

Republic of Rwanda



Ministry of Health

**Rwanda National HIV and Viral Hepatitis
Annual Report
2017-2018**



A Healthy People. A Wealthy Nation

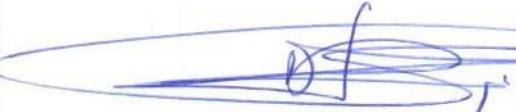
FOREWORD

The Ministry of Health would like to take this occasion to express its deep appreciation and sincere thanks to all who contributed to the compilation of this annual report.

This report represents a collaborative effort between the Government of Rwanda and its partners. Representatives from all groups of stakeholders involved in the annual HIV response participated in the production of this report.

I would like to acknowledge the efforts of dedicated staff in the various institutions of the Government of Rwanda who worked tirelessly to complete this report. We remain grateful to the inputs and support provided by our partners, members of the civil society, local and international Non-Government and bilateral organizations. I would also like to thank all members of technical working group that reviewed and validated the content of this report.

We believe that this document provides a realistic picture of Rwanda's progress in HIV and Viral Hepatitis response as of 30th June 2018.


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Minister of State in the Ministry of Health
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1.1. EXECUTIVE SUMMARY

This report presents the progress of HIV and Viral Hepatitis response in Rwanda and highlights progress in NSP implementation and achievement against NSP results and targets for the fiscal year July 2017 to June 2018. The report contains all areas of HIV management including HIV prevention, care and treatment, social impact mitigation, STIs and Viral Hepatitis, governance mechanisms, health system strengthening, financing HIV national response and monitoring and evaluation.

Following WHO recommendation, the GOR has adopted HIV self-testing as an additional HIV testing approach. From July 2017 to June 2018, in total, 2,568,182 tests have been done across the country, among which 14,996-tested HIV positive yielding a positivity rate of 0.58%.

The number of males who received Voluntary Male Circumcision (VMMC) significantly increased from 190,282 to 328,629 in 2017/2018 due to increased outreach circumcision campaigns.

For this fiscal year, 352,830 pregnant women attended ANC; among them 9219 (2.36%) were HIV Infected of whom, known HIV Positives were 6996 and newly identified were 2223. Furthermore, 85.9% of pregnant women were tested together with their male partners and 95.9% of HIV positives received antiretroviral therapy to reduce the risk of mother to child transmission. In addition, 96% of HIV exposed infants received Nevirapine at birth. A cohort of exposed infants born from April to June 2016 was followed up for 24 months. The follow up results suggested that 98.5% of them were free from HIV by 24 months representing 1.5% MTCT rate.

HIV Care and treatment services were established and increased over time. As of June 2018, 189,362 (83% of all PLHIV) patients were on ART. This increase is attributable to Treat All policy that was adopted in Rwanda and implemented since 1st July 2016. In addition, during this year, the retention on ART was 91.5% and the suppression of the viral load (below 100 copies/ml) after 12 months on treatment was 93.5% while the overall VL on ART was 91%.

During this fiscal year, the national HIV Treatment and Prevention guideline was developed and disseminated. Major changes include mainly AZT in HIV exposed infants ‘prophylaxis integration of Dolutegravir in HIV treatment guidelines.

The national HIV and Viral Hepatitis program also implemented activities related to HIV co-infections including Hepatitis B and C organized campaigns targeting People living with HIV for vaccination and screening of viral Hepatitis. During the 2017-2018 fiscal year over 420,000 people including adults and children were vaccinated against HBV. Several campaigns were organized across the country and to date 500,000 people were screened for HBV and HCV from the beginning of the program and followed-up for further confirmation and treatment resulting into 6,573 patients received treatment (DAAs) for HCV while 848 patients received treatment for HBV.

The social impact mitigation was also emphasized to ensure that people infected and affected by HIV have continued maintenance or improvement of their economic status, orphans and vulnerable children affected by HIV have socioeconomic protection and the stigma and discrimination are reduced. Certain measures such as working with civil society organizations, Faith Based Organizations and non-health sector public institutions as well as government programs have been put in place to manage social burden of HIV to individuals and communities. Another key area of interventions has been on increasing food security and working towards decreasing gender based violence in regards to those affected by the virus.

The Rwanda Biomedical Center, through HIV-AIDS, STIs and Viral Hepatitis division, implemented and planned various HIV interventions including routine programmatic, surveillance and research activities. Routine data systems have been strengthened during regular monitoring of quality of data and services. Different studies were planned and approved through such as Active Case Based Surveillance for HIV in Rwanda; HIV Drug Resistance Monitoring in people living with HIV in Rwanda; Integrated Behavioral and Biological surveillance survey among Men having Sex with Men; Integrated Behavioral and Biological surveillance survey among Female Sex workers, Rwanda 2018; Female Sex Workers size estimation in Rwanda using three source capture-recapture, 2018; Evaluation of



Post Exposure Prophylaxis in Rwanda; Rwanda Population based HIV Impact Assessment survey , 2018 (RPHIA) .

In addition, three studies were completed: The prevalence and factors associated with hepatitis B and C in people living with HIV (PLHIV), Determinants of HIV Transmission among HIV Exposed Infants in Rwanda, Monitoring of Differentiated Service Delivery Model for Care and Treatment Services Provision at Health Facilities in Rwanda. Key results from these surveys are presented in this report.

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ABREVIATIONS

AIDS	Acquired Immune Deficient Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Therapy
AZT	Azidothymidine
CD4	Cluster of Differentiation 4 (Stands for T4 Lymphocytes)
COP	Country Operational Plan
CSOs	Civil Society organizations
DAAs	Direct Antiviral Agent
DDPs	District Development Plans
DH	District Hospital
DHS	Demographic Health Survey
DSDM	Differentiated Services Delivery Model
e-LMIS	electronic Laboratory Management Information System
ECD	Early Child Development
EDPRS	Economic Development and Poverty Reduction Strategy
EIMC	Early Infant Male Circumcision
EMTCT	Elimination of Mother to Child Transmission
EPP	Estimated Population Projection
FSW	Female Sex Worker
GBV	Gender Based Violence
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund for AIDS, TB and Malaria
GOR	Government of Rwanda
HBV	Hepatitis B Virus
HC	Health Center
HCC	Health Communication Center
HCV	Hepatitis C Virus
HCW	Health Care Worker
HESR	HIV Epidemiology, Surveillance and Research unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRTT	Health Resource Tracking Tool
HSSP	Health Sector Strategic Plan
HTS	HIV testing and counseling services
ICASA	International Conference on Aids and STIs in Africa
IGA	Income Generating Activities



IHDPC	Institute of HIV Disease Prevention and Control
KPs	Key Populations
M/E	Monitor and Evaluation
MOH	Ministry of Health
MPPD	Medical Procurement and Production Division
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
MTEF	Mid-Term Expenditure Framework
MVC	most vulnerable children
NCBT	National Center for Blood Transfusion
NCC	National Commission for Children
NCDs	Non Communicable Diseases
NGO	Non Governmental Organization
NRL	National Reference Laboratory
NSP	National Strategic Plan
NST	National strategy for transformation
OI	Opportunistic Infection
OPD	Out of Patient Department
OVC	Orphan and Vulnerable Children
PEPFAR	President's Emergency Plan For Relief
PLHIV	People Living with HIV
PMTCT	Prevention Mother to Child Transmission
POC	Point of Care
RAIHS	Rwanda Aids Indicator and HIV Incidence Survey
RBA	Rwanda Broadcasting Agency
RBC	Rwanda Biomedical Centre
RCLS	Faith-Based Organizations Network against AIDS
RDTs	Rapid Diagnostic Tests
RMH	Rwanda Military Hospital
RPHIA	Rwanda Population HIV Impact Assessment
RRP+	Rwanda network of PLHIV
RTV	Rwanda Television
SDGs	Sustainable Development Goals
FMIS	Integrated Financial Management Information System
SMS	Short Message Service
SRHR	Sexual and reproductive health and rights
STIs	Sexual Transmitted Diseases
TB	Tuberculosis
TVET	Technical and Vocational Educational Training
UN	United Nations Children Fund
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children Fund
UPHLS	Umbrella of People with Disabilities in the Fight against HIV and AIDS
USG	United State
USPLS	Public-Sector Umbrella in the Fight against AIDS
VL	Viral Load

VMMC	Voluntary Male Circumcision
VPD	Vaccine-Preventable Diseases Division
WAD	World Aids Day
WHO	World Health Organization
YBE	Years Basic Education



1. INTRODUCTION

HIV infection is a major public health concern in Rwanda, where it is still among the main causes of morbidity and mortality posing negative social and economic consequences. Rwanda has made significant progress toward creating universal access to HIV services. This was possible through national strategic planning to respond to HIV epidemic in a multi-sectoral approach.

This report presents the progress of HIV response in Rwanda, highlighting progress made in NSP implementation and achievement against results and targets. It also aims at informing key stakeholders on the progress against outputs and strategies in order to re-evaluate and change actions and interventions to maximize the results towards an AIDS-free nation.

1.1. Overview of the HIV epidemic in Rwanda.

Most recent finding from DHS 2015 indicated that, in Rwanda HIV prevalence has remained stable at 3% in the last ten years.¹ The results of the survey showed that 3.6% of women and 2.2% of men are HIV positive. In addition, the prevalence differs by geographical area and age groups. The HIV prevalence in urban areas is 6.2% higher than 2.2% in rural. The lowest HIV prevalence was found in Northern Province (2.3%) and the highest in Kigali City (6.3%). For the first time, the DHS 2015 included HIV prevalence among children less than 15 years old, and the prevalence in this age group was found to be 0.2%.²

In general, Rwanda's HIV prevalence rises with age. Among women, the HIV prevalence increases from 1% at age 15-19 to a pic of 8% at age 40-44 and down to 6% at age 45-49. Among men, the prevalence increases by less than 1% at age 15-19 to 4% at age 40-44 and reaches a pic of 9% at age 45-49.³

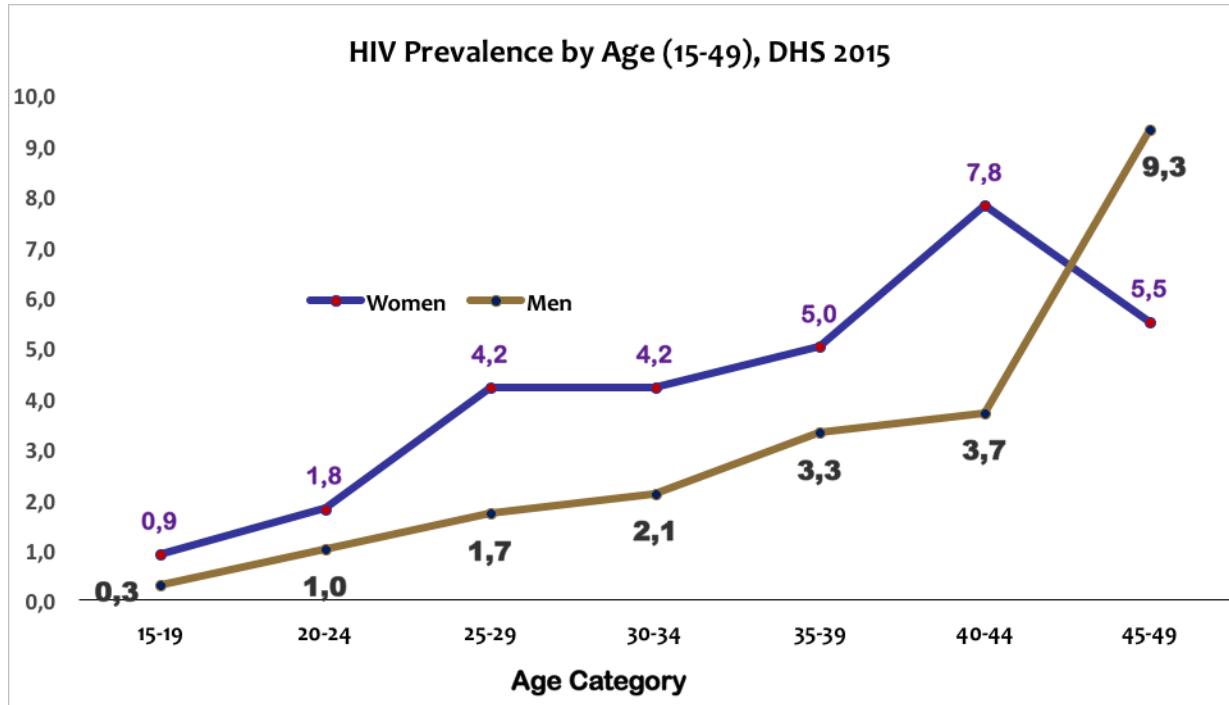
Having said that the prevalence of HIV remained constant for the last decade, the analysis of HIV prevalence data in 2010 and 2015 stratified by sex and age groups indicate that, HIV epidemic in Rwanda is aging as the highest prevalence shift overtime to the right. The pattern of HIV prevalence as per DHS 2015 is displayed in the figure bellow.

Figure 1: Pattern of Rwanda's HIV Prevalence as per DHS 2015

¹ Rwanda Demographic Health Survey, 2015

² Rwanda Demographic Health Survey, 2015

³ Rwanda Demographic Health Survey, 2015



According to data from the first population based HIV incidence survey in 2013/14, the overall incidence of HIV in Rwanda is 0.27 per 100 person-years. Divorcees, widows and singles were found to have a high incidence of 1.3, 0.36 and 0.35 per 100 person-years respectively. In addition, people who reported having been involved in paid sex in the last 12 months had a highest incidence of 3.67 per 100 person-years.⁴

⁴ Rwanda AIDS Indicator and HIV Incidence Survey 2013 (RAIHS-2013)



1.2. Response to the HIV epidemic.

Since the first case of HIV in Rwanda, in the early 1980s, the Government demonstrated efforts and commitment in fighting the HIV-AIDS epidemic. Concrete HIV interventions and services were implemented after the genocide against the Tutsis in 1994. By 1999, the Ministry of Health started expanding HIV testing facilities and laboratory capacity in preparation for the expansion of access to Antiretroviral Therapy (ART). In the same year, PMTCT program was piloted in KICUKIRO HC and later expanded in 2001. In early 2000, the universal treatment program began with a small government-created-fund to offer free ART at the Kigali Teaching Hospital. With support of Global Fund and PEPFAR, in 2004, the national ART program was established and progressively scaled up, for both adults and pediatric HIV-infected people. Later on, the PMTCT program was implemented, with hopes of reaching EMTCT; as well as other HIV prevention programs.

In the past years, Rwanda have been monitoring the HIV epidemic through various surveys and studies: The Rwanda Demographic and Health Surveys, Behavioral and Biological Surveillance Surveys among Youth and other Key populations, HIV and Syphilis Sero-surveillance surveys among pregnant women at ANC/PMTCT sentinel sites, Rwanda AIDS Indicator and HIV incidence Survey, etc.

During the year 2017/18 a new guideline on HIV Prevention and treatment was developed and disseminated.

1.3. Policy responses to AIDS epidemic.

In line with the National response to HIV-AIDS, the Government of Rwanda developed national policy documents, in which the response to the HIV epidemic is seen as a major public health concern involving all levels of government and ministries, and as a long-term development objective in Rwanda, intrinsically linked to development goals around poverty reduction and economic growth.

In 2017-18, as the Government of Rwanda developed its third HIV and AIDS NSP, it took the opportunity to redouble its efforts to understand the Rwandan epidemic and sharpen the national response. Working through national agencies and various development partners, it set out to better define the problem and understand the dynamics of the changing HIV and Viral Hepatitis epidemic in the country.

Over the past years, the Government of Rwanda (GOR) demonstrated political commitment and has put in place different policies and strategies in the fight against HIV and Viral Hepatitis. The following documents form the GOR's cornerstone in the fight against HIV and AIDS in Rwanda: (i) The Vision 2020 and the Second Economic Development and Poverty Reduction Strategy (EDPRS 2) which recognizes HIV and AIDS as a cross cutting issue that should be addressed in all sectors of the economy. (ii) National Strategic Plans for HIV (NSP 2009-2012 and 2013-2018).

