Republic of Rwanda

REPUBLIC OF RWANDA

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Acknowledgements

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The civil society umbrellas have played a remarkable role to ensure the views expressed in this report are representative of the views of civil society and PLHIV. We also thank the several human rights organizations for their inputs. We assure all civil society groups that the government values their continued support of the HIV response in the country, and that their views are critical components in charting the way forward.

We would also like to acknowledge the work done by various Government ministries and departments – in particular the Ministry of Health, TRACPlus - Center for Treatment and Research on HIV/AIDS, Malaria, Tuberculosis and Other epidemics, the Ministry of Education, CAMERWA, the National Blood Transfusion Centre, the National Institute of Statistics, the Ministry of Gender and Family Promotion, the CDLS and other key government authorities – to provide us with the information required for this report in a timely fashion.

We appreciate the efforts of our development partners and programs that have participated in the collection and validation of the information in this report, including the United Nations agencies, the United States Agency for International Development/ the President's Emergency Plan for AIDS Relief, the Global Fund to fight AIDS, Tuberculosis and Malaria, and Population Services International.

Finally, we would like to thank the Joint United Nations Programme on HIV and AIDS (UNAIDS) for the technical and financial assistance provided in the development of this Report.

This is the fifth progress report of the UNGASS commitments to fight HIV/AIDS in Rwanda. Since the last report, we have continued our progress in areas identified as successes, while addressing the challenges identified in 2007 and achieving significant results in new dimensions. Our sustained and coordinated efforts and the support of partners in Rwanda should place us firmly on the path of meeting UNGASS targets.

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List of acronyms

ADB	African Development Bank
AESD	Action of Evangelical Churches for the Promotion of Health and Development
AIDS	Acquired Immunodeficiency Syndrome (Syndrome d'Immunodéfience Acquise)
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behavioural Change Communication
BSS	Behavioural Surveillance Survey
CAMERWA	Central Purchasing of Essential Medicines in Rwanda
CDLS	District AIDS Control Committee (Comité de District de Lutte contre le SIDA)
CI	Confidence Interval
CLADHO	Collectif des Ligues et Associations de Defence des Droits de l'Homme
CNLS	National AIDS Control Commission (Commission Nationale de Lutte contre le Sida)
CNTS	National Blood Transfusion Centre (Centre National de Transfusion Sanguine)
CRIS	Country Response Information System
CSOs	Civil Society Organizations
CTS	Blood Transfusion Centre (Centre de Transfusion Sanguine)
DFID	Department for International Development (UK)
DOTS	Directly Observed Therapy Short-course
EABC	Education, Abstain, Be faithful, use a Condom
EDPRS	Economic Development and Poverty Reduction Strategy
FARG	Genocide Survivors Fund (Fonds des Rescapés du Génocide)
FAAS	Forum of Activists on AIDS Scourge
FBO	Faith-based Organization
FHI	Family Health International
GDP	Gross Domestic Product
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HSP	Health Sector Policy
HSSP	Health Sector Strategic Plan
HIV	Human Immunodeficiency Virus
IDUs	Injecting Drug Users
IEC	Information Education Communication
KAP	Knowledge, Attitudes and Practices
M&E	Monitoring and Evaluation
MAP	Multisectoral AIDS Project (World Bank)
MDGs	Millennium Development Goals
MIFOTRA	Ministry of Public Sector and Labour
MIGEPROF	Ministry of Gender and Family Promotion
MIJESPOC	Ministry of Youth, Sports and Culture
MINAFET	Ministry of Foreign Affairs
MINAGRI	Ministry of Agriculture, Animal Husbandry and Forestry
MINALOC	Ministry of Local Government, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MOE / MINEDUC	Ministry of Education
MOH / MINISANTE	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MTCT	Mother-to-child Transmission
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
NGO	Non-governmental Organization
NHA	National Health Accounts
NISR	National Institute of Statistics of Rwanda
NRL	National Reference Laboratory
NSP	National Strategic Plan
OIs	Opportunistic Infections
OOP	Out of Pocket
OVC	Orphans and other Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PM&E	Planning, Monitoring and Evaluation
PMTCT	Prevention of Mother-to-child Transmission
PNILT	Integrated National Program of Fight against Leprosy and Tuberculosis (Programme Nationale Intégré de la Lutte contre la Lèpre et la Tuberculose)
PSI	Population Services International
RDHS-II, III	Rwanda Demographic and Health Surveys II, III
RRP+	Network of Associations of People Living With HIV/AIDS (Le Réseau Rwandais des Personnes Vivant avec le VIH)
RwF	Rwandan Francs
STI	Sexually Transmitted Infections
SWAp	Health Sector-wide Approach
TB	Tuberculosis

TRACPlus	Center for Treatment and Research on HIV/AIDS, Malaria, Tuberculosis and Other epidemics
TRACNet	Information System for Monitoring HIV and AIDS medical component at TRAC
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollars
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

1 Status at a Glance

1.1 Report Preparation Process

At the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS in June 2001, Rwanda was one of 189 Member States that adopted the Declaration of Commitment on HIV and AIDS, a framework for halting and beginning to reverse the HIV epidemic by 2015. In order to monitor the progress in achieving the concrete, time-bound targets set out in the Declaration of Commitment on HIV and AIDS, countries report on a core set of indicators at the national level. This UNGASS report presents data for Rwanda for the reporting period of January 2008 through December 2009, identifies challenges that need to be addressed and suggests recommendations to ensure targets are achieved.

The National AIDS Control Commission (CNLS) was the leading institution for the development of this report. From the beginning, CNLS engaged all relevant partners from public and civil society sectors to gather relevant inputs and views.

Data for the National Composite Policy Index (NCPI) Questionnaire Part B were collected under the leadership of the Network of People Living with HIV (RPP+) and the NGO Forum on HIV/AIDS and health promotion. The NCPI Part B questionnaire was distributed to all the main NGOs working in the field of HIV, several human rights organisations, the HIV umbrellas civil society organisations, the UN agencies and other development partners/donors. Following preparatory consultation with different constituencies, more than 55 stakeholders met on 18th December 2009 at Sports View Hotel for a large consensus meeting on the answers to the questionnaire. In order to guarantee full independence in the information provided, the government of Rwanda did not participate in that meeting.

Figure 1: NCPI Part B - Consensus meeting

Figure 2: NCPI Part B - Consensus meeting

Part A of the NCPI Questionnaire was completed by CNLS staff, representatives from District AIDS Control Committees (CDLS), the Ministry of Health (MOH), the Treatment and AIDS Research Center (TRACPlus), the National Blood Transfusion Centre (CNTS) and the EDPRS Sectors.

Under the leadership of CNLS and MOH, a national consultant and 15 data collectors were contracted and trained to conduct the National AIDS Spending Assessment (NASA) for the years 2007 and 2008. AIDS expenditure data was collected from all major HIV donors and implementers in the country. The NASA exercise was harmonised with the National Health Accounts (NHA) methodology.

Data collection for UNGASS indicators 3 to 25 was carried out by the CNLS and the Joint United Nations Programme on HIV and AIDS (UNAIDS) in collaboration with major actors in all HIV response areas in the country and with reference to key national documents such as the Joint National review (2005-2009) and the new National Strategic Plan for HIV 2009-12.

A large participatory workshop to validate the report prior to its approval by national authorities took place on 24th March 2010 at Laico Hotel in Kigali.

1.2 Status of the Epidemic

HIV prevalence in the general population aged 15 – 49 in Rwanda is 3%. HIV prevalence in urban areas (7.3%) is much higher than in rural areas (2.2%); and HIV prevalence in women (3.6%) significantly higher than in men (2.3%) [*Source: RDHS (2005)*]. The RDHS 2010 is ongoing at the time of this report.

During the most recent sentinel surveillance survey (ANC, 2007) HIV prevalence in pregnant women was 4.3%. The percentage of young pregnant women who are HIV infected remains very high, particularly for the 15-19 age group in Kigali. Although there has been an overall decrease since 2003 (5.2% HIV prevalence), the estimate for ANC 2007 was higher than that for ANC 2005 (4.3% compared to 4.1%), showing no improvement in the situation in recent years.

There is low HIV prevalence among young people aged 15-24 compared to the general population. However, young women are far more often infected than men by HIV: respectively 3.9% versus 1.1% in urban areas and 1% versus 0.3% in rural areas.

Behavioural studies show a mixed picture, with different sources showing very different results in terms of reported knowledge, condom use, and partner exchange rates. Regional variations are observed in data, related to both prevalence and risk behaviour.

Most at risk populations for HIV infections are HIV sero-discordant couples (2.2% of heterosexual couples are HIV positive); commercial sex workers (although the extent of the commercial sex industry remains difficult to characterize in Rwanda); prisoners; truck drivers; men who have sex with men (MSM), for which a first behavioural study was carried out in Kigali in 2008-2009 suggesting that MSM in Kigali are at elevated risk for HIV infection compared to the general population. There is not information currently available for Injecting drug users.

1.3 Policy and Programmatic Response

The NCPI Questionnaires Parts A and B were used to collect information on policy and strategy development and implementation over the past two years. The full questionnaires are annexed to this report.

Government respondents completed Part A of the questionnaire, which covers strategic planning, political support, prevention, treatment, care and support, and monitoring and evaluation (M&E) issues. Strategic planning efforts were rated very highly for both 2008 and 2009. In fact, they resulted in the development of the evidence-based and result-based National Strategic Plan 2009-12, which was awarded funding by the Global Funds in the first wave of National strategies applications. The planning process was deemed to be well-organised, largely participatory, and useful to set country priorities for stakeholders to align to. Political support was rated as excellent (10 out of 10). Efforts in treatment, care and support have significantly improved and were rated highly (10 out of 10). HIV prevention area has seen marked improvement though some challenges were identified (rated as 9 out of 10) to ensure continuity and geographic coverage of a full prevention package for the general population, and in particular for most at risk populations. Components of the M&E system were reported as being well-developed and harmonized overall (score of 8 out of 10).

Civil society representatives, UN agencies and developing partners reached consensus regarding responses for Part B of the questionnaire covering human rights, civil society involvement, prevention, and treatment, care, and support. The overall rating of policies, laws, and regulations in place to promote and protect human rights in relation to HIV and AIDS on a scale of zero to ten was 8 for 2009. Understanding of HIV in relation to human rights issues has improved, with greater integration of HIV into overall programmes for human rights. Also, more organizations are advocating for the rights of PLHIV and other vulnerable people. Civil society participation was rated as excellent (9 out of 10) during this period. However, access to financial support for civil society was rated mildly (3 out of 5). Achievements in prevention and in treatment and care were reported as significant, as was the level of political support.

Limitations of the Report

Up to date data availability

The last Rwanda Demographic and Health Survey (RDHS) with an HIV module took place in 2005. A survey covering 2010 is ongoing at the time of the writing of this report. Therefore, for the indicators based on a population survey, namely indicators 7, 10, 12, 16, and 17 we were not able to fully assess the progress in 2008 and 2009. The same applies to indicators on most at risk populations, in particular sex workers, informed by the Behavioural Surveillance Survey of 2006 (BSS, 2006). A BSS survey covering 2009 is ongoing but only data for youth could be used in the development of this report.

Overall *rating* in the National Composite Policy Index Questionnaire

Stakeholders in Rwanda feel that some of the ratings in the National Composite Policy Index Tool are subjective and this makes it difficult to compare the ratings over the years and assess progress. For instance, when evaluating overall efforts in HIV prevention, the perspective of stakeholders in 2010 was informed by a deeper understanding of the HIV epidemic in Rwanda and therefore different than the perspective of the evaluation in 2008. The rating over the two years is constant not because the HIV prevention efforts in the country are stagnant but because participants to the consensus meeting had higher and clearer expectations on how the response on HIV prevention should be based on outcomes awaited.

1.4 Overview of UNGASS Indicator Data

Table 1: Overview of UNGASS Indicator Data

	2006 Report			2008 Report		2010 Report		
Core Indicators	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Sources**
National Commitment and Action								
1. Domestic and international AIDS spending by categories and financing sources	USD 7.7 million	USD 40.3 million	USD 78.5 million	USD 87.6 million	USD 74.6 million	USD 110.8 million	-	NASA and NHA
2. National Composite Policy Index	See Annex 2006 UNGASS Report			See Annex 2008 UNGASS Report		See Annex 2010 UNGASS Report		Participatory consensus meetings
National Programmes								
3. Percentage of donated blood units screened for HIV in a quality assured manner	-	29,000	100%	38,539/ 38,539 =100%	32,543/32,543 =100%	35,495/35,495 =100%	40,567/40,567 =100% Target 100% (NSP 2009-2012)	National Centre for Blood transfusion
4. Percentage of adults and children (0-14) with advanced HIV infection receiving antiretroviral therapy	4,189 patients	8,355 patients	19,058 patients	Adult Men 11,302 Adult women 20,077 Children 2,757 Total 34,136	Adult Men 15,827 Adult women 27,892 Male Children 2,153 Female Children 2,197 Total 48,069	Adult Men 21,254 Adult women 36,260 Coverage: 57,514/87,400= 66% Male Children 2,804 Female children 2,831 Coverage: 5,635/10,600= 53% Total (all) 63,149	Adult Men 26,431 Adult women 43,616 Coverage: 70,047/91,400= 77% Male Children 3,364 Female children 3,315 Coverage: 6,679/13,500= 49% Total (all) 76,726 Target coverage 90% (CD4 less than 200, NSP 2009-2012)	Numerator: TRAC Denominator: EPP/Spectrum estimates, 2010

5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	-	-	5,762 women	7,082 women	7,241	N: 6,387 D: 10,400 Coverage= 61%	N: 7,030 D: 10,300 Coverage = 68 % Target 90% (NSP 2009-2012)	Numerator: TRAC Denominator: EPP/Spectrum Estimates, 2010
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	-	-	-	Numerator: 2,201 Denominator: 15,000 (12,000-20,000) = 14.7 %	Numerator: 1,036 Denominator: 14,000 (11,000 – 18,000) = 7,4 %	Numerator: 1,148 Denominator: 13,000 (9,600 – 17,000) = 8,83 %	Numerator: 1,558	Numerator: TRACPlus Denominator (estimated number of incident TB all types in HIV+): WHO, www.who.int/tb/country/en
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results				RDHS 2005 Male: 3.6% (15-19); 13.6% (20-24); 13.4% (25-49); 11% (15-49) Female: 4.8% (15-19); 16.6% (20-24); 12.5% (25-49); 11.6% (15-49) All: 11.4% Target for 2012 (NSP 2009-12): 35%				RDHS 2005
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	BSS 2000 Sex Workers: 35.9% Truck Drivers: 26.8%			BSS 2006 Sex Workers: 65.3% Truck Drivers: 55.6%			MSM 46.6% In Kigali (snowball, non representative sample)	BSS 2000, 2006 Definition used: "Have undergone an HIV test and received the results" (ever instead of in last 12 months)
9. Percentage of most-at-risk populations reached with HIV prevention programmes				-				
10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child	-			0-17: 12.6% at least one type of support 0.2%: all of the types of support Target for 2012 (NSP 2009-12): 30% at least one type of support, 10% all types				RDHS 2005
11. Percentage of schools that provided life skills-based HIV education in the last academic year	-			-	-	98% of secondary schools	-	Ministry of Education/ Routine data
Knowledge and Behaviour								
12. Current school attendance among orphans and among non-orphans aged 10–14	RDHS 2000 Ratio orphans to non orphans: Male: 0.91; Female: 0.94			RDHS 2005 Orphans: Male: 70.1%; Female:78.8%; All: 74.6 Non-orphans: Male: 90.4%; Female: 91.5%; All: 91 Target for 2012 (NSP 2009-12): more than 90% for boys and girls				RDHS 2000, 2005

13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	BSS 2000 Male: 9.7% (15-19) Female: 9.1% (15-19) All: 9.3% (15-19) RDHS 2000 Male: 15.9% (15-19); 27.3% (20-24); 20% (15-24) Female: 19.3% (15-19); 29.1% (20-24); 23.4% (15-24) All: 23% (15-24)	BSS 2006 Male: 16.8% (15-19) Female: 12.9% (15-19) All: 14.8% (15-19) RDHS 2005 Male: 49% (15-19); 59% (20-24); 53.6% (15-24) Female: 45.3% (15-19); 57.1% (20-24); 50.9% (15-24) All: 51.7%(15-24) Target for 2012 (NSP 2009-12): All 70% (15-24)	BSS 2009 Male: 11% (15-19); 13% (20-24); 11.8% (15-24) Female: 9.4% (15-19);11.7% (20-24); 10.3% (15-24) All: 10.2% (15-19); 12.4% (20-24); 11.1% (15-24)	BSS 2000, 2006, 2009 RDHS 2000, 2005
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	BSS 2000 Sex Workers: 26.8% Truck Drivers: 32.0%	BSS 2006 Sex Workers: 36.2% Truck Drivers: 39.1%		BSS 2000, 2006
15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	BSS 2000 Male: 17.5% (15-19) Female: 6.6% (15-19) All: 12.4% (15-19) RDHS 2000 Female: 3% (15-19); 3.8% (20-24); 3.3% All Male: 9.3% (15-19); 7% (20-24); 8.5% All All: 4.4% (15-24)	BSS 2006 Male: 16% (15-19) Female: 7% (15-19) All:11.2% (15-19) RDHS 2005 Female: 5.2% (15-19); 2.6% (20-24); 3.9% All Male: 15.3% (15-19); 10.8% (20-24); 13.2% All All: 6.6% (15-24)	BSS 2009 Male: 14.7% (15-19); 10.5% (20-24); 13.1% (15-24) Female: 6.1% (15-19); 10.2% (20-24); 5.1% (15-24) All: 10.2% (15-19); 7.1% (20-24); 9% (15-24)	BSS 2000, 2006, 2009 RDHS 2000, 2005
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	-	Female: 0.1% (15-19); 0.4% (20-24); 0.4% (25-49); 0.3% (15-49) Male: 0.3% (15-19); 1.3% (20-24); 4.5% (25-49); 2.7% (15-49) All: 1% (15-49) Target for 2012 (NSP 2009-12): stabilize at less than 5%		RDHS 2005
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse		Female: 19% (15-49) Male: 25% (25-49); 25% (15-49) All: 24% (15-49) Target for 2012 (NSP 2009-12): 60% in women and 75% in men		RDHS 2005
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	BSS 2000 Sex workers (female): 81.8%	BSS 2006 Sex workers (female): 86.6%		BSS 2000, 2006

19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	-			-			50% last sex with boyfriend 51% last casual male partner	MSM Exploratory study in Kigali, 2009 (snowball sample)
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	-			-				
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	-			-				
Impact								
22. Percentage of young women and men aged 15–24 who are HIV infected	Sentinel Surveillance, 2002 4.8% (15-19); 4.5% (20-24) Sentinel Surveillance, 2003 5.2% (15-19); 4.3% (20-24)		Sentinel Surveillance 2005 Women : 3.7% (15-19); 3.5% (20-24)	RDHS 2005 Women: 0.6% (15-19); 2.5% (20-24); 1.5% (15-24) Men: 0.4% (15-19); 0.5% (20-24); 0.4% (15-24) All: 1% (15-24)	Sentinel Surveillance 2007 Women: 5.1% (15-19); 3.5% (20-24); 3.7% (15-24) Target for 2012 (NSP 2009-12): 0.5% in total pop. 15-24			Sentinel Surveillance Reports RDHS 2005
23. Percentage of most-at-risk populations who are HIV infected	-			-	No data available			
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		Numerator: 3,175 Denominator (sample): 3,482 Percentage: 91.1% Evaluation study covering 2004, 2005			On ARV > 12: 94%	94.5%	-	TRACPlus
25. Percentage of infants born to HIV-infected mothers who are infected	23.4%	10%	11.9%	11%	10.3%	6.9%	4.1% at 18 months of age	TRACPlus Routine data

2 Overview of the AIDS Epidemic

2.1 Context

Rwanda is a small, landlocked country in East Africa, bordered by Burundi, the Democratic Republic of Congo, Tanzania, and Uganda. The country is administratively divided into 5 provinces – Kigali, North, South, East and West – and 30 districts.

With an estimated population of over 9,200,000 and a population density of 351 persons/sq km, Rwanda is the most densely populated country in Africa. The urban population is estimated to be 21.8% and is growing.

The population is relatively young, with 43.5% of the entire population under 15 years old and 55.2% in the 15-49 year age bracket. The median age is 19 years and life expectancy at birth is 53.1 years. Rwanda has one of the highest fertility rates in sub-Saharan Africa, with 6.1 children per woman.

Rwanda's gross domestic product (GDP) per capita is US$ 272; 57% of the population lives below the national poverty line and 37% live in extreme poverty. In the most recent UNDP Human Development Report, Rwanda was ranked 161st out of 179 countries on the Human Development Index [*http://hdrstats.undp.org/countries/data_sheets/cty_ds_RWA.html*]. Although poverty levels remain high, Rwanda has made progress in stabilizing and rehabilitating its economy to pre-genocide (1994) levels. The Government is focused on increasing production and reducing poverty while creating an environment of good governance.

Vulnerable households (headed by women, widows and children) represented 43% of all households in 2006 (against 51% in 2001) and were concentrated in rural areas. Poverty among vulnerable households is around 60%, indicating that vulnerability remains a serious concern.

Recent years have seen progress on gender equality, as indicated by both girls' primary school enrolments and women's representation in parliament, where Rwanda has the highest proportion of female parliamentarians in the world (55%). However, much remains to be done. Much violence against women, such as rape and domestic assault, goes unreported and hence unpunished.

There are about 1,350,800 orphans and vulnerable children in Rwanda between the ages of 0 and 17. It is estimated that AIDS accounts for nearly a fifth of these [*Source: NSP 2009-12*].

2.2 HIV Prevalence in the General Population (*Ref. Indicator 22*)

The last population-based survey on HIV prevalence was the Rwanda Demographic and Health Survey 2005 (RDHS 2005). The RDHS 2010 is still ongoing at the time of this report. The survey found HIV prevalence of 3.0% (95% confidence interval: 2.6 - 3.5) in the general population aged 15 - 49. The total estimated number of people living with HIV in Rwanda was about 169,200 (146,100 -193,400) in 2009, including about 22,200 (11,100 – 34,200) children [*Source: EPP/Spectrum national estimates, 2010*].

HIV prevalence in urban areas (7.3%) is much higher than in rural areas (2.2%); and HIV prevalence in women (3.6%) significantly higher than in men (2.3%) [*Source: RDHS, 2005*].

HIV prevalence data are also sourced from sentinel surveillance of pregnant women attending antenatal clinics (ANC). During the most recent survey (2007), HIV prevalence in pregnant women was 4.3% (95% confidence interval: 3.8 - 4.5). Like the DHS data, the ANC data show significantly higher HIV prevalence in urban sites than in rural sites (Figure 3). The percentage of young pregnant women who are HIV infected remains very high, particularly for the 15-19 age group in Kigali. As per ANC 2007, overall HIV prevalence for young pregnant women aged 15-24 is 3.7% (5.1% for women 15-19 years old and 3.5% for women 20-24 years old). Both the DHS 2005 and the ANC 2007 data show regional variation in HIV prevalence.

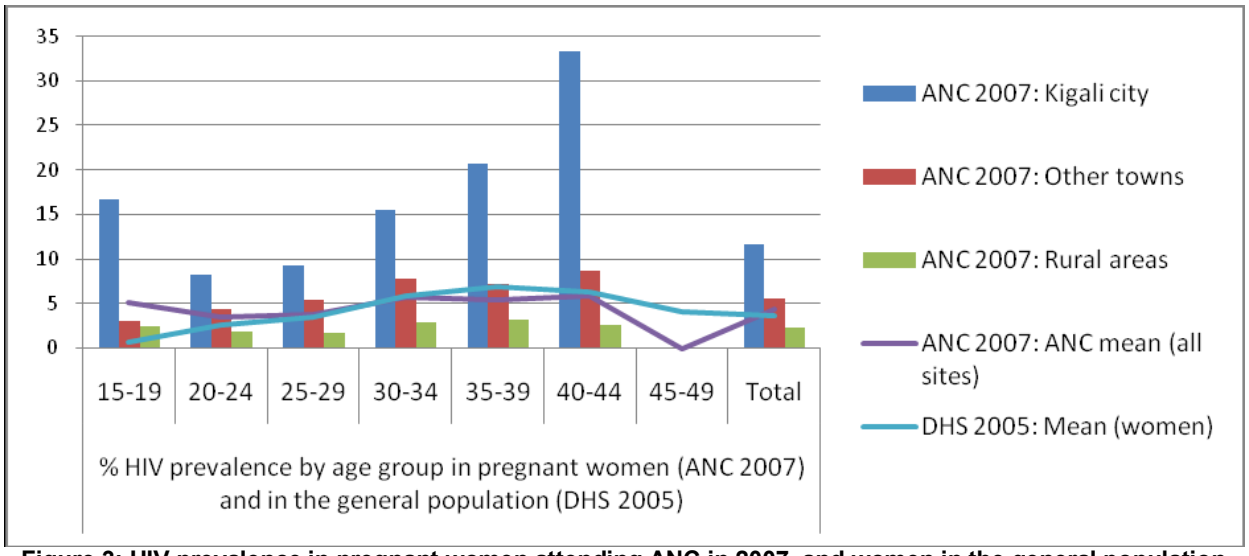

Figure 3: HIV prevalence in pregnant women attending ANC in 2007, and women in the general population 2005, by age group [TRACPlus, DHS 2005]

HIV prevalence surveillance in antenatal clinics has been carried out since 1988, providing some indication of trends over time. Although there has been an overall decrease since 2003 (5.2% HIV prevalence), the estimate for 2007 was higher than that for 2005 (4.3% compared to 4.1%), showing no improvement in the situation in recent years.

