



Republic of Rwanda
Ministry of Health



NATIONAL HIV, STIs AND VIRAL HEPATITIS

ANNUAL REPORT
July 2021- June 2022



Forward

The Ministry of Health Rwanda through the Rwanda Biomedical Centre is pleased to share the annual HIV/AIDS, STI, and Viral hepatitis report for the fiscal year 2021/2022, ending in June 2022. The report covers the major achievements in the control of HIV, STIs, and Viral Hepatitis diseases in Rwanda.

Achievements drawn up in this report are the results of several engagements and collaboration between the Government of Rwanda, development and implementing partners, civil society organizations, UN agencies, and other members of communities in response to HIV. Valuable partners that day to day provide their assistance and contribute towards alleviating the burden of HIV, STIs, and viral Hepatitis in Rwanda.

The dissemination of this annual report sets an opportunity to recognize tireless work rendered by health care workers at different levels of health services delivery, health program managers, scientists, and epidemiologists working in the various technical working groups. Most importantly, people living with HIV and peer group supporters at the community level.


The major highlighted achievements in this fiscal year reports include progress made in case findings, linkage of HIV positives to antiretroviral treatments and care services, and HIV negatives to an array of behavioural and biomedical prevention activities in Rwanda.

Moreover, by increasing adherence to Antiretroviral treatments and ensuring viral suppression for those on ART, The HIV response in Rwanda performs highly even at a time when the response is challenged by the COVID-19 pandemic.

The report also indicates that there are still disparities in achievements among population categories in vis a vis services uptakes in the entire HIV treatment cascade and attaining clinical outcomes, hence, the need to intensify efforts on children, adolescents and key populations.

The report also shows the need for financial and programmatic sustainability to maintain the gains recorded in the last decade.

The Ministry of Health appreciates the continuous partnership with all stakeholders and beneficiaries in HIV response and likes to call upon to strengthen the collaboration toward sustainable HIV epidemic control and ending AIDS by 2030.


Dr. NGAMIJE M. Daniel
Minister of Health



Executive Summary

This report presents the key achievements of all actors in HIV/AIDS, STIs, and viral hepatitis response, from July 2021 to June 2022, as referred to reporting period. It covers essential areas of interventions in the fight against HIV/AIDS, STIs, and viral hepatitis, namely prevention, care and treatment, social impact mitigation, health system strengthening, financing HIV national response, and strategic information.

The national program prioritizes targeted testing. As result, the number of HIV tests decreased from 3,348,337 in 2020-2021 to 2,283,301 HIV in 2021-2022 tests conducted in the fiscal year. A high decrease was seen in HIV testing services (HTC). Further overall, HIV testing yield increased from 0.48 to 0.70% in the same period. The highest HIV testing yield of 4.4% was identified in the partner's notification services modality, through the index testing.

During this reporting period, people who were diagnosed with HIV were linked to HIV care and treatment services. By end of June 2022, 214,074, representing 92% of all people living with HIV on ART.

Rwanda embarked at the plan for the elimination of mother to child HIV transmission. From July 2021 to June 2022, 277,565 women were tested for HIV with the overall positivity rate of 0.34%. Overall 98.4% pregnant women living with HIV received ART to reduce mother to child HIV transmission. Further, a cohort of exposed infants born from July 2019 to June 2020 was followed up for 24 months. The results showed that 98.7% of them were free from HIV by 24 months representing 1.3% MTCT rate.

Rwanda is implementing oral Pre-exposure prophylaxis (PrEP) among key populations and sero discordant couples as part of the HIV prevention package. By June 2022, 10,372 eligible HIV negative female sex worker and men having sex with men and 320 sero-discordant couples were receiving on PrEP. Also, during this fiscal year, 319,653 men were circumcised.

As Rwanda is still in the eliminating Hepatitis C virus (HCV) campaign, at least 1,924,901 individuals have been screened in this current fiscal year. The figure number increased the total number of populations screened for HCV to 6,986,919 (98%) of the target population. People who were initiated on HCV treatment and those cured after sustained virological response at twelve weeks after treatment (SVR-12), are respectively 5,196 and 5,279.

Alongside, 5,177,507 people screened for sexual transmitted Infections (STIs) with 4.2% screened positive and treated from January 2019 to end June 2022. Successful implementation to contain HIV, STIs and viral hepatitis and sustain the gains during this last fiscal year, is a sign of effective collaboration between the government of Rwanda, development partners, united nations (UN) agencies, implementing partners, civil society organisations and beneficiaries toward targets set by the national strategic plan.

Despite efforts to properly allocate financial resources to various health sectors, this area has suffered due to the unstable donor environment. Rwanda needs to strengthen public financing of its health system for the country to reach its goals of ownership and sustainability of its health care system

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Acronyms

ARV	Antiretroviral
ART	Antiretroviral Therapy
BSS	Behavioural Surveillance Survey
CDC	Centres for Disease Control and Prevention
EIDSR	Electronic integrated Diseases Surveillance and Response
EID	Epidemic and Infectious Disease
FELTP	Field Epidemiology Laboratory Training Program
FY	Fiscal Year
GSMM	General Senior Management meeting
HCV	Hepatitis C Virus
HQ-I	HEALTHQUAL-International
HPV	Human Papilloma Virus
HR	Human Resources
ICT	Information, Communication and Technology
IHDPC	Institute of HIV and Disease Prevention and Control
IPPIIS	Integrated Personnel and Payroll Information System
ICAP	International Centre for AIDS Care and Treatment Programs
EQA	International External Quality Assurance
MINECOFIN	Ministry of Finance and Economic Planning
MOH	Ministry of Health
NCD	Non-Communicable Diseases
OPD	Outpatient Department
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission of HIV
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement
RBC	Rwanda Biomedical Centre
SPIU	Single Project Implementation Unit
SSF	Single Stream Funding
GFATM	The Global Fund to Fight AIDS, TB and Malaria
TTI	Transfusion Transmission Infections
VPPD	Vaccines Preventable Diseases Division
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

1. HIV PROGRAM AT GLANCE

HIV prevalence among the adult population (aged 15-49 years) in Rwanda has been stabilized and maintained at 3% between 2005 and 2015. The Rwanda Population-based HIV Impact Assessment (RPHIA), a national household-based survey conducted in 2018-19, showed that the overall HIV prevalence among people aged 15-64 was 3.0%, 3.7% in women and 2.0% in men. It also indicated a decreased prevalence to 2.6% among adults aged 15-49. HIV prevalence was approximately two or more times greater in older adolescent girls and young women (ages 15-24 years) compared to older adolescent boys and young men (1.2% [95% confidence interval (CI): 0.9%-1.5%] vs. 0.5% [95% CI: 0.3%-0.7%]), and in women aged 25-29 years and 30-34 years compared to men in the same age groups (3.4% [95% CI: 2.5%-4.3%] and 3.7% [95% CI: 2.7%-4.7%], respectively, vs 1.3% [95% CI: 0.6%-1.9%] and 1.4% [95% CI: 0.8%-2.0%] respectively). HIV prevalence among those aged 10-14 years was 0.4%.

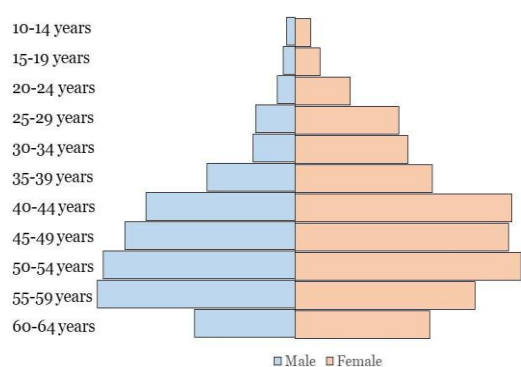


Figure 1: HIV prevalence by age category and gender

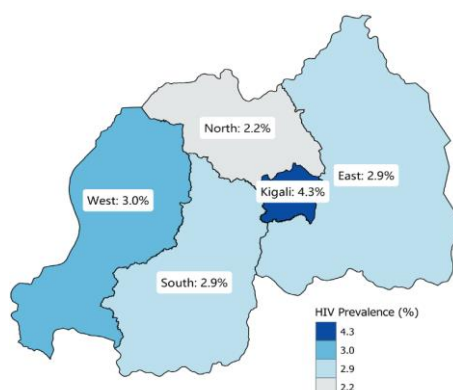


Figure 2: HIV prevalence by province

According to the same survey, HIV prevalence is estimated at 4.8% in urban areas and 2.5% in rural areas, with a higher prevalence of (4.3%) in the capital city of Kigali, and lower prevalence in the Northern Province (2.2%)

Although the HIV prevalence is lower in the general population, female sex worker's prevalence is still higher at 35.5%. Further, the last RPHIA demonstrated a remarkable decrease of the HIV Incidence from 2.7 per hundred person years (Pyr) in 2013-14 to 0.08 per 100 Pyrs, corresponding to approximately 5,400 new cases of infections among adults yearly.

In the last decade HIV services have been scaled-up across the country. As results, Rwanda is on track to achieve the 95-95-95 goals by 2030, according to Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates of 2022, 98% of the 227,134 people are living with HIV are aware of their status, and of those who knew they were living with HIV, 94% were on treatment, with 96% having a suppressed viral load (<1000 copies/ml). Further, new HIV infection and AIDS deaths have significantly reduced. Further, new infections and mortality have decreased by 82% and 86% in the last twenty-five years, respectively. Consequently, life expectancy of people living with HIV on ART increased by 25.6 additional years.

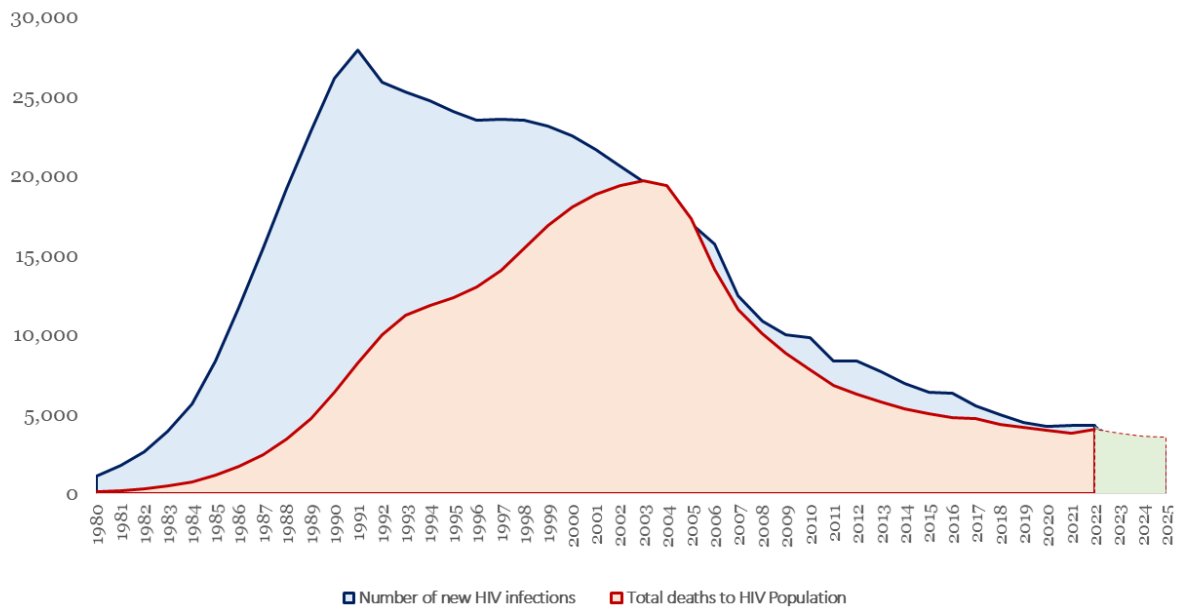


Figure 3: Trend of new infections and AIDS deaths from 1980 -2025 (source: EPP Spectrum 2022)

Rwanda has put efforts in biomedical interventions for HIV prevention. The male circumcision has increased from 13% in 2010 to 56% in 2020 and the mother to child HIV transmission has stabilised below 2% in the last seven years.

2. HIV PREVENTION

2.1. Introduction

Prevention of HIV is the cornerstone of the HIV national response to reduce the HIV incidence and ensure that people living with HIV are early diagnosed. The government of Rwanda and its national partners have implemented innovative approaches and new strategies toward ending the AIDS epidemic by 2030 as part of the Sustainable Development Goals (SDG).

The package of prevention interventions offered in Rwanda includes:

- (i) Optimised HIV Testing Services (HTS)
- (ii) HIV case-finding strategies through index testing and partner notification services
- (iii) HIV Recency testing
- (iv) Prevention Mother to Child Transmission (PMTCT)
- (v) Voluntary medical male circumcision (VMMC)
- (vi) Condom programming and distribution
- (vii) HIV prevention services for key populations (KPs)
- (viii) Pre-exposure prophylaxis
- (ix) HIV awareness, targeting people at high risk of acquiring HIV infection.

In addition to the mentioned interventions, different strategies are put in place to halt new HIV infections by accelerating the country’s commitment in achieving the UNAIDS first 95 target by 2030.

2.2. HIV testing services (HTS)

HIV testing and counselling is an essential component for HIV prevention and a critical entry point into the HIV continuum of care and treatment. Apart from helping clients to know their HIV status and serving as an entry point to HIV care and treatment for the people infected with HIV, HTS have been shown to influence positive behaviour changes despite the status.

HIV testing services are merged and integrated with other HIV services such as medical male circumcision, post-exposure prophylaxis (PEP), prevention of mother-to-child transmission (PMTCT), and screening and management of sexually transmitted infections (STIs). HIV testing services also provide a valuable opportunity for service providers to offer health information and education, behaviour changes information and create awareness of HIV/AIDS, but also keep creating demand to engage more even population hard to reach.

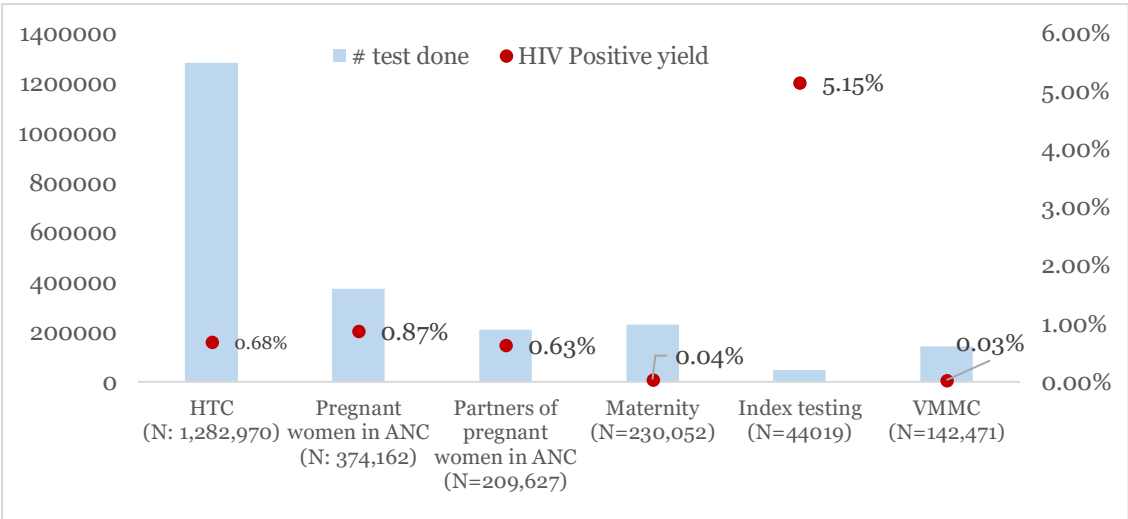


Figure 4: HIV testing and positivity yield by modality, July 2021-June 2022

From July 2021 to June 2022, health facilities provided 2,286,931 HIV tests across the country, with an overall positivity yield of 0.70%. The highest being 5.57%, was recorded from partner notification through index testing modality.

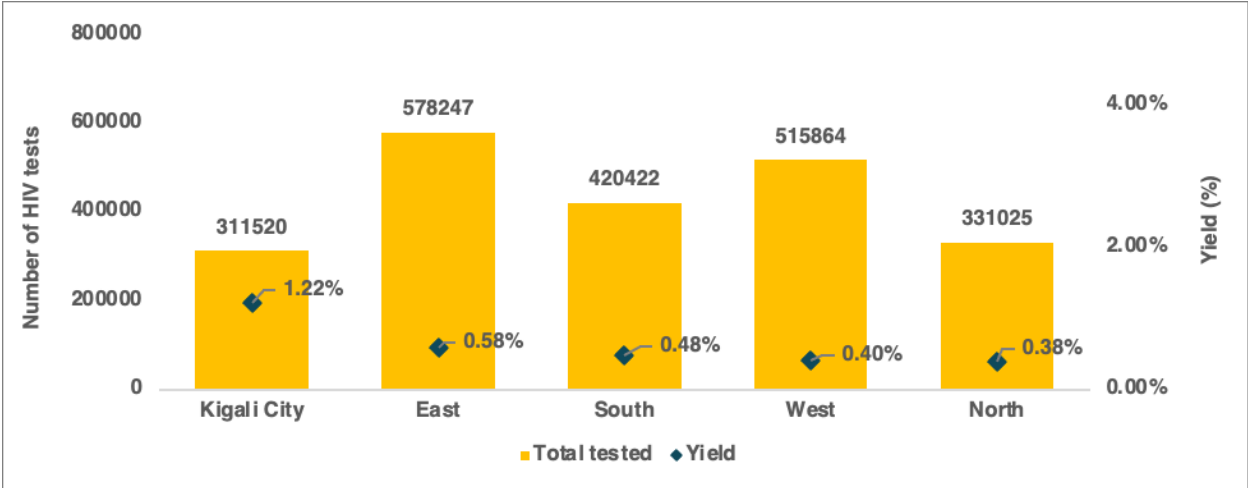


Figure 5: HIV testing yield in HTC by province

Furthermore, the HIV testing yield was higher in the City of Kigali with 1.22%; the lowest was recorded in the Northern and western provinces, with 0.38% and 0.40%, respectively.

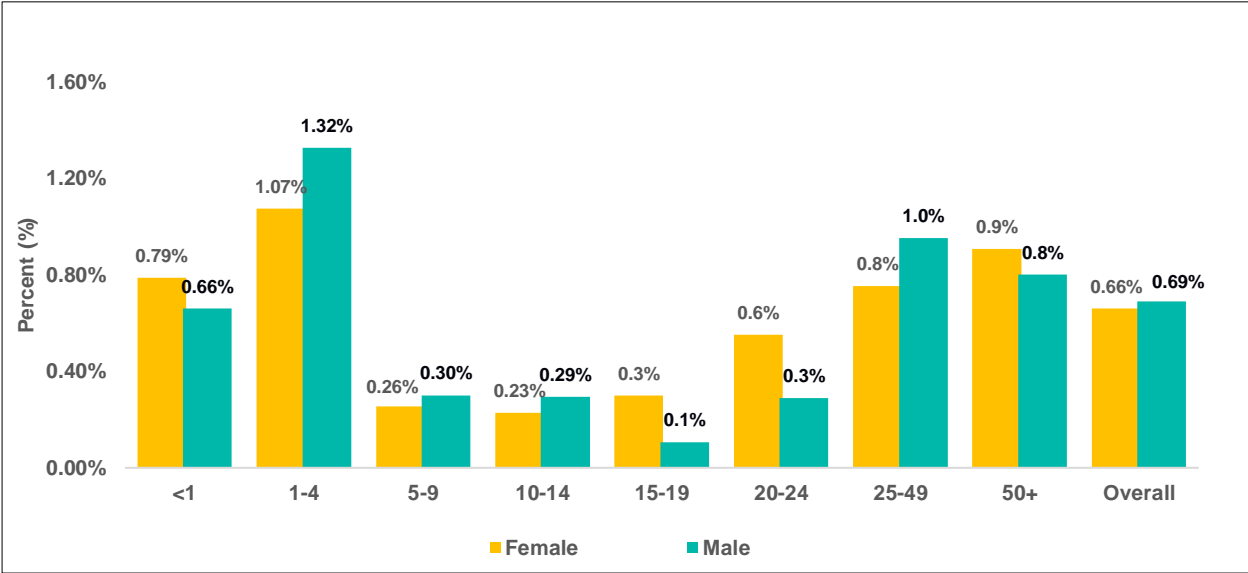


Figure 6: HIV testing yield in VCT/PIT by age category

2.3.HIV self-testing

HIV self-testing is a process whereby an individual collects their specimen, performs a test, and interprets the results, often in a private setting, alone or with a trusted person. A trained provider confirms reactive results at the health facility, nonreactive effects are linked to HIV prevention services, and confirmed positive clients are linked to HIV care and treatment services.

