Republic of Rwanda
Ministry of Health

Rwanda Biomedical Centre
Healthy People, Wealthy Nation

National HIV and Viral Hepatitis

Annual Report 2019-2020

FOREWORD

Each year, the National HIV Program presents the progress and key achievements in the national HIV and Viral Hepatitis response for the previous financial year. This report provides a picture of Rwanda's progress in the national response as of 30 June 2020. Everything presented in this report is the result of a collaborative effort between the Government of Rwanda and its partners. The Ministry of Health recognizes all people, organizations, and institutions for their significant contribution in the fight against HIV/AIDS in Rwanda, in particular during the period from July 2019 to June 2020. This past year was particularly challenging period given that implementation of most HIV activities were affected by the ongoing COVID-19 pandemic. Despite the pandemic, our sincere gratitude goes to the HIV workforce at all levels for their commitment that drove the achievements presented in this report.

I would like to also acknowledge the efforts of dedicated staff from various institutions who worked tirelessly to complete this report. We remain grateful to the input and support provided by our partners, members of the civil society, members of various technical work groups related to HIV, and local and international non-government and bilateral organizations.

Finally, yet importantly, the details presented in this document are a call to all HIV program stakeholders to continue to strengthen and adapt actions and interventions to maximize progress towards an HIV free nation.

Dr. NGAMIJE M. Daniel
Minister of Health

EXECUTIVE SUMMARY

Annually, the Ministry of Health through Rwanda Biomedical Centre (RBC) publishes the National HIV and Viral Hepatitis Annual Report. The report gives an update on the progress in the national HIV, STIs and Viral Hepatitis response. It highlights the achievements of the national program during the period of July 2019 to June 2020. This was a critical period given the occurrence of COVID-19 pandemic that negatively impacted some HIV interventions. This Annual Report 2019-2020 presents the progress in the implementation of interventions towards achieving HIV global targets as response to HIV, STIs and Viral Hepatitis control.

In addition to existing interventions, the national program has scaled up new approaches and strategies to achieve annual targets. For instance, in the area of HIV Prevention, the National HIV program introduced and scaled up HIV self-testing, index testing and partner notification, HIV case-based surveillance and recency testing. The HIV Care and Treatment program initiated the provision of DTG to all PLHIV above 20 kg including women of childbearing age, TB Preventive Therapy (TPT), the full phase out of AZT and Nevirapine-based regimens at ART first line, and updating the Differentiated Service Delivery Model (DSDM) stability criteria.

This annual report shows the national progress based on key intervention areas of the National HIV program, namely prevention, care and treatment, STIs and Viral Hepatitis, health system strengthening, strategic information and planning, HIV financing and governance mechanisms.

During the reporting period, out of 2,632,630HIV tests conducted across the country, 15,829 individuals tested HIV positive and 98.4% of HIV-exposed infants tested HIV negative 24 months after their birth. This represents a Mother to Child Transmission (MTCT) rate of 1.7%. In the period from July 2019 to July 2020, 401,987 people were medically circumcised through the VMMC program. The overall prevalence of male circumcision is 39.9%.

From July 2019 to June 2020, 11,311 people began HIV antiretroviral therapy, which makes a total number of 201,629 people living with HIV on ART by June 2020. During the same period, in the context of the HCV elimination plan, 2,408,291 and 2,756,762 people were screened for HBV and HCV respectively. Of them, 6,689 were confirmed viral load positive for HBV and 21,653 were confirmed viral load positive for HCV. During this fiscal year, 2,611 mono-infected patients were initiated on HBV treatment and 16,891 patients were initiated on HCV treatment.

None of the achievements presented in this report could have been realised without the continuous technical and financial support from the Government of Rwanda (GoR) and its partners. During the reporting period, the GoR and partners invested a total of $160,995,102 in the HIV response.

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ABBREVIATIONS

ABASIRWA	Network of Journalists in HIV response HIV/AIDS
ACBS	Active Case-Based Surveillance for HIV
ACF	Active Case Finding
AEE	African Evangelistic Enterprise
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Therapy
AZT	Azido thymidine
CBS	Case-Based Surveillance for HIV
COP	Country Operational Plan
CPDS	Coordinated Procurement and Distribution System
CSB+	Corn Soya Blend
CSOs	Civil Society organizations
DDP	District Development Plans
DHs	Demographic Health Survey
DQA	Data Quality Assessment
DSDM	Differentiated Services Delivery Model
DTG	Dolutegravir
EAC	East Africa Community
ECD	Early Child Development
EDPRS	Economic Development and Poverty Reduction Strategy
EIMC	Early Infant Male Circumcision
e-LMIS	electronic Laboratory Management Information System
EMR	Electronic Medical Record
EMTCT	Elimination of Mother to Child Transmission
EPP	Estimated Population Projection
FSW	Female Sex Workers
FSW	Female Sex Worker
FY	Fiscal Year
GBV	Gender Based Violence
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund for AIDS, TB and Malaria
GIZ	German
GOR	Government of Rwanda
HBV	Hepatitis B Virus
HC	Health Center
HCC	Health Communication Center
HCV	Hepatitis C Virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HIVDR	HIV Drug Resistance

HMIS	Health Management Information System
HRTT	Health Resource Tracking Tool
HSSP4	Health Sector Strategic Plan
HTS	HIV testing and counseling services
IBSS	Integrated Behavioral and Biological Surveillance Survey
ICASA	International Conference on Aids and STIs in Africa
IEC	Information and Education Communication
IFMIS	Integrated Financial Management Information System
IGA	Income Generating Activities
IRIS	Immune reconstitution inflammatory syndrome
KPs	Key Populations
LIS	Laboratory Information System
LMIC	Low and Middle Income Countries
M/E	Monitor and Evaluation
MIFOTRA	Ministry of Public Service and Labour
MIGEPROF	Ministry of Gender and Family promotion
MOH	Ministry of Health
MPPD	Medical Procurement and Production Division
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NCBT	National Center for Blood Transfusion
NCC	National Child Commission
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NRL	National Reference Laboratory
NSP	National Strategic Plan
NST	National strategy for transformation
NSTP	National strategy for transformation
OBBI	Other Blood Borne Infections
OI	Opportunistic Infection
OP	Operation Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PIT	Partner Initiated Testing
PLHIV	People Living with HIV
PMTCT	Prevention Mother to Child Transmission
POCT	Point of Care for Testing
PrEP	Pre-Exposure Prophylaxis
RAIHS	Rwanda Aids Indicator and HIV Incidence Survey
RBA	Rwanda Broadcasting Agency
RBC	Rwanda Biomedical Centre
RCS	Rwanda Correctional Services
RDHS	Rwanda Demographic Health Survey
RICH	Rwanda Interfaith Council for Health
RNGOF	Rwanda Non-Government Organization Forum
RPHIA	Rwanda Population HIV Impact Assessment

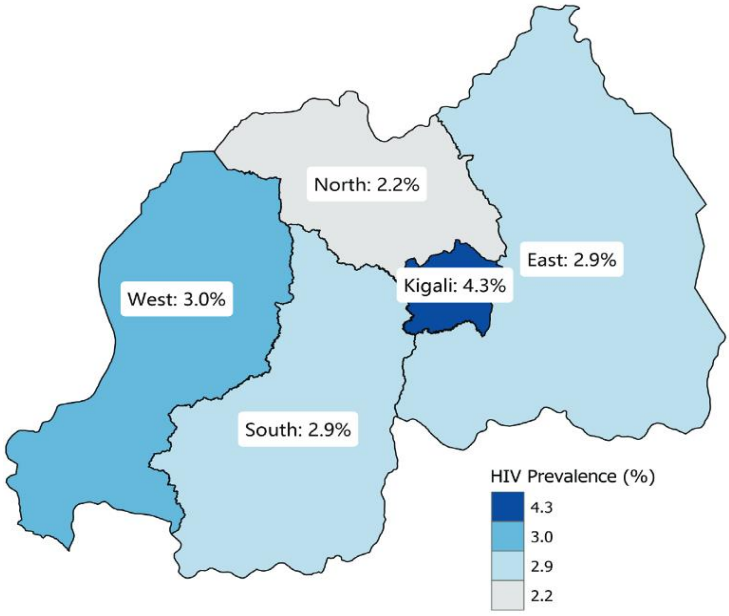
RRP+	Rwanda network of PLHIV
SDG	Sustainable Development Goals
SDGs	Sustainable Development Goals
SGBV	Sexual Gender Based Violence
SPIU	Single Project Implementation Unit
STIs	Sexual Transmitted Diseases
TAT	Turn Around Time
TB	Tuberculosis
TLD	Tenofovir-Lamividune-Dolutegravir
TLE	Tenofovir-Lamividune-Effavirenz
TPT	Tuberculosis Preventive Therapy
TVET	Technical and Vocational Educational Training
UN	United Nations Children Fund
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children Fund
USG	United States Government
USG	United State
USPLS	Public-Sector Umbrella in the Fight against AIDS
VCT	Voluntary Counselling and Testing
VL	Viral Load
VLS	viral load suppression
VLSMS	Viral Load Short Message Service
VMMC	Voluntary Male Circumcision
VPD	Vaccine-Preventable Diseases Division
WAD	World Aids Day
WHO	World Health Organization

1. INTRODUCTION

Over the years, the Rwanda National HIV program has invested many efforts to combat the HIV and AIDS epidemic. Despite significant progress made, HIV continues to be a key public health priority given the social and economic consequences the epidemic causes in the country. In addition, viral hepatitis emerged as an important HIV co-infection affecting the population. The present report highlights the national HIV and viral hepatitis response from July 2019 to June 2020. The purpose of the report is to inform our stakeholders on the strategies used to strengthen, reset and adapt actions and interventions to maximize progress towards an AIDS-free nation.

1.1. Overview of the HIV epidemic in Rwanda

Over the last 15 years, HIV prevalence among the general population in Rwanda has stabilized at 3%, varying by age and sex. According to recent findings from the Rwanda Population-based HIV Impact Assessment (RPHIA) conducted in 2019, the overall HIV prevalence among people aged 15-64 was 3.0%; 3.7% in women and 2.0% in men. The assessment indicated a lower prevalence of 2.6% among adults aged 15-49. RPHIA revealed that HIV prevalence was 4.8% in urban areas and 2.5% in rural areas. Furthermore, the HIV prevalence was higher in the City of Kigali (4.3%), which is predominantly urban, and lower in the northern province (2.2%).



Map 1: HIV Prevalence by province in Rwanda, 2018-19

The HIV prevalence was about two times greater in older adolescent girls and young women (ages 15-24 years) compared to older adolescent boys and young men (1.2% vs. 0.5%). In general, Rwanda's HIV prevalence rises with age. The HIV prevalence peaked at 6.5% among men aged 55-59 years and 7.4% among women aged 50-54 years.

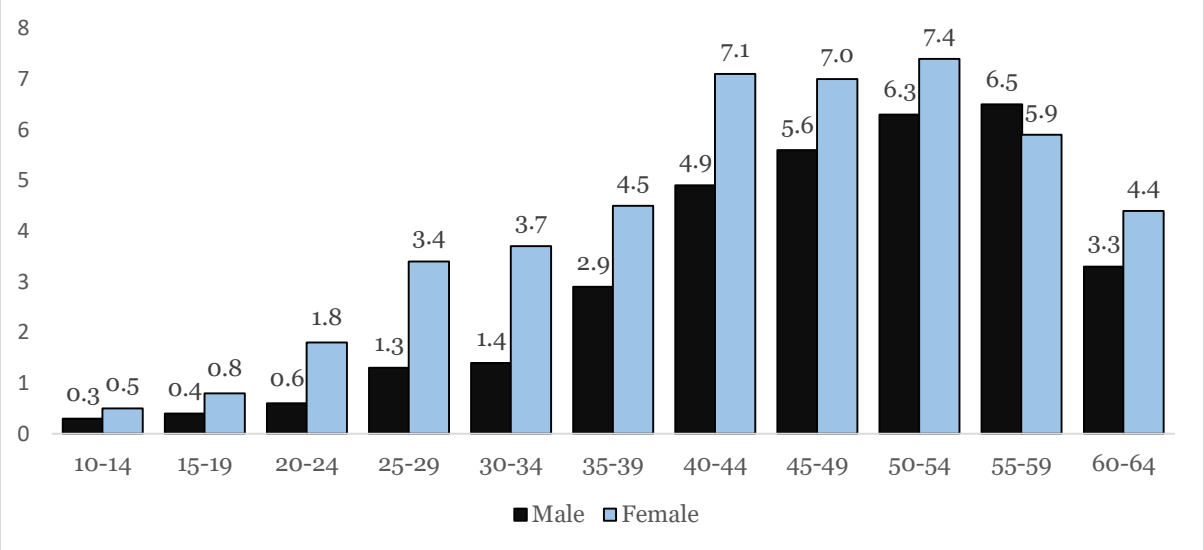


Figure 1: HIV prevalence by age group and sex

According to the same assessment, the overall annual incidence of HIV infection among adults was 0.08% (95% CI: 0.02% - 0.14%) which corresponds to approximately 5,400 cases of new HIV infection among adults in the country during the year. Annual incidence of HIV infection among adults in the City of Kigali was 0.11% (95% CI: 0.00% – 0.26%).

Due to the increased life expectancy caused by increased treatment coverage and effectiveness of ART, the UNAIDS model estimates that almost 25% of PLHIV age will be older than 50 years in 2019 and approximately 35% of the population will be aged over 50 years in 2025.

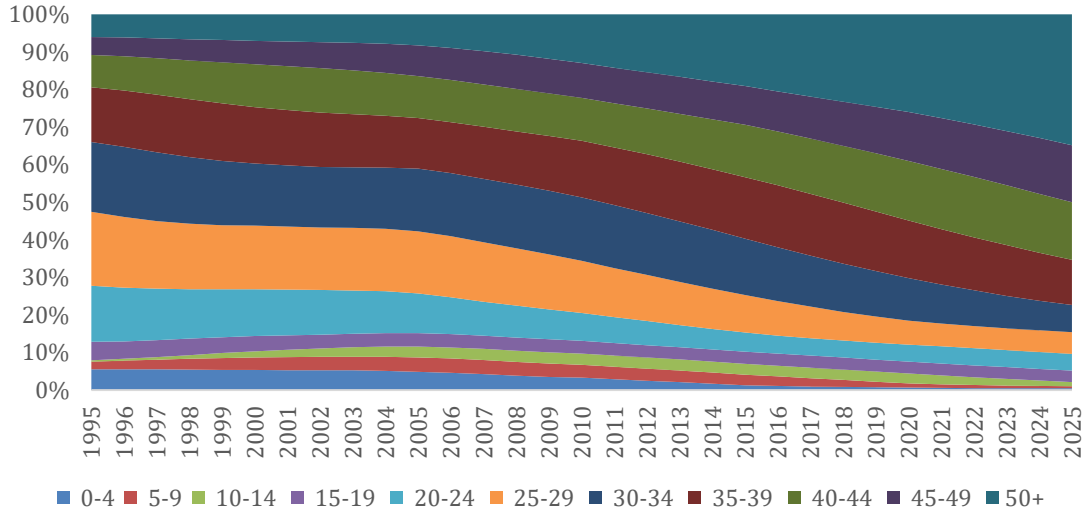


Figure 2: Projection of PLHIV by age group

1.2. Response to the HIV epidemic

In Rwanda, the first case of HIV was discovered in the early 1980s. Since then, the Government has implemented various interventions and services to fight the HIV epidemic. Under the coordination of the Ministry of Health, national and international partners have joined the battle. In 1999, the HIV testing services started and expanded in different health facilities in preparation for the expansion of access to Antiretroviral Therapy (ART). In the same year, the PMTCT program started in health facilities in the City of Kigali and were scaled up in 2001. In 2004, with the support of Global Fund and PEPFAR, the national ART program was established and was progressively scaled up for both adults and children. At the moment, HIV services are accessible and free of charge across the country; and various innovations are being implemented to reduce new HIV infections and ensure improved health outcomes of people living with HIV.

In order to inform the HIV program on progress, a monitoring system was introduced, mainly accomplished through routine data recording and reporting, periodic surveys, and surveillance activities. The most known surveys are the Rwanda Demographic and Health Surveys (RDHS), Integrated Behavioural and Biological Surveillance Surveys (IBBSS) among Key Populations, mainly female sex workers and men who have sex with men, HIV and Syphilis Sero-surveillance surveys among pregnant women, Rwanda AIDS Indicator and HIV incidence Survey, Rwanda Population-based Impact Assessment, and others. Results of the RPHIA indicate that 84% of all PLHIV know their HIV status. Of those who know their HIV status, 97% are on ART, 90% of whom have a suppressed viral load (<1000 copies/ml).

1.3. Policy responses to the HIV epidemic

The Government of Rwanda recognises HIV/AIDS as a cross-cutting public health issue that needs to be addressed through joint efforts of all sectors, from central to lower levels. The response to HIV is highlighted through different National policy and guiding documents, namely the National Strategy for Transformation (NST 1), Health Sector Strategic Plan IV (HSSP IV) and Sustainable Development Goals (SDGs). The interventions implemented during the period of July 2019 throughout June 2020 were guided by the most recent National Strategic Plan for HIV, covering 2018-2024. The success achieved during the reporting period is the result of joint collaboration in both development and implementation of those key documents guiding the HIV response.

2. HIV PREVENTION

2.1. Introduction

The HIV Prevention program has been a cornerstone of the national response. Evidence-based combination prevention interventions are implemented as outlined in the national HIV guidelines. The interventions and strategies in this package are HIV Testing Services and counselling (HTS), Prevention Mother to child Transmission (PMTCT), Voluntary Medical Male Circumcision (VMMC), Condom programming, Key Populations (KPs) services, Pre-Exposure Prophylaxis (PrEP) and increasing awareness of HIV to reach those who are at risk of acquiring HIV across the country. These approaches have allowed Rwanda to successfully reach the UNAIDS goal of 90% of people living with HIV (PLHIV) being aware of their status.