There is low HIV prevalence among young people aged 15-24 compared to the general population. However, young women are far more often infected than men by HIV: respectively 3.9% versus 1.1% in urban areas and 1% versus 0.3% in rural areas. The differences in HIV prevalence between men and women aged 20-24 are particularly striking. While in the 15-19

age group they are nearly equal (0.4% for men and 0.6% for women), in the 20-24 age group HIV prevalence is five times higher for women than for men (0.5% for men and 2.5% for women). These figures suggest that women in the age group 20-24 are particularly at risk for HIV infection, most likely becoming infected in the context of relationships with older men. In general, women become infected at younger ages than men [*Source: RDHS, 2005*]

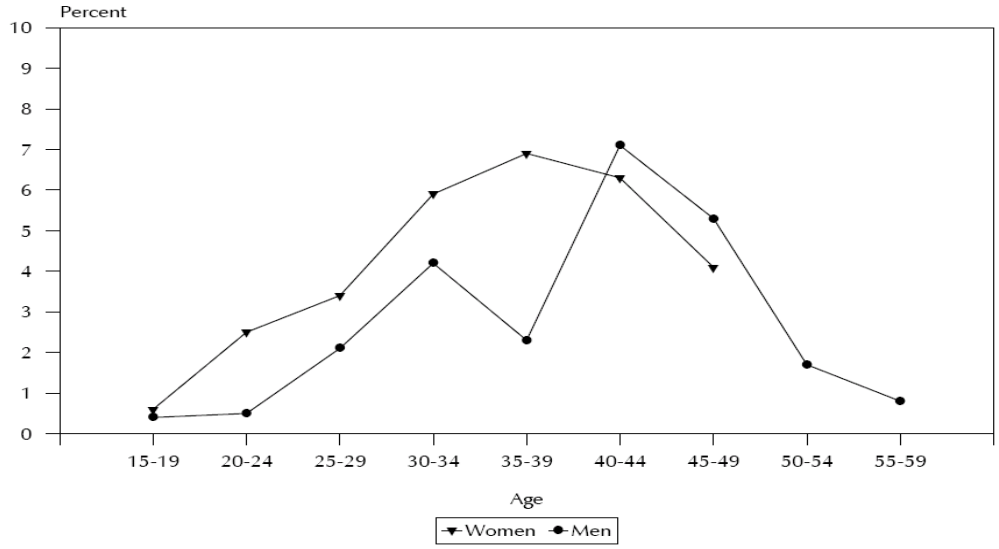

Figure 4: HIV Prevalence by Age and Sex (RDHS 2005)

As per the EDPRS 2009-12 and the NSP 2009-12 targets, the HIV prevalence among young people aged 15-24 should decrease to 0.5% by 2012. This indicator is taken as a proxy measure for a target decrease in HIV incidence.

Behavioral studies show a mixed picture, with different sources showing very different results in terms of reported knowledge, condom use, and partner exchange rates. Young people in general cannot be considered a risk group, but many incident infections occur in this age group. Some specific subgroups of young people are clearly at higher risk and should be priority targets for HIV prevention efforts.

2.2.1 Regional variation

Regional variations were observed in data, related to both prevalence and risk behavior.

Urban sites outside Kigali show an apparent rise in HIV prevalence between 2005 and 2007.

Kigali Province, which has by far the highest levels of HIV prevalence, also has high levels of risk behavior. It is also estimated that 7.6% of stable heterosexual couples in Kigali are sero-discordant, a much higher proportion than the national average.

The prevalence of HIV in ANC sites in East Province is stable or declining. However, it is unclear why; hypotheses include that isolation and low urbanization may be contributing to the maintenance of lower levels of HIV infection.

Overall, North Province has relatively low HIV prevalence, but in most ANC sites it is increasing. Rapid urbanization in this province may explain increasing HIV prevalence.

South Province has low overall HIV prevalence, though once again the ANC study indicates recent increases. The data suggest that the presence of the University of Butare in the province, as well as the existence of transport routes, seasonal workers and commercial centers, may be the key factors contributing to the epidemic in the province.

The West province has the highest HIV prevalence outside of Kigali, with even the rural ANC locations showing higher HIV prevalence than the national average. The epidemic in this province is probably more mature and less concentrated than elsewhere. The greater economic opportunity for males resulting from the presence of tea plantations and commerce around the lake could be a risk factor contributing to a higher prevalence in this province.

[*Source: the Data Synthesis (or Triangulation) project, 2008, TRACPlus*]

2.3 HIV in Most-at-risk Populations *(Ref. indicator 23)*

HIV sero-discordant couples

In Rwanda, 2.2% of heterosexual couples are HIV sero-discordant (around 60,000 couples), putting the HIV-negative members of these discordant couples at high risk for HIV infection. According to the ANC data from 2007, HIV prevalence is much lower for married women (2.5%) than for separated (14.6%), widowed (9.7%), single (6.8%), divorced (6.4%), and cohabiting (5.9%) women. The pattern for women in the DHS survey is similar, although in the case of that survey HIV prevalence was higher among widows than separated or divorced women. [*Source: The Data Synthesis (or Triangulation) project, TRACPlus (2008)*]

Commercial sex workers

The extent and magnitude of the commercial sex industry remains difficult to characterize in Rwanda. In 2009, BSS covered HIV prevalence among this population for the first time and carried out a sex works mapping that identified a minimum of 5,000 commercial sex workers in the country. Unfortunately, data are under analysis at the time of writing of this report. There are thus no recent representative studies of HIV prevalence in sex workers in Rwanda. The data that are available were obtained from the records of HIV testing facilities and confirm that sex workers are at higher risk of HIV than other subgroups by some order of magnitude (19.2% in mobile VCT by PSI in 2007 and 16.4% in 2008). [*Source: Mapping of HIV prevention, care and treatment with sex workers, CNLS (November 2009)*]

Prisoners

While HIV prevalence in prisons does not appear to be significantly higher than outside, there is evidence of sexual activity within prisons, where condoms are unavailable. [*Source: The Data Synthesis (or Triangulation) project, TRACPlus (2008)*]

Truck drivers

HIV prevalence among truck drivers appears to be higher than in the general population, but reported risk behaviors are not particularly high. Though truckers are highly mobile, they only

constitute a small population. [*Source: The Data Synthesis (or Triangulation) project, TRACPlus (2008)*]

Men who have sex with men (MSM)

The first behavioral study of MSM was carried out in Kigali in 2008-2009, using a snowball (non representative) sample. 98 MSM aged 18 to 52 years participated in the study. Key results include:

- Men reported an average of two male sexual partners in the 12 months prior to survey.
- 37 respondents reported casual sex in the one month prior to survey and 18 of these men reported unprotected sex with a casual sex partner in this timeframe.
- MSM have wide sexual networks. One-quarter of respondents reported sex with a woman in the year prior to survey.
- A high proportion of MSM in Kigali may engage in commercial and/or transactional sex: one in ten respondents reported exchanging sex for money in the year prior to survey.
- 27 respondents reported experiencing at least one STI symptom previously and 13 respondents reported a prior STI diagnosis.

The results of this exploratory study suggest MSM in Kigali are at elevated risk for HIV infection compared to the general population, and require specific HIV/STI prevention services/support. Data on HIV prevalence among this population are not available so far.

Injecting drug users

Injecting drug use (IDU) appears to be rare in Rwanda, but a comprehensive study of injecting drug use is yet to be conducted. Action of Evangelical Churches for the Promotion of Health and Development (AESD) released a project report indicating that though youth are using drugs that impair their judgment and put them at greater risk for contracting HIV, no person has yet indicated that they have engaged in injecting drug use.

Refugees

Refugees stand out as subpopulations moving toward reduction of HIV transmission, with much emphasis on prevention programs in the past years. Refugee camps have been shown to be protective for women in Rwanda in terms of abstinence, low levels of high-risk sex, and condom use with high-risk sex. The camps have relatively high programmatic coverage of VCT and PMTCT services. Refugees do not appear to be driving the HIV epidemic in Rwanda. This group should be studied further as a possible source of lessons learned for other at-risk groups. [*Source: The Data Synthesis (or Triangulation) project, TRACPlus (2008)*]

3 National Response to the AIDS Epidemic

3.1 National Commitment

3.1.1 HIV and AIDS Expenditure *(Ref. Indicator 1)*

National AIDS Spending Assessment (NASA) - Overall methodology

National AIDS Spending Assessment (NASA) is a comprehensive and systematic resource tracking method used to measure the flow of resources in the national response to HIV and AIDS. The main objective of resource tracking at the country level is to determine what is actually disbursed or spent. The process follows funds from the origin (financing source) down to the beneficiaries who actually receive goods and services. At the same time, it offers an understanding of the current levels of spending across categories/programme areas.

NASA methodology addresses the following questions:

- who finances the AIDS response?
- who manages the funds?
- who provides the goods and services?
- which intervention was provided?
- who benefits from the funds?
- what was brought to realize the intervention?

To this end, the funds are tracked from the financing source – public, private or foreign – through the different providers to the ultimate beneficiaries (target groups). NASA captures both health and non-health spending related to HIV and AIDS.

In order to measure the actual spending, NASA uses both top-down and bottom-up techniques for obtaining and consolidating information. To avoid double counting of the transactions, the NASA process uses a specific software called RTS that facilitates data entry and reconstruction of resources flows at every transaction point as opposed to adding up the expenditure of every agent that commits and expends resources towards HIV and AIDS intervention. [Source: *NASA Classification and Definitions, UNAIDS (2007)*]

Table 2 below shows the key concepts and definitions used as per standard NASA methodology.

Table 2: NASA concepts and definitions [*Source: NASA Classification and Definitions, UNAIDS (2007)*]

Financing	
Financing sources (FS)	Entities that provide resources to financing agents.
Financing agents (FA)	Entities that pool financial resources to finance service provision programmes and also make programmatic decisions (purchaser-agent).
Provision of HIV services	
Providers (PS)	Entities that engage in the production, provision, and delivery of HIV services.
Production factors (PF)	Resources used for the production of ASC.
Use	
AIDS spending categories (ASC)	HIV-related interventions and activities.
Beneficiary segments of the population (BP)	Populations intended to benefit from specific activities.

NASA Process in Rwanda

The process used in Rwanda strives to harmonize NASA and NHA resource tracking frameworks. The CNLS in collaboration with UNAIDS and NHA team led by the Ministry of Health developed an harmonized questionnaire that was administrated to all major HIV and AIDS stakeholders. With financial and technical support by UNAIDS, fifteen data researchers were trained in data collection techniques and a national consultant recruited to lead the process. A NASA workshop to launch the inception report took place at CNLS headquarters with participation of all relevant HIV stakeholders. The survey was conducted in 2009 and covered expenditure data for 2007 and 2008.

Sources of data and data collection

A questionnaire was designed with the following components: origin of funds, destinations of funds and use of funds against AIDS spending categories and beneficiary population. Survey respondents were actors involved in the response to HIV in Rwanda. They were categorized according to the NASA definitions into Financing Sources, Agents and Service Providers.

The survey was administered to all financing sources: Government of Rwanda that channels funds through the Ministry of Finance and Economic Planning, donors, UN agencies, bilateral agencies, the GFATM, the African Development Bank (ADB), and USG.

Other public institutions that were administered the questionnaire (as financing agents) include line ministries (Ministry of Health, Ministry of Education, Ministry of Internal Affairs) and public institutions (CNLS, TRACPlus, National Blood Transfusion Centre and School of Public Health). Additional financing agents in the survey were non-governmental organizations, faith based organizations and community based organizations. Expenditure data from hospitals and health centers was captured at financing agent level (what the hospitals and health centers reported back at financing agent level as amount spent). A detailed list is available on the full NASA report.

A questionnaire in three parts was administrated to financing sources and financing agents. The response rate was as follows: 22 out of 25 financing sources and 55 out of 79 financing agents. All of the 24 financing agents that did not respond were USG partners, 9 of them based outside Rwanda. 43 of the financing agents indicated that they also played a role of service providers. Overall, the response rate was 74%.

Primary data accounted for more than 80% of the data processed. In a minority of cases, secondary data were also consulted. For example, the project evaluation report for the CNLS/ADB project was used because the project was already closed at the time of the survey and it was not possible to administer the questionnaire.

Data processing and analysis

The expenditure data collected was first captured into data processing Excel spreadsheets for cleaning, calculations and estimations. At this level, data were verified and in instances were data did not balance, a second round of field data verification was carried out. Finally, data in the spreadsheets were transferred to the NASA Resource Tracking Software (RTS). The NASA RTS outputs were exported to Excel software to produce summary tables, and graphs for analysis.

Survey Limitations and Assumptions

Differing financial years

Some organizations use differing financial calendars than the government (January to December for 2007 and 2008). In these cases, we took expenditures incurred in the calendar period corresponding to the government fiscal year.

Pooled funds

In some cases, the data indicated the sources of the pooled funds and their contributions, but it was not possible to link each source to specific activities. For instance, a hospital might have received funds from USG and GF and spent these funds on PMTCT and VCT, but it is not able to report on how much of the spending on PMTC or VCT was from GF or from USG since it pooled funds at its level. In such situations, we assumed proportional distribution to the identified activities based on each source's proportional contribution to the total pool of funds for the institution.

Genocide Survivors' Fund (FARG)

The fund was created to support victims of genocide and its consequences, such as OVC. In coherence with assumptions used for previous years (NASA 2005 and 2006), an estimated 20% was applied to the amount spent for the overall OVC in areas of school fees and basic health care to extract funding for OVC specifically related to HIV.

USG Expenditure data

The United States Government declared to have transferred funds to 58 partner institutions/projects. However, six institutions that executed in 2007 did not receive the questionnaire since they only received funds in 2006. One institution covering two projects only filled the questionnaire for one project. Overall, 51 institutions/projects received the NASA questionnaire. Only 27 institutions (out of 51) did reply to the questionnaire. The amount for which expenditures could not be confirmed for USG partners was approximately declarations from USG of: (i) US$ 23.5 million in 2006 (part of which may have been spent in 2007); (ii) US$ 13.2 million in 2007 (13% of the resources allocated in 2007) and (iii) US$ 21.4 million in 2008 (17% of the resources allocated in 2008). We therefore conclude that due to gaps in data reporting from USG partners, the total financial support of USG to Rwanda might be underestimated.

The private sector, corporations and out-of-pocket expenditures

The NASA survey did not collect data from the private sector and corporations and out-of-pocket/households, while NHA/NASA methodology in 2006 captured these expenditures. Therefore, the survey results underestimate the total expenditures for 2007 and 2008 compared to 2006.

Sources of funding for 2007 and 2008

The financing of the HIV and AIDS response in Rwanda is mainly through international partners and the government. International partners are the Global Fund, the United States Government (USG) through PEPFAR, bilateral agencies, UN agencies, the ADB and other donors.

Table 3 below shows the spending per type of source over 2007 and 2008. For comparative purposes, data for 2006 are also provided. Please refer to the 2008 UNGASS report for detailed methodology used for 2006.

Table 3: Sources of Financing for HIV and AIDS in Rwanda for the period 2006 - 2008
National Bank of Rwanda: Average Exchange rate 2006: 1$= 551.74 RwF, 2007: 1$=544 RwF, 2008: 1$=547 RwF

	2006		2007		2008	
Financing Source	US$	%	US$	%	US$	%
USG	28,844,816	32	43,210,466	58	59,529,512	54
Global Fund	13,004,277	15	11,235,324	15	26,924,796	24
Others (bilaterals, foundations...)	22,706,639	25	7,988,037	11	12,317,152	11
GOR	4,397,311	5	6,081,417	8	6,133,292	6
UN agencies	2,196,519	2	3,215,993	4	2,718,463	2
ADB	867,751	1	1,847,896	2	2,821,479	3
MAP/World Bank	11,577,224	13	985,805	1	366,902	0
Out-of-pocket	3,541,185	4	NA		NA	
All other private	392,037	0	NA		NA	
Corporations	45,773	0	NA		NA	
	87,573,532	**100%**	**74, 564,938**	**100%**	**110,811,596**	**100%**

Total expenditure on HIV and AIDS in Rwanda increased from USD 74.6 million in 2007 to USD 110.8 million in 2008 (an increase of about 33%). The decrease in spending in 2007 relative to 2006 can be explained by the fact that MAP/World Bank completed its activities in the country. Some bilaterals, such as Medecins Sans Frontieres and TROCARE, left the country, while others, such as the Clinton Foundation, decreased their contribution in 2007. More analysis is still going on at the time of submission of this report to clarify the reasons for this decrease.

The main financial contributor to HIV response was USG, which contributed 58% and 54% of the overall total in 2007 and 2008 respectively. Global Fund was the second largest contributor and its share increased from 15% in 2007 to 24% in 2008. The increase in the GF contribution was due to:

- delays in procurement processes in 2007 for the construction of VCT, ARV sites and equipment causing allocation of funds to 2008 instead;
- doubling of funds in 2008 to purchase ARV drugs;
- an increase in remuneration for GF staff in hospitals and health centres.

The government of Rwanda ranks as the third largest single contributor in terms of financing HIV and AIDS interventions (after the group of bilaterals). The share of the total expenditure

contributed by the Rwandan government was 8% in 2007 and 6% in 2008, but the amount spent in absolute terms was approximately the same in both years. Public funds are spent in two main areas: first, to support OVC education and basic health care; and second, support of public institutions mandated to plan and coordinate the epidemic, such as CNLS, TRAC and CNTS.

AIDS spending categories in 2007 and 2008

This section presents a breakdown with respect to AIDS spending categories in 2006, 2007 and 2008 and the relative weight of each.

Table 4: Breakdown by AIDS Spending Categories in Rwanda for the period 2006 - 2008

Spending category	2006 (in US$)	2007 (in US$)	2008 (in US$)	% variation from 2007 to 2008
Prevention programmes	20,878,368	17,115,251	29,308,085	+42%
Care and treatment component	27,142,088	27,793,912	44,670,057	+38%
Programme management and administration strengthening	25,828,454	10,790,812	13,272,550	+19%
Incentives for human resources	416,132	5,839,282	4,915,545	-19%
Social protection and social services excluding OVC	5,634,419	579,841	1,283,576	+55%
Orphans and vulnerable children	7,033,937	9,358,637	12,850,247	+27%
Enabling environment and community development	196,058	2,310,109	2,868,683	+19%
HIV and AIDS related research	485,344	777,094	1,642,853	+53%
Total	**87,573,532**	**74,564,938**	**110,811,596**	+33%

National Bank of Rwanda: Average Exchange rate 2006: 1$= 551.74 RwF, 2007: 1$=544 RwF, 2008: 1$=547 RwF

HIV prevention programs expenditure increased from US$ 17 million in 2007 to US$ 29 million in 2008. This increment shows the renewed commitment of the government of Rwanda and its partners to reduce the number of new HIV infections. For instance, over the two years there was an expansion of PMTCT services (about 75% of women attending ANC were tested for HIV in 2008); 1,000,000 HIV tests were performed in VCT sites; and IEC and BCC campaigns were increased. Moreover, part of the funds planned to be spent for the construction of VCT and ARVs in 2007 were spent in 2008 instead as a result of delays in procurement.

Expenditures on care and treatment rose from US$ 27 million in 2007 to 44 US$ million in 2008. Data analysis indicated that the largest portion of the funds was directed towards to hospital care, ARVs and nutritional support associated to ARV therapy. This increase in care and treatment spending is evident by the increased number of patients on ARV: from 34,136 in 2006 to 48,069 in 2007 and 63,149 in 2008. Further analysis is ongoing to determine the reasons for the unexpected small increase in expenditure in this category from 2006 to 2007.

The management and administrative cost of HIV and AIDS programs increased by 18% in 2008 compared to 2007. USG contributed approximately US$ 5 million in 2007 and US$ 6 million in

2008 for this component. The government of Rwanda was the second largest contributor and the funds were spent by public institutions to plan and coordinate for the epidemic. Our hypothesis for the large decrease from 2006 to 2007 was increased efficiency of programs and the efforts of the government to cut overhead costs.

Incentives for human resources were largely introduced in 2007 and there was a slight decrease from US$ 5.8 million in 2007 to US$ 4.9 million in 2008. This category is comprised of monetary incentives for physicians, nurses, formative education and training. The amount targeted at health care workers decreased from US$ 3 million in 2007 to US$ 2.9 million in 2008, which includes monetary incentives, training and use of safe medical equipments.

According to the findings, there has been an increase in social protection interventions excluding OVC from US$ 0.52 million in 2007 to US$ 1.2 million in 2008. The main contributors were USG and ADB. This increase is attributed to funding for HIV institutional development and income generating activities targeting population living with HIV.

OVC Funding rose from US$ 9.3 million in 2007 to US$ 12.8 million in 2008. USG was the largest contributor and the funds were channelled through CHAMP. The Government of Rwanda funding for OVC remained almost stable from 2007 to 2008. An estimated proportion of 20% (same proportion as in 2006) of the Genocide Survivors' Funds for overall OVC education and health basic care was considered to cater specifically for OVCs who are affected by HIV and AIDS. Other contributors to OVC interventions were UN agencies.

There was an increase of funds for HIV and AIDS-related research (excluding operation research) from about US$ 0.80 million to US$ 1.6 million. More and more HIV research-related activities are conducted under the coordination of TRACPlus and CNLS to provide data and information for planning.

Figure 5 below shows the percentage share across AIDS Spending Categories for 2008. We observe that in 2008 care and treatment consumed the largest share of HIV and AIDS funds (40%), which is attributed to the high number of patients receiving ARVs and associated support. This was followed by the prevention component consuming 26% of the total funds. OVC and Programme management and administration components accounted for 12%. The least funded components are HIV and AIDS-related research (2%) and social protection excluding OVC (1%). The distribution pattern for 2007 was similar to 2008.

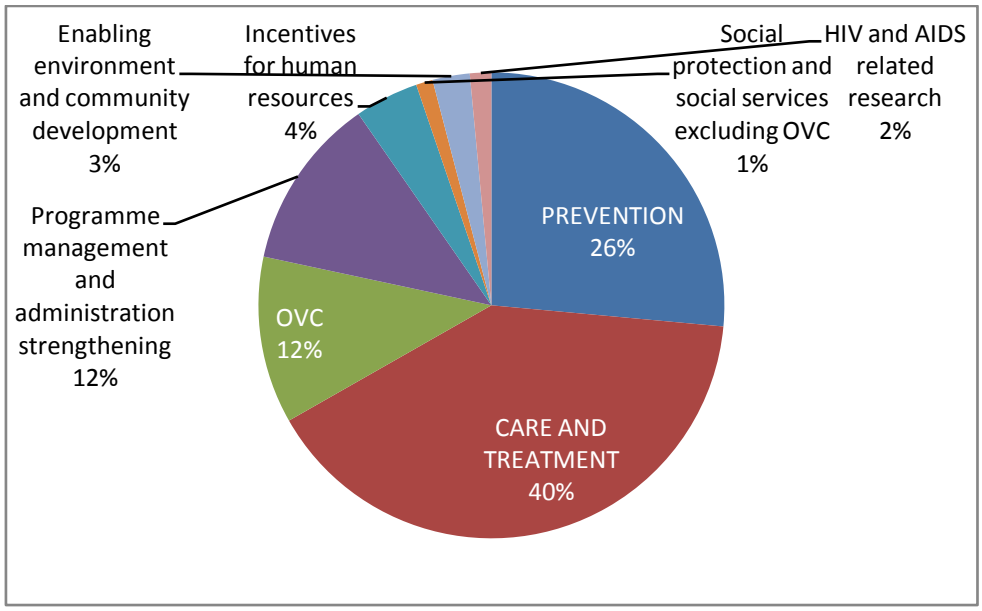

Figure 5: Financing by spending categories (Proper and clear labelling)

Figure 6 below plots expenditure by spending categories in 2008, highlighting the percentage contributions by financing source. Again, the pattern for 2007 is very similar.

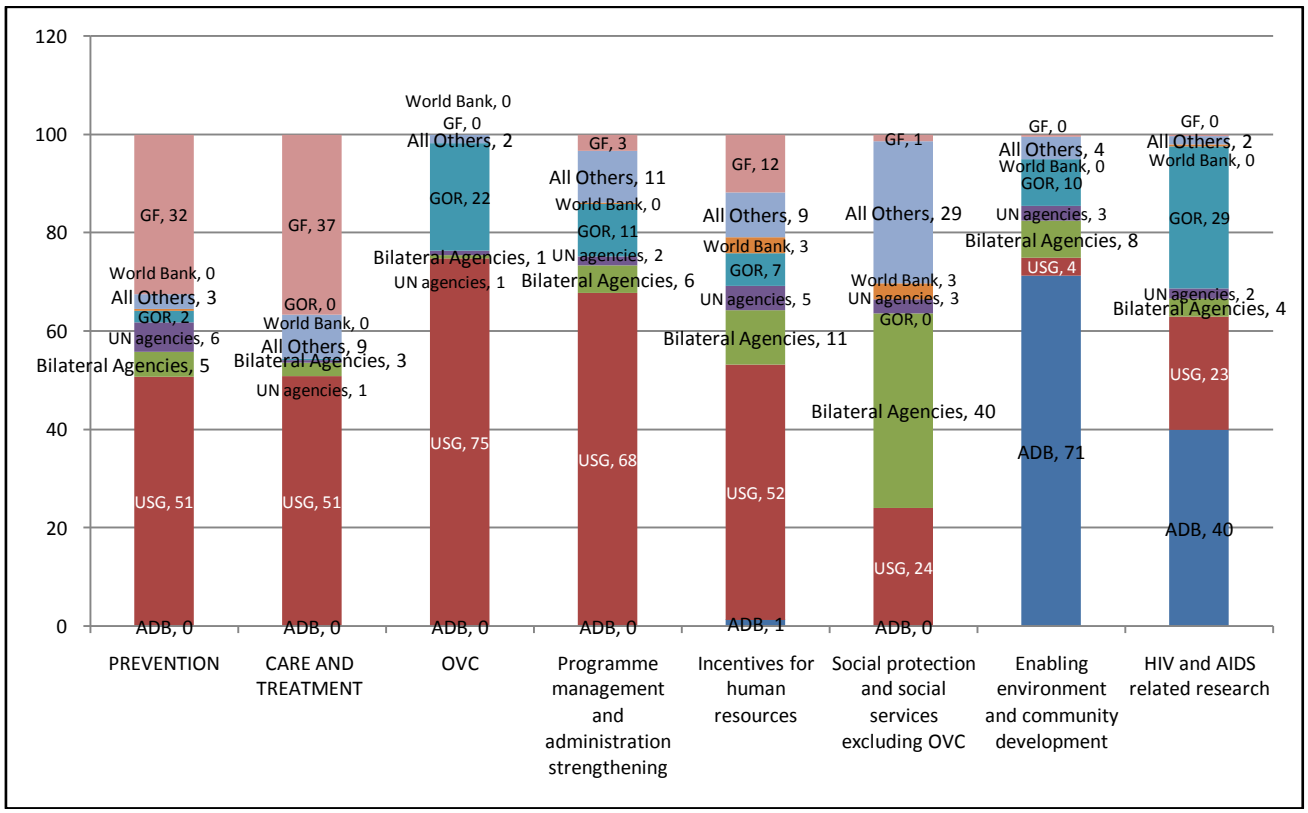

Figure 6: Expenditure by spending category and financing source

We can see that USG is the main contributor in all categories apart from enabling environment. The Global Fund focuses more on care and treatment and social protection. The Government of Rwanda covers higher percentages in OVC, HIV and AIDS related research. Bilateral organizations spend across categories, with a focus on social protection and incentives for human resources. The UN has a relatively prominent role in HIV and AIDS prevention. Most of African Development Bank funding was spent on the component enabling environment and community development, which encompasses strengthening of national structures such as district committees to respond to the epidemic.