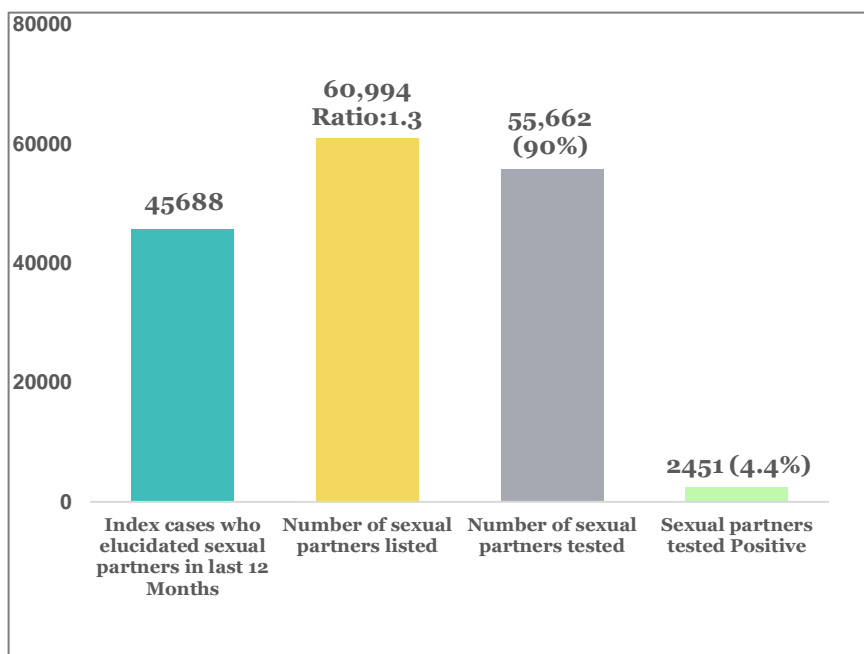
The test kits ((index testing and PNS) reach the community through two main models of distribution:

- Distribution through health facility, Integrated HIV self-testing with index testing and partner notification services to offer HIV testing services to invited partners who refuse to come to the facility but still need to be tested. During this fiscal 21-22, 73,770 HIV Self-test kits were distributed within 280 health facilities across the country.

- Distribution from private pharmacies: From July 2021 to June 2022, 6,450 HIV self-test kits were distributed by 70 private pharmacies across the country.

2.4. Index testing and partner notification

This focuses on identifying and tracing sexual partners and biological children of the index client for HIV testing services. In contrast, partner notification is a voluntary process where counsellors and/or health care workers ask people on ART who have had extramarital sexual relationships and newly diagnosed HIV patients, referred to as index clients, about their sexual partners and family members. If the index cases consent to elucidate sexual partners, they are invited to the health facility and offered an HIV test voluntarily.



By the end of June 2022, the index testing and partner notification services were scaled up in all health facilities countrywide. Among the partners elicited who were reached and tested, the yield of HIV is estimated at 4.40%. The aim of partner notification services through index testing is to increase the HIV testing yield and reach the 1st UNAIDS target of 95% of people living with HIV should know their HIV status by 2030.

Figure 7: Cascade of Index Testing and Partner Notification by June 2022.

2.5. Case-Based Surveillance (CBS) testing.

The current figure represents data from the subset of health facilities where Case-Based Surveillance, with recency testing, is implemented. Moreover, during the initial phase of case-based surveillance rollout, newly identified HIV positives with documented risk factors for HIV transmission were prioritized for enrolment as index cases. More recently, case-base surveillance

is enrolling established ART patients that could potentially explain the trend of HIV positivity yield in this modality.

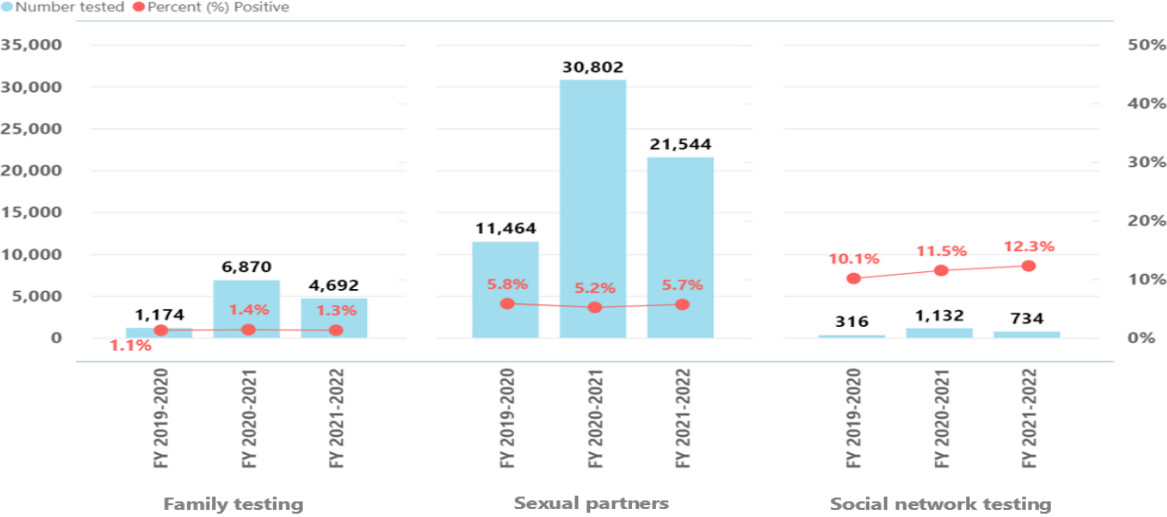


Figure 8: Case-based surveillance testing by modality

2.6.HIV Recency testing

A laboratory-based rapid HIV test detects whether an HIV infection is recent (less than twelve months). Information received from the HIV recency testing helps assess how HIV is transmitted, clusters of new HIV infections, describe the behaviours that contribute to ongoing HIV transmission, and optimise data use to inform prevention interventions.

Two testing approached in the lab network modes are currently used:

- **Centralised HIV recency testing:** Performed at the National Reference Laboratory (NRL) and HIV viral load testing hubs in all provinces. In 2021, the national program finalised the centralised HIV Recency testing scale-up in all District Hospitals countrywide.
- **Point-of-care testing (POCT):** Performed at 23 health facilities in the City of Kigali, the national program has improved the quality of these services. The map below shows the district's recent and long-term HIV infections. The highest number of cases of recent HIV infection is in the City of Kigali.

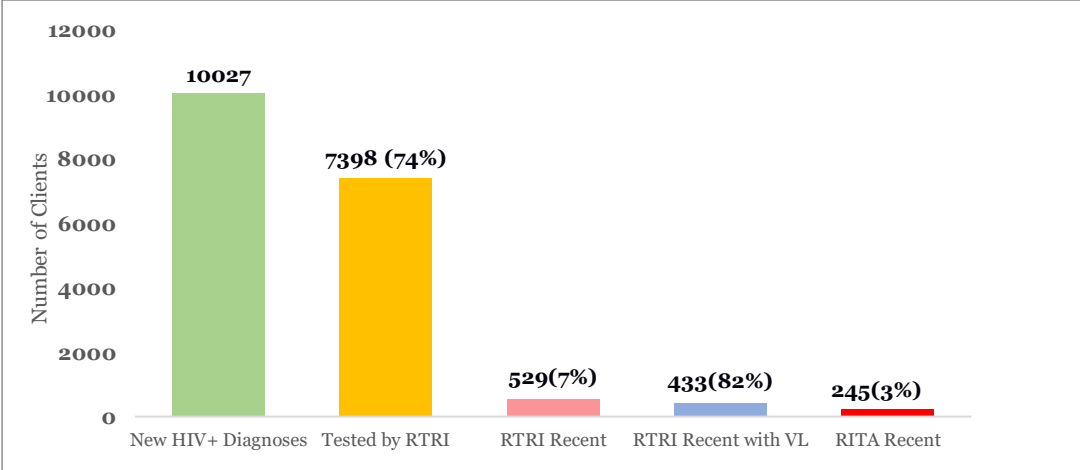


Figure 9: Cascade of HIV Recency testing, July 2021-June 2022

The figure above shows the cascade of HIV recency testing for the reported fiscal year. Overall, 7398 out of 10,027 new HIV diagnosed persons were tested through the rapid test for recent infections. Of them 529(7%) were tested with recent infection using the RTRI; of whom testing 433(82%) were tested for viral load to eliminate the bias of prior exposure to ARVs. Of those, tested for viral load 245(3%) were confirmed as recent infections using the recent infection testing algorithm.

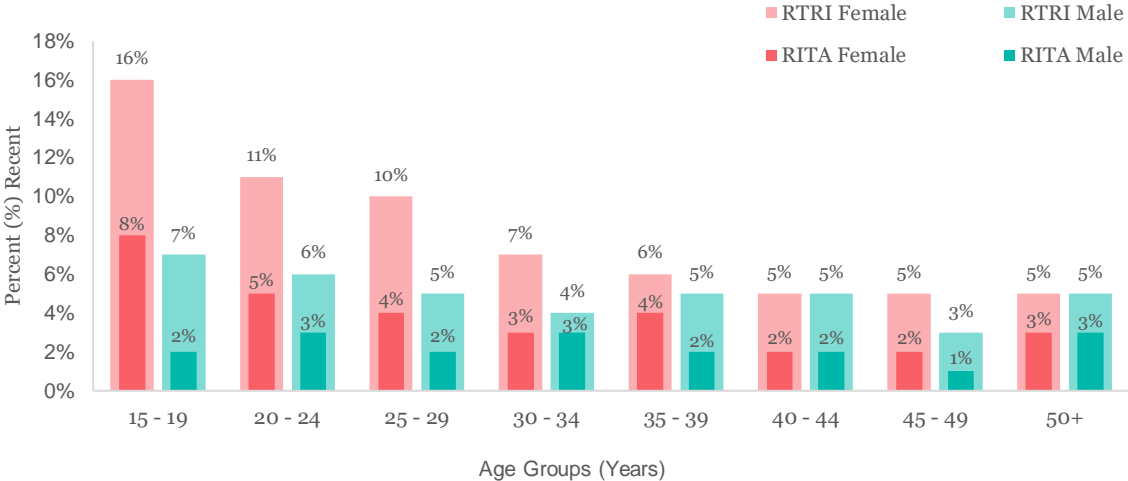


Figure 10: HIV recent infections by age group and gender, July 2021- June 2022

Overall high level of recent infection is documented in 15-19 years old girls. Confirmatory viral load testing has shown a potentially high proportion of reclassifications, in certain age and sex group than in others, which potentially signal a repeat tester in some age group than others. Investigating these potential repeat testers can generate critical data for testing program screening efforts

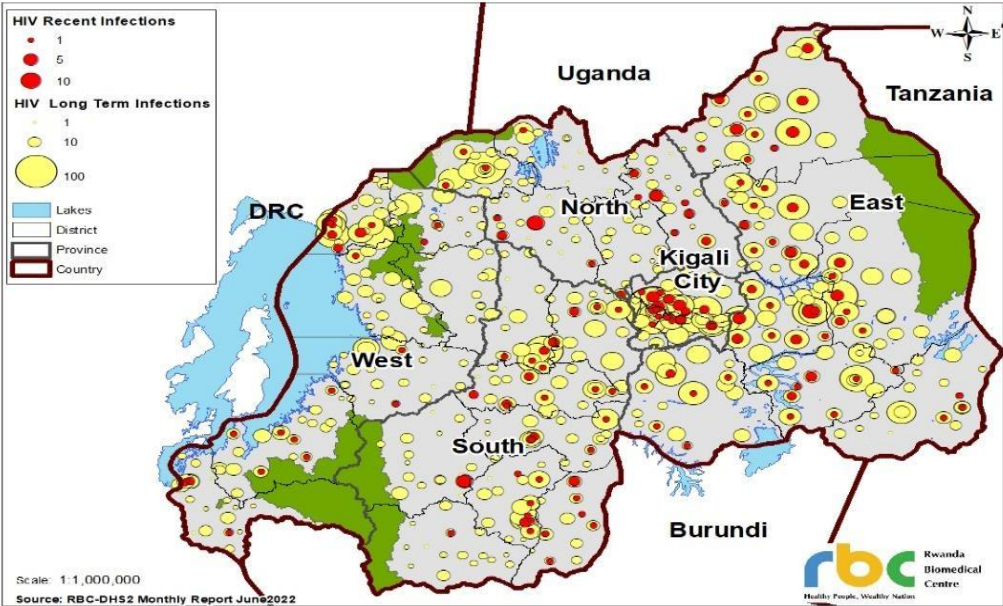


Figure 11: Distribution of Recent and long-term infections across Rwanda, July 2021-June 2022

HIV Recency testing is critical in the surveillance of new infections and their spatial distribution across the country. Many clusters of recent infections among newly diagnosed patients were seen in the city of Kigali and around the national main roads. [Figure 11]

2.7. Prevention of Mother-To-Child HIV Transmission

In 2004, Rwanda started the scale-up of PMTCT. It joined the solid commitment to the elimination of mother to child transmission of HIV through the four prongs of PMTCT:

- (i) primary prevention (education on HIV prevention, HIV testing for pregnant women in antenatal consultation and at labour and other prevention measures)
- (ii) prevention of unintended pregnancies among infected mothers
- (iii) provision of high active ART to HIV infected mothers and ART prophylaxis for HIV-exposed infants, and
- (iv) post-natal follow-up of mother-infant pairs until 24 months after delivery.

2.8. HIV testing and continuum of care for pregnant women with HIV

HIV testing is systematically provided to all pregnant women and their partners with unknown HIV status at their first antenatal care visit. Thus, those tested HIV positive are linked to care and treatment to prevent the mother to child HIV transmission. From July 2015 to June 2022, the HIV prevalence among pregnant women who attended antenatal care visits decreased from 2.78% to 1.86%. Further, the proportion of newly HIV diagnosed pregnant women in antenatal care decreased from 29.7% in 2015-16 to 18.0% in 2021-22. Overall, 98.4% of HIV infected pregnant women receiving ART to prevent the mother to child HIV transmission.

According to the national guideline, women who are tested HIV negative and those who missed the HIV testing during antenatal care are retested before delivery. In total 277, 565 women were tested for HIV with the overall positivity rate of 0.34%.

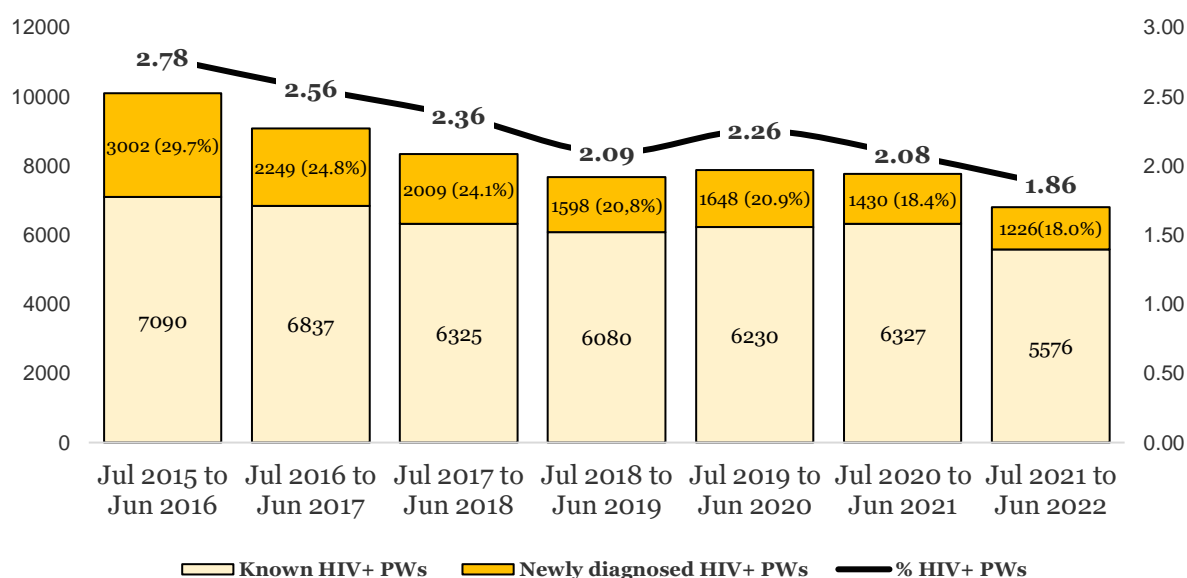


Figure 12: HIV prevalence among pregnant women attending ANC services, July 2021-June 2022.

2.9. Follow-up of HIV-exposed Infant

The uptake of follow-up of infants born to HIV-infected mothers in the PMTCT program is up to 24 months' post-partum to monitor their HIV status closely. To enable timely early infant diagnosis and rapid ART initiation for those tested for HIV during follow-up, HIV-exposed children are tested at different points (6 weeks, 9 months, 18 months, and 24 months) as a standard of care. Children are tested using polymerase chain reaction (PCR) at six weeks of age and serology at (9,18 and 24 months); an immediate PCR Test then confirms a positive serology test.

Every year, Rwanda Biomedical Centre conducts a retrospective analysis of the cohort of children who were born to HIV positive mothers. This year, we included children born to HIV positive

mothers from July 2020 to June 2022 who completed their two years' anniversary in the current reporting period. In total 3660 children were included in the analysis. Of them 51 (1.37%) were confirmed HIV positive at 24 months.

2.10. Voluntary medical male circumcision

Since 2007, the World Health Organization has recommended voluntary medical male circumcision (VMMC) as a critical component of a combination of HIV prevention in countries with a high HIV prevalence and low levels of male circumcision. Scientific evidence shows that male circumcision reduced the HIV transmission by 60%. (WHO/UNAIDS, 2007) Therefore, male circumcision remains a priority intervention to reduce the risk of HIV infection.

In 2008, Rwanda started scaling up male circumcision as an HIV prevention strategy. The circumcision services have now been integrated into most public hospitals and health centres, NGO-supported fixed sites, outreaches, mobile services, and targeted campaigns. Intensified advocacy for MC has resulted in improved MC uptake, as evidenced by the high uptake of the service by young men during school holidays. Recent findings from Rwanda Demography and Health Survey (DHS) conducted in 2019 and 2020, show that 56% of male aged 15-49 are circumcised.