2.2. HIV testing services

HIV testing services are essential to determining a person's HIV status and ensuring linkage to appropriate HIV prevention, treatment, care and other support services for PLHIV. The national HIV program has been expanding innovative evidence-based HIV case finding strategies, including HIV self-testing, index testing and partner notification. The Active HIV Case-Based Surveillance (ACBS for HIV) was introduced in more than 60 health facilities to follow PLHIV through the cascade of care, and report on index testing, partner notification services, and recency testing. From July 2019 to June 2020, health facilities provided 2,632,630 HIV tests countrywide, with an overall positivity rate of 0.46%.

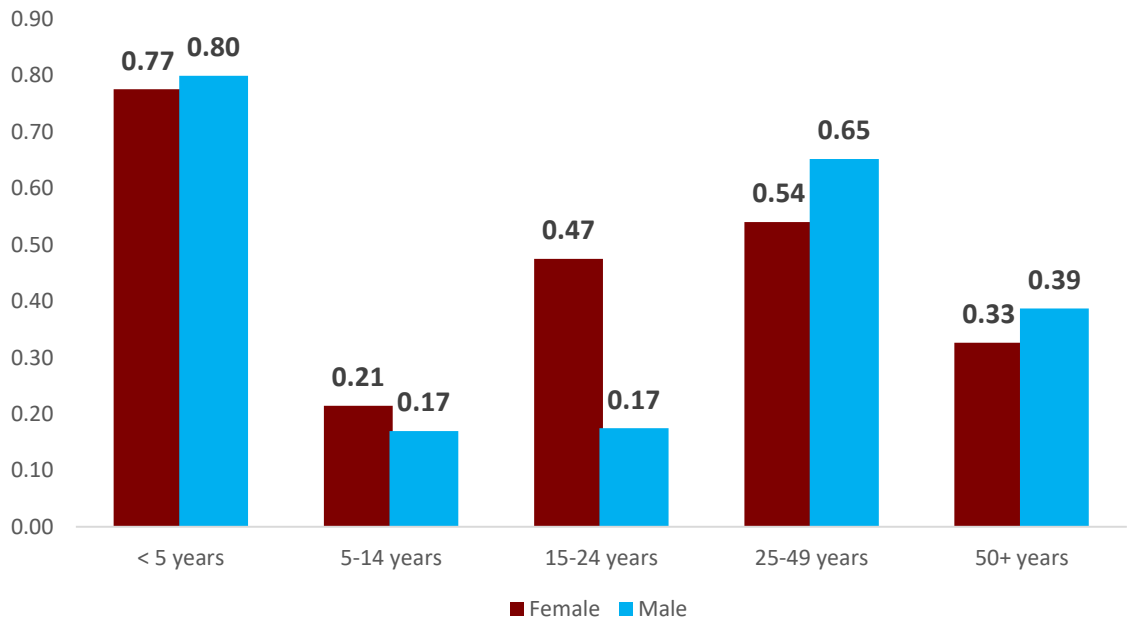


Figure 3: HIV sero-positivity rate by age group

An HIV testing screening tool was piloted in 21 health facilities in the City of Kigali and Eastern Province, as one approach to reduce the number of unnecessary tests conducted. Forty-six health care providers were trained on the HIV testing screening tool in order to reach targeted people at high risk. To improve the quality of testing services, mentorship, trainings, and experience-sharing sessions were conducted among 265 health care providers from all hospitals. Topics covered included new HIV-testing strategies, including index testing, partner notification, recency testing, HIV self-testing, and Case Based Surveillance (CBS).

2.2.1. HIV self-testing

In 2017, HIV self-testing was introduced as an additional testing strategy to reach people living with HIV with unknown HIV status and those at high risk of HIV.
The test kits reach the community through two main models of distributions:

- Facility-based distribution integrated with index testing and partner notification services as a way to offer HIV testing services to invited partners who refuse to come to the facility, but still want to be tested;
- Online distribution through private pharmacies.

Reactive results are confirmed by a trained provider at health facility, nonreactive results are linked to HIV prevention services, and confirmed spositive clients are linked to HIV care and treatment services.

Between July 2019 and June 2020, 68,804 HIV self-test kits were distributed within health facilities and 3,600 HIV self-test kits were distributed by private pharmacies. During the same period, the number of private pharmacies distributing HIV self-testing increased from 19 to 59 across the country.

2.2.2. Index testing and partner notification

Partner notification is a voluntary process whereby a trained provider asks people who are diagnosed HIV-positive ("index clients") about their sexual partners and family members. If the HIV-positive client agrees, the provider offers his or her partners HIV testing services. Between July 2019 to June 2020, 6,514 index clients were identified in health facilities implementing index testing and partner notification. Among the partners elicited who were reached and tested, the yield of HIV is estimated at 6%. Implementation of index testing and partner notification improve HIV testing coverage. The national program will continue to scale up and implement quality improvement activities for these services.

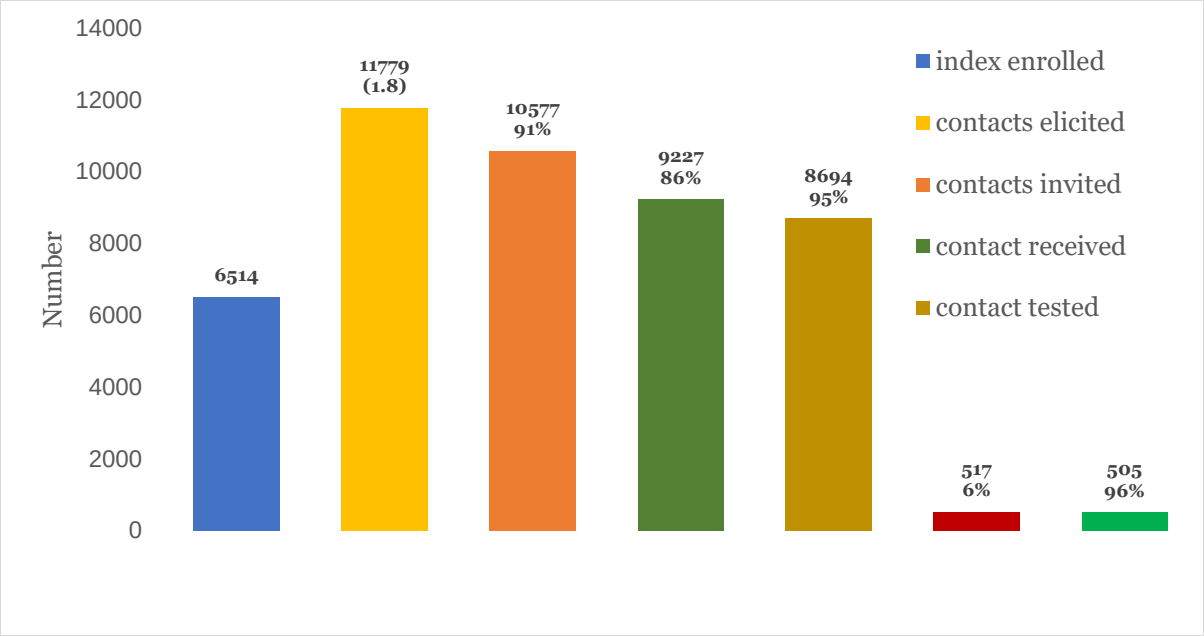


Figure 4: Cascade of Index Testing and Partner Notification

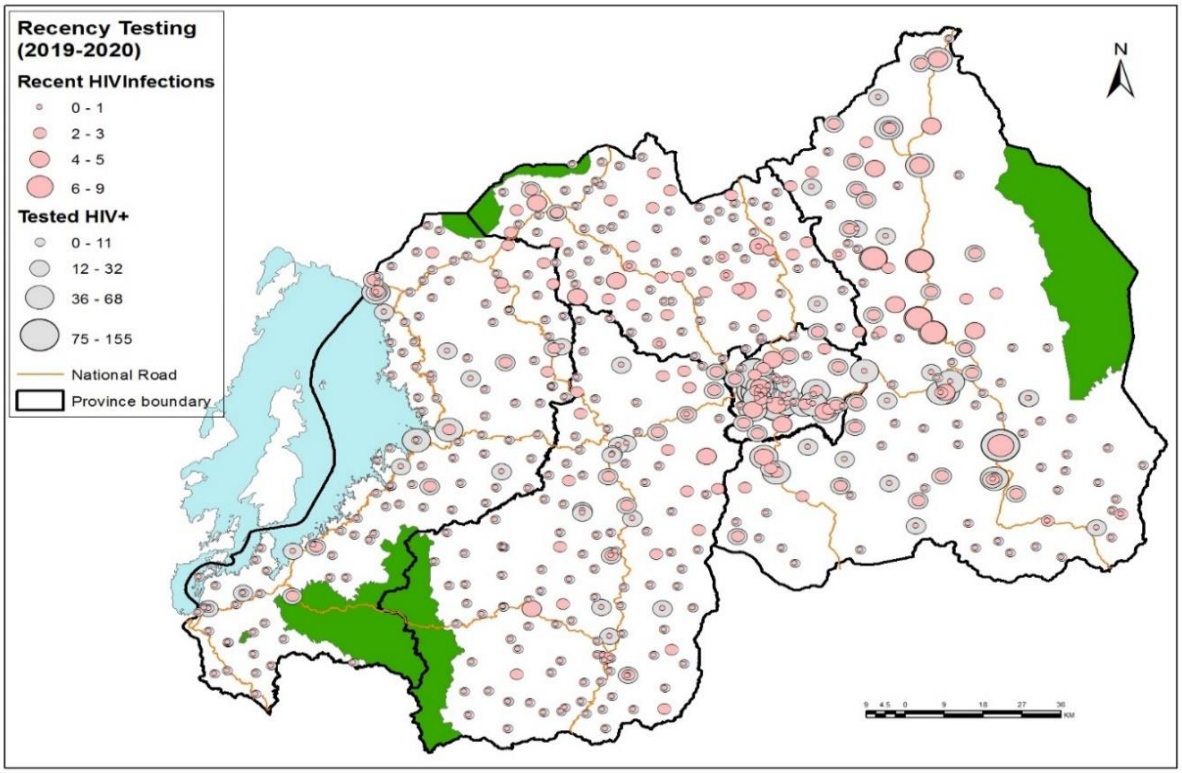
2.2.3. HIV Case-based surveillance and recency testing

Since 2018, Case-based surveillance (CBS) was introduced as a strategy to improve measurement and monitoring of the incidence, progression and outcome of people tested for HIV via the collection of patient level data for a series of key or sentinel events.

For comprehensive monitoring of the HIV epidemic, recency testing was integrated into CBS and routine HIV testing services. Recency testing differentiates between individuals who were recently infected with HIV (≤12 months ago) and those with long-term infection acquired more than 12 months ago. Two modes of service delivery are currently used:

- Centralized HIV recency testing: Performed at the National Reference Laboratory (NRL) and at viral load hubs located in all provinces of the country;
- Point-of-care testing (POCT): Performed at 23 health facilities in Kigali City.

The map below shows the number of recent and long-term HIV infections by district. The highest number of cases of recent HIV infection is located in the City of Kigali.



Map 2: Distribution of Recent and Long-Term Infection across Rwanda

The graphic below shows that HIV recent infections by age group and gender.

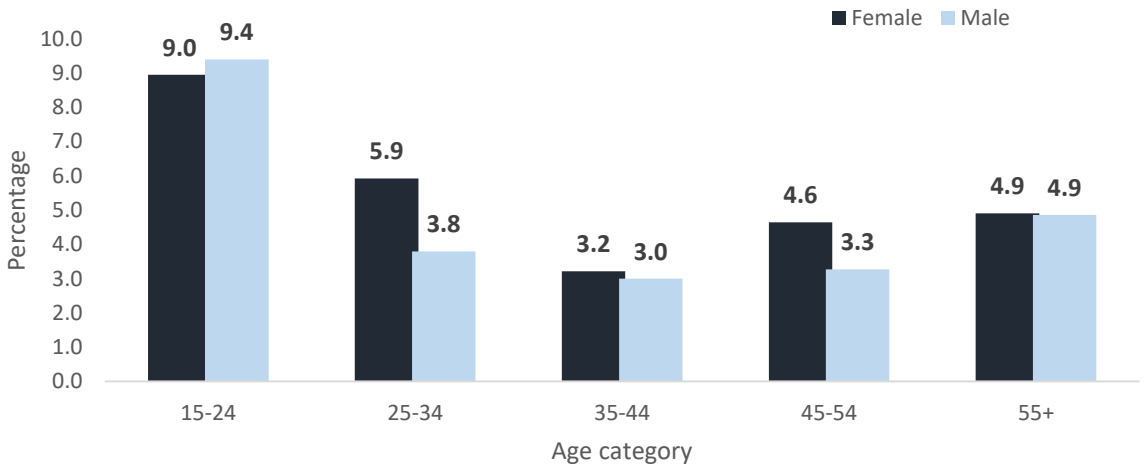


Figure 5: Distribution of recent infections among newly diagnosed PLHIV by recency Status, July 2019 - June 2020

2.3. Prevention of Mother-To-Child HIV Transmission

The comprehensive package of PMTCT services includes HIV education, HIV testing for pregnant women in antenatal consultation and maternity, provision of lifelong ART to HIV infected mothers and ARV prophylaxis for HIV-exposed infants, and post-natal follow-up of mother-infant pairs until 24 months after delivery.

2.3.1. HIV Testing in antenatal care (ANC) services

From July 2019 to June 2020, 349,199 pregnant women with unknown HIV status were tested for HIV, a decrease from 352,654 tested in the last fiscal year. Among them, 1,648 (0.47%) tested HIV positive.

The prevalence of HIV among all women in ANC (including those who already knew their status) was estimated at 2.26%. Of the 253,154 male partners tested for HIV in PMTCT, 0.35% (887 male partners) were HIV-positive. HIV testing is done during labour and delivery for women who have not been tested earlier during their pregnancy and those who might have seroconverted after the first negative result in antenatal care. Of the 292,272 pregnant women (women tested HIV negative during ANC and those who have not been tested earlier in their pregnancy) tested during labour and delivery, 1,345 (0.46%) tested HIV positive. Out of the total number of HIV-infected pregnant women who were identified in this reporting period, 97.5 % initiated ARV treatment.

- **HIV self-testing among male partners of pregnant women attending ANC**

HIV counselling for couples along with testing and treatment of those who test positive greatly contributes to the prevention of mother to child transmission of HIV. The national coverage of male partner testing in PMTCT is estimated at 85%, but this coverage varies between health facilities. To reach the remaining gap, the program has introduced the distribution of HIV self-test kits to target “hard to reach” partners of pregnant women received in the PMTCT program. Six health centres in the City of Kigali with relatively low partner testing were selected as pilot sites. A total number of 5,441 self-test kits were distributed within these health facilities. HIV self-testing (HIVST) was integrated into routine ANC services and enhanced counselling on the importance of partner testing was provided to all women coming for the first ANC visit without their partners. Acceptability of HIV self-testing was 100% and there was no reported or observed negative impact. At six months of the pilot phase, there was an average increase of 20% (from 66% to 86%) in partners testing.

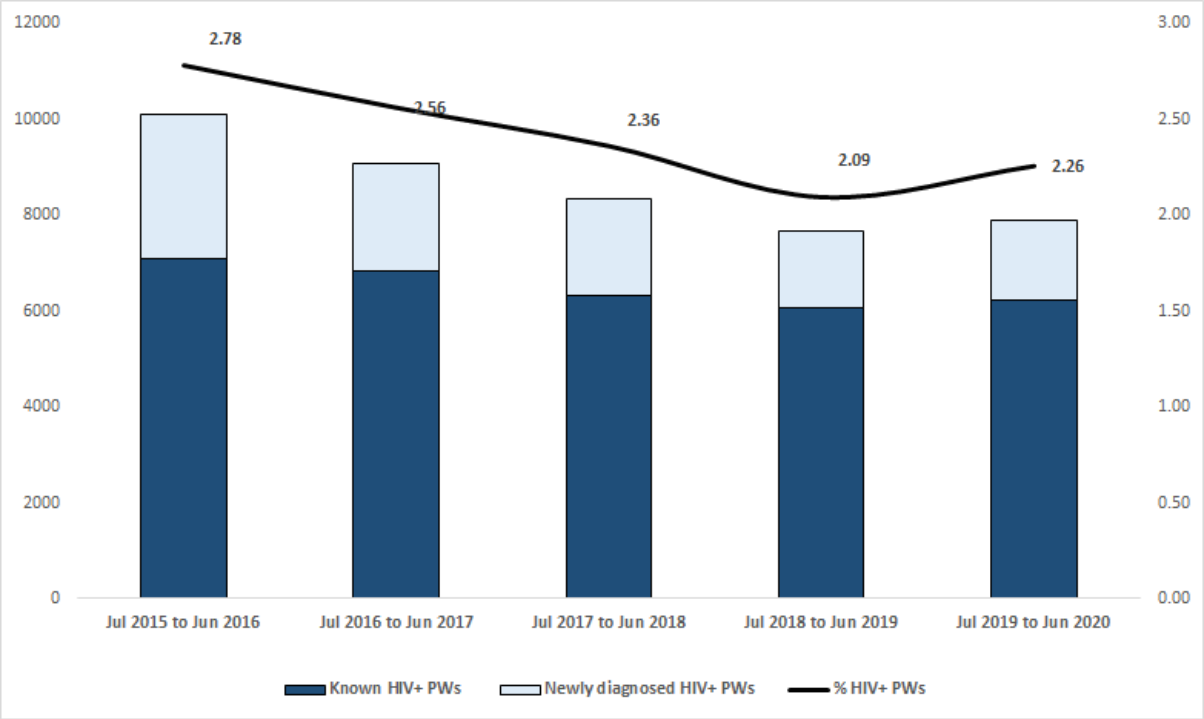


Figure 6: Trend of HIV sero-positivity in PMTCT

- **Follow up of HIV exposed children**

According to the current National HIV Guidelines, infants born to HIV-infected mothers are followed up in the PMTCT program until 24 months post-partum to closely monitor their HIV status. To enable timely early infant diagnosis and rapid ARV initiation for those tested HIV during follow up, HIV-exposed children are tested at different points in time (6 weeks, 9 months, 18 months and 24 months) as a standard of care. Children are tested using PCR at six weeks of age. Testing beyond this age uses a rapid test followed by PCR confirmation to those who test HIV positive. In an effort of reduce turnaround time, PCR testing is done using a combination of conventional and point of care methods. With the scale up of point of care EID capacity in high-volume sites, the turnaround time in these particular sites has been reduced to only 3 days from sample collection to ARV initiation.

