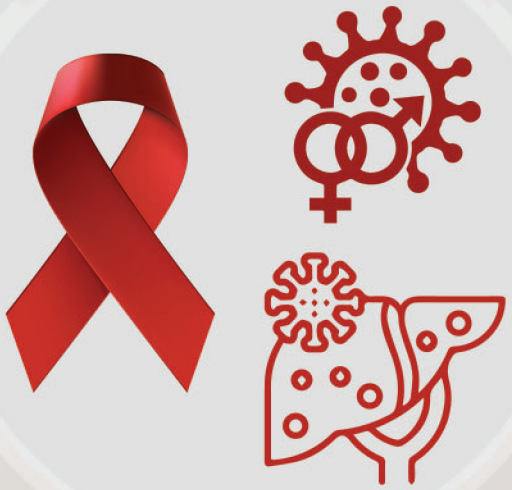
Republic of Rwanda
Ministry of Health

Rwanda Biomedical Centre
Healthy People, Wealthy Nation

HIV, STIs and Viral Hepatitis

ANNUAL Report 2024-2025



2024/25

Foreword

The Government of Rwanda remains firmly committed to ending AIDS by 2030. Over the past decade, the country has built a resilient HIV response rooted in strong leadership, collaboration, and community engagement. Achieving the UNAIDS 95-95-95 targets by 2024 is a remarkable milestone that positions Rwanda as a global model.

This Annual Report, covering the period from July 2024 to June 2025, presents a comprehensive overview of Rwanda's HIV response. It highlights the remarkable progress achieved in prevention, care, and treatment while acknowledging the persistent challenges that require continued effort.

Around 1,987,601 HIV tests were conducted during this reporting year, treatment coverage was sustained at 96.9 %, and viral suppression remained consistently above 97%. Rwanda also expanded its prevention efforts through voluntary medical male circumcision, the piloting of long-acting injectable PrEP, and increased access to HIV self-testing. Community engagement remained central to the response, with civil society organizations and peer networks reaching key and priority populations across the country.

While progress has been remarkable, the report also acknowledges persistent challenges. New HIV infections among key populations remain a concern, gaps in human resources continue to delay equitable service delivery, and funding constraints underscore the importance of sustainable financing. In addition, strengthening the health workforce is essential to maintain the quality and continuity of services.

The Ministry of Health extends heartfelt appreciation to all partners, communities, and stakeholders for their contributions. Rwanda's success reflects shared vision and commitment, and as we move forward, it is vital to sustain momentum, strengthen interventions, and ensure future generations live free from HIV and AIDS.

Dr. Sabin NSANZIMANA
Minister of Health

Executive Summary

This report highlights Rwanda's key achievements in the HIV, STIs, and Viral Hepatitis response between July 2024 and June 2025. It outlines progress across core areas of intervention, namely prevention, care and treatment, social impact mitigation, health system strengthening, sustainable financing, and the application of strategic information.

HIV prevalence in the general population remains stable at around 2.7% but continues to be significantly higher among key populations. Female sex workers recorded a prevalence of 35.2% in 2023, a major decline from 51% in 2010, while prevalence among men who have sex with men is 5.8% in 2024. Rwanda is now estimated to have 236,538 (UNAIDs 2024) people living with HIV, with prevalence highest in Kigali City at 5% and lowest in Northern province at 2%. Rwanda also surpassed the UNAIDS 95-95-95 targets in 2024, achieving 96% of PLHIV diagnosed, 98% of those diagnosed are on treatment, and 98% of those on treatment are virally suppressed.

HIV prevention efforts combined biomedical, behavioral, and structural approaches. Around 1,987,601 HIV tests were conducted during the year, with a positivity rate of 0.62%. Index testing yielded the highest results, with 3.9% positivity and 97% linkage to treatment. Recency testing and case-based surveillance continued to inform programming with timely data. The PMTCT program sustained a mother-to-child transmission rate below 2%, supported by universal ART coverage among HIV-positive pregnant women. The Triple Elimination Initiative for HIV, syphilis, and hepatitis B also advanced significantly through universal antenatal screening.

Biomedical prevention expanded with 332,804 circumcisions performed, covering 88.7% of annual targets, strong distribution of condoms with over 24 million units provided nationwide, and continued scale-up of PrEP, which enrolled 13,572 key population by June 2025. Rwanda also introduced long-acting injectable PrEP (cabotegravir) in December 2024. Adolescents and young women remained a central focus of the prevention program, with more than 209,000 reached with comprehensive services despite financial constraints.