During this reporting period, the surgical male circumcision procedure is the primary method used for service delivery. The non-surgical method using Shang-ring devices is still under the pilot phase through Adverse Events (AEs) Surveillance, following WHO requirements to assess the new adverse event which may occur in the country before the scale-up.

To optimize VMMC services delivery and align with WHO recommendations, the following amendment was made:

- *All clients aged 15 years and above with a high risk of HIV transmission are offered an HIV test before the procedure*
- *Detailed clinical evaluation of client before procedure*
- *For children under 18 years, parents or guardians must sign a consent form before the procedure*
- *Administration of one dose of a tetanus vaccine for both surgical and non-surgical (Shang-ring device) method.*

In line with the HIV national strategic plan to increase the VMMC prevalence and program's sustainability, notable efforts have been deployed nationwide. During this reporting period, the main activities have been undertaken, particularly capacity building targeting health providers on non-surgical and surgical male circumcision methods. Consequently, 319,654 males were circumcised, 297,091 (92.9%) were circumcised using the surgical method, and 22,562 (7.1%) were circumcised using the medical device.

More than sixty percent of male circumcision was performed in the eastern and western provinces.

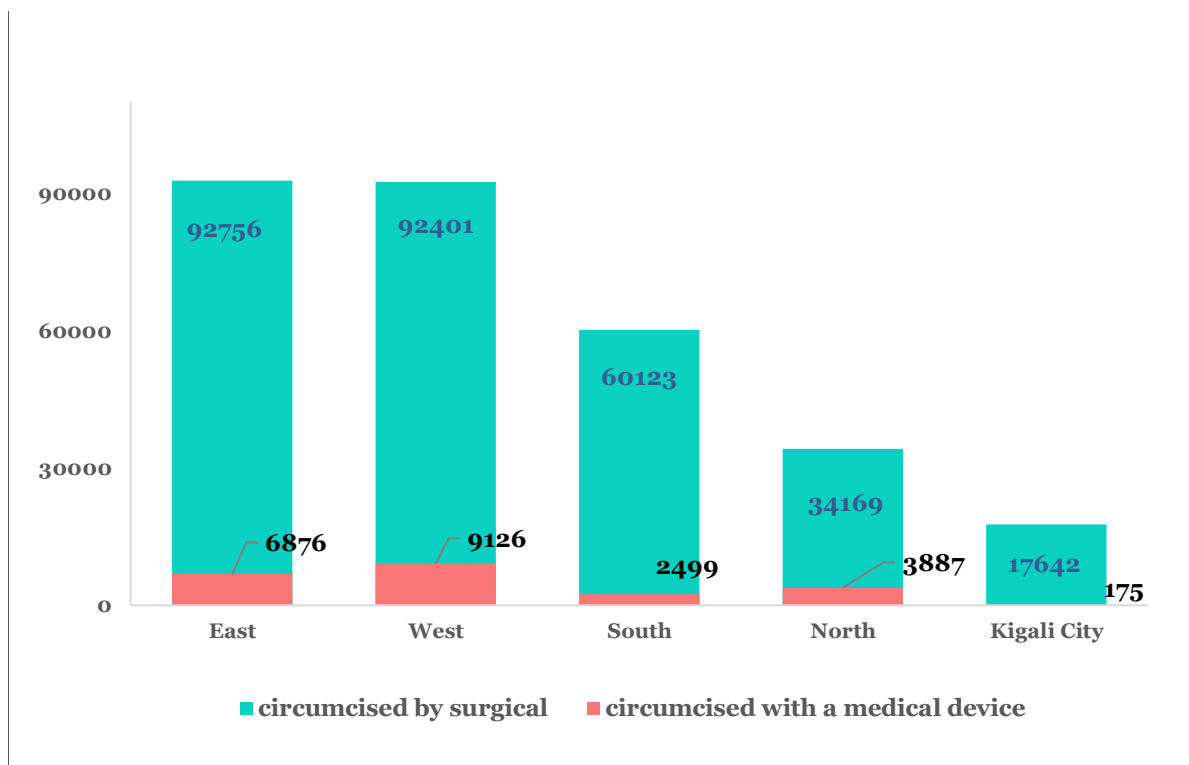


Figure 13: Number of VMMC performed by province and method, July 21-June 22.

The high proportion of male circumcised in the current fiscal year were aged 15-19 years 142,135(44.5%), followed by those aged 20-24 years, 55,250(17.3%), 10-14 years 54,004(16.9%), and 25-49 years 52,926(16.6%), respectively.

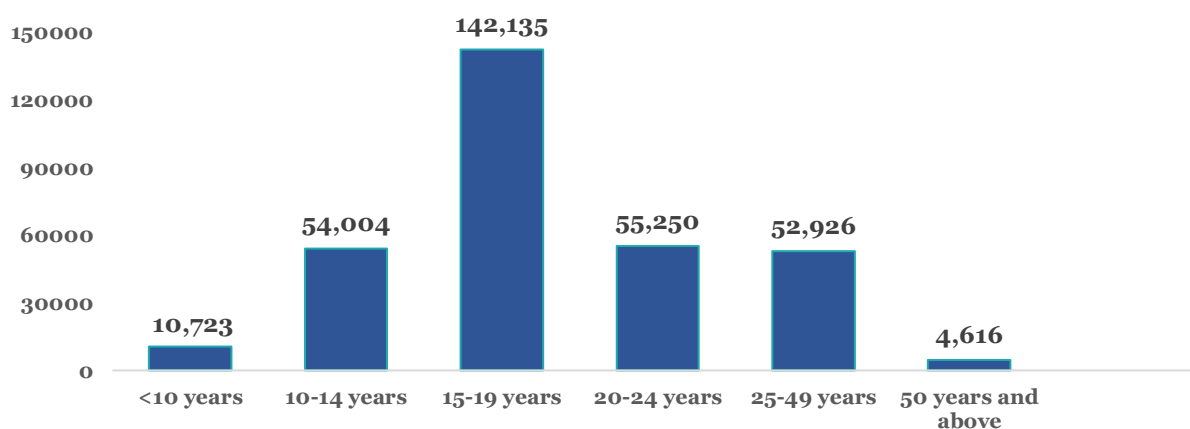


Figure 14: Number of VMMC performed by age group, July 21-June 22

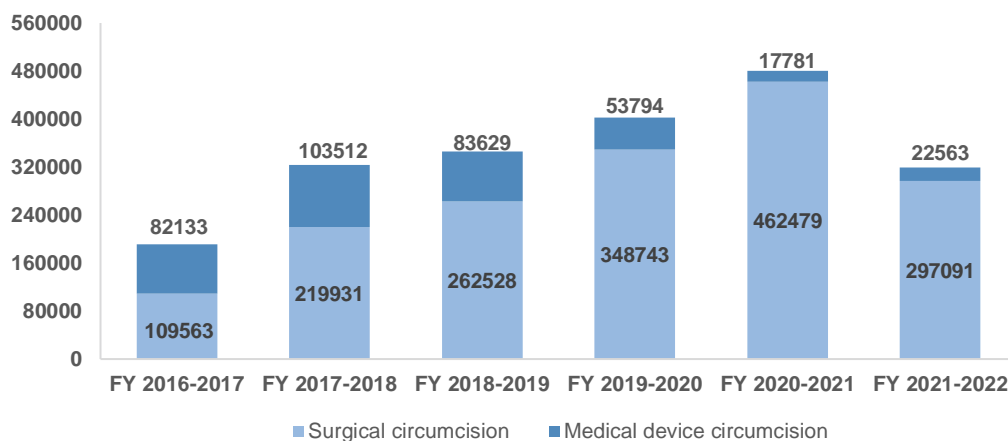


Figure 15: Trend of VMMC Surgical vs medical circumcision, July 2016-June 2022

The figure above shows the trend of male circumcision over the last six years. The proportion of male circumcised using the medical device decreased from 42.8% in the fiscal year (FY) 2016/17 to 7.1% in FY2021/22. Further, more VMMC were performed in both FY2019-20 and FY2020-21 as result of campaigns that were carried on.

2.11. HIV Prevention Services for key and priority populations

Key populations are groups with vulnerability and high risk of being infected by HIV. They play a key role as drivers of HIV spreads in the general population. Their vulnerability is fuelled by various factors, including personal attitudes, social mobility, diverse sexual orientation and gender identity, risky behaviours such as alcohol and drug abuse, unprotected sex, and exchange of sex for gain. Environmental factors include poverty, stigma & discrimination, and inaccessibility to services. In Rwanda, this category includes men who have sex with other men female sex workers, clients of, female sex workers and Adolescent Girls and Young Women (AGYW).

Health facilities are trained to provide key population friendly services, HIV testing and counselling services, condom provision as well as comprehensive HIV prevention messages.

2.12. Pre-Exposure prophylaxis (PrEP)

The PrEP initiative has been implemented in phases targeting key population and other groups at high risk such as Female Sex Workers (FSWs), Men who have sex with men (MSM), HIV sero-discordant couples (SDCs), index partners and AGYW at substantial risk. By end of June 2022, the number of female sex workers and Men who have sex with men receiving PrEP gradually increased from 378 in July 2019 to 10,372 in June 2022.

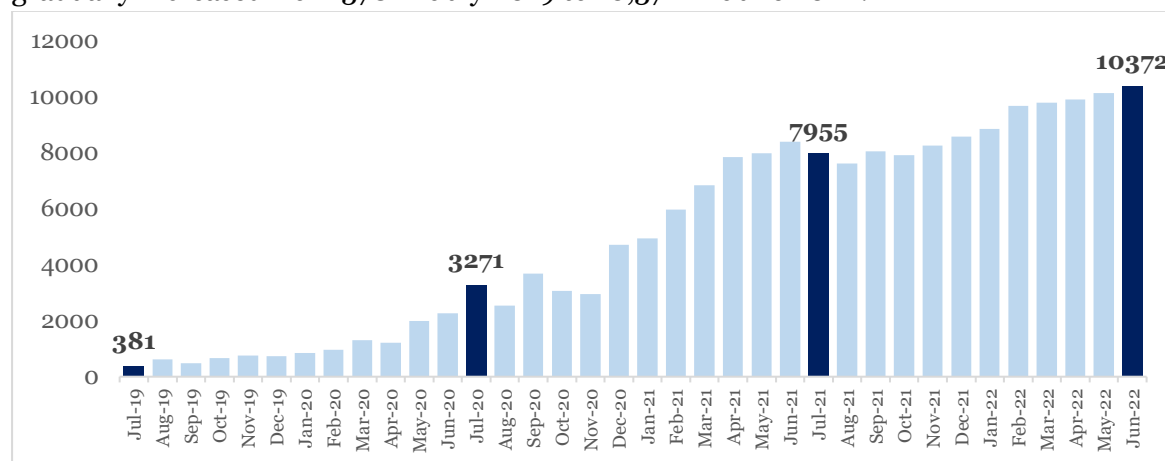


Figure 16: Trend of the number of FSW receiving Pre-Exposure prophylaxis at the health facility

2.13. HIV Prevention services among Adolescent Girls and Young Women (AGYW)

HIV prevention programming targeting adolescent girls and young women is another approach of priority as this category contributes more to the occurrence of new infections globally like in Rwanda.

The National HIV program is currently implementing the AGYW program in partnership with stakeholders and community-based organizations in different districts. The program's primary aim is to foster the development of women and girls to be determined, resilient, empowered, AIDS-free, Mentored, and Safe (DREAMS) individuals with the ability to realize their full potential.

HIV Prevention program among AGYW has main objective to understand the most vulnerability exposures and optimize access to Biomedical and non-biomedical HIV prevention services including PrEP for those on substantial risk of HIV acquisition.

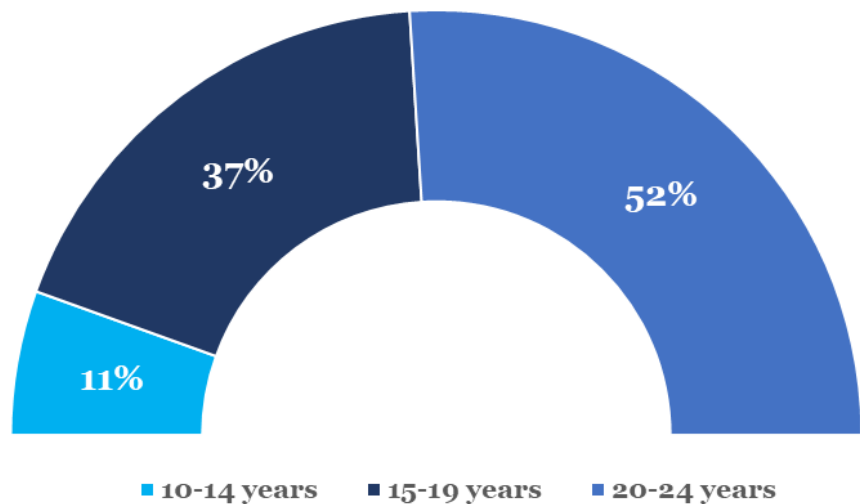


Figure 17: HIV Prevention services distribution among Adolescent Girls and Young Women

Furthermore, sexual reproductive health is mainly masked by socio-cultural habits that impede the uptake of comprehensive HIV prevention services among AGYW. By end of June 2022, at least 82,500 of adolescent girls and young women were enrolled in the program. The program initially is implemented with partnership of USAID through DREAMS approach in five Districts.

AGYW are selected based on vulnerability criteria such as the history of pregnancy, no or irregular condom use, out of school, STI (diagnosed or treated), and transactional sex (including staying in a relationship for material or financial support). Among them, 30,884 AGYW were in the 10-14 age band, 42,524 AGYW in the 15-19 age band, 9,092 AGYW in the 20-24 age band. Among those enrolled 2,140 were initiated on PrEP.

2.14. Pre-Exposure Prophylaxis service delivery

Moreover, 112 out of 204 trained health facilities are offering PrEP. Nevertheless, developing monitoring and evaluation (M&E) tools is crucial to ensure that KPs are reached with HIV prevention programs and to improve KP's services and data quality.

2.15. Condom programming

Condom use has gradually increased in Rwanda over the past two decades at approximately 0.9% per year for sex amongst non-married, non-cohabiting partners. The National Condom Strategy plan (2021) guides condom programming, including leadership, coordination, and partnerships; supply and commodity security; access, demand, and utilization; and condom programming and support systems.

The condom program also supports interventions targeting key affected populations, including sex workers, men who have sex with men, and long-distance truck drivers. Such targeted intervention includes special condom distribution deliveries at hot spots frequented by critical populations. Condom programming is one of the HIV Prevention approaches provided at both health facility and community levels, and condoms are one of the essential services received by key populations.

In total, 32,592,675 condoms were distributed across the country during fiscal year, including social marketing and 9 condoms kiosks displayed in Kigali City (6), Rubavu, Rusizi, and Huye Districts. In addition, another important number of condoms were distributed in the community through peer educators during outreach sessions.

In summary, fifty-five per cent of condoms (18,033,038) were distributed in the community through peer educators during outreach sessions, 8% (2,541,637) distributed through direct condoms kiosks, while 37% (12,018,000) distributed through social marketing.

2.16. Behaviour Change Communication/ Information Education and Communication.

Rwanda is committed to promoting behaviour change and communication (BCC) programs that focus on individual behaviour changes and behavioural changes at the community and social level. BCC aims to transform structural factors that impact the adoption and maintenance of positive behaviours. BCC interventions will promote accurate knowledge and perception of risk and increase individual motivation to avoid risky behaviour.

Delivering BCC interventions will require a combination of strategies that target risky behaviours and the drivers of the epidemic. BCC will also demand increased access, uptake, and adherence to behavioural and biomedical interventions.

The behaviour change and communication (BCC) and Information Education & Communication (IEC) programs aim to strengthen public awareness and comprehensive knowledge of HIV risks and vulnerabilities to increase personal risk reduction and uptake of prevention services.

2.17. HIV Awareness

HIV awareness is one of the interventions to prevent HIV. The knowledge of the general and key populations about the availability and accessibility of HIV prevention, care, and treatment services is crucial. During this fiscal year, different interventions to increase awareness of the population on HIV, STIs, and viral Hepatitis were conducted through media (radio & TV spot production and airing, newsletter), social media, and mass campaigns.

2.17.1. Mass campaigns

Prevention campaigns contributed widely to facilitating access to HIV comprehensive package services for the general population and key population groups whose access &, or utilization is lower, as well as the provision of knowledge about comprehensive HIV prevention.

RBC, through its division in charge of HIV control, organized and launched a national campaign mainly during the preparation of World AIDS Day 202. In the same line, follow up outreach campaigns were conducted at district level targeting the community in each province with partnership of local NGOs in response to HIV within their respective working districts.

2.17.2. World AIDS Day (WAD) 2021 campaign

On 1st December 2021, Rwanda joined the rest of the World to commemorate World AIDS Day (WAD) for its 33rd time; it was an opportunity to call for communities to unite in the fight against HIV/AIDS by ending the inequalities that drive this epidemic and another pandemic around the World. It was commemorated at the National level in Nyagatare District under the theme **"Together We End AIDS"**.



In the presence of the Minister of Health, Ambassador of USA in Rwanda, Director General of RBC, representatives of UN Family and partners in HIV response, key achievements of the national HIV program were presented, and gaps were raised and discussed for improvement. Participants were briefed on the continuous availability and accessibility of HIV prevention, care, and treatment services in Rwanda to the beneficiaries despite the COVID-19 pandemic and the implementation of the global targets to

end AIDS by 2030 and different speakers increased community awareness about their role in HIV prevention and impact mitigation; the willingness of the general population to participate in HIV interventions conducted for them. They recommended the youth change their attitude, adopt positive behaviour, and know their HIV status.

Different activities were organized and conducted one week before the campaign launch and continued after the launch. HIV testing was one of the activities undertaken in the hotspots in Nyagatare District. Other activities supporting the event like COVID-19 testing among participants, COVID-19 vaccination, exhibition, and different awareness activities, including the display of banners, stickers, and edutainment by musicians. The media houses produced news supplements about the theme, and leaders' speeches were one way of disseminating critical messages around the theme of the year.

Different stakeholders have been involved in the organization and implementation. In collaboration with RRP+, conducted "cow donation" to support the vulnerable community of people living with HIV to improve on their nutrition and income generation.

2.17.3. Radio and TV shows

During this last year, 2021-2022, public and private media houses were used to provide information and education on available HIV prevention services, including new strategies for HIV service delivery. During this reporting period, 204 DJ mentions, 226 Jingle shows, 35910 units of radio spots, 4 TV talk shows, eight radio live talk shows were produced and displayed, 28 Radio weekly healthy programs (with a brand name), 12 Radio programs recorded, 7 TV program recorded, 50 Daily top health tips, two radio, and 2 TV programs were produced.

3. HIV CARE AND TREATMENT

3.1. Introduction

HIV care and treatment services are paramount as far as PLHIV's well-being is concerned. All efforts are made toward achieving the 95-95-95 target by 2030. Care and treatment services are key priorities in controlling the HIV epidemic toward ending AIDS by 2030. Key activities performed mainly focused on continuous quality improvement (CQI) through mentorship to strengthen the differentiated service delivery (DSD) and ensure the transition of adults and children to Dolutegravir (DTG) based regimen. Additionally, other activities implemented focused on nutrition and psychosocial support, ART optimization, improving laboratory commodities supply chain, and opportunistic infections (OIs) management. All these activities aim to improve the quality of life among people living with HIV and prevent HIV transmission by optimizing treatment outcome.

3.2. HIV Case-based surveillance (CBS)

The HIV case-based surveillance is a longitudinal follow-up of HIV-positive clients to monitor their clinical outcomes as well as risk of HIV transmission.