A retrospective cohort analysis of HIV exposed infants who were tested for HIV during the PMTCT follow-up period showed that 98.35% of exposed infants were HIV-free at 24 months.

2.4. Voluntary Medical Male Circumcision

Since 2008, Voluntary Medical Male Circumcision (VMMC) is a part of a comprehensive set of HIV prevention interventions. Different service delivery models are used to provide VMMC services. Those include routine service delivery and special campaigns. Both the conventional surgical method and device-based methods are used. Furthermore, Early Infant Male Circumcision (EIMC) for infants younger than 2-months old continues to be

provided in 11 districts hospitals. The graph below shows how the prevalence of VMMC decreases by age.

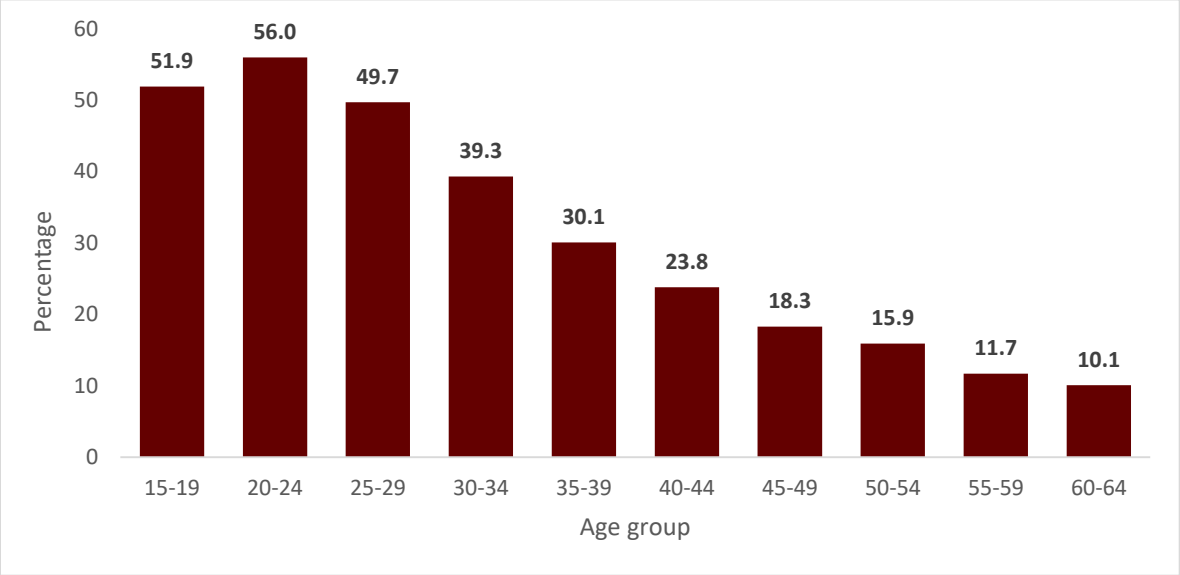


Figure 7 : Male circumcision by age group

According to the RPHIA conducted in 2018-19, male circumcision (MC) prevalence was estimated at 39.9% nationally, with a higher prevalence among younger adolescents and men in the city of Kigali. The graph below shows the MC prevalence per province according to RPHA

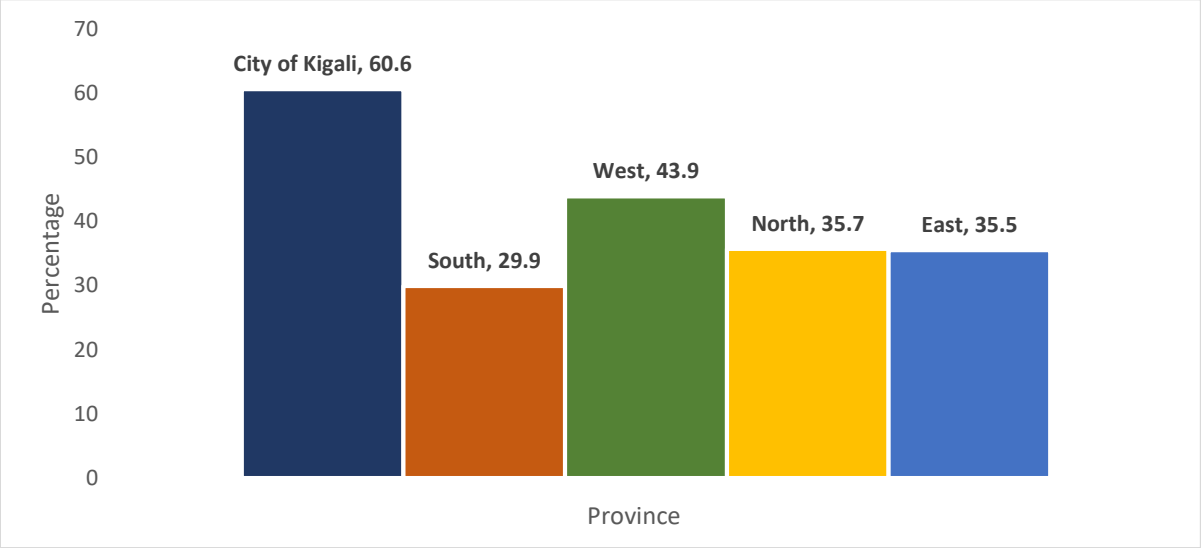


Figure 8: Male circumcision prevalence by province, RPHIA 2018-19

During this reporting period, MC campaigns were put on hold due to strategies put in place to curtail the spread of COVID-19. However, from the previous fiscal year, VMMC procedures performed increased from 346,157 to 401,987, including 348,154 (86.8%) using the surgical method and 53,833 (13.2%) using the medical device. The circumcision procedure using medical devices has decreased from 32% to 13% due to phase out of Prepex devices. In this reporting period, active surveillance of the Shang Ring device was

introduced to complement the conventional surgical method. The graph below presents VMMC performance by district.

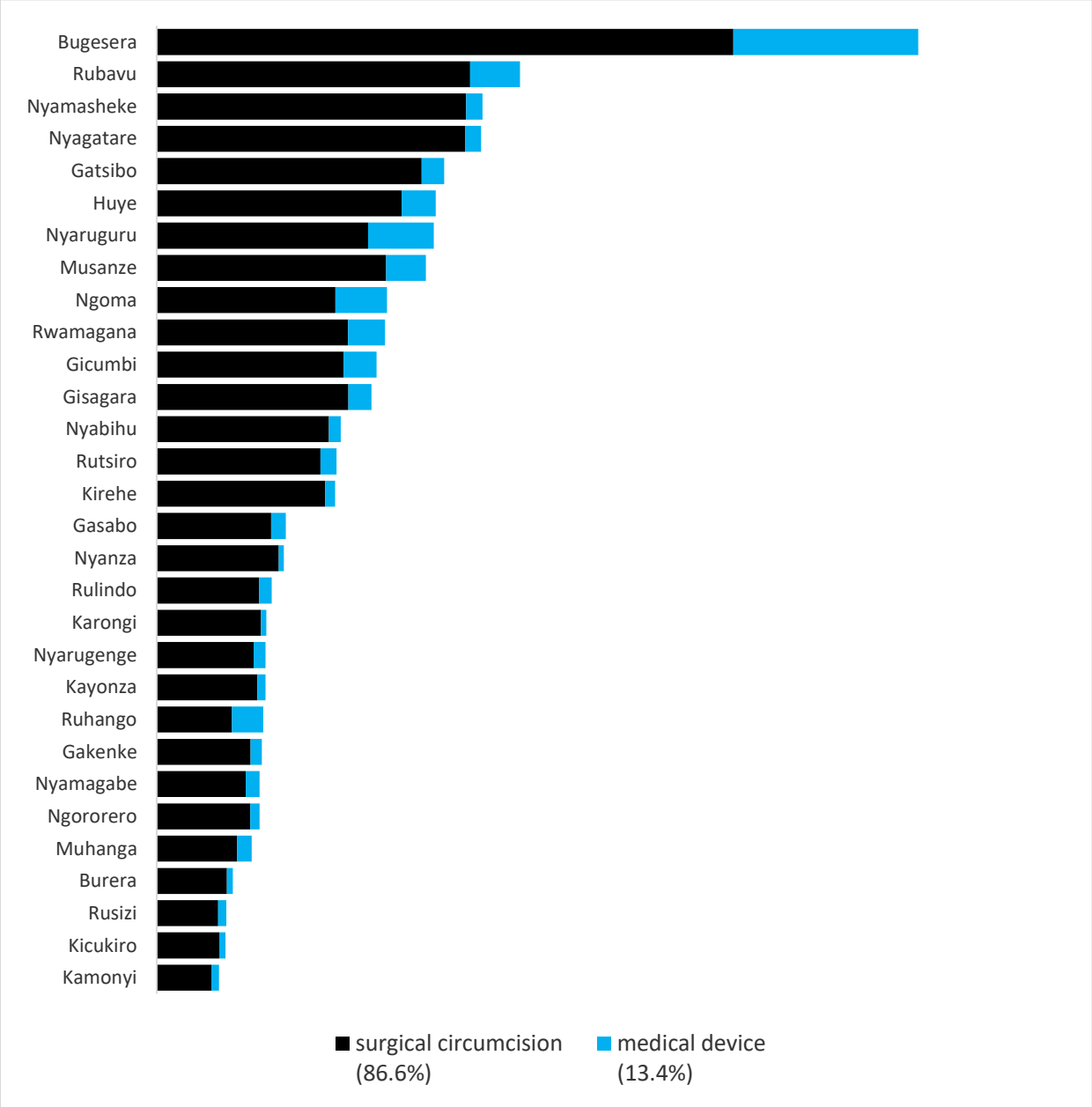


Figure 9: Number of VMMC performed by district, HMIS July 2019-June 2020

The National HIV program has made an effort to increase access to male circumcision services to young adults who are sexually active and at greater risk of HIV acquisition. The graph below shows an increase in VMMC performance by 10% for young men 2024 years old and an increase of 8% for men 25-49 years old.

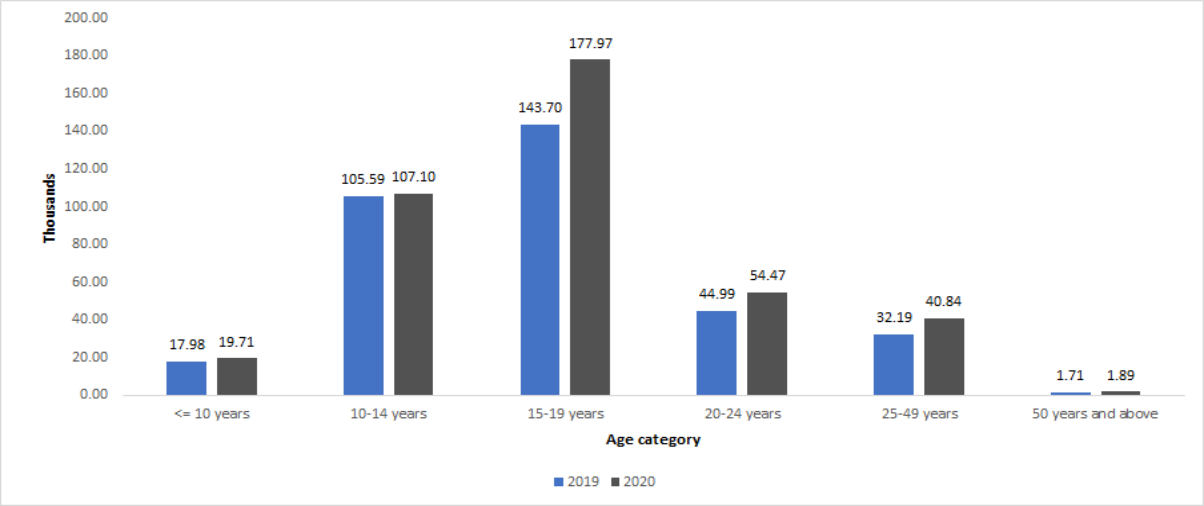


Figure 10: VMMC performed by age, HMIS 2019 - 2020

2.5. HIV Prevention services for Adolescent Girls and Young Women (AGYW)

Rwanda Biomedical Centre in collaboration with its partners initiated interventions focused on adolescent girls and young women (AGYW) as a group at risk of acquiring HIV in order to empower and strengthen families and mobilize the community. The aim of this initiative is to foster the development of women and girls to be Determined, Resilient, Empowered, AIDS-free, Mentored and Safe individuals (DREAMS) with the ability to realize their full potential.

During this reporting fiscal year, the focus was to train peer educators in and out of school on sexual and reproductive health (SRH), HIV and STIs, gender-based violence (GBV), life skills, interpersonal communication, referral for HIV testing and VMMC. Moreover, outreach activities targeting adolescent women were conducted to strengthen the knowledge of HIV prevention, SRHR services and linkage to HIV services.

2.6. HIV Prevention Services for Key Populations

The HIV prevalence among key populations (KPs) has been estimated to be higher than the general population in Rwanda at 35.5% among female sex workers (FSW) and 7.0% among men who have sex with men (MSM). The Government of Rwanda has included specific interventions in the NSP to target key populations, especially FSWs and MSM, to reduce their risk of HIV acquisition and ensure linkage to HIV treatment services for those living with HIV. In this program, activities focused mainly on training of FSW and MSM peer educators on HIV/AIDs and sexual health issues, referral for HIV testing, promotion of condom use, and diagnosis of STIs.

Between July 2019 and June 2020, 19,416 FSW were enrolled in prevention programming. A comprehensive package of services was provided to key populations including HIV testing, condoms, PrEP and ARV treatment.

2.6.1. Condoms programming

Condoms are provided through multiple channels in Rwanda. In total, 29,912,778 condoms were distributed during the reporting period; 11,885,725 distributed through health facilities, 16,580,813 through social marketing, and 1,446,240 through eight condoms kiosks displayed in the three districts of the city of Kigali as well as Rubavu, Rusizi and Huye Districts.

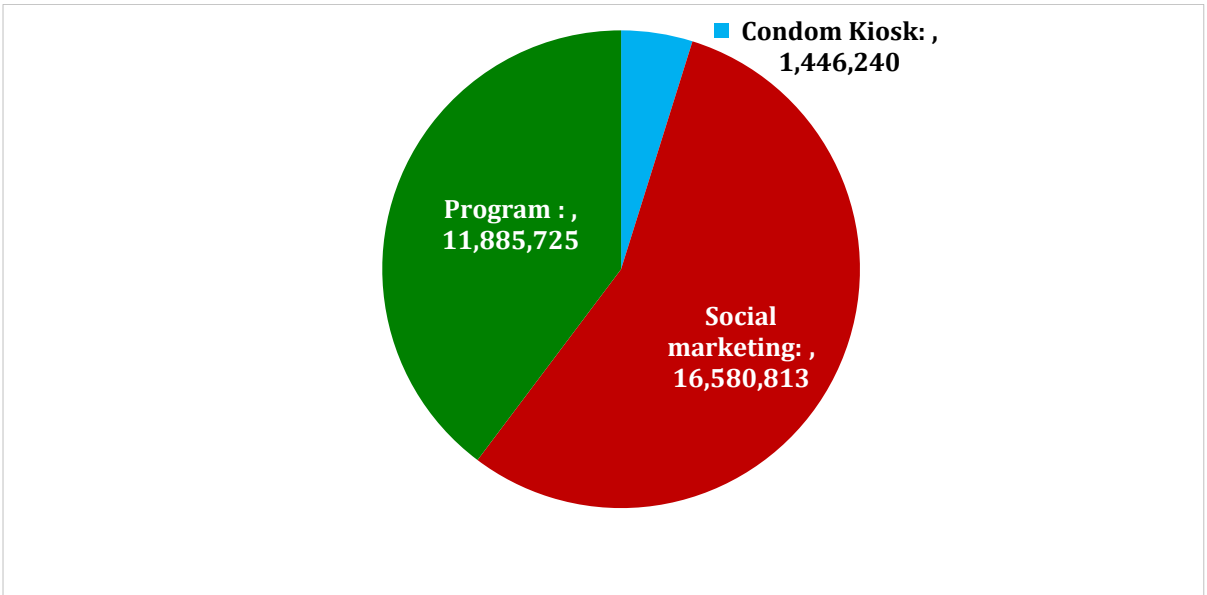
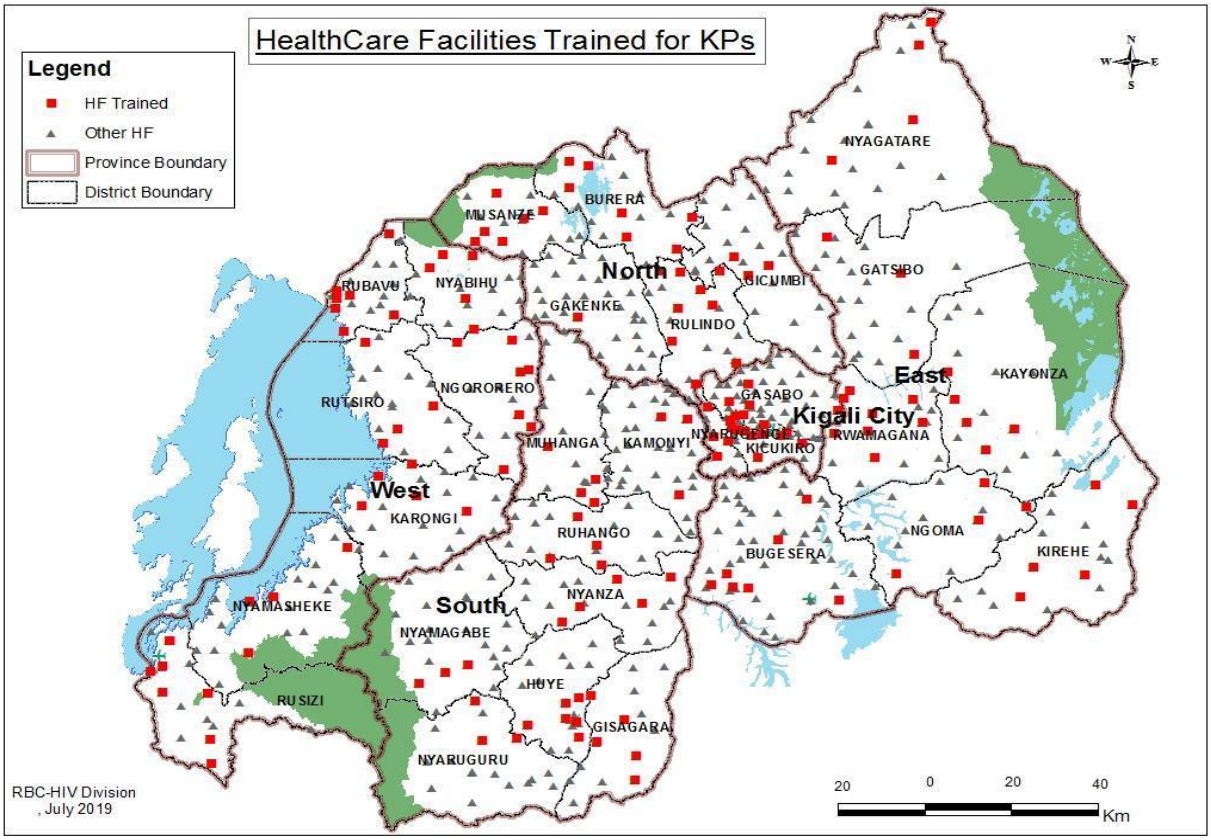