A new NSP for the next 6 years was developed to cover a period from July 1st, 2018 until 30th of June 2024. This strategy was developed with broad participation from stakeholders including the community, civil society, partners, and the Government of Rwanda.

The coordination of HIV services in Rwanda was scaled-up by focusing on the decentralization of care.



2. HIV PREVENTION

To curb the trend of new HIV infections in Rwanda, the national program is implementing a combination of HIV prevention interventions that include efficacious biomedical and behavioral package of services. The simultaneous implementation of prevention interventions has contributed to the stable HIV prevalence observed at national level.

2.1. HIV Counseling and Testing Services.

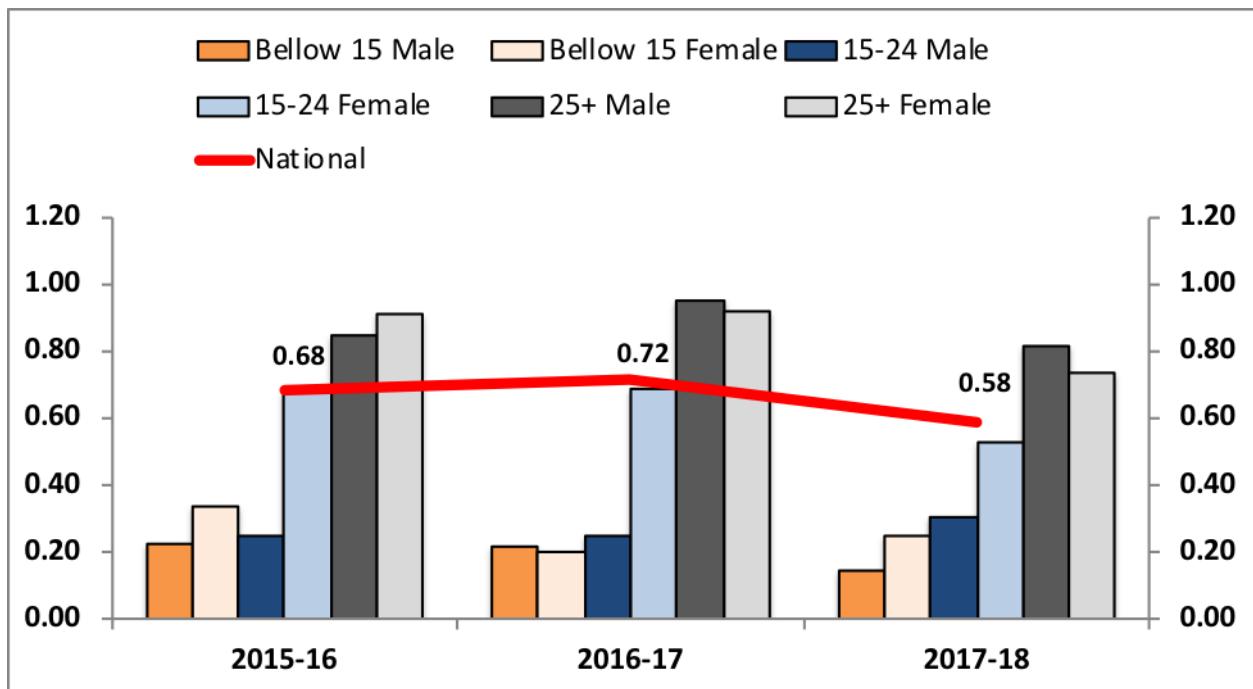
HIV testing and counseling services (HTS) is the only entry point to care and treatment and long-term HIV prevention. Furthermore, HIV testing services are offered both at health facility level and community level through outreach strategy. Combined strategies for HIV testing services delivery contribute to its increased accessibility and uptake. In particular outreach testing help to reach hard populations especially key populations in hotspots and people who don't have access to the existent HIV Testing services within health facilities.

Since 2017, home HIV testing using HIV self-testing was added among strategies in place to increase access to and utilization of HIV testing for those who have never been tested through existing testing strategies due to different reasons. Two main approaches channels are used: free distribution and purchase through private pharmacies. During this reporting period, 7609 HIV self-testing kits were distributed.

From July 2017 to June 2018, in total 2,568,182 tests were done in health facilities providing HIV testing services countrywide.

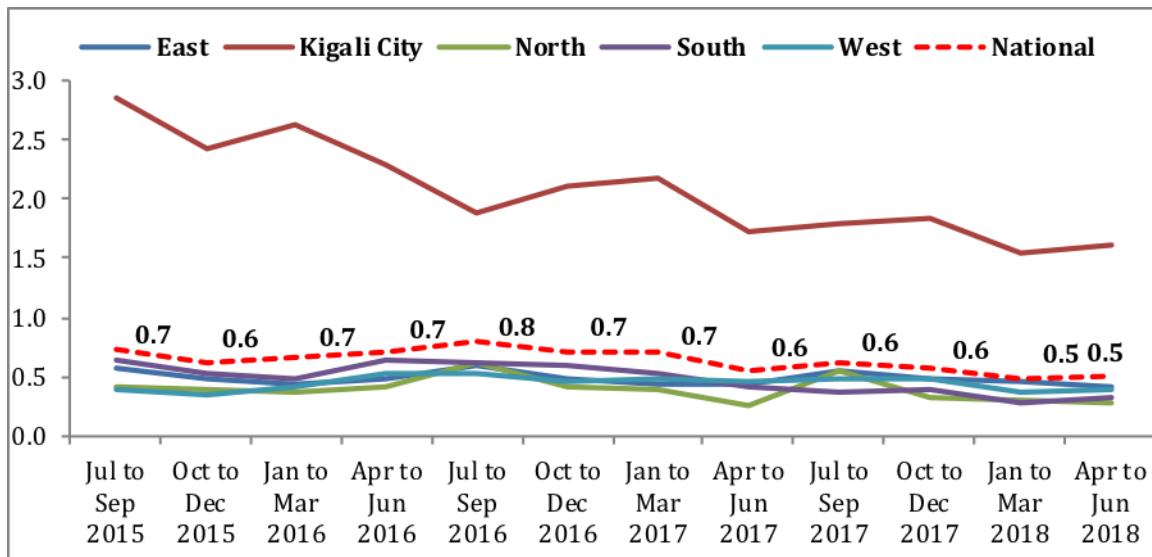
Between 2015 and 2018, the overall HIV positivity rate from 0.68% to 0.58%. Throughout the past 3 years, HIV positivity rate was high among women compare to men in the same age category except the age category of 25 and above in the last 2 years.

Figure 2 Trend of HIV Sero-positivity by age group, HMIS 2015-18



Overall positivity rate was 0.58%, however, there is a difference in HIV positivity rate between provinces and the City of Kigali.

Figure 3 HIV Seropositivity, HMIS 2015-June 2018



Training

The national program in collaboration with partners is implementing a combination of new initiative to actively find HIV positive people who don't know their HIV status and link them to HIV care and treatment services. These initiatives include index testing and partner notification, self-testing and recency testing.

To facilitate their implementation, a training of trainers was organized for central level staff that in turn supported the training of providers of health facilities from all districts hospitals have been trained.

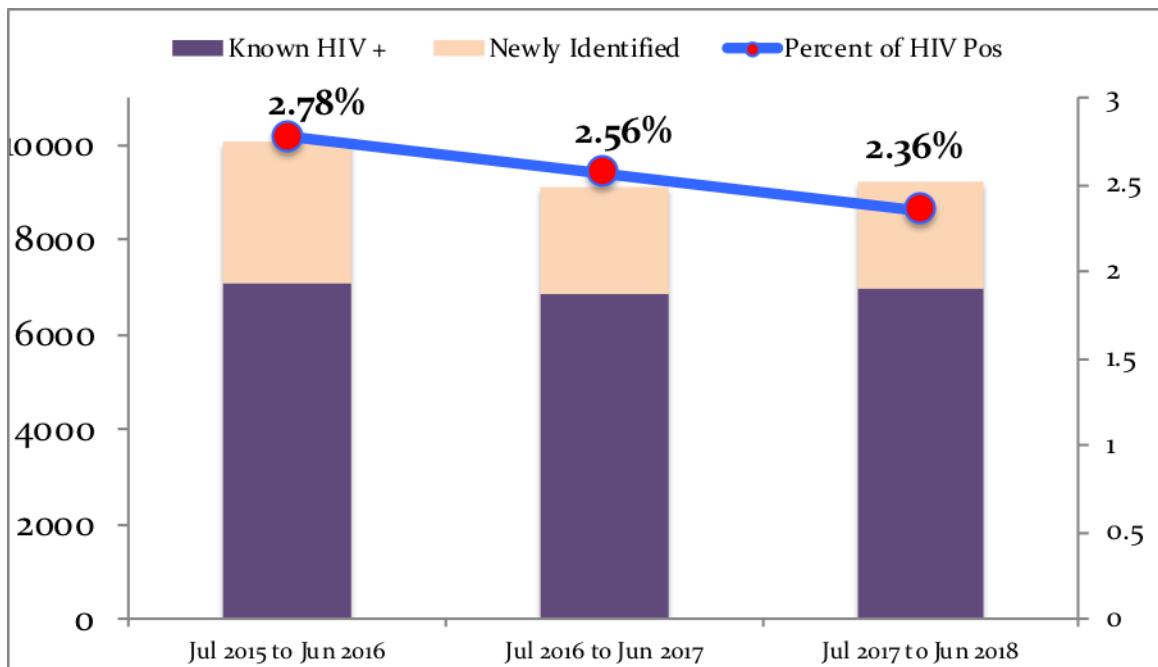
2.2. Prevention of Mother to Child HIV transmission.

In Rwanda, the commitment to achieve and sustain elimination of mother to child HIV transmission goal is among the top priorities. For that reason, a comprehensive package of services for mother infant pair is provided across health facilities in the country,

In the period of 2017-2018, a comprehensive analysis of PMTCT national program data shows that a total of 352,830 pregnant women came in antenatal care services. Among them, a total of 2.36% were HIV positive.

From 2015 up to 2018, program data show a consistent high number of known HIV positive women who get pregnant compare to newly identified HIV positive women in PMTCT program. However, the number of the new HIV positive women identified in antenatal care also still high given different HIV prevention interventions in place.

Figure 4 Trend of HIV Infected Pregnant Women, HMIS 2015-18



Among those women who tested HIV positive, 95.9% started ART in the framework of PMTCT program.

The rate of male partner attending antenatal care services for couple counseling and testing is 85.9% % during this reporting period.

On yearly basis, the national program calculates the rate of Mother to Child HIV transmission at the end of the breastfeeding period using retrospective cohort analysis. Between 2017-2018, the rate of maternal to child transmission is 1.5%.

2.3. Introduction of point-of-care early infant diagnosis

To increase access to timely early infant diagnosis and early ARV, the national program has introduced Point-Of-Care Early Infant Diagnosis machine (POC EID) in March 2017. Between July 2017 and June 2018, the focus was on the scale up of the program, health facilities accessing POC EID increased from 20 (2 hubs and 18 spokes) in 2016-2017 to 89 health facilities (1 standalone site, 12 hubs and 76 spokes) by June 2018. Further, by this reporting period, 13 Alere Q platform (machines), 1400 cartridges and related accessories (tubes, printers,) were provided to sites performing POC/EID.



Capacity building of providers using these machines was prioritized and by end of June 2018, 702 health care providers were trained on various aspects of POC/EID (testing, SMS printers

As result HIV exposed infants tested increased from 135 by June 2017 to 1158 by June 2018 and caregivers received the results for 100% percent of valid tests administered, with a median turnaround time of 1 day from sample collection to return of results. Among the infants tested, 23 infants (1.9%) were diagnosed as HIV positive at 6 weeks in selected sites. All infants with positive diagnosis, were initiated on treatment within a median turnaround time of 2 days (0-53)

2.4. Mentorship and HIV cases documentation

During the year 2017-2018, clinical mentorship to support PMTCT services delivery was conducted in 20 districts hospitals and their health centers in their catchment areas program at health facility level. Mentorship sessions gave opportunity to both central and decentralized level to review the use and compliance of the current national guidelines. Technical support was provided to health care providers in areas that required improvement.

This year, mentorship was combined with documentation of HIV positive cases in PMTCT to understand risk factors associated with HIV transmission in HIV exposed infants followed in PMTCT program in order to take preventive measures in the concerned health facilities specifically and other health facilities national wide as well.

2.5. Enhanced monitoring of PMTCT program

Between 2017-2018, enhanced monitoring activities, continued to be implemented in 32 health facilities located in Kigali City. Through the use of prospective cohort analysis, key program indicators were continuously monitored and have informed program changes to improve the current PMTCT program.

Supervision and coordination meetings were organized to monitor and improve key indicators within implementing sites.

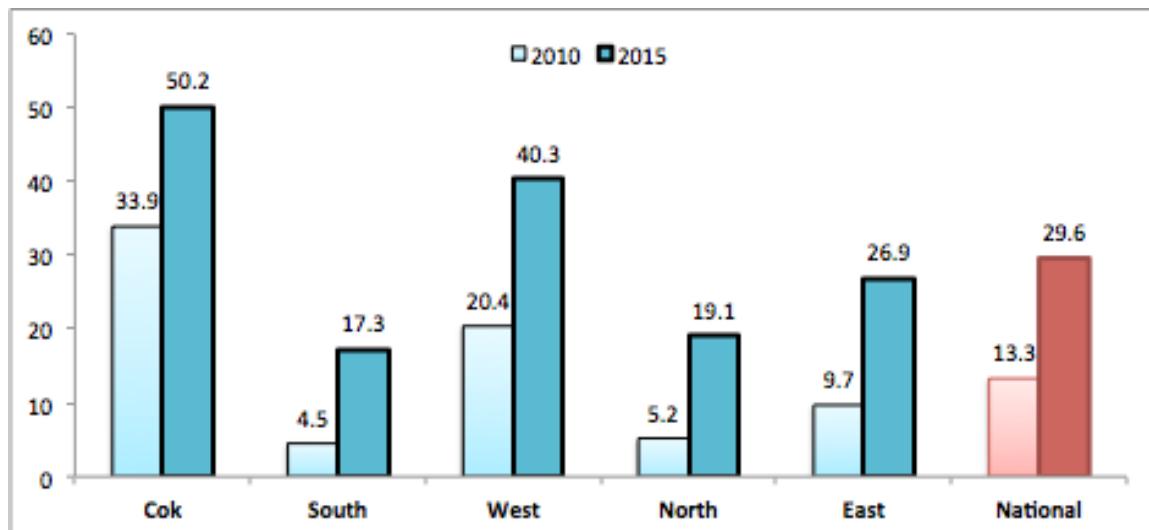
2.5.1. Trainings and Capacity building

To improve the capacity of health care providers in preventing HIV transmission from mother to child and pediatric HIV and to ensure quality service delivery, 376 health care providers from 25 District Hospitals and related health centers were trained on PMTCT, HTS and STIs component. Trainees included nurses and medical doctors from public and private health facilities.

2.6. Voluntary medical male circumcision

Since 2008, Rwanda Ministry of Health adopted VMMC as an additional HIV prevention intervention approach. Since then, Rwanda has made significant strides in scaling up the VMMC program. The adoption of VMMC has doubled (From 13% to 30%) between 2010 and 2015. Since then, Rwanda has made significant strides in scaling up the VMMC program.