Two main arms composed CBS: active case finding and routine longitudinal follow-up of the client in care and treatment.

HIV case based- surveillance starts with an enrolment of the HIV-positive client into care and treatment and documenting all the programmatic packages provided to him/her including Index testing, recency testing, biological, and clinical outcomes. For comprehensive monitoring of the HIV epidemic, recency testing was integrated into CBS and routine HIV testing services.

From July 2021 to June 2022, the number of health facilities implementing HIV case- based surveillance increased from 438 to 552 in the City of Kigali and all provinces. In the same period, the cumulative number of clients enrolled in the CBS program increased progressively with time.

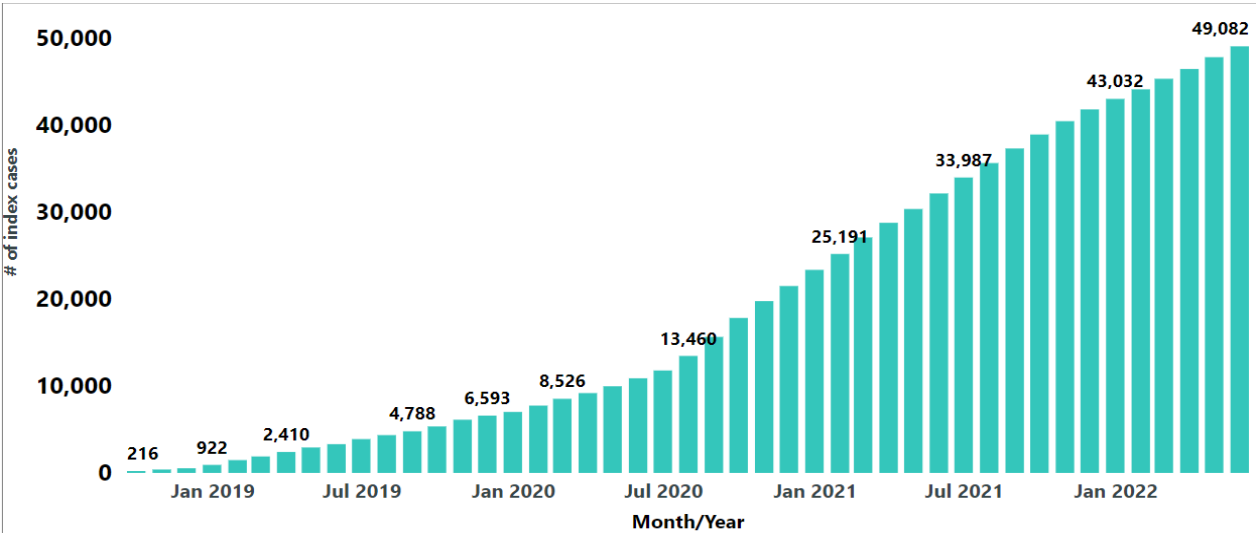


Figure 18: HIV Case Based Surveillance (CBS) enrolment growth (Cumulative enrolments)

3.3. Differentiated service delivery

3.3.1. Multi-month Prescription (MMD)

There is an increasing number of clients eligible to ART due to global changing guidelines and ambitious targets, therefore facilities and health care providers have continuously become overwhelmed compromising service delivery and client satisfaction. Following the WHO guidance in 2016 on multi-month dispensing (MMD), Rwanda started the 3-MMP initiative in 2017 and moved to 6-MMD in July 2020.

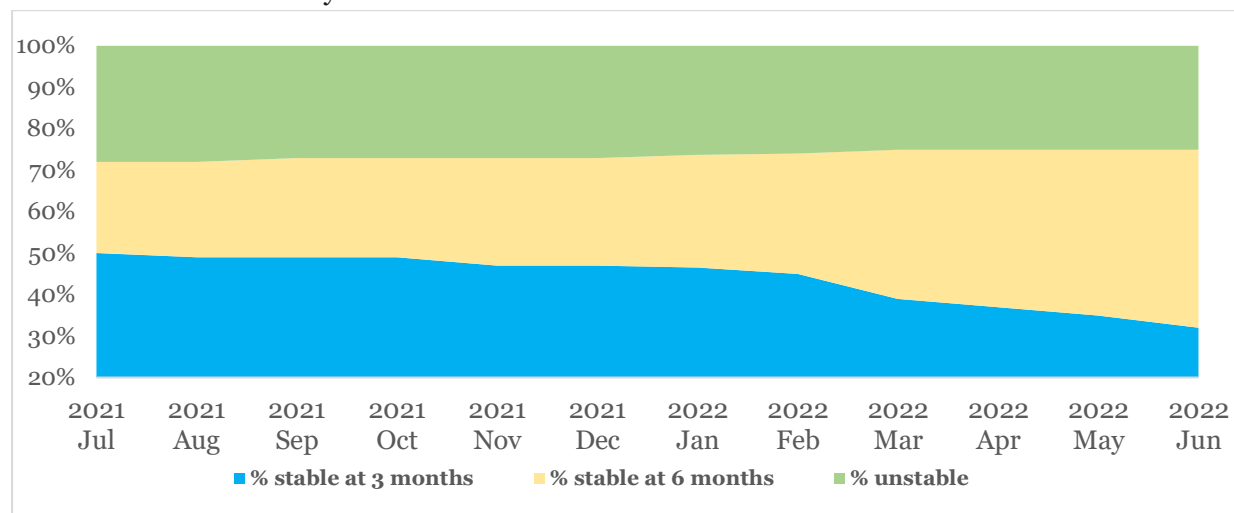


Figure 19: Trends in the scale-up of DSD model categories from July 2020 to June 2022.

People Living with HIV (PLHIV) who meet eligibility criteria (age >18, on ART for >12 months with at least 2 consecutive viral load tests [VLT] <200 copies/ml) can opt into the 6-MMD model, which includes twice-yearly clinic visits and VLT, and provision of 6 months of ART at each visit. The HIV care and treatment unit spearheaded the scale-up of 6MMD since its adoption in July 2020.

- By end of the 1st quarter, we had extended 6MMP in 15 districts covering over half of the health facilities in Rwanda.
- Furthermore, over the past 2nd and 3rd quarters, we have trained and mentored the rest of the 15 districts to fully scale up 6MMP covering all the 30 districts in Rwanda.

3.3.2. Paediatric Dolutegravir (pDTG 10mg) Optimization

Paediatric DTG 10 mg dispersible, scored tablets is a new generic formulation of DTG for children living with HIV (CLHIV). It is the preferred paediatric regimen for all CLHIV over 4 weeks and ≥3 kg. Since August 2021 to February 2022, HIV care & treatment unit supported all steps regarding development of tools, implementation plan, training, and monitoring of the molecule that has led to the adoption of paediatric DTG 10mg at full scale across all health facilities in the country. The status shows that it is in use and has been adopted as the preferred molecule for children that fall in the eligibility criteria. Furthermore, almost all health facilities have been either trained or mentored to optimize use of DTG in paediatrics population.

3.3.3. Differentiated service integration for Family Planning

It is paramount for all Women living with HIV to be able to prevent unintended pregnancies by reducing the risk of mother-to-child transmission. Great strides have been made in improving universal access to ART and the provision of effective contraception in resource-limited settings.

However, data showed that worldwide, there are 225 million more women with unmet needs for Family planning (FP) annually, with 45% unmet need in sub-Saharan Africa, (SSA). 44% of pregnancies in SSA are unintended and this rate remains higher among women living with HIV. The goal is to increase contraceptive uptake among WLHIV wanting to avoid pregnancy and improve safer conception for those desiring a pregnancy. This is possible through integration of family planning and comprehensive sexual education in HIV service delivery. It will respond to DSD by delivering tailored person centered care.

The 2025 AIDS targets for sexual and reproductive health rights highlights the need to integrate and avail family planning, STI services and comprehensive sexual education in HIV service delivery. Therefore, through DSD coordination with the maternal, child and community health program. RBC conducted joint workshop to train 33 health care providers and equip them with comprehensive SRH, STIs and family planning knowledge and skills. It is expected that the trainees will cover an eligible population (15-49 years) of close to 20,000 WLHIV attending selected health facilities in city of Kigali. Furthermore, routine family planning implementation guide has been updated to reflect integration of disseminated service delivery.

3.3.4. Quality Improvement to enhance Differentiated Service Delivery (DSD)

Following the “Treat all” strategy in Rwanda since 2016, the number of clients eligible for ART has been gradually increased resulting to potential overwhelming visits to providers, and affecting the quality of services delivered to PLHIV.

To address the issue, Rwanda, like many other countries adapted its national HIV management guidelines to include DSD. In efforts to strengthen further the DSD program, Rwanda joined the *HIV coverage, quality, and impact network* (CQUIN) in August 2020. Among the key goals set by the HIV program is a commitment to improving quality domain score on the DSD dashboard by defining and disseminating national quality standards for DSD program and carrying out quality assessments using national standards for quality assurance. Therefore, we conducted a facility assessment focusing on DSD quality indicators to inform on program priorities.

It is in that spirit, that RBC and partners proposed the use of Quality Improvement (QI) Initiative to address the identified gaps currently affecting optimal DSD performance. QI training was conducted to enhance DSD in 30 health facilities; 39 Health care providers (11 mentors and 28 nurses working in ART clinic) from 30 sites were trained, followed by an ongoing supervision to track progress.

3.4. Antiretroviral therapy coverage among people living with HIV

Antiretroviral Therapy (ART) has been shown to reduce mortality among those infected with HIV, and efforts are being made to make it more affordable within low- and middle-income countries. With the adoption of “test and treat” strategy, all clients who test HIV-positive are linked to care enrolled and initiated on ART, preferably, on the same day (where feasible), regardless of their CD4 count. While 214,074 clients are recorded to be initiated on ART by end of June 2022, UNAIDS estimates show that ART coverage among PLHIV in Rwanda is at 94%.

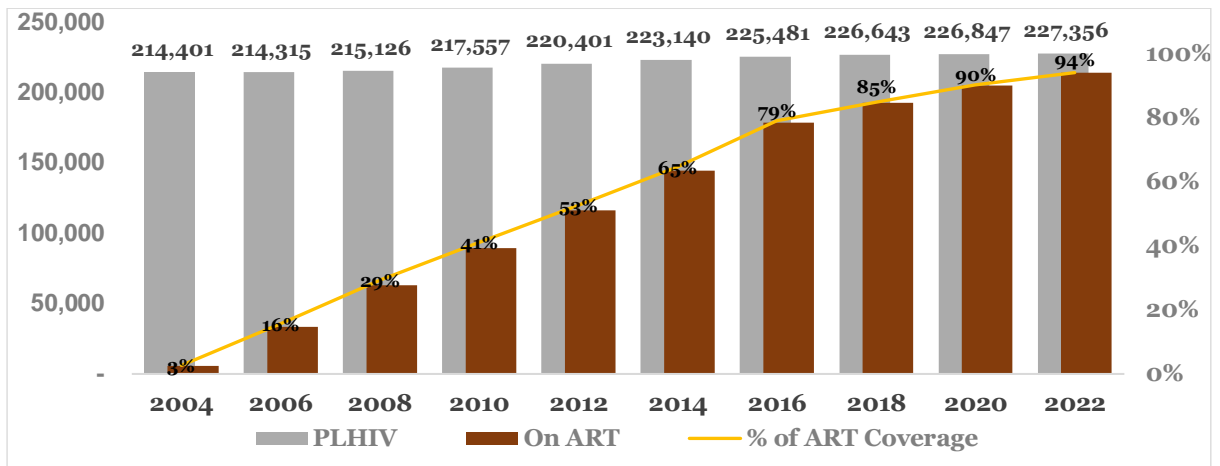


Figure 20: Trends of Antiretroviral therapy coverage, Rwanda

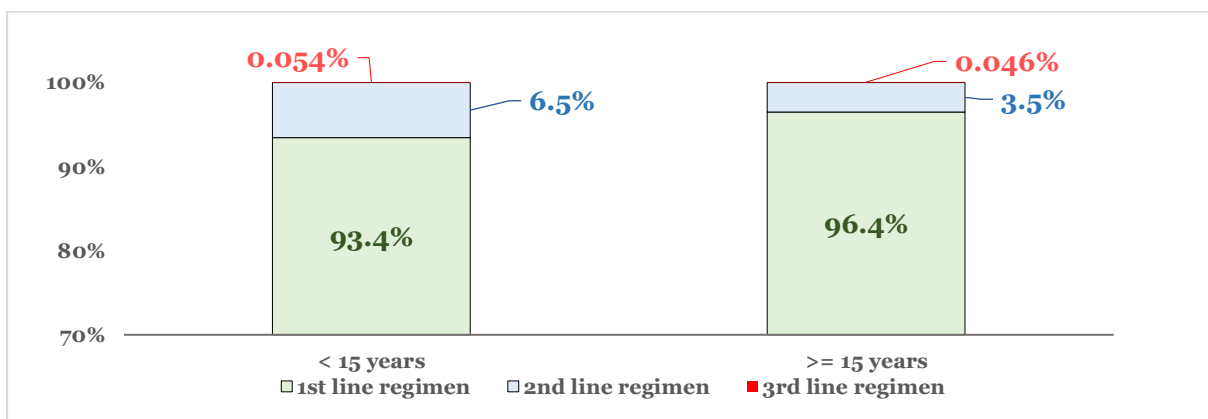


Figure 21: ART coverage by Regimen and age

3.4.1. Anti-retroviral Treatment optimization

Paediatrics HIV treatment optimization in Rwanda aims to reduce the number of ART regimens among children living with HIV (CLHIV) and enrol existing and new patients on more effective molecules and regimens. The clinical advantages of paediatric Dolutegravir (pDTG) over other ARV used among children include fewer side effects, easily administered, favourable taste, rapid viral load suppression, and less risk of treatment failure. The shift in the existing treatment regimen to a pDTG-based regimen was inevitable. Paediatrics DTG simplified doses approved for use in Rwanda is DTG 10 mg dispersible tablet. Currently, pDTG has been scaled up throughout the country for all eligible children living with HIV.

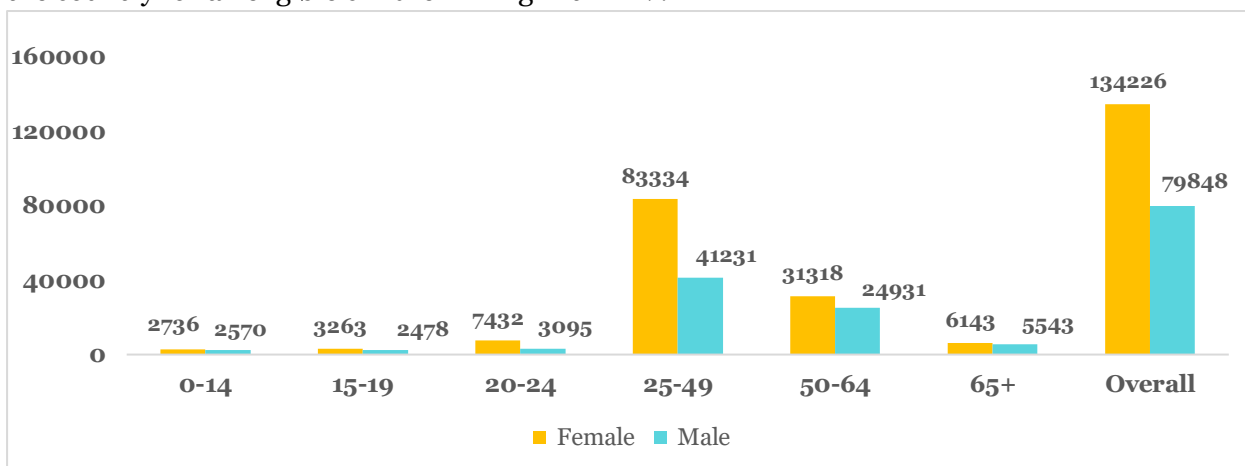


Figure 22: ART distribution by age category and gender as of July 2022

3.5. Linkage and retention to antiretroviral treatment

Early linkage to care and treatment reduces HIV/AIDS-related morbidity and mortality. It effectively prevents further HIV transmission; it optimizes the health benefits of treatment and prevents secondary transmission. To improve the linkage and initiation to ART for all patients newly tested positive, the HIV care and treatment program in Rwanda has strengthened strategies to improve communication between testing entry points and ART services, by ensuring same-day enrolment, enhanced counselling at enrolment, and mentorship of health care providers.

Retention in care is a spectrum of continuum care packages, from diagnosis of HIV infection to lifelong services. Nearly, all public health centers and private and at the community level, known as health centres, provide comprehensive antiretroviral treatment allowing maximum retention to care.

As observed on the graph below, the retention after one year of ART initiation to care is lower among children and adolescents compared to adults.

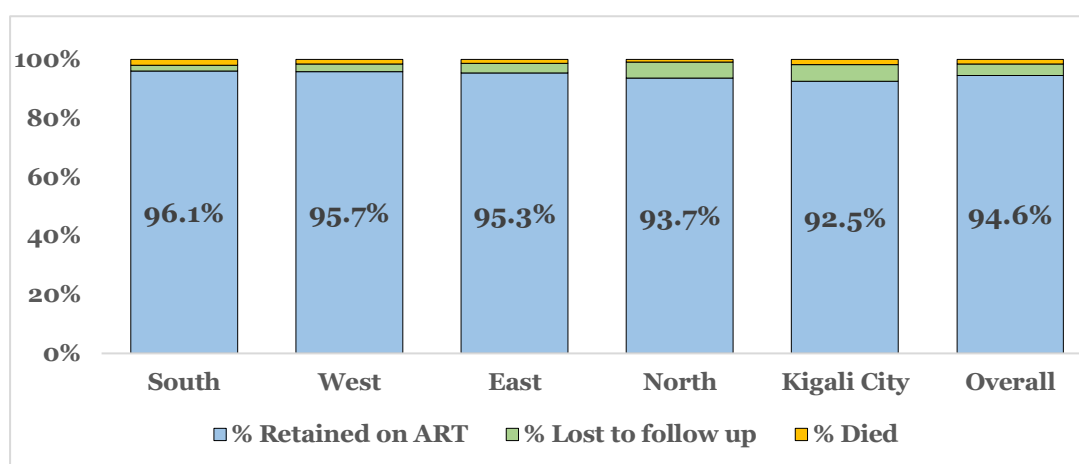


Figure 23: Retention after one year on treatment

3.6. HIV Viral load testing and monitoring

Viral load monitoring is the cornerstone of the HIV program within Care & Treatment. Viral load suppression is the main outcome of ART initiation. Regular monitoring of Viral load helps the program to early detect, prevent and effectively manage HIV treatment failure. The program has put more effort into training health care providers to monitor viral load as per the guideline in place and manage patients according to results. By support of Viral Load Sample Management System (VLSMS), in addition to Laboratory Information System (LIS) in HIV viral load testing hubs, we observed reduced turn around time (TAT) of VL results and supports timely clinical decisions.

Currently, each site can access the system, record their VL samples at the health facility level, and send samples to hubs. Results are generated in the system, and all referral sites can access HIV viral load results in the system at their sites. This has resulted in increased viral suppression, the gold standard indicator of ART optimization. As per the National Guidelines for HIV management, patients on ART are considered to have suppressed the viral load when their VL is under 200 HIV RNA copies/ml. Among the results collected from July 2021 to June 2022, the rate of VLS among PLHIV on treatment was at 93%. However, we still observe low viral load suppression among children and young adolescent compared to adults. Hence, the need to emphasize on treatment support including parents/ guardian and peer support approaches within these categories.