Figure 11: Condoms distributed, July 2019-June 2020

2.6.2. Pre-Exposure Prophylaxis (PrEP)

The National HIV guidelines recommend PrEP as an additional intervention in the package of services for key populations. In the first phase of PrEP implementation, female sex workers, Male who have sex male and discordant couples were targeted in 22 health facilities located in the City of Kigali. During this reporting period, 2,248 FSWs and 177 discordant couples initiated on PreP.



Map 3 : Health centres trained on KPs

2.7. HIV Awareness

Multiple interventions were conducted to increase awareness of HIV, STIs and Hepatitis. Interventions included the production and distribution of information, education and communication (IEC) materials, mass media (newsletter supplements, Radio & TV shows and spots), mass campaigns, and outreach campaigns.

2.7.1. Radio shows and spots

Live talk shows were organized on both public and private radio to provide the general population with information on new HIV programs & services and to increase awareness of how to access HIV services. In this reporting period, ten TV shows and 42 radio talk shows were conducted on new HIV strategies including HTS, PMTCT, VMMC, Care and Treatment services (test and treat and adherence on ART), and for other blood borne infections (STIs and Viral Hepatitis).

In addition, radio and TV advertisements on HIV prevention were broadcasted on two TV stations and ten radio stations. Information was provided through public and private radio and TV stations. The web banners also have been displayed on four different online newspapers (Igihe.com, New Times, Umuseke and Kigali Today).

2.7.2. Development and distribution of IEC Materials

Educational materials were developed and distributed to provide the population with Information, Education and Communication strategies and Behaviour Change Communication related to HIV and other blood borne infections. Posters on PMTCT, adolescent sexual and reproductive health (ASRH) and opportunistic infections (OIs) were distributed to all health facilities, including Youth Friendly Centres.

2.8. Capacity building and Quality improvement for HIV Services

The success of HIV prevention services depends largely on the knowledge and skills of healthcare providers working in different HIV prevention areas. During the reporting period, the national HIV program conducted capacity building and quality improvement activities, namely training, workshops, experience sharing sessions and mentorship activities. Those activities aim at providing an updated comprehensive package of HIV prevention services (HIV Testing, PMTCT, VMMC and services for key populations), as per national guidelines. It is also an opportunity to present and familiarize staff with new M&E tools.

3. HIV CARE AND TREATMENT

3.1. Introduction

HIV Care and treatment is a priority of the national HIV program to control the HIV epidemic. Care and treatment is one of the pillars to prevent HIV transmission but also improves the quality of life of PLHIV. In this reporting period, the HIV Care and Treatment program placed emphasis on the follow up and implementation of the changes in HIV management, mainly:

Introduction of Dolutegravir (DTG) for all PLHIV 20kg and above
Transition to Dolutegravir (DTG) for women of childbearing age
Updated DSDM categorization
Piloting TPT implementation
Phase out of AZT and Nevirapine 200 mg in the first line regimen, and Cotrimoxazole drawdown.

The following section highlights:

HIV care continuum
Progress made towards global targets
Screening and management of Opportunistic Infections (OIs)
Supply chain activities

3.2. HIV Continuum of Care

3.2.1. Linkage and enrolment

Timely linkage of HIV-positive clients to care and treatment is an important to improving the health of PLHIV and reducing the transmission of HIV. Understanding this, the National HIV program has been implementing 'Treat All' strategy since 2016. All clients who test HIV-positive should be linked the same day and enrolled or initiated on Antiretroviral Therapy (ART) regardless of their CD4 count. The Treat All strategy has led to a large increase in the number of patients on ART in Rwanda. The HIV Care and Treatment program in Rwanda has developed and enhanced strategies to improve linkage and initiation on ART for all patients who have been newly diagnosed HIV-positive, namely:

Communication between testing entry points and ART services
Same-day enrolment
Enhanced counselling at enrolment
Same-day initiation on ART where feasible and if not, initiation within one week

The figure below shows that 11,311 clients were enrolled and initiated on ART during the reporting period. The figure shows that Kigali City has the highest number of patients newly initiated on ART (3,220), representing 28.5% of the total patients enrolled from July 2019 to June 2020.

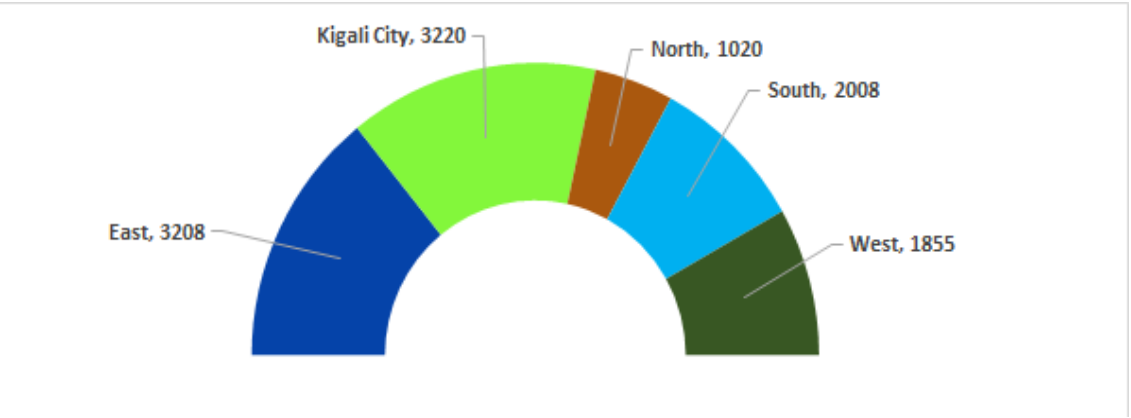


Figure 12: Number of Patients enrolled on ART from July 2019 to June 2020

3.2.2. Antiretroviral treatment coverage

HIV management guidelines are revised every two years and eligibility criteria for being initiated to ART has changed from a minimum CD4 count of 200 to the current strategy of treating all PLHIV regardless of CD4 count ("Treat All").

The figure below shows the trend of ART initiation from 2004 as compared to the estimated number of PLHIV. By June 2020, the overall number of patients on ART was 201,629, representing coverage of 87.5%. Adolescents aged 10-19 represent 4.6% of all patients on ART, while elders aged 50 years and above represent almost 30%. The figure below represents the patients on ART by age category and gender.

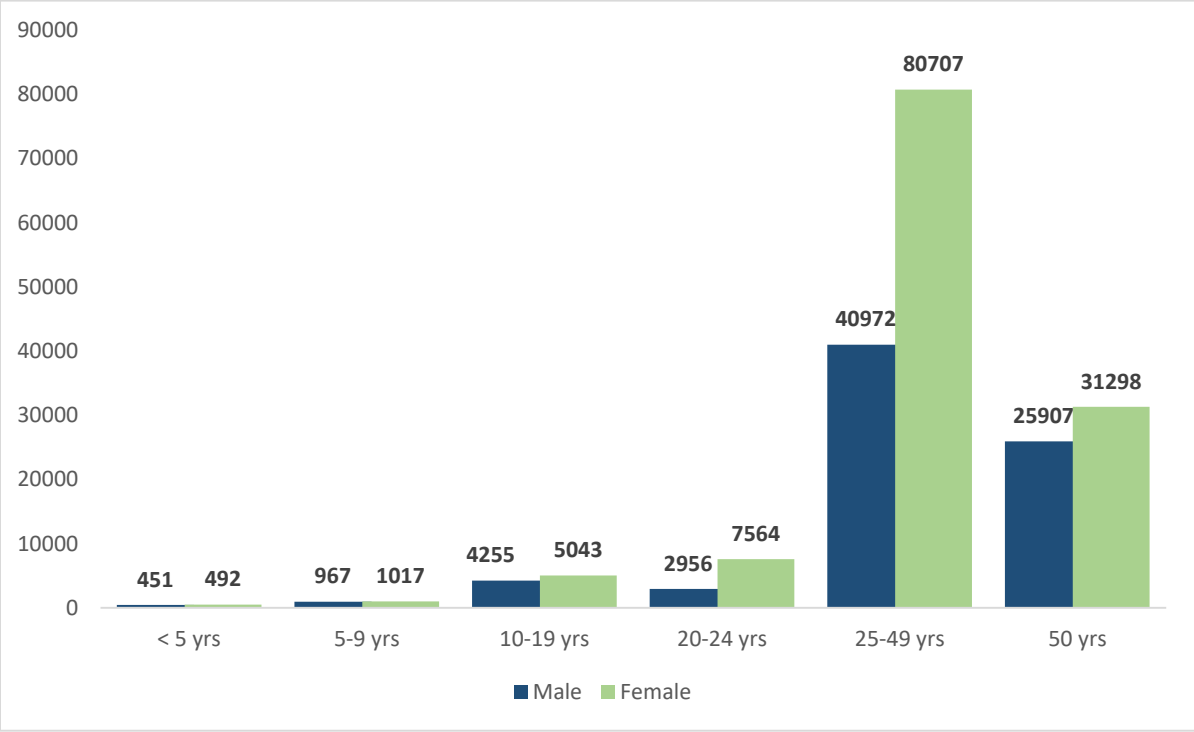


Figure 13 : Distribution on Patients on ART by age and gender

The coverage of ART has increased significantly from 2004 when ART scale-up began in Rwanda.

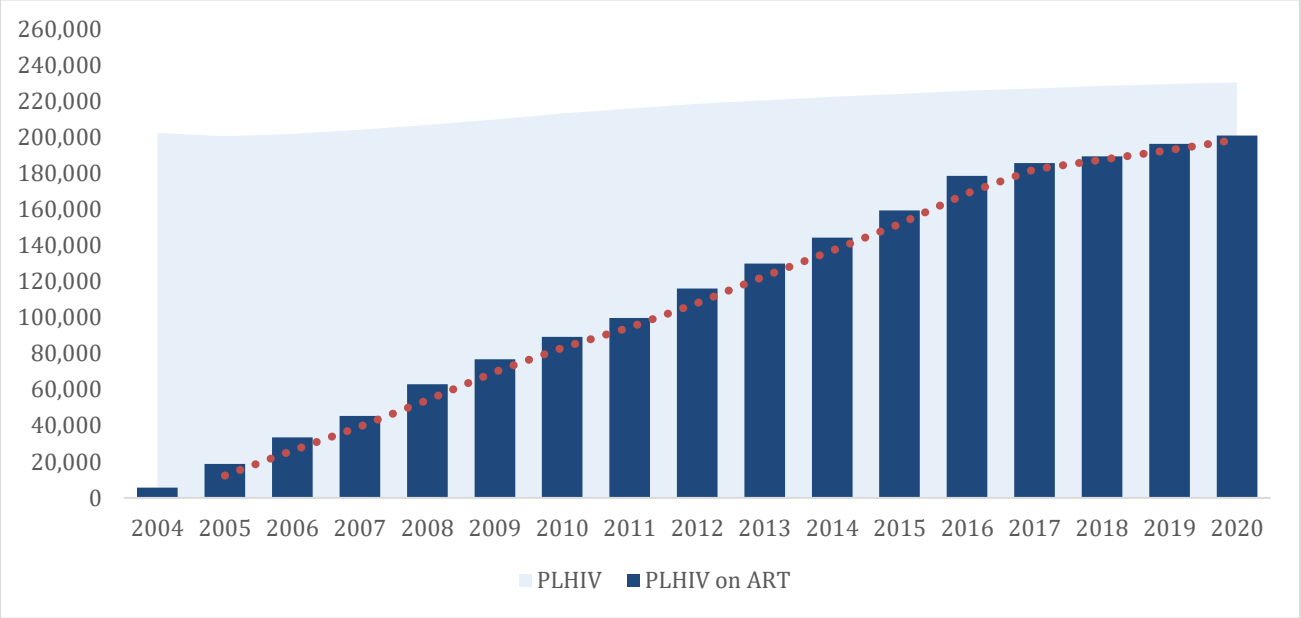


Figure 14: Trend in treatment coverage, 2004-2020

Different strategies were implemented during the reporting period resulting in the achievements mentioned above:

New HIV Testing strategies including self- testing, index testing and partner notification
Enhanced counselling and support interventions from testing to ART initiation
Improved linkage and ART initiation to minimize loss to follow up
Availability of ART and other HIV commodities at health facilities
Clinical mentorship and onsite trainings conducted countrywide to support healthcare providers
Training of healthcare providers on updated HIV guidelines

3.2.3. Retention on Treatment and viral load monitoring

- **Retention on ART**

Retention of PLHIV on treatment with good adherence is expected to increase viral load (VL) suppression, which is the gold standard indicator of ART outcome. Below are several strategies that have contributed to improving retention, adherence and VL suppression among PLHIV:

Redefinition of the stable category criteria under differentiated service delivery model (DSDM) that allowed patients with 12 months on ART to be part of the stable category.

Transition to DTG-based regimen for eligible PLHIV who weigh at least 20kg regardless of age and sex.
Refresher training of healthcare providers working in ART service on psychosocial components in management of HIV.
Introduction of adapted ART provision in line with COVID-19 preventive measures.

Retention is generally good across age categories, with an estimated 96.8% retention overall. There was no significant difference in retention noted by age or sex.

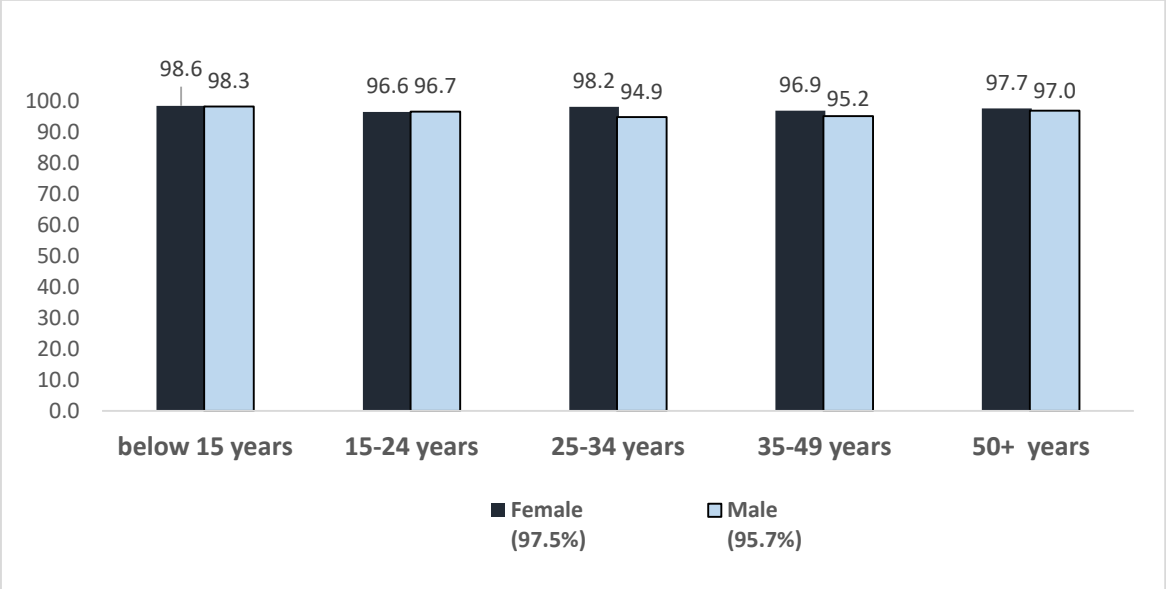


Figure 15: Retention of patients after one year on treatment

- **Viral load monitoring**

Viral load (VL) monitoring is the cornerstone of HIV Care & Treatment; it supports prevention, early detection, and management of treatment failure. The program has increased efforts to train healthcare providers to monitor viral load and manage patients according to their VL results. Viral load is also a key factor for patients to be classified under stable category. Since DSDM was launched, the definition of categories has been continually revised. In December 2019, the stable category was revised to include more PLHIV, where a client who has been on ART for at least 12 months and suppressing viral load could be in a stable category (along with fulfilling other criteria).The introduction of Viral Load Sample Management System (VLSMS) in addition to Laboratory Information System (LIS) in HIV VL testing hubs has decreased Turnaround Time (TAT) of VL results and supports timely clinician decisions. All testing sites have been trained on both lab electronic-based systems. The VLSMS in particular has helped to reduce TAT from 3 months to 2 weeks.