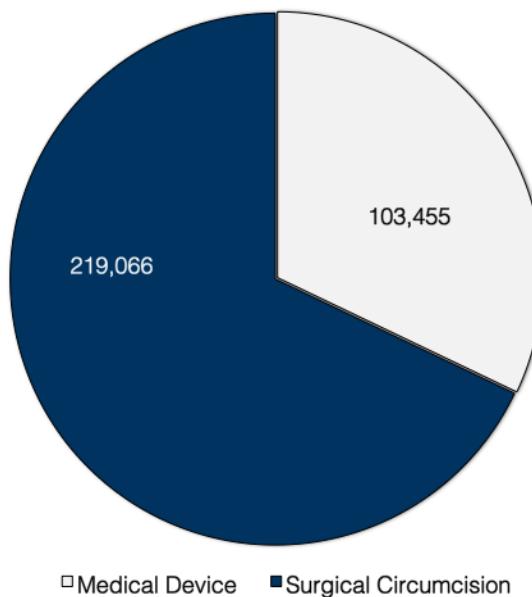
Figure 5 Trend in Male Circumcision Prevalence, DHS 2010-2015



Between July 2017-2018, 322 521 people have been circumcised across the country. The pie chart below shows the number of male circumcision performed by conventional surgical male circumcision and by the device during this reporting period.

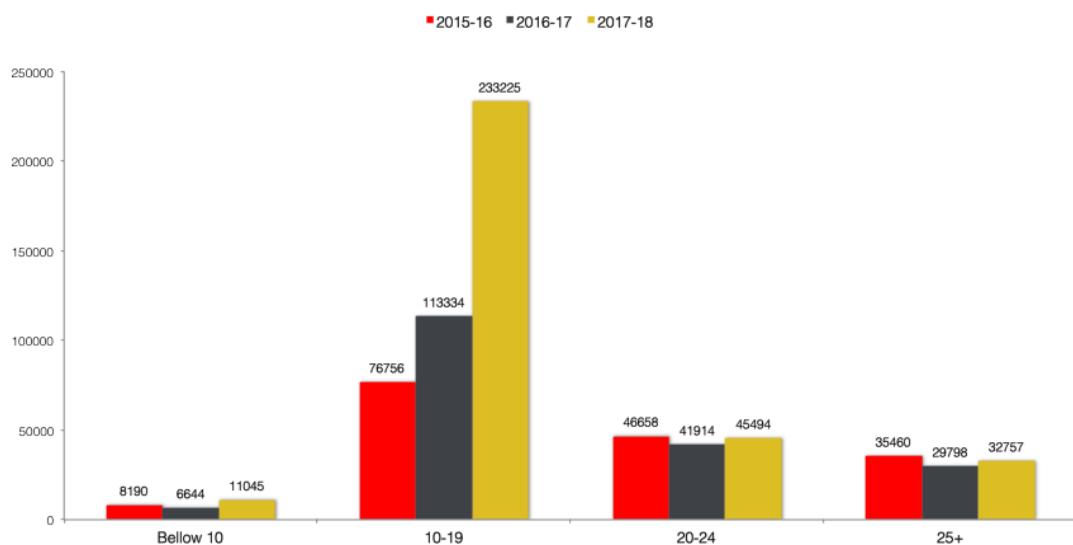


Figure 6 Trend of VMMC performed per method, HMIS July 2017-June 2018



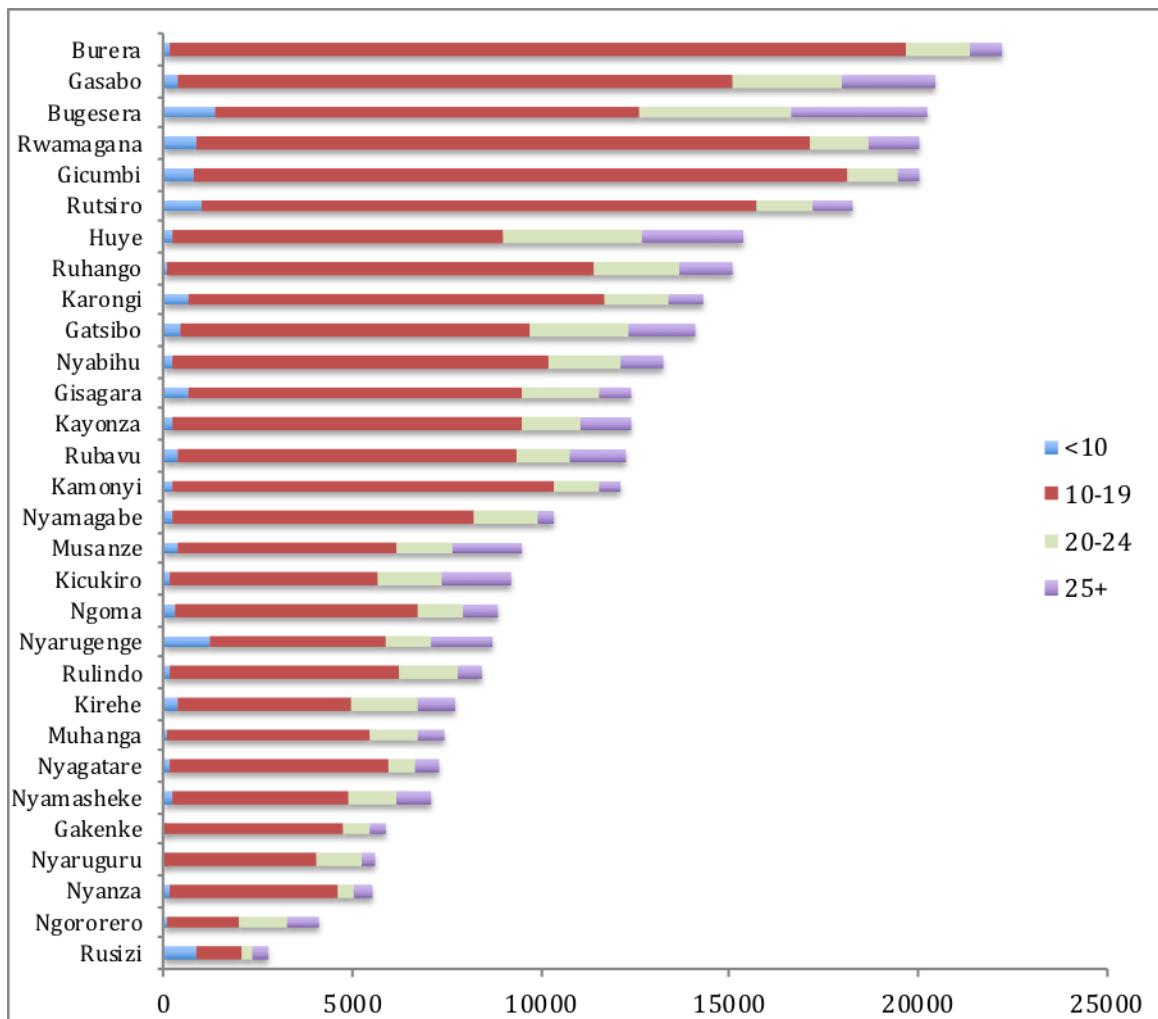
Of the total number of people who have been circumcised, majority of them were in the age category of 10 to 19 years old.

Figure 7 Trend of Male circumcision by Age Group, HMIS 2015-2018



Data analysis at District level shows a difference in VMMC service delivery performance among the 30 districts of the country. Gasabo District is the district, which had a high number of male circumcision cases while Rusizi had few male circumcision cases.

Figure 8 Male Circumcision Performed by District



During this reporting period, the package of services has been revised to reflect WHO guidelines as well as program experience as follows:

- Provision of HIV testing services recommended for boys and men aged 15 years and above,
- Administration of 2 doses of tetanus vaccine for non-surgical method (prepex) and 1 dose for surgical method



2.6.1. Early Infant Male Circumcision

Early Infant Male Circumcision is a long-term VMMC strategy that includes a system strengthening component to ensure continuous availability and sustainability of EIMC services for male newborns.

Since 2015, Rwanda Biomedical Center (RBC) in collaboration with Jhpiego under UNICEF support is implementing EIMC in height health public hospitals including Muhima, Kibagabaga, Gisenyi, Kabutare, Gihundwe, Kibungo, Ruhengeri and Rwamagana.

Between June 2017 to July 2018, 959 newborns below the age of 2 months have been circumcised using Mogen Clamp device.

Training

To support health facility VMMC service delivery, during the present reporting period, 197 health care providers were trained on male circumcision method. Currently, all district hospitals have 2 trained staff that can provide VMMC services using both conventional surgical and non-surgical method while half of health centers are able to use the two methods.

Mentorship

Provision of male circumcision services requires continuous support for quality services delivery. In the period under review, Rwanda Biomedical Center organized 5 mentorship sessions combined with VMMC services delivery across the country. At the end of these sessions, health care providers have gained experience in VMMC service delivery and a total of 19,753 clients have been circumcised.

2.7. Key Populations

In Rwanda context, key populations including sex workers and men who do sex with men and discordant couples. As these groups are disproportionately affected by HIV and they are recognized by the National Strategic Plan as focus group to reduce the number of new HIV infections, specific activities were carried out during this reporting period.

Between July 2017-June 2018, for 6 implementing partners under GF funding **3,939** FSW are enrolled in program and among them **598** FSW were linked to care and treatment.

During this reporting period, comprehensive services were provided to key population to key populations. Condoms is essential among the services received by key populations, in total, **1,023,045** condoms were distributed through 8 condoms kiosks displayed in Kigali City, Rubavu, Rusizi and Huye while **10,205,492** were distributed through health facilities versa **3,153,356** KPs community-based distribution.”

Training

The purpose the training is to sensitize health care providers to provide a comprehensive package of HIV prevention and treatment and other related services to Key Populations, in a non-stigmatizing and competent manner.

Participants in the trainings were health care workers that have direct interactions with key populations. In total 70-health care providers were trained on Key Populations health friendly services including M/E system.

Further, specific condoms supply chain training was conducted to ensure uninterrupted condoms supply and distribution in the key population programing. Participants were from 7 district pharmacists and 10 head of health centers.

Continuous Quality improvement

RBC organized addition, quarterly technical working group with all stakeholders supporting implementation of key population program. This is a platform to share experience between implementers and program and to address issues faced during implementation. Finally, it helps to reinforce the partnership between health facilities and implementing partners to improve community linkage.

Behavior change communication

During this reporting, three main approaches including Mass campaign, IEC materials production and distribution and mass media (newsletter supplements, Radio & TV shows and spots) were used to improve individual and general population awareness on HIV, STIs and Hepatitis.



Campaigns

RBC/HIV Division in partnership with all partners in HIV response organized national campaign started with the cerebration of 2017 World AIDS Day under the theme “***Get tested for HIV. If positive, start and stay on life-saving treatment***”.

Among key activities done during this campaign include:

- Community mobilization through different communication channels
- Distribution of IECs materials
- Launching oral HIV self testing approach by the Minister of Health,
- Extension of 24/7 condom kiosks to other regions of the country namely Rubavu, Rusizi and Huye.
- Service delivery including condoms distribution, HIV testing and family planning methods
- Competition on HIV knowledge (Quiz) on radio
- Cerebration of WAD at District level (Nyabihu, Rubavu and Nyarugenge)
 - In Rubavu, national program participated in the Rwanda Catholic Youth Forum to increase their HIV awareness. Around 5,000 youth from all over the country participated in this event.
 - In Nyabihu, a team of two staff with facilitated outreach campaign in two different sites where condoms were freely distributed and free HIV testing was conducted as well as providing voluntary family planning methods.
 - In Nyarugenge, during 2 days of HIV testing service and circumcision awareness campaign coupled with service delivery was conducted at Nyabugogo taxi parking

Radio shows and spots

Aired live talks were conducted to provide to the general population with important information around newer HIV programs & services as well as to increase awareness and utilization rate of HIV services. Radio Spots, mentions during popular talk shows and the food tube shows were aired on Rwanda Broadcasting Agency (RBA), Umucyo Community

Radio, Energy Radio and TV spots on RTV and TV1 for 14 days. In addition, 8 live radio talk shows and 1 TV live talk shows were done.

IEC Materials

Educational materials were produced (some of them were developed and others were updated) to provide to the population with Information, Education and Communication strategies as well as Behaviour Change Communication to equip the population with enough information to make a personal decision to promote positive behaviour changes. Among materials developed, there are posters on VMMC, Posters on STIs management and Boite à image on PMTCT while others were updated like Pediatric and ART dosing chart and Algorithm on DSDM.



3. HIV CARE AND TREATMENT

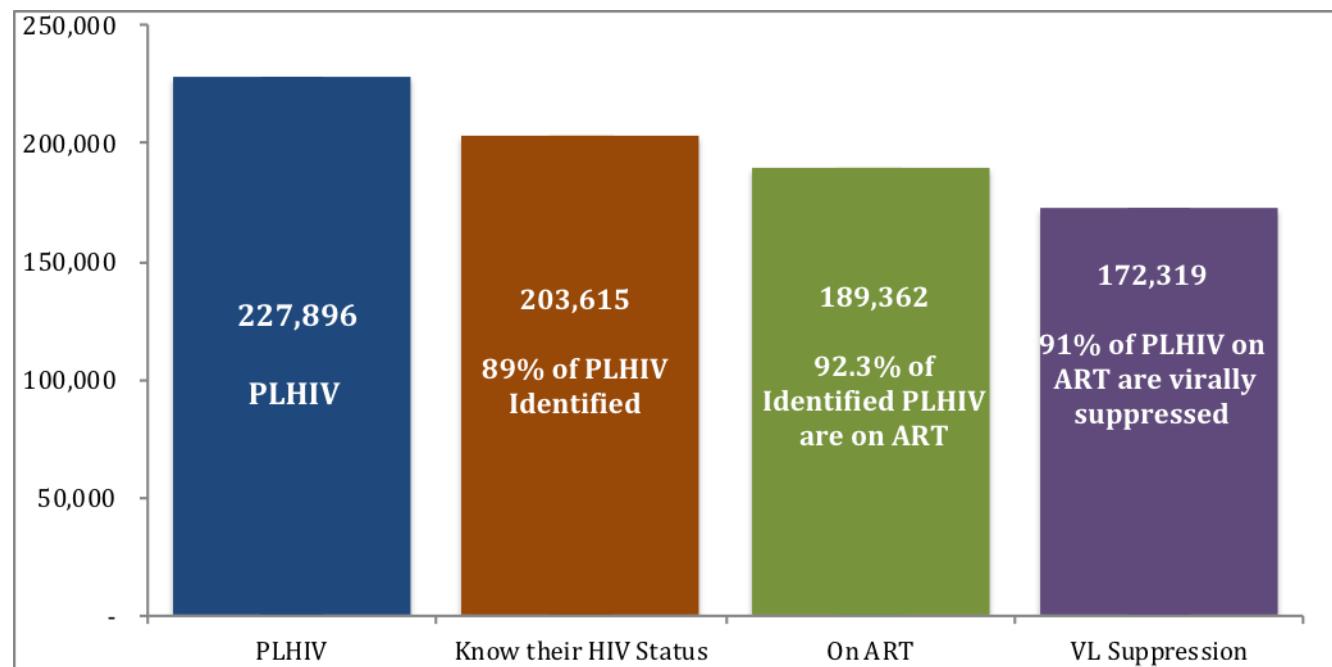
3.1. Introduction

Treatment of People Living with HIV (PLHIV) is a priority of the national HIV program towards HIV epidemic control.

Since 2016, Rwanda has adopted the WHO recommendations of, “Treat All”, where all patients tested positive are timely initiated on treatment. This contributed tremendously to almost achieving the 90-90-90 targets ahead of 2020.

The figure below summarizes the progress of the country for each of the 90s:

Figure 9 Rwanda progress towards three 90s



Of the estimated 227,896 people living with HIV in Rwanda (UNAIDS EPP Spectrum, 2018), 89% (203,615/227,896) know their status (DHS15); of which, 92.3% (189,362/203,615) receive ART (HMIS2018), and 91%(172,319/189,362) of them suppress viral load below 1000 copies/ml (HMIS2018).

Reinforcement of the treat all implementation and improvement of quality of services have been strengthened to keep people on treatment and improve their quality of life.