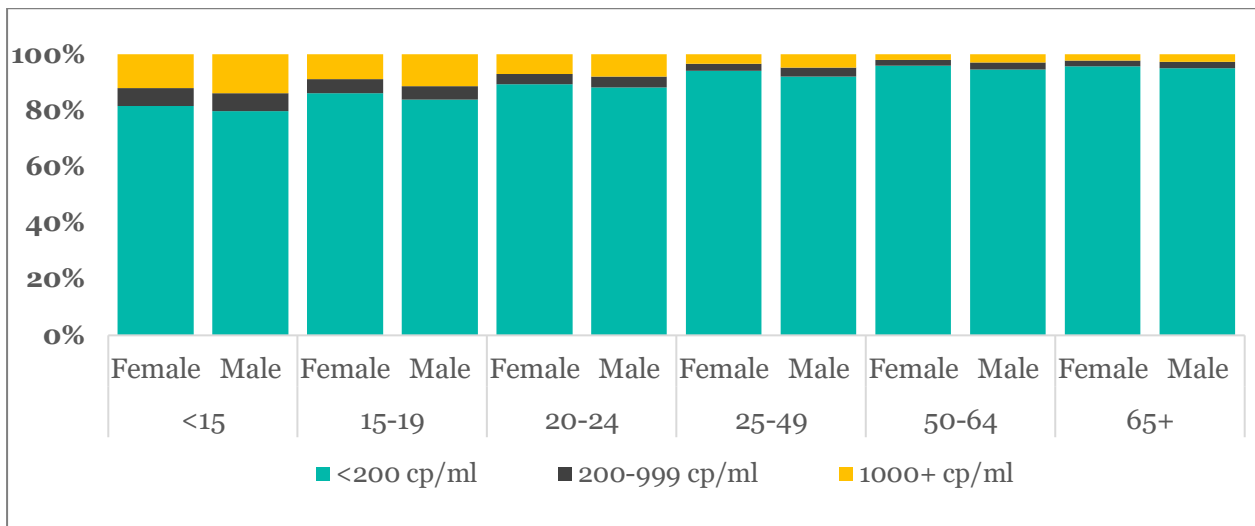


Figure 24: Status of viral load suppression among patients on ART by sex and age

3.7. Patients' movements

During this fiscal year 2021-2022, the number of PLHIV on ART increased by 3.1% from 207,580 to 214,074. The increase is due to the net increase of inward movements (new patients initiated to ART, retraced lost to follow up who are reengaging in care and transfers in at the health facilities).

Patients lost to follow-up at different stages of the HIV cascade may contribute to increase in HIV transmission, mortality, and morbidity as well as the drug resistance. At health facility level, efforts are put in working day to day with the peer educators, in collaboration with the network of people living with HIV (RRP+) to retrace the lost to follow up clients. Thus, in this fiscal year, 3,447 patients were reported as lost to follow up while 2,674 were retraced and re-engaged in care. The HIV program is committed to know more the bottleneck of lost to follow up and re-engagement in care.

In total transfers 10,398 patients have initiated ART and the national HIV program recorded 1,534 deaths from all causes among PLHIV who were on ART.

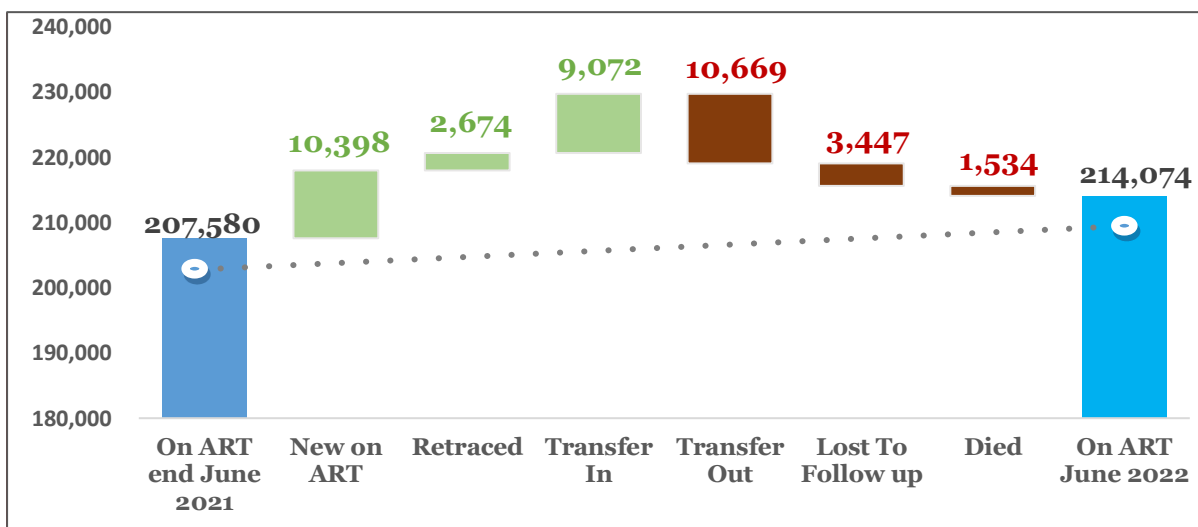


Figure 25: Patients' movements/Continuity of care

3.8. Opportunistic infections and NCDs management in PLHIV

Rwanda has considered the management opportunistic infections (OIs) among people living with HIV. This is because OIs frequently appear among clients whose CD4 counts are low and those who poorly adhere to ART; OIs contribute to the deterioration of PLHIV health. The preventive measures and treatment of OIs reduce morbidity and mortality among PLHIV. For early detection and management of OIs, immunological status is evaluated before ART initiation through a CD4 count test. In 2019, the TB preventive therapy (TPT) was initiated and scaled up to twenty-two out of thirty districts countrywide. Cumulatively, 134,000 patients were initiated to TPT.

The routine screening of non-communicable diseases is being integrated into HIV services at the health facility level. Therefore, for each clinic visit, in addition to managing HIV, non-communicable diseases are screened whenever deemed necessary. This has led to a one-step toward early prevention and management of NCDs, especially among PLHIV who are at a high risk of developing like long time on treatment, age above 50 years, etc.

3.9. Psychosocial Care support to People living with HIV

Rwanda has made significant progress in providing treatment, care, and support services.

All progress made resulted in reducing the morbidity and mortality due to HIV/AIDS through prevention, early diagnoses, appropriate treatment of OIs, together with early antiretroviral (ART) initiation and follow-up of PLHIV.

To improve treatment adherence, 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, screening, and management of mental health problems.

Almost ,5804 children under 15 years old and 16719 adolescents between 15-24 years old. The HIV disclosure to children has been done according to the guidelines. During this year, different activities have been done to improve health care providers' capacity to support patients for better adherence. Among those activities include introducing the child depression screening tool. In collaboration with the partners, 535 health care providers (Nurses head of HIV services at all hospitals and health centres) were trained on this tool.

Training of social workers working in HIV services at the hospitals on psychosocial support with an emphasis on children and adolescents and consultative meetings with the dean of discipline in boarding schools from East, South, and the City of Kigali has been conducted to discuss challenges faced by adolescents living with HIV. Appropriate interventions were discussed to improve adherence to ALWHIV in boarding schools and when they return home for holidays.

Additionally, in collaboration with Partners, we conducted a consultative meeting with beneficiaries (adolescents, males, peer educators, and FSWs). The purpose was to understand their opinions on new initiatives and adopt relevant community-grown strategies to enhance their retention and adherence to ART treatment. Moreover, it was an excellent opportunity to discuss and provide crucial information on resiliency, HIV risk factors minimization strategies, and advancing positive personal growth agenda among adolescents.

3.10. Addressing Stigma and Discrimination

The devastating impact of HIV- related stigma and discrimination spans social and clinical contexts and affects the entire HIV continuum of care, from prevention to care and treatment. Though sometimes seen as complex, the fundamental issue of stigma and discrimination must be addressed for sustainable progress. Several measures have been implemented to mitigate and eliminate HIV-related stigma and discrimination. Community support structures and community

based organizations (CBOs) share information on HIV and provide peer counselling for stigma reduction. Radio and TV talks on sensitization on stigma reduction and discrimination were produced and displayed through media.

3.11. Nutritional Support to PLHV

Adequate nutrition plays a crucial contribution to ART retention and prevents the occurrence of nutritional deficiencies, maintains body weight and fitness, and delays the progression from HIV to AIDS-related diseases. Nutrition care and support are one of the packages of PLHIV to promote good nutrition and well-being. Nutrition care and support are implemented through nutrition assessment, education, and nutrition support. During this fiscal year, 36 nutritionists from hospitals were trained on nutrition evaluations, education, and counselling.

Mentorship activities were conducted at 45 hospitals and health centres in the catchment area to improve their knowledge, practice, and attitude around nutrition commodities management and proper supply chain from hospitals to health centres. Nutritional commodities have been provided to 46 hospitals and health centres in their catchment area. During this reporting period, 54,490 and 2,994 PLHIV benefited the nutrition support of fortified corn soya blends (CSB +) and ready to use therapeutic food (RUTF) respectively.

3.12. Support for vulnerable groups

Thirteen adolescents living with HIV from Ruhango health centers and 22 from Rwamagana provincial hospital have been enrolled in income-generating activities to reinforce their treatment adherence. Five adolescents who were homeless have been reintegrated into school and family. The process of coping with HIV and family remediation continues to be enhanced through counselling twice a month. The mentorship focused on HIV prevention, and psychosocial support of community adolescents' treatment supporters (CATS) in 11 health centers has been conducted.

3.13. HIV- related commodities supply chain management

The overall purpose of supply chain activities under the HIV program is to ensure the availability and accessibility of Anti-retroviral drugs and other HIV-related commodities including lab supply and consumables for needy clients. Quantification of health commodities for supply plan 2022-2023 was reviewed to ensure smooth and uninterrupted availability of ARVs drugs and HIV-related commodities. Through monthly patient information reports, regular monitoring and the execution of guidelines changes were done in collaboration with Rwanda Medical Supply Ltd.

Stock status reviews were conducted monthly to monitor stock for all levels (central, districts, and service delivery points) to recommend mitigation strategies to prevent stockouts and overstock. Health facility store managers' capacity building and mentorship to targeted molecules in implementation or phase-out were conducted countrywide.

3.14. Mentorship and Continuous Quality Improvement in HIV services Delivery

Providing comprehensive HIV quality health care services requires training, mentorship, and continuous quality improvement. Clinical mentorship is aimed at improving the skills and knowledge of health care practitioners, including nurses, doctors, and pharmacists. Training and mentorship activities were conducted to ensure that healthcare providers deliver comprehensive HIV, STIs, and viral hepatitis prevention, care, and treatment services, per current clinical guidelines. Some training activities were not conducted due to COVID-19 prevention measures,

and onsite training sessions were organized to continue the capacity building for quality services delivery.

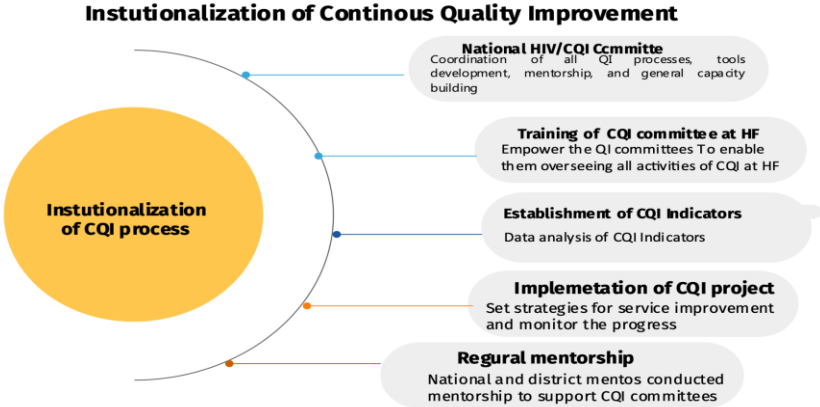


Figure 26: Continuous Quality Improvement in HIV services

Through experience-sharing sessions, new clinical mentors received orientation on HIV guidelines to equip them with knowledge of HIV Care and treatment services. Mentorship targeted interventions such as nutrition commodities to ensure good management, Abacavir transition, Mental health, HIV integration, and psychosocial care for PLHIV.

Clinical mentors supported in one-site training on the DSD categorization, especially on 6MMP. HCPs at health facilities are equipped to conduct self-audit of nutrition commodities; clients on Abacavir without an acceptable reason per the guideline were shifted to the TDF-based regimen. experience-sharing sessions created a space for sharing good practices with clinical mentors to improve the quality of HIV services.

4. VIRAL HEPATITIS AND SEXUALLY TRANSMITTED INFECTIONS

4.1. Introduction

The World Health Organization (WHO) estimates that viral hepatitis B and C are responsible for 1.1 million deaths and 3.0 million new infections yearly. Nearly 3,000 people die from hepatitis B and C every day, meaning one person passes every 30 seconds (WHO Global Report 2021 on HIV, Hepatitis and STIs). Chronic viral hepatitis infection can lead to liver inflammation and, subsequently, chronic liver disease, cirrhosis, and liver cancer, contributing to an increased disease burden and mortality. With effective vaccination and treatment for hepatitis B (HBV) and increasingly affordable treatment options for hepatitis C (HCV), both diseases can be eliminated (WHO, Interim guidance for country validation of viral hepatitis elimination, June 2021). New data show that 9.4 million people are receiving treatment for chronic HCV globally, representing a nearly 10-fold increase since 2015 and halting the trend of increasing hepatitis C deaths.

The government of Rwanda is building on its experience in rapidly expanding HIV services, has reduced the burden of viral hepatitis and was the first country in the region to launch a national viral hepatitis program by establishing a dedicated hepatitis unit in 2011. Furthermore, Rwanda implemented the first national guidelines in 2013, provided the first hepatitis C treatment in 2015, conducted catch-up HBV vaccination and mass screening in 2017, to launch the Hepatitis C elimination plan in December 2018.

4.2. Management of viral hepatitis B and C

4.2.1. Sensitization, trainings and mentorship on HBV and HCV prevention and management

HBV and HCV prevention methods were used through awareness, mass screening, vaccination, and treatment of infected individuals, which are the most effective ways to reduce the burden of HBV and HCV. Radio talks, television programs, and the distribution of leaflets have been conducted to raise awareness. To sustain the existing hepatitis management services shifted to nurses and decentralized to health centres, trainings were conducted for health care providers including physicians, nurses, laboratory technicians, laboratory managers, and data managers. Thus, 565 hospital and health centres data managers, 105 lab managers and lab technicians, 51 hospital physician mentors and 592 nurses working in hospitals and health centres were trained on comprehensive Hepatitis management.

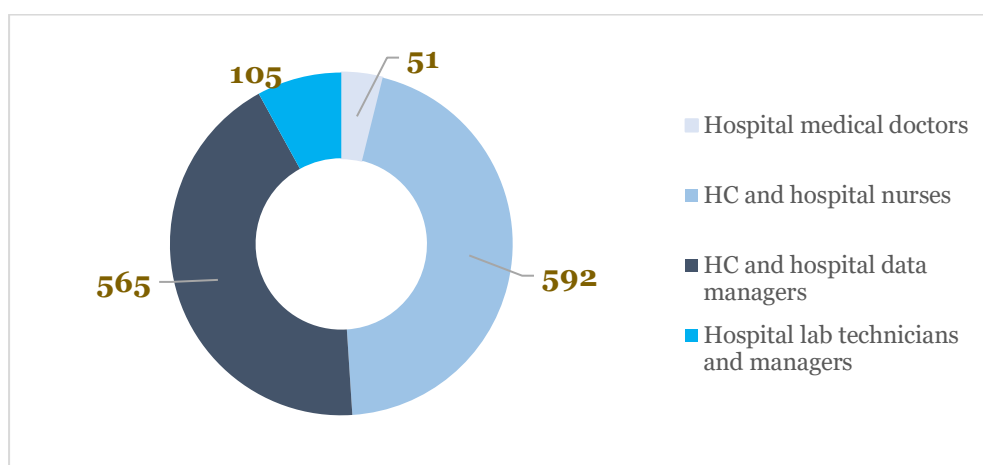


Figure 27: Healthcare providers trained during the fiscal year July 2021- June 2022

4.2.2. Vaccination of HBV

Infant immunization against HBV has been in place since 2002 in Rwanda, and the national coverage reached 99% in 2020 (Rwanda DHS, 2019-2020). Subsequently, more than 7,000,000 individuals benefited from this service. From July 2021 to June 2022, more than 144,094 adults and high-risk groups including PLHIV, survivors of the genocide against tutsi in 1994, MSM, FSWs, and refugees residing in Rwanda were vaccinated against HBV. Overall, 489,021 people vaccinated against HBV during this fiscal year.

4.2.3. HBV testing and treatment



As of July 2021, RBC prepared and conducted awareness campaigns on viral hepatitis, and different categories of the population were sensitized and screened. HBV screening was conducted in all districts of Rwanda, with 882,243 people screened for HBV from July 2021 to June 2022. Of 13,655 persons who screened HBs Ag positive, 3,074 were confirmed positive after HBV viral load testing, and 1,587 were eligible and initiated treatment.

The prevalence of HBV infection based on the viral load results was 0.35 %. For continuity of service, individuals with confirmed positive results were linked to treatment.

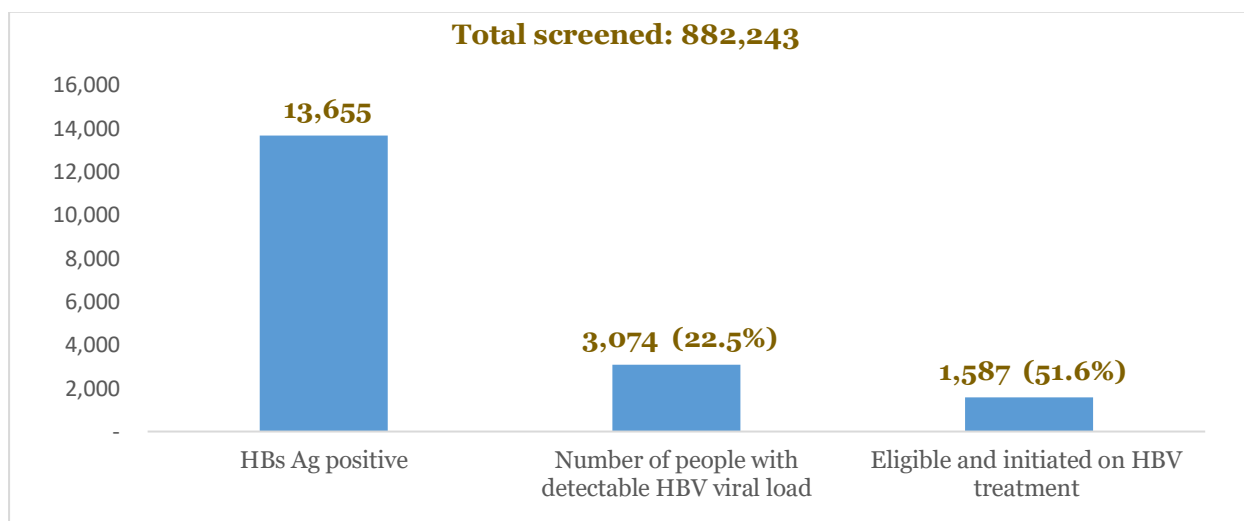


Figure 25: HBV cascade of care, July 2021 – June 2022

Considering the period from which HBV vaccination and testing services began, 4,128,843 individuals were screened for HBV and 15,587 were confirmed positive after an HBV DNA test, and 7,135 people were eligible and initiated HBV lifelong treatment (Figure 3).