Beneficiaries of HIV and AIDS spending in Rwanda

The NASA approach attempts to track all expenditure down to the actual beneficiaries. According to survey responses, people living with HIV form the largest beneficiary group, accounting for 38% of the total expenditure in both 2007 and 2008. This large fraction is explained by the increased number of PLHIV on ART and nutritional therapy, as indicated above. The second largest share of expenditure benefits the general population, consisting mostly of preventive intervention.

Table 5 below also shows that HIV and AIDS spending towards non-targeted intervention accounted for 18% in 2007 and 20% in 2008. Non-targeted intervention includes coordination, planning and management of epidemic, monitoring and evaluation, training, HIV institutional development and research related to HIV and AIDS.

Small amounts were spent on most-at-risk groups including sex workers, men who have sex with men, injecting drug users (IDU), internally displaced populations, police, and truck drivers. As these groups may account for a higher proportion of new HIV infections, we recommend that funds be reallocated with more focus on these groups as per the strategic plan for 2009-12. The same observation and recommendation applies to children and most-at-risk youth.

Table 5: Expenditures by beneficiary population, 2007 and 2008

BENEFICIARIES	2007		2008	
	US$	%	US$	%
Children (under 15 years) living with HIV not disaggregated by gender	138,381	0	259,374	0
Children born or to be born of women living with HIV	1 487,616	2	2,936,839	3
Children and youth out of school	1,408,764	2	1,059,064	1
Factory employees (e.g. for workplace interventions)	49,144	0	65,315	0
General population not disaggregated by age or gender.	10 801 116	14	24,397,099	22
Health care workers	3,053,200	4	2,931,548	3
Junior high/high school students	2,548,577	3	2,493,213	2
Orphans and vulnerable children (OVC)	9,358,637	13	12,850,247	12
People living with HIV not disaggregated by age or gender	29,194,740	39	42,585,793	38
Police and other uniformed services (other than the military)	42,380	0	82,703	0
Sex workers, not disaggregated by gender, and their clients	20,540	0	224,142	0
Specific targeted populations not elsewhere classified	70 766	0	18,877	0

Truck drivers/transport workers and commercial drivers	45,186	0	4,655	0
Youth (age 15 to 24 years) not disaggregated by gender	36,176	0	5,287	0
Adult and young women (15 years and over) living with HIV	0	0	626,410	1
Female sex workers and their clients	0	0	2,696	0
Injecting drug users (IDU) and their sexual partners	0	0	17,238	0
Internally displaced populations (because of an emergency)	0	0	16,788	0
Non-targeted intervention	16,309,715	22	20,234,308	18
Total	**74,564,938**	**100%**	**110,811,596**	**100%**

3.1.2 Policy/Strategy Development and Implementation

Rwanda fully adheres to the "Three Ones" principles: the existence of one national coordinating body, one strategic national plan of action and one sole monitoring and evaluation framework.

Overall coordination is the function of CNLS (National AIDS Commission) in collaboration with CDLS (District AIDS Control Committees), its decentralised structures at the district level. Each CDLS supports its corresponding district mayor in managing the HIV and AIDS response and is comprised of representatives of decentralized public services (health, education, planning), mass organizations (national women and youth councils) and civil society organizations (PLHIV, NGO, FBO networks as well as people living with disabilities (PWD) in some districts). Every year, the CDLS facilitate a participatory process to develop an Annual Action Plan for their districts.

Within the public sector, the Ministry of Health/TRACPlus is central to the HIV response. Other ministries involved include Ministry of Finance and Economic Planning (MINECOFIN), Ministry of Education (MINEDUC), Ministry of Youth (MINIYOUTH), Ministry of Gender and Family Promotion (MIGEPROF), Ministry of Local Government, Community Development and Social Affairs (MINALOC), Ministry of Public Sector and Labour (MIFOTRA), Ministry of Agriculture (MINAGRI), Infrastructures (MININFRA) and Justice (MINIJUST).

Civil society organizations, mass organizations, and the private sector are also active in the national response. The mass organizations are the National Women's Council and the National Youth Council. There are several umbrella organizations in charge of the coordination of civil society in the response to HIV: ABASIRWA (Media Umbrella); Rwanda NGO Forum on HIV/AIDS and Health promotion; Network of FBOs in the Response to HIV/AIDS (RCLS); Rwanda Network of People Living with HIV and AIDS (RRP+); Umbrella of People with disabilities in the fight against HIV and AIDS (UPHLS); and Umbrella of Transporters. There is also an umbrella in charge of the coordination of HIV-related activities in the private sector, namely the HIV/AIDS Unit of the Private Sector Federation. The Network of People living with HIV and the NGOs Forum have branches in all 30 districts. The Network of People living with HIV brings together about 1,300 associations at the national level, many of them in the process of becoming cooperatives. There are numerous community-level initiatives, which are primarily focused on sensitizing community members and delivering educational campaigns.

The key reference documents for the HIV and AIDS response in Rwanda are:

- the Government of Rwanda's **Vision 2020**, which includes the six pillars describing strategies for achieving the country's long-term development objectives.
- the **Economic Development and Poverty Reduction Strategy (EDPRS) 2008-2012,** the medium term strategy for achieving Rwanda's Vision 2020. The EDPRS provides the framework for multi-sectoral action on HIV and AIDS, and **the strategic plan for each economic sector** includes areas of action on HIV and AIDS. The EDPRS sectors incorporate all actors, including the private sector and communities, with each sector under the leadership of a government Ministry.
- the **National Strategic Plan on HIV and AIDS 2009-12**, the reference document for all sectors, institutions and partners involved in the fight against HIV and AIDS, outlines the contribution required of each to ensure that Rwanda achieves its ambitious targets. The NSP aims to make Universal Access to HIV Prevention, treatment, care and support a reality. The overarching results that this plan will achieve by 2012 are: first, halving the incidence of HIV in the general population; second, reduced morbidity and mortality among people living with HIV; and third, that people infected and affected by HIV have the same opportunities as the general population.
- the **Health Sector Strategic Plan (HSSP) 2009-2012**, which defines the Government of Rwanda's health strategy. The HSSP II aims to strengthen institutional capacity, to increase the quantity and quality of human resources, to ensure that health care is accessible to the entire population, to increase the availability and accessibility of drugs, to improve the quality of services in the fight against diseases and to hold up the demand for such services.
- the **TRACPlus HAS unit Strategic Plan 2009-2012**.

The NSP 2009-12 is closely aligned with Rwanda's Economic Development and Poverty Reduction Strategy 2008-2012 (EDPRS) as shown in Figure 7 below. The multi-sectoral EDPRS includes the Health Sector Strategic Plan (HSSP II), which is also one of the bases of the NSP.

Figure 7: How the NSP contributes to EDPRS and to Vision 2020

3.2 Programme Implementation

As a part of the overall national response, concerted efforts aimed at prevention, care, treatment, and support are being carried out across Rwanda. UNGASS indicators to assess programme implementation in each area are included in this section.

3.2.1 Prevention

Blood safety (Ref. indicator 3)

The National Centre for Blood Transfusion is in charge of the country's blood security. The number of blood units collected has risen from around 29,000 in 2004 to 35,495 in 2008 and 40,567 in 2009. All blood units come from volunteer donors. 100% of the blood units donated since 2005 were screened for HIV in a quality-assurance manner following a documented standard operating procedure and with participation in an external quality assurance scheme. While blood was screened using semi-automated method with ELISA technology in 2007 and 2008, blood was screened using automated machines ARCHITECT i2000 SR with CMIA technology in 2009.

Prevention of Mother-to-Child Transmission (Ref. Indicator 5 and 25)

During 2008, 6,387 HIV-positive pregnant women received ARVs to reduce the risk of mother-to-child transmission (MTCT), and this number increased 7,030 in 2009. According to EPP/Spectrum estimates, there were about 10,400 (5,300-15,700) and 10,300 (5,200-15,600) HIV-positive pregnant women in need of ARVs for PMTCT in 2008 and 2009 respectively, revealing an estimated increase in coverage from 61% to 68% towards the target of 90% coverage for 2012 (NSP 2009-12). We note that an additional 916 and 1,160 women HIV negative were provided ART for PMTCT because in sero-discordant couples in 2008 and 2009.

Most importantly, in 2008, two-thirds of pregnant women who were eligible for HAART for treatment received it during pregnancy. However, one-third of PMTCT sites are not yet equipped to initiate HAART.

The number of health facilities offering PMTCT increased from 11 in 2001 to 372 in 2009. Given that the current total number of health facilities in Rwanda is 517, this number corresponds to 72% coverage across all districts in the country.

Although less than 25% of pregnant women had the four WHO recommended ANC visits, nearly all women come at least for one antenatal care visit, which has been used as an excellent opportunity to provide PMTCT services. In order to increase the uptake of HIV testing among pregnant women, provider-initiated testing and counselling with informed consent was initiated in 2008 and is currently included in national PMTCT guidelines. Rapid HIV testing with same-day return of results is also currently provided.

The number of pregnant women tested for HIV reached 294,704 and 294,457 in 2008 and 2009 respectively. Nearly all women tested received their results in 2009 [*Source: TRACPlus*]. In 2009, 235,113 of these women were also tested for syphilis (2% prevalence found). Figure 8

below shows the percentage of pregnant women attending ANC that were tested for HIV from 2002 to 2009.

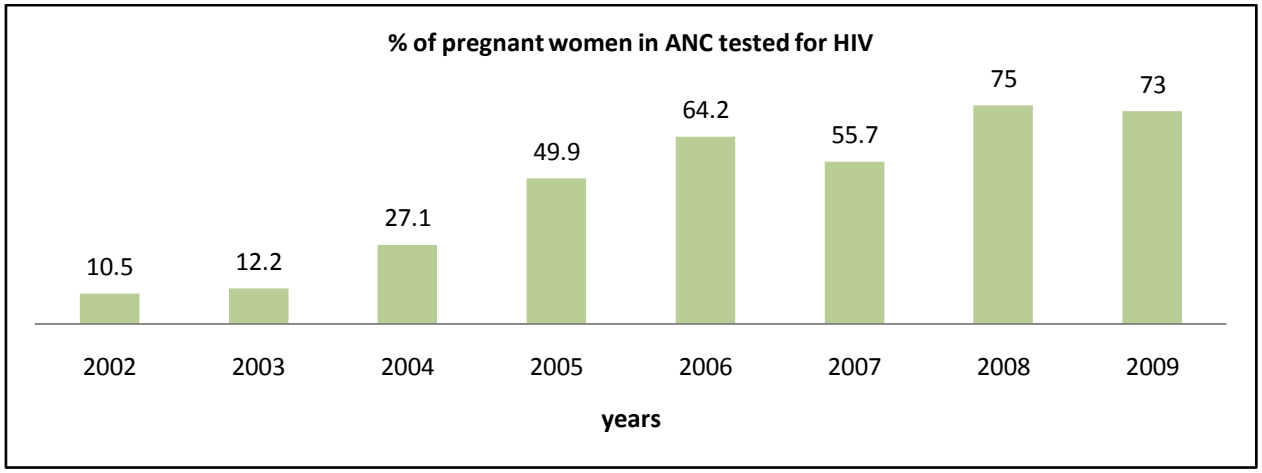

Figure 8: Percentage of Pregnant Women attending ANC tested for HIV: 2001-2009

In Rwanda, great efforts are made to encourage the partners of pregnant women to be tested for HIV and to offer couple counselling and testing. Among pregnant women who tested for HIV, an average of 78% in 2008 and 84% in 2009 of their partners agreed to have a test [*Source: TRACPlus*], while the number of partners who tested was only 33% in 2005.
Expanding this approach is very important given the high number of discordant couples. About 3.7% of heterosexual couples are HIV sero-discordant as per national VCT data[*Source: TRACPlus*]. In Kigali, 7.1%% of cohabiting couples seeking voluntary counselling and testing services are HIV discordant (TRACPlus, 2009). The proportion of discordant couples with an HIV positive man is almost the same as that of discordant couples with an HIV positive woman[1]. Knowing the HIV status of the partner is a first step to avoid HIV infection during pregnancy, where the risk of HIV transmission to the child is higher.

The number of infants receiving prophylaxis at birth has also increased steadily since 2001, reaching 5,755 and 6,684 in 2008 and 2009 respectively. These represent about 86% of all notified births from HIV positive mothers. About 50% of PMTCT sites in 2008 and 70% of sites in 2009 offer Early Infant Diagnosis of HIV (EID) to increase chances of early initiation of treatment for children. However, only 28% of children are in fact accessing EID in 2008 [*Source: TRACPlus*].

The percentage of infants born to HIV-infected mothers who are infected decreased to 6.9% in 2008 from about 10% in previous years according to routine data collected by TRACPlus.

Rwanda is currently revising national PMTCT guidelines in accordance to the 2009 WHO recommendations, which include providing HIV positive women with HAART during breastfeeding and transitioning over time from NVP and bitherapy regimens to HAART.

[1] Dunkle K, Stephenson R, Karita E, Ewyn C, Kayitenkore K, Vwalika C et al. New heterosexually transmitted HIV infections in married or cohabiting couples in urban Zambia and Rwanda: an analysis of survey and clinical data. Lancet 2008; 371: 2183-2191.

Behaviour Change Communication - General Population (*Ref. indicators 13, 15, 16*)

Rwanda's behaviour change strategy is based on promoting EABC: Education, Abstinence, Being Faithful, and using Condoms. A range of methods are used to deliver IEC and BCC, including but not limited to community events, mobile video shows, counselling, peer education, radio and television programs, posters and billboards, theatre, songs, documentation centers, printed material, and a telephone hotline. Many of these methods were used as part of organised thematic campaign such as the "STOP cross generational and transactional sex" campaign organised by PSI in 2008. Another major strategy has been the creation of youth anti-AIDS clubs, with at least 1,500 being functional in 2008. Overall, existing data about the level of effort for each type of IEC/BCC activity are incomplete. Still, it is estimated that a large proportion of the population was reached by basic HIV and AIDS information in 2008 and 2009 and the number of people reached seem to have steadily increased [*Source: CNLS Joint Review, Final Report (2009)*].

As per RDHS 2005, 45.3% of girls aged 15-19 and 57.1% of girls aged 20-24 correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission, as did 49% of boys aged 15-19 and 59% of boys aged 20-24. BSS also assessed comprehensive knowledge of HIV among youth: in 2006, only 12.9% of girls aged 15-19 and 16.8% of boys could mention three methods of preventing HIV and reject two misconceptions in relation to HIV transmission. Among boys and girls without education, among those from a rural setting, and among those from the poorest quintile, the proportion of those with correct information was much lower than among the remainder of the population [*Source: BSS (2006)*]. In 2009, the percentage of comprehensive knowledge among youth aged 15-19 decreased slightly to 9.4% for girls and 11% for boys [*Source: BSS (2009)*]. It is of concern that in 2009 only 11.1% of boys and girls aged 15-24 showed to have a comprehensive knowledge of HIV as defined above, while the NSP 2009-12 target is as high as 70%.

One of the HIV prevention strategies with young people is delaying age of sexual debut. RDHS 2005 showed a relatively late sexual debut (at 20 years): 3.9% of girls aged 15-24 and 13.2% of boys in the same age range had had sexual intercourse before the age of 15. According to BSS 2006 data, the proportion of girls and boys aged 15-19 who had their first sexual intercourse before the age of 15 was 7% and 16% respectively. These proportions have decreased to 6.1% and 14.7% in 2009. The overall percentage of youth aged 15-24 who had their first sexual intercourse before the age of 15 was 9% in 2009 [*Source: BSS (2009)*].

An additional prevention strategy in Rwanda is the reduction in the number of sexual partners, in particular concurrent partners. RDHS 2005 showed that only 0.3% of women aged 15-49 and 2.7% of men had sex with more than one partner in the last twelve months. Given the moral considerations in having multiple sexual partners, it may be that the actual number of people having more than one partner was largely underreported through the population based survey in 2005. The target of the NSP 2009-12 is to stabilize this percentage at less than 15%.

Condom Use – general population (*Ref. Indicator 17*)

In 2008, the CNLS conducted a situational analysis for condom programming in Rwanda to provide an overview of the situation for the supply of and demand for both male and female condoms. In 2009, based on the results from the situational analysis, the CNLS developed a strategy for a coordinated response to comprehensive condom programming (CCP), reiterating the importance and effectiveness of condoms in the prevention of unintended pregnancies and

HIV/STIs and in line with the National Condom Policy 2005 and the Reproductive Health Commodity Security Strategic Plan for Rwanda (RHCS Strategic Plan).

By the end of 2010, MOH and CNLS expect to make condoms available in all cells at the community level and to increase demand of condoms and societal acceptance of mass-media messages regarding condoms. In 2011, condoms are expected to be accessible in all *Imdugudu* (community villages). According to the NSP 2009-12, male and female condoms should be available and accessible to all populations by 2012.

MOH is responsible for the overall supply of condoms through CAMERWA, district pharmacies and health facilities. Links are being created between health facilities and peer educators in community-based organizations and community health workers. PSI-Rwanda is the sole social marketing agency for condoms in Rwanda. The role of the private sector in the procurement of condoms is not very significant. Despite the existing supply chains for condoms, there is a need to reinforce availability and accessibility, especially in the hard-to-reach rural areas, through the creation of more condom sales outlets.

During 2008 and 2009, there was a substantial increase in the supply of condoms as shown in Table 6, with a 21% increase from 2008 to 2009 alone. In 2006, the number of condoms distributed by the MOH was of 833,863 male and 2,441 female condoms only.

Table 6: Distribution/sales of condoms in 2008 and 2009 [*Source: RHC quantification data 2009*]

Sector		**2008**	**2009**
Public sector (free condoms)	Male condoms	4,139,917	7,173,234
	Female condoms	3,512	52,290
	AHF MC	0	403,200
Social Marketing	Prudence MC	10,320,440	10,683,984
Total		**14,463,869**	**18,312,708**

Male and female condoms are available in health facilities free of charge to all. Other distribution networks have also been identified and used to distribute free condoms, including the "community health basket" of basic reproductive health commodities for community based distribution. Awareness building about responsible sexual behaviour and the involvement of different stakeholders in advocacy and campaigns to de-stigmatize condoms has also played a role in the increase of condom consumption.

By 2011, Rwanda expects to distribute 26 million condoms annually. The number of condoms per capita in the reproductive age (15-49 for women and 15-59 for men) was about 3 in 2008 and 3.8 in 2009 [*Source: CNLS and RNIS*].

The percentage of people aged 15-49 who had more than one sexual partner in the past 12 months and who reported the use of a condom during their last sexual intercourse was 19% in female (15-49) and 25% in male (15-49) [*Source: RDHS 2005*]. Targets for 2012 are 60% and 75% for females and males respectively [*Source: NSP 2009-12*].

Behaviour Change Communication and condom use - Most-at risk Populations

Sex workers (*Ref. indicators 14,18*)

The percentage of sex workers with a comprehensive knowledge of HIV increased from 26.8% in 2000 to 36.2% in 2006. Data for BSS 2009 are still under analysis at the time of the preparation of this report. As expected, illiterate sex workers have a much lower chance of having comprehensive knowledge than those who have at least secondary education [*Source: BSS (2006)*]. The percentage of female sex workers reporting the use of a condom with their most recent client is quite high and increased from 81.8% in 2000 to 86.6% in 2006. Only female sex workers were included in the sample [*Source: BSS (2006)*].

A survey on clients of sex workers is not yet available in Rwanda. The only established client group that has been covered by HIV-related surveys is truck drivers. In the 2006 BSS, 18.5% of truck drivers reported having had sex with sex workers in the previous year, compared to 47% in the 2000 study. In 2000, 32.0% of truck drivers had a comprehensive knowledge of HIV. By 2006, this percentage rose to 39.1%. Illiterate truckers are 60% less likely to have a comprehensive knowledge of HIV [*Source: BSS (2006)*].

Men who have sex with men (*Ref. indicators 19*)

As mentioned in section 2.3.5, the exploratory study on MSM in 2008-2009 shows that condom use among MSM in Kigali is low. Thirty-four out of 98 respondents reported that they had never previously used a condom with a male or female sexual partner. Among men reporting sex with another man in the 12 months prior to survey, only one-third reported consistent condom use with all male partners. 50% reported using a condom last time they had sex with a boyfriend and 51% with a casual male partner. Only one-third of respondents reporting sex with a female partner in the 12 months prior to survey reported condom use during their last sexual intercourse with a female partner.

Most-at risk Populations - Injecting drug users (*Ref. Indicators 20, 21*)

There is no information available on behaviours for injecting drug users. An exploratory behavioural and size estimation study for this population is planned for 2010.

Management of Sexually Transmitted Infections

As part of the country HIV prevention strategies, Rwanda offers a comprehensive package of services for the prevention and management of STIs other than HIV. These services include counselling, an offer to test for HIV, advice on safer sex and access to STI treatment. STI detection is based on systematic screening, and syndromic case management. The percentage of women and men with STIs appropriately diagnosed, treated and counselled at health facilities were 49% and 52% respectively [*Source: RDHS (2005)*].

The main achievements in 2008 and 2009 were:

- the development of the New National STI Guidelines (validation ongoing);
- the increased availability of essential drugs for treating STIs;
- the availability of new and revised STIs Indicators in the online reporting tool TRACnet;
- capacity building/trainings in the management of STIs of doctors and nurses in all districts in order to improve quality of services;
- development of an STIs screening tool and its use for both HIV-negative and HIV-positive people.

There has also been a significant reorientation of HIV prevention efforts towards MARPs with a focus on targeted interventions for sex workers and their clients. Strategies to decrease risks of HIV infection in sex workers through early diagnosis and treatment of STIs are also an entry point for broader prevention activities and for HIV treatment and care/mitigation services to this population group.

Male circumcision (MC)

Current prevalence of MC in males of ages 15-59 is estimated at 15% [*Source: Interim DHS (2008)*].

Rwanda has adopted Male Circumcision (MC) as part of a comprehensive package of HIV prevention strategies since 2007, and has defined national targets for infants, adolescent and adults MC within the 2009-2012 National Strategy Plan (NSP) to fight HIV and AIDS. In addition, MC has been integrated into the national HIV prevention policy.

The MOH/TRAC PLUS is leading the programme. A Technical Working Group was formed in early 2008 and a national advocacy campaign carried out in September/October 2008. During 2008 and 2009, a facility readiness assessment was completed, a cost-effectiveness study (available at www.plosmedicine.org/doi/pmed.1000211) and a KAP survey study carried out. A national evidence-based implementation strategy and an operational plan are under development, while clinical guidelines already available as of the end of 2009. A communication plan will be developed in 2010.

Service delivery has started in the military health facilities as of 2009, with a first cohort of 250 men being circumcised from October to December 2009. Health staff has been trained (2 national coordinators, 6 trainers for a Training of Trainers (TOT) strategy, 69 counsellors and about 40 medical doctors). 2010 will be the first year for implementation of the programme for the non-military. The Government of Rwanda is addressing human resources challenges, possibly using task shifting strategies, and envisaging how to integrate MC into maternal and child health services.

3.2.2 Treatment, Care and Support

HIV Treatment: Antiretroviral Therapy (Ref. indicator 4)

The number of health facilities offering antiretroviral therapy (ART) in Rwanda has increased substantially from 4 in 2002 to 195 in 2008 and 269 in 2009 (52% of all health facilities). Figure 9 below shows the number of sites providing ART over the last few years.

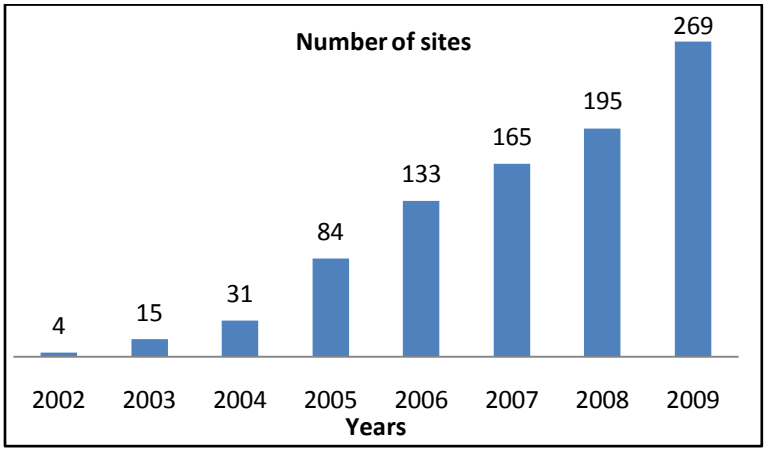

Figure 9: Number of sites providing ART

Coverage of patients has also increased steadily. In 2002 there were only 870 people on ART; there were 63,149 patients on ART in 2008 and 76,726 patients on ART in 2009. In 2009, 61% of patients were women. Efforts have been made to ensure access to ART in all districts.

Figure 10 below provides information on the number of adults and children receiving ART over the last few years. Between 2008 and 2009, treatment programmes were initiated with at least 1,000 new adults each month [*Source: TRACPlus*].