3.2.4. Care and Support

HIV care and support refers to key non-antiretroviral therapy clinical services, the treatment of HIV-related infections, and non- clinical services. In combination with antiretroviral therapy, these services contribute to retention of clients on treatment, good adherence, the reduction of HIV-related death, and improving the social wellbeing of PLHIV.

During this reporting period, the Care and Treatment program focused on enhancing psychosocial support, improving same day enrolment, and the provision of mental health screening for PLHIV to strengthen adherence and retention on antiretroviral therapy. Social workers from all public health centres and district hospitals together with clinical psychologists from all district hospitals were trained on mental health/HIV integration and HIV Disclosure for children living with HIV.

From July 2019, in Collaboration with Dream Village, the HIV program introduced Community Adolescents Treatment Supporters (CATS) program in 11 pilot sites whereby adolescents living with HIV (ALHIV) with good adherence support their peers who demonstrated poor retention in the program. Through this program, PLHIV diagnosed with moderate and severe malnutrition are supported with supplementary or therapeutic food in accordance with the national nutrition guidelines.

3.3. Progress towards 90-90-90

Rwanda has made great strides towards achieving the United Nations Program on HIV/AIDS (UNAIDS) 90-90-90 target that helps end the epidemic. Innovative strategies in HIV prevention and management have been adopted based on evidence to achieve the global target by 2020. This led the country to nearly reach the UNAIDS target by 2020.

According to the RPHIA, 83.6% of all PLHIV in Rwanda know their HIV status (1st 90). 97.5% of PLHIV who know their status are on ART and 90.1% of those receiving ART have achieved viral suppression (<1000 copies /ml).

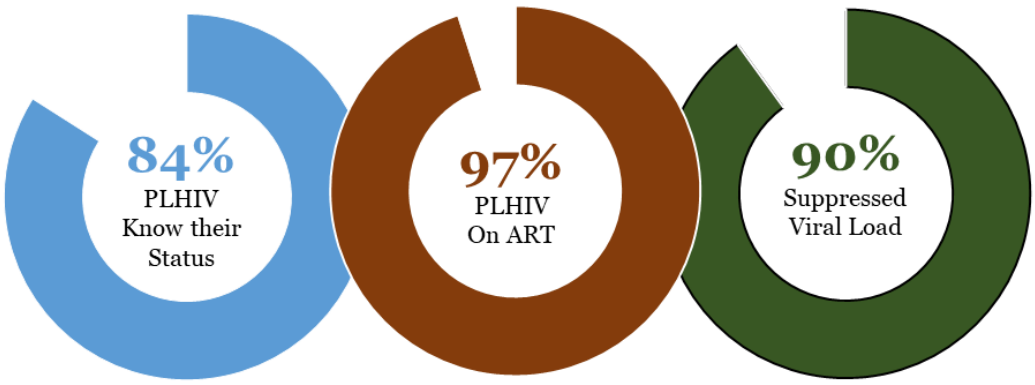


Figure 16: Cascade of Care and Treatment

3.4. Screening and Management of Opportunistic Infections

Scale up of the "treat-all" strategy has substantially decreased HIV comorbidities and HIV mortality in Rwanda. However, national guidelines still specify that every PLHIV should be screened for opportunistic infections (OIs) at enrolment and each clinical visit in order to identify patients with the highest risk of OIs and immune reconstitution inflammatory syndrome (IRIS). Non-Communicable Diseases (NCDs) are now emerging with high prevalence in PLHIV. NCD screening has been integrated at health facilities in order to increase retention in care for HIV/NCD patients through reduced appointment frequency. Hypertension, diabetes and cervical cancer are screened at each clinical visit. Tuberculosis (TB) has been the most prevalent OI among PLHIV. Tuberculosis Preventive Therapy (TPT), has been adopted for PLHIV who have screened TB negative using symptoms screening and X-ray. Monitoring and Evaluation (M&E) tools are being used for their follow up.

3.5. Supply Chain

Supply chain management of antiretroviral medicines and other HIV-related commodities involves a series of activities to ensure products are continuously available for clients in need.

Below are some of the activities completed during the year 2019-2020 fiscal year:

- *The annual quantification of program commodities and other essential medicines:* HIV/AIDS, Tuberculosis, Malaria, MCCH and other essential medicines needs were estimated during an integrated quantification exercise. The forecasted needs for 2020-2024 and the supply plans for 2020-2021 were determined and a report was produced and approved for implementation.
- *Quarterly Supply plan review:* This exercise provides an opportunity to review the forecasted commodity consumption against actual records. Based on the measured forecast accuracy, necessary adjustments are carried out to ensure optimal supply of health commodities.
- *Training on the Differentiated Service Delivery Model and the transition to Dolutegravir:* Supply Chain Staff from district harmacies, Hospitals, Health centres and private health facilities providing ART services were trained to ensure proper management of the supply chain and implications associated with changes in the HIV Prevention and Management guidelines.
- *Health commodity stock status review*: Stock status analysis and pipeline monitoring is a routine exercise conducted on a monthly basis and as required. Stock levels at central, district and health facilities are reviewed with reference to national min-max policy and appropriate decisions are taken to prevent both shortages and expiries.

- *Continuous monitoring of new molecules being introduced and those being phased out according to guideline recommendations:* Some have been recalled from sites while others were distributed to secure optimal stock levels at service elivery Popints.
- *Training of supply chain staff on Laboratory Bundling:* this is a tool which sfacilitate ordering lab commodities based on the number of tests performed and provides sufficient commodities to run a given number of tests in a given period of time without shortage, wastage or expiry. All lab technologists and store managers at district pharmacies were trained.

3.6. Continuous quality improvement

Quality of care is a key factor for the success of the HIV response. Apart from trainings, quality improvement for HIV care and treatment was realised through experience sharing, coordination meetings, clinical mentorship, and monitoring activities to enhance and improve the quality of care provided to PLHIV.

The integrated clinical mentorship conducted during the reporting period focussed on key changes in HIV guidelines, prevention and management of comorbities, transition to DTG, phase-out of NVP & AZT, definition of HIV indicators, data sources, data timeline reporting and completeness of tools. In addition, coordination meetings with all ART services providers from health facilities were held to discuss HIV service delivery, new strategies to reach national and global targets, new changes in the HIV guidelines and any other issues related to HIV services. These meetings were also an opportunity to share experiences and best practices between the central level, clinical mentors and partners involved in the HIV response.

4. SOCIAL IMPACT MITIGATION

4.1. Introduction

Impact mitigation interventions are important in the HIV response to ensure that the burden of HIV at the individual, family, community and national level is reduced. The impact mitigation program in accordance with HIV National Strategic Plan (NSP 2019-2024) aims to ensure that:

People infected and affected by HIV have improved their socio-economic status and protection

Sexual Gender Based Violence (SGBV) and HIV-related Stigma and discrimination are reduced.

4.2. Working with Civil Society Organizations and non-health sector Institutions

The mitigation of the impact of HIV is important in the HIV response to ensure that the burden of HIV at all levels is reduced. In accordance with HIV National Strategic plan (NSP 2018-2024), the impact mitigation program aims to ensure that (1) people infected and affected by HIV have improved their socio-economic status and protection (2) sexual gender-based violence (SGBV), HIV-related Stigma and (3) discrimination are reduced.

From July 2019 to June 2020, different partners were involved in the implementation of social impact mitigation interventions and activities. The Ministry of Health (MoH) through RBC works in close collaboration with members of Civil Society Organizations (CSOs) and Non-Governmental Organizations (NGOs) such the Network of PLHIV (RRP+), Profemme Twese Hamwe and non-health sector public institutions such as the Ministry of Gender and Family Promotion/National Commission for Children (MIGEPROF/NCC). Most of the impact mitigation activities were implemented at the community level.

Activities carried out during the reporting period focused on the following areas:

- Orphans and Other Vulnerable Children (OVC)
- Sexual Gender-Based violence & Stigma and Discrimination and,
- Income generating Activities.

4.3. Orphans and Vulnerable Children (OVC)

The vision of the Government of Rwanda is that OVC will be assisted to reach their full potential and have the same opportunities as other children. It is in this regard that advocacy has been done and funds have been mobilised OVC care and support of OVC. Organisations that spearhead this are USAID (PEPFAR) and Global Fund.

In Rwanda, a minimum package of services for OVC including health services, nutrition support, education support, shelter support, and social protection by community volunteers, psychosocial support by peer educators, and socio-economic support, was established.

During this reporting period, different organizations contributed. Through the USAID/PEPFAR OVC & DREAMS programs, OVC living with HIV have been supported to access HIV care and treatment by linking them to the nearest health facilities, and their households were economically empowered (loans and savings groups, cooperatives, income generating activities and conditional household grants as appropriate) to improve financial stability. On top of that, some of them have been trained onto be ready for employment and business opportunities. Others have been supported to attend primary and secondary schools as well as market-based technical and vocational education and training - TVET). Early childhood development (ECD) services and linkage to other forms of community social support were also provided.

With the support of Global fund, OVC related activities implemented by the National commission for children (NCC) in eight districts included mainly: Provision of education support through scholastic materials, payment of school feeding to OVC in 12 Year Basic Education (12YBE), payment of school fees for OVC in Technical and Vocational Educational Training (TVET), renovation of Early Childhood Development (ECD) and provision of equipment as well as providing income generating activities (IGA) to parents/caregivers of OVC in 12YBE for their empowerment and resilience. Moreover, NCC paid school fees for 1,000 MVC in TVET and provided scholastic materials and school feeding for 322 MVC.

4.4. SGBV & HIV related Stigma and Discrimination

The NSP for HIV/AIDS 2018-2024 outlines the goal of reducing new infections by two thirds; halving the number of HIV-related deaths; and ensuring that PLHIV have the same opportunities as all others in Rwanda.

During the reporting period, 6,627 were reported being at risk of HIV infection as a result of rape/sexual assault through the Health Management Information System (HMIS, July 2019 - June 2020). These individuals received appropriate services including counselling and medical care with provision of Post-Exposure Prophylaxis (PEP) through ISANGE one-stop centers. In addition, civil society organisations contributed to the fight against SGBV by counselling and referring SGBV victims, training local authorities on SGBV laws, concepts, rights and responsibilities of people living with HIV and victims of GBV. Furthermore, CSOs conducted mass campaigns to sensitize the community on SGBV and supported in management of rape cases by assisting SGBV victims with legal services.

Based on the Stigma index carried out by RRP+ in collaboration with RBC, GIZ, UNAIDS, GNP+ and WHO, HIV-related stigma and discrimination were drastically reduced

compared to the last 10 years. However, some isolated cases of stigma and self-stigma are still observed. Overall, the composite indicator resulting from several stigma and discrimination related questions was rated very low (13.2%).

4.5. Income generating Activities

Income Generating Activities (IGA) are believed to improve economic well-being of people affected and infected by HIV. In this framework, the national HIV strategic plan 2018-2024 suggested that the well-being of PLHIV is improved through IGAs and as people become financially autonomous, their self-stigma reduced, which leads to increased self-esteem.

In collaboration with RBC through Global Fund support, UN WOMEN and RCA, RRP+, 300 PLHIV cooperatives including key populations were trained on Cooperative management, development of profitable projects, marketing and the development of business plans. After the training, 65 selected cooperatives were awarded a start-up capital equivalent to 2,500,000 FRW each.

To enhance the preventive measures of COVID-19, RRP+ initiated the community-led monitoring through a community call center with a free hotline to accept community feedback. In collaboration with GIZ and UNAIDS, 5,226 peer educators received support for personal preventive equipment such as hand sanitizers, face masks and soaps. In addition, due to restricted movements related to COVID-19 preventive measures, ART home delivery was initiated and conducted by peer educators.

5. VIRAL HEPATITIS AND SEXUALLY TRANSMITTED INFECTIONS

5.1. Introduction

With effective vaccines and treatment for Hepatitis B (HBV) and an increasingly affordable cure for Hepatitis C (HCV), combating viral hepatitis has become a focus for national strategic plans in Rwanda.

The Government of Rwanda, capitalizing on its success in rapid expansion of HIV services and care, has led the way in reducing its hepatitis burden. Rwanda has been the first country in the region to launch a national viral hepatitis control program, to establish a dedicated hepatitis unit in 2011, to put in place first national guidelines in 2013, to put in place first hepatitis C treatment from 2015, vaccination and screening campaigns from 2016, and finally to launch hepatitis C elimination plan in 2018.

During the period of 12 months from July 2019 throughout June 2020, several activities were conducted to support the prevention, care and treatment of viral hepatitis B and C, and STIs. The following key achievements were noted:

- Awareness, sensitization, mass screening and vaccination campaigns as the most effective ways to reduce the burden of HBV and HCV. Radio talks and TV shows were broadcast to raise general population's awareness. Beginning in 2002, HBV vaccination was administered to more than 6,000,000 people with a goal to have all people aged 0 to 17 years old vaccinated. In 2019-2020 alone, more than 50,000 adults and 352,750 children were vaccinated against HBV, for a total of 402, 750 people vaccinated against HBV during this fiscal year.
- Training for healthcare providers including medical doctors, nurses and data managers to ensure proper decentralization of Hepatitis and STI management services;
- Implementation of HCV elimination joint Umuhigo in all districts aimed at testing individuals aged 15 years and above;
- Initiation of HBV for 2,611 patients and HCV treatment for 16,891 patients;
- Viral hepatitis indicators were included in HMIS.

5.2. Prevention of STIs and Viral Hepatitis

5.2.1. Prevention of STIs

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

In line with the WHO vision, beginning in 2011, the Ministry of Health (MOH) through Rwanda Biomedical Centre (RBC) urged systematic screening of STIs in order to reduce unmet need in STI prevention and treatment services. This strategy helped to recognize clients with symptomatic STIs who do not seek health care and thus increase the number of cases treated. However, although we are aware that a significant number of people remain asymptomatic while they continue to spread the disease, socio-economic status is still a challenge to remarkably reduce the burden of STIs in Rwanda. So far, in Rwanda, patients aged 15 years and above visiting different health facilities for several health issues are actively checked for STIs signs and symptoms and all pregnant women and their partners are systematically screened for STIs, especially for syphilis. The figures below show STIs cases respectively from 2014-2020 and during 2019-2020 fiscal year.

