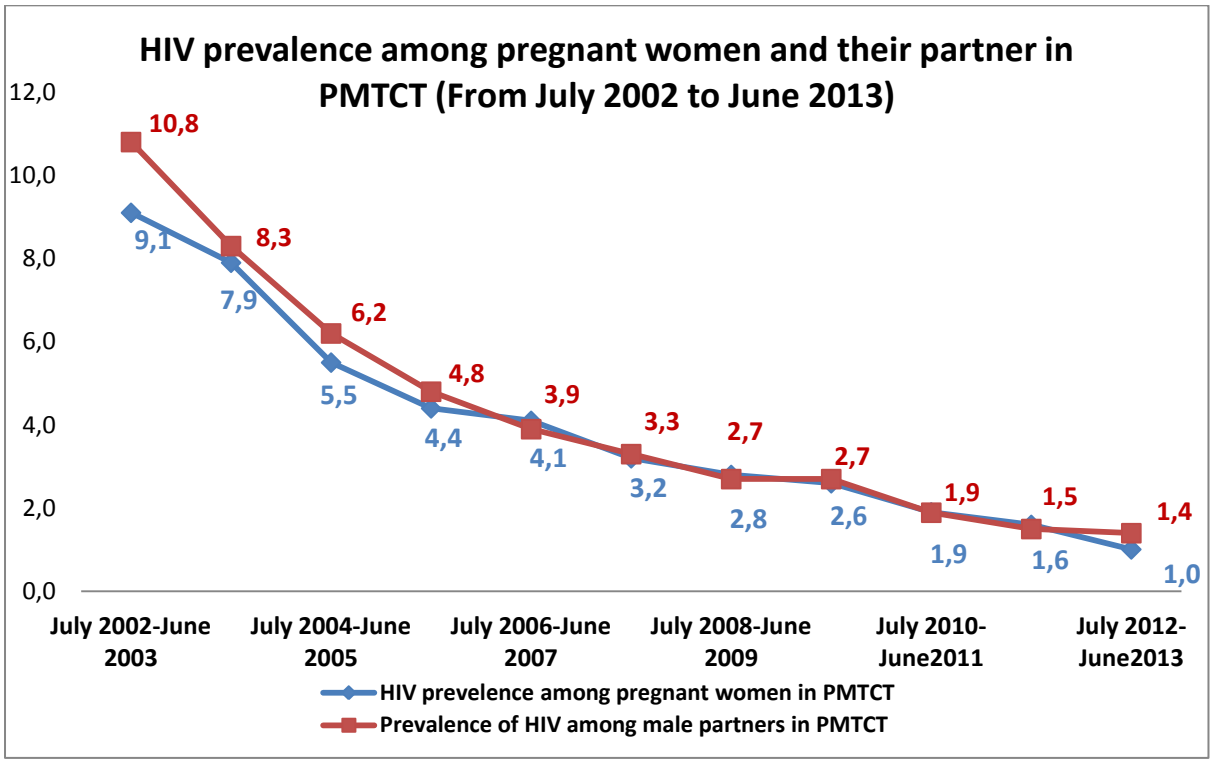


Figure 9: HIV positivity rate among pregnant women and their male partners in PMTCT (July 2002 to June 2013)



Source: TRACnet, 2012-2013

The Figure 11 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 June 2013.

Increase delivery by pregnant women at health facilities

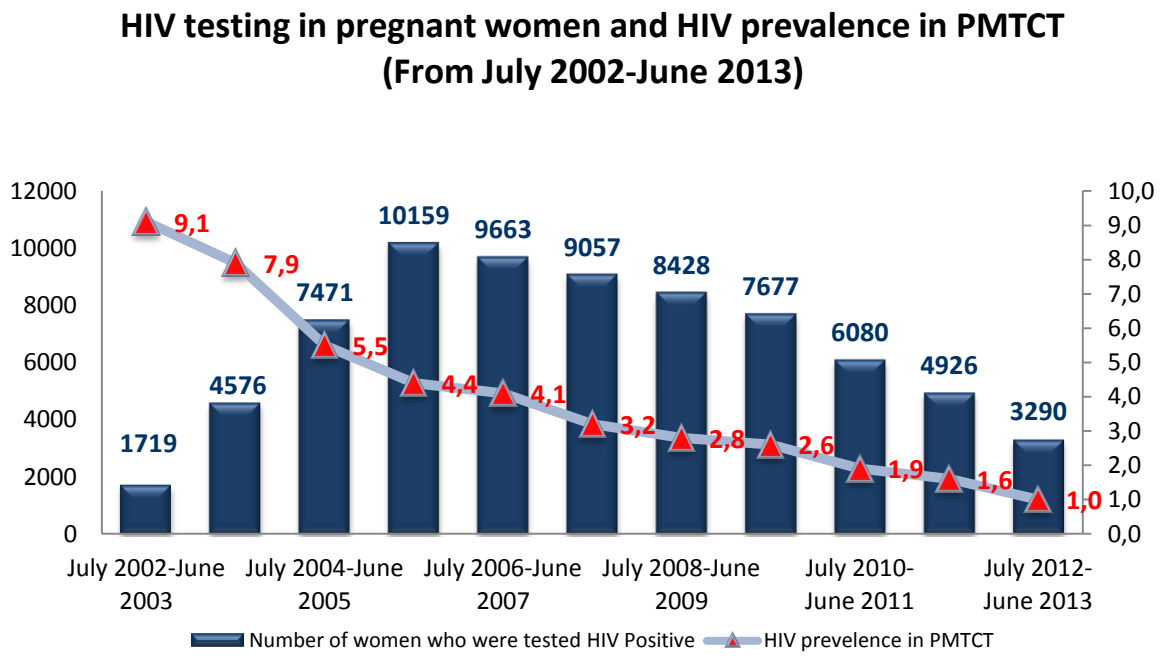
The community health system linked to health facilities supported by the strong involvement of local leaders multiplies efforts to sensitize women towards improved maternal and child health. This includes a systematic use of antenatal care and delivery at health facility. We are progressively following 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%.