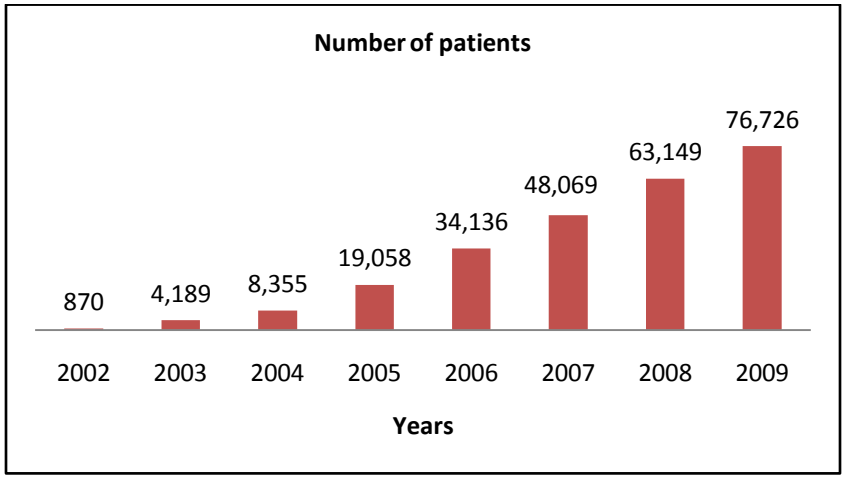

Figure 10: Number of patients (adults and children) receiving ART

The number of children on treatment reached 6,678 by December 2009. Measures have been put in place to scale up paediatric care and treatment, such as decentralisation of sites (269 sites provide paediatric care and treatment in 2009), training of providers (using trainings of trainers) and quality improvement through better supervision and mentorship.

The vast majority of people are on first-line treatment, numbering 56731 in 2008 and 75,041 in 2009. The number of people on second-line treatment is rising (783 in 2008 and 1,685 in 2009) but still below 2%. Since 2007, national guidelines recommend initiation of ART for a CD4 count below 350, instead of a CD4 count below 200 in previous years. At present, the majority of all adults and children on treatment are in WHO clinical stage 1 and 2, a clear indication that treatment starts much earlier [*Source: TRACPlus*].

People are considered lost to follow-up if they have not attended an appointment for more than three months. The number of patients lost to follow-up at the end of December 2009 was 2,749, less than half of what was reported in the previous UNGASS period.

The sustained scale-up of ART coverage for adults is a major success for the country. Based on Spectrum estimates, there were about 87,400 (upper bound estimate) adults (15+) in Rwanda in need of ART in 2008. In 2009, this number was 91,400 (upper bound estimate). Thus, at the end of 2008, 70% of adults in need of ART were receiving treatment. This percentage rose to 77% in 2009. Coverage of ART for children (0-14) is much lower: 54% in 2008 (5,653 children receiving treatment out of 10,600 [5,900-15,900] needing it) and 49% only in 2009 (6,679 children receiving treatment out of 13,500 [7,400-20,500] needing it). More efforts to diagnose and treat HIV positive children need to be put in place.

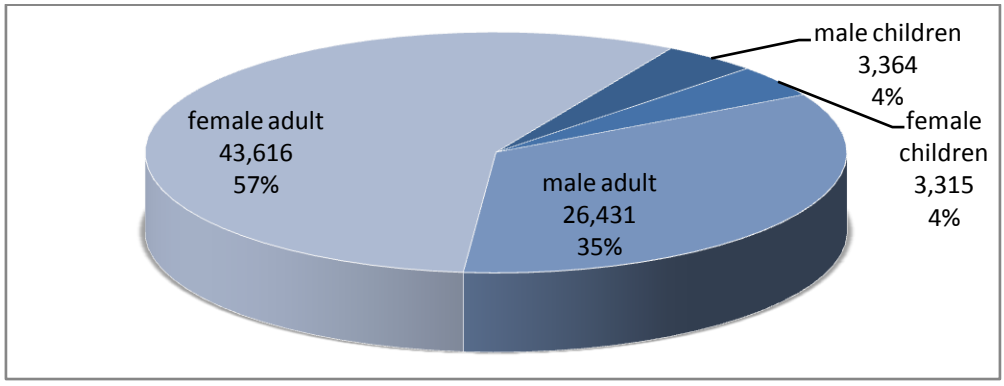

Figure 11: Proportion of adults and children on ARVs by sex, December 2009

Co-management of Tuberculosis and HIV Treatment (ref. indicator 6)

Treatment success rate for TB has been improving in Rwanda, rising from 86% in 2007 to 87% in 2008. However, the detection rate for TB is still low. Efforts are being made to improve detection through case tracking and directly observed therapy short-course (DOTS) [*Source: Integrated National Programme of Fight against Leprosy and Tuberculosis (PNILT) Report (2009)*].

Overall, 7,642 tuberculosis patients were registered on TB treatment by the national tuberculosis programme in 2009. In 2005, second-line TB treatment was introduced. The number of patients under second line treatment for TB rose from 35 patients in 2005 to 86 patients in 2008 and 81 patients in 2009. Currently (as of March 2010), there are more than 334 patients under second-line treatment for tuberculosis.

Health facilities have a policy of systematic screening for HIV among all TB patients. HIV testing is now routinely offered at the time of TB diagnosis for most patients. All health facilities classified as CDT (qualified for the detection and treatment of TB) are able to carry out HIV testing [*Source: PNILT*].

In 2008, among all registered TB patients in Rwanda, 95.8% were screened for HIV and 34% were found to be HIV-positive. Of these patients, 44.8% were recorded as having received ARVs after TB treatment. By comparison, in 2009, 97.4% of all registered TB patients were screened for HIV, with 34% being found HIV-positive. 62% of these patients co-infected with HIV were recorded as having received ARVs and 92.1% to have been started on cotrimoxazole preventive therapy.

According to TRACPlus data (ART patients registers), 59% of HIV positive patients were screened for TB in HIV care settings in 2008. The number of HIV positive patients that were diagnosed for TB and received treatment for HIV and TB was 1,148 in 2008 and 1,558 in 2009. As per WHO estimates (available at www.who.int), the estimated number of incident TB cases in HIV positive people was 13,000 (95% confidence interval: 9,600 – 17,000) in 2008. Therefore, the percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV in 2008 was about 9%.

HIV Testing and Counselling in the General Population (Ref. Indicator 7)

Among women of ages 15 - 49 surveyed in RDHS 2005, 11.6% had been tested in the past 12 months and received their results. Among men of ages 15 - 49 surveyed, 11% had been tested in the past 12 months and received their results. Women and men in urban areas with secondary-level education or higher and with greater wealth were much more likely to have had a test in the last 12 months and received the results [*Source: RDHS, 2005*]. According to the NSP 2009-12, these values should triple by 2012 with a target of 35%.

Among youth respondents, only 0.8% of girls and 0.9% of boys aged 15-19 in 2000 had been tested for HIV and received the result; in 2006, 12.6% of girls and 11.3% of boys aged 15-19 had done so, revealing significant behaviour change in the six-year period [*Source: BSS, 2006*]. In 2009, these values increased up to 54.8% for girls and 57.7% for boys aged 15-19, showing the success of the Voluntary Counselling and Testing (VCT) policy and implementation in Rwanda. 50.1% of youth aged 15-24 had an HIV test [*Source: BSS (2009)*].

The number of sites (FOSA) providing VCT increased considerably in the last years. In 2003, there were only 44 sites offering VCT. By 2008, a total of 386 VCT sites were functioning and in 2009, there were 395 VCT sites (76% of health facilities). The number of tests conducted at VCT sites is also on the rise. The number of tests performed in VCT sites (and for which a result was given – 98.5% of all tests-) during 2008 was 976,859; during 2009, this number rose to 1,370,326, which is more than double the number for 2006 (Figure 12).. People tested through mobile VCT are fewer: only 20,125 tests performed (with results shared) in 2009. [*Source: TRACPlus*].

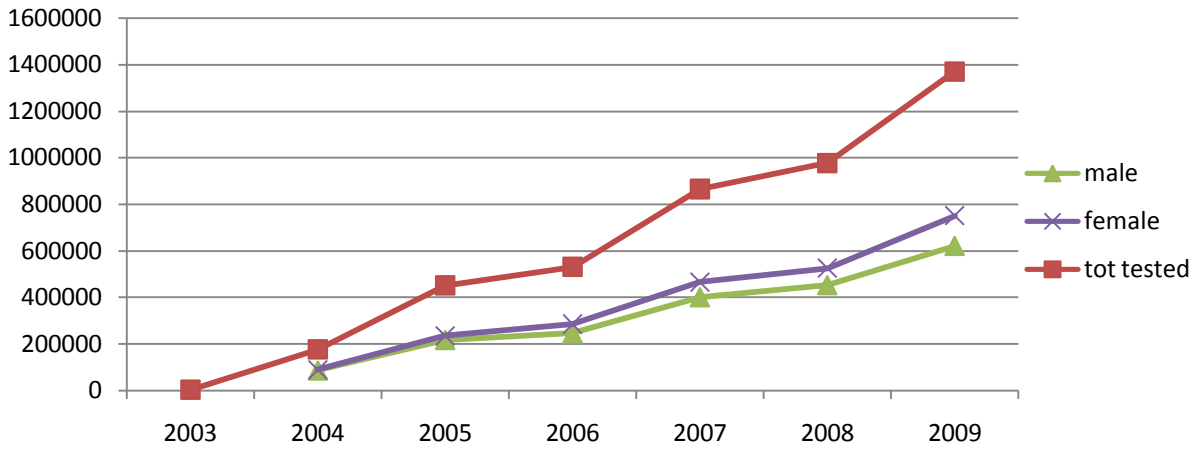

Figure 12: Number of people tested at VCT sites by sex during 2003-2009

HIV testing and prevention programmes in most-at-risk populations (Ref. indicators 8 and 9)

Data on HIV testing for sex workers and truck drivers are available through BSS conducted in 2000 and 2006. 2009 BSS data are under analysis at the time of writing of this report.

In 2000, 35.9% of the sex workers interviewed responded that they had received an HIV test at some point and knew their results. This percentage nearly doubled by 2006 (65.3%). Among truck drivers surveyed in 2000, 26.8% had been tested for HIV at some point and received their results. In 2006, this percentage rose to 55.6% of the truck drivers surveyed.

Much emphasis was on prevention programs for truckers in the past few years. Data from BSS among truckers shows that the interaction between truck drivers and sex workers is decreasing. The trucker population is small but mobile. Although levels of risk behaviours seem to be decreasing, questions about discordance in couples are important as 67% of truckers reported being married during the 2006 BSS [*Source: Rwanda data synthesis/triangulation project, 2008 TRACPlus*].

A broad overview (CNLS, 2009) of the extent to which HIV interventions for sex workers are available in different districts suggests that more needs to be done to ensure that sex workers have access to each type of service in each sex work site. Such efforts could include awareness raising, condoms, VCT/Family Planning, care and HIV treatment, vocational training, social integration and income generation. The survey also reveals that certain interventions are particularly under-supported, for instance the distribution of female condoms, support for fighting

and responding to violence against sex workers, and support for the creation of associations of sex workers. Support for sex worker groups tends to focus solely on creation of cooperatives as a means of alternative income, and this limits the ability of sex worker groupings to carry out peer education and support for sex workers.

The exploratory study on men who have sex with men in Kigali in 2009 (using a snowball, non-representative sample), show the following HIV testing history:

- Among the 88 respondents who reported that they had heard of HIV/AIDS, 55 reported a previous HIV test for which they obtained their results.
- Of the 57 respondents reporting a previous test, nearly three-quarters (42) reported an HIV test in the last 12 months and 46.6% (41) reported to know their results.
- The majority of respondents reporting a previous HIV test said that their most recent test was by choice. Six men reported that their last HIV test was required by their employer (n=4) or for an international visa (n=2).

No specific HIV prevention activities addressing MSM were carried out during 2008 and 2009. However, MSM are now included in the NSP 2009-12. Half of all respondents of the MSM 2009 study felt there was a need for a dedicated, confidential health clinic for MSM, and more than one-third expressed a need for better availability of condoms and lubricants for anal sex. Nearly one third of respondents voiced a need for HIV/AIDS stigma reduction campaigns.

No systematic research has been done for injecting drug users.

The prisoner population in Rwanda is declining. The mobile VCT prevalence declined from 10% in 2006 to 4% in 2007 and remains static (4%) as of July 2008. In prisons, condoms are contraband and there is a poor rate of condom knowledge. The practice of men having sex with men in prisons is done in exchange for food, security, or power, or because there are no alternative partners. The extent of interaction between prisoners and women from surrounding villages during daily work duties – placing these local populations at risk – is not known. It is not certain whether planned scale-up of services is adequate and whether prisoners are a diminishing factor in HIV transmission [*Source: Rwanda data synthesis/triangulation project, TRACPlus (2008)*].

Today Rwanda has over 50,000 refugees. Refugees are moving toward reduction of HIV transmission, with much emphasis on prevention programs in the past years. Refugee camps have been shown to be protective for women in Rwanda in terms of abstinence, low levels of high-risk sex, and condom use with high-risk sex. The camps have relatively high programmatic coverage of VCT and PMTCT services [*Source: Rwanda data synthesis/triangulation project, TRACPlus (2008)*].

Programme records indicate that people living with HIV rarely receive a comprehensive package of support for “positive” prevention. HIV prevention programs among sero-discordant couples (identified as one of the main sources of HIV new infections in Rwanda) are a key priority for the new NSP 2009-12.

3.2.3 Impact Alleviation

Support for Children affected by HIV and AIDS and school attendance of orphans (Ref. indicators 10 and 12)

Orphans are more vulnerable in the education system: while 91% of non-orphans aged 10-14 attend school, just 74.6% of orphans do so [*Source: RDHS (2005)*].

MIGEPROF reports that OVCs and young heads of household have more difficult living conditions, problems in accessing education, and suffer psychological distress. Nevertheless, as per RDHS (2005), only 0.2% of OVC aged 0-17 had access to all types of support needed (medical, emotional, school related, social/material). The target set in EDPRS 2009-12 and NSP 2009-12 is 10% by 2012. The percentage of households of OVC aged 0-17 that received at least one type of support in caring for the child or children was 12.6% [*Source: RDHS (2005)*]. The relevant national target for at least one type of support is 30% by 2012.

In Rwanda, a minimum package for OVC support has been defined and it covers health (including PMTCT, HIV prevention services and VCT), nutrition, formal and non-formal education, protection, psychosocial and socio-economic support. However, coordination of partners providing services for OVC is still low, funds are insufficient and the identification of OVC at the district level remains challenging.

The substantial support to OVCs for access to education is a major achievement of the last few years and will help to decrease the vulnerability of these children and youths. Access to health services (Mutuelles de Sante) has also improved significantly in 2008 and 2009. Important steps have been made in the establishment of an enabling environment for the creation of a legal and policy framework to protect the rights of OVCs. However, identification of OVC at district level has suffered from a lack of transparency and consistent application of criteria, meaning that support does not always reach all of those in need. At the same time, efforts are required to scale up the numbers reached by essential support and to ensure that in each case at least the minimum service package is provided.

Life Skills-based HIV Education in Schools (Ref. Indicator 11)

In Rwandan secondary schools, life skills in the HIV context are taught to students through anti-AIDS clubs. Of 689 secondary schools nationwide, 98% had functioning anti-AIDS clubs in 2008, with an average coverage of 95% of schools in each district [*Source: MINEDUC*].

About 12% of teachers (1,326 out of 10,715) were trained in HIV during 2008. HIV issues are integrated into teaching curriculums for disciplines such as civic education, sciences (in both primary and secondary schools), and teaching/learning tools have been developed to support teachers.

The development of a comprehensive health guide integrating an HIV component (in addition to nutrition and hygiene) is ongoing and is based on the National School Health Policy.

HIV Treatment: Survival rate on ART (Ref. indicator 24)

A study carried out by TRACPlus over the years 2004 and 2005 found that 91% of adults and children with HIV were alive and on treatment 12 months after initiation of ART[2]. In 2007, 94% of HIV patients were known to be on treatment 12 months after initiation of ART. Data were from a national cohort (patients initiated in June 2006 and followed over 12 months). In 2008, TRACPlus sampled 57 of 234 sites, analysed a cohort of patients initiating on ART between May and July 2008 and assessed the outcome at 12 months. 94.5% of patients (1,241 out of 1,312) with HIV in the cohort were known to be on treatment 12 months after initiation of ART.

Although more work needs to be done to ensure support for and follow-up of persons on ART, the survival rate is very encouraging and improving over the years. Still, sustaining the uptake of HIV testing and the extension of the ART programme is critical, as there were still more than 6,800 (1,500-15,100) AIDS-related deaths in 2009 alone (EPP/Spectrum estimates, 2010); 1,281 deaths were reported in TRACNet.

Socio-economic Support to PLHIV

The Stigma Index study of 2009 showed that around 20% of people living with HIV of either sex are unemployed and not working at all. 37.2% of respondents reported that they had been refused employment opportunities as a result of HIV status. Women living with HIV are more affected than men: they are more likely to be in extreme poverty (living on less than 1 USD a day) than HIV positive men, with 50.2% of women below this threshold compared to 38.6% of men. The proportion of HIV positive people who have not had any formal education is also higher among women (18.5%) than men (12.2%).

Income generation activities (IGA) funded through the micro project mechanisms of various projects (MAP, GF, CHAMP, CNLS/UNDP/ADB) have helped a large number of HIV-positive member associations to initiate or strengthen collective projects that have had profound effects on their livelihoods, more so in terms of decreased stigmatization and social isolation than in terms of economic status per se. However, there are gaps in support for management and technical assistance to IGAs, as well as in access to credit [*Source: CNLS Joint Review, Final report (2009)*].

Important steps have been made in the establishment of an enabling environment for a legal and policy framework to protect the rights of people living with HIV and AIDS and for the prevention and prosecution of sexual violence. Access to numerous services for vulnerable groups has also significantly improved during this period, specifically access to health services (Mutuelles de Santé), education, social protection and legal services through various projects [*Source: CNLS Joint Review, Final report (2009)*].

RRP+ has considerably strengthened its coordination mechanisms with the setting up of district coordinators in half of the districts and the strengthening of its central staff for coordination and M&E purposes. The delegation of representation from the grassroots level to the national level ensures the participation of local communities in the planning, implementation and evaluation of activities concerning HIV [*Source: CNLS Joint Review, Final report (2009)*]. However, members of PLHIV associations are still largely comprised of women (about 90%). Likewise, there is little representation of educated HIV-positive persons in PLHIV associations.

[2] TRAC Report on the evaluation of clinical and immunologic outcomes from the national antiretroviral treatment program in Rwanda, 2004-2005 (November 2007)

The transformation of the associations into cooperatives is also a mechanism to ensure fuller participation of members into the decision making process of the organization: well-established rules for the functioning of the cooperatives describe clearly the transparency and inclusiveness that must be respected in distribution of profits from the organization's activities and in decisions about the management of these activities [*Source: CNLS Joint Review, Final report (2009)*].

Understanding of rights is a gap, and emphasis should be placed on ensuring that vulnerable people know their rights. It is also important to provide legal support and to enhance the collaboration system between health service providers, local authorities and the police [*Source: CNLS Joint Review, Final report (2009)*].

4 Best Practices

In 2009, the CNLS led an exercise to select best practices in the prevention area in the country over the period 2006-2009. A guide/questionnaire defining criteria for a best practice (demonstrated results, impact, relevance, applicability and sustainability) was developed and shared with the 30 CDLS for them to identify and submit possible best practices to CNLS. 27 districts submitted their best interventions. On the basis of the criteria defined, CNLS designed an evaluation form and constituted an *ad hoc* committee to rank the 27 interventions. To collect more detailed information, field visits were also carried out to meet stakeholders and recipients of programs. Discussions with stakeholders covered activities, strategies and results achieved. Focus groups with beneficiaries centered on the impact of the interventions on their living conditions. Two of the selected interventions are reported below. The full report for the exercise is available at: http://www.cnls.gov.rw.

Sensitization of secondary school students on HIV in Nyagatare district

This intervention was undertaken in 2006 by the Volunteer Service Oversees (VSO) through the PHARE project (Prevention HIV and AIDS in Rwanda through Education). The project was designed for 13 schools in Nyamagabe district to improve knowledge on HIV as well as reduce sexual behavioural risks among secondary school youth. The objective of the intervention was to make anti-AIDS clubs operational, strengthen peer education and establish linkages between anti-AIDS clubs in the 13 secondary schools and those in their vicinity.

The following activities were implemented:

- Members of anti-AIDS clubs were trained on HIV and the clubs equipped with training manuals, condoms and wooden penises, radios and microphones, televisions and films on HIV.
- Inter-club competitions on prevention against HIV were organized (composition of songs, poems, traditional and modern shows and plays on HIV).
- For sustainability of the intervention, income generating micro-projects proposed by the anti-AIDS clubs were supported: hairdressing salons, cafeteria, and telephones in schools.

The following results were achieved:

- 13 anti-AIDS clubs in schools are now operational and more and more students are becoming their members. For example, at Rukomo school, members of the anti-AIDS club were 47 in 2007 and 187 in 2009, whereas the anti-AIDS club for Nyagatare Secondary school now has 500 members out of the 1900 students of the school.
- School management and staff members are increasingly supporting anti-AIDS clubs.
- Anti-AIDS clubs members have contributed to the creation of other 44 anti-AIDS clubs in the surrounding community.
- Anti-AIDS clubs members carried out sensitization of secondary and primary schools pupils, community sensitization and home visits.

The following impacts were reported during focus group discussions with students:

- Students are well-informed on reproductive health, no longer fear talking about sexuality in public and have better knowledge about condoms.
- The number of students who accept voluntary HIV tests has increased.

- Unwanted pregnancies have almost disappeared in schools of Nyagatare and Rwempasha.
- Anti-AIDS clubs report stigma to have decreased.
- Young girls reported that they no longer accept gifts from older men in exchange for sex.

This experience shows that anti-AIDS clubs that are well-supervised constitute an efficient and effective channel to convey messages on HIV and AIDS prevention to young people. There is now a need to renew club leadership by truly integrating the youngest members. The support and involvement of school authorities in the management of anti-AIDS clubs have been crucial for the success of this intervention. The project staff recommends that educated young people should be accompanied outside the school environment to sustain good habits acquired at school.

PMTCT in health centers supported by ICAP in Karongi district

ICAP has been working in the district of Karongi since 2005 in the areas of treatment, PMTCT and VCT. ICAP's support to care and treatment started in January 2005, while support to PMTCT services started in July 2006 with 3 district hospitals (Kibuye, Mugonero and Kilinda). Currently ICAP supports HIV services in 14 out of the 21 health centres in the district. Personnel were trained in the provision of PMTCT services and the necessary equipment was made available to them. Coverage of women attending antenatal consultation is 98%.

Provision of PMTCT service has been strengthened over the years. Pregnant women are encouraged to bring their partners for testing. When a pregnant woman is found to be HIV-positive, she receives same-day post-test counselling and her blood is drawn for a CD4 count. She is enrolled into comprehensive care and followed up until her baby is 18 months old. ART prophylaxis is provided. Six weeks after delivery, the mother comes for counselling on family planning and the child receives PCR and syrup bactrim. Every month, the mother brings the child for follow up, during which the height, weight, cranial perimeter and the neurological and psychomotor development of the child are assessed. She also receives nutrition counselling; health personnel examine the nutrition status of the child and refer cases as needed. After 6 months, the child receives nutritional supplements. At 9 and 18 months, the child undergoes a serology test.

Other activities include training, recruitment of additional personnel, training of community health workers, provision of equipment in the maternity ward and laboratory, provision of reagents and drugs, and sensitization of women to turn up for antenatal consultation (utilising peer education to ensure community involvement).

Among key results CDLS and ICAP report that:
- The rate of HIV testing amongst pregnant women increased from 93% in 2006 to 100% in 2008; and this has remained consistent since then.
- The rate of partner testing has increased from 56.2% in 2006 to 81.5% in 2009.
- 100% of all HIV infected women get CD4 testing within one month of attending ANC compared to 0% in 2006.
- A high rate of health facility delivery (81.3% overall and 100% amongst HIV-positive pregnant mothers during 2009)
- An increase in the rate of acceptance of modern contraception by HIV-positive women from 36.8% in 2008 to 100% in 2009

Focus groups with beneficiaries have suggested that to sustain the increase in the use of condoms and other family planning methods there is a need to increase the engagement of men into the programme.

Beneficiaries praised the PMTCT programme because it has not only allowed them to have healthy children, but has also helped them improve their own health due to the treatment received. They also declared that the programme has enabled them to improve their nutritional status and clothing hygiene and that of their children. HIV-positive women seem to have regained hope and attend to their business without difficulty. The knowledge imparted to these women has assisted them in efficiently preparing food for their children. Additionally, some of these women have revealed their HIV status; they have become spokespersons and peer educators for the health facilities in sensitizing other women on the importance of testing and family planning. They also help with follow-up of HIV-positive women that do not return for the visits to the health facilities.

Two additional best practices, suggested by key stakeholders during this UNGASS Report preparation and validation meetings are reported below.

Gender Based Violence (GBV) – One Stop Centre

The One Stop Centre was opened in Kacyiru Hospital in mid-July 2009 and is a relatively new multi-sectoral initiative of the Government (in particular the Rwanda National Police) and the UN (UNFPA, UNIFEM and UNICEF). As its name suggests, the Centre is designed to provide the full range of services to meet the health, psycho-social and legal needs of survivors of sexual and gender-based violence in one location. Though this kind of centre is not unique to the region, it is the first of its kind in Kigali and in Rwanda as a whole. Its approach and the commitment of its staff and of all partners warrant its inclusion as a best practice. In addition, the centre addresses an identified and urgent need and is providing opportunities for individual and institutional learning which will in turn assist the rollout and scale up of similar centres and services in other locations.

The Centre has not been in operation long enough to provide the kind of data and evidence of its reach and success. However, staff members are reporting increasing numbers of clients since it opened its doors with the number of clients quadrupling from July 2009 to October 2009.