Different strategies have been initiated to maintain patients on treatment and support adherence.

3.2. Linkage and enrollment to care and treatment

With “Treat All” HIV+ strategy, each client confirmed HIV positive initiates antiretroviral treatment regardless any other criteria, immunological and/or clinical.

Enrolment into care and treatment represents the step where the client tested positive is registered and constitutes the beginning of follow up into HIV care services and the start of prophylaxis against opportunistic infections.

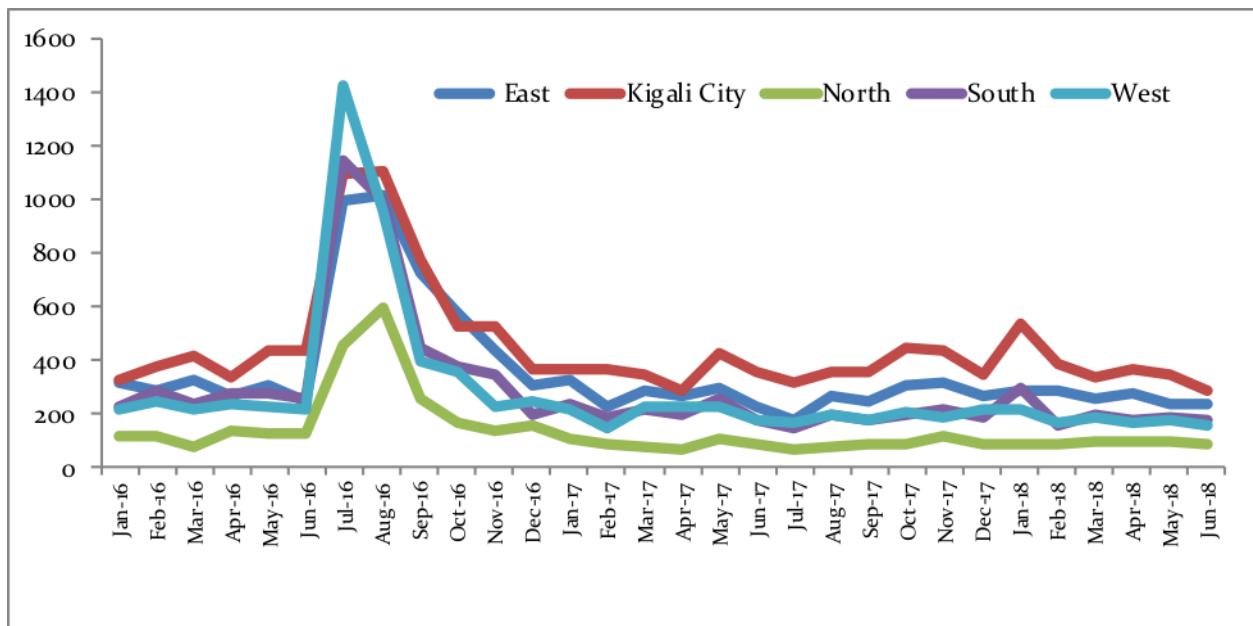
During this year, **same day enrollment** has been reinforced at all health facilities through training and mentorship to decrease lost to follow up between testing and enrollment.

During enrollment, a special focus has been put on counseling and adherence, nutrition support. All health facilities implemented systematic screening, diagnosis and treatment of OIs to prepare for ART initiation. All these efforts contributed to the achievements of the reported results.

Below is the graph showing enrollment trend since Treat all implementation up to the reporting period as of June 2018.

Figure 10: New Enrolment of Patients in ART since the initiation of Treat ALL





During three months of treat all initiation, a pick of enrollment into care and treatment has been observed. All patients in pre-ART were initiated to ART.

We observed that initiation to ARVs varied by province, age groups and gender as presented in the graph below. The majority of patients were aged 25 years and above; Kigali city contributed more people on ART; northern province brought in less patients.

Figure 11: New enrolment by age and province

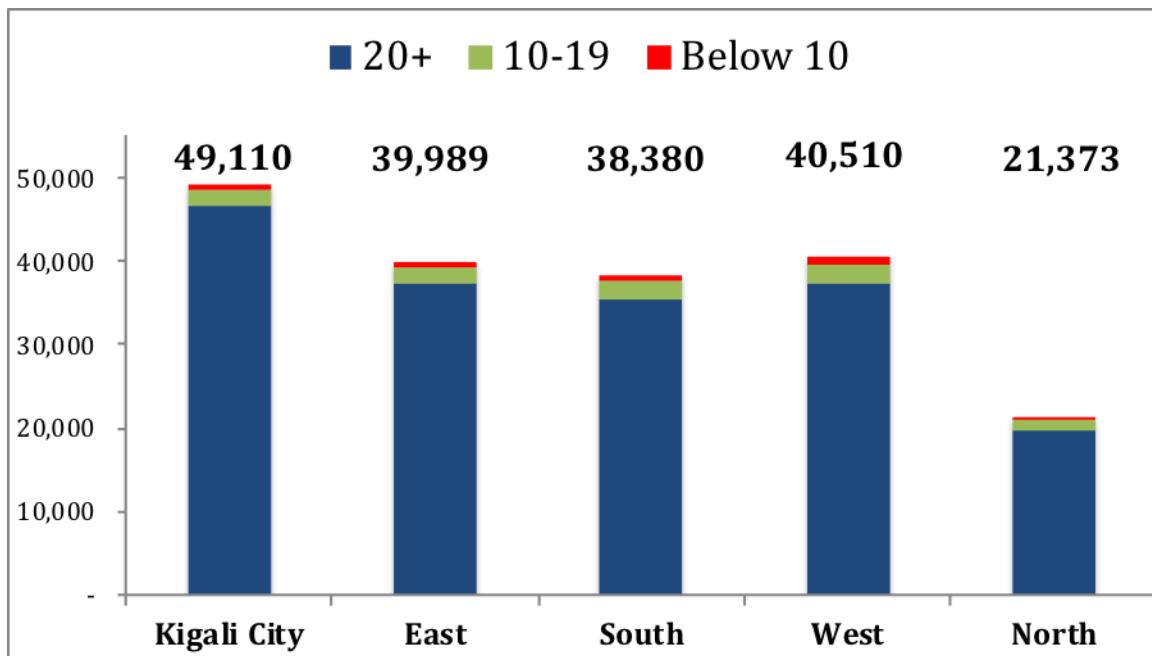
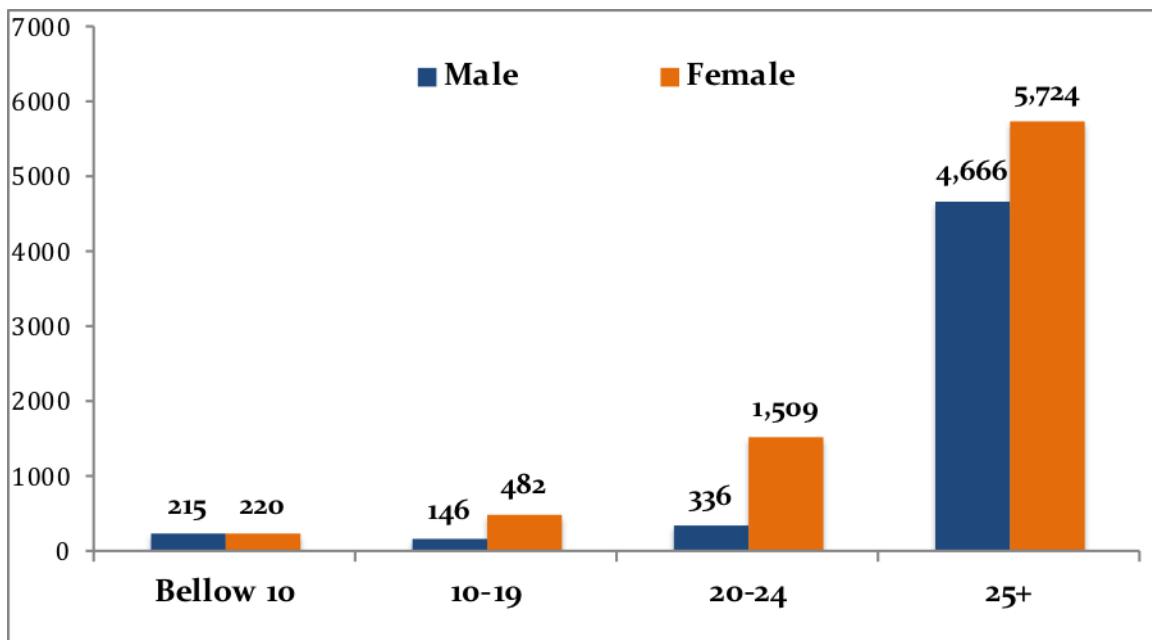


Figure 12: New enrolments by age and gender



3.3. Treatment initiation

With Treat All strategy, all people tested HIV+ start ART within the same week and preferably same day. Clinical and biological exams are also performed to assess clinical, immunological and biological status of the patients.



Progress made towards treatment coverage has been remarkable in the past 14 as shown in the graph below. Treatment coverage and gaps are highlighted by province and age categories. These differentiations will help to focus implementation where major gaps remain but also keeping the gains high.

Figure 13: Trend in treatment coverage over years

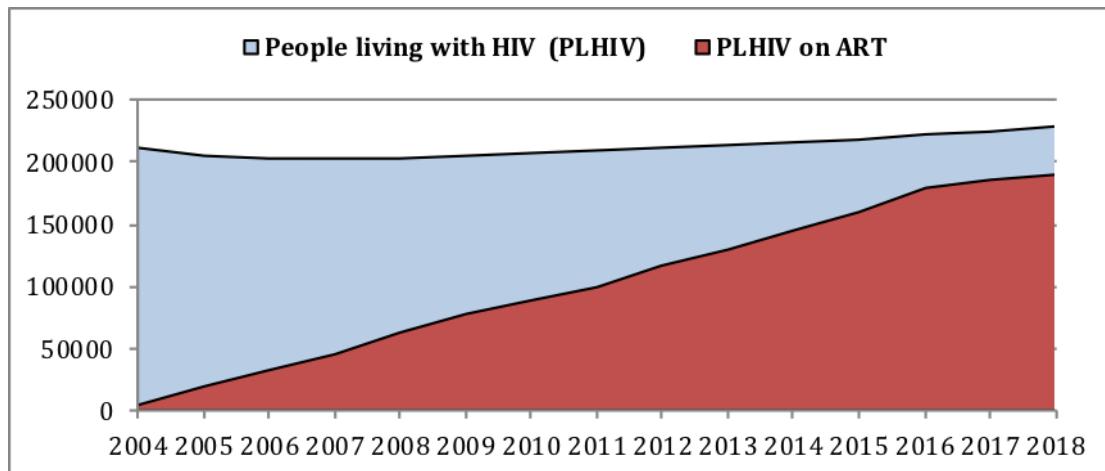


Figure 14: Treatment coverage and Gap

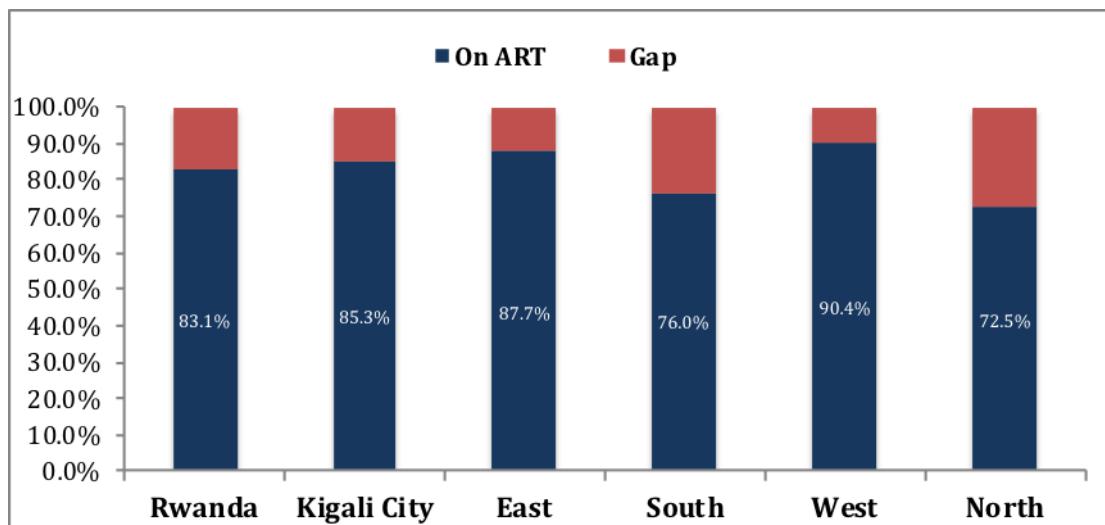
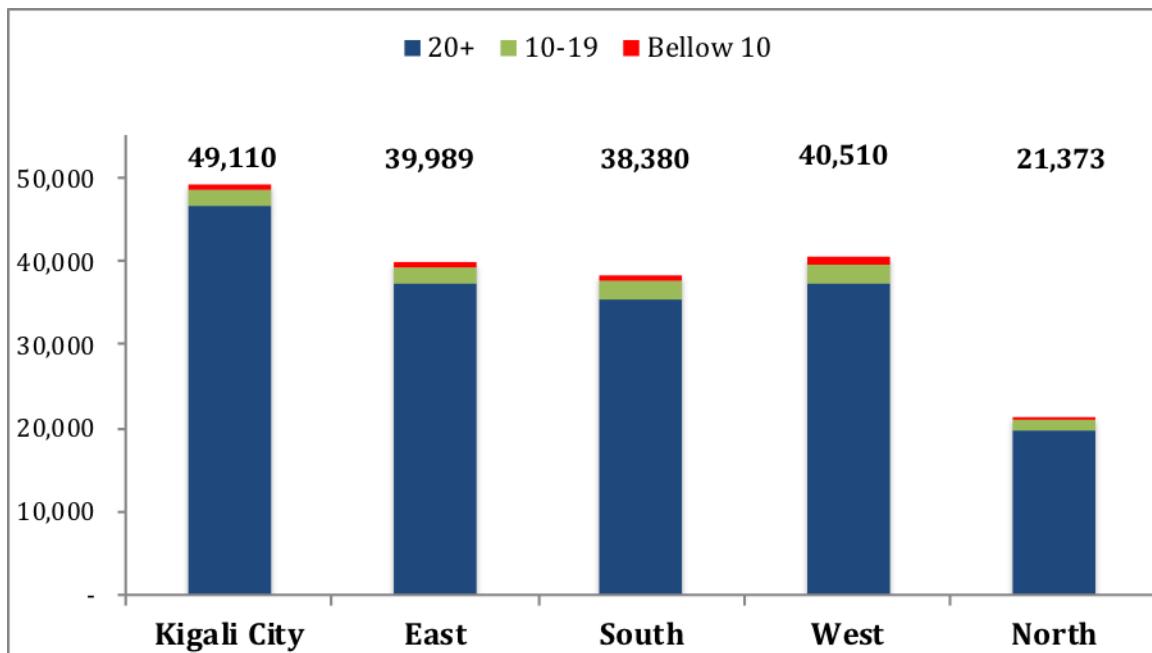


Figure 15; Patients on ART by Province and Age



All these achievements resulted from different strategies implemented during this reporting year such as:

- Treat All strategy implemented countrywide
- A differentiated service delivery model to decrease patients ‘time at health facility and provider’s workload to allow focus on complicated cases.
- Emphasis on adolescents for diagnosis, retention and treatment follow up under the “All In” initiative.
- HIV adolescent minimum package has been integrated in HIV packages offered at health facility with adequate mentorship and trainings related to better management of adolescent living with HIV.
- Clinical mentors from all district hospitals played a major role supporting guidelines implementation at health facility levels.; in total 1109 health care providers were trained according to new HIV guidelines and most updated scientific evidence on HIV management.