Care, treatment, and support remained robust, with ART coverage of 96.9%. Differentiated service delivery models were strengthened, with 65% of clients on six-month refills. Viral load testing coverage was 88%, with suppression rate consistently at 97.6% (VLS <1000 copies/mL). HIV services were further integrated with TB, non-communicable disease, and mental health services to ensure holistic care. Retention was reinforced through psychosocial and nutritional support. Peer educators supported over 166,000 recipients of care through home visits, referrals, and adherence support, while youth ambassadors expanded outreach, reaching more than 39,000 young people directly and over 41,000 through digital platforms.

Civil society organizations played a critical role in bridging service gaps, working in different districts to reach vulnerable populations with prevention, care, and adherence support, and

addressing gender-based violence. Community-led monitoring initiatives amplified the voices of service users and strengthened accountability in health facilities.

Rwanda also made progress in addressing hepatitis and other STIs. Screening and treatment services for hepatitis B and C expanded further, contributing to national elimination goals. More than 3.6 million people were screened for STIs, with syndromic management ensuring timely treatment. Integration with HIV services helped address co-infections and improve overall health outcomes.

Rwanda's HIV response in 2024/25 consolidated past gains and demonstrated continued resilience, adaptability, and inclusiveness. The achievements reported are anchored in strong national leadership, effective collaboration between the Government of Rwanda, development partners, united nations (UN) agencies, implementing partners, civil society organizations and active community engagement. Nevertheless, challenges remain, including new HIV infections among key populations, funding constraints, and the need to further strengthen the health workforce. Addressing these gaps is vital to sustain momentum and ensure Rwanda remains on track to achieve the 2030 goal of ending AIDS as a public health threat.

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List of Acronyms

AGYW – Adolescent Girls and Young Women
AHF – AIDS Healthcare Foundation
ANC – Antenatal Care
ART – Antiretroviral Therapy
ARV – Antiretroviral
CAB-LA – Cabotegravir Long-Acting
CATS – Community Adolescent Treatment Supporters
CBS – Case-Based Surveillance
CHUB – Centre Hospitalier Universitaire de Butare
CHUK – Centre Hospitalier Universitaire de Kigali
CHW – Community Health Worker
CLM – Community-Led Monitoring
DHS – Demographic and Health Survey
DHIS2 – District Health Information Software 2
DREAMS – Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSD – Differentiated Service Delivery
EMR – Electronic Medical Record
FSW – Female Sex Worker
GF – Global Fund
GoR – Government of Rwanda
HBIG – Hepatitis B Immune Globulin
HBsAg – Hepatitis B Surface Antigen
HBV – Hepatitis B Virus
HCV – Hepatitis C Virus
HF – Health Facility
HIV – Human Immunodeficiency Virus
HMIS – Health Management Information System
HTS – HIV Testing Services
IBBSS – Integrated Biological and Behavioral Surveillance Survey
IEC – Information, Education and Communication
KPs – Key Populations
LIS – Laboratory Information System
M&E – Monitoring and Evaluation
MINISANTE – Ministry of Health (Rwanda)
MoH – Ministry of Health
MSM – Men who have Sex with Men
MTEF – Medium-Term Expenditure Framework
NCD – Non-Communicable Disease
NGO – Non-Governmental Organization
NSP – National Strategic Plan
PE – Peer Educator

PEP – Post-Exposure Prophylaxis
PLHIV – People Living with HIV
PMTCT – Prevention of Mother-to-Child Transmission
PNS – Partner Notification Services
PrEP – Pre-Exposure Prophylaxis
RBC – Rwanda Biomedical Center
RICH – Rwanda Interfaith Council on Health
RMH – Rwanda Military Hospital
RRP+ – Rwanda Network of People Living with HIV
SNS – Social Network Strategy
SOP – Standard Operating Procedure
STI – Sexually Transmitted Infection
TB – Tuberculosis
U=U – Undetectable = Untransmutable
UNAIDS – Joint United Nations Program on HIV/AIDS
UPHLS – Umbrella of Organizations of Persons with Disabilities in the Fight against HIV/AIDS & for Health Promotion
VLSMS – Viral Load Sample Management System
VL – Viral Load
VMMC – Voluntary Medical Male Circumcision
WHO – World Health Organization

1.HIV EPIDEMIC OVERVIEW

Although HIV prevalence in the general population remains relatively low and stable, it remains markedly higher among key populations. Recent bio-behavioral surveys estimated the HIV prevalence at 35.2% among female sex workers (FSWs) and 5.8% among men who have sex with men (MSM). Among FSWs, prevalence has declined significantly over the past 15 years, from 51% in 2010 to 35.2%% in 2023, reflecting the positive impact of targeted prevention, testing, and treatment initiatives.