The One Stop Centre represents one strand of a strategic approach to GBV, which also includes addressing prevention. The programme has adopted the twin-track approach of addressing legal and policy issues (UN agencies are working with the judiciary and government in formulating a GBV policy) as well as establishing systems and procedures for effective response, giving the broader initiative both substance and authority while simultaneously meeting existing demand for survivor assistance services.

In working closely with hospital staff, the police and the judiciary and providing the necessary training and institutional support, UNICEF and its partners are helping ensure the kind of "accessible, compassionate, respectful and confidential services" which can be documented and systematised, thus becoming an appropriate model for scale up. In conjunction with close attention to prevention and policy, creating such a scalable model is the essence of good gender-mainstreaming approach.

Male participation in PMTCT in Rwanda

Traditionally, information about PMTCT in most communities comes from female antenatal clinic patients, although research shows that men prefer to receive information directly or through their peers. As a result, men may feel marginalized by the inadequate access to information. Male involvement could improve men's and women's sexual and reproductive health and rights, and promoting a family-centred approach to HIV prevention, care and treatment services.

The following strategies were used in Rwanda to increase male involvement in PMTCT:

- High-level advocacy with the involvement of high-level leaders and authorities
- Capacity building of health care staff on HIV counselling and testing for couples
- Public awareness campaigns using mass media for couples' testing
- Introduction of partner testing indicators into the performance contract of local authority with the government
- Community mobilization with local authorities and community health workers
- Performance-based financing integrated couples' HIV counselling and testing indicators at health facilities and at the community level
- Introduction of invitation letters for male partners
- Organization of weekend HIV counselling and testing sessions for partners who are not available on weekdays

Results:
The uptake of male partners' HIV testing has dramatically increased from a national average of 7% in 1999 to 84% in 2009, with some health facilities reaching 90% partner testing uptake. However, the testing rate among male partners still remains low in a few areas in Rwanda (slightly less than 50%). Men are described as „resistors' by community health workers and need more motivation to participate in couples' testing. As many as 15-20% of „hard-to-reach' males in many communities have not been tested. Furthermore, male involvement in the HIV counseling and testing should lead to men's participation in all PMTCT programme services, thereby promoting maternal health and child survival.

Key Elements of Success:

- Involvement of high-level authorities and local leaders in advocacy: His Excellency Mr. President of the Republic and other political leaders launched the couples' counselling and testing programme in 2003.
- Couples' HIV counselling and testing indicators were introduced in the performance-based financing approach at health facilities and the community level as well as in the performance contract that signed by His Excellency Mr. President of the Republic and district authorities. When pregnant women are unable to come with their partners, local cell leaders must notify the health centre and invitations letters are sent to the absent partners.
- Massive community mobilization campaigns undertaken by various groups to motivate all pregnant women and their spouses to test for HIV.
- Fast- tracking of women attending the antenatal care visit (ANC) with their spouses and provision of testing and counselling on weekends for partners who cannot attend ANC during working hours.

Lessons Learned:

- The high-level endorsement is a major motivating factor for accelerating increased male involvement in the PMTCT programme.
- It is crucial to hold local leaders accountable for the community mobilization of males in health care services.
- Promoting couple HIV counselling and testing as a national policy in PMTCT has increased awareness among health care staff and communities.
- The role of male champions (including community health workers and some volunteer patients) as peer educators and agents of change is decisive in promoting partner involvement in their communities' PMTCT programmes.

5 Major Challenges and Remedial Actions

5.1 Progress Made on Key Challenges Reported in 2007

In the UNGASS report submitted in 2008 (ref. 2007), a number of areas were identified as challenging to the achievement of the UNGASS targets. Some of them are discussed below.

5.1.1 HIV Prevention

Challenges as reported in 2007

An **evidence-based prevention strategy** was not developed and fully implemented as of 2007. Rwanda had plans to initiate a broad analysis of the drivers of the epidemic and an assessment of the needs of most-at-risk populations (such as sex workers and men who have sex with men) to ensure coherence of prevention efforts with observed HIV transmission patterns.

An additional challenge remained in **condom acceptance, use and availability**. Condoms were still associated with promiscuity, making it difficult for young people and married couples to negotiate condom use for HIV protection and as a family planning method. Moreover, condom distribution was not proportional to its use and there was a need to increase access by making condoms more easily available geographically and convenient for people to buy. There was a need for full alignment to the national condom policy, requiring at least a neutral stance by Faith Based Organizations with respect to messages about condoms.

There was widespread national discussion on the possibility of **male circumcision** in children and men to prevent the spread of STIs, including HIV.

Achievements in 2008 and 2009 and remaining challenges

In 2008 and 2009, focus was placed on „knowledge of the HIV epidemic'. A large body of evidence was built and analysed, including coverage of most-at-risk populations. In particular, the following studies were conducted:

- a joint review of the **HIV prevention** programme nationwide was carried out, including focus groups with beneficiaries at the district level – available at http://www.cnls.gov.rw/pdf/jointreview.pdf;
- the UNAIDS Modes of Transmission Model was used;
- a large HIV data synthesis/triangulation study was carried out by TRACPlus in 2008 with focus on prevention needs and coverage of services;
- a BSS on sex workers including biomarkers was initiated;
- a mapping of sex workers in the country was carried out;
- an exploratory study on men who have sex with men was conducted – available at www.cpc.unc.edu/measure/ publications/pdf/tr-09-72.pdf).

The new evidence on HIV transmission patterns and prevention needs was used to develop result-based strategies for the National Strategic Plan 2009-12. The remaining challenges are being able to build the capacity to align partners to the defined prevention priorities, in particular for most at risk populations, and to accelerate implementation so to achieve the target of halving HIV incidence by 2012 [*Source: EDPRS 2009-12, NSP 2009-12*].

Big advances were made in relation to **condoms**. In 2008, the WITERGERIZA Social Support Campaign, a large mass media campaign, was conducted to address parental support for young people with respect to sexual reproductive health information, including teaching young people how to use condoms. A religious leaders' workshop was organised to accelerate implementation of the Declaration that joined all religions denominations in a common commitment to work with and support Government efforts in family planning, condom use and open dialogue in families on sexual and reproductive health. In 2009, the World AIDS Campaign focused on condoms: a large mass media campaign was organised with the key message: *"Condom as a means of dual protection. Let's talk about it, let's access it, let's use it: a fundamental right for all!"* A condom demonstration kit was developed, over 500 kits distributed to support IEC agents and peer educators and about 600 out-of-school peer educators trained on condom demonstration. To normalize condom use and promote double protection, starting February 2009, 60 condoms were offered to each VCT client regardless of HIV status at youth centers. To date, over 1.1 million condoms have been distributed to high risk youth and mobile populations. In response to demand for a Rwandan studded condom, the Plaisir brand was developed based on extensive consumer input. Vending machines were launched in hot spots such as bars, restaurants, nightclubs and hotels. In addition, 2009 saw the inclusion of sex workers living around military barracks as peer educators into military anti-AIDS Clubs. Through the military HIV prevention programme, 2 million condoms were distributed in 2009.

However, condom use has not yet been „normalized' among the general population and it has been difficult to establish condoms as a form of dual protection due to high stigmatization among stable couples. Apart from availability at selected youth-friendly sites, access to condoms for youth remains low. Condoms are not yet widely available in high-risk settings such as bars, restaurants, hotels and cabarets. Establishing an effective and efficient private sector distribution chain outside of Kigali also remains a challenge.

In 2009, **male circumcision** was included in the 2009-2012 National Strategy Plan (NSP) to fight HIV and AIDS. Preliminary studies have been conducted (cost-effectiveness, KAP, facility readiness assessment) and an implementation strategy and plan are under development. Service delivery has started in the military health facilities in 2009 and 2010 will be the first year for implementation of the programme for the non-military (newborns, youth and adults).

5.1.2 HIV Integration

Challenges reported in 2007

There is need for better integration of HIV and AIDS with reproductive health and vice versa. For example, Rwandan women lack adequate exposure to and acceptance of family planning messages, HIV testing and sufficient ANC. Enhanced integration of PMTCT and reproductive health into overall health services would allow better follow-up of women and their children from a mother-child perspective. There is also a need to finalise the breast-feeding policy for HIV-positive women in accordance with country-specific needs.

Achievements in 2008 and 2009 and remaining challenges

The number of VCT, ARV and PMTCT services integrated into health services is increasing over the years (refer to specific sections in this report). Child follow up improved since growth cards were modified to accommodate for HIV. By 2010, the Government of Rwanda aims to increase to 80% the level of integration of HIV into family planning services at FOSA (HFS). This last action is particularly important considering the low level of family planning uptake, in particular

for long-term and permanent methods. Overall, Maternal, Newborn and Child Health programs provide a great venue for an integrated approach to the delivery of Family Planning, PMTCT, Malaria and Nutrition interventions and services. A justification for integration is to reach an at-risk audience of women of childbearing age at a time when the probability that they will visit a health service is greatest. In 2008 and 2009, the principles for the integrated approach, modalities of integration and implementation strategies were discussed in technical working groups an pilot experiences carried out by some implementing partners.

5.1.3 Funding issues

Challenges reported in 2007

Financial gaps exist at the level of health infrastructure. Though overall funding is high, there remains a large gap between the needs and the available resources for interventions for PLHIV, OVC and most at risk populations at the community level. In general, donor partners are unwilling to finance infrastructure, human resources and nutritional support for PLHIV.

Achievements in 2008 and 2009 and remaining challenges

Funding gaps in areas such as health infrastructure and nutrition for PLHIV remain. There is a need to review allocation of funds by donors (tracking resource exercises such as NASA and NHA will be useful for this matter) to ensure focus on effective HIV interventions. In general, allocation of HIV resources to vulnerable populations such as OVC is not sufficient. The challenge is to identify OVCs that need aid the most to make programs targeted at OVCs more prioritised and effective. Expectations are that the Global Fund financial support to the national strategy starting 2010 will help address this situation.

5.2 Challenges faced in 2010 and Remedial Actions planned

- ✓ Alignment of partners and effective implementation of the NSP 2009-2012. Funding by the GFTAM to the National Strategy Application is a new funding mechanism and it may require some adjustment and/or learning period. The scale up of implementation will need consequent human resources and capacity building.

- ✓ Build national capacity to provide HIV prevention services as a comprehensive package and ensure full geographic coverage and continuity, in particular for youth and for most at risk population (sex workers, MSM, prisons inmates). Design specific outreach strategies adapted to the different situations of these population groups and build CSOs capacity to work with these populations.

- ✓ Strengthen coordinating bodies (human resources) in particular for non-health EDPRS sectors for more effective HIV mainstreaming. Additionally, HIV institutions in Rwanda are undergoing profound changes with the creation of a Rwanda Biomedical Centre under the MOH that will include both the National AIDS Commission (CNLS) and TRACPlus. Partners will need to adjust to these institutional changes.

- ✓ Enhance the decentralized coordination structures; increase the capacity of CDLS to coordinate all district partners and civil society implementing organizations and to take an active role in fund allocation and decision making. Currently, there is a need to reduce

high turnover of staff and to ensure salaries in a sustainable way since development partners rarely support salaries for human resources.

- ✓ Coverage of PMTCT and ART services have reached high levels in Rwanda, the challenge for 2010 will be to ensure quality of these services and follow-up of patients, in particular for children and adolescents.

- ✓ The needs of most vulnerable children (OVC) are enormous, and access to even the minimum package of services is very limited. There is also a lack of reliable data both to estimate the actual needs and to assess the degree of access to needed services for OVC. Coordination of OVC activities at both district and national levels requires improvement. MIGEPROF is in charge of implementation, though they have a limited number of staff for this ambitious activity. It is urgent to conduct an audit of district-level OVC lists to see how many children on list meet national definition of "OVC".

- ✓ Addressing sexual and gender based violence remains a challenge, in particular for children. There is a need for more training to health staff on GBV issues and to ensure availability of kits for emergency treatment in all health centers.

6 Support from development partners

6.1 Key Support Received from Development Partners

Rwanda's commitment to the HIV response is well supported by donors and partners. Main donors include:

- The GFATM: Rwanda has received funding under Rounds 1, 3, 6 and 7 to: (i) scale up prevention activities; (ii) expand treatment and care; (iii) improve care and support for PLHIV and OVC; (iv) improve linkages between TB and HIV and AIDS services; (v) strengthen the health system and (vi) civil society capacity building. New National Strategic Application (NSA) 2010-2012 grants for HIV (for about 300 USD millions) and Tuberculosis (TB) are presently under negotiation with Global Fund;
- PEPFAR has supported all clinical and community activities and services in HIV and AIDS area;
- The African Development Bank (ADB) has also assisted the Government and the Civil society by supplying equipments and materials at national and decentralized levels;
- The Great Lakes Initiative on AIDS (GLIA) which is a regional project supporting interventions with migrant workers and refugees for HIV Prevention and access to Care and Treatment across 6 member countries.

Implementing partners are too many to mention and they are almost all funded by donors listed above. Technical assistance has been provided by a number of partners, notably, UNAIDS, the United Nations Development Programme (UNDP), the World Health Organization (WHO), the USG, and the GTZ.

In 2008, the "One UN pilot Programme in Rwanda" launched its Joint UN Plan for HIV and AIDS which brings together the work of all UN agencies in the country in a coordinated and comprehensive manner (as a sub-set of UNDAF 2008-12 and the Common Operational Document (COD) 2008-12). At the beginning of each year key deliverables, activities and funds for the entire UN system are defined and validated with national authorities, civil society and other national partners under three main outcomes: 1) Coordination, planning, M&E and partnership; 2) Prevention of HIV; 3) Mitigation of AIDS.

The interventions of all development partners in the Heath sector, including all HIV related activities, are consolidated in a Joint Annual Work Plan (JAWP).

6.2 Actions Necessary to the Achievement of the UNGASS Targets

For UNGASS targets to be met, partners should sustain their support to the national response in a harmonized and coordinated way. The National Strategic Plan on HIV and AIDS 2009-2012 has been developed with wide participation of all HIV stakeholders to reflect the priorities outlined in the EDPRS 2009-12 and cement the linkages between the country's development strategies, which already well-integrate HIV issues. The support of all partners support is aligned to national priorities. Among the most important innovations of the new strategic plan are the targeting of most-at-risk populations (MARPs) for prevention efforts and the increased involvement of non- health sectors and of civil society organizations in the national HIV response.

At the international level, efforts should be made to accelerate the harmonization process and to reduce reporting requests to countries. This would save time and resources and allow staff to concentrate on actual work at country level. On a positive note, in Rwanda there is now a national list of standard HIV indicators used by all development partners in the country and harmonised with EDPRS, MDGs, Universal Access, UNGASS, PEPFAR and Global Fund proposed Indicators. Where HIV resource tracking is concerned, harmonisation between NASA and NHA is in good progress: for 2010 a unique survey will be carried out responding to the main needs of health and non-health HIV stakeholders and the survey questionnaire and NASA-NHA categories are being integrated into the new national online Health Planning and Reporting tool so to track health and HIV spending in a routine way starting 2011.

7 Monitoring and Evaluation Environment

7.1 Overview of the Current Monitoring and Evaluation System

The National M&E system is primarily divided between health facility-based and community-based components of monitoring and evaluating the national response, and is decentralized from the national to district levels.

The health facility-based components of the M&E system are led by MOH and TRACPlus at the national level and District Health Officers at the district level. In general, health facility-based HIV M&E is integrated and mainstreamed within the existing M&E structures of MOH.

The community-based components of the M&E system generally refer to non-facility-based interventions at the community level. At the national level, CNLS coordinates the M&E of community-based interventions across EDPRS sectors, including public and private sector institutions, and the civil society response through the umbrella organizations. At the district level, the CDLS are responsible for the M&E of community-based interventions from implementing partners and the decentralized structures of the public and private sector institutions and civil society umbrellas.

Though the organizational structure of the M&E system at the national level is well established and functional, it has not been adequately decentralized to the district and community levels. An M&E assessment conducted in 2009 shows that the national level should improve the decentralized dissemination of the tools, guidelines and other reports and resources developed. At the same time, community and district-level stakeholders need to reinforce data collection and reporting measures from the district to national level. This would result in better instances of data use for decision making at all levels.

In 2009, simultaneously with the development of the NSP 2009-12, a national M&E Plan 2009-12 was developed. Following the organizing Framework for a Functional National HIV M&E System – 12 Components, the M&E plan describes how to assess the degree to which interventions are contributing to the achievement of national HIV NSP targets, while consistently monitoring trends in HIV prevalence and HIV related behaviours in the population as well as trends in HIV service delivery. For each of the NSP 2009-12 results, standard indicators (with baseline and targets) are developed and validated by all HIV stakeholders in the country. The plan is divided into twelve main components, as displayed in Figure 13, organized into three broad areas with sub-components in each area. The use of data for decision-making is the central component of the Plan/framework and reflects the ultimate purpose of M&E in general: using data to answer fundamental questions about a programme.

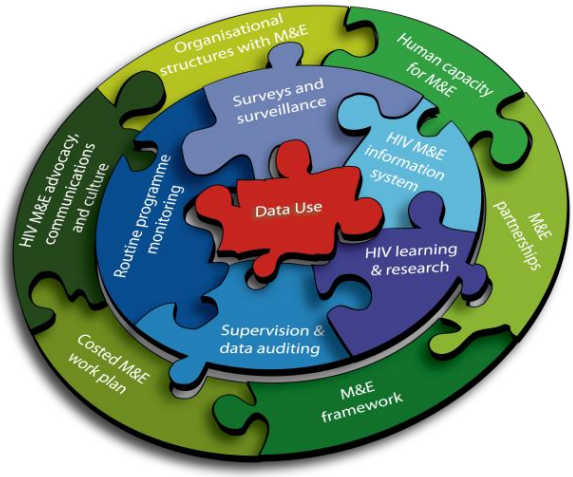

Figure 13: Organizing Framework for a Functional National HIV M&E System

7.2 Challenges for the Implementation of a Comprehensive Monitoring and Evaluation System and Remedial Actions Planned

A Monitoring and Evaluation Systems Strengthening Tool (MESST) Workshop was conducted by CNLS and MOH/TRACPlus in November 2009 with support by the Global Funds, UNAIDS and MEASURE Evaluation. The objective of the workshop was to assess the progress in HIV M&E activities from 2008 to 2009. The assessment was based on the 12 Components of the organizing framework of a functional national M&E system (see Figure 13 above). The Workshop findings indicate that the monitoring and evaluation system at the national level is reasonably strong, but that the M&E systems within the district and community levels still need more efforts for their improvement.

An integrated and costed Monitoring and Evaluation work plan was elaborated on the M&E system assessment with participation from government institutions at the national and decentralized level, civil society and international stakeholders involved in HIV and AIDS.

Challenges and recommended actions were identified and classified by some of the 12 M&E components as following:

Challenges	Remedial Actions Planned
Organisational Structures with HIV M&E Functions and Human Capacity for HIV M&E	
Though the structure is well defined from national to decentralized level, the individual capacities of staff needed for the system to work is limited and it has been difficult to recruit qualified staff at all levels and adequately train existing staff to better perform their job functions. Another major challenge is that there are not adequate numbers of staff at all levels. As a result, existing staff are overwhelmed by their job responsibilities.	• Revise the job descriptions of two technical assistant positions for CDLS into (i) one position for planning and coordination and (ii) one position for M&E • Provide external technical assistance to all EDPRS sectors to help fulfil M&E mandate related to HIV • Prepare and disseminate the National M&E training curricula (in service); train CDLS, Umbrellas, EDPRS sectors and Implementing partners on National HIV Planning, Monitoring and Evaluation system and tools
Routine programme monitoring	
Parallel reporting systems still exist. Also, linked to the human capacity challenges mentioned above, it is difficult to to make the community-based M&E system function	• Develop standard national guidelines and procedures for planning, data collection and reporting of routine programme data from CSOs • Update, print and disseminate existing HIV programme monitoring tools for community-based M&E system
HIV M&E Information system	
It has been difficult to set up linkages between national databases, as each institution has their respective data needs	• Update the National HIV database with the new NSP 2009-12 • Create linkages between relevant databases, but ensure that confidentiality is maintained and access is given to relevant

	individuals/institutions
Supervision and data auditing	
Difficult to establish a regular system of supervision and data quality audit. This could possibly due to the fact that it is labor intensive and takes a lot of time to develop and implement a robust supervisory system and feedback mechanism that is conducted on a regular basis.	• Strengthen supportive supervision and mentoring in M&E activities by updating tools and guidelines for supervision and data quality audit for CDLS (include sample supervisory checklist and a mechanism that fosters providing feedback and follow-up)
HIV learning and research	
	• Conduct annual international research conference (with a session on identifying research gaps and prioritize the research agenda) • Conduct regular HIV/AIDS research committee meetings • Develop an electronic inventory of all HIV and AIDS studies and research already conducted in Rwanda
Data use	
Data use principles and strategies are more or less integrated at the national level but still some work to do at the district level.	• Disseminate the 2008 review findings of the HIV/AIDS NSP (Joint Review of NSP 2005-9) • Provide feedback to district level partners on quarterly and annual reports of HIV and AIDS activities • Update current functioning resource center including e-library, acquisition of books on M&E, collect and send documents to update the national HIV/AIDS digital library.

8 Annexes

8.1 Annex 1: Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes*	No
b) NAP (National AIDS Programme)	Yes	No
c) Others	Yes	No

(please specify)

2) With inputs from

Ministries:

Education	Yes*	No
Health	Yes*	No
Labour	Yes*	No
Foreign Affairs	Yes	No*
Others	Yes*	No

All sectors in Rwanda participated in providing relevant inputs and in the review process

Civil society organizations	Yes*	No
People living with HIV	Yes*	No
Private sector	Yes*	No
United Nations organizations	Yes*	No
Bilaterals	Yes*	No
International NGOs	Yes*	No
Others	Yes*	No

(please specify) Other government institutions responsible for HIV; TRACPlus, CNTS, NRL and Districts' AIDS Control Committees, Civil society Umbrella organizations, human rights organizations

3) Was the report discussed in a large forum? Yes* No
4) Are the survey results stored centrally? Yes* No
5) Are data available for public consultation? Yes* No
6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Signature: 

Name / title: Dr. Anita ASIIMWE, CNLS Executive Secretary, Date: 31st March, 2010

Please provide full contact information:
Address: B.P. 7162, Kigali, Rwanda
Email: info@cnls.gov.rw ; anita.asiimwe@cnls.gov.rw
Telephone: + 250 503 980 Mobile: + 250 788 304 829

8.2 Annex 2: National Funding Matrix – 2007 and 2008

Cover Sheet

Contact Person at the National AIDS Authority/Committee (or equivalent):

Name: ITETE KARAGIRE Title: Data Analyst

Contact Information for the National AIDS Authority/Committee (or equivalent):
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Email: info@cnls.gov.rw
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Reporting Cycle: Calendar years 2007 and 2008

For a fiscal year reporting cycle, please provide the start and end month/year: Jan___ 2007___ to December___ 2008__

Local Currency: Rwanda francs

Average exchange rate with US dollars during the reporting cycle:

In 2007: 1 USD = 544 RwF
In 2008: 1 USD = 547 RwF

Methodology:

National AIDS Spending Assessments supplied the data for the National Funding Matrix.
The full report will be available at http://www.cnls.gov.rw

Unaccounted Expenditures:

(Please specify if there were expenditures for activities in any of the AIDS Spending Categories or subcategories that are not included in the National Funding Matrix and explain why these expenditures not included)

Not applicable

Budget Support:
Is budget support from an international source (e.g. a bilateral donor) included under the Central/National and/or Sub national subcategories under Public Sources of financing?

No

The National Funding Matrices for 2007 and 2008 are included below as Table 7 and **Error! Reference source not found.** respectively.