2.1.8 Output 1.2.1.2. All HIV positive pregnant women complete the full PMTCT program

All pregnant women are routinely tested and counseled for HIV during pregnancy (at least at first ANC)

The number of pregnant women with unknown HIV status attending ANC from July 2012 to June 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 10: HIV testing in pregnant women and HIV prevalence in PMTCT.



Source: **TRACnet, 2011-2012**

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.

Increase 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. 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. The update of the above mentioned protocol was done in 2011 where all HIV positive pregnant women receive ART treatment for life, and WHO 2013 updates have been integrated. The new 2013 protocol has been already approved and initial phases of implementation were launched, including training of providers on new protocol and updating follow up tools.

Increased case-finding so that HIV+ pregnant women who initiated PMTCT are followed-up on a regular basis

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.

Reinforce linkages between health facilities and community

Community health workers and peer educators operate at community level and have among their responsibility the follow up of pregnant women. It ranges from sensitizing and mobilizing them to attend the ante natal consultation to encouraging them for delivering at health facility.

A booklet to guide the integration of follow up of HIV exposed infant at community level was developed and disseminated to community health workers. At each health facility, there is also a healthcare professional that support and guide community health workers in their daily tasks, and ensures their linkage to the health facility.

Reinforcement of nutritional support for pregnant and lactating women - and babies

Nutritional support is given to pregnant and lactating women who present signs of moderate malnutrition. For HIV Exposed infants, the nutrition support is given to all children regardless of nutrition status.

Reinforcement of OI and STI screening, prophylaxis, treatment and referrals for HIV+ pregnant women

The screening, prophylaxis and treatment of OIs and STIs are included in the routine package offered to HIV+ pregnant women during follow up.

Improvement of OI prophylaxis and treatment for HIV exposed infants

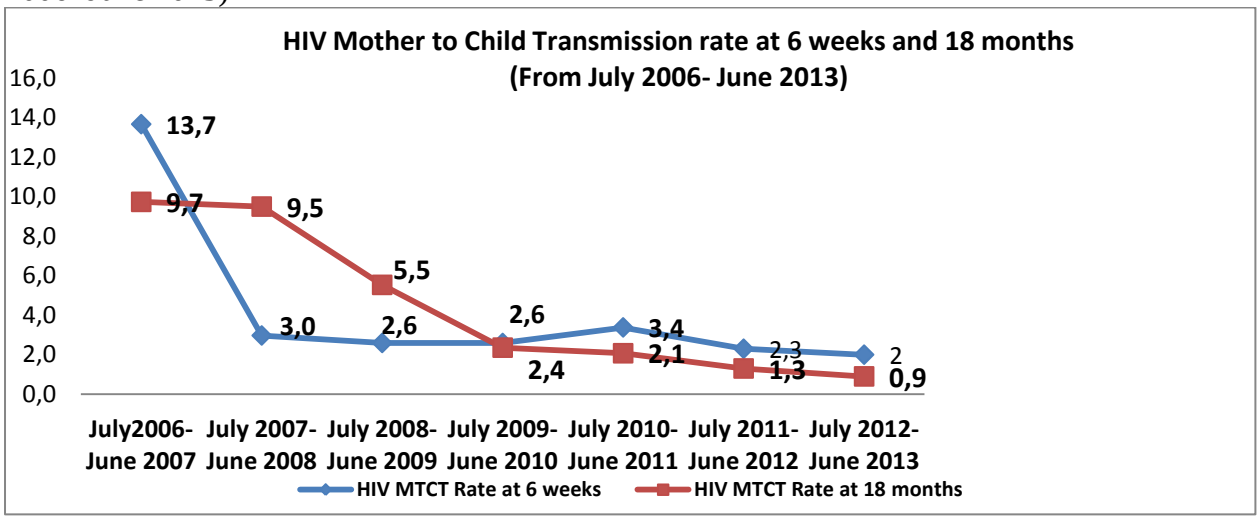
The screening of OIs is done during the whole period of follow up of HIV exposed infants and the treatment is offered to the infant diagnosed from IOs. Co-trimoxazole to prevent an important number of OIs is given to all HIV exposed infants from their 6th week of life.