In the general population aged 15-49 years, HIV prevalence decreased from 3% in 2015 to 2.7% in 2019-2020, according to the Rwanda Demographic and Health Survey (RDHS2020). The peak age of HIV prevalence has shifted from 40-44 years to 50-54 years, primarily as a result of a cohort effect. This shift is attributed to the widespread availability of effective antiretroviral therapy (ART), sustained retention in care, high viral load suppression rates, and reductions in HIV-related morbidity, mortality, and comorbidities among people living with HIV (PLHIV).

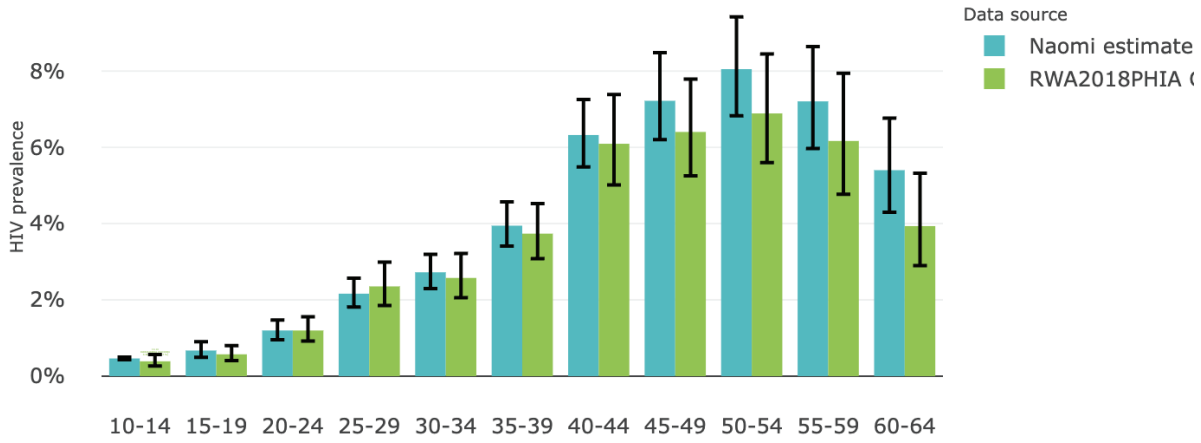

Figure 1: HIV prevalence by age

According to the latest UNAIDS 2025 estimates, HIV prevalence among adults aged 15 years and above in Rwanda varies considerably across provinces. Kigali City continues to record the highest prevalence in the country, estimated at around 5%, reflecting its urban nature, higher population density, and the concentration of people with high-risk behaviors. The Eastern Province shows a relatively high prevalence, averaging around 3-4%, particularly in districts along major transport corridors and border areas. The Southern Province presents a mixed pattern, with some districts approaching 3-4%, while others remain closer to 2%.

The Western Province reports generally lower prevalence levels, averaging 2-3%, with the lowest estimates in remote rural districts near the southwestern borders. The Northern Province records some of the lowest HIV prevalence rates in the country, mostly around 2%, consistent with its more rural and less densely populated profile.

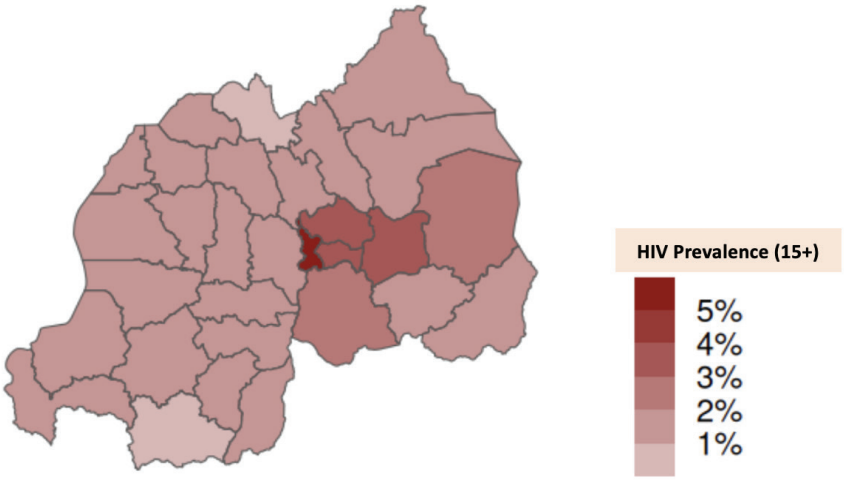

Figure 2: HIV prevalence among people aged 15+ by province (source: UNAIDs 2025)