Table 7: National Funding Matrix 2007

National Funding Matrix			FINANCING SOURCE											
YEAR _2007_														
Calendar Year: Yes __X___ No _____														
Fiscal Year: Jan-Dec, 2007														
Average Exchange Rate for the year _____	1$=544RwF													
		TOTAL in US$	Public sources				International Sources							
AIDS Spending Categories			Public Sub Total	Central / National	Sub-National	All Other Public	International Sub Total	Bilateral	UN Agencies	Global Fund	MAP Project + PDRH World Bank	ADB	USG	All Other International
74 564 938		6,081,417	6,081,417			68 483 521	3,578,008	3,215,993	11,235,324	985,805	1,847,896	43,210,466	4,410,029	
1. Prevention (sub-total)		**626,483**	**626,483**			**16 488 768**	**687,749**	**2,372,545**	**2,339,119**	**179,820**	**29,641**	**10,293,939**	**585,955**	
1.1 Mass media			27,003				193,270	25,770	20,029	43,102	8,863	1,839,810	17,738	
1.2 Community mobilization			77,103				82,405	851,364	62,444	128,878	19,472	106,833	81,558	
1.3 Voluntary counseling and testing							156,519	56,629		1,487		1,762,726	91,389	
1.4 Programs for vulnerable and special populations													5,000	
1.5. Youth in school							195,361	579,402	9,576			1,333,554	55,082	
1.6 Youth out of school												321	5,000	
1.7 Prevention programs for PLHA													20,901	
1.8 Programs for sex workers and their clients													-	
1.9 Programs for MSM													-	
1.10 Harm reduction programs for IDUs													-	
1.11 Workplace activities							12,122	25,418				223,575	10,734	
1.12 Condom social marketing													-	
1.13 Public and commercial sector condom provision			3,980				48,072	1,243	2,832	6,353	1,306	541,992	22,510	
1.14 Female condom													-	
1.15 Microbicides													-	
1.16 Improving management of STIs								11,000				242,600	983	
1.17 Prevention of mother-to-child transmission								772,719				178,6781	150,000	
1.18 Blood safety			361,362										-	

1.19 Post-exposure prophylaxis													-
1.20 Safe medical injections												1,572,470	-
1.21 Male Circumcision													-
1.22 Universal precautions													-
1.99 Others / Not-elsewhere classified			157,035					49,000	2,244,238			88 ,277	125,060
2. Care and Treatment (sub-total)		**183,207**	**183,207**			**27,610,705**	**715,232**	**359,522**	**8,076,100**	**-**	**-**	**15,894,882**	**2,564,969**
2.1 Outpatient care							92,160	11,000				847,143	-
2.2 Provider initiated testing												1,123,905	-
2.3 Opportunistic infection (OI) prophylaxis													20,000
2.4 Antiretroviral therapy							73,522	29,000	118,821			10,118,353	1,523,309
2.5 Nutritional support							432,152	268,367				146,003	576,584
2.6 Specific HIV laboratory monitoring							32,821					470,839	-
2.7 Dental care													-
2.8 Psychological care							1,727	51,155				96,533	23,461
2.9 Palliative care													-
2.10 Home-based care							50,145					172,216	-
2.11 Additional/informal providers													300,000
2.12 Hospital care							32,705					447,768	-
2.13 Opportunistic infection (OI) treatment												173,195	-
2.99 Others / Not-elsewhere classified			183,207						7,957,279			2,298,927	121,615
3. Orphans and Vulnerable Children * (sub-total)		**2,599,863**	**2,599,863**			**6,758,774**	**101,201**	**132,514**	**-**	**-**	**-**	**6,477,785**	**47,274**
3.1 Education			2,424,111				101,201	82,585				1,022,778	34,390
3.2 Basic health care			175,752					38,414				2,800	2,216
3.3 Family/home support													
3.4 Community support								11,515				2,368	
3.5 Administrative costs													
3.9 Others / Not-elsewhere classified												5,449,839	10,668
4. Program Management and Administration Strengthening (sub-total)		**1,694,393**	**1,694,393**			**9,096,419**	**655,923**	**119,274**	**518,607**	**211,909**	**25,187**	6,855,165	710,354
4.1 Program management			151,566				128,615	18,893	13,194	32,413	5,974	1,646,206	200,733
4.2 Planning and coordination			934,185				441,914	70,477	232,728	71,886	14,551	1,457,377	388,281
4.3 Monitoring and evaluation			113,997				47,802	29,904	272,685	107,610	4,662	1,180,803	121,091
4.4 Operations research													
4.5 Sero-surveillance													249
4.6 HIV drug-resistance surveillance													
4.7 Drug supply systems												630,365	

4.8 Information technology												49,175	
4.9 Supervision of personnel													
4.10 Upgrading laboratory infrastructure			494,645				12,046					941,280	
4.11 Construction of new health centers							25,546					251,453	
4.99 Others / Not-elsewhere classified												698,507	
5. Incentives for Human Resources (sub-total)		**330,802**	**330,802**			**5,508,480**	**1,064,150**	**98,666**	**192,226**	**550,120**	**71,182**	**3,276,379**	**255,757**
5.1 Monetary incentive for physicians							41,305						
5.2 Monetary incentive for nurses							1,022,845						
5.3 Monetary incentive for other staff													
5.4 Formative education and build-up of an AIDS workforce													
5.5 Training			118,587					12,556	18,394	211,379	1,530	1,280,606	171,291
5.9 Others / Not elsewhere classified			212,215					86,110	173,832	338,741	69,652	1,995,773	84,466
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)		**1,215**	**1,215**			**578,626**	**124,146**	**28,694**	**100,995**	**33,562**	**399**	**99, 085**	**191,745**
6.1 Monetary benefits							31,006						
6.2 In-kind benefits			1,215				8,289	379	864	1,939	399		969
6.3 Social services													10,000
6.4 Income generation							37,568	28,315	100,131	31,623		3,795	154,041
6.9 Others / Not elsewhere classified							47,283					95,290	26,735
7. Enabling Environment and Community Development (sub-total)		**115,494**	**115,494**			**2,194,615**	**191,711**	**94,382**	**3,644**	**-**	**1,721,487**	**151,530**	**31,861**
7.1 Advocacy and strategic communication								94,382				9,028	31,861
7.2 Human rights													
7.3 AIDS-specific institutional development			115,494								1,721,487	1,425,01.4	
7.4 AIDS-specific programs involving women													
7.9 Others / Not elsewhere classified							191,711		3,644				
8. Research excluding operations research which is included under (sub-total)		**529,960**	**529,960**			**247,134**	**37,896**	**10,396**	**4,633**	**10,394**	**-**	**161,701**	**22,114**
8.1 Biomedical research							4,552						-
8.2 Clinical research								8,362					5,000
8.3 Epidemiological research							31,346						5,000
8.4 Social science research												161,701	-
8.5 Behavioral research													-
8.6 Research in economics													10,000
8.7 Research capacity strengthening													-
8.8 Vaccine-related research													-
8.9 Others / Not elsewhere classified			529,960				1,998	2,034	4,633	10,394			2,114

Table 8: National Funding Matrix 2008

National Funding Matrix			FINANCING SOURCE											
YEAR _2008_														
Calendar Year: Yes __X___ No _____														
Fiscal Year: Jan-Dec, 2008														
Average Exchange Rate for the year _____	1$=547RwF													
		TOTAL in US$	Public sources				International Sources							
AIDS Spending Categories			Public Sub Total	Central / National	Sub-National	All Other Public	International Sub-Total	Bilateral	UN Agencies	Global Fund	MAP Project + PDRH World Bank	ADB	USG	All Other International
110 811 596			6,133,292	6,133,292			104,678,304	4,853,897	2,718,463	26,924,796	366,902	2,821,479	59,529,512	7,463,255
1. Prevention (sub-total)			676, 015	676,015			28,632,070	1,502,966	1,738,769	9,511,270	114,551	32,965	14,842,873	888,676
1.1 Mass media				23,820				194,543	27,905	15,679	16,980	6,958	1,555,520	53,376
1.2 Community mobilization				89,026				234,557	786,437	54,129	97,571	26,007	658,111	104,486
1.3 Voluntary counseling and testing								333,837	49,850				1,500,551	96,591
1.4 Programs for vulnerable and special populations														5,000
1.5. Youth in school								285,648	594,505	1,799			368,927	6,495
1.6 Youth out of school								40,978					262,701	5,000
1.7 Prevention programs for PLHA								34,960						83,340
1.8 Programs for sex workers and their clients														-
1.9 Programs for MSM														-
1.10 Harm reduction programs for IDUs														-
1.11 Workplace activities								33,978	5,000				910	25,427
1.12 Condom social marketing								14,727						-
1.13 Public and commercial sector condom provision								287,221		192,992			930,115	-
1.14 Female condom														-
1.15 Microbicides														-
1.16 Improving management of STIs													268,700	2,696
1.17 Prevention of mother-to-child transmission									40,577	211,629			2,678,358	200,000
1.18 Blood safety				423,941									3,000,000	-

1.19 Post-exposure prophylaxis													-
1.20 Safe medical injections												1,482,420	-
1.21 Male Circumcision								76,393					-
1.22 Universal precautions													-
1.99 Others / Not-elsewhere classified			139,228				42,517	158,102	9,035,042			2,136,560	306,265
2. Care and Treatment (sub-total)		**162,433**	**162,433**			**44,507,624**	**1,188,935**	**224,932**	**16,369,446**	**-**	**-**	**22,748,233**	**3,976,078**
2.1 Outpatient care							107,650					1,139, 038	-
2.2 Provider initiated testing												1,241,855	-
2.3 Opportunistic infection (OI) prophylaxis													30,000
2.4 Antiretroviral therapy							252,503	22,499	140,038			11,779,798	2,216,657
2.5 Nutritional support							439,074	60,392	45,602			232,815	961,674
2.6 Specific HIV laboratory monitoring							35,742	84,963				3,996,385	-
2.7 Dental care													-
2.8 Psychological care							1,727	57,078				85,028	46,682
2.9 Palliative care													-
2.10 Home-based care							69,377					497,276	-
2.11 Additional/informal providers													350,000
2.12 Hospital care							198,299					250,195	-
2.13 Opportunistic infection (OI) treatment												1,572,021	-
2.99 Others / Not-elsewhere classified			162,433				84,563		16,183,806			195,821	371,065
3. Orphans and Vulnerable Children * (sub-total)		**2,801,731**	**2,801,731**			**10,048,516**	**69,340**	**128,863**	**-**	**-**	**-**	**9,624,763**	**225,550**
3.1 Education			2,713,236				69,340	73,197				501,336	141,465
3.2 Basic health care			88,495					45,530				15,053	31,641
3.3 Family/home support													
3.4 Community support								10,136				113,635	42,172
3.5 Administrative costs													
3.9 Others / Not-elsewhere classified												8, 994,739	10,272
4. Program Management and Administration Strengthening (sub-total)		**1,417,370**	**1,417,370**			**11,855,180**	**756,846**	**231,680**	**430,488**	**42,549**	**17,437**	**8,976,694**	**1,399,486**
4.1 Program management			136,364				98,691	16,099	225,441	14,499	5,942	1,270,841	540,798
4.2 Planning and coordination			698,977				106,891	83,471	184,511	19,001	7,787	2,495,144	683,508
4.3 Monitoring and evaluation			59,104				436,033	16,348	20,536	9,049	3,708	2,695,253	175,180
4.4 Operations research													-
4.5 Sero-surveillance								30,000					

													-
4.6 HIV drug-resistance surveillance													-
4.7 Drug supply systems												1,494,788	-
4.8 Information technology												153,557	-
4.9 Supervision of personnel													-
4.10 Upgrading laboratory infrastructure			416,789				10,862	85,762				2,610,705	-
4.11 Construction of new health centers			106,136				104,369						-
4.99 Others / Not-elsewhere classified												606,041	-
5. Incentives for Human Resources (sub-total)		**327,161**	**327,161**			**4,588,384**	**546,196**	**240,238**	**576,168**	**162,060**	**66,413**	**2,549,793**	**447,516**
5.1 Monetary incentive for physicians													
5.2 Monetary incentive for nurses													
5.3 Monetary incentive for other staff													
5.4 Formative education and build-up of an AIDS workforce													
5.5 Training			103,630				82,282	98,559	411,140	2,716	1,113	765,353	291,777
5.9 Others / Not elsewhere classified			223,531				463,914	141,679	165,028	159,344	65,300	1,784,440	155,739
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)		**-**	**-**			**1,182,569**	**1,283,576**	**36,661**	**17,339**	**40,501**	**-**	**2,549,793**	**371,397**
6.1 Monetary benefits							43,136						-
6.2 In-kind benefits								9,501				7,101	1,406
6.3 Social services								2,235					10,000
6.4 Income generation							423,665	24,925	17,339	40,501		15,871	347,251
6.9 Others / Not elsewhere classified							41,887					185,011	12,740
7. Enabling Environment and Community Development (sub-total)		**274,330**	**274,330**			**2,539,166**	**2,594,353**	**83,083**	**14,299**	**-**	**2,047,248**	**101,494**	**128,537**
7.1 Advocacy and strategic communication							34,960					31,211	82,208
7.2 Human rights								83,083					5,496
7.3 AIDS-specific institutional development			274,330								2,047,248	23,977	1,771
7.4 AIDS-specific programs involving women													
7.9 Others / Not elsewhere classified							184,732		14,299			46307	39,062
8. Research excluding operations research which is included under (sub-total)		**474,252**	**474,252**			**1,168,601**	**1,168,601**	**34,237**	**5,786**	**7,241**	**657,416**	**376,672**	**26,015**
8.1 Biomedical research													-
8.2 Clinical research											654,449		5,000
8.3 Epidemiological research							55,481					1,671	5,000

8.4 Social science research							2,032						-
8.5 Behavioral research													-
8.6 Research in economics													10,000
8.7 Research capacity strengthening													-
8.8 Vaccine-related research													-
8.9 Others / Not elsewhere classified			474,252				3,721	34,237	5,786	7,241	2,967	375,001	6,015

8.3 Annex 3: National Composite Policy Index (NCPI)

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: GAKUNZI Sebaziga, Monitoring & Evaluation Officer, National AIDS Control Commission (CNLS)

Postal Address: P.O Box: 7162 Kigali/Rwanda

Email: gakunzi.sebaziga@cnls.gov.rw

Tel: (+250) (0) 788 407 969

Date of submission: 31 March, 2010

Describe the process used for NCPI data gathering and validation:

Data for the National Composite Policy Index (NCPI) Questionnaire Part B were collected under the leadership of the Network of People Living with HIV (RPP+) and the NGO Forum on HIV/AIDS and health promotion. The NCPI Part B questionnaire was distributed to all the main NGOs working in the HIV field, to several human rights organisations, the HIV umbrella civil society organisations, the UN agencies and other development partners/donors. Following preparatory consultation with different constituencies, more than 55 stakeholders met on 18th December 2009 at Sports View Hotel for a large consensus meeting on the answers to the questionnaire. In order to guarantee full independence in the information provided, the government did not participate in that meeting.

Part A of the NCPI Questionnaire was completed by CNLS staff, representatives from District AIDS Control Committees (CDLS), the MOH, the Treatment and AIDS Research Center (TRACPlus), the National Blood Transfusion Centre and the EDPRS Sectors.

Describe the process used for resolving disagreement, if any, with respect to the response to specific questions:
No major disagreements were recorded around answers to the questionnaire. Large consultations and consensus meetings were held; discussions were transparent, open and constructive. Evidence/data was used to reach consensus when opinions were different.

Highlight concerns – if any – related to the final NCPI data submitted: N/A

Respondents

NCPI - PART A [government officials]

Organization	Name/Position	**Respondents to Part A** *Indicate which parts each respondent was queried on*				
		A.I	A.II	A.III	A.IV	A.V
CNLS	ASIIMWE Anita	√	√	√	√	√
CNLS	AYINGOMA Jean Pierre	√	√	√	√	√
CNLS	DONGIER Pierre	√	√	√	√	√
CNLS	GAKUNZI Sebaziga	√	√	√	√	√
CNLS	IYAMUREMYE Marc Antoine	√	√	√	√	√
CNLS	KARAGIRE Itete	√	√	√	√	√
CNLS	KIROTA Kyampof	√	√	√	√	√
CNLS	KOLEROS Andrew	√	√	√	√	√
CNLS	MUTAMULIZA Florida	√	√	√	√	√
CNLS	NDENGEYE Joseph	√	√	√	√	√
CNLS	NZEYIMANA David	√	√	√	√	√
CNLS	RUSINE Emmanuel	√	√	√	√	√
CNLS	RWAKUNDA U. Amina	√	√	√	√	√
CNLS	UMUHIRE Sabine	√	√	√	√	√
CNLS	UWIMPUWE Sidonie	√	√	√	√	√
CNLS/UNFPA	NTWALI Andrew	√	√	√	√	√
CDLS/Gisagara	KAYIRANGA Callixte	√	√	√	√	√
CDLS/Kayonza	MUHIMA L. Edouard	√	√	√	√	√
CDLS/Kicikiro	MUKAMANZI N. Clotilde	√	√	√	√	√
CDLS/Musanze	MUTUYIMANA Justin	√	√	√	√	√
CDLS/Nyabihu	MUGWANEZA Clémentine	√	√	√	√	√
CDLS/Nyagatare	BIZIMANA B. Rolanda	√	√	√	√	√
CDLS/Nyamagabe	BANA Emma-Marie	√	√	√	√	√
CDLS/Nyarugenge	BUKEYENEZA Christelle	√	√	√	√	√
CDLS/Rubavu	TUYIZERE Joseph	√	√	√	√	√
CDLS/Rulindo	GATO Fredrick	√	√	√	√	√
MININFRA	MUSONI Emmanuel	√	√	√	√	√
MINIYOUTH	MUTABAZI Vianney	√	√	√	√	√
MINIYOUTH	NIYITEGEKA Jean Marie Vianney	√	√	√	√	√
TRAC Plus/HIV	HAJABASHI Jeanne d'Arc	√	√	√	√	√
TRAC Plus/HIV	HINDA Ruton	√	√	√	√	√
TRAC Plus/HIV	KARANGWA Chaste	√	√	√	√	√
TRAC Plus/TB	HABIMANA Innocent	√	√	√	√	√

NCPI - PART B [Civil society umbrellas, NGOs, Human rights organizations, bilateral agencies, UN]

Organisation	Name/Position	Respondents to Part B (indicate which parts each respondent was queried on)			
		B.I	B.II	B.III	B.IV
UNAIDS	PEGURRI Elisabetta, M&E Adviser	√	√	√	√
UNAIDS	RUTURWA-H Dieudonné, SMA	√	√	√	√
WHO	SOBELA François, Team Leader, HIV Focal Point	√	√	√	√
UNICEF	KAMUKUNZI Mecthilde, Youth/HIV Officer	√	√	√	√
RRP+ (PLHIV)	MUTAGOMA Madina, M&E Coordinator	√	√	√	√
RRP+ (PLHIV)	GASAMAGERA Jean de Dieu, Directeur des Programmes	√	√	√	√
RRP+ (PLHIV)	NIZEYIMANA Isabelle, Animatrice Communautaire	√	√	√	√
RRP+ (PLHIV)	KAGOYIRE Beatrice, Présidente	√	√	√	√
RRP+ (PLHIV)	GUMUYIRE Joseph, Executive Secretary	√	√	√	√
RRP+ KICUKIRO	UWABASINGA Rose, Présidente	√	√	√	√
Rwanda NGO Forum	Aimable MWANANAWE, President	√	√	√	√
Rwanda NGO Forum	NSENGIMANA Fabien, Accountant	√	√	√	√
Rwanda NGO Forum	RUSANGANWA Léon Pierre, Secrétaire Executif	√	√	√	√
Rwanda NGO Forum	DUSABAMAHORO M. Gorethi, Assistante Administrative	√	√	√	√
Rwanda NGO Forum	HAKIZIMANA Théophile, Reporter	√	√	√	√
Rwanda NGO Forum	RUSIMBI John, M&E	√	√	√	√
Rwanda NGO Forum	MUREBWAYIRE Aline, Programme/Assist	√	√	√	√
AVEGA	Dr. RANGIRA Ephrem, Représentant de l'ONG	√	√	√	√
FAAS Rwanda	TURYAHEBWA Robert, Chairman of the Board of Governors	√	√	√	√
KANYARWANDA	RUBAYIZA Samuel, Secrétaire Exécutif	√	√	√	√
Journal UMUSINGI	GATSIMBANYI Nerson, Editor-in-Chief	√	√	√	√
Ejonzamerante	RUKWATAGE Janvier, Représentant	√	√	√	√
SOLUVAS	BIGIRIMANA Célestin, Programme Coordinator	√	√	√	√
CREDI	NTAGANIRA Martin, Programme Officer	√	√	√	√
ATEDEC	MAHORO Rubibi Alexis, Coordinateur	√	√	√	√
Hope for living	NDUWAYO Clémence, Coordinatrice	√	√	√	√
SODECO	KAGABO M. Jean de Dieu, Accountant	√	√	√	√
VSO	NSHIMIYIMANA J. Claude, HIV Project Coordinator	√	√	√	√
Right to Play	KAMANZI Steve, Project Coordinator	√	√	√	√
RCLS	UZAMUSHAKA Ernestine, Gestionnaire	√	√	√	√
ARDIF	KANKINDI Jeanne, Chair	√	√	√	√
UPHLS	MAKAZI Roger, Stagiaire	√	√	√	√
ABASIRWA	TUMWESIGIRE Peace, Secretary General	√	√	√	√
HDI-Rwanda	Dr. KAGABA Aflodis, Executive Director	√	√	√	√
AIMR	TINYA Joseph, Program Director	√	√	√	√
Rwanda News	RUTAZIGWA Alphonse, Reporter	√	√	√	√

Agency					
PREFED	MPAKANIYE Laban, ProgramManager	√	√	√	√
World Vision Rwanda	MUTEBUTSI Hubert, HIV Program Coordinator	√	√	√	√
ASSIST-Rwanda	SHAMAKOKERA Emmanuel, Board-Chairman	√	√	√	√
EPR	Dr. KAYIHURA Félix, Program Coordinator	√	√	√	√
AFRICAIRE	GATAMBIYE Jean Pierre, HCTO	√	√	√	√
FACT-Rwanda	Dr. KASHAKA KAREGEYA Davis, Executive Director	√	√	√	√
FACT-Rwanda	MUKASAKINDI Hildegarde, Rehabilitation Centre Manager	√	√	√	√
PSI Rwanda	Philibert RUGUMIRE, HIV PSI Rwnda Director	√	√	√	√
Radio FLASH	NTAWUYIRUSHAMABOKO Célestin, Journalist	√	√	√	√
Radio SALUS	NYANDWI Benjamin, Journalist	√	√	√	√
Journal Amahoro	NTAKINDI Amani, Journalist	√	√	√	√
FAWE	INGABIRE J. Claude Pacifique, APO	√	√	√	√
CSDI	KIMENYI B. Dieudonné, Chairman Board	√	√	√	√
VCO	MWUNGURA Armstrong, Field Facilitator	√	√	√	√
SWAAR	MUTABAZI Alex, OVC / Officer	√	√	√	√
City Radio	MUVARA Eric, Journalist	√	√	√	√
Rushyashya	BYIRINGIRO J. Elysée, Journalist	√	√	√	√
VOCO	RWAGASORE R. Jean, Project Manager	√	√	√	√
ANSP+	TWAGIRIMANA François, V/S Président	√	√	√	√
ICAP	MUGISHA Veronique, Clinical director	√	√	√	√
	Idi Gaparay, Human rights consultant	√	√	√	√

Part A

[Administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

Yes √	No	Not Applicable (N/A)

Period covered: 2009-2012

IF NO or N/A, briefly explain

***IF YES*, complete questions 1.1 through 1.10; otherwise, go to question 2.**

1.1 How long has the country had a multisectoral strategy?

Number of Years: 8 years

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	**Strategy/Action framework**	**Earmarked budget**
Health	Yes √ No	Yes √ No
Education	Yes √ No	Yes √ No
Labour	Yes √ No	Yes √ No
Transportation	Yes √ No	Yes √ No
Military/Police	Yes √ No	Yes √ No
Women	Yes √ No	Yes √ No
Young people	Yes √ No	Yes √ No
Other3: Agriculture	Yes √ No	Yes √ No
Human Resources	Yes √ No	Yes √ No
Justice	Yes √ No	Yes √ No
Minerals and Energy	Yes √ No	Yes √ No
Public Works	Yes √ No	Yes √ No
Add in a line for every EDPRS sector: Social protection, Education, Justice, Infrastructures, etc	Yes √ No	Yes √ No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities

[3] Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. Yes √ No
b. Young women/young men	b. Yes √ No
c. Injecting drug users	c. Yes No√
d. Men who have sex with men	d. Yes √ No
e. Sex workers	e. Yes √ No
f. Orphans and other vulnerable children	f. Yes √ No
g. Other specific vulnerable subpopulations	g. Yes √ No
Refugees	h. Yes √ No
Truckers and transport workers	i. Yes √ No
Sero-discordant couples	j. Yes √ No
People with disabilities	k. Yes √ No
Uniformed personnel	l. Yes √ No
Settings	
h. Workplace	h. Yes √ No
i. Schools	i. Yes √ No
j. Prisons	j. Yes √ No
Cross-cutting issues	
k. HIV and poverty	k. Yes √ No
l. Human rights protection	l. Yes √ No
m. Involvement of people living with HIV	m. Yes √ No
n. Addressing stigma and discrimination	n. Yes √ No
o. Gender empowerment and/or gender equality	o. Yes √ No

1.4 Were target populations identified through a needs assessment?

Yes√	No

IF YES, when was this needs assessment conducted? Year:

- Truckers: 2006 BSS, VCT data from FHI Roads
- Young women and girls: youth data from DHS, national BSS in 2006 which included youth, UNICEF KAP on youth in 2007, qualitative studies by PSI in 2007/8
- Prisoners: VCT data since 2008, some qualitative studies by PSI in 2007, KAP in Kimironko and PCK in 2007
- Situational analysis of OVC conducted in 2008
- Joint review of the NSP conducted in 2008 provided an overall assessment of HIV epidemiology and current response in order to identify gaps and recommendations that were used during NSP development
- 2009 for MSM in Kigali
- CSWs in 2009: sex worker mapping by PSI and TRAC Plus, sex worker programming workshop held by UNFPA and CNLS in 2009

- Stigma and discrimination baseline conducted in 2009 by UNAIDS and RRP+ (stigma index)
- People with disabilities: UHLPS conducted a situational analysis of HIV and people with disabilities in 2009
- Sero-discordant couples: empirical evidence from recent research studies conducted by Projet San Francisco (PSF), DHS data on sero-discordance

IF NO, How were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country? *[Write in]*

Please refer to the list of target populations described in 1.4 above. This list includes all target populations identified in the multisectoral strategy.

1.6 Does the multisectoral strategy include an operational plan?

Yes √	No

1.7 Does the multisectoral strategy or operational plan include: *

a. Formal programme goals?	Yes √	No
b. Clear targets or milestones?	Yes √	No
c. Detailed costs for each programmatic area?	Yes √	No
d. Indications of funding sources?	Yes √	No
e. Monitoring and Evaluation framework?	Yes √	No

*The development of the operational plan began in 2009 and is currently ongoing. The aspects mentioned above are in varying levels of development as part of the operational plan. A final plan is expected within the first year of the 2009-2012 National Strategic Plan implementation.

1.8 Has the country ensured "full involvement and participation" of civil society [4] in the development of the multisectoral strategy/action framework?

Active involvement √	Moderate involvement	No involvement

IF active involvement, briefly explain how this was done:
The National Strategic Plan was developed between January and March 2009. The process, was led by the Executive Secretariat of the National AIDS Commission (commonly known by its French abbreviation "SE-CNLS"). It was designed to ensure broad participation in both the interpretation of the various analyses and the development of priorities and implementation strategies for the new Plan. The key stages in the process were as follows: 1. Design and Preparation of the National Strategic Plan development process: The

[4] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

process was designed by the SE-CNLS. As well as defining the remaining stages, timelines and modalities for ensuring participation at the appropriate stages, the SE-CNLS consolidated the key findings of the analytical work carried out in preparation for the strategic planning process, and reviewed evidence of effective HIV interventions from Rwanda and globally.

2. Workshop, *Know your epidemic; know your response*, 20-22 January 2009: The aims of this workshop were to analyze the HIV epidemic in Rwanda; to review the national, regional and global evidence base for a number of key strategies to fight HIV and AIDS; and to define priorities for the next plan. Over 100 participants attended the workshop, representing all of the main government sectors, the key agencies involved in the response to HIV and AIDS, civil society organizations, district AIDS coordinators, and technical and financial partners.