Implementation of strategies for EMTCT

The overall goal of the national EMTCT initiative is to eliminate new pediatric HIV infections and improve maternal, newborn and child health (MNCH) and survival in the context of HIV. Continuous technical and financial supports as well as monitoring system are in place to ensure that no district is left behind, which could hinder national progress. This includes an operational plan specific to each district, guiding the implementation of activities stated as specific needs of the population in the district.

So far, reported data show an encouraging progress towards the elimination of mother to child transmission in the country. The figure below shows the rate of Mother to Child Transmission of HIV at 6 weeks and 18 months for this reporting period.

Figure 11 HIV Mother to Child Transmission rate at 6 weeks and 18 months (From July 2006- June 2013)



Source: TRAC net, 2012-2013

The successful implementation of the national strategic plan for the elimination of MTCT that we are witnessing has required a high level of commitment and a new way of working to scale up and support EMTCT initiatives at national and district levels. Strong leadership and enhanced partnership at all levels is critical, in combination with increased and sustained financial support to render services outlined in the strategic plan. Therefore, the strategy emphasizes on reorientation and reorganization of existing program activities in order to scale up and expand service coverage, upgrade quality and improve access to and utilization of maternal, neonatal and child health services both at national and district level to achieve the elimination targets by 2015.

III CARE AND TREATMENT

3.1 IMPACT 2: MORBIDITY AND MORTALITY AMONG PEOPLE LIVING WITH HIV ARE SIGNIFICANTLY REDUCED

3.1.1 Output 2.1.1.3. People living with HIV and tuberculosis receive appropriate treatment for TB

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

In the same line of improving the quality of intensified TB case finding and reporting, in collaboration with TB &ORD Division, HIV/AIDS, STIs and other Blood Bone Infections Division, conducted evaluation meetings with care providers and district hospital M&E team from ART clinics nationwide. The meetings took place at district hospital levels and lasted for one day: In total, 393 health facilities were represented (40 DHs and 353 HCs) out of 416 health facilities planned (94%). Out of 608 participants expected, 558 (92%) health care workers including DH supervision team, administration and ART clinic nurses attended the meetings.

A. Cryptococcal Infections screening program among PLVIH

As people with advanced immunodeficiency are highly exposed to have asymptomatic and symptomatic cryptococcal infection, 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. Below are two key elements :

- ✓ To screen for cryptococcal disease in every patient with CD4 below 200, using cryptococcal antigen testing (CRAG) on plasma. Any patient with neurologic symptoms should have a CRAG performed on CSF after lumbar puncture for diagnosis.
- ✓ When the diagnosis is confirmed, the curative treatment will be fluconazole or Amphotericin B as described in new guideline for Opportunistic infections.

The posters, the LFA tests are available in the country now for this program implementation. The lab technicians training are now planned for January 2014, the TOT of health providers has been done.