District-level analysis provides further insights into the heterogeneity of the HIV epidemic across the country. The highest prevalence is recorded in Nyarugenge District (5%), followed by Kicukiro and Gasabo districts, all located within Kigali City, where urbanization and higher mobility contribute to increased vulnerability. Outside Kigali, elevated prevalence is observed in Rwamagana, Bugesera, and Kayonza districts in the Eastern Province, aligning with the province's overall higher prevalence rates. In contrast, the lowest prevalence is observed in Burera, Nyaruguru, Gisagara, and Gakenke districts (below 2%), predominantly rural areas with less urban influence.

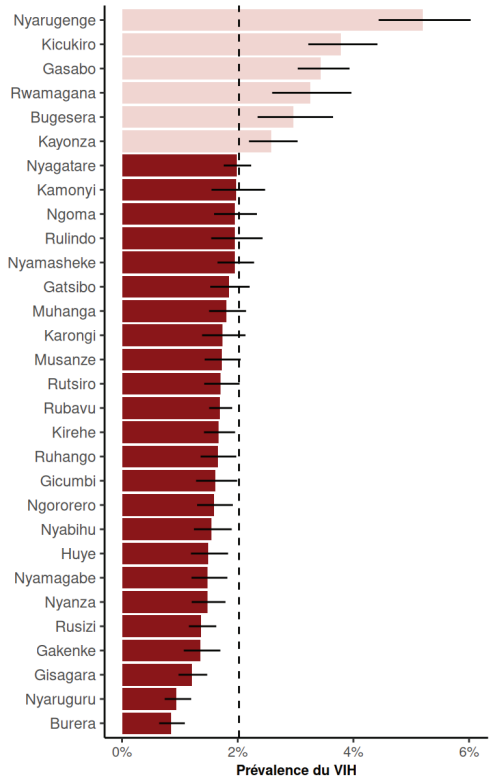

Figure 3: HIV prevalence among people aged 15+ by District (source: UNAIDs 2025)

Over the past decade, Rwanda has significantly expanded HIV services nationwide, earning global recognition for its effective approach to controlling the epidemic. The 2024 Global UNAIDS Report, released in July 2025, identified Rwanda as one of only five African nations to have reached the 95-95-95 targets with approximately 96% of PLHIV knowing their status, over 98% receiving antiretroviral therapy, and over 98% achieving viral suppression. These results place Rwanda firmly on track to end AIDS by 2030 and reflect the country's strong commitment to eliminating the HIV/AIDS epidemic while enhancing the quality of life for those affected.