During this year, new HIV treatment guidelines included new molecules such as “Dolutegravir” in first line ART as first option and in second line as second option. Concerns about Dolutegravir side effects (teratogenicity) for patients in childbearing



ages have been noted and are currently subject to regular messaging to health care providers.

3.4. Systematic OI screening, prophylaxis and treatment

The screening of OIs is one of the packages offered to all PLHIV from enrolment and during clinical follow up. **Cotrimoxazole**, the commonly useable medicine in prophylaxis has been provided to all PLHIV or replaced by Dapsone in case of contraindication. This provision will be targeted to advanced disease cases only starting with the New Year.

Tuberculosis remains the most prevalent OI and for this reason, it is screened widely at every clinical visit for PLHIV. During this year, all PLHIV have been screened at enrollment and during follow ups per national HIV guidelines.

Since 2013, according to HIV guidelines, **cryptococcal meningitis** screening has been systematically done for every patient whose CD4 were less than 200 at enrolment and for every HIV positive client with signs reflecting Meningitis by performing lumbar puncture and detect cryptococcal antigen in the liquid Fluconazole is given for all uncomplicated cases as treatment and prophylaxis.

Non-Communicable Diseases (NCDs) are now emerging with high prevalence in people living with HIV. Integration and linkage of HIV and NCDs services is key for a holistic management of patients. During this year, a screening questionnaire of NCDs among PLHIV have been developed and integrated into the HIV management guideline as well as tools. This screening will be done at each clinical visit of patients for counseling and appropriate referral. The focus will be on diabetes and high blood pressure.

3.5. Retention on Treatment and Suppression

The ultimate goal of antiretroviral treatment is to retain patients in care, ensure good adherence to treatment and services for good viral load suppression. The overall retention was 91.5% while the viral load suppression was 93.6% after 12 months on ART.

Figure 16: Retention of patients after one year on treatment

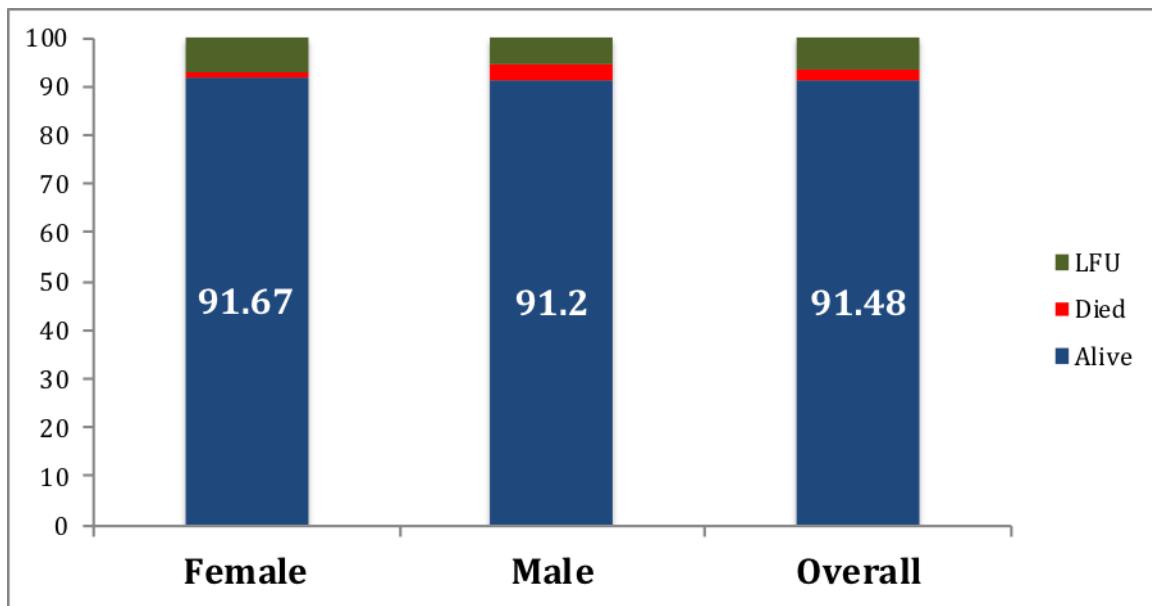
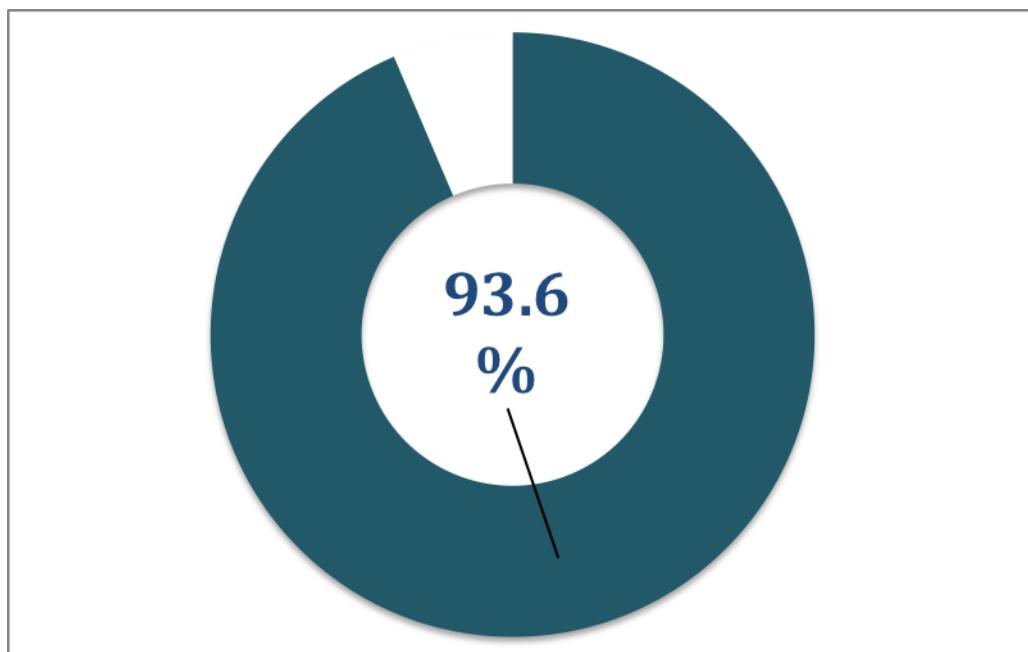


Figure 17: Viral Load suppression



These achievements resulted from implementation of different strategies:

A differentiated service delivery model (DSDM) spacing visits to the clinic have been one of solution to decrease provider's workload and reducing frequency of clinic visits for stable patients, potentially receiving ART drugs that can serve them for a longer period of time,



rather than coming to the clinics every month and encouraging community support through peer education. Classification of patients into the 2 groups (stable and unstable) defined into DSDM has been initiated since December 2016 and is a continuous activity. This model rationalized the delivery of care to reduce the burden on health facilities; multiple visits of patients to the health facility and waiting times.

With the implementation of this strategy there have been an increase adherence and retention by decreasing lost to follow up and mortality.

During trainings and mentorship, an emphasis has been put on early prevention and management of treatment failure.

Monitoring of viral load is the cornerstone of HIV program; it supports prevention and management of treatment failure. Program has put more efforts to train health care providers to monitor viral load as per guideline in place, manage patients according to results.

Below is a map showing decentralization of viral load at provincial level

In addition, support to decentralized viral load testing in different hubs have been a priority this years through mentorship to lab technician in different hubs, strategies to decrease turnaround time of VL results have been a priority during this year: increase staff in Hubs supporting region in testing of VL, inter-laboratory support in Hubs with workload, avail reagents on time.

An electronic system, e-LMIS, has started to be implemented in sites sending samples in the national reference laboratory with a plan to decentralize to other hubs in next year; this will be another opportunity to decrease turnaround time.

3.6. Care and Support

In order to improve the adherence to treatment, thereby maximizing the benefits of ARVs, an emphasis has been put on psychosocial care with a focus on HIV status disclosure and support groups for children and adolescents, which is a great contribution to service and treatment adherence. Nutritional assessment, Counseling and Support for PLHIV is integrated in Care and Treatment Package.

During this year, different activities have been done to improve health care providers capacity to support patients for better adherence.

In collaboration with the mental health division and the Rwanda neuropsychiatric hospital, 86 health care providers from western province were trained on HIV& Mental health Integration

remaining provinces are also targeted for next year in line with mental health HIV integration scale up.

At least 2 health care providers by each health facility have been trained as trainers on health on peer education program, for the community support in HIV follow up; in additional, related tools to support peer education model have been developed (training Manuel, job aids...)

In collaboration with Health [e] foundation, 120 health care providers (clinical mentors from all districts hospitals and practitioners from referrals hospitals) were trained on HIV and palliative care, Stigma and HIV management among children

Targeted clinical mentorship to reinforce HIV disclosure has been done in 3 districts with the practices difficulties to improve adherence of children and adolescent.

In the same line, mentorship focused for adolescent and young people have been done to support them to create income-generating activities, this year 66 youths have been mentored

The relationship between HIV and nutrition is multifaceted and multidirectional. HIV can cause or worsen under nutrition by reducing food intake, increasing energy requirements, and poor nutrient absorption. Under nutrition in turns further weakens the immune system, increasing vulnerability to infection and worsening the disease's impact. Nutritional care and support helps break this cycle by helping people living with HIV (PLHIV) maintain and improve their nutritional status, boost their immune response and improve their response to antiretroviral therapy (ART).

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 have been carried out in this area such as:

The continuous management of moderate and severe malnutrition was ensured in accordance with the national protocol. During this reporting period, the emphasis was putted on the management of severe and moderate malnutrition in all health facilities. For this purpose, the procurement of RUTF for severely malnourished PLHIV and CSB+ for moderate



malnourished was done and distributed in all health facilities (District Hospitals and Health Centers) with ART services across the country. Mentorship to support health care providers in nutritional assessment and counseling were also provided at health facilities with high burden.

3.7. Mitigation of Impact

Different activities are performed to support PLHIV to mitigate the impact of the diseases, mainly by improving their social economic support and be productive for themselves, for their families and for the country.

During the reporting period, the focus has been on most vulnerable children (MVC) and young girls through DREAMS program.

With the support of Global Fund and PEPFAR through the National Commission for Children (NCC) and others PEPFAR implementing partners through USAID, different activities have been implemented for the reporting years, such as provision of education support to OVC through scholastic materials in twelve years basic education (12 YBE) as one of government priority; Payment of school fees to MVC in Technical and Vocational Educational Training (TVET) and provision of income generating activities (IGA) to parents/caregivers of OVC in 12 YBE for their empowerment and resilience; renovation of Early Childhood Development (ECD) and their equipment to make them operational contributing to the HIV mother to child elimination; support to young girls and adolescent, through DREAMS program, to improve their knowledge and their socio economic status as one of strategies to decrease new infections in this particular group.

Through NCC, with Global funds support in 8 districts, school fees for **754** MVC in TVET have been paid and **41** MVC in 12YBE supported with scholastic materials.

Coordination meetings have been done with different stakeholders in this program, mainly schools, district and parents. In additional, through USAID implementing partners, MVC program continued to strengthen service delivery to targeted families and communities, reaching 97,803 beneficiaries out of 115,948 teargetted for OVC and DREAMS combined, across 14 districts and 137 geographical sectors. Main activities focused on were demand creation and referrals for HIV testing of MVC beneficiaries; care and support for people living with HIV; household economic strengthening activities (loans and savings groups,

cooperatives, income generating activities and conditional household grants as appropriate) to improve financial stability; work readiness education for youth to prepare them for employment and business opportunities; education support (primary and secondary school and market-based technical and vocational education and training - TVET); early childhood development (ECD) services for children under 6 to expose them to early learning in diverse areas that affect their and their caregivers' health and wellbeing; child rights education and protection; home visits and linkages to other forms of support; sexual and reproductive health and rights (SRHR) for young people aged 10–24, especially for adolescent girls, knowledge and adoption of positive health behaviors; and health promotion services, including linkage and referral to health related services to respond to beneficiaries' unique needs in health, food security, nutrition, and messaging on water, sanitation and hygiene (WASH) practices, gender-based violence (GBV) prevention and response, and HIV prevention and care.

All these activities are coordinated under the ministry of Gender and Family promotion through its implementing agency NCC.



4. STIs and Viral HEPATITIS

4.1. Introduction

An estimated 325 million individuals worldwide are living with viral hepatitis with more than 80% of the burden in low or middle income countries (LMIC)[1]. Chronic infection with viral hepatitis can lead to liver inflammation and further cause chronic liver disease, cirrhosis and liver cancer [2], contributing to an increasing burden of morbidity and mortality [3]. With effective vaccines and treatment for Hepatitis B (HBV) and an increasingly affordable cure for Hepatitis C (HCV), combatting viral hepatitis has become a focus for national strategic plans in Rwanda.

The Rwandan government, capitalizing on its success in rapid expansion of HIV services and care, has led the way in reducing its hepatitis burden, the first country in the region to launch a national viral hepatitis control program in 2015 and establish a dedicated hepatitis unit. The unit has since initiated the national technical working group on hepatitis, revised national guidelines and introduced viral hepatitis services for the management of HBV and HCV towards the reduction of related morbidity and mortality.

Prevention means were used through awareness, sensitization, screening and vaccination campaigns as the most effective way to reduce the burden of HBV disease. Since the introduction of the pentavalent vaccine in 2002, infants receive routine vaccination against hepatitis B. To help protect unvaccinated adults, the government has conducted catch-up vaccination through campaigns among general population and vaccination at employment institutions. Over 6,000,000 people including adults and children have received so far HBV vaccine from 2002 meaning that all people aged 0 to 16 years old are vaccinated. In 2017-2018 only, over 420,000 people including adults and children were vaccinated against HBV.

Since program launch, the government has shown strong commitment to expanding its capacity to treat patients chronically infected with HBV and HCV. During the 2017-2018 fiscal year, the government secured treatment for patients infected with HBV and HCV and so far, 6,573 patients received treatment for HCV while 848 patients received treatment for HBV. In an effort to expand enrollment in timely care and treatment accessibility, the treatment was made “free for all” by the government of Rwanda to allow people with less

financial capacity to access treatment but also task-shifting of patient management to lower cadres of healthcare workforce was conducted through training of General Practitioners and nurse mentors on viral hepatitis. So far 90 new Doctors were trained in addition to 20 prescribers and currently 110 Doctors are treating viral hepatitis across the country with at least 2 Doctors per hospital. In addition, 82 nurses were trained to have in total 1 nurse mentor and 1 nurse at the service of Out Patient Department (OPD) in all hospitals. Doctor's mentors also were trained to have at least 1 Doctor mentor per hospital. With an effort to increase access to screening and treatment, Rapid Diagnostic Tests (RDTs) for HBV and HCV were validated and tendered for procurement.

To reach the above number of treated patients, strong screening campaigns were conducted in July 2017 for all 30 Districts and in 2018 for 13 Districts with high burden of Viral Hepatitis based on the findings from the previous campaign of 30 Districts. Campaigns have been conducted from the beginning of the program and, to date; over 500,000 individuals have been screened for HBV and HCV during campaigns. Screened people were followed-up for further confirmation and treatment.

For the program management, improvement as well as monitoring and evaluation, guidelines and other tools were revised for STIs and hepatitis B and C but also mentorships, research were conducted.