3.1.2 Output 2.2.1.3. Coverage of facilities offering ART is increased

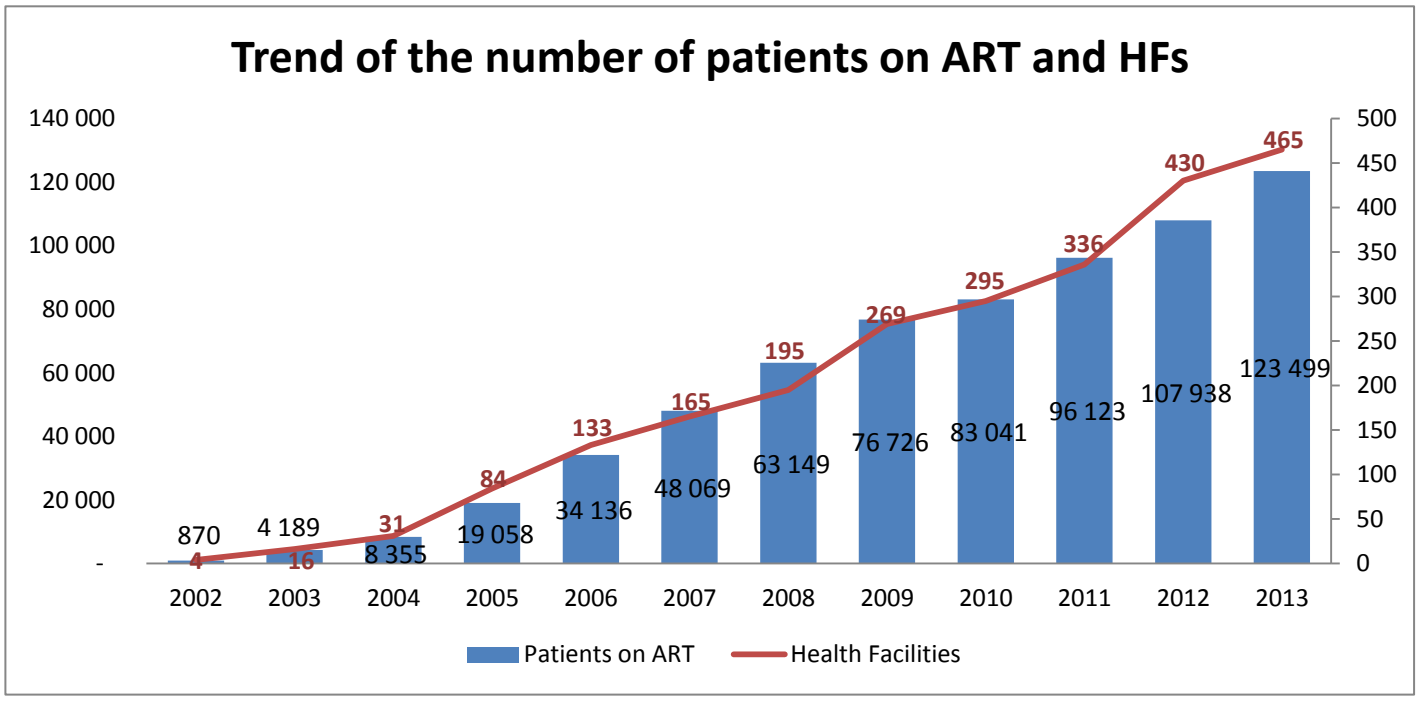
A- Increase the availability and coverage of ART at health facility level

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, the number of patients on treatment has increased from 107,938 to 123,499.

Again, this year in Rwanda national HIV guidelines, ART treatment 3rd line regimen was added and 22 patients are now receiving it.

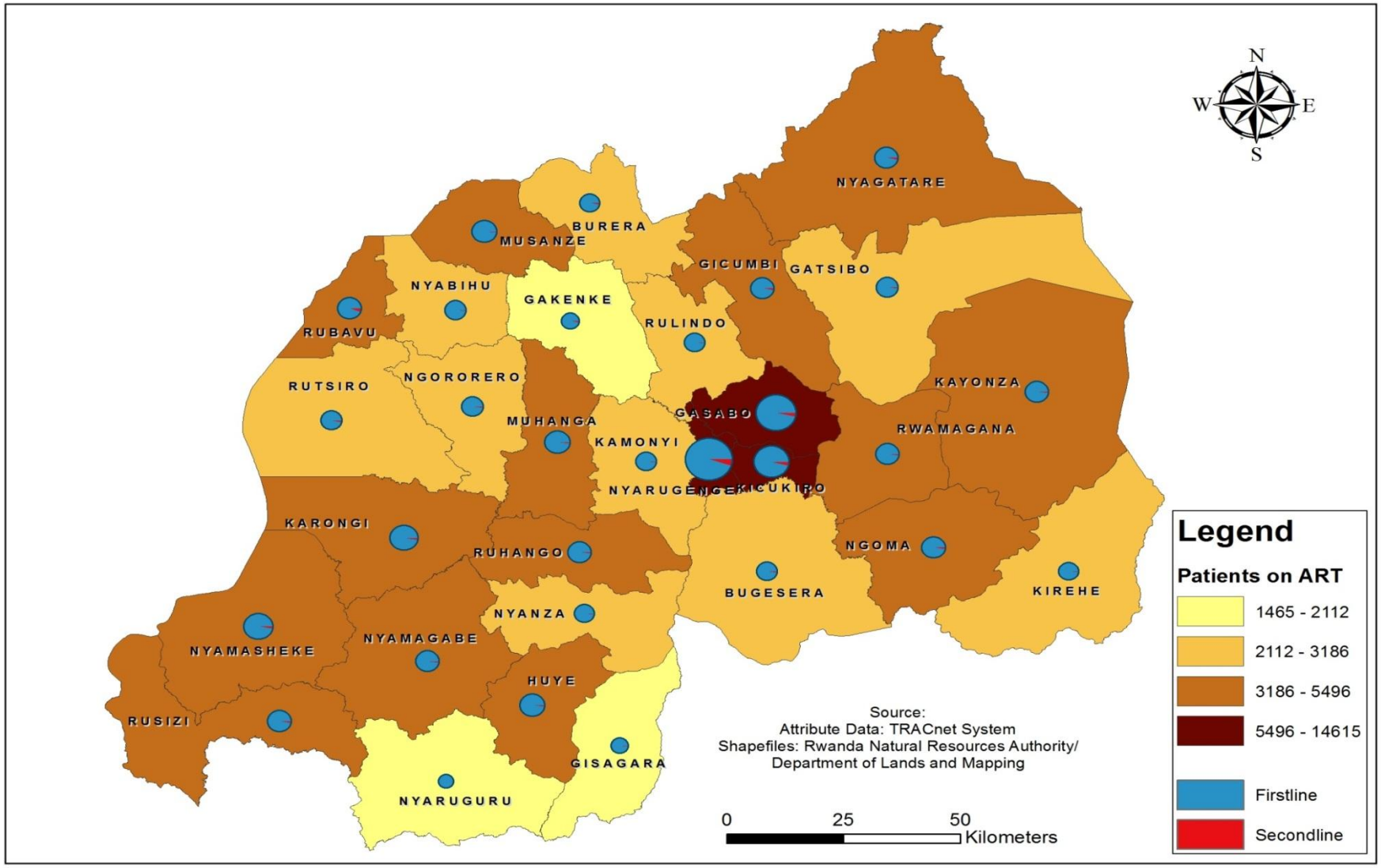
Figure 12 Trend of the number of patients on ART and HFs