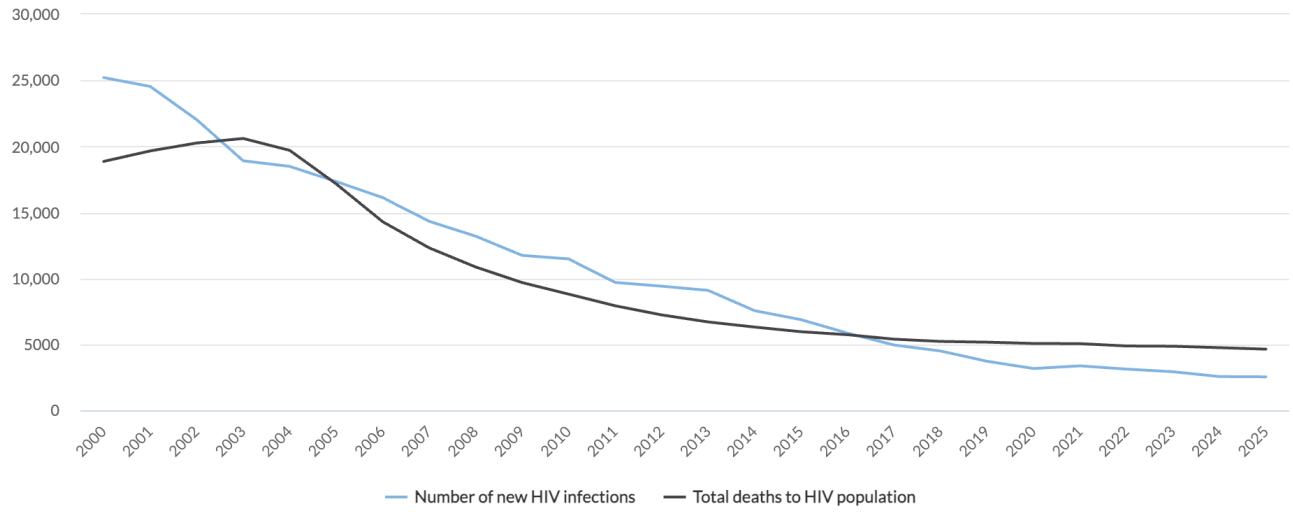

Figure 4: Trend of new infections and AIDS deaths from 2000-2025 (source: Spectrum 2025)

Rwanda has made substantial progress in implementing biomedical HIV prevention strategies. Male circumcision coverage rose from 13% in 2010 to 56% in 2020, while the mother-to-child transmission rate has remained consistently below 1.5%, thanks to the effectiveness of facility-based prevention of mother-to-child transmission (PMTCT) programs.

2.HIV PREVENTION

2.1 Background

Rwanda's national HIV prevention program aims to reduce new HIV infections by 15% through a comprehensive and integrated approach. At its core is HIV testing within the case-based surveillance system, including index testing, which ensures early identification of cases and timely linkage to care.

The program also reinforces PMTCT services to protect mothers and infants, sustains Voluntary Medical Male Circumcision (VMMC) as a key biomedical intervention, and delivers targeted prevention for key and priority populations. Alongside these, wide-reaching condom programming strengthens accessibility and consistent use, ensuring that prevention efforts are both evidence-based and inclusive across the population.

2.2 Goal and outcome of the HIV prevention program in alignment with the HIV National Strategic Plan (NSP).

The HIV Prevention program designs its goal and outcomes to establish a comprehensive and effective response to the HIV epidemic. They generally encompass:

Goal

- Reduction of new HIV infections by 15% by 2027.

Outcomes

- Reduction of new HIV infections transmitted through sexual intercourse.
- Most-at-risk populations have access to combination reproductive health and prevention services.
- People access and use services to eliminate mother-to-child transmission of HIV, syphilis, and hepatitis.

Policy and guideline changes affecting FY 2024-2025 implementation.

- Rwanda piloted long-acting cabotegravir (CAB-LA) as an additional PrEP option in FY 2024-2025, launched in December 2024 at two health facilities to expand choices alongside oral PrEP and reach hard-to-reach populations.
- The ongoing policy of over-the-counter HIV self-testing kits through private pharmacies continues to drive demand creation and support earlier diagnosis, especially among

youth and high-risk groups.

- Updated 2024 viral hepatitis and STI guidelines strengthened integrated screening and care within ANC and PMTCT services, advancing efforts toward elimination of mother-to-child transmission (eMTCT) of HIV, syphilis, and hepatitis B.

- The program introduced the Shang Ring method in FY 2024–2025 as part of circumcision services, diversifying delivery approaches and potentially increasing uptake, particularly among older men who may prefer a less invasive option.

Achievements of HIV prevention programs in FY 2024-2025

2.3 HIV Testing Services (HTS)

Rwanda provides nationwide HIV Testing Services (HTS) to ensure early diagnosis, timely ART initiation, and strong linkage to care. Testing is integrated with VMMC, PEP, PrEP, and PMTCT, delivered through key entry points such as PITC, VCT, ANC, labor and delivery. Prioritizing index testing, family testing, and the Social Network Strategy (SNS) within Case-Based Surveillance (CBS), HTS strengthens early detection and continuity of care, driving national progress toward epidemic control.

Key achievements

In FY 2024–2025, Rwanda sustained high targeted HIV testing coverage with around 1.9 million tests conducted, despite reduced global funding. Index testing remained the most effective approach, supported by strong Case-Based Surveillance (CBS) performance that ensured timely diagnosis and linkage to ART. Alongside this, recency testing and broader HIV Testing Services (HTS) continued to identify new infections, guide targeted prevention, promote safer practices, and expand access for underserved populations, reinforcing national progress toward epidemic control.

The graph below of the positivity trend across HIV testing entry points shows consistently low yields in HTC (0.9%), ANC (0.4%), Maternity (0.1%), PMTCT partners (0.2%), and VMMC (0.04%). In contrast, Index Testing stands out with a markedly higher yield of 3.0%, highlighting its effectiveness in identifying HIV-positive individuals compared to other entry points.