3. Definition of strategic outline: Work was carried out internally by the SE-CNLS team, in consultation with the Centre for Treatment and Research on HIV/AIDS, Malaria, Tuberculosis and other epidemics and the Rwandan national network of people living with HIV (RRP+), in order to define the overall outline and vision for the National Strategic Plan.

4. Workshop, *Strategic planning*, 27-29 January 2009: During this workshop, stakeholders defined the key results and the strategies that could be used to achieve them for inclusion in the new National Strategic Plan. The workshop was attended by the same participants as the *Know your epidemic; know your response* workshop.

5. Development of operational details: Major operational details include targets, resource needs analysis, operational plan, budget, and the monitoring and evaluation plan. These aspects were developed through ongoing consultations with the relevant agencies and partners, including an operational planning workshop. The workshop also ensured harmonization of the NSP with the Health Sector Strategic Plan II and health sector plans for HIV and tuberculosis.

6. Situation analysis of the role of civil society in the response against HIV and AIDS in Rwanda: In order to better describe civil society's role in the national HIV response, a thorough process was undertaken by the coordinating agencies of CSOs (Civil Society Umbrellas) to analyze the present contribution of this sector to the HIV response and to identify the gaps and needs for the strengthening of the sector.

7. Finalization of the National Strategic Plan: The plan was drafted and finalized on the basis of the inputs described above. The final plan was validated by ongoing consultation with all the main actors during the finalization of the document, by thorough analysis of the document by a group of peer reviewers at the national and international levels and by a validation meeting including all the main stakeholders of the national HIV response, including civil society.

IF NO or MODERATE involvement, briefly explain:

1.9 Has the multisectoral strategy been endorsed by most external Development Partners (bi-laterals, multi-laterals)?

Yes √	No

1.10 Have external Development Partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners √	Yes, some partners	No
IF SOME or NO, briefly explain		

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/United Nations Development Assistance Framework, c) Poverty Reduction Strategy, d) Sector Wide Approach?

Yes √	No	N/A

2.1 ***IF YES***, in which development plans is policy support for HIV and AIDS integrated?

a.National Development Plans	Yes √	No	N/A
b.Common Country Assessments/UN Development Assistance Framework	Yes √	No	N/A
c. Poverty Reduction Strategy (EDPRS)	Yes √	No	N/A
d. Sector Wide Approach (HSSP II)	Yes √	No	N/A
e. Others:	Yes √	No	N/A

- District Development Plans (in 2007)
- Rwanda District Health System Strengthening Framework – undertaken by the Ministry of Health. This framework provides a full picture of the current state of the health system, and provides strategies to improve the system with estimates of the associated investment and operational costs. Based on this framework, detailed plans were developed with each district.
- Vision 2020
- OVC National Strategic Plan
- National Youth strategic plan

2.2 ***IF YES***, which specific HIV-related areas below are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV Prevention	Yes √	No
Treatment for opportunistic infections	Yes √	No
Antiretroviral therapy	Yes √	No
Care and support (including social security or other schemes)	Yes √	No
AIDS impact alleviation	Yes √	No
Reduction of **gender** inequalities as they relate to HIV prevention/treatment, care and/or support	Yes √	No
Reduction of **income** inequalities as they relate to HIV	Yes √	No

prevention/ treatment, care and /or support		
Reduction of stigma and discrimination	Yes √	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes √	No
Other: *[write in]* Research, OVC, Health system strengthening, M&E	Yes√	No

3. **Has the country evaluated the impact of HIV on its socio-economic development for planning purposes?**

Yes √	No	N/A

3.1 ***IF YES***, to what extent has it informed resource allocation decisions?

Low					High
0	1	2	3	**4**√	5

4. **Does the country have a strategy for addressing HIV issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?**

Yes√	No

4.1 ***IF YES***, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	Yes √	No
Condom provision	Yes √	No
HIV testing and counselling*	Yes √	No
STI services	Yes √	No
Treatment	Yes √	No
Care and support	Yes √	No
Others: *[write in]* Male circumcision	Yes √	No

If HIV testing and counselling is provided to uniformed services, briefly describe the approach taken (e.g., indicate if HIV testing is voluntary or mandatory etc):
The HIV testing and counselling is provided on a voluntary basis to uniformed personnel. Care and support programmes reach uniformed services as much as is given to the general Population.

Military and police hospitals all provide VCT and HIV care and support services including ART. Male circumcision services are also available on a voluntary basis at these hospitals.

5. **Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?**

Yes√	No

5.1 If YES, for which subpopulations?

a.	Women	Yes √	No
b.	Young people	Yes √	No
c.	Injecting drug users	Yes	No √
d.	Men who have sex with men	Yes	No√
e.	Sex workers	Yes	No√
f.	Prison Inmates	Yes √	No
g.	Migrants/mobile populations	Yes √	No
h.	Other:	Yes	No

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes√	No

5.1 If YES, for which subpopulations?

a.	Women	Yes	No
b.	Young people*	Yes	No
c.	Injecting drug users	Yes	No
d.	Men who have sex with men	Yes	No
e.	Sex workers	Yes √	No
f.	Prison Inmates	Yes √	No
g.	Migrants/mobile populations	Yes	No
h.	Other:	Yes	No

* Not an enabling environment for condom distribution in schools though not an official law, regulation or policy
Condom utilization is avoided in prison while we know that homosexuality exist among prisoners.

If yes, briefly explain what mechanisms are in place to ensure these laws are implemented:
This question is not clear – CNLS Rwanda suggests revision of it

Briefly comment on the degree to which these laws are currently implemented:
This question is not clear – CNLS Rwanda suggests revision of it

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes √	No

7.1 Has the National Strategy and national HIV budget been revised accordingly?

Yes √	No

7.2 Have the estimates of the size of the main target population been updated?

Yes √	No

7.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs √	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes for facility-based services √	No for community-based services

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes for facility-based services √	No for community-based services

(b) ***IF YES***, is coverage monitored by population groups?

Yes for facility-based services in some populations √	No for community-based services

IF YES, for which populations groups?

Coverage of facility-based services is monitored for the following groups:

- Men and women
- Adults and children
- Prisoners
- Refugees
- People in uniform

No coverage data for community-based services by population groups

Briefly explain how this information is used:

Is used to ensure geographic equity of interventions for facility-based services

(c) Is coverage monitored by geographical area?

Yes for facility-based services √	No for community-based services

IF YES, at which levels (provincial, district, other)?

- District level

Briefly explain how this information is used:

- Is used to ensure equitable repartition of interventions based on district needs.

7.4 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes √	No

Overall how would you rate *strategy planning efforts* in the HIV programmes in 2009?										
2009	Very Poor									Excellent
0	1	2	3	4	5	6	7	8	9	10 √

Since 2007, what have been key achievements in this area?

- ✓ Development of an evidence-based national strategic plan using a results-based approach to planning and management
- ✓ Full alignment of NSP to other national strategic planning documents including EDPRS and HSSPII

What are remaining challenges in this area?

- ✓ Development of comprehensive HIV prevention packages targeted to most at risk populations and ensuring that they are implemented in a quality-assured and continuous manner
- ✓ Coordination of service delivery at the decentralized level, particularly among civil society implementing organizations

II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings, allocation of national budgets to support the HIV programmes and effective use of government and civil society organizations to support HIV programmes.

1. **Do high officials speak publicly and favorably about HIV efforts in major domestic forum at least twice a year?**

President/Head of government	Yes √	No
Other high officials	Yes √	No
Other officials in regions and/or districts	Yes √	No

2. **Does the country have an officially recognized national multisectoral AIDS management/ coordination body? (National AIDS Council or equivalent)?**

Yes √	No

IF NO, briefly explain:

2.1 ***IF YES***, when was it created? Year: 2001

2.2 ***IF YES***, who is the Chair? Dr WAYITU Apolline
[write in name and title/function]

2.3 ***IF YES***, does it:

Have terms of reference?	Yes √	No
Have active Government leadership and participation?	Yes √	No
Have a defined membership? If yes, how many members? Include civil society representatives? If yes, how many? Include people living with HIV? If yes, how many? Include the private sector	Yes √ 7 Yes 2 Yes √ 1 Yes √	No No No No
Have an action plan?	Yes √	No
Have a functional Secretariat?	Yes √	No
Meet at least quarterly? Review actions on policy decisions regularly? Actively promote policy decisions? Provide opportunity for civil society to influence decision-making? Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes √ Yes √ Yes √ Yes √ Yes √	No No No No No

3. **Does the country have a mechanism to promote interaction between government, civil society, and the private sector for implementing HIV strategies/programmes?**

Yes √ **No** **N/A**

IF YES, what are the main achievements

Some of the achievements of umbrella organizations (ref. Situation Analysis of the role of civil society in the response to HIV/AIDS in Rwanda, April 2009) were:

- Most umbrellas have created decentralized committees at district level. In many districts representatives of umbrellas participate in the District AIDS Committees (CDLS), which are in charge of the overall coordination of planning and monitoring and evaluation of all HIV-related activities in the district.
- The existence of umbrellas and their advocacy efforts have led to a greater participation of civil society in planning and formulation of policies at the community and national levels.
- Technical support coordinated by the umbrellas for their member organizations has had some positive outcomes in terms of improved interventions, for example the production of materials adapted to the needs of PWDS (UPHLS) or to religious leaders and communities (RCLS). Institutional strengthening has improved governance in associations and cooperatives of PLHIV (RRP+). However capacities to provide technical support remain limited and umbrellas still rely on external partners.

Briefly describe the main challenges:
Capacities to provide technical support by umbrellas to their constituencies remain limited and umbrellas still need to rely on external partners.

Please refer to civil society situational analysis, April 2009, for more details

4. **What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?**
   Percentage**:** Please refer to NASA 2007-2008 – for 2009 data are not available

5. **What kind of support does the NAC (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?**

Information on priority needs	Yes √	No
Technical guidance	Yes √	No
Drugs/supplies procurement and distribution	Yes √	No
Coordination with other implementing partners	Yes √	No
Capacity-building	Yes √	No
Other: *[write in] Financial support, Equipments, Technical Assistant*	Yes √	No

6. **Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?**

Yes √	No

6.1 ***IF YES***, were policies and legislation amended to be consistent with the National AIDS Control policies?
Currently ongoing in collaboration with partners including USAID and UNAIDS. This is part of national strategy

Yes √	No

IF YES, name and describe how the policies/laws were amended:
Penal code revision concerning the criminalization of men who have sex with men and Ministerial orders and instructions to strengthen enabling environment for HIV service delivery. For example:

- Ministerial instructions for task shifting for provision of ART by nurses
- Ensuring that all people eligible for ART are receiving it, etc.

Name and describe any inconsistencies that remain between any policies/laws and the national AIDS control policies:
Penal code revision will criminalize sex work and the purchase of sex

Overall, how would you rate political support for the HIV programmes in 2009?										
2009	Poor									Excellent
0	1	2	3	4	5	6	7	8	9	10√

Since 2007, what have been key achievements in this area?

- ✓ HIV was mainstreamed in the Economic and Development Poverty Reduction Strategy (EDPRS) and in the Rwanda Vision 2020;
- ✓ Each economic sector (e.g. Socio protection, Infrastructure, Agriculture, Education, Youth, etc.) has a HIV focal person.
- ✓ With decentralisation structure the Government of Rwanda dedicated 2 persons in charge of HIV/AIDS in each administrative district.
- ✓ Mayors of district signed annually a Memorandum of Understanding with the National Aids Control Commission for HIV activities in their respective district.
- ✓ Existing and working HIV and AIDS EDPRS sectors
- ✓ There is strong political will concerning HIV and AIDS in Rwanda.
- ✓ Successful revision of penal code decriminalizing MSM
- ✓ Integration of HIV in GBV management

What are remaining challenges in this area?

- ✓ Integrating HIV in all EDPRS sectors at National and District levels, particularly in implementation of HIV mainstreaming is a work in progress
- ✓ District support for integrating HIV interventions (need for better communication between central and district levels for adequate financial resources allocation at district level for implementation of HIV response)

III. PREVENTION

1. Does the country have a policy or strategy that promotes Information, Education and Communication (IEC) on HIV to the G*eneral Population*?

Yes √	No	N/A

1.1 ***IF YES***, what key messages are explicitly promoted?
√ Check for key message explicitly promoted

a. Be sexually abstinent	√
b. Delay sexual debut	√
c. Be faithful	√
d. Reduce the number of sexual partners	√
e. Use condoms consistently	√
f. Engage in safe(r) sex	√
g. Avoid commercial sex	√
h. Abstain from injecting drugs	N/A
i. Use clean needles and syringes	√
j. Fight against violence against women	√
k. Greater acceptance and involvement of people living with HIV	√
l. Greater involvement of men in reproductive health programmes	√
m. Males to get circumcised under medical supervision	√
n. Know your HIV status	√
o. Prevent mother to child transmission of HIV	√
Other: *[write in]* Individual responsibilities; family responsibilities; focus on children; end stigma; be compliant (with drug regimens); go for testing; behave well to break the chain of transmission; live positive (for those who are HIV+), use of condom, talk about condom.	√

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes √	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes √	No	N/A

2.1 Is HIV education part of the curriculum in?

Primary schools?	Yes √	No
Secondary schools?	Yes √	No
Teacher training?	Yes √	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes √	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes √	No

3. **Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?**

Yes √	No

IF NO, briefly explain:
In the current National Strategic Plan on HIV and AIDS 2009-12, one of the most important priorities is focused on MARPs for the period covered by the Plan.

3.1 ***IF YES***, which populations and what elements of HIV prevention do the policy/strategy address? NACC has one based on the previous MARPs identified in the former NSP 2005-09. The strategy is under update to align it with new MARPs identified in the new NSP 2009-12.

Populations;
- Women 15-24 years old
- Female sex workers
- People with disabilities
- Prisoners
- Migrant workers (truck drivers, moto taxi drivers, fishermen)
- MSM
- People in uniforms
- Refugees
- Sero-discordant couples
- Victims of GBV

Elements:
- BCC (EABC),
- Peer education,
- Referral to relevant health services (VCT, STI, HIV, FP,…)
- Condom distribution,
- Impact mitigation (access to health care,
- Income generating activities),
- Advocacy,
- Involvement of target groups in policy development and programme implementation,
- Mobile VCT,
- Operational research to identify and assess adapted strategies for different target groups (with their participation)

√ Check for policy/strategy included

	IDU	MSM	Sex Workers	Clients of sex workers	Prison inmates	Other
Targeted information on Risk reduction and HIV Education		√	√	√	√	OVC, Persons in uniform, Youth, PLWH, Track drivers, General population
Stigma & discrimination reduction		√	√	√	√	PLWH and general population
Condom promotion		√	√	√	√	Others MARPs and general population
HIV testing & Counselling		√	√	√	√	Others MARPs and general population
Reproductive health, including STI prevention & treatment		√	√	√	√	Youth, PLWH, OVC
Vulnerability reduction (e.g. income generation)	N/A	N/A	√	N/A	N/A	OVC, PLWH
Drug substitution therapy	N/A	N/A	N/A	N/A	N/A	
Needle & syringe exchange	N/A	N/A	N/A	N/A	N/A	

Overall, how would you rate *policy efforts* in support of HIV prevention in 2009?

2009	Very Poor									Excellent
0	1	2	3	4	5	6	7	8	9√	10

Since 2007, what have been key achievements in this area:

- ✓ All people are requested to use condoms when having sexual relations, whether it is MSM or heterosexual,
- ✓ A small survey on MSM was conducted in Kigali City,
- ✓ In prevention programmes, we do not differentiate between safer sex that is MSM or heterosexual

What are remaining challenges in this area:

- ✓ Finalize the process of integration of HIV in school curricula
- ✓ Finalize strategy for a comprehensive prevention package for youth (14-35)
- ✓ Develop a strategy for young adolescents (10-14)
- ✓ Put more efforts in policy or strategy to promote IEC and other preventive health interventions for Sex workers, MSM, IDU and Prison inmates,

4. Has the country identified specific needs for HIV prevention programmes?

Yes √	No

IF yes, how were these specific needs determined?
Through the previous NSP review and through the KYE exercises (Triangulation, Mode of Transmission), we have identified gaps in our prevention strategies and designed new strategies in the new NSP.

IF no, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**		
Blood safety	Agree √	**Don't Agree**	**N/A**
Universal precautions in health care settings	Agree √	**Don't Agree**	**N/A**
Prevention of mother-to-child transmission of HIV	Agree √	**Don't Agree**	**N/A**
IEC on risk reduction	Agree √	**Don't Agree**	**N/A**
IEC on stigma and discrimination reduction	Agree √	**Don't Agree**	**N/A**
Condom promotion	Agree √	**Don't Agree**	**N/A**
HIV testing & counselling	Agree √	**Don't Agree**	**N/A**
Harm reduction for injecting drug users	**Agree**	**Don't Agree**	N/A √
Risk reduction for men who have sex with men	**Agree**	Don't Agree √	**N/A**
Risk reduction for sex workers	Agree	Don't Agree √	**N/A**
Reproductive health services including STI prevention & treatment	Agree √	**Don't Agree**	**N/A**
School-based AIDS education for young people	Agree √	**Don't Agree**	**N/A**
Programmes for out-of-school young people	Agree	Don't Agree √	**N/A**
HIV prevention in the workplace	Agree	Don't Agree √	**N/A**
Other *[write in]*	**Agree**	**Don't Agree**	**N/A**

Overall, how would you rate *policy efforts* in the implementation of HIV prevention programmes in 2009?

2009 Poor										Excellent
0	1	2	3	4	5	6	7	8	9√	10

Since 2007, what have been key achievements in this area?

There has been an increased awareness in the importance to target MARPs in HIV prevention programmes and an attempt to scale up prevention services for these groups. There has been significant effort to overcome social taboos and address explicitly issues that were previously ignored (condom use, especially for young people, pre-marital sex, extra-marital sex, sexual abuse of children by adults, transgenerational sex, ...).

Scaling up of VCT/PMTCT services in the whole country (PMTCT from 285 in 2007 to 373 in 2007 and VCT from 316 to 403)
Implementation of a better PMTCT regimen (dual therapy instead of single dose nevirapine)

Initiation of Male circumcision program
80% increase in number of condoms distributed(from 10 millions to 18 millions)
PIT started being implemented, Couple counselling and testing promoted

What are remaining challenges in this area?
Implementation of comprehensive prevention package for marginalized and stigmatized groups (sex workers, MSM, prisoners) with specific outreach strategies adapted to their different situations. Ensure continuity and geographic coverage of full prevention package for general population and for target groups.

IV. TREATMENT, CARE and SUPPORT

1. **Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).**

Yes √	No

1.1 ***IF YES***, does it address barriers for women?

Yes √	No

1.2 ***IF YES***, does it address barriers for women most-at-risk populations?

Yes√	No

2. **Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?**

Yes √	No

If YES, how were these determined?
In terms of geographic area, there is a mapping that is done regularly to assess the geographic coverage of HIV services. New Health facilities are equipped to deliver HIV services in under serviced areas. The target of the HIV NSP is that by 2012, all health centres will offer comprehensive services, so that all Rwandans would have access to services within one hour walking distance from their homes.

IF NO, how are HIV treatment, care and support services being scaled up?

2.1 To what extent have the following HIV treatment, care and support services been implemented?
√ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV treatment, care and support services	**The majority of people in need have access**		
Antiretroviral therapy	Agree √	**Don't Agree**	**N/A**
Nutritional care	Agree	Don't Agree √	**N/A**
Paediatric AIDS treatment	Agree √	**Don't Agree**	**N/A**
Sexually transmitted infection management	Agree √	**Don't Agree**	**N/A**
Psychosocial support for people living with HIV and their families	Agree √	**Don't Agree**	**N/A**
Home-based care	Agree √	**Don't Agree**	**N/A**
Palliative care and treatment of common HIV-related infections	Agree √	**Don't Agree**	**N/A**
HIV testing and counselling for TB patients	Agree √	**Don't Agree**	**N/A**
TB screening for HIV-infected people	Agree √	**Don't Agree**	**N/A**
TB preventive therapy for HIV-infected people	Agree √	**Don't Agree**	**N/A**
TB infection control in HIV treatment and care facilities	Agree √	**Don't Agree**	**N/A**

Cotrimoxazole prophylaxis in HIV infected people	Agree √	Don't Agree	**N/A**
Post-exposure prophylaxis(e.g. occupational exposures to HIV, rape)	Agree √	Don't Agree	**N/A**
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree √	**N/A**
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree √	**N/A**
Other programmes: Treatment in Prisons, Treatment and Care for Refugees	Agree √	Don't Agree	**N/A**

3. **Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?**

Yes √	No

4. **Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?**

Yes √	No

4.1 ***IF YES***, for which commodities? : *[write in]* Procurement of all commodities occurs at once or two times per year through CAMERWA. But condoms are also supplied by partner organizations like UNFPA and PSI.

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support services in 2009?										
2009	Poor									Excellent
0	1	2	3	4	5	6	7	8	9	10√

Since 2007, what have been Key achievements in this area:

- ✓ Existing and working Policy for HIV and AIDS care and treatment,
- ✓ There is a regular procurement plan of commodities and drugs,
- ✓ Civil society is participating and has increased awareness in HIV and AIDS care and treatment,
- ✓ Drugs to treat all population (including children infected) are available, but the families are still not bringing their children to receive drugs, so we are not reaching all the children who are in need.
- ✓ The number of people under treatment (ART) has rapidly increased over the last few years (check exact numbers, but I would say from 47,755 in 2007 to than 76,726 in 2009. The coverage is increasing but we are still around 70%, especially with the newly adopted criteria for initiating treatment (from CD4<200 to CD4<350)
- ✓ Lab quality control and scaling up of early infant diagnosis

What are remaining challenges in this area:

- ✓ For children infected and affected by HIV, there is a possibility that some families are still not bringing them to receive drugs on time, so we are not reaching all the children who are in need of ART in timely manner.
- ✓ With the new threshold for treatment initiation, we are targeting people who are still asymptomatic, and therefore less likely to be diagnosed and to be compliant to regular ART. We have to increase efforts for testing of people at risk, especially those in discordant couples, and to sensitize infected people to the importance of treatment, even if they are asymptomatic.

- ✓ Problem of patients lost to follow up (patients in care but not in treatment)
- ✓ Problem of timely detection of treatment failures that need second line treatment
- ✓ Psychosocial support of families of PLWHA.

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children (OVC)?

Yes √	No	N/A

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes √	No

5.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes √	No

5.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions?

Yes √	No

IF YES, what percentage of OVC is being reached? According to the RDHS (2005), 12.6% of households hosting OVC received at least one type of support. But this percentage from DHS is underestimated the reality of support available for OVC in the country because much help is provided by from communities, families and Government programs.

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?										
2009 Excellent										Poor
0	1	2	3	4	5	6	7	8√	9	10

Since 2007, what have been key achievements in this area:
Mutuelles gives easier access to health care for people who would otherwise be unable to pay for services, including OVC. Programs for OVC support have been scaled up in recent years, but are still far from covering the needs of even the most vulnerable children.

What are remaining challenges in this area:
The needs of most vulnerable children are enormous, and access to minimum package of services is limited. There is also a lack of reliable data both to estimate the actual needs and to assess the degree of access to needed services for OVC.

V. MONITORING and EVALUATION

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

Yes √	In progress	No

If No, briefly describe the challenges:

1.1. ***IF YES***, years covered? 2009-2012

1.1. ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes √	No

1.2. ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes √	No

1.3. ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners*√	Yes, most partners	Yes, but only some partners	No

If YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the Monitoring and Evaluation plan include?

A data collection and analysis strategy If yes, does it address:	Yes √	No
- Routine programme monitoring	Yes √	No
- Behavioural surveys	Yes √	No
- HIV surveillance	Yes √	No
- Evaluation/ research studies	Yes √	No
A well-defined standardized set of indicators	Yes √	No
Guidelines on tools for data collection	Yes √	No
A strategy for assessing quality and accuracy of data	Yes √	No
A data analysis strategy	Yes √	No
A data dissemination and use strategy	Yes √	No

3. Is there a budget for the M&E plan?

Yes √	In progress	No

3.1 ***IF YES***, what percentage of the total HIV programme funding is budgeted for M&E activities? 6 %

3.2 IF YES, has full funding been secured?

Yes	No√

If NO, briefly describe the challenges:

Some M&E activities are included in the Global Fund National Strategy Application (NSA) which is still pending final signature.

3.3 If YES, are M&E expenditures being monitored?

Yes√	No

4. Are M&E priorities determined through a national M&E system assessment?

Yes √	No

If YES, briefly described how often a national M&E assessment is conducted and what the assessment involves:
A national M&E system assessment is conducted once every 2 years using an M&E assessment tool called the Monitoring and Evaluation Systems Strengthening Tool (MESST) based on the 12 components of a functional M&E system as approved by the international Monitoring and Evaluation Reference Group (MERG). This exercise includes government and non government HIV M&E stakeholders.

If NO, briefly describe how priorities for M&E are determined:

5. Is there a functional M&E Unit or Department?

Yes √	In progress	No

IF NO, what are the main obstacles to establishing a functional M&E Unit?

5.1 ***IF YES***, is the M&E Unit based

In the NAC (or equivalent)?	Yes √	No
In the Ministry of Health?	Yes √	No
Elsewhere? *[write in] PLWHIV Network (RRP+), TRAC Plus, Umbrella of PWD,*		

5.2 ***IF YES***, how many and what type of professional staff are working in the M&E Unit?

Number of permanent staff: 5		
Position: Director	Full time	Since 2005
Position: M&E Officer	Full time	Since 2007
Position: Analyst	Full time	Since 2005
Position: Analyst	Full time	Since 2009
Position: Data manager	Full time	Since 2006
Number of temporary staff: 2		
Position: School of Public Health M&E Fellow	Full time	Since 2009
Position: School of Public Health M&E Fellow	Full time	Since 2009
Position:	Full time/ Part time?	Since when?