Source: TRAC net, 2012-2013

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

Map 5 Patients on ART, Rwanda -June 2013



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.

1. **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.

2. **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.

3. **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.

B- Training of Trainers in HIV Services:

1. 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.

2. 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.

From February to March 2013, six sessions of initial TOT were organized countrywide and a total of 108 participants from RBC, Implementing Partners (IPs) and District Hospitals were trained as initial Trainers.

At the same time, eight initial trainers have qualified to advanced level after facilitating 1 to 3 initial TOT sessions and are therefore candidates for participation in the Master's level trainings. All 108 participants received a National Certificate of Initial Trainers and 8 of them qualified as advanced trainers.

In addition, refresher training in pharmaco-vigilance have been organized and conducted and health providers were sensitized to report adverse drugs reaction in general and ARVs in particular. In collaboration with MoH , 176 health care providers were trained in pharmaco-vigilance.

3. Training of Trainers on Hepatitis B Screening and Vaccination

Persons with HIV who acquire hepatitis B are more likely to become chronically infected with hepatitis B than persons who do not have HIV. In the line of improving the quality of life of HIV-positive people in Rwanda, the national guidelines recommend that all HIV-positive people with Hepatitis B co-infection (HBsAg +) start ART including TDF-3TC and vaccinate those who screen HBsAg-.

From June 2013, RBC-HIV, STIs and OBBI Division in collaboration with VPDD will start a national program of Hepatitis B screening and vaccination of HIV-Positive people in Rwanda and Healthcare providers.

For a successful implementation of this program, there is a need to train trainers and healthcare providers involved in HIV services in Rwanda on the Hepatitis B vaccine and screening plan. In that context, RBC/IHDPC through HIV Division and Vaccine Preventable Diseases Division conducted a training of trainers (TOT) countrywide on June 17th, 2013 with a total of 20 participants.

4. Hepatitis B Vaccination of the Ministry of Health, RBC staff and their families.

For the prevention of hepatitis B infection, all staff from the Ministry of Health, RBC staff as well as their families eligible were provided hepatitis B vaccine. The first two doses were

given between April and June 2013. During this program, a leaflet on most asked questions and answers about Hepatitis B infection was distributed to all people.

3.1.3 Output 2.2.1.4. Quality standards for ART are maintained

A- 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.

In clinical mentorship we distinguish "**Mentor**" who got HIV / AIDS advanced trainings at central level or District level who conduct mentoring, and "**Mentee**" who is a health care provider in HIV service at District Hospital and Health center.
In order to provide quality of HIV care and treatment to PLHIV, reducing HIV related mortality and morbidity, mentorship program aims to develop the following strategies and activities:

- Capacity building for clinical mentors:
    - Advanced training in HIV management from 12 to 23 November 2013 in Huye. 30 clinical mentors were trained: 14 MD and 16 Nurses.
    - Refresher training in Quality Improvement from 4th to 8th February 2013 in Kigali, at La Palisse Nyandungu. 30 clinical mentors were trained: 14 MD and 16 Nurses.
- HIV Division conducted a debriefing meeting with Medical Directors from Hospitals which were supposed to receive clinical mentors, for explaining the purpose of mentorship program: a one day meeting in February 2013.
- Mentorship baseline assessment has been conducted in 10 DHs from February to April 2013.
- Integrated mentorship and supervision with Health Care providers focusing on difficult cases and continuing education on ART sides effects:
- On site trainings and updates on HIV guidelines: presentations in clinical staff meetings;

Mentorship program covers health facilities in transition process: 10 DHs with their 100 HCs.

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.

According to lesson learnt during clinical mentorship and a study done in Kigali city for adherence in adolescent and young people, a supervision and onsite assessment was done to identify challenges in adherence and psychosocial care especially for children, adolescents and young people. The excise was done in 7 DH and 31 HC (38 health facilities). Among identified challenges, there is turnover of trained staff. This requires a new plan for refresher training.