4.2. Policy and guidelines orientations

During 2017-18 fiscal year, the guidelines for STIs and Hepatitis B and C were revised and merged. The management of STIs is based on both syndromic and etiologic approaches with a progressive shift emphasis on the last. Some changes for the guidelines of STIs and Hepatitis B and C were noted and some guidelines for Viral Hepatitis also have been reviewed as follows:

- *The screening of HBV will be done using a single screening test and eligibility criteria will follow using other tests as needed for enrolment in treatment as per the 2017 WHO guidelines on hepatitis B and C testing.*



- *APRI score for eligibility and enrolment in treatment for both hepatitis B and C will be APRI > 2.*
- *For STIs, some changes in testing of Syphilis as well as changes in treatment of gonorrhea are noted in the new guidelines.*

4.3. Trainings and mentorships on viral hepatitis and STIs

Trainings on STIs and viral hepatitis management

In order to ensure successful program implementation, an expanded and suitably trained workforce is required at all levels of the healthcare system. As a prerequisite, all healthcare workers need to be sensitized on STIs and viral hepatitis infection, and all appropriate staff trained on the content of the new guidelines. As a priority, personnel requiring training include policy makers and program managers at the central and decentralized levels and include specialists, clinical mentors, general practitioners, nurses, laboratory technicians, nutritionists and pharmacists. For this, theory and practical trainings were conducted.

In total 90 Doctors managing viral hepatitis, 82 nurse mentors and nurses from OPD, 43 pharmacists were trained on theory and practice as required. The 90 Doctors were certified as HBV and HCV prescribers for continuous management of the said diseases to have a total of 110 Doctors treating Viral Hepatitis across the country

Mentorships on STIs and viral hepatitis management

To continuously monitor and strengthen the management of STIs and viral hepatitis management, mentorships were conducted in all hospitals. Mentorships were conducted to Hospital Doctors, Nurses, Lab technicians and Pharmacists for the monitoring and emphasis on quality services delivery.

In addition, mentorships activities were conducted to link positive patients to confirmatory testing and treatment for hepatitis as well as to monitor the use of tests and drugs for an equitable distribution in different Hospitals.

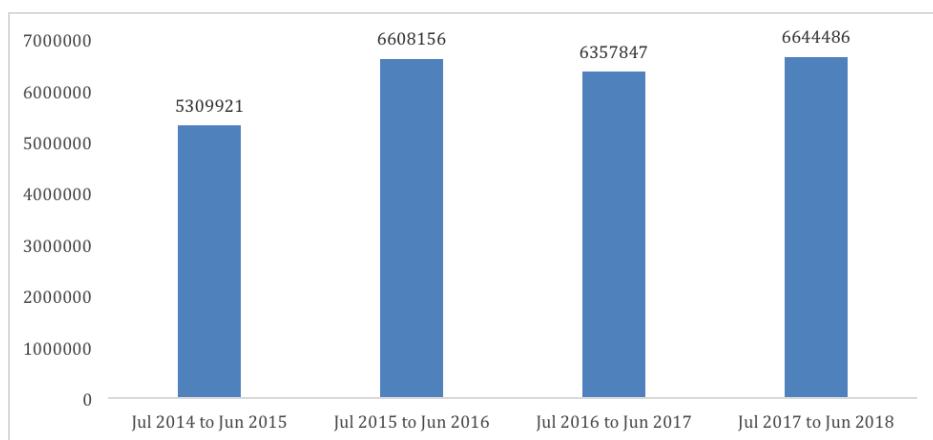
4.4. Prevention of STIs and Viral Hepatitis

Prevention of STIs

By 2030, World Health Organization (WHO) has a vision of zero new infections, zero sexually transmitted infection-related complications and deaths, and zero discrimination in a world where everybody has free and easy access to sexually transmitted infection prevention and treatment services, resulting in people able to live long and healthy lives. This aiming to end STIs as a major public health concern using strategies like universal health coverage, the continuum of services and a public health approach.

In the same line with WHO vision, from 2011, the Ministry of Health (MOH) through Rwanda Biomedical Centre (RBC) urged for STIs systematic screening in order to reduce unmet need in STIs prevention and treatment services. This strategy helped to recognize clients with symptomatic STIs who do not seek health care and thus increase the number of cases treated. However, although we are aware that a significant number of people remain asymptomatic while they continue to spread the disease, socio-economic means that should help to use advanced method to recognize them still represent a challenge to remarkably reduce the burden of STIs in Rwanda. So far, in Rwanda, patients aged 15 years and above visiting different health facilities for several health issues are actively checked for STIs signs and symptoms. From 2014, clients ranging between five and six million were screened in different health facilities as it is shown in the figure below:

Figure 18: Clients who received counselling and screening for STIs



In addition to failure to recognize asymptomatic cases, the screening of STIs is only based on self-reporting prior to physical exam, and some health care providers may not take enough time for patients counseling and explanation on why the information is needed. Trained and dedicated health care providers should be helpful in educating and increasing the awareness of all clients about STI related problems.

4.5. Awareness and vaccination of HBV

Prevention of HBV infection was done through awareness messages, radio talks, campaigns, vaccination as well as screening. Vaccination is a significant contributor to HBV infection control. Routine administration of the HBV vaccination schedule for infants is already in place since 2002, and nationally almost all one-year-olds have received three doses of the HBV vaccine (~97% within a given year) (WHO, 2013).

Given that infant vaccination is relatively new to the routine practice, it will take some decades before all persons are vaccinated against HBV. Thus, vaccination of other populations is an essential element in effective infection control.

Rwanda Biomedical Centre through HIV Division organized the awareness campaign on viral hepatitis prevention focusing on vaccination. The targeted immunization of populations at high risk of infection has the greatest impact on transmission of the disease, and as such, vaccination of such groups was prioritized. Those involved in vaccination include pregnant women, PLHIV, HCW/CHWs, other high-risk groups and general population. The main objective of HBV vaccination was to increase awareness and availability of HBV and HCV services to the population in order to reduce the morbidity and mortality related to HBV infection. . Overall, over 6,000,000 people including children and adults were vaccinated from 2002 up until to date and during 2017-2018 fiscal year, around 420,000 people were vaccinated. The campaign included general population, prisons, key population (FSW, MSM, PLHIV) as well as 2,499 staff vaccinated from 34 public and private institutions.

4.6. Screening and testing of HBV and HCV

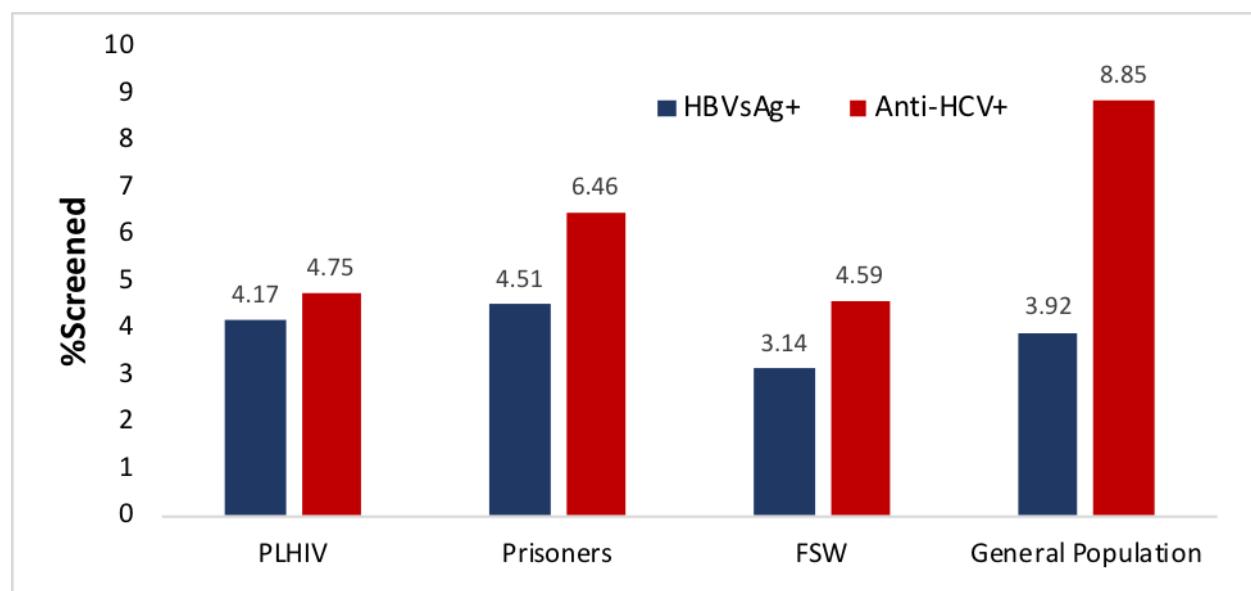
From July 2017, RBC prepared awareness on STIs and viral hepatitis campaign and different categories of the population were educated, vaccinated against hepatitis B and screened for HBV& HCV. For services continuum, people confirmed positive were linked to confirmatory

testing and treatment. During this fiscal year, two campaigns of awareness on STIs and viral hepatitis were conducted: the first one was done in all 30 districts from July-October 2017 and the second one was done from March- May 2018 for 13 districts with high burden of viral hepatitis.

Considering the 1st campaign in 30 Districts, a total of 202,973 samples from individuals were collected for screening and included 52,902 prisoners, 3,660 FSWs ,21,503 PLHIV and 124,908 people from the general population. Number of individuals who screened positive for HBs Ag in different populations were 7,254(4.0%). Number of individuals who screened anti-HCV positive was 14,561(8.1%).

Among people screened positive for HCV, 52.8% of them were confirmed positive for chronic HCV. The high prevalence of HCV for both Antibodies and Viral Load was found in aged people.

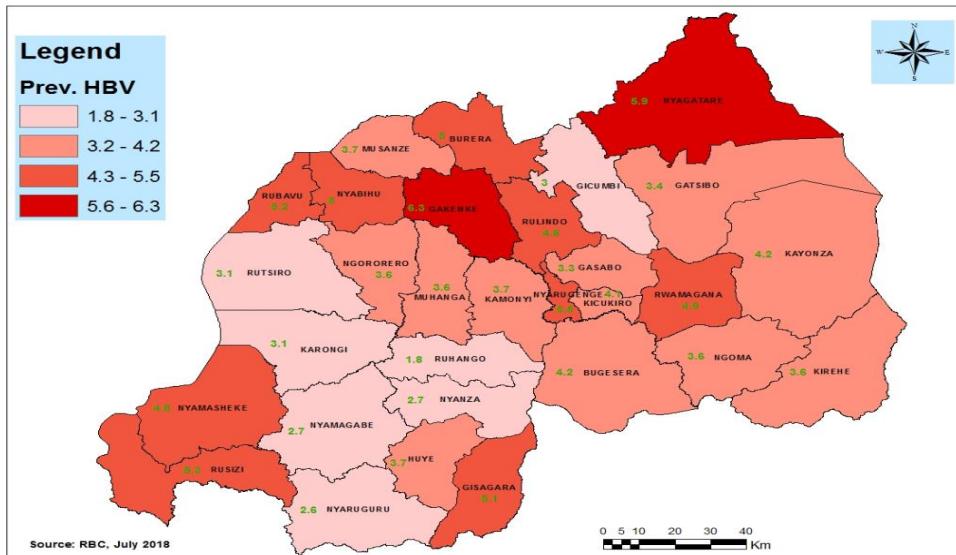
Figure 19 Proportion of individuals who screened positive for HBsAg and anti-HCV among different population groups screened during 2017 campaign in Rwanda



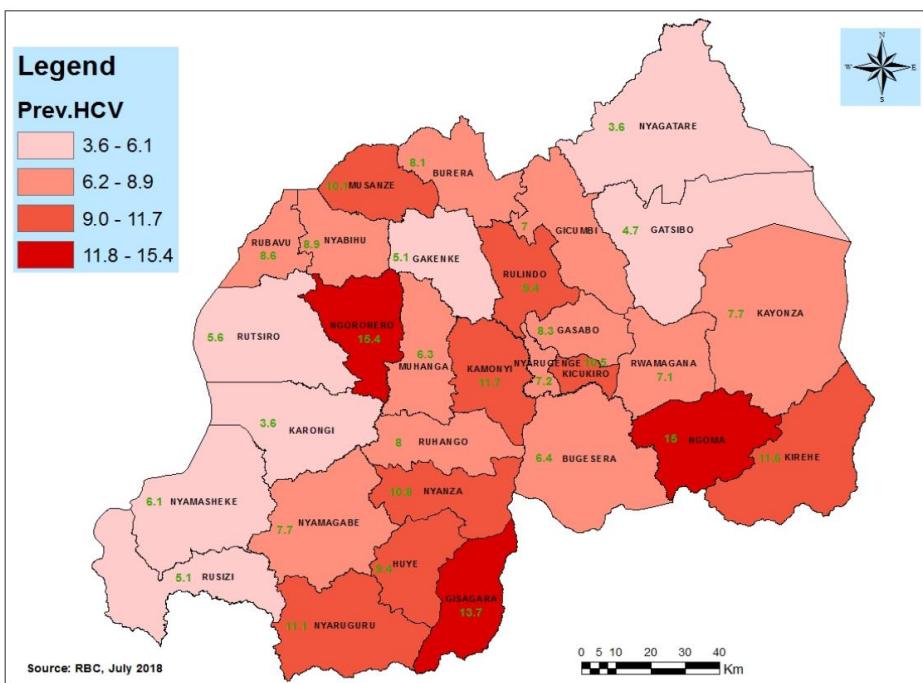
Considering prevalence of HBV and HCV in all districts, prevalence of HBV was higher in Gakenke district (6.3%) and lower in Ruhango district (1.8%) while the prevalence of HCV was higher in Ngororero district (15.4%) and lower in Karongi and Nyagatare districts (3.6%).

Map 1 : Distribution of HBs Ag around the country (2017 campaign findings in 30 districts).



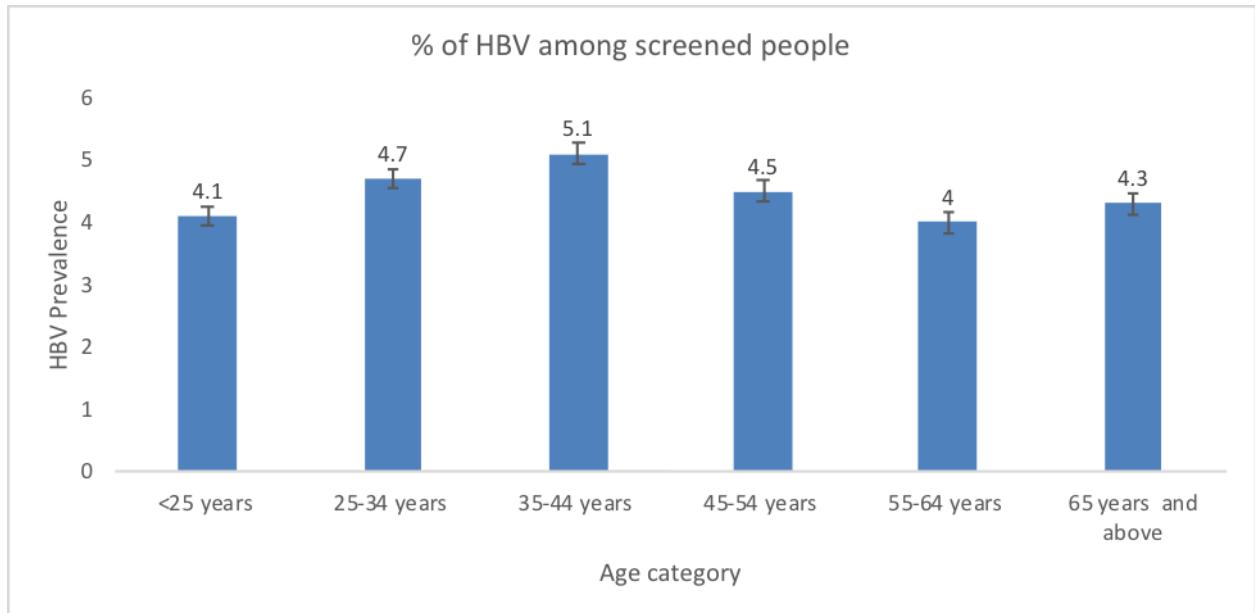


Map 2 Distribution of HCVAb around the country (2017 campaign findings in 30 districts)



Results from the campaign conducted in 2017 showed that HCV was higher than 5% in 27 Districts. Among these districts, a follow-up campaign was conducted in 13 districts to conduct screening of hepatitis B and C from March to May 2018. The 13 districts are the following: Huye, Gisagara, Nyamagabe, Nyaruguru, Nyanza, Ruhango, Muhamanga, Musanze, Bugesera, Kirehe, Gatsibo, Ngoma, Nyagatare. In total 162,089 samples were collected for screening during the campaign in 13 districts where 7,207(4.5%) were screened positive for HBs Ag and 12,830 (8.0%) screened positive for HCV Ab.