5.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes √	No

IF YES, briefly describe the data-sharing mechanisms:
The National HIV M&E Plan describes the overall reporting mechanism and data flow for routine program data from service delivery level to the national HIV database (CNLSnet),

including all relevant data collection and reporting tools. Data is aggregated at the district level and shared with district-level stakeholders through quarter meetings (Joint Action Forum). Data at the national level is accessible to all stakeholders through the CNLS database CNLSnet.

What are the major challenges?

- Some implementing partners don't report at all, others don't report on time
- Joint Action Forums sometimes aren't regularly held in the district each quarter
- Issues with data quality in routine programmatic data aggregated at district and national levels
- Insufficient feedback from central to district level about quality and content of reports

6. Is there a M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly √	Yes, meets regularly

6.1 Does it include representation from civil society?

Yes √	No

IF YES, briefly describe who the representatives from civil society are and what their role is:
All civil society HIV umbrella groups are represented in the HIV M&E Technical Working Group and actively participate in meetings. These umbrella organizations represent their constituencies, largely comprised on HIV implementing partners at the service delivery level.

7. Is there a central national database with HIV-related data?

Yes √	No

7.1 ***IF YES***, briefly describe the national database and who manages it? *[write in]*
There is a CNLS database that includes programme monitoring indicators from the decentralized level (CDLS): type of activities (coded), geographical areas, implementers, beneficiaries, funds budgeted and spent, result indicators. It is a web-based database. Data are entered from the district and transferred up to national level for aggregation and analysis.

There is also a database for HIV clinical and treatment data: TRACNet, managed by TRACPlus. . Data atHealth facilities are entered into a phone data capture interface and electronically submitted to TRAC Plus via TRACnet. The TRACnet database currently collects site-level ART data from each health facility providing ART in the country and it is being expanded to collect VCT, PMTCT, HIV/TB, STI and nutritional (for HIV positive patients) data and will be updated to include patient-level monitoring from electronic medical records, in addition to site-specific information, so that real-time data will be available on individual patient outcomes over time. The database will ensure patient confidentiality while improving access to relevant information to the selected end users.

7.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

a. yes all the above √ and more!
b. yes, but only some of the above:
c. no, none of the above

7.3 Is there a functional* Health Information System?

National level It is based in the Ministry of Health	Yes √	No
Sub-national level; ***IF YES***, at what level(s)? *[write in]* At district level (District Hospitals)	Yes √	No

(*Regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels).

8. Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?

Yes √	No

9. To what extent are M&E data used

9.1 In developing/revising the national AIDS strategy?:

Low					High
0	1	2	3	4√	5

Provide a specific example:
In general, M&E data has been used to inform national strategic planning processes such as Economic Development and Poverty Reduction Strategy (EDPRS) 2008-12 and the NSP 2009-12. For example, HIV-discordant cohabitating couples have been highlighted as a priority risk group for targeted HIV prevention based on the results of recent research and epidemiological modelling.

What are the main challenges if any:
The main challenge involves the use of routine programmatic data to inform programmatic decisions, both at central and at the decentralized level.

9.2 For resource allocation?:

Low					High
0	1	2	3	4√	5

Provide a specific example:
M&E data was used to inform the costing exercises of recent Global Fund grant proposals, including the National Strategic Application (NSA), particularly for epidemiologic and programmatic assumptions.

What are the main challenges if any:
As mentioned above, the use of programmatic data for resource allocation remains a major challenge.

9.3 For programme improvement?:

Low					High
0	1	2	3	4 √	5

Provide a specific example:
Routine health data included in the health information system (HMIS) is used at the facility level to orient community health workers' community education campaigns.(clinical programs: stock outs, new treatment regimen, ...)

What are the main challenges if any:
Routine use of community-based routine program data for program improvement. In general, data use is improving at national level but still challenging at the district level.

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?

a. Yes, at all levels √ but only in some areas

b. Yes, but only addressing some levels
c. No

10.1 In the last year, was training in M&E conducted

At national level?	Yes √	No
IF YES, Number trained: *[write in]* 11		
At sub-national level?	Yes √	No
IF YES, Number trained: *[write in]* 60		
At service delivery level Including civil society?	Yes √	No
IF YES, Number trained: *[write in]* 15		

10.2 Were other M&E capacity-building activities conducted other than training?

Yes √	No

If yes, describe what types of activities:
Participation in skills-building workshops including the use of EPP and SPECTRUM

Overall, how would you rate the *M&E efforts* of the HIV programme in 2009?										
2009	Very Poor									Excellent
0	1	2	3	4	5	6	7	8√	9	10

Since 2007, what have been key achievements in this area:

- New M&E plan 2009-2012 with new indicators
- The web based tools facilitate planning and reporting of activities.
- More M&E trainings to increase capacity of M&E professionals

What are remaining challenges in this area:

- Definition of indicators at all levels by category and setting all targets and baselines for the indicators is work in progress
- Data quality issues, particularly of routine program data from the community-based M&E system
- Insufficient of use of data generated at all levels

Part B

[administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]

Data were gathered by the National Control Commission against Aids (CNLS). Validation was done in collaboration with TRAC Plus, CNTS, MOH, Districts Representatives and EDPRs Sectors.

I. HUMAN RIGHTS

1. **Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)**

Yes*	No

1.1 ***IF YES***, specify: *[write in]*
In the Constitution of Rwanda it is stated that all forms of discrimination are illegal (Articles 11, 16 and 46).
However, there is no specific provision for people living with HIV (PLHIV) within the Constitution, nor are there specific laws on non-discrimination to protect PLHIV. Regulations and policies are in place to protect PLHIV as part of general non discrimination provisions. For example, the Ministerial Decree on Equal Employment Rights includes PLHIV, but does not specifically mention this group. In the Health Sector Strategy there are provisions for non-discrimination against PLHIV.
Rwanda has a new labour law (Article 12) but this fails to regulate accommodation at the workplace or termination of PLHIV.

2. **Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?**

Yes*	No

2.1 ***IF YES***, for which sub-populations?

Women	Yes*	No
Young people	Yes*	No
IDU	Yes	No*
MSM	Yes	No*
Sex Workers	Yes	No*
Prison inmates	Yes*	No
Migrants/mobile populations	Yes*	No
Other: *Refugees, Disabled People*	Yes*	No

IF YES, Briefly explain what mechanisms are in place to ensure these laws are implemented, the content of these laws and comment on the degree to which they are currently implemented:

Women: There are specific provisions for women in the Constitution of Rwanda (Articles 185 and 187 of the Constitution)

Young People: Law 27-2001 protects minors from violence. The National Youth Council is also in place (Article 186 of the Constitution)

Prison Inmates: Protective measures for prison inmates are included in the Constitution, the

Penal code, and in policies for the treatment of prisoners living with HIV.

Migrants/mobile Population: The Constitution protects migrants and mobile populations. Rwanda has ratified the African Charter of Human and Peoples Rights, including the right to free movement (Article 16).

Refugees: Rwanda is a signatory to the 1941 UN Convention on Refugees.

Disabled: Regarding people with disabilities, a protective law was introduced in 2005.

Additionally, we can mention the Policy of protection of OVC (MIGEPROF), the Convention for child protection, the New gender policy, the Law on prevention, protection and punishment of any GBV.

Mechanisms: Policies for the protection of vulnerable sub-populations include Vision 20/20, the Economic Development and Poverty Reduction Strategy (EDPRS), and health and HIV policies. National institutions with an emphasis on the protection of vulnerable sub-populations include MIGEPROFE, CNLS, National Youth Council, National Refugee Commission, National Women's Council, and National Council for Disabled People.
In addition, civil society, the media, and trade unions contribute processes designed for the protection of vulnerable sub-populations.

The existing problem with all international instruments is enforcement; there remains the need to educate and sensitise people about these instruments.

The judicial system, the police, and the Court of Appeal provide means for redress for all Rwandans in case of unfair treatment or discrimination. Other resources include the judiciary police department, the Law Society, the Ombudsman, and umbrella organisations/civil society.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes	No*

3.1 ***IF YES***, for which sub-populations?

Women	Yes	No*
Young people	Yes	No*
IDU (N.A)	Yes	No*
MSM	Yes	No
Sex Workers	Yes	No
Prison inmates	Yes*	No
Migrants/mobile populations	Yes	No*
Other: *[write in]*		

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

Existing challenges are:

- Rwanda does not have a specific law and relies on laws of general application for protection of PLHIV
- Article 206 of the Civil Code book I, which stipulates that husband is the head of the household is based on traditional gender roles, as a result, marital property is usually registered under the name of the husband. In this economic context, women

feel that they have no choice but to remain in a married relationship, however abusive or detrimental. This lack of choice increases their vulnerability to HIV infection.
- Gender based violence law does not provide for post-exposure prophylaxis as a right of victims of GBV. Criminalisation of HIV transmission with lack of legal means to establish criminal intent.
- Prison inmates do not have access to condoms because the Ministry of Justice does not wish to be seen as condoning sexual intercourse among inmates.
- There are cultural barriers blocking interventions for sex workers, and successful intervention may require a protection law.

Advocacy is still ongoing to avoid the following:
- Draft bill on Reproductive Health: compulsory testing before/during marriage, universal screening of pregnant women
- Draft Penal Code, article 221. Code criminalises prostitution/. Penalty: 2-6 months imprisonment or a fine of 50.000- 500.00 or both. Penalty applicable to partner caught "having sexual intercourse with a prostitute"

In 2009, advocacy by civil society succeeded in removing from the draft penal code a provision criminalising "incitement" to same sex relationship or sexual practice (article 191) specifying a penalty of 5-10 years imprisonment and a fine of 50,000 to 500,000 Rwanda francs.

4. **Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?**

Yes*	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

The NSP 2009-12 states that:
"As well as strengthening the existing system, alternative justice mechanisms will be introduced, and citizens will be sensitized to new laws and mechanisms to ensure justice and protection of rights. New legislation against gender-based violence is a pre-condition for ensuring access to justice for women, and will be accompanied by training of judicial personnel, police officers and prison staff on human rights, gender-based violence and the management of cases involving vulnerable and disadvantaged groups. Special attention will be given to the monitoring and protection of human rights in general, and those of women, children, people living with HIV and AIDS and vulnerable groups in particular".

5. **Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?**

Yes	No*

IF YES, briefly describe this mechanism:

A specific mechanism does not exist. However, there is the general application of the constitutional provisions and other laws that prohibit discrimination of any kind under Article 11 of the Constitution.

The National Commission of Human Rights has a focal point dealing with HIV cases. The Commission can provide legal aid and other assistances.

6. Has the Government, through political and financial support, involved most at-risk populations in governmental HIV-policy design and programme implementation?

Yes*	No

IF YES, describe some examples

The national strategy on HIV was designed with the participation and consultation of civil society and representatives of most-at-risk populations. Funding has been allocated for planning meetings and income-generating activities (IGA) for most-at-risk populations.

7. Does the country have a policy of free services for the following:

HIV prevention services	Yes*	No
Anti-retroviral treatment	Yes*	No
HIV-related care and support interventions	Yes*	No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

There is a policy of free VCT, ART, PMTCT, and TB treatment throughout the country.
Treatment for other opportunistic infections is not free but can be covered through health insurance (*mutuelle de santé*).

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support?

Yes*	No

8.1. In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes*	No

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?

Yes*	No

9.1 Are there differences in approaches for different most-at-risk populations?

Yes*	No

IF YES, briefly explain the differences:

The most at risk populations identified in the new NSP 2009-12 are sex workers, discordant couples, and young women aged 19-24. Each of these populations has a number of specific vulnerability factors that need to be addressed through targeted interventions to reduce HIV infection. Many other groups have been identified as being at risk for HIV infection because of their behaviours or situations (for instance men who have sex with men, mobile populations, prisoners, and people with disabilities), and although these groups do not account for as high a proportion of new HIV infections, it is still important that they are reached by prevention programs.

Many of the interventions will contribute not only to stemming the spread of HIV, but also to improving life skills in general and sexual and reproductive health in particular – not only are these important ends in themselves, but they are also known to be good entry points for HIV prevention efforts.

In addition, according to the multi-sectoral approach, the CNLS has prepared IEC guides proposing different approaches for groups such as youth, people who are disabled, and truck drivers. The respective umbrellas also use different approaches with the different most-at-risk populations.

Prisoners do not receive complete prevention measures (there is HIV sensitization in prisons but condoms are not available). Prison inmates do not have access to condoms because the ministry of justice does not wish to be seen as condoning sexual intercourse among inmates.

In boarding secondary schools, access to condoms is limited if not absent.

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Note: The National Policy on HIV Testing states clearly that all testing and counselling has to be voluntary and confidential. However, there is no specific law to prohibit HIV screening before recruitment. Also, the military and the police force are exceptions to this Policy, as all new recruits must undergo mandatory HIV testing.

Yes	No*

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes*	No

11.1 ***IF YES***, does the ethical review committee include representatives of civil society and people living with HIV?

Yes*	No

IF YES, describe the effectiveness of this review committee

RPP+, which represents PLHIV in Rwanda, is a member of the committee. Meetings are held on a monthly basis and on average ten proposals are reviewed per session. An administrator has been appointed within the Ministry of Health to manage the committee. All study proposals in Rwanda need to pass through the committee to ensure that national and international standards are followed to protect the rights of the population studied.

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes*	No

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	No*

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes*	No

Note: There are human rights standards in place; however, indicators could be improved and work needs to be done to collect data as there is no system available to register cases.

The stigma index study shows that PLHIV have heard of the Declaration of Commitment on HIV/AIDS, which protects the rights of people living with HIV. Some cases of PLHIV rights abuse because of their HIV status have been reported. GoR government employees have taken action in each case and resolved the matter.

IF YES, on any of the above questions describe some examples:

National Institutions: HIV and AIDS issues have been integrated into all organizations and institutions working on human rights in Rwanda. Examples include National Human Rights Commission, RWANDA , AJPRODHO, HAGURUKA, CLADHO, LDGL, ARDHO and FACT Rwanda.
Performance indicators: As per NSP 2009-2012, people infected and affected by HIV have the same opportunities as the general population. As per NSP output 3.3.1.1, the rights of people infected and/or affected by HIV are assured in the legal framework.

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes*	No

14. Are the following legal support services available in the country?

– Legal aid systems for HIV and AIDS casework

Yes*	No

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes*	No

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes*	No

Note on 14: Although initiatives and activities are in place (ex. the ones offered by World Vision, Lutheran World Federation, EJO NZAMERA NTE), there is no nationwide programme.

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes*	No

IF YES, what types of programmes?

Media	Yes*	No
School education	Yes*	No
Personalities regularly speaking out	Yes*	No
Other: *[write in]* Counselling, involvement of religious leaders and communities, and cultural activities		

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV and AIDS in 2009 ?										
2009	Very Poor									Excellent
0	1	2	3	4	5	6	7	8*	9	10

Comments on progress made since 2007:

During this period, the National Strategic Plan 2009-2012 was put in place with a key outcome to promote the rights of people who are affected by or infected with HIV. The EDPRS 2008-2012 integrates HIV prevention in all sectors of government; in particular, the justice sector reviewed laws to ensure they address Human Rights and HIV.

Prevention efforts have been intensified, with additional emphasis on education. There has been increased participation in policy design, with new umbrellas for faith-based organisations and people who are disabled. There are now more organisations advocating for the rights of PLHIV. Understanding of HIV/AIDS human rights issues have improved, with greater integration of HIV/AIDS into overall programmes for human rights. Work has been done in the area of policy-change with regards to increased access to health insurance. The process of decentralisation has been strengthened since 2009. EDPRS has been put in place and CNLS, FAAS, and CLADHO have held regional meetings regarding the rights of PLHIV.

Civil society has carried out advocacy to ensure that revisions of laws respect the rights of MARPs and vulnerable groups.

What are the remaining challenges in this area?

- Ensure implementation of NSP 2009-12, in particular in relation to HIV services for most-at-risk groups
- Enforcement of existing laws

Overall, how would you rate the *effort to enforce* the existing policies, laws and regulations in 2009?										
2009	Very Poor									Excellent
0	1	2	3	4	5	6	7	8 *	9	10

Comments on progress made since 2007:

- Authorities are regularly asked to speak about HIV and AIDS and human rights at public functions.
- A meeting has been held for all public authorities at national and district levels, encouraging them to integrate the fight against stigma and discrimination into their programmes.
- The Initiative of the First Lady to protect the rights of children has helped to fight stigma related to HIV/AIDS, encouraging adults to treat each child as their own.
- A media umbrella organisation has been created to promote positive messages in the media.
- Training sessions to educate people about their rights have been conducted within PLHIV organisations.
- There are an increased number of VCT, PMTCT, and ART sites.
- Health insurance membership has increased, making treatment for opportunistic infections more accessible.
- A performance-based approach has been established to improve the quality of care being provided.
- VCT and ART have been introduced in prisons.

What are the remaining challenges in this area?

- Access to condoms in prisons
- Increase prevention of and protection from sexual and gender-based violence

II. CIVIL SOCIETY[5] PARTICIPATION

1. **To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?**

Low					High
0	1	2	3	4	5*

Comments and examples:

Civil society has initiated some studies that informed the development of the new NSP 2009-12 such as the first Rwanda Stigma Index Study (2009), the exploratory study on MSM and the evaluation of capacity of the network of people living with HIV in the prevention area ("Evaluation des capacités des associations members du RRP+ en matière de prévention").

Civil society is more and more involved in advocacy meetings related to HIV.

2. **To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts)**

Low					High
0	1	2	3	4	5*

Comments and examples:

Civil society has been involved in the evaluation of the former NSP (2005-2009) and has strongly participated in all steps ofthe process of planning and budgeting for the new NSP 2009-2012.

3. **To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in**

a. the National AIDS strategy?

Low					High
0	1	2	3	4	5*

b. in the national AIDS budget?

Low					High
0	1	2	3	4*	5

c. national AIDS reports?

[5] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

Low High
0 1 2 3 4* 5

Comments and examples:

Monitoring of CSOs interventions and results needs to improve (CNLSnet should focus more on achievements/results by CSOs at district level).
During the evaluation of the former NSP 2005-2009, there was a lack of data concerning civil society interventions and related coverage.

4. **To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?**

a. developing the national M&E Plan?

Low High
0 1 2 3 4* 5

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low High
0 1 2 3 4 5 *

c. M&E efforts at local level?

Low High
0 1 2 3* 4 5

Comments and examples:

Civil society representatives participate in:
- joint action forum meeting at district level
- regular field visits to evaluate the progress of HIV response at the local level organized by NACC (CNLS)

Also, civil society representatives are member of M&E technical working group; however, work sessions need to be more regular.

5. **To what extent is the civil society sector representation in HIV-related efforts inclusive of diverse organizations (e.g. networks of PLHIV, organizations of sex workers, faith based organizations)?**

Low High
0 1 2 3 4 5*

Comments and examples:
PLHIV:
- Umbrella CSO's (PLHIV, Disabilities, NGO Forum, ABASIRWA, FBOs, PSF

- National NGOs and international NGOs (see list with NGO forum)
- CBOs
- Non health sectors

Cfr CSOs situation analysis report at NGO Forum web: www.rwandangoforum.org

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

Low					High
0	1	2	3*	4	5

b. adequate technical support to implement its HIV activities?

Low					High
0	1	2	3	4*	5

Comments and examples:

Since HIV interventions related to care and treatment/ clinical interventions are more expensive, civil society organizations working with communities have lower budget allocations.

7. What percentage of the following HIV programmes/services is estimated tbe provided by civil society?

Prevention for youth	<25%	25-50%	50-75%	>75%*
Prevention for vulnerable sub-populations				
- IDU	<25%*	25-50%	50-75%	>75%
- MSM	<25%*	25-50%	50-75%	>75%
- Sex workers	<25%	25-50%*	50-75%	>75%
Counselling and Testing	<25%	25-50%	50-75%*	>75%
Reduction of Stigma and Discrimination	<25%	25-50%*	50-75%	>75%
Clinical services (OI/ART)*	<25%	25-50%*	50-75%	>75%
Home-based care	<25%	25-50%	50-75%	>75%*
Programmes for OVC**	<25%	25-50%	50-75%*	>75%

**ART= Antiretroviral Therapy, OI= Opportunistic infections;*
***OVC Orphans and other vulnerable children*

Overall, how would you rate the efforts to increase *civil society participation* in 2009?

2009	Very Poor								Excellent
0	1	2	3	4	5	6	7	8	9*	10

Comments on progress made since 2007:

- CSOs situation analysis
- Involved in the review of NSP and the development of New NSP
- Development of NSA

- Training on Result Based Management
- Active advocacy on the ongoing process of draft bills (Reproductive Health, Penal code, GBV)
- Decentralization of CSOs umbrellas structures
- Trained in Leadership and Networking
- Meaningful participation in JADF (Joint Action Development Forum)
- Trained in GF grant mobilization and Management

More and more civil society organizations are involved in the HIV response and there is increased funding. Prospects for increased finding are very positive from 2010 due to the involvement of civil society in the National Strategy Application (NSA) to the Global Fund that has been awarded to Rwanda.

What are remaining challenges in this area:

Cfr CSOs situation analysis, 2009

III. PREVENTION

1. **Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?**

Yes*	No

IF YES, how were these specific needs determined?

The new NSP 2009-12 was based on the review of the old one (2005-09), including research findings but also focus groups with beneficiaries at the local level. Representatives from civil society have participated in all phases of its development, including PLHIV, other beneficiaries of services and HIV implementers.

IF NO, how are HIV prevention programmes being scaled up?

1.1 To what extent have HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree*	Don't Agree	N/A
Universal precautions in health care settings	Agree*	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	Agree*	Don't Agree	N/A
IEC on risk reduction	Agree*	Don't Agree	N/A
IEC on stigma and discrimination reduction	Agree*	Don't Agree	N/A
Condom promotion	Agree*	Don't Agree	N/A
HIV testing & counselling	Agree*	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A*
Risk reduction for men who have sex with men	Agree	Don't Agree*	N/A
Risk reduction for sex workers	Agree	Don't Agree*	N/A
Programmes for other most-at-risk populations	Agree	Don't Agree*	N/A
Reproductive health services including STI prevention and treatment	Agree	Don't Agree*	N/A
School-based AIDS education for young people	Agree*	Don't Agree	N/A
Programmes for out-of-school young people	Agree*	Don't Agree	N/A
HIV prevention in the workplace	Agree	Don't Agree*	N/A
Other programmes: *[write in]*	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2007 and in 2005?

2009 Very Poor ... Excellent

0 1 2 3 4 5 6 7 8* 9 10

Comments on progress made since 2007

See table above – number of services in existence are high:

- Interventions of civil society mainly focus on prevention targeting general population and most at risk covering all country although need for scale up
- For sex workers refer to "mapping of interventions" study (CNLS and UNFPA, 2009)
- Civil society contributed to include most at risk groups in NSP 2009-12
- Advocacy on male circumcision

- Strategic Plan condoms
- WAC
- Introduction of health mentors in community to offer psychosocial treatment and sensitization about prevention
- Inclusion of activities on disability in NSP
- More VCT
- Open discussion about sex in society, the debate is opening up

What the remaining challenges

- Cultural obstacles for key populations MSM, sex workers
- Access of condoms in prisons
- Some health centres do not allow condoms distribution
- Need to scale up – accelerate
- Preventions intervention were not focused on MARPs but more on general population
- Continuity of funds – NGOs funds not sustained (some years it breaks)
- Some donors support implementation but with no coordination – staffing, functioning costs not provided for
- Disparate geographical coverage – remains a problem – NGOs do not go in far away areas
- Monitoring of prevention activities needs strengthening

IV. TREATMENT, CARE and SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes*	No

IF YES, how were these specific needs determined

There has been an evaluation of existing care and treatment services. Civil society intervening in this domain has been involved in the overall planning process.

IF NO, how are HIV and AIDS treatment, care and support services being scaled up?

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV and AIDS treatment, care and support services	The majority of people in need have access		
Antiretroviral therapy	Agree*	Don't agree	N/A
Nutritional care	Agree	Don't agree*	N/A
Paediatric AIDS treatment	Agree*	Don't agree	N/A
Sexually transmitted infection management	Agree*	Don't agree	N/A
Psychosocial support for people living with HIV and their families	Agree*	Don't agree	N/A
Home-based care	Agree*	Don't agree	N/A
Palliative care and treatment of common HIV-related infections	Agree*	Don't agree	N/A
HIV testing and counselling for TB patients	Agree*	Don't agree	N/A
TB screening for HIV-infected people	Agree*	Don't agree	N/A
TB preventive therapy for HIV-infected people	Agree*	Don't agree	N/A
TB infection control in HIV treatment and care facilities	Agree*	Don't agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree*	Don't agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree*	Don't agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't agree*	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't agree*	N/A
Other programmes: *[write in]*			

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?

2009	Very Poor									Excellent
0	1	2	3	4	5	6	7	8*	9	10

Comments on progress made since 2007

- Mobilisation and sensitization of PLHIV to have "jardin potagers" (gardens) to improve nutritional status
- Sensitization of PLHIV for good adherence

- Strengthening linkage between community and health services for increase access
- ART coverage was increased – decentralization continued – sustained availability of ART
- Prophylaxis post exposure not only for health staff but also for victims of rape
- Increased number of sites offering ART
- Associations of PLHIV changed in cooperatives in 2008 – with IGAs to become sustainable

Remaining challenges

- Nutritional support very weak
- Workplace programs insufficient
- Improve psychological support for PLHIV

2. Does the country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes*	No	N/A

2.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes*	No

2.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes*	No

2.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions?

Yes*	No

IF YES, what percentage of OVC is being reached? % *[Not available]*

Overall, how would you rate the efforts to meet the needs of OVC?										
2009	Poor									Excellent
0	1	2	3	4	5	6	7*	8	9	10

Comments on progress made since 2007

- Development of OVC policy
- Development of OVC selection criteria
- Definition of minimum prevention package in 2008
- Organization of one national Paediatric Conference per year

Challenges

Many OVC still do not receive support. The minimum package of services is not complete, e.g. school fees are paid but there is no contribution for books.

Though the criteria to define OVC are clear, the mechanisms in place to identify them have some shortcomings. For instance, OVC have to be identified in public, which is unfair to them.

There is still stigma and discrimination in schools.