3.1.4 Output 2.3.1.1. People living with HIV receive psychosocial support and community support including palliative care

A. PLHIV receive adherence support at FOSAS and in community

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. In January 2013, a pool of 49 trainers at central level was trained and will carry out decentralized trainings of community health workers around the country.

B. Integrate psychosocial support and mental health in the 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 42 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.

3.1.5 Output 2.3.1.2. People living with HIV receive nutritional support according to needs

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: 116 Health care providers was trained on Nutritional counseling and assessment.
- **The continuous care and support of moderate and severe malnutrition among PLHIV**: at all health facilities in the country, the management of malnutrition was

reinforced according to the national protocol. Nutritional assessment and counseling are also provided at all health facilities.

- **Harmonization of food and nutritional support for eligible PLHIV in needs**: nutritional support at the national level was harmonized and the food package was defined and available nutritional supplements are distributed accordingly.
- **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

IV IMPACT MITIGATION

4.1 IMPACT 3: PEOPLE INFECTED AND AFFECTED BY HIV HAVE THE SAME OPPORTUNITIES AS THE GENERAL POPULATION

4.1.1 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 RRP+ support, and CHF Higa Ubeho. had provide training and ongoing technical support to assist associations of PLWHA to acquire cooperative status, training on development of business plans for cooperatives and technical support.

In the year 2012-2013 24% of RRP + member organizations have certificates of RCA (Rwanda Cooperative Agency) and 26% are still searching for the official document.

During fiscal year 2012-2013, the Network of People Living with HIV and AIDS (RRP+) has registered new cooperatives from associations with Global Fund support. Advocacy was also done with HSP and CARITAS Rwanda to assistance associations and cooperatives of people living with HIV revolving credit, where 28 % of PHAs have received 575 health insurance cards.

RRP+ with partner institution like HAGURUKA has provided the legal assistance for person living with HIV and AIDS in some judicial cases.

4.1.2 Households of Persons Infected/Affected by HIV have Food Security (Improve Food Production 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 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, mainly those supported by SSF/HIV.

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 PHAs have gardens at home and know how to prepare comprehensive food, thus reducing the level of malnutrition among people living with HIV.

4.1.3 Increased Percentage of OVC has Minimum Package of Services (Improve Management and Coordination 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.

Table 1. OVC service provision reporting by implementing organization

	Service	HEALTH		NUTRITION		PRE PRIMARY EDUCATION		PRIMARY EDUCATION		SECONDARY EDUCATION		TVET		LEGAL PROTECTION		PSS		SHELTER		ECONOMIC EMPOWERMENT	
No	NAME OF ORGANIZATION	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1	Food for the Hungry Rwanda	0	0	0	0	0	0	2486	2627	318	374	28	24	0	0	389	352	0	0	0	0
2	We-ActX for Hope	168	169	167	142	102	98	219	263	5	13	0	2	218	279	0	0	4	16	4	16
3	Kanyarwanda	3	6	0	0	0	0	17	15	182	215	0	0	0	0	71	97	0	0	0	0
4	Young Women's Christians Association of Rwanda (YWCA)	1	3	0	2	0	0	0	0	0	0	88	122	0	1	1	0	1	0	88	122
5	International Justice Mission (IJM)	0	6	5	1	0	1	0	16	0	5	0	2	0	42	0	14	0	5	0	4
6	Coperative des Femmes de Mururu (COFEM)	212	203	5	6	0	0	63	51	101	102	8	1	5	3	344	350	12	13	12	19

7	World Relief Rwanda	4,265	2'224	0	0	0	0	0	0	10	14	0	0	0	0	13	17	0	0	27	23
8	AEE Rwanda	55	66	0	0	179	388	3,989	8584	4,647	7827	61	287	0	0	1024	1,712	0	2	952	5001
9	ASOFERWA	256	241	121	139	0	0	121	139	135	102	0	0	0	4	659	785	0	0	45	91
10	AVSI	1060	1096	40	43	9	4	694	581	236	282	91	62	3013	30	1096	1173	0	1	0	0
11	Centre Intiganda	63	0	63	0	0	0	23	0	15	0	12	0	0	0	63	0	46	0	0	0
12	CHF International	0	0	1127	1038	1271	1291	4672	4671	2446	3339	141	167	0	0	1106	1855	0	0	3730	11651
13	FHI/Byumba Diocese	752	525	752	585	0	0	92	71	123	112	0	0	1	1	752	585	1	4	32	3
14	Friends of Handicap in Rwanda	0	0	0	0	0	0	37	36	0	0	15	19	0	0	0	0	0	0	0	0
15	FXB Rwanda	549	604	876	933	87	88	889	904	294	349	33	23	11	11	166	221	52	32	247	387
16	Hope and Homes for Children	0	183	139	191	139	191	11	9	3	1	1	0	0	0	75	108	8	10	9	264
17	Vision Jeunesse Nouvelle (VJN)	0	0	0	0	0	0	62	41	35	28	0	0	0	0	281	281	0	0	101	68
18	Association MwanaUkundwa	325	487	90	153	0	0	268	78	58	0	0	0	0	0	0	0	0	0	0	0
19	Sinapisi Rwanda	0	0	0	0	0	0	252	312	635	643	7	3	0	0	962	890	0	0	0	0
20	Strive Foundation	530	654	24	35	0	0	183	284	208	231	47	53	2	5	13	18	0	0	0	0