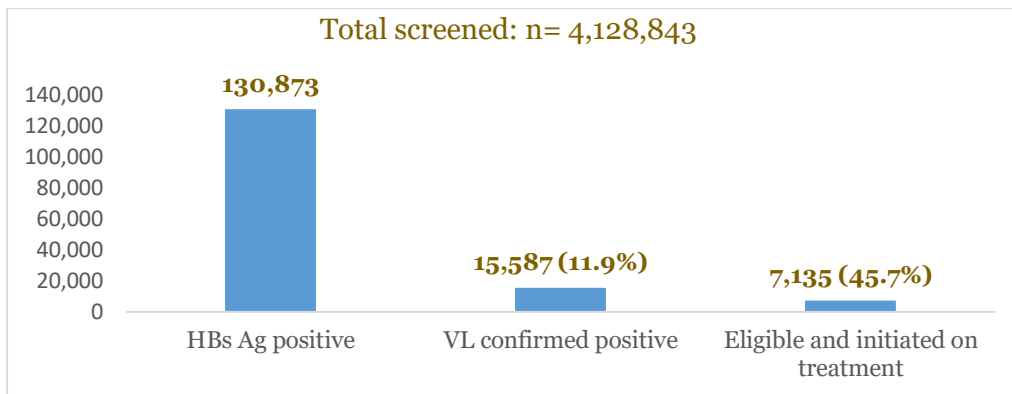


Figure 28: HBV cumulative cascade of care from 2015 to 2022

4.2.4. HCV testing and treatment

The joint HCV elimination “umuhigo”, which aimed to screen for HCV in the population aged 15 years and above, was conducted in all districts of Rwanda and as of today, out of the 7,157,116 people targeted to be screened, 6,986,919 (98%) have been screened. Based on this umuhigo for the current fiscal year, 1,924,901 people were screened for HCV. For the continuum of services, those screened positive were also linked to confirmatory testing and treatment.

During this reporting period, 28,243 individuals were screened positive for, HCV viral load tests were detectable for 7,272 individuals. People who were initiated on HCV treatment and those cured after sustained virologic response (SVR) after 12 weeks post-treatment are 5,196 and 5,279 respectively, (including cases from the previous fiscal year). Two hundred fifty-eight patients who failed first-line treatment of Sofosbuvir and Daclatasvir were initiated for a second-line treatment regimen made of Sofosbuvir /Velpatasvir and Ribavirin. (Figure 4). The prevalence of HCV infection measured through the HCV viral load test is 0.39 %.

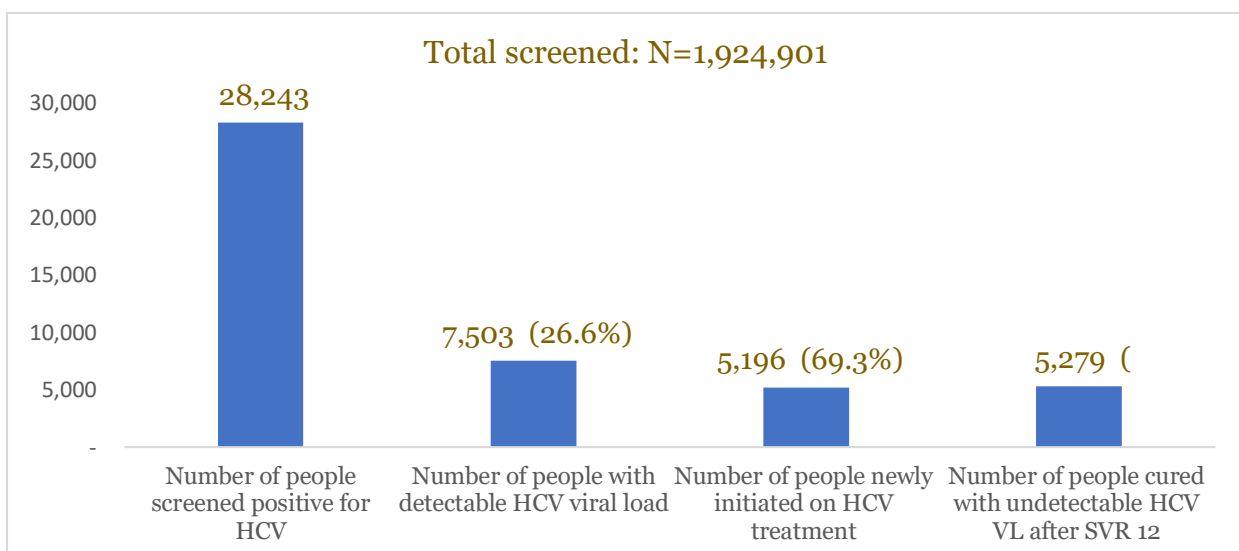


Figure 29: HCV cascade of care, July 2021 – June 2022

From the start of active HCV testing services in 2015 through June 2022, 6,986,919 individuals have been screened, of which HCV RNA has been confirmed, 60,623, and 57,418 (94.71%) have been treated (Figure 5).

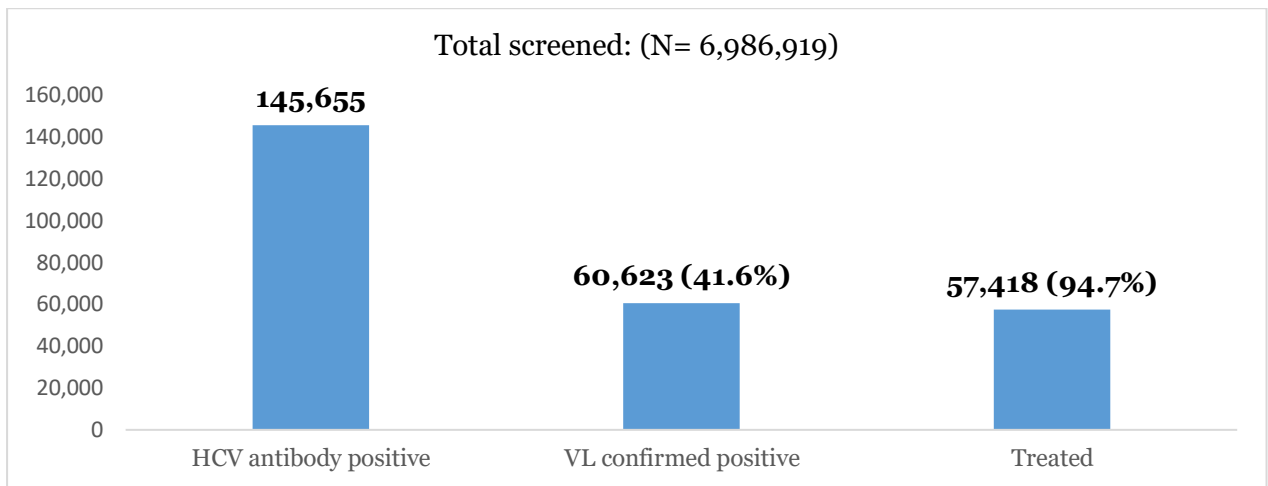


Figure 30: HCV cumulative cascade of care from 2015 to 2022

4.2.5. HBV and HCV prevalence and the performance of HCV elimination “umuhigo”

The prevalence of HBV and HCV in different districts, where Rusizi, Burera, Musanze, Rulindo, Nyamagabe, Karongi, and Ngororero districts have HCV prevalence of 0.50% and above. For HBV prevalence, Kirehe, Nyarugenge, Burera, Kamonyi, Ruhango, and Karongi districts have a prevalence of 0.50% and above. The average country prevalence for HBV and HCV based on viral load tests is 0.35% and 0.39%, respectively, the performance of HCV elimination umuhigo which is shown by the district's total population with the achieved percent in each district.

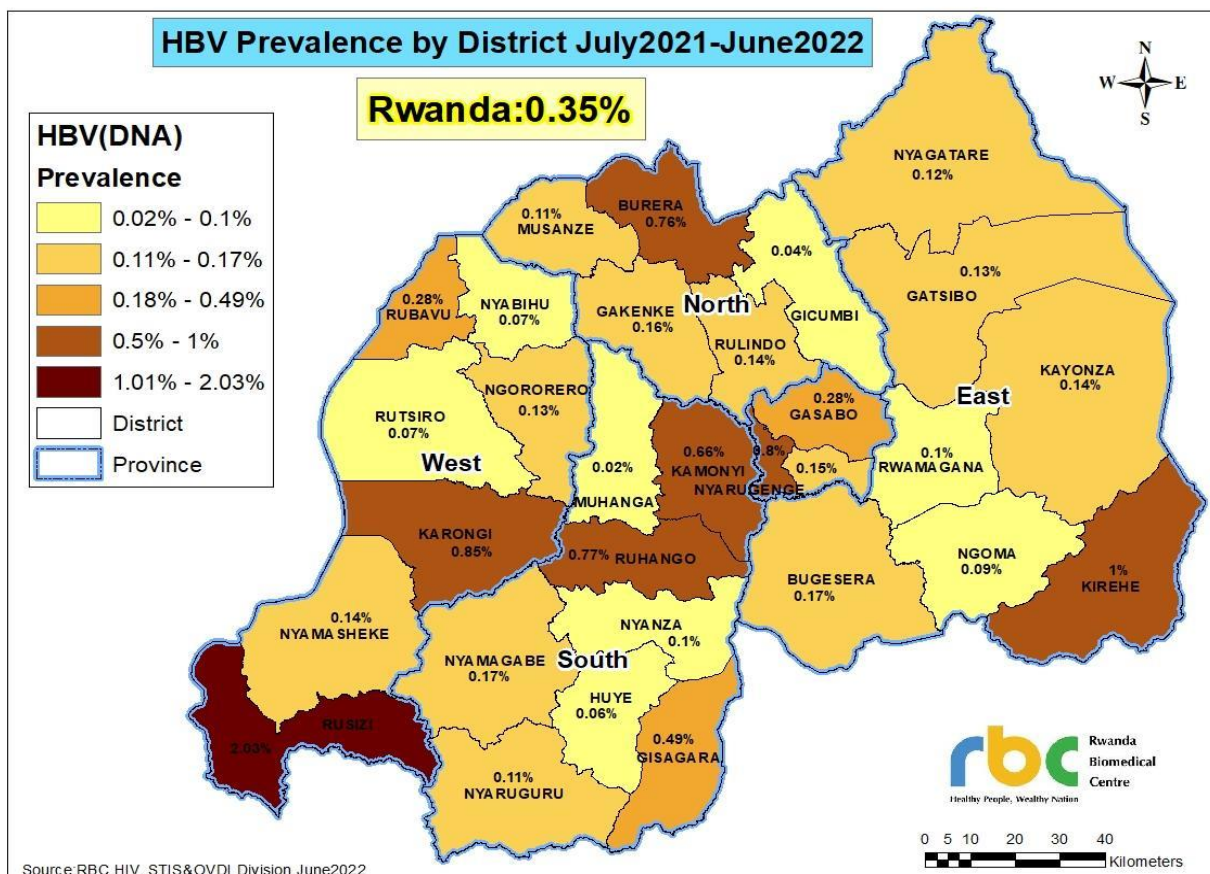
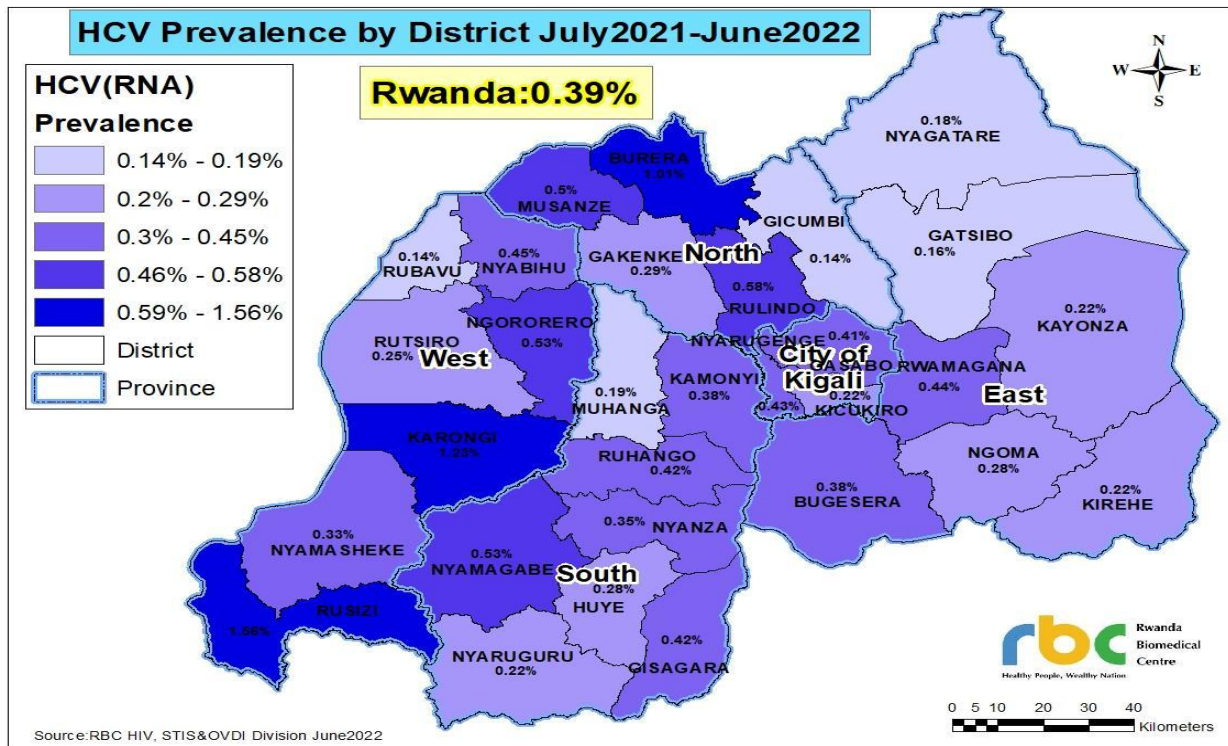
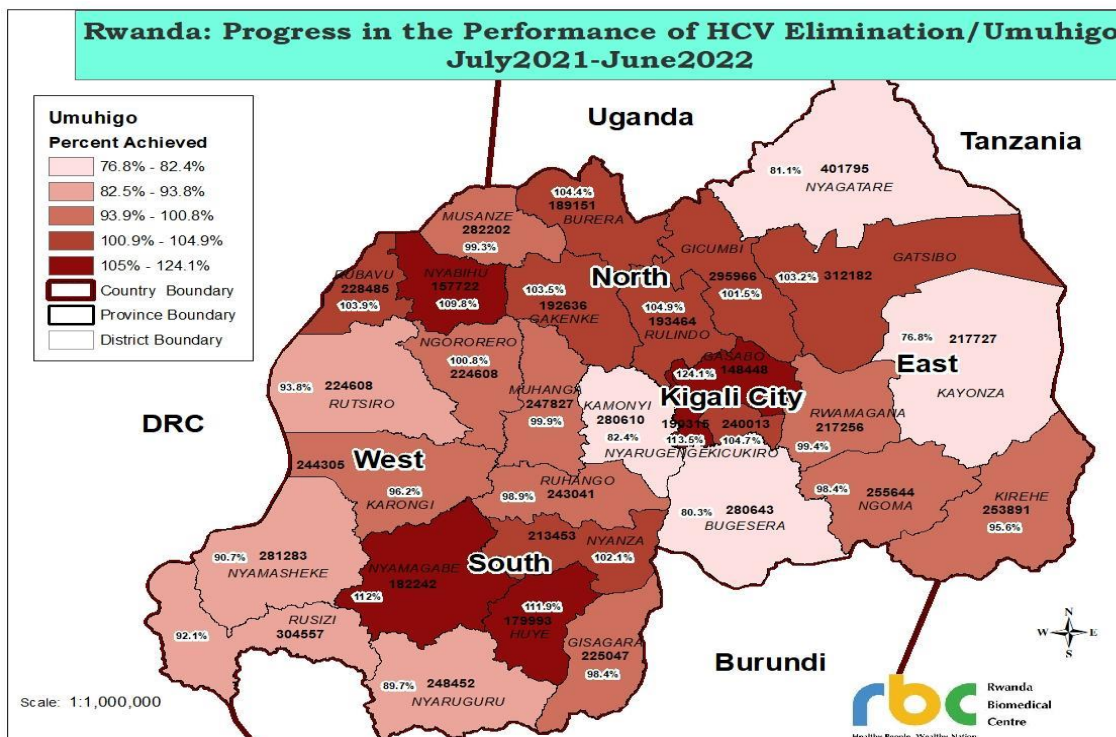


Figure 31: HBV prevalence in Rwandan Districts, July 2021 – June 2022



Map 1: HBV prevalence in Rwandan Districts, July 2021 – June 2022

4.2.6. Progress in the performance of HCV elimination “umuhigo” by districts



Map 2: Performance of HCV elimination umuhigo by different districts, July 2021 – June 2022

4.3. Management of sexually transmitted infections

Sexually transmitted infections (STIs) have been difficult to eradicate for decades due to several obstacles, including health priorities and cultural barriers. By 2030, World Health Organization (WHO) aims to reduce new infections, complications, and deaths from STIs to zero. This is to achieve a world where everyone has free and easy access to STI prevention and treatment services, enabling people to live longer and healthier lives. The goal is to end STIs as a major public health problem using strategies such as universal health coverage, the continuum of services, and a public health approach.

In the same line with the WHO guidance, from 2011, the Ministry of Health (MOH), through Rwanda Biomedical Centre (RBC), urged STI systematic screening among pregnant women, HIV-infected persons and all adult patients visiting health facilities in all departments, to reduce unmet need for STI prevention and treatment.

This strategy contributed to the early identification of clients with symptoms who do not consults specific for STIs services and increased the number of treated cases. Consequently, during the current fiscal year, 5,177,507 individuals visiting HF were screened, 215,686 (4.2%) were confirmed and 248,045 cases (including those from the previous fiscal year), were treated. (Figure 9). The highest number of clients (1,074,641) was screened in November 2021, while the remaining months were almost similar and varied from 345,155 to 412,480 per month.