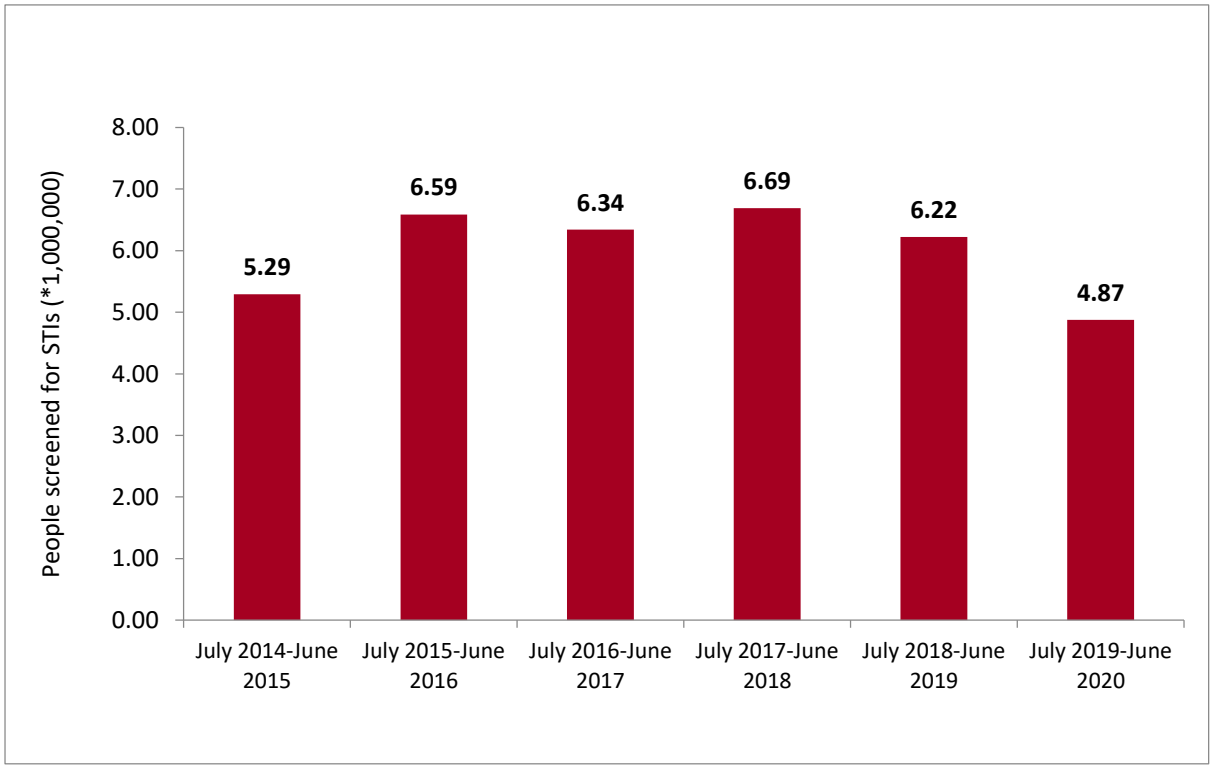


Figure 17: Clients who received counselling and screening for STIs (2014-2019)

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

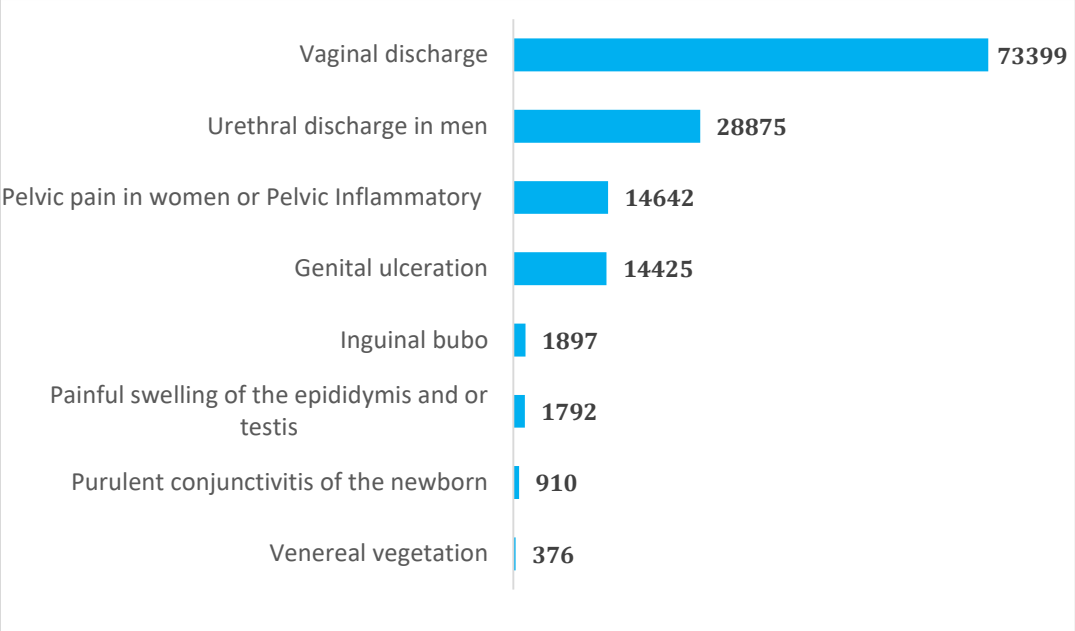


Figure 18: Sexually Transmitted Infections Cases: July 2019-June 2020

5.3. Prevention of Viral Hepatitis

5.3.1. Awareness and vaccination of HBV

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

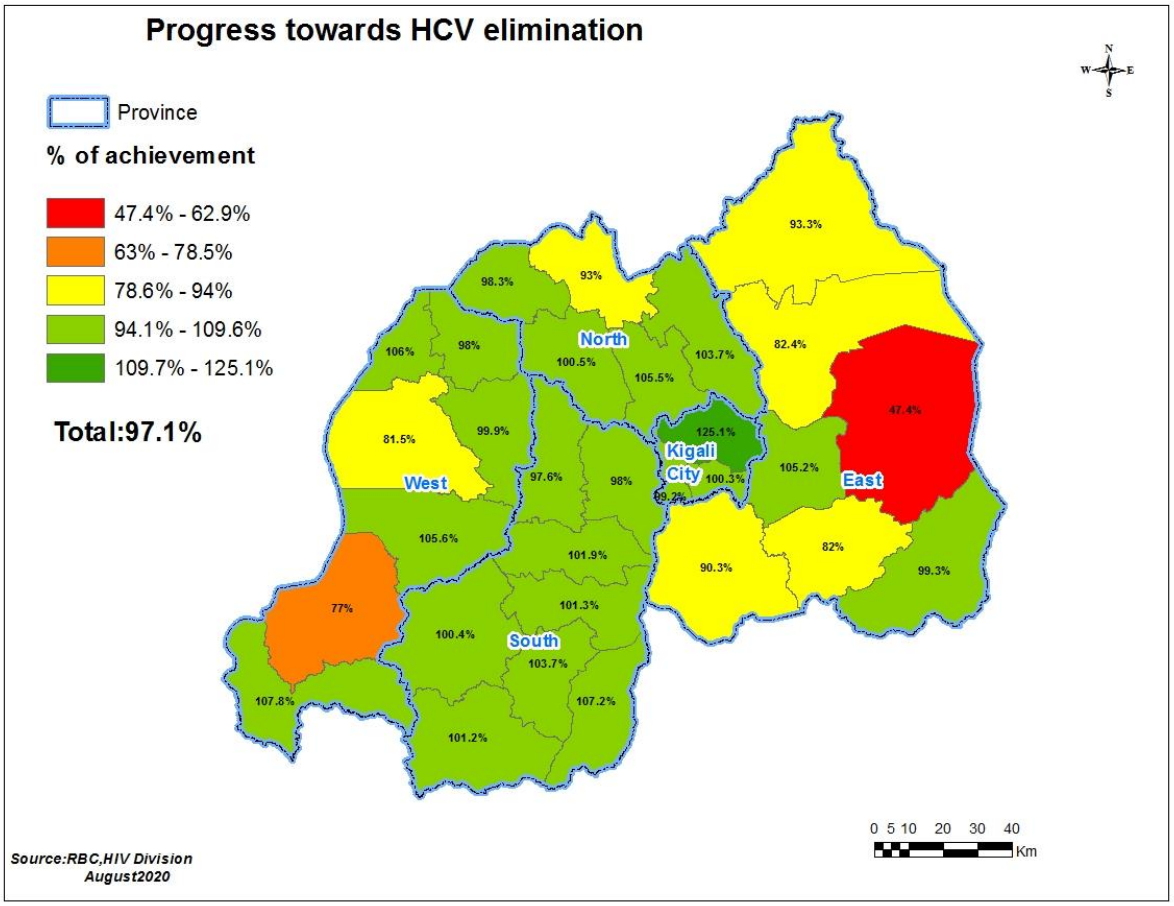
HBV vaccination has been done to over 6,000,000 people since 2002, including adults and children, meaning that all people aged 0 to 17 years old are vaccinated.

In 2019-2020 alone, over 50,000 adult people including genocide survivors, people with disabilities, blood donors, community health workers, staff from different institutions, prisoners as well as people from the general population were vaccinated against HBV. Once we include children that received a pentavalent vaccine, the total number of adults and children vaccinated in 2019-2020 financial year is more than 402, 750 people.

5.3.2. Screening of HBV and HCV

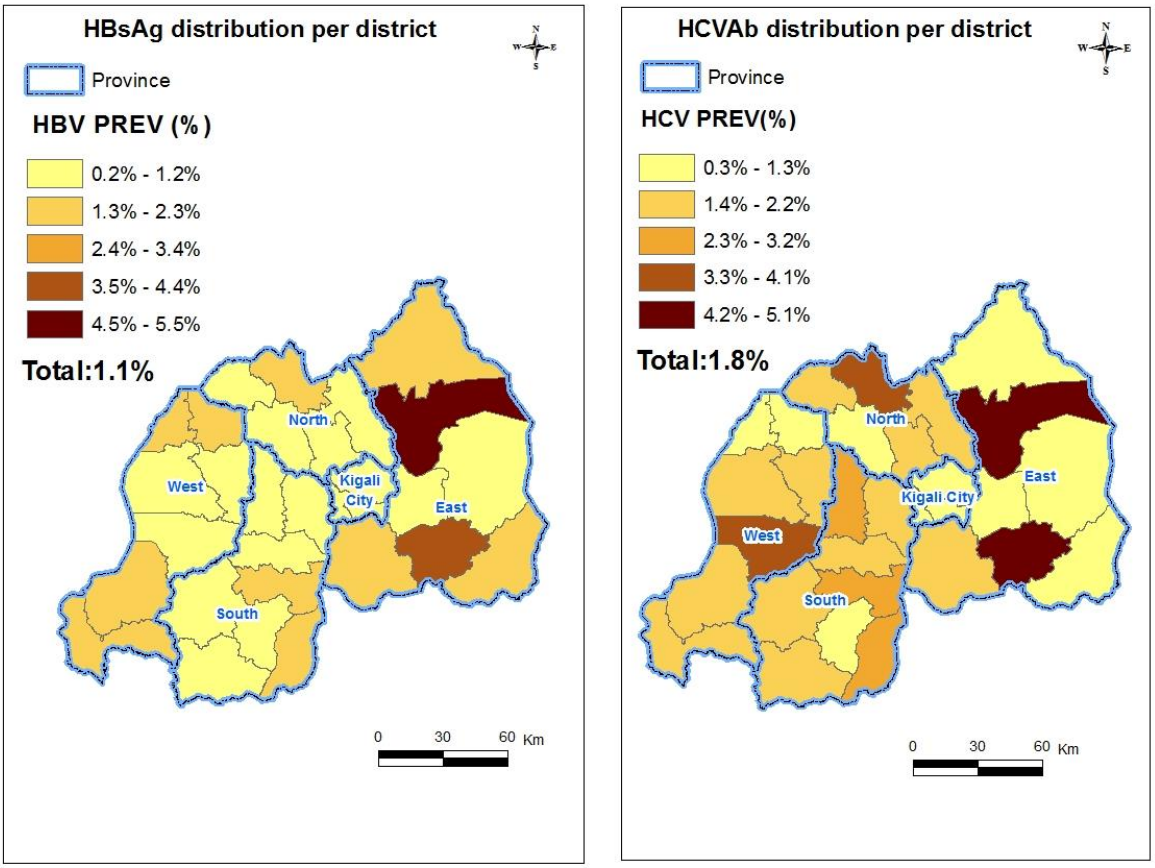
From July 2019, in line with the viral hepatitis elimination plan in Rwanda, RBC prepared and conducted awareness campaigns on viral hepatitis across the country. Different categories of the population were educated and screened for HBV & HCV. The joint Umuhigo for HCV elimination was implemented in all districts of Rwanda. Based on that Umuhigo, a total of 2,408,291 were screened for HBV and 2,756,762 people were screened for HCV from July 2019 till June 2020. For services continuum, people screened positive

were linked to confirmatory testing and treatment. At the first test, a total of 35,809 people screened positive for HBV and 66,310 people screened positive for HCV. Among them, 6,689 were confirmed viral load positive for HBV and 21,653 were confirmed viral load positive for HCV. The prevalence of HBSAg and HCVAb generally ranged respectively between 1.49% and 2.41% respectively for HBV and HCV. You will find below the distribution of viral hepatitis HBsAg and HCVAb per district.



Map 4 : Progress toward HCV elimination

Out of 2,358,898 and 2,775,126 people respectively screened for HBV and HCV, a total of 26,559 and 49,092 people were respectively screened positive for HBsAg and HCVAb and among them, 6,689 and 21653 were respectively confirmed viral load positive for HBV and HCV. The prevalence of HBSAg and HCVAb was respectively 1.1% and 1.8% for HBV and HCV. You will find below the distribution of viral hepatitis HBsAg and HCVAb per district.



Map 5: Prevalence of HBV and HCV

5.4. Care and Treatment of Viral Hepatitis

5.4.1. HBV and HCV care and treatment

During the 2019-2020 fiscal year, 2,611 mono-infected patients were initiated on HBV treatment while 16,891 patients were initiated on HCV treatment. Patients with chronic HBV were treated according to the national protocol with Tenofovir and Entecavir. Treatment of chronic HCV was done using generic pangenotypic drugs (Sofosbuvir and Daclatasvir).

5.4.2. STIs care and treatment

In Rwanda, apart from syphilis etiologically diagnosed in Ante-Natal Care (ANC), other STIs are diagnosed and treated using a syndromic approach. Although the syndromic approach has advantages like high sensitivity among symptomatic patients, taking account of multiple infections, and client satisfaction, its success requires regular monitoring, evaluation, supervision and training that are not regularly prioritized. Furthermore, the approach has some limitations including: over-diagnosis, over-treatment, and unnecessary side-effects. However, it has been shown to be the best strategy for STIs control in resource-limited settings as compared to the laboratory

approach, which requires a rapid increase in investment in the STI response by equipping laboratories and trained personnel.

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

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

STIs partner notification, care of asymptomatic cases as well as knowing the real course of the syndrome have to be continuously improved. The following figure shows STIs cases syndromically diagnosed and treated from July 2014 to June 2020.

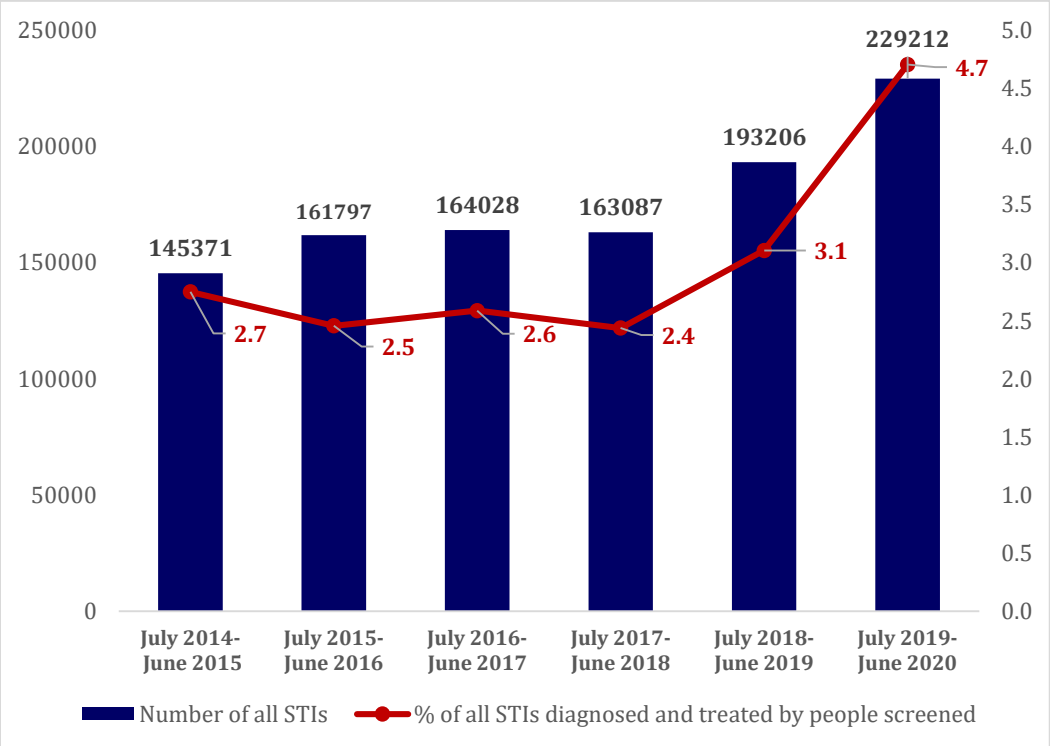


Figure 19 : STIs cases diagnosed and treated from 2014 to 2020

5.5. Quality Improvement and Next steps

5.5.1. Trainings on viral hepatitis and STIs

In order to ensure successful STIs and viral hepatitis program implementation, an expanded and trained workforce is required at all levels of the healthcare system. In this sense, the task shifting and decentralization of HBV and HCV management services is being done to accelerate HCV elimination.

As a priority, personnel require training including policy makers and program managers at central and decentralized levels, include medical doctors, nurses, laboratory technicians, nutritionists and pharmacists. For this, theory and practical training were conducted.

In total 574 health care workers were trained in two sessions, including 44 data managers and 530 nurses from health centers and some hospitals. This number is in addition to the existing 225 medical doctors prescribed for HBV and HCV. Hepatitis management services are being shifted to nurses to allow the decentralization to health centres.

5.5.2. Next year priorities

Much progress has been made but there is still a lot to do. Priorities for next year include:

- Continued implementation of HCV elimination plan (2nd phase) in districts to all people aged 15 years and above.
- Strengthen the existing task-shifting and decentralization of HBV and HCV management services in health centers as routine services
- Strengthen viral hepatitis M&E including the introduction of the DHIS2 system for data management as well as the improvement in reporting through HMIS.

6. HEALTH SYSTEM STRENGTHENING

6.1. Introduction

As part of health system strengthening mechanism, the Ministry of Health adopted several central and decentralized mechanisms including the Integrated Supportive Supervision & Data Quality Assessment (ISS/DQA), which aims to improve quality of data reported at national level as well as to improve quality of services in health facilities.

Health information systems, as an important tool for the delivery of quality services and improved data quality, have been prioritized.

6.2. Integrated Supportive Supervision and Data Quality Assessment

During the 2019-2020 fiscal year, Integrated Supportive Supervision & Data Quality Assessment (ISS/DQA) was conducted in all the 43 district hospitals (including Provincial Hospitals) and 42 selected health centers falling in each District Hospital's catchment area (except one District Hospital without a health center in its catchment area).

The findings from the exercise showed that all district hospitals are providing ART. Home visits for patients who missed HIV appointments as well as psychosocial support activities for HIV infected children were conducted in 93% of district hospitals.

Regarding the quality of data reported by health facilities in Rwanda Health Management Information System (RHMIS), comparison of the total number of clients currently on ART versus total number of patients on different ART regimens for the cumulative period of July to September 2019, the variance was only 0.1% (the acceptable threshold is a variance of less than 5%). For the total number of clients currently on ART, (HMIS vs Registers - end September 2019), the data quality assessment showed that all the district hospitals and health centers had a discrepancy below 5%.