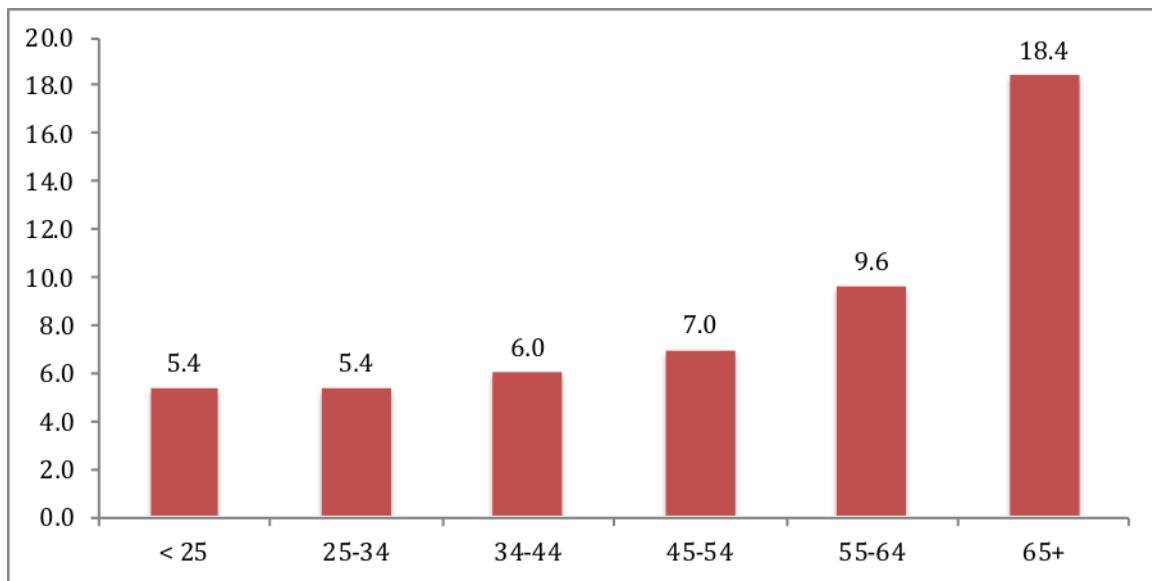
Figure 20 Prevalence of HBs Ag by age category of Participants (2018 campaign findings in 13 districts)



From these individuals screened anti-HCV positive, HCV VL test was performed and for the part completed during the fiscal year, 5025 were tested for HCV VL and 1995 people (39.7%) HCV VL was confirmed having chronic HCV using HCV Viral Load test. .

Figure 21. Prevalence of HCV Ab by age category of Participants (2018 campaign)





4.7. Care and Treatment for HBV, HCV and STIs

Care and Treatment of STIs

In Rwanda, a part from syphilis etiologically diagnosed in Ante Natal Care (ANC), other STIs are diagnosed and treated using syndromic approach. Although the syndromic approach has advantages like high sensitivity among symptomatic patients, taking account of multiple infections, and client satisfaction, its success requires regular monitoring, evaluation as well as supervision and training that are regularly not prioritized. Furthermore, the approach has some limitations including; over-diagnosis, over-treatment, and unnecessary side-effects.

However, it has been shown as a best strategy for STIs control in resources limited settings if compared with laboratory approach, which requires using a rapid increase in investment in STIs response by equipping laboratories and trained personnel.

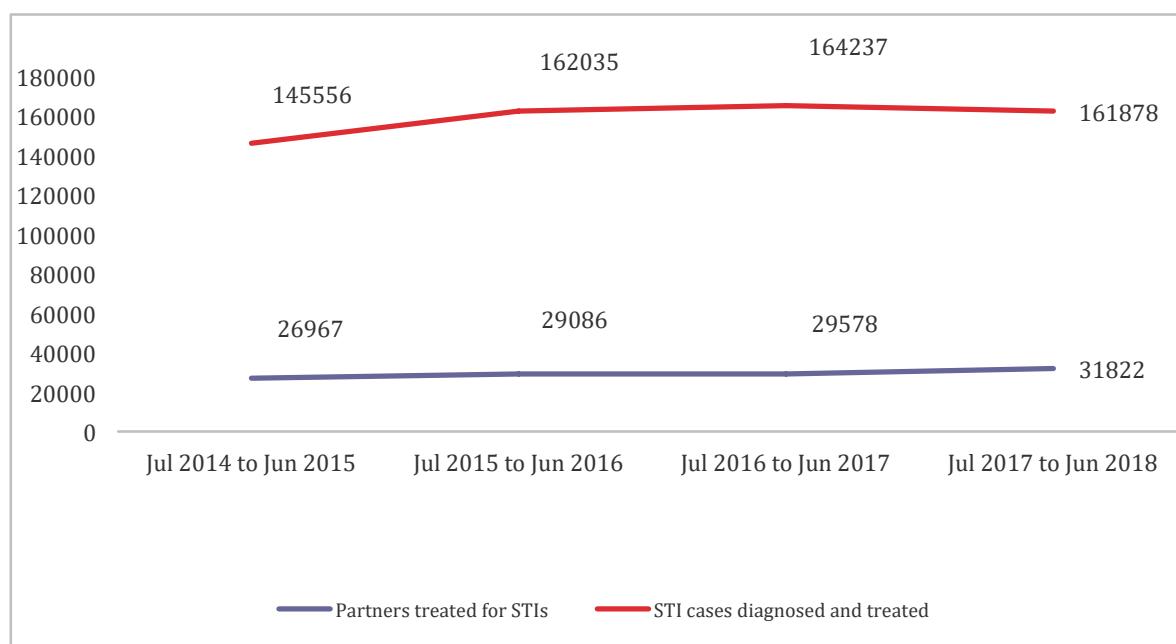
Driven by the Vision 2020 targets to reach middle-income status by 2020, Rwanda has achieved impressive social and economic gains over the past two decades. The Second Economic Development and Poverty Reduction Strategy (EDPRS II) has been developed to achieve these ambitious goals and to transform Rwanda's economy into a knowledge-driven and service oriented economy. By 2018 the main goals of the strategy are to increase gross domestic product (GDP) per capita to 1,000 USD, reduce the poverty rate to 30%, and reduce the extreme poverty rate below 9% in order to remain on target to meet the Vision 2020 goals.

So far, significant efforts have gone into successfully strengthening the national health system in Rwanda. These advances have facilitated improved access to medicines and have contributed to the success of different national programs including Human papilloma virus control and syphilis in pregnant women. However, other STIs have been lagging behind for many years, despite their impact on public health.

Neisseria gonorrhoea is currently a growing threat worldwide due to antimicrobial resistance. Unfortunately, for a long decade, Rwanda has adopted the WHO recommendation for the treatment of gonorrhea and other STIs, with no particular regard for the country context.

STIs partner notification, care of asymptomatic cases as well as knowing the real course of the syndrome have to be continuously improved. The following figure shows STIs cases syndromically diagnosed and treated from July 2014 to June 2018, and partner treatment.

Figure 22 STIs cases and partners diagnosed and treated from 2014 to 2018



Care and Treatment of HBV & HCV

In 2017, Rwanda Biomedical Centre carried an ambitious campaign under umbrella of World Hepatitis Day 2017. Over 9,000 chronic hepatitis C and 722 chronic hepatitis B patients were targeted



to be linked to care and treatment for free. The objectives of the free hepatitis treatment were to increase financial and geographical accessibility to viral hepatitis treatment for Rwandan population in targeting its elimination, delivery for equity and reduce the burden of viral hepatitis among Rwanda citizens. The results of hepatitis treatment in 2017-2018 fiscal year are the following:

- 6573 chronic hepatitis C patients have been initiated on DAAs since July 2017,
- 848 chronic hepatitis B patients are being treated on Tenofovir 300mg since July 2017,
- The accessibility of Viral Hepatitis B and C services to people in need was improved by availing all services in all 48 Hospitals across the country. This is a big achievement as only 4 centers (King Faisal Hospital, CHUK, RMH and CHUB) in the past were offering hepatitis treatment services.
- Patients are getting now drugs at nearest public hospital: previously patients used to take their medicines at one private pharmacy in Kigali but now, all 48 public hospital pharmacies are dispensing hepatitis C and B drugs.
- The burden of Viral hepatitis was reduced by screening campaigns and treatment of patients before the onset of complications such as cirrhosis, hepatocellular carcinoma. The life expectancy will consequently increase.
- Free hepatitis treatment was offered as equitable service to all Rwandan citizens to have access to hepatitis C drugs, which normally is very expensive.

Regarding the drugs, during 2017-2018 financial year, we had initially 21,000 bottles of Harvoni (Sofosbuvir and Ledipasvir combination) for 7,000 patients and 6,000 bottles of Sofosbuvir for 2,000 patients purchased and distributed. These drugs were given respectively to 6,573 and 848 patients for HCV and HBV.

5. HEALTH SYSTEM STRENGTHENING

5.1. Integrated supervision

For HIV program, the exercise looked at the indicator total patients currently on ART. Findings revealed that all District Hospitals (n=43) had discrepancies below 5% while during the last ISS DQA exercise it was found that 96% of DHs at the discrepancy below acceptable range of 5%. In other words, all the DH were within the acceptable range of discrepancy for the indicator total patients currently on ART.

The indicator total patients currently on ART was assessed at HC level as well and findings revealed that 93% (n=42) of HCs that were assessed had relative discrepancies below 5%. Although there is no comparability at HC because of the sampling selection, during the last ISS DQA, close to 100% (98%) of the Health Centers assessed fell in a green category which is referred to as good quality data.

5.2. Supply chain system

For the fiscal year, the Quantification exercise, based on the updated protocol, has been completed and the report of findings and supply plan submitted to procurement entities on time. Regular stock monitoring has been done to minimize any losses due to expiries and avoid stock out at maximum. A continuous support to district pharmacy, through mentorship have been done to reinforce reporting and on time requisition using e-LMIS and this will continue for coming years



6. STRATEGIC INFORMATION

Introduction

The Rwanda Biomedical Centre through HIV-AIDS, STIs and OBBI Division implements various interventions in the context of HIV response. Those interventions include routine programmatic and research activities. The monitoring and evaluation component comes in to determine the impact of all activities focusing on the eradication of HIV-AIDS, STIs and Other Blood Borne Infections. This section presents the achievements of RBC/HIV Division in terms of research activities and routine monitoring of HIV epidemic during 2017-2018. Those include surveys, surveillance and research, health information and routine data systems, and data management and reporting.

6.1. HIV surveillance and research

Development of research protocol

For the fiscal year July 2017-june 2018, HIV Epidemiology, Surveillance and Research unit (HESR) at RBC, developed protocols for planned research and HIV program activities. This was in order to provide recommendations for policy development, improvement and guide evidence-based interventions in the near future. Below are the protocols developed and/or implemented:

Protocol developed and approved

1. *Active Case Based Surveillance for HIV in Rwanda*
2. *HIV Drug Resistance Monitoring in people living with HIV in Rwanda*
3. *Integrated Behavioral and Biological surveillance survey among Men having Sex with Men*
4. *Integrated Behavioral and Biological surveillance survey among Female Sex workers, Rwanda 2018*
5. *Female Sex Workers size estimation in Rwanda using three source capture-recapture, 2018*
6. *Rwanda Population HIV Impact Assessment, 2018 (RPHIA)*

Protocols Implemented

1. *The prevalence and factors associated with hepatitis B and C in people living with HIV (PLHIV).*
2. *Determinants of HIV Transmission among HIV Exposed Infants in Rwanda.*
3. *Monitoring of Differentiated Service Delivery Model for Care and Treatment Services Provision at Health Facilities in Rwanda*

6.2. Research Dissemination

Research dissemination is one of the HIV Monitoring and Evaluation. During the fiscal Year 2017-18, Rwanda has hosted the Interest conference from June 11th -15th. Known as the “African CROI” the INTEREST Conference brings together scientists involved in HIV treatment, pathogenesis, and prevention research in Africa to share pivotal findings, promote collaboration, and transfer experiences across several fields and many continents. The conference has showcase cutting-edge knowledge in the diagnosis and treatment of HIV and the prevention of the HIV-1 infection. Additionally, it continued to foster building a community of African physicians and scientists to facilitate the implementation of local solutions for the management of patients living with HIV-1 infection and for the prevention of HIV transmission.

Furthermore, Rwanda was selected to host 2019 International Conference on Aids and STIs in Africa (2019 ICASA) to be held in December 2019.



7. STRATEGIC PLANNING

7.1. National strategic plan

HIV national program is the national strategies and approaches to prevent and controlling HIV/AIDS in Rwanda. The national strategic plan (NSP) based on previous NSPs, review reports, updated scientific epidemic facts on HIV and new policies.

The National Strategic Plan (NSP) was aligned with other key national priorities and strategies such as Vision 2020, National strategy for transformation (NST) 1, the Health Sector Strategic Plan (HSSP IV) as well as international priorities such as the drive to realization of the Sustainable Development Goals (SDGs) and new guidelines for the management of HIV. The NSP is guided by a number of core principles: national mobilization and ownership, equity and human rights, gender equity, integration of HIV services into the national health system, cost effectiveness of interventions, and national capacity building.

The current HIV NSP focuses on vulnerable groups that face a high burden of disease and who are key to the transmission of the epidemic, including sex workers and their clients and discordant couples in order to consolidate the gains of the last few years, and to continue making headway in a cost-effective manner. This NSP has three core ambitious goals for its timeframe of execution, notably reducing the new infection rate, halving the number of HIV-related deaths and ensuring that people living with HIV (PLHIV) have the same opportunities as all others.

To achieve these goals, three main levels of intervention are available: prevention of new infections, care and treatment, and impact mitigation. It is under these three levels that this NSP develops and prioritizes specific activities that will deliver on the goals with the highest impact for a given investment. This NSP is meant to provide guidance, clarity of purpose, and national alignment as we tackle the scourge of HIV, it does not imply that the strategy is frozen for the next six years. As a result, we expect that this NSP will evolve during its six-year lifespan as new facts and evidence come to light and new contexts emerge.

7.2. Country Operational Plan

The operational plan of NSP extension for the first year has been implemented as planned apart delayed disbursement, which implied catch-up plan to ensure smooth

implementation of expected activities. The detailed catch-up plans are tailored in finance components.



8. GOVERNANCE MECHANISMS

8.1. Introduction

The RBC-Institute of HIV Disease Prevention and Control (IHDPC) is the national coordinating agency responsible for ensuring that all HIV interventions in Rwanda are harmonized and aligned with national priorities and strategies and that the Three Ones principle (one national coordinating body, one national strategy, one national M&E framework) is followed. To achieve this, a standard format has been designed for both annual plans and for quarterly and annual reporting that is used by all partners involved in the national response to HIV and AIDS. Annual plans and annual reports are developed by all districts, economic sectors, and umbrella organizations and are consolidated into a national HIV annual plan and report.

RBC/IHDPC coordinates clinical and non-clinical aspects of the national response to HIV and other disease prevention and control. Within IHDPC, the HIV Division coordinates HIV, AIDS and STI and other blood borne infection activities. It is responsible for national planning, formulation of policies, training of trainers, and the development of the curricula for clinical programs. It provides technical assistance and gives guidelines in the organization and effective management of HIV and AIDS, STI, and other blood borne infection control programs. It is also responsible for monitoring, evaluating, and coordinating health sector activities in response to HIV. It ensures the coordination of research on STI, OI, VCT/PMTCT, TB and ART, as well as socio-behavioral research.