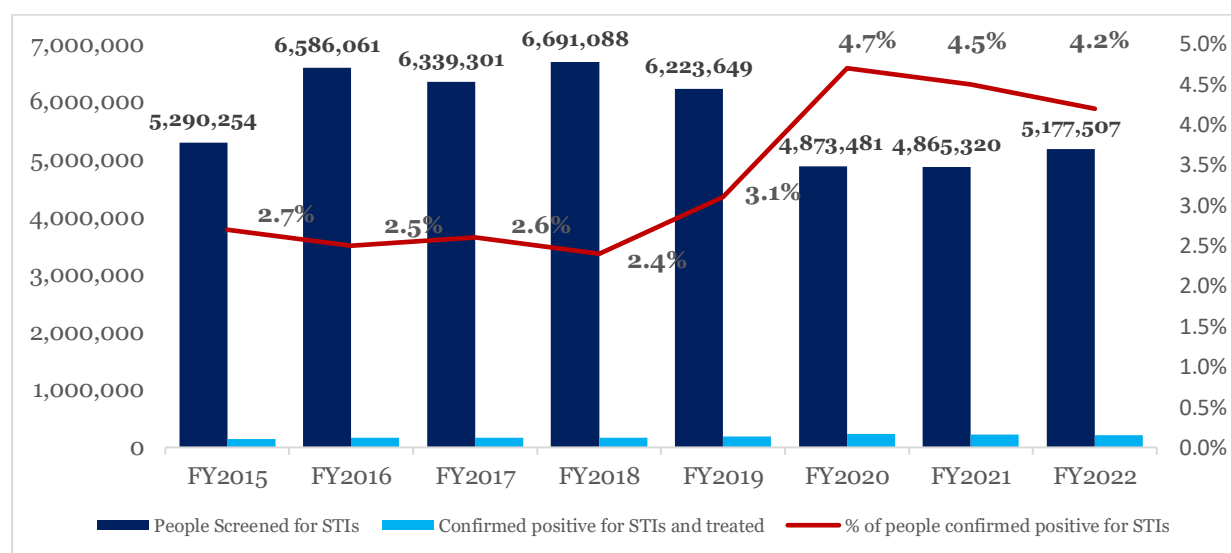


Figure 32: Trends of individuals screened, diagnosed, and treated for STIs from FY 2014/2015 to FY 2021/2022

4.3.1. Sensitization, trainings, and mentorship on STI prevention and management

A standard method to raise awareness on STI among the public, is by displaying messages through the media and community activities. To increase service demand, RBC regularly uses television and radio channels to discuss STI prevention and treatment and distribute brochures, and booklets to the public. Training and refresher courses are conducted at all levels of the health system to ensure a successful implementation of the STI program and increase and update the skills of health care providers. In the current fiscal year, approximately five radio talks and two television programs were conducted to raise awareness. Three training sessions for health care workers and data managers from 565 hospitals and health centres were conducted, during which

105 laboratory technicians, 51 physician mentors and 592 nurses were trained in STIs prevention and management. Furthermore, all health facilities were mentored to ensure the implementation of the guidelines and recommendations provided during the training.

4.3.2. STI prevention, care, and treatment

In Rwanda, apart from syphilis, which is diagnosed etiologically as part of antenatal care (ANC), other STIs are diagnosed and treated using a syndromic approach.

Although the syndromic approach has advantages such as high sensitivity in symptomatic patients, consideration of multiple infections, and client satisfaction, its success requires regular follow-up, continuous mentorship, supervision, and trainings.

This approach has some limitations, including overdiagnosis, overtreatment and unnecessary side effects of used antibiotics. Nevertheless, it has proven to be the best strategy for STI control in resource-limited settings compared to the laboratory-based approach, which requires significant investment in laboratories equipment and highly skilled personnel.

Figure 30 shows that diagnosed syndromes are presented below and predominate vaginal discharge, which constitutes 55.5% (119,716 cases) of all confirmed cases.

Partner notification of STI, management of asymptomatic cases, and knowledge of the actual course of the syndrome need to be continuously improved. For example, of the 248,045 index clients treated, only 31,207 (12.6%) of their partners were treated, which is not a good promise for ending STIs and requires a solid strategy to strengthen this process.

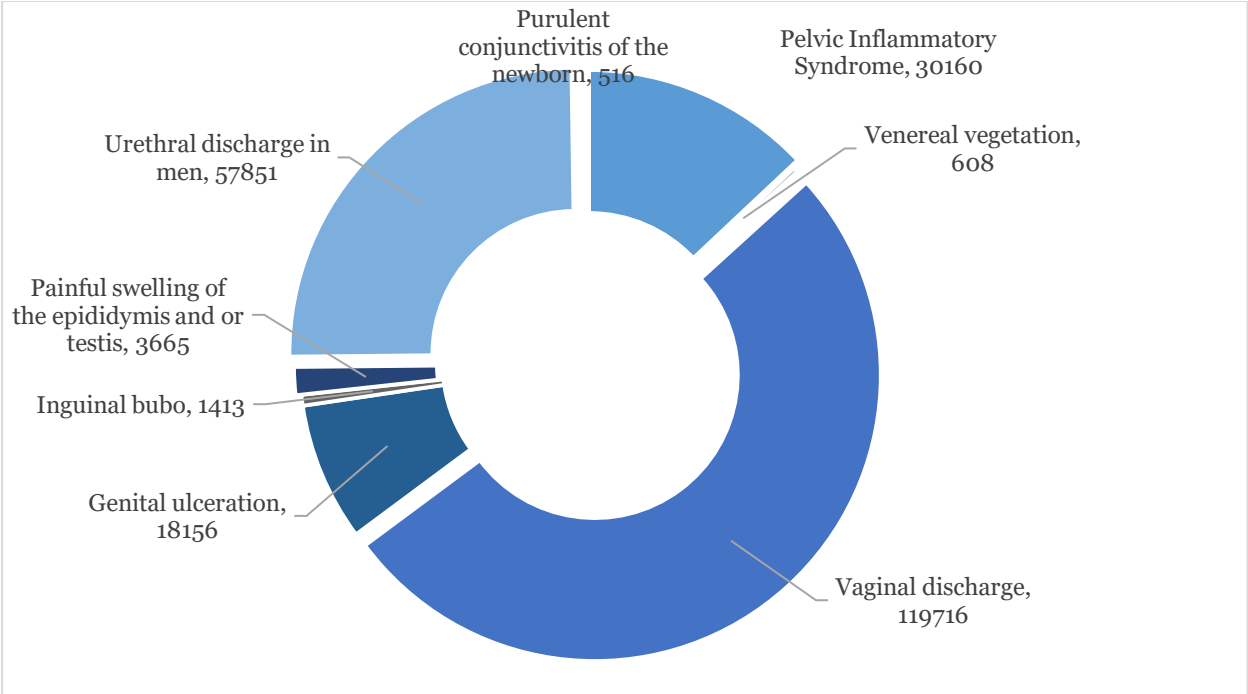


Figure 33: STI cases by syndrome, July 2021-June 2022

Ongoing training and mentorship to health care providers are critical to overcoming these challenges, starting with the provinces with an effective screening and diagnostic deficit. The city of Kigali, despite having many health facilities and a larger population, has a low number of screened clients in the current fiscal year.

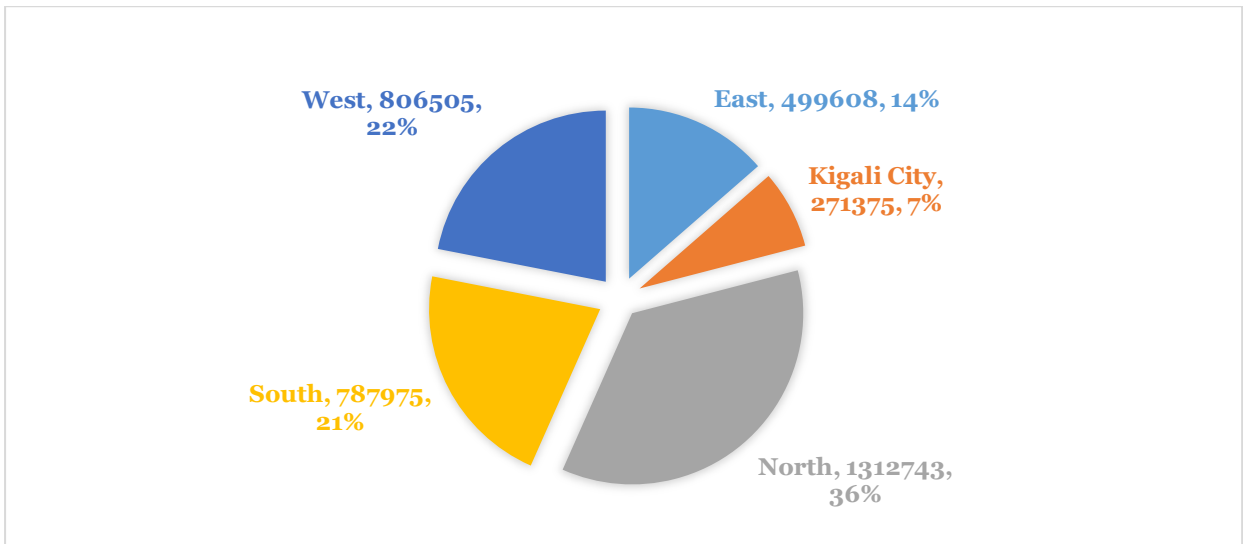


Figure 34: Clients screened for STIs by Province, July 2021-June 2022

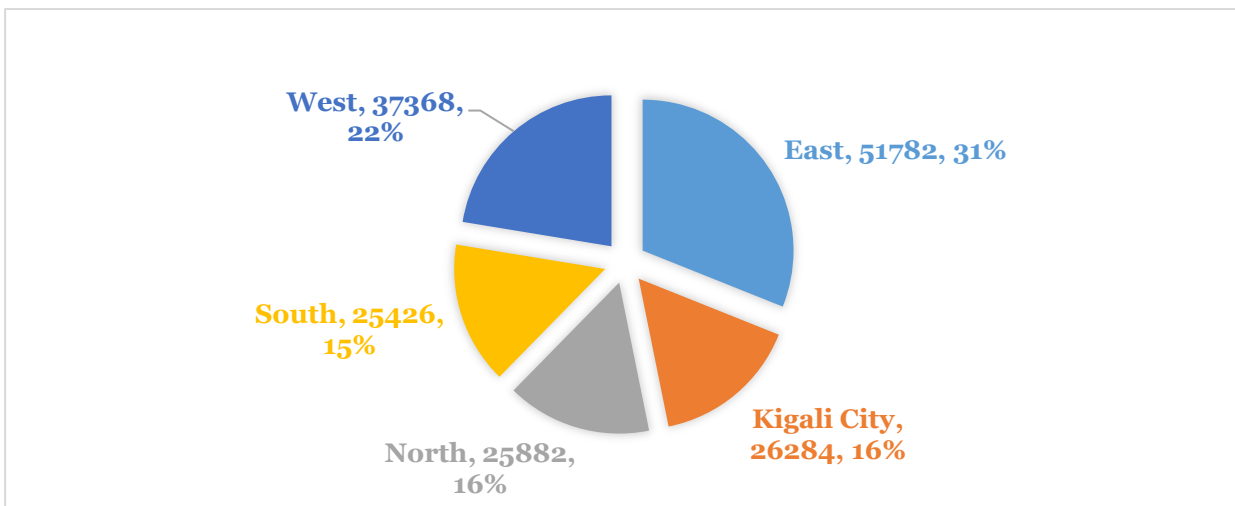


Figure 35: Clients treated for STIs by Province, July 2021-June 2022

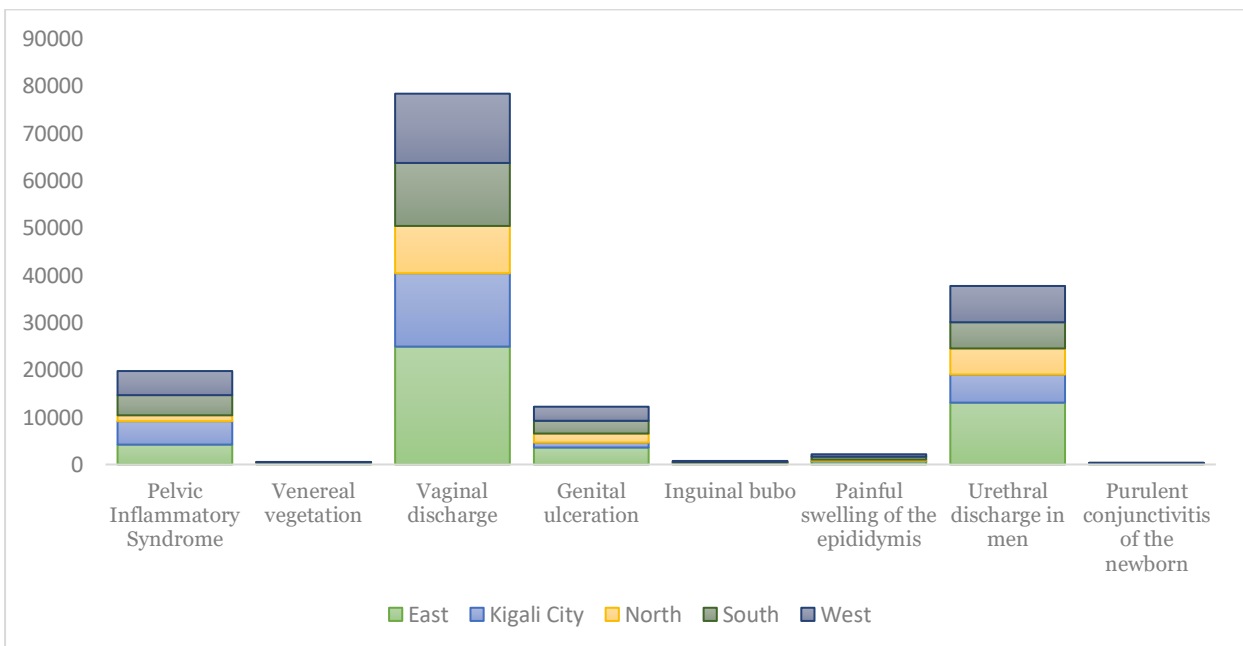


Figure 36: STI cases by syndrome and by Province, July 2021-June 2022

The provinces with populations most at risk for STIs, whereas the Eastern Province shows a higher prevalence of STI syndromes probably linked to the population risk behaviours.

Although we cannot routinely isolate it in the laboratory, *Neisseria gonorrhoea* is a growing global threat due to antimicrobial resistance. Hence, there is a need for local data and research to orient specific prevention and control measures

4.3.3. Monitoring and Evaluation

A DHIS2 system has been set up to collect the existing hepatitis data and assemble them in a single database. Medical doctors and nurses in charge of hepatitis, data managers, and lab technicians have been trained to use DHIS2. At least one medical doctor, one data manager and two nurses per hospital, and two nurses, one data manager and the head of the health centre from each health centre, were trained. Tablets, modems and internet connections have been provided to public health facilities (hospitals, health centres, rehabilitation centres, refugee camps and prisons) to support continuous data collection and entry into the DHIS2 system.

5. STRATEGIC INFORMATION FOR HIV

5.1. Introduction

The HIV strategic information aims at generating reliable and timely health information to inform decision-making. During this reporting period, the National HIV program implemented various interventions and activities to improve HIV strategic information. The SI helps to guide health policy, planning, resource allocation, program management, service delivery, monitoring and evaluation, and survey and surveillance. During July 2021 to June 2022, new activities were initiated, implemented, and scaled up while the existing ones improved.

5.2. Health information systems

To strengthen the electronic information system, the Rwanda Health Management Information system has been upgraded to reflect new HIV guidelines as well as refresh end users on changes, regarding Electron Medical Records (EMR), ARV nurses and data managers were trained on the upgraded Open-MRS and HMIS version which included new HIV guidelines and a new reporting framework.

This initiative was operationalized by initiating an integrated health information system that synchronizes data entry and reporting across various health databases to reduce transcription errors, eliminate data capture errors, and reduce the time spent in reporting. By June 2021, the project’s first phase has been successfully tested and piloted in 6 sites.

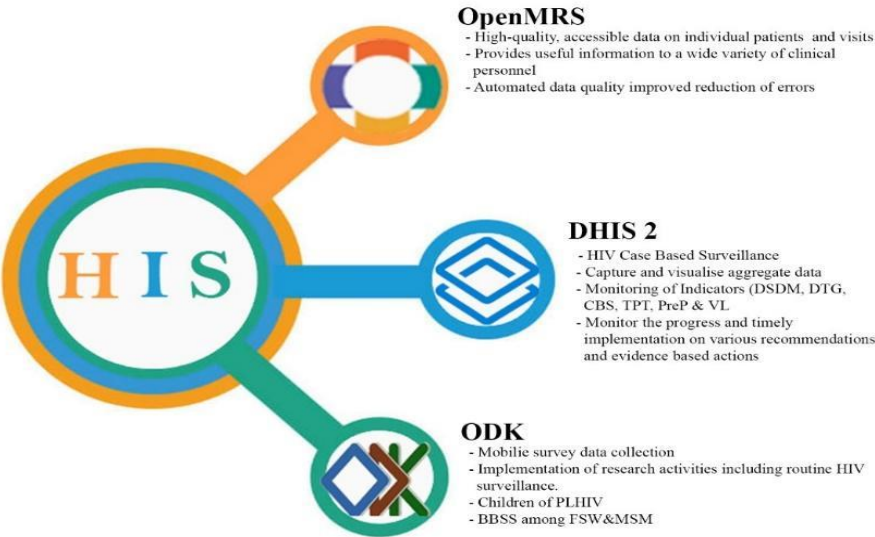
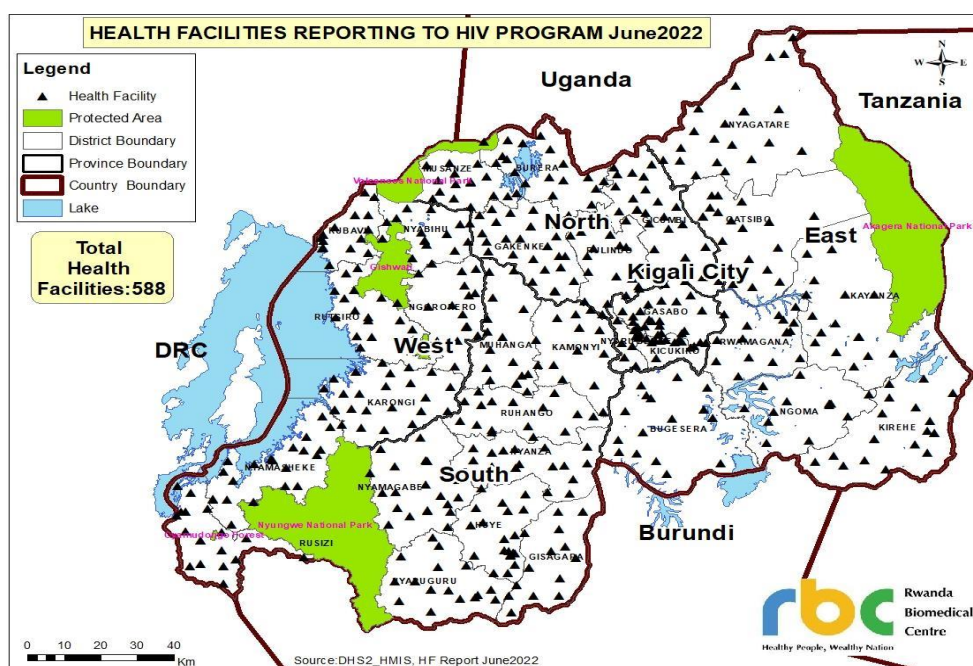


Figure 37: Schematic illustration for health information systems

To move toward an AIDS-free generation, data is needed to identify new HIV patients, patients linked to care and treatment, patients who initiated ART, those who were referred to other health facilities, those who were lost to follow-up, and those who suppressed viral load and those who died. This can be achieved through HIV Case Based Surveillance system (CBS) which includes two main components: Active case finding (ACF) to detect new HIV patients and routine case-based surveillance (RCBS) to track HIV patient care journey. The HIV case based surveillance is implemented as a routine program at all health facilities in Rwanda and data recorded in DHIS2 to facilitated ongoing surveillance to fast track HIV continuum of care and also facilitated to follow up HIV recent case clusters. The HIV case based surveillance is implemented as a routine program at all health facilities in Rwanda and data recorded in DHIS2 to facilitated ongoing surveillance to fast track HIV continuum of care and also facilitated to follow up HIV recent case clusters.