	Rwanda																			
21	SOS Children's Village Kigali	0	0	80	80	12	11	56	45	21	23	0	0	0	0	0	0	0	0	0
22	Plan International Rwanda	0	0	21632	22293	270	330	0	0	71	390	59	122	181	0	0	0	0	0	2104	3665
23	World Vision Rwanda	1037	1022	1400	2587	945	988	18307	21766	3803	4416	312	338	1180	1154	4787	5543	655	904	5759	7689
24	NCC SSF-HIV Project	11,870	14,156	0	0	0	0	3550	3603	10750	12299	1120	1857	0	0	0		0	0	0	0
	Total by sex	21146	19421	26521	28228	3014	3390	35991	44096	24096	30765	2023	3082	4611	1530	11802	14001	779	987	13110	29003
	Grand total by service	**40,567**		**54,749**		**6,404**		**80,087**		**54,861**		**5,105**		**6,141**		**25,803**		**1,766**		**42,113**	

In this reporting, USAID HigaUbeho program supported **35,078 OVC** with OVC Programs. This is 123% of the annual target to support 28,586 OVC. It includes 17,718 OVC who were provided with education and/or vocational training; and supporting 17,360 OVC to access early learning programs (playgroup for under 5).

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 Network of People Living with HIV and AIDS (RRP+) with partner institution like HAGURUKA has provided the legal assistance for person living with HIV and AIDS in some judicial cases.

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).

Challenge: It is still a challenge for NCC to calculate the percentage of OVC that have Minimum Package of Services because the general OVC identification that will help to know the total OVC in need of each service is not yet conducted.
NCC is planning to conduct this identification by this quarter between January and March 2013.

4.1.4 People living with HIV and AIDS and Orphans and Vulnerable Children have access to Legal Aid Services (Ensure the Accessibility of Legal Aid Services to 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.

The has been a study carried out ***(Stigma and Discrimination Index Survey)*** by RBC/IHDPC in collaboration with partners which aimed at establishing the level of stigma and discrimination for the people infected and affected by HIV for better interventions.
The survey among other aspects focused on:

- Establish the existence of stigma and discrimination against infected and affected people with HIV and AIDS in Rwanda,
- quantify the existence of stigma and discrimination against infected and affected people infected and affected with HIV and AIDS in Rwanda and
- Generate evidence, which can be used to improve policies and ensure that policies are grounded in the realities of infected and affected people with HIV and AIDS in Rwanda.

RRP+ Integrated "gender" and "youth" in the organization structures, RRP + with the support of RBC and UNWOMEN , began the process of integrating women and youth in the organization of RRP + , to better contribute to the agenda for accelerated advancement of women , girls and gender equality work in the context of HIV . In addition , the RRP + may participate this time more than ever concert of various organizations working in the field of gender and youth.

It is in this context that on 12 July 2012 , under the sponsorship of RBC / IHDPC the RRP + convened a meeting of its national general meeting which unanimously adopted the integration of women's representation and young people in the board of directors and executive committees of RRP + , as well as the establishment of a unit of professional gender and youth in the Executive secretariat.

In Bugesera district RRP+ in partnership with ADRA Rwanda , 300 PLHIV from RRP + member associations in Bugesera were trained on HIV / AIDS and the fight against stigma, where Participants pledged to educate the community to fight against stigma.RRP+ with the support of Millennium Village Project, a trained associations on the management of cooperatives, HIV / AIDS and the fight against stigma was organized for 105 PVV from associations.

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.

4.1.5 CDLS Coordinators Empowerment

CDLS Coordinators are the staffs with support of coordinating HIV community activities at districts level. With aim of good delivered services needed, RBC-IHDPC through Social Impact Mitigation Unit has been keeping on empowering those staffs in different aspects of skills needed. Different training were given to CDLS coordinators

- Social impact mitigation in collaboration with M&E unit, trained 30 district Coordinators and 30 Technical Assistants on the use of Monitoring and Evaluation Tools and reporting system for key populations.
- In the year 2012-2013 30 CDLS Coordinators received training on the Basics of Monitoring and Evaluation with the support of RBC in collaboration with the National University of Rwanda/School of Public Health;
- With the process of migrating IHDPC Database to HMIS (Health Management Information System), CDLS Coordinators received trainings on capturing data in HMIS as they used so in IHDPC Database.