Verification factor was also conducted for the indicator representing the total number of patients currently on ART. It verifies whether the information contained in source documents has been transmitted correctly to the next higher level of reporting, for each level of reporting, from health facility levels to the national level. This activity assists in the identification of systematic errors and the sources of reporting errors. As a result, during the period of assessment July-September 2019, the verification factor at national level between reported data and verified data for the above mentioned indicator was "1" which means that the indicator is of high quality or that source documents are matching with HMIS reports for the selected data elements.

Two key recommendations from the ISS DQA on HIV perspective were developed:

1. The first recommendation was to complete the registers with respect to the updated HIV guidelines as well as to conduct a check on completeness and accuracy of the registers at least every month
2. The second recommendation was to conduct a triangulation between drug consumption and patient's data, determine any variance, and identify the root causes and appropriate action to be taken.

6.3. Health information systems

To strengthen the health systems, the Rwanda Health Management Information system has been upgraded to reflect new HIV guidelines as well as refreshing end users on changes.

On Electronic Medical Records, ARV nurses and data managers were trained on the upgraded OpenMRS software which included new HIV guidelines and a new reporting framework.

In order to move towards an AIDS-free generation, data is needed to identify new HIV Patients, HIV Patients linked to treatment, and HIV Patients who have been virally suppressed. This can be achieved through Case Based Surveillance system (CBS) that includes two components;

- Active case finding (ACF) to detect new HIV patients
- Routine case-based surveillance (RCBS) to track HIV patient care journey;

In order to operationalize the above initiative, the Government of Rwanda initiated an integrated health information system that synchronizes data entry and reporting across various health databases to reduce transcription errors, eliminates data capture errors, and reduce the time spent in reporting. The first phase of the project has been successfully tested and piloted in 6 sites.

7. STRATEGIC INFORMATION FOR HIV

7.1. Introduction

The National HIV program implements strategic information-related interventions that guide health policy, planning, resource allocation, program management, service delivery, monitoring and evaluation, and surveys and surveillance. Being part of the response to the HIV epidemic, those interventions focus on generating reliable and timely strategic health information on which to base decisions at different levels of national HIV program. This section presents the achievements of RBC/HIV Division in terms of Epidemiology, research, survey and surveillance activities, data management and reporting, and routine monitoring of HIV epidemic during the Fiscal Year 2019-2020.

7.2. HIV Epidemiological Surveillance

During this reporting period, in order to inform and guide the national HIV program based on scientific evidence, the HIV Division developed and implemented research activities including HIV epidemiological surveys and surveillance.

7.2.1. HIV Epidemic surveillance through Active Case-Based Surveillance for HIV in Rwanda 2018-2020.

With an HIV prevalence of less than 5% over the past 15 years among the adult population, the national HIV program has been implementing various strategies to identify new HIV cases and to track the HIV continuum of care at an individual level. It is in that context that Active Case Based Surveillance (ACBS) for HIV has been implemented. This strategy allows HIV programs to use patient-level data to identify new cases as well as monitor the patient's course of HIV disease from diagnosis to entry into care, and to monitor the treatment and health status of the patient over time. In addition, in a bid to reach the newly infected HIV positive individuals who are the probable source of HIV transmission, the HIV Division has incorporated tracking of recent infection through recency testing in the ACBS. This initiative began with 23 health facilities located in Kigali City in October 2018 with the purpose of scaling up the program in other health facilities across the country. For the fiscal year 2019-2020, ACBS was scaled up in 165 facilities in addition to the initial 23 health facilities.

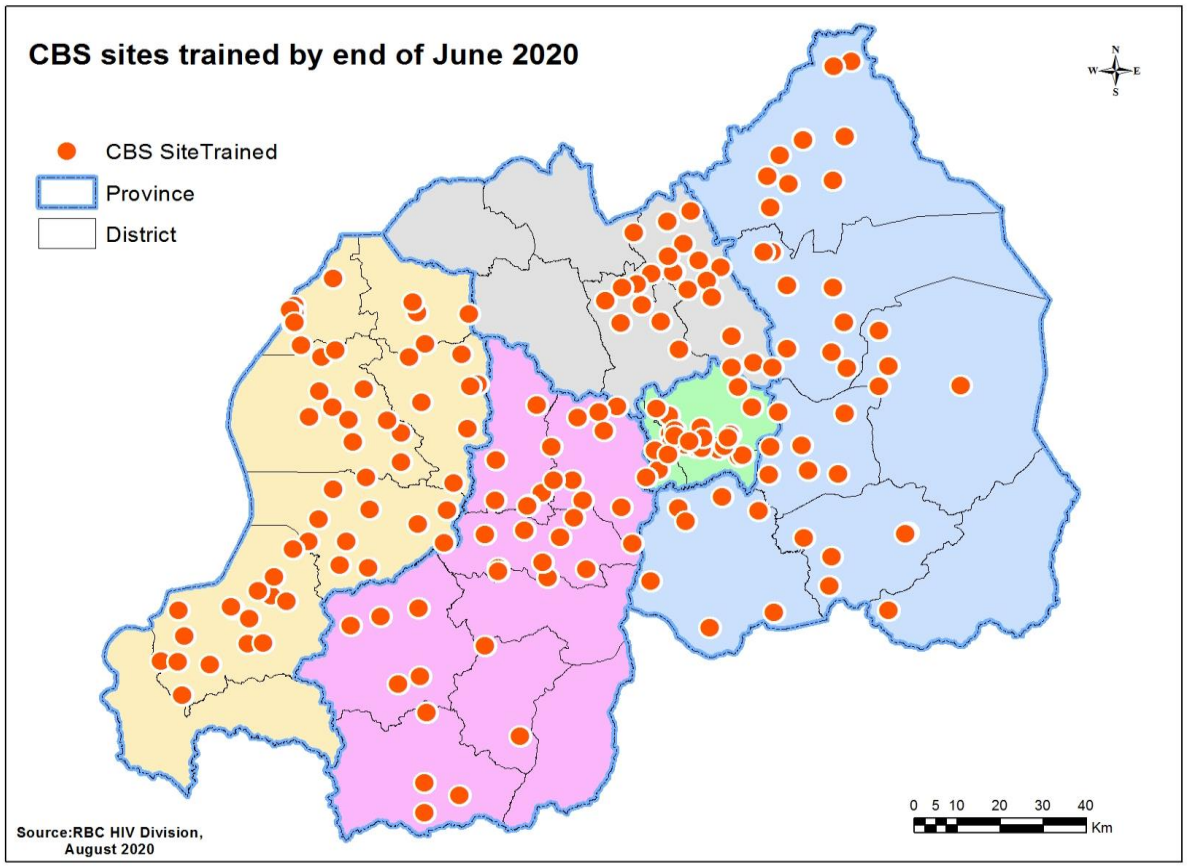


Figure 20: Trained CBS sites by end of June 2020

Three index testing strategies are used to actively find new cases of PLHIV, namely partner notification, family testing and social network testing. Partner notification is done by client referral, provider referral and contract referral. The cases identified through Active Case Finding (ACF) are linked to care and treatment services, and followed up longitudinally in the CBS program to document their HIV sentinel events in the routine HIV prevention and treatment program. Newly diagnosed HIV-positive cases receive a voluntary recency test to identify whether they were infected in the last 12 months for surveillance and epidemic control.

7.2.2. Monitoring of HIV Drug resistance among patients on first line ART and those initiating and/or re-initiating first line ART

Given the length of time the Rwanda HIV program has been established (since 2002) and the extent of ART coverage in Rwanda, there is a likelihood that HIV Drug Resistance (HIVDR) among PLHIV on 1st-line regimens was expected and worth investigating.

In Rwanda, HIVDR is only routinely monitored for patients on 2nd line regimens, who need a clinical decision to shift to 3rd line ART regimen. Patients failing first line ART are shifted based on Viral Load monitoring results. The magnitude of HIVDR in adult patients who were on 1st line ART regimen and those initiating or re-initiating ART needed to be monitored in order to inform policy makers and guideline change over time. Two surveys were conducted on HIVDR to inform HIV care and treatment services and

to prevent and deal with emerging HIVDR. The first survey targeted 66 randomly selected health facilities to assess the prevalence of acquired HIVDR (ADR) and the second targeted 150 health facilities to assess the prevalence of transmitted HIVDR (PDR).

The Acquired HIVDR survey enrolled 702 patients on first line ART regimen with the most recent VL result of >1000 copies/ml. After a second VL test, 414 (59.0%) still had VL >=1000 and therefore qualified for Genotyping. 378 samples (91.3%) were successfully genotyped. Among them, 355 (93.9%) of patients had any drug resistance mutation, 291 (82.0%) had NRTIs resistance mutations, 347 (97.7%) had NNRTIs resistance mutations, and 13 (3.7%) had PI accessory resistant mutations. The most common resistant mutations are M184V (40.8%), K103N (14.2%), L33F (41%) for NRTIs, NNRTIs and PIs drug class respectively.

For the PDR survey, 928 samples were collected among first line ART naive patients or those re-initiating ART who had stopped treatment for not more than 3 months. A second VL was done to evaluate samples eligible for HIVDR genotyping, 802 samples had a VL >=1000 copies/ml and therefore qualified for genotyping. The evaluation of PDR mutations among 802 samples with a VL >=1000 copies/ml are undergoing genotyping at the Rwanda National Reference Laboratory.

7.2.3. Integrated Behavioural and Biological Surveillance Survey among Female Sex Workers (IBBS among FSW)

Female Sex Workers (FSW) are considered as key population given the higher risk of HIV acquisition. Without updated data on FSW in Rwanda, it will be hard in the future to evaluate the impact of sex work on national HIV prevalence or the necessary scope of programs designed to meet the needs of sex workers. Updating data on BSS in FSWs will aid in further understanding the magnitude and dynamics of HIV in this population and enable evaluation of targeted programs for this population. To respond to this gap, during the Fiscal Year 2018-2019, RBC/HIV Division conducted Combined Biological and Behavioural Surveillance Survey among a representative group of Female Sex Workers considered as people at high risk of HIV infection in Rwanda. The survey was conducted in 115 sampled FSWs hotspots located in 25 districts across the country. This was a cross-sectional national representative survey, which included self-reported FSWs, aged 15 years and above involved in transactional sex work in the 12 months prior to the survey. According to the findings, the HIV prevalence has decreased from 45.8% in 2015 to 35.5%. Also, 82% of Female sex workers responded as having used condoms during the last sexual intercourse. However, only 55% self-reported consistently using condoms.

7.2.4. Integrated Bahavioural and Biological Surveillance survey among Men who have Sex with Men (IBBS among MSM), 2020.

Although men who have sex with men (MSM) are not very prevalent in Rwanda compared to other countries, they are characterised with risk behaviours that might contribute to increased HIV prevalence and incidence. An effective response to HIV/AIDs requires improved strategic information of risk groups including MSM.

In addition to the IBBSS among FSWs, during the fiscal year 2019-2020, the National HIV Program implemented the IBBSS among MSM. The 2020 MSM survey was a nationally representative survey targeting all MSM enrolled in eight study sites across the country. This was a cross-sectional anonymous IBBSS for MSM using Respondent Driven Sampling (RDS). It consisted of a quantitative survey that was carried out using an interview with a standardized structured questionnaire and blood sample collection for HIV testing. In total, 1,426 MSM aged 18 years and above were enrolled in the survey country-wide and 1,317 provided blood samples for HIV and syphilis testing. The findings from that survey showed that HIV prevalence in MSM population is 7.0%, while 54% and self-reported having used a condom during the last instance of anal sex and 78% self-reported having used lubricants during the last instance of anal sex.

7.2.5. People living with HIV stigma index survey, 2020

HIV-related stigma and discrimination is one of the barriers to HIV prevention and management. Stigma and discrimination limit access to existing and available HIV prevention, care and support services. The most recent evidence related to stigma and discrimination in Rwanda was previously from 2009; updated data were needed to guide intervention and support advocacy efforts. The Stigma Index survey was intended to determine the level of stigma and document various experiences of PLHIV of HIV -related stigma and discrimination.

This was a cross sectional mixed-method design conducted by RRP+ in collaboration with RBC. The survey targeted PLHIV enrolled in care, aged 18 years and above and who were willing to provide voluntary informed consent. The qualitative component of the study included PLHIV from the general population, MSM, FSWs and adolescents enrolled into HIV care. In addition, interviews were conducted with PLHIV who were not enrolled in HIV care at any health facility.

The overall HIV stigma index in Rwanda was very low (Index 15). The comparison of Stigma and Discrimination Index (SDI) results in 2009 and 2020, revealed 80% decrease of the experience of stigma and discrimination in the last 12 months (specifically on exclusion from religion activities, social gatherings, family activities, physical harassment or discriminatory gossip). This shows an impressive progress regarding HIV-related stigma. The findings of this survey showed a decrease of more than 50% regarding PLHIV rights abuse, forcing PLHIV to be tested either for insurance, health care, and visa.

7.2.6. Behaviour survey among people who inject drugs in the city of Kigali 2020.

The Rwanda NGOs Forum on HIV/AIDS and Health Promotion (RNGOF on HIV/AIDS & HP) with the support of OSIEA and in partnership with RBC conducted a baseline study to assess the practices of the substance use and its association to HIV infections among People Who Use or Inject Drugs (PWUD/PWID) in selected hotpots in the City of Kigali:

- Study participants were 529 which exceeded the original target of 440 participants indicated in the study protocol
- PWID were identified, tested for HIV and profiled for socio- demographic characteristics. Of the PWID surveyed, 12.8% self-reported as HIV-positive, which is far above the HIV prevalence in the general population in Rwanda.
- Respondents who self-reported injecting drugs were 27.9%. Of them 47% shared syringes/needles.
- The highest number of respondents reported using Cannabis or marijuana (87.6%), heroin (45.3%), and Opium (35.9%)
- 56.9% reported having had no access to health services including HIV testing and counselling, Care and Treatment, family planning services, or condoms
- The PWID surveyed expressed fear of being arrested by the police since drug use is illegal in Rwanda. It was found out that most PWUD were between 18-35 years of age. Many of the respondents reported having received primary and lower secondary education and have unstable jobs.

7.3. Research Dissemination

The International Conference on AIDS and Sexually Transmitted Infection in Africa (ICASA), which is the biggest AIDS conference in Africa was hosted in Rwanda in December 2019 at Kigali Convention Center. The conference theme was “AIDS FREE AFRICA- Innovation, Community, and Political Leadership” and it engaged the whole continent and stakeholders in the post SDG framework.

Among key discussions were the fact that sustainability of the response in reaching 90, 90, 90 targets of UNAIDS will not be possible if human rights are not key priority for leadership in the context of strengthening the application of evidence-based science.

ICASA 2019 was an opportunity for the international community, and all Africans, to join efforts in committing to achieving an AIDS-free Africa. Between 7,000 and 10,000 of the world’s leading scientists, policymakers, activists, people living with HIV (PLHIV), government leaders – as well as a number of heads of state and civil society representatives were in attendance. Below are some key events captured during ICASA.

WORLD AIDS DAY Celebration on 1st December 2019

World AIDS Day was combined with "Kigali Car Free Day" where several Kigali citizens convened together with different high authorities including the First lady, the Director of WHO, UNAIDS Deputy Executive Director, and the Minister of Health for sport activities. Key messages for World AIDS Day were delivered by different dignitaries including the Mayor of the City of Kigali, the Minister of Health, the UNAIDS Deputy Executive Director and the WHO Director, Dr. Tedros Adhanom.

OPENING CEREMONY

The opening ceremony was officialised by high authorities including H.E. President Filipe Nyusi of Mozambique and H.E. Paul Kagame, the President of the Republic of Rwanda.

8. STRATEGIC PLANNING

The HIV National Strategic Plan 2018-2024 is being implemented as planned since officially launched on 30 November 2018. Though some implementation adjustments due to COVID-19 were made to minimize any risk of loss of effort gained in the last decades in Rwanda in the HIV response. The HIV program infrastructure, such as laboratory and human resources that Rwanda built in the past contributed to the COVID-19 response, by using HIV machines and their staff experience on HIV testing.

The HIV Operational Plan (OP) 2021 to 2024 was elaborated in line with HIV NSP components. The HIV OP narrows down all activities and their cost for the period 2021 to 2024. The elaboration was done using participatory approaches that involved all partners, civil society organizations and government institutions contributing to HIV programs. The consultation was done through workshops and virtual meetings during COVID-19 period. The operational plan was approved and used for fund mobilization activities such as the Global Fund grant application.

The HIV Operational plan 2022-2024 provides details on the NSP strategies used to tackle the scourge of HIV/AIDS. The main goals are to reduce new infections, halve the number of HIV-related deaths, and ensure equal opportunities for PLHIV.

9. FINANCING OF HIV NATIONAL RESPONSE

9.1. Introduction

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

- Government resources, including revenue generated from taxed and non-taxed loans, grants, and donations – reported as Government contribution/budget allocation and part is allocated as earmarked transfers
- Development partner contributions through sector budget support and project support. Donor funds, on the budget is indicated in the development budget. These include the Global Fund for HIV & AIDS, TB and Malaria, PEPFAR and contribution from One UN.
- Health insurance pooled funds (Mutuelle de Santé or Community based health insurance) from household expenditures. This is not captured in this report.
- Health related household expenditures are not yet captured in this report
- Private funds are also not captured in this report.
- Income generated from health facilities services are not captured in this report. The related expenditures will be reported next financial year as their utilization will be captured and reported in IFMIS

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

9.2. Public and external sources of funds for HIV NSP

The Ministry of Health and the Rwanda Bio-medical Centre in collaboration with its partners worked on the financial data reported in HIV/AIDS annual report 2019-2020. To facilitate the collection of financial information for this year's report, a separate data collection process was adopted using SMART FMIS (Integrated Financial Management Information System) for Global Fund grant and Government contribution; and directly from the in-country office for PEPFAR and UN agencies (One UN) contribution.