5.3. HIV data reporting and monitoring

Accurate, timely, accurate and accessible health care data play a vital role in the health care economic planning, development, and maintenance of health services. Following the revision and changes made in the National HIV guidelines, version 2020, some HIV, STIs, and Viral Hepatitis indicators were also revised and/or incorporated into HMIS to align with the national HIV guidelines. The indicators related to DSDM, DTG optimization, AGYW program, TPT initiation, PrEP program, and Viral load monitoring were revised, incorporated, and disaggregated by age and sex.



Map 3: Mapped health Facilities that report about indicators under follow-up.

- **580 health facilities** submit their monthly reports on 13 core national indicators in HMIS that provide minimum necessary information for national-level monitoring and response to the HIV epidemic: STIs and Viral Hepatitis focusing on ensuring data quality.
- **Development of HIV Indicators user Manual**, for the hepatitis program, setting up DHIS2 system for collect existing hepatitis data and assemble them in a single database.
- Training nurses and data managers on the use of DHIS2, Tablets, modems, and internet connections have been provided to public health facilities to support continuous data collection and entry into the DHIS2.

5.4. Integrated Supportive Supervision and Data Quality Assessment



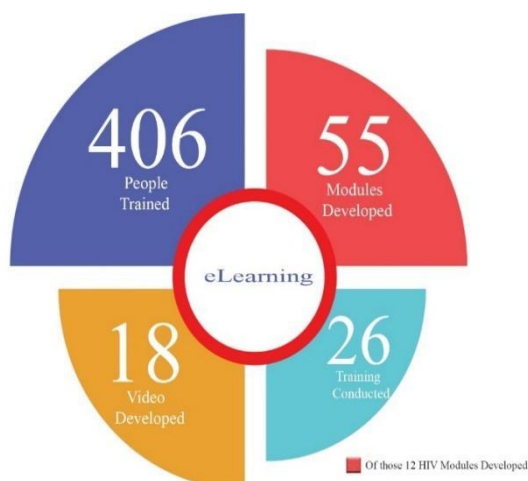
Data quality assessment was conducted in Rwandan health facilities at Rubeus, Rwamagana, Musanze, Muhanga districts, and Kigali city promoted efficient, effective, equitable, and quality health care in HIV clinics and connected services like NCDs, Laboratory examination among others.

- Capacity building for healthcare providers in visited health facilities in delivering quality HIV healthcare services with efficiently recorded data in the HIV Clinic and connected services complying with the current HIV guidelines and good clinical practice standards, in general.

5.5. HIV surveillance and surveys

- **Integrated biological, behavioural, survey and Surveillance and size estimation among men having sex with men 2021-2022:** the study's objective were to assess the risk of HIV infection, sexual transmitted diseases, viral hepatitis B and C and risky behaviour among men having sex with men, and to estimate the size of MSM for better program planning. The results indicated HIV prevalence estimated at among 6.5% among MSM with a population size estimate of 18,141. Detailed report is undergoing institutional approval
- **HIV and syphilis surveillance among pregnant women attending ANC/PMTCT services in sentinel sites in Rwanda, completed: 2021,** the study focused on assessing the prevalence and trend of syphilis among pregnant women who attended integrated ANC/PMTCT services, the results demonstrated and HIV transmission rate of 1.7%, whose prevalence increases across age and peaked at 40 – 44 years, and age specific prevalence was observed among women aged 35 – 39 years with 4.8%.
- **Assessment of HIV Services delivery to key populations in Rwanda, 2021.** The study objective was to analyse the 2021 situation of services provided to key population in Rwanda after introduction of HIV-friendly prevention services, the results demonstrated among FSW 16% were 25 years and HIV positive, 86% of them were on antiretroviral therapy attaining 97% viral load suppression.
- **Survey on Nutrition, Food Security, and Vulnerability of People Living with HIV in Rwanda 2021.** The object was to determine the nutrition, food security, and vulnerability status of people living with HIV in Rwanda the results with exception of pregnant and lactating women, all other participants in the age groups the rate of malnutrition was high, • One in 10 patients (10.93%) taken in the study missed at least one or more doses of ART within the 30 days preceding the survey and one in 5 patients (21.1%) evoked a lack of food as a reason for not taking the treatment.
- **Pharmacovigilance for Dolutegravir, 2021 – Ongoing surveillance study,** the objectives of the study way to control the occurrence of safety profile of DTG-based regimens including TDF/3TC/DTG and ABC/3TC+DTG with both short and long term effects of antiretroviral medicines is being conducted in 10 health facilities selected in all provinces and Kigali city.
- **Viral Hepatitis C second-line treatment with sofosbuvir/velpatasvir and ribavirin – 2021 - Ongoing surveillance study** the objective of the study was to conduct assessment on patients who did not respond to the first-line treatment regimen of sofosbuvir and daclatasvir.

5.6. Innovation and use of technology in HIV program activities



Innovation in healthcare delivery and use of technology in the program activities has been put on the forefront in strengthening mentorship, training programs and other program activities.

Figure 38: Development of eLearning platform

In the area of course design, the methodology of acquiring skills can be acquired while sitting in a board room, or by having seminars, using E-learning technologies in HIV division will bridge a step ahead of those which still have the traditional approach to learning, tele-mentorship in delivering knowledge and information.

5.7. Coordination of Partners in HIV Response

To avoid duplication of efforts and to minimize the cost of field activities, partners in HIV response who conduct supervision activities will be brought together and integrated as far as data quality assessment and supervision are concerned. Among the expectations of effective coordination of different partners, include: integrating all data quality assessment and supervision activities into one process; supporting data quality assessment activities where possible and applying best practices and knowledge to improve the process.

5.8. Contribution to HIV program and Health sector

This integrated supportive and data quality assessment will strengthen the capacity of healthcare providers in visited health facilities in delivering quality HIV healthcare services with efficiently recorded data in the HIV Clinic and connected services complying with the current HIV guidelines and good clinical practice standards.

6. FINANCING HIV/AIDS PROGRAMS

6.1. Introduction

Financing HIV/AIDS program in Rwanda is a subset of the Health Sector Financing strategy. Focusing on the progress to improve access of the population to health services, including HIV services.

The major funding sources for the Rwanda HIV programs are:

- Government resources, 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 and project support. On the budget, the donor funds 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 expenditures are not yet captured in this report
- Private funds are also not captured in this report.
- Income generated from health facilities services, but are not also captured in this report.

The data collection for the contribution of these sources is conducted on an annual basis. Therefore, the report is focused on funding sources where data were available at the time of reporting as explained above.

6.2. Public and External Sources of funding for HIV/AIDS National Strategic Plan

The Ministry of Health and the Rwanda Biomedical Centre in collaboration with its partners worked on the financial data reported in HIV/AIDS annual report 2021-2022.

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

6.3. HIV/AIDS Expenditures in Rwanda FY 2021/2022 by Sources of Financing.

The Global Fund for AIDS, TB, and Malaria (GFATM) contributed the budget of \$ 82,083,169 for the FY 2021/2022; whereas the United States Government (USG contribution for the FY 2021/2022, through PEPFAR is \$ 73,776,000. The Government of Rwanda contributed the budget of \$ 25,279,590 while One UN contributed \$ 671,185 contributions, totaling the entire budget to support the National Strategic Plan for the FY 2021/2022 to \$ 181,809,944.

Source of funding for NSP/HIV	Revised Budget FY 2021/2022	Expenditures FY 2021/2022	Variance	Budget execution rate
Global Fund for HIV/AIDS, TB and Malaria	82,083,169*	53,518,280	28,564,889	65%
PEPFAR	73,776,000	73,776,000	0	100%
One UN	671,185	671,185	0	100%
GoR	25,279,590	25,151,444	128,146	99%
Grand Total	181,809,944	153,116,910	28,693,034	84%

Table 1: Expenditures by sources of finance for NSP, FY 2020/2021

The overall total expenditure for HIV NSP was \$ 152,778,655 which represents 84% of the revised budget.

6.4. Government contribution to HIV/AIDS National Strategic Plan FY 2021/2022

The GoR funds are allocated to different health programs during the annual planning and budgeting process, which entails sectoral consultations to discuss prioritization and budget allocation between the Ministry/ RBC and decentralized levels based on HSSP IV 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 expenditure was then extracted and analysed based on the disease burden.

MTEF Chapter	Initial budget FY 2021/2022	Revised budget FY 2021/2022	Expenditures FY 2021/2022	Variance FY 2021/2022	B.E rate
21 Compensation of Employees	10,994,890	11,173,625	11,147,164	26,461	100%
22 Use of Goods and Services	2,113,402	2,460,972	2,413,140	47,832	98%
25 Subsidies	470,162	615,437	574,336	41,100	93%
26 Grants	1,267,292	1,272,501	1,357,726	-85,225	107%
27 Social Benefits	1,798,284	2,527,182	2,496,880	30,302	99%
28 Other Expenditures	3,060,178	4,138,590	4,269,041	-130,450	103%
33. Inventory	10,624	9,135	7,471	1,665	82%
34. Fixed tangible non-financial Assets	1,780,287	3,082,148	2,885,687	196,461	94%
Grand Total	21,495,120	25,279,590	25,151,444	128,146	99%

Table 2: GoR contribution to NSP per MTEF chapter, FY 2021/2022

From the above table, the initial budget for the financial year 2021/2022 was \$ 21,495,120 which was revised to \$ 25,279,590. Out of the revised budget of \$ 25.3 Million, a total of US\$ 25.2 Million had been effectively spent by different budget entities with 99% of budget execution rate.

Budget Entities	Initial budget	Revised budget	Expenditures	Variance	B.E rate
RHs	2,413,038	2,550,205	2,550,205	0	100%
Earmarked Transfers to Districts	8,883,642	9,027,295	9,115,457	-88,161	101%
Other Public Institutions	2,252,178	2,357,192	2,054,613	302,579	87%
MOH	3,821,058	4,945,325	5,216,851	-271,526	105%
RBC	4,125,205	6,399,573	6,214,319	185,254	97%
Grand Total	21,495,120	25,279,590	25,151,444	128,146	99%

Table 3: GoR contribution to NSP per budget agencies, FY 2021/2022

6.5. The Global Fund contribution

For the Global Fund contribution, the total approved budget C19RM inclusive is \$ 82,083, for the financial year 2021-2022. During this financial year; the expenditure was \$ 53,180,026. Hence, the total budget execution rate for the FY 2021/2022 was 65%. This total variance of 35% was mainly due to C19RM activities that required procurement and most of them were committed by 30th June 2022.

Budget Entities	Approved Budget FY 2021 - 2022	Expenditures FY 2021 - 2022	Variance	B.E rate
Referral hospital	142,056	145,891	-3,834	103%
Ministry of Health	2,371,615	2,165,293	206,321	91%
Other public institutions	1,010,499	966,971	43,528	96%
RBC	78,558,998	50,240,125	28,318,874	64%
Grand total in USD	82,083,169	53,518,280	28,564,889	65%

Table 4: GF budget execution per budget entities, FY 2021/2022

NSP Cost category	Approved Budget FY 2021 – 2022	Expenditures FY 2021 - 2022	Variance	B.E rate
1.0 Human Resources (HR)	9,192,627	8,870,750	321,877	96%
2.0 Travel related costs (TRC)	3,588,074	3,477,069	111,005	97%
3.0 External Professional services (EPS)	1,353,586	358,451	995,135	26%
4.0 Health Products - Pharmaceutical Products (HPPP)	13,021,262	8,114,567	4,906,695	62%
5.0 Health Products - Non-Pharmaceuticals (HPNP)	25,937,212	18,825,597	7,111,615	73%
6.0 Health Products - Equipment (HPE)	11,019,745	3,460,109	7,559,636	31%
7.0 Procurement and Supply-Chain Management costs (PSM)	6,680,999	2,740,820	3,940,178	41%
8.0 Infrastructure (INF)	4,058,570	3,119,312	939,257	77%
9.0 Non-health equipment (NHP)	2,178,589	62,017	2,116,571	3%
10.0 Communication Material and Publications (CMP)	426,333	274,720	151,613	64%
11.0 Indirect and Overhead Costs	1,057,455	1,131,715	-74,261	107%
12.0 Living support to client/target population (LSCTP)	2,914,411	2,750,604	163,807	94%
13.0 Payment for results	654,307	332,549	321,758	51%
Grand Total	82,083,169	53,518,280	28,564,889	65%

Table 5: GF Grant expenditure per NSP cost category, FY 2021/2022

The table above shows the HIV NSP budget execution per cost category for the period of July 2021 to June 2022. It is clearly reflected that the expenditures incurred during this financial year reached 65% of the approved annual budget.

It is important to highlight that during this financial year 2021/2022, the Global Fund invested additional amount of \$ 35,554,914 in the fight against COVID-19 pandemic disease that was topped up to the normal grant to reach approved annual budget of \$ 82,083,169. Hence, it paramount relevant to show the details of expenditures as per normal grant as well as per C19RM for better understanding of users of the report.

NSP Cost category	Approved Initial Budget July 2021-June 2022	Expenditures July 2021-June 2022	Variance	Budget Execution rate
1.0 Human Resources (HR)	9,071,568	8,870,750	200,818	98%
2.0 Travel related costs (TRC)	3,175,989	3,188,868	-12,878	100%
3.0 External Professional services (EPS)	1,327,018	358,451	968,567	27%
4.0 Health Products - Pharmaceutical Products (HPPP)	13,021,262	8,114,567	4,906,695	62%
5.0 Health Products - Non-Pharmaceuticals (HPNP)	13,545,834	11,184,198	2,361,636	83%
6.0 Health Products - Equipment (HPE)	1,188,504	1,063,886	124,618	90%
7.0 Procurement and Supply-Chain Management costs (PSM)	2,119,639	2,110,292	9,346	100%
9.0 Non-health equipment (NHP)	316,887	62,017	254,870	20%
10.0 Communication Material and Publications (CMP)	410,202	257,853	152,349	63%
11.0 Indirect and Overhead Costs	1,035,721	1,109,605	-73,884	107%
12.0 Living support to client/ target population (LSCTP)	991,876	937,748	54,128	95%
13.0 Payment for results	323,755	332,549	-8,795	103%
Grand Total	46,528,255	37,590,784	8,937,471	81%

Table 6: GF Normal Grant expenditure per NSP cost category, FY 2021/2022

For C19RM grant budget, out of the approved budget of \$ 36.5 Million, \$ 15.6 Million has been effectively spent which represents 81% of budget execution. The remaining balance which is 19% stands for the health commodities and health equipment, oxygen power plant and oxygen spare parts whose commitments will be cleared in the next first semester.

NSP Cost category	Approved Initial Budget July 2021-June 2022	Expenditures July 2021-June 2022	Variance	Budget Execution rate
1.0 Human Resources (HR)	121,059	0	121,059	0%
2.0 Travel related costs (TRC)	412,085	288,202	123,884	70%
3.0 External Professional services (EPS)	26,568	0	26,568	0%
5.0 Health Products - Non-Pharmaceuticals (HPNP)	12,391,378	7,641,399	4,749,979	62%
6.0 Health Products - Equipment (HPE)	9,831,241	2,396,223	7,435,018	24%
7.0 Procurement and Supply-Chain Management costs (PSM)	4,561,360	630,528	3,930,832	14%
8.0 Infrastructure (INF)	4,058,570	3,119,312	939,257	77%
9.0 Non-health equipment (NHP)	1,861,701	0	1,861,701	0%
10.0 Communication Material and Publications (CMP)	16,131	16,866	-736	105%
11.0 Indirect and Overhead Costs	21,734	22,111	-376	102%
12.0 Living support to client/ target population (LSCTP)	1,922,535	1,812,855	109,680	94%
13.0 Payment for results	330,552	0	330,552	0%
Grand Total	35,554,914	15,927,496	19,627,418	45%

Table 7: GF C19RM Grant expenditure per NSP cost category, FY 2021/2022

6.6. The USG/PEPFAR contribution

From 1st July 2021 to 30th June 2022, the US Government invested approximately \$ 77,830,212 in 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's budgeting period (i.e., the COP year begins on October 1 and ends on September 30 of the following year), this figure is an estimate based upon portions of two COP years – one-quarter of July to September 2021 from the implementation period starting from October 1, 2020, to September 30, 2021, and three remaining quarters of FY 2021/2022 starting from October 1, 2021, to June 30, 2022.

6.7. ONE UN Contribution

The One UN developed several flagship programs to fund HIV activities implemented from July 2021 to June 2022. The total budget for the flagships is USD 671,185. This was used as a planned funding level for ONE UN.

7. Key performance Indicators achievement

Indicators	Data Source	Results July 1, 2021 – June 30, 2022
HIV Prevalence (15 -64)	RPHIA, 2018 -19	3%
HIV Incidence	RPHIA, 2018 -19	0.008 PYRS
HIV Prevalence among female sex workers	IBBSS, 2019	35.5%
HIV prevalence among Men having sex with Men	IBBSS, 2021	6.5%
Number HIV tests conducted	HMIS, July 2021 – June 2022	2,283,301 (0.70%)
HIV sero-positivity rate (Overall)	HMIS, July 2021 – June 2022	
▪ <i>VCT/PIT</i>	HMIS, July 2021 – June 2022	1.282,913 (0.68%)
▪ <i>ANC Women</i>	HMIS, July 2021 – June 2022	374,162 (0.87%)
▪ <i>ANC male partners</i>	HMIS, July 2021 – June 2022	209,627 (0.63%)
▪ <i>VMMC</i>	HMIS, July 2021 – June 2022	142,471 (0.03%)
▪ <i>Maternity</i>	HMIS, July 2021 – June 2022	230,052 (0.04%)
▪ <i>Index testing</i>	HMIS, July 2021 – June 2022	47,631 (5.15%)
Percent of HIV infected pregnant women in PMTCT	HMIS, July 2021 – June 2022	1.86%
Pregnant women who received ART to reduce mother to child transmission	HMIS, July 2021 – June 2022	98.4%
Percent of infants born to HIV+ mothers, who are not infected by 24 months (MTCT)	Cohort data (health facility registries)	98.63%
Number of medical male circumcision performed according to national standards.	HMIS, July 2021 – June 2022	22,562 (7.1%)
Surgical circumcision	HMIS, July 2021 – June 2022	297,091 (92.9%)
Medical circumcision	HMIS, July 2021 – June 2022	22,562 (7.1%)
Prevalence of male circumcision (number of males circumcised on the total male population)	RPHIA, 2018 -19	39.9%
Number of female sex workers followed at health facility	HMIS, July 2021 – June 2022	33,720
Number of HIV negative female sex workers on PrEP	HMIS, July 2021 – June 2022	10,372
Percent of adults and children retained on treatment 12 months after ART initiation	Cohort data (health facility registries)	94.58%
Percent of adults and children currently receiving ARVs (ART coverage)	HMIS, July 2021 – June 2022 and EPP spectrum, 2021	214,074 (94%)
Percent of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml)	Facility registries review, July 2021 – June 2022	97.7%

Number of new patients initiating ART	HMIS, July 2021 – June 2022	10,398
Number of condoms distributed		32,592,675
Number of people aged 15 years and above have been screened for HCV	HMIS, July 2021 – June 2022	1,924,901
Number of people with HCV RNA positive	HMIS, July 2021 – June 2022	28,243
Number of people-initiated HCV treatment	HMIS, July 2021 – June 2022	5,196
Number of people vaccinated against HBV	HMIS, July 2021 – June 2022	144,094
Number of People screened for HBV	HMIS, July 2021 – June 2022	882,243
Number of people screened for HBV positive	HMIS, July 2021 – June 2022	13,655
Number of people screened for STIs	HMIS, July 2021 – June 2022	5,177,507
Number of people confirmed with at least one STI.	HMIS, July 2021 – June 2022	217,455 (4.2%)