Apart from the HIV Division, several other divisions within RBC are also playing important roles in contributing to the HIV response, including: National Reference Laboratory (NRL) Division, National Center for Blood Transfusion (NCBT), Health Communication Center (HCC), Medical Procurement and Production Division (MPPD), Tuberculosis and Other Respiratory Diseases Division (TB), and Vaccine-Preventable Diseases Division (VPD).

Decentralized/district level leadership and coordination

Within the decentralization process, the local government at district level is responsible for the management of all public services. The coordination of the HIV response at district level is located within the District Health Unit, which oversees planning and monitoring all health interventions in the district.

8.2. National Strategy for transformation (NST)

Implementation: In NST 1 covering the 2018–2024 period, HIV is addressed as a crosscutting issue and priority activities have been identified in Social Transformation pillar of NST1. Not only ministries and public institutions, but also all private and community organizations involved in the same field of activities. HIV and AIDS activities implemented by each sector at the district level are integrated into the five-year District Development Plans (DDP) and district annual work plans.

Coordination: Under the coordination of a lead ministry, each has a strategic plan, as well as an annual work plan, within which HIV activities are integrated. Each sector has put in place an HIV focal point that has the responsibility to coordinate the implementation of its HIV priority activities at central and decentralized levels. RBC/IHDPC/HIV Division supports each lead ministry to coordinate HIV activities undertaken by the sector at the district level and ensure that HIV interventions of different sectors are delivered in a coordinated way at the district level.

Civil society organizations

Implementation: Civil society organizations are among contributors to the implementation of the NSP. In the field of prevention, many outreach activities for the general population are implemented by community health workers and/or civil society organizations. Civil society organizations contribute to delivery of a comprehensive package of preventive interventions for identified key populations and most vulnerable groups (FSW and their clients, MSM, mobile workers, discordant couples, PLHIV for positive prevention, people with disabilities, etc.).

HIV division has improved collaboration and coordination mechanisms between civil society organizations (CSOs) and the health services to ensure complementarity and synergy of their interventions. Each CSO was given a specific package to offer and areas to operate. In addition, indicators were set and agreed between RBC and CSOs to be evaluated periodically with implication for those failed to met the targets.

In the field of care and treatment, 40 percent of healthcare facilities are managed by faith-based organizations and are fully integrated into the healthcare system. Further, there is strong collaboration with MoH and public coordinating bodies to ensure quality of care and respect of national guidelines and standards.



Associations and cooperatives of PLHIV and affected people have been key players in the implementation of activities aimed at mitigating the impact of HIV and AIDS, including income-generating activities. Faith-based organizations are also strongly involved in the provision of psychosocial support to PLHIV and OVC. In all these areas of activities, civil society's role as a major implementer was enhanced through improved mechanisms of collaboration with public services and through the established national framework for comprehensive packages of services.

Coordination: The different sectors of civil society are coordinated by five umbrella organizations: Rwanda NGO Forum on HIV and AIDS, Faith-Based Organizations Network against AIDS (RCLS), Rwanda network of PLHIV (RRP+), Umbrella of People with Disabilities in the Fight against HIV and AIDS (UPHLS) and ABASIRWA network of journalists (newspapers, radio and TV stations).

Civil society umbrella organizations have various roles in common in relation to coordination: planning, monitoring, documentation and sharing of best practices, capacity-building of their members, participation in national decision-making bodies and technical working groups, and advocacy for a better recognition of the role of civil society in the response to HIV.

Private sector

To coordinate the HIV response in private and para-public sector enterprises, the Rwandan Private Sector Federation has set up an HIV unit. This unit has the mandate to support and oversee HIV committees established in private enterprises and business development committees at the district level.

Public sector

Similarly, to coordinate workplace programs in public sector institutions, MIFOTRA has established the Public-Sector Umbrella in the Fight against AIDS (USPLS). USPLS mobilizes the public sector to provide a coordinated and effective response to the epidemic. One hundred and thirty public institutions are registered in its database.

9. FINANCING THE HIV NATIONAL RESPONSE

9.1. Introduction

Financing the national HIV response is a subset of the Health Sector Financing strategy. The aim remains to improve the access of the population to health services, including HIV services. HIV programs continue to benefit funds from government and development partners and technical support. The major funding sources for the Rwanda HIV programs are:

- Government resources, which includes revenues generated from taxes and non-taxes, loans, grants, donations – reported as Government contribution/budget allocation and part is allocated as earmarked transfers
- Development partner contributions through sector budget support and Project support. Donor funds, on the budget are indicated in the development budget. These include the Global Fund for HIV & AIDS, TB and Malaria, PEPFAR and contribution from One UN.
- Health insurance pooled funds (Mutuelle de Santé or Community based health insurance) from household expenditures. This is not captured in this report.
- Health related household, private and health facilities own revenues related expenditures are not yet captured in this report

The data collection for the contribution of these sources is not conducted on a regular basis; therefore, the report will focus on funding sources where data were available as explained above.

9.2. Public and external sources of funds for HIV NSP

The Ministry of Health and the Rwanda Bio-medical Centre in collaboration with its partners worked on the design and development of the Health Resource Tracking Tool (HRTT), where all health sector actors (government institutions and development partners) report on a periodic basis. The system is designed to collect expenditures and budgets on a quarterly and annual basis. Although the system is currently operating, data of the actual financial report were generated through



SMART FMIS given that HRTT captured so far budget and expenditures of 2016/2017.

To facilitate the collection of financial information for this year's report, a separate data collection process was adopted using SMARTIFMIS (Integrated Financial Management Information System) for Global Fund grant and Government contribution; and directly from the in-country offices for PEPFAR and UN agencies (One UN) contribution.

9.3. Funding Source for HIV Expenditures in Rwanda FY 2017/18

The Global Fund for AIDS, TB and Malaria (GFATM) contribution was \$ 71,527,510 that includes cash balances from previous year. The United States Government (USG contribution for the FY 17/18 is \$ 80,318,743 and the Government of Rwanda contributed \$ 22,929,383 whereas the UN with \$ 1,921,330. Hence, the total budget for the FY2017/2018 was \$ \$176,697,025.

Regarding expenditures, Global Fund for AIDS, TB and Malaria (GFATM) spent \$ 60,321,325 during the reporting fiscal year 2017-2018, The United States Government spent \$ 79,526,033 whereas the GoR expenditures were \$ 22,338,780. Lastly, the UN spent \$ 1,878,842.

For the FY 2017/18, the overall total expenditure for HIV NSP was \$163,177,111 which represents 92% of the total budget.

Table 1: HIV NSP Budget and Expenditure as per source of funds July 2017– June 2018

Source of funds	Total budget	Expenditures	Budget Execution rate
Global Fund for AIDS, TB and Malaria	71,527,510	60,321,325	84%
PEPFAR	80,318,743	79,526,033	99%
One UN	1,921,390	1,878,842	98%
GoR	22,929,383	22,338,780	97%
Grand Total	176,697,025	164,064,980	93%

9.4. Government contribution to HIV NSP

The GoR funds are allocated to different health programs during the annual planning and budgeting process, which entails sectorial consultations to discuss prioritization and budget allocation between the Ministry/ RBC and decentralized levels basing on HSSP III implementation and different disease program strategic plans serve as

guiding documents. The planning phase also uses the disease burden and services utilization data from HMIS to inform an effective resource allocation. The output from this process is entirely reflected in the Mid-Term Expenditure Framework (MTEF) that becomes part of the budget law voted by the Parliament.

Apart from program specific financing, the GoR contribution takes into account all other health related programs costs, categorized as health systems strengthening costs in the categories of (i) Human resources (salaries) (ii) Infrastructures (including constructions, renovation and equipment) (iii) Quality of services (including performance based financing and accreditation programs (iv) Specialized health services (v) Health commodities (drugs, consumables...) and (vi) Health insurance for indigents.

Table 2: GoR HIV NSP budget and expenditure per NSP cost category FY 2017/2018

NSP Cost Category	Total budget	Expenditures	Variance	Budget execution rate
Human Resources	9 162 893	8 429 411	733 482	92%
Technical Assistance	234 915	231 856	3 059	99%
Training	9 511	2 899	6 612	30%
Health Products and Health Equipment	89 356	77 577	11 779	87%
Medicines and Pharmaceutical Products	1 354 630	1 278 241	76 389	94%
Procurement and Supply Management Costs	4 835 436	5 166 325	-330 889	107%
Infrastructure and Other Equipment	1 790 167	1 760 133	30 034	98%
Communication Materials	89 358	83 748	5 610	94%
Monitoring & Evaluation	242 274	224 363	17 910	93%
Living Support to Clients/Target Populations	3 906 898	3 901 507	5 392	100%
Planning and Administration	627 917	639 788	-11 871	102%
Overheads	586 029	542 931	43 098	93%
Grand Total	22 929 383	22 338 780	590 604	97%

The budget execution rate for GoR contribution was at 97% for the financial year 2017/2018.



9.5. The Global Fund contribution

For the Global Fund contribution, the budget for the financial year 2017 – 2018 was USD 71,527,510 and this was spent at 84% during the reporting period.

The GF contribution for the FY 17/18 is composed of budget from two different grants: old grant that covers the period from July 2017 to December 2017 and new grant that covers the period from January to June 2018. Hence, the tables reflecting budget and expenditures are presented separately for the period of July –December 2017 and the period of January to June 2018.

Table 3: GF contribution to HIV NSP budget and expenditure per NSP cost category for the period of July - December 2017

NSP Cost category	Total budget	Expenditures	Budget Execution rate
Human Resources	10 414 157	8 762 240	84%
Technical support	6 000	5 915	99%
Training	335 393	325 060	97%
Health Products and Health Equipment	7 359 167	7 185 857	98%
Medicines and Pharmaceutical Products	7 886 913	8 322 271	106%
Procurement and Supply Management Costs	1 257 276	1 233 588	98%
Infrastructure and Other Equipment	4 032 658	4 008 741	99%
Communication material	603 042	651 727	108%
Monitoring and evaluation	1 109 644	979 099	88%
Living Support to Clients/Target Populations	7 971 717	8 648 525	108%
Planning and Administration	152 937	150 941	99%
Overheads	799 274	876 060	110%
Grand Total	41 928 180	41 150 023	98%

From above table, it is shown that the GF budget for the period of July to December 2017 was \$ 41,928,180. Out of this budget, a total of US\$ 41.1 Million has been effectively spent by different budget entities and this represents 98% of budget execution.

The variance of 2% was due to the exchange rate fluctuations occurred during the grant implementation period as the cash flow has been fully spent.

Table 4: Contribution budget and expenditure per NSP cost category for the period of January-June 2018

NSP Cost category	Total budget	Expenditures	Budget Execution rate
Human Resources (HR)	9 258 823	6 106 038	66%

Travel related costs (TRC)	2 383 634	1 686 022	71%
Health Products - Pharmaceutical Products (HPPP)	6 230 723	3 716 448	60%
Health Products - Non-Pharmaceuticals (HPNP)	5 702 734	4 257 607	75%
Health Products - Equipment (HPE)	1 079 577	358 885	33%
Procurement and Supply-Chain Management costs (PSM)	1 197 307	819 304	68%
Infrastructure (INF)	74 543	0	0%
Non-health equipment (NHP)	244 495	216 134	88%
Communication Material and Publications (CMP)	572 739	479 631	84%
Programme Administration costs (PA)	1 709 519	1 316 135	77%
Living support to client/ target population (LSCTP)	1 145 236	215 098	19%
Grand Total	29 599 329	19 171 303	65%

As it is shown in the table above, the budget execution rate is 65%. The variance stands for the commitments such pharmaceutical and non-pharmaceutical products, nutrition support, Procurement and Supply-Chain Management costs and health equipment that will be paid after end June 2018.

9.6. The USG/PEPFAR contribution

From July 1, 2017 to June 30, 2018, the US Government budgeted approximately \$80,318,743 to the national HIV response in Rwanda. Because the US Government plans its budgeting periods using fiscal years in its PEPFAR Country Operational Plan (COP) that do not align with the Government of Rwanda budgeting period (i.e., the PEPFAR COP year begins on October 1 and ends on September 30 the following year), this figure is an estimate based upon portions of two COP years - one quarter of COP16 (FY 2017, October 1, 2016 to September 30, 2017) and three quarters of COP17 (FY 2018, October 1, 2017 to September 30, 2018). Estimated expenditures of US Government PEPFAR funding is based on semi-annual expenditure data and projections of final quarter expenditures. The estimate is that 99% of the budget will



be spent but at the time of this report the amount spent is an estimation based on the budget.

9.7. ONE UN Contribution

From July 1, 2017 to June 30, 2018, the One UN contribution to the national HIV response in Rwanda through the HIV Operational Plan was USD 1,921,390. The expenditures done under One UN total budget amount to 1,878,842 in FY 2017/2018.

10. GOVERNANCE MECHANISMS

Introduction

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10.1. Decentralized/district level leadership and coordination

Within the decentralization process, the local government at district level is responsible for the management of all public services. The coordination of the HIV response at district level is located within the District Health Unit, which oversees planning and monitoring all health interventions in the district.

10.2. National Strategy for transformation (NST)

In NST 1 covering the 2018–2024 period, HIV is addressed as a crosscutting issue and priority activities have been identified in Social Transformation pillar of NST1. Not only ministries and public institutions, but also all private and community organizations involved in the same field of activities. HIV and AIDS activities implemented by each sector at the district level are integrated into the five-year District Development Plans (DDP) and district annual work plans.

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10.3. Civil society organizations

Implementation: Civil society organizations are among contributors to the implementation of the NSP. In the field of prevention, many outreach activities for the general population are implemented by community health workers and/or civil society organizations. Civil society organizations contribute to delivery of a comprehensive package of preventive interventions for identified key populations and most vulnerable groups (FSW and their clients, MSM, mobile workers, discordant couples, PLHIV for positive prevention, people with disabilities, etc.).

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10.4. Private sector

To coordinate the HIV response in private and para-public sector enterprises, the Rwandan Private Sector Federation has set up an HIV unit. This unit has the mandate to support and oversee HIV committees established in private enterprises and business development committees at the district level.



10.5. Public sector

Similarly, to coordinate workplace programs in public sector institutions, MIFOTRA has established the Public-Sector Umbrella in the Fight against AIDS (USPLS). USPLS mobilizes the public sector to provide a coordinated and effective response to the epidemic. One hundred and thirty public institutions are registered in its database.

Annexes

Table 5: Key Performance Indicators, July 2017-June 2018

Program area	Indicator	Data Source	Results
			July 2017- June 2018
Prevention	% Of infants born to HIV+ mothers, who are not infected by 24 months (MTCT)	Cohort Data (health facility registers)	98.5%
Prevention	Number of medical male circumcisions performed according to national standards	Health Facility records	328,629
Prevention	HIV Seropositivity (New HIV cases identified in routine HIV testing services)	HMIS June 2018	0.58
Prevention	Percent of women tested with their male partners in ANC (Male Uptake)	HMIS, June 2018	85.90%
Prevention	Pregnant women who received ART to reduce Mother to Child Transmission	HMIS. June 2018	95.90%
Prevention	Prevalence of Male circumcision (number of male circumcised on the total male population)	DHS 2015	29.60%
Care and Treatment	% Of adults and children with HIV known to be on treatment 12 months after initiation of ARVs (retention on ART)	Cohort Data (health facility registers)	91.50%
Care and Treatment	% Of eligible adults & children currently receiving ARVs (ART Coverage)	HMIS, June 2018 And EPP Spectrum, 2018	83.10%
Care and Treatment	% Of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml)	Facility Registries review, June 2018	93.60%
Care and Treatment	Percent of PLHIV Identified	HMIS	89%
Care and Treatment	# of new Patients initiating ART	HMIS	13,298