9.3. Sources of Financing for HIV Expenditures in Rwanda FY 2019/20

The Global Fund for AIDS, TB and Malaria (GFATM) contributed the budget of $64,737,250 for FY 2019/2020; whereas the United States Government (USG) contribution for the FY 2019/2020, is $74,909,306. The Government of Rwanda contributed the budget of $22,022,290 and lastly the UN contributed $1,256,468. Hence, the total budget for the FY2019/2020 was $162,925,314.

HIV NSP GF Grant Budget Agencies	Revised Budget July 2019-June 2020*	Expenditures July 2019-June 2020	Variance	Budget Execution rate
Global Fund for AIDS, TB and Malaria	64,737,250	49,844,534	14,892,716	**77%**
PEPFAR	74,909,306	74,909,306	0	**100%**
One UN	1,256,468	1,256,468	0	**100%**
GoR	22,022,290	21,375,771	646,519	**97%**
Grand Total	**162,925,314**	**147,386,078**	**15,539,235**	**90%**

Table 1: Sources of financing for HIV NSP Grant FY 2019/2020

Revised budget comprises of in county cash balance as of 1st July 2019 of $ 16,145,160 and approved initial budget FY 2019-2020 equivalent to $ 48,592,090.

Regarding expenditures, The United States Government spent $ 74,909,306; The Global Fund for AIDS, TB and Malaria (GFATM) spent $49,844,534, and the GoR spent $21,375,771. Lastly, the UN spent $1,256,468.

For the FY 2019/20, the overall total expenditure for HIV NSP was $147,386,078, which represents 90% of the revised budget.

9.4. Government contribution to HIV NSP

GoR funds are allocated to different health programs during the annual planning and budgeting process, which entails sectoral consultations to discuss prioritization and budget allocation between the Ministry/RBC and decentralized levels based on Health Sector Strategic Plan (HSSP-III) implementation and different disease program strategic plans serve as guiding documents. The planning phase also uses the disease burden and services utilization data from HMIS to inform an effective resource allocation. The expenditure was then extracted and analyzed based on the disease burden.

MTEF Chapter	Initial budget July 2019-June 2020	Revised budget July 2019-June 2020	Expenditures July 2019-June 2020	Variance	Budget execution rate
Compensation of Employees	7,466,486	9,723,626	9,378,221	345,405	**96%**
Use of Goods and Services	171,961	1,978,283	1,762,135	216,148	**89%**
Acquisition of fixed assets	0	3,244,760	2,754,087	490,674	**85%**
Subsidies	0	127,550	185,102	-57,552	**145%**
Grants	9,908,671	1,397,368	1,499,836	-102,468	**107%**
Social Benefits	2,525,985	2,335,236	2,325,303	9,934	**100%**
Other Expenditures	18,974	3,215,466	3,471,087	-255,621	**108%**
Grand Total	**20,092,078**	**22,022,290**	**21,375,771**	**646,519**	**97%**

Table 2: GoR contribution to HIV NSP per MTEF Chapter FY 2019/2020

From the above table, the initial budget as per operational plan is $20,092,078 which was revised and to $22,022,290. Out of the approved budget of $22.0 Million, a total of US$21.3 Million was effectively spent by different budget entities with a 97% budget execution rate.

The Medium Term Evaluation Framework (MTEF) chapter with the highest budget execution rate is Subsidies with 145%, followed by Oher Expenditures with 108%, then Grants with 107% followed by Social benefits with 100%. The compensation of employees is with 96%, followed by Use of Goods and Services with 89%. The last MTEF chapter with the lowest budget execution rate is Acquisition of Fixed Assets with 85%.

Type of Budget agency	Revised budget July 2019-June 2020	Expenditures July 2019-June 2020	Variance	Budget execution rate
RHs	2,935,091	2,927,898	7,193	**100%**
Earmarked Transfers to Districts	7,739,058	7,451,237	287,821	**96%**
Other Public Institutions	263,762	215,455	48,307	**82%**
MOH	5,201,580	5,115,503	86,076	**98%**
RBC	5,882,799	5,665,677	217,122	**96%**
Grand Total	**22,022,290**	**21,375,771**	**646,519**	**97%**

Table 3: GoR contribution to HIV NSP per type of budget agency FY 2019/2020

As reflected in the table below, the revised budget is $22.0 Million whereas the expenditure is $21.3 Million. The type of budget agencies with the highest budget execution rate is referral hospitals with 100%, followed by Ministry of Health with 98%, then RBC and Earmarked transfers to districts with 96%, which is lastly followed by Other Public Institutions with 82%.

9.5. The Global Fund contribution

For the Global Fund contribution, the total approved initial budget of $48,592,090 was increased with in county cash balance of $16,145,160 to totalize the revised budget of $64,737,250 for the financial year 2019-2020. During this financial year; the expenditure was $49,844,534. Hence, the total budget execution rate for the FY 2019/2020 was 77%. The variance is therefore 23% and most of this variance will be used to pay the end June 2020 commitments related health products, reagents and health commodities.

Grouped Budget Entities	Revised Budget July 2019-June 2020	Expenditures July 2019-June 2020	Variance	Budget Execution rate
Referral Hospital	352,433	356,608	-4,175	**101%**
Ministry of Health	6,178,864	4,814,168	1,364,696	**78%**
Other Public Institutions	1,003,403	636,794	366,609	**63%**
RBC	57,202,549	44,036,963	13,165,586	**77%**
GRAND TOTAL IN USD	**64,737,250**	**49,844,534**	**14,892,716**	**77%**

Table 4: HIV NSP GF budget and expenditure as per type of budget entity FY 2019/2020

From the above table, out of the approved budget of $64.7 Million, a total of US$49.8 has been effectively spent by different budget entities and this represents 77% of budget execution rate.

The type of budget entity with the highest budget execution rate is Referral Hospital with 101%. This 1% is due to foreign currency exchange rate fluctuation. Ministry of Health with 78% of budget execution followed by RBC with 77%. Lastly Other Public Institutions with 63% of budget execution. The variance is for the commitments that will be paid after end June 2020.

NSP Cost category	Revised Budget July 2019-June 2020	Expenditures July 2019-June 2020	Variance	Budget Execution rate
Human Resources (HR)	14,068,710	12,336,161	1,732,549	88%
Travel related costs (TRC)	3,125,235	3,126,439	-1,204	100%
Health Products - Pharmaceutical Products (HPPP)	14,629,964	9,083,500	5,546,464	62%
Health Products - Non-Pharmaceuticals (HPNP)	19,344,216	15,590,526	3,753,690	81%
Health Products - Equipment (HPE)	2,288,660	1,143,327	1,145,333	50%
Procurement and Supply-Chain Management costs (PSM)	2,469,975	2,292,874	177,101	93%

Infrastructure (INF)	82,301	26,421	55,880	32%
Non-health equipment (NHP)	43,499	43,392	107	100%
Communication Material and Publications (CMP)	549,792	491,614	58,178	89%
Programme Administration costs (PA)	4,050,984	3,775,535	275,449	93%
Living support to client/ target population (LSCTP)	4,083,913	1,934,743	2,149,170	47%
Grand Total	**64,737,250**	**49,844,534**	**14,892,716**	**77%**

Table 5: HIV NSP GF Grant expenditure per NSP cost category FY 2019/2020

The table above shows the HIV NSP budget execution per cost category for the period of July 2019 to June 2020. It is obvious that the expenditures incurred during this financial year reached 77% of the revised annual budget. The variance of 23% stands for end June commitments to be cleared beginning the financial year 2020/2021.

As it is reflected in the table above, the cost category with the highest budget execution rate are Non-health equipment (NHP) and Travel related costs (TRC) with 100%. The second are Procurement and Supply-Chain Management costs (PSM) and Programme Administration costs (PA) with 93%; which are also followed by Communication Material and Publications with 89%. The third is Human Resources with 88%, then Health Products - Non-Pharmaceuticals (HPNP) with 81%, Health Products - Pharmaceutical Products (HPPP) with 62% and then Health Products - Equipment (HPE) with 50%. The last two cost categories are Living support to client/ target population (LSCTP) with 47% whereby the variance will be used to clear the related end June 2020 commitments and finally Infrastructure (INF) with 32%. The variance stands for end June 2020 commitments.

9.6. The USG/PEPFAR contribution

From July 1, 2019 to June 30, 2020, the US Government invested approximately $74,909,306 to the national HIV response in Rwanda. Because the US Government plans its budgeting periods using fiscal years in its PEPFAR Country Operational Plan (COP) that do not align with the Government of Rwanda budgeting period (i.e., the PEPFAR COP year begins on October 1 and ends on September 30 of the following year), this figure is an estimate based upon portions of two COP years - one quarter of July to September 2019 FY 2019, from the financial year starting from October 1, 2018 to September 30, 2019) and three remaining quarters of FY 2019/2020 starting from October 1, 2019 to June 30, 2020. Expenditure analysis will be conducted after the fiscal year ends September 30, 2020. The expectation is that 100% of the budget will be spent but at the time of this report the amount spent is an estimation based on the budget.

9.7. ONE UN Contribution

The One UN developed several flagship programs to fund HIV activities implemented from July 2019 to June 2020. The total budget for the flagships is US $1,256,468. This was used as a planned funding level for ONE UN.

10. GOVERNANCE MECHANISMS

10.1. Introduction

The RBC Institute of HIV Disease Prevention and Control (IHDPC) coordinates HIV interventions in Rwanda and ensures its harmonization. The development, implementation and monitoring of NSP is under RBC responsibilities. All partners involved in HIV and AIDS response are accountable to report directly to RBC. Annual plans and annual reports are developed by all districts, economic sectors, and umbrella organizations and are consolidated into a national HIV annual plan and report.

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

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

10.2. Decentralized/district level leadership and coordination

The local government at district level is responsible for the management of all public services. The District Health Unit is responsible for coordinating HIV response at the district level. For efficiency and effective intervention, the districts ensure equity and quality interventions of HIV stakeholders in their respective district. The District Health Unit, which oversees planning and monitoring all health interventions in the district work directly with stakeholders.

10.3. National Strategy for transformation (NST)

A seven-year Government plan (NST 1) addressed HIV as a crosscutting issue and priority activities identified in the Social Transformation pillar of NST1. Ministries and public institutions, all private and community organizations are involved in HIV response and control in Rwanda. HIV and AIDS activities implemented by each sector, at the district level HIV activities are integrated into the five-year District Development Plans (DDP) and district annual work plans.

Ministries and public institutions, all private and community organizations address prevention strategies in their strategic plan, as well as an annual work plan. HIV activities are integrated in Rwanda. Each sector has put in place an HIV focal point that has the responsibility to coordinate the implementation of its HIV priority activities at central and decentralized levels. At village level, the community health workers, youth clubs and other community-based organization frameworks contribute to HIV prevention activities such awareness.

10.4. Civil Society Organizations

Rwanda NGOs Forum on HIV/AIDS and Health Promotion conducted advocacy activities, calling on the Ministry of Local Government to Include Vulnerable Women involved in sex work in the ongoing National Relief Support to mitigate the impact of COVID-19 and HIV.

The call was to make sure sex workers are also considered in the general emergency food relief for vulnerable populations in the community. Considering sex workers would help maintain those on ART to be able to continue taking ARVs and avoid the drop out on ARVs which at the end would cause the increase of opportunistic infections among PLHIV especially in Female Sex Workers.

Rwanda NGOs Forum on HIV/AIDS and Health Promotion conducted a National TV and Radio Talk show on several topics including, mitigating the impact of COVID-19 and HIV. Participants were WHO, UNAIDS, RBC and CSOs and topics discussed included measures that can be taken to fight COVID-19 and other epidemics like HIV, Tuberculosis, and Malaria and other widespread issues such as Gender Based Violence.

CSOs mobilized resources equivalent to 163,461,746 FRW to support vulnerable populations with emergency food support and hygiene kits to sex workers, MSM, young mothers and vulnerable families with children under 5 years.

Rwanda NGOs Forum to work closely with the City of Kigali and designed strategies and a plan on how hotels and lodges can be mobilized to meaningfully support the reduction of new HIV infections through availing and accessing condoms to clients in hotels and lodges.

Through the representation of Rwanda NGOs Forum District Coordinators at the District Level, Rwanda NGOs Forum has coordinated and supervised member's interventions at the District Level to discuss and share the project implementation progress, issues around female sex workers and calling for actions and collaboration mechanisms towards reducing new HIV infections among key populations (FSWs and MSM). Thirty participants per District were invited to participate in a meeting. These include District Local Authorities, staff from health centers and representatives of female sex workers.

Through received resources for supportive supervision, Rwanda NGOs Forum on HIV/AIDS and Health Promotion conducted supportive supervision to monitor the interventions done by various implementing partners across the country. During the reporting period, the implementing partners working in HIV field managed to distribute a total of 6,391,200 Condoms and 42,480 lubricants in City of Kigali, Southern, Eastern and Western Province. During the same period, more than 1400 peer educators were trained and 17,276 Female sex Workers were identified and offered prevention services, including HIV self-testing kits and condoms. A total of 2,930 Sex Workers were encouraged to be enrolled in ART Program.

10.5. Private sector

Private Sector Federation, HIV unit coordinates HIV response in private and para-public sector enterprises, advocated for availing condoms in hotels and public business venues as well as sensitive people to test for HIV in order to know their status. The unit monitored the routine activities undertaken by HIV committees established in private enterprises and business development committees at the district level. The private sector of Rwanda mobilized internal fund to support government plan to eliminate Hepatitis in Rwanda

10.6. HIV Fast Track City

The authorities of City of Kigali have long demonstrated their commitment to addressing the challenges of the HIV epidemic and they reaffirmed this commitment in 2015 by endorsing the Paris Declaration. Kigali has made good progress in this regard and is one of the first African cities to approach global treatment targets.

IAPAC (International Association of Providers of AIDS Care) and UNAIDS in collaboration with City of Kigali, RBC/HIV, RRP+ and Civil Society Organization are supporting the City of Kigali to implement the six objectives of Fast Track cities.

The **Objective 1** (Support City of Kigali to strengthen HIV service delivery and implementation by working with key partners) and **Objective 2** (Utilize data to inform action for Fast-Tracking the HIV response in Kigali) are supported by UNAIDS. Under objectives 1 and 2, the following activities were accomplished:

- *Roll out of the Weltel mobile service to improve retention in care in two additional city clinics. Over 1000 patients were reached to date in the first clinic, and it is expected that an additional 4,600 patients will be reached through the additional clinic.*
- *Community mobilization and advocacy activities to address Fast-Track HIV-TB coinfection and to reach the global targets for 2020.*
- *Conducted in-depth analysis of data on HIV and ageing and the report was disseminated. The analysis showed that the proportion of people living with HIV older than 59 years almost doubled in the last 9 years, from 13% in 2010 to 25% in 2019.*
- *Dissemination of new HIV treatment guidelines to promote the transition to Dolutegravir to improve treatment and retention in care outcomes.*

Under **Objective 3**, online platforms (Big Marker, GotoWebinar, Zoom) for data-for-care, capacity-building, and stigma trainings were identified to address contingencies in place due to the COVID-19 pandemic. The Dashboard utilization checklist was filled in across multiple stakeholder groups including the health department, communities, and clinicians. Stakeholders reported that they are effectively leveraging the dashboard across the following domains: visualize key data; track progress against 90-90-90 targets; map HIV services; highlight community advocacy through key leadership messages; strengthen policy and decision making; enhance political leadership and advocacy. The dashboard that report updated 90-90-90, HIV care continuum, and other relevant data for Kigali was availed and accessible (http://www.fast-trackcities.org/cities/kigali).

Under **Objective 4,** the following activities were achieved:

- *Online capacity-building modules were accessed by above 200 clinicians from 23 health facilities in Kigali.*
- *Individual tablet-enabled training took place in one health facility with 30 trainees.*
- *Based on consultation with local stakeholders, training modalities for the capacity-building training have been amended from exclusively online and individual tablet-enabled training to also include group training.*
- *Group capacity-building training took place in eight health facilities with above 150 trainees.*
- *Health facilities are being approached to approve webinar-based group training.*

For **Objective 5,** online stigma modules were accessed by 300 clinicians and individual tablet-enabled stigma training took place in one health facility with 13 trainees. Based on consultation with local stakeholders, training modalities for the stigma training have been amended from exclusively online and individual tablet-enabled training to also include group training.

For **Objective 6** related to the quality of care study, data collection was completed, a total sample size of 415 participants were surveyed.

Both IAPAC and UNAIDS contributed in developing a funding request to the Global Fund. Gaps in the HIV response in the City of Kigali are included in the funding request. Implementing partners in the City of Kigali and the City of Kigali are key contributors to the Global Fund request.

Table 6: Key HIV Performance Indicators, 2019-2020

Indicator	Data Source	Results
		July 2019 - June 2020
% Of infants born to HIV+ mothers, who are not infected by 24 months (MTCT)*	Cohort Data (health facility registers)	**98.35%**
Number of medical male circumcisions performed according to national standards	HMIS, July 2019- June 2020	**401,987**
HIV Sero-positivity (New HIV cases identified in routine HIV testing services)	HMIS, July 2019 - June 2020	**0.46%**
Prevalence of Male circumcision (number of male circumcised on the total male population)	RPHIA, 2018-19	**39.9%**
Percent of HIV infected Pregnant women in PMTCT	HMIS, July 2019 - June 2020	**2.26%**
Pregnant women who received ART to reduce Mother to Child Transmission	HMIS, June 2019	**97.50%**
% Of adults and children with HIV known to be on treatment 12 months after initiation of ARVs (retention on ART)*	Cohort Data (health facility registers)	**93.70%**
% Of eligible adults & children currently receiving ARVs (ART Coverage)*	HMIS, June 2019 And EPP Spectrum, 2020	**201,629 (87%)**
% Of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml)	Facility Registries review, Apr-June 2019	**94.40%**
# of new Patients initiating ART	HMIS, July 2019 - June 2020	**11,311**

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