Apart from those trainings, CDLS Coordinators have quarterly carried on capturing data and action plans of IPs in IHDPC Database of activities tackling 11 HIV Community Indicators which were designed to collect HIV and AIDS data from community.

V FINANCIAL SECTION

ANNUAL FINANCIAL REPORT ON HIV EXPENDITURES 2012-2013

The financial section of the Annual HIV report is expected to provide a comprehensive assessment of HIV expenditures during the reporting period, analysing the sources of funding, the allocation of resources according to different programmatic areas and cost categories, and also according to different categories of implementing partners. The data source designed to provide all needed information is the Health Resource Tracker (HRT), an online database where all implementers of the HIV National response in Rwanda enter detailed budget information about the activities they plan to carry out for the current fiscal year as well as expenditure information for the last fiscal year. Unfortunately, this tool is currently under revision, and the data for the reporting period (July 2012-June 2013) has not yet been entered by the different stakeholders. The data used for the present report is therefore taken from the programmatic reports provided by the main funding sources for the national HIV response: the GOR annual budget execution report to estimate the National counterpart, and USG, Global Fund and One UN reports for the estimation of external funding for the HIV response.

Table 1 below presents a summary of the resources committed to the HIV response by the main funding sources for the reporting period and the best available estimate of the financial resources effectively spent by each funding source for the same period.

Table 2: HIV/AIDS Funding Sources, 2012-2013

	Commitment in USD (Budget from programs)	**Share as % of commitments**	**Amount Spent in USD**	**Share as % of expenditures**
Global Fund	126, 218,748	53%	133,314,205	56%
USG PEPFAR	92,366,603	39%	84,448,850	35%
One UN	1,772,724	1%	1,708,348	1%
GOR	17,748,631	7%	19,946,468	8%
Total	238,106,706	100%	239,417,871	100%

For the Global Fund contribution, the reporting period corresponds to the last year of the HIV Single Stream of Funding (SSF/HIV) program which consolidated all HIV grants supported by GFATM in Rwanda for the 2010-2013 period for a total budget of 372 million USD, of which 310 million USD have been effectively spent by the sub-recipients or 83% of the total budget. For year 2012-13, the planned budget was 126 million USD and the total expenditures represent 133 million USD or 105.6% of budget execution.

For the USG contribution, the budget for COP 12 (October 2012-September 2013) is taken as a proxy for the budget committed for the reporting period (July 2012-June 2013). The total COP 12 budget is 105,428,378 USD, and an amount of 13 million USD is deducted from this total as it is allocated to overheads and management costs. The amount planned to be transferred to implementing partners is 92,366,603 USD and is considered as the USG budget committed to HIV. The estimate for USG HIV expenditures for the same period is 84,448,850, as reported by PEPFAR Expenditures analysis for FY 13 (COP 12 implementation period). The budget execution according to these estimates is 91%.

For the One UN contribution, the planned budget was 1.77 million USD and the actual expenditures were 1.7 million USD, for a budget execution of 96%. The UN agencies contributing the largest amounts to this total are UNAIDS (681,316 USD), UNFPA (328,601 USD) and UNICEF (235,722 USD).

On the basis of the GOR budget projections for 2012-13, GOR contribution to HIV was expected to be 17.7 million USD. The estimated expenses reach 19.9 million USD, for a budget execution of 112% and representing 8% of the total HIV expenditures. The methodology to arrive at this estimate is described in the following paragraph.

Methodology for estimation of the National Counterpart

To estimate the GOR contribution to the total HIV expenditures, we have used the same methodology as last year. For each of the budget lines where the health expenditures are not earmarked for different disease programs, but where we know that a significant proportion of these expenses are allocated to HIV activities, we have applied the 21% obtained from the 2009-2010 HRT as the part of the total health expenses that are related to HIV activities. The following table details the MOH budget lines taken into account to estimate this year's contribution from GOR for HIV expenditures.

Table 3. GOR contribution to HIV expenditures (2012-2013)

MTEF Budget categories	GOR Total Health expenditures (THE) 2012-13	HIV expenditures (21% of THE) 2012-13
HRH (Salaries and HRH development)	42,168,073	8,855,295
Financial accessibility (Mutuelles de santé)	9,903,904	2,079,820
Geographic accessibility (Infrastructures, equipment, transport)	28,317,505	5,946,676
Quality and demand (Community health)	732,236	153,769
Quality and demand (PBF)	11,924,524	2,504,150
HIV Prevention (100%)	406,758	406,758
Total	**93,453,000**	**19,946,468**

This exercise, in spite of its somewhat arbitrary approximation, has the advantage to give a realistic picture of the main budget lines from the GOR budget execution report that have a direct impact on the implementation of HIV activities. With this methodology, the GOR contribution to the overall national HIV response for year 2012-13 is estimated at 19,946,468 USD. This still represents only a small part of the total HIV expenditures (8%), but it clearly shows the continuing commitment of the Rwandan government to increase its investment in the health sector, and specifically in the HIV response.