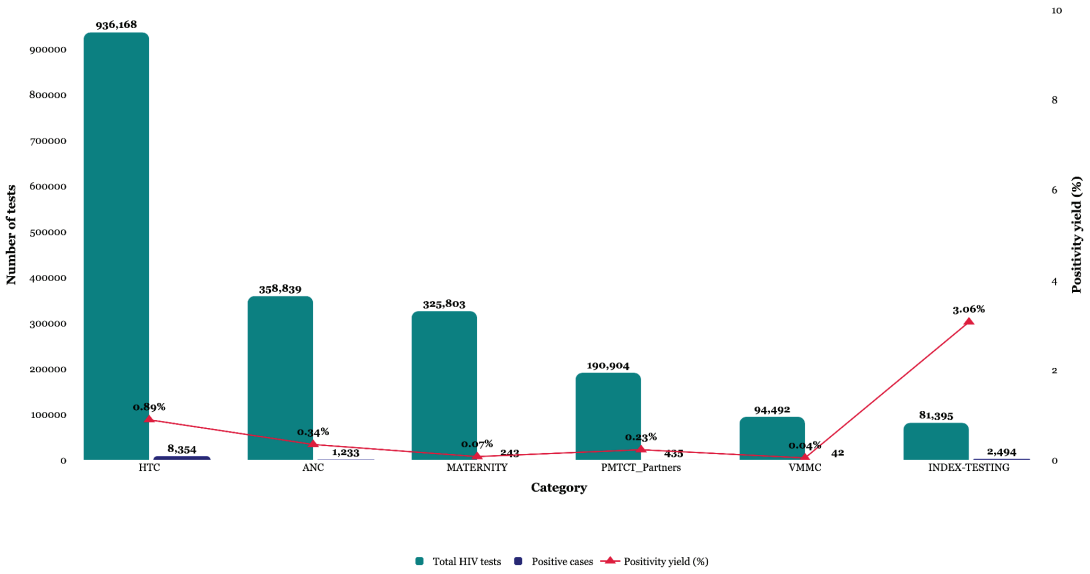

Figure 5: HIV testing and positivity yield by different entry points

HIV positivity rates in July 2024–June 2025 were lowest in western and northern districts (0.28%–0.61%), moderate in central and southern districts (0.62%–1.26%), and highest in the East particularly Kayonza, Kirehe, and Ngoma ranging from 1.27% to 1.58%. This concentration in the Eastern Province highlights where testing and prevention efforts should be prioritized.

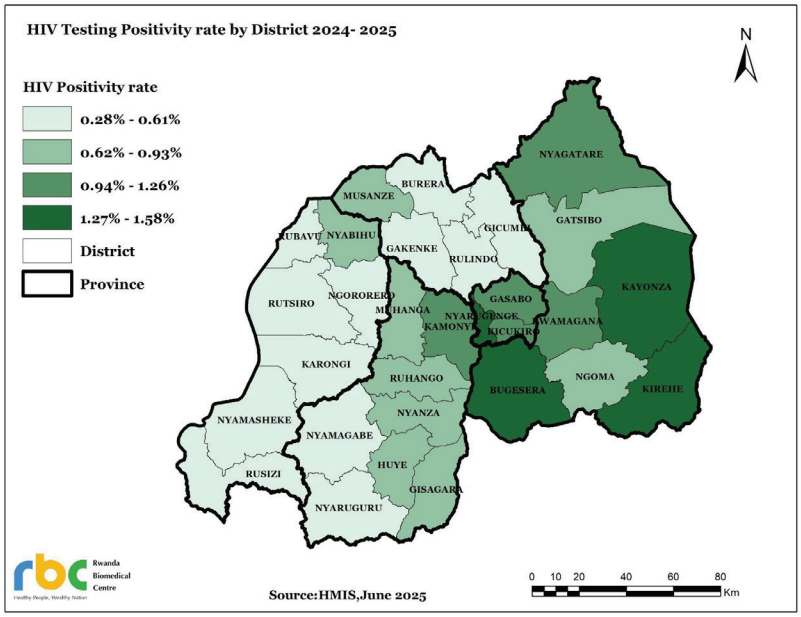

Figure 6: Relative HIV testing yield in HTC by Districts from July 2024-June 2025

The graph below shows a clear decline in HIV positivity yield from 2019 to May 2025, with PIT/VCT dropping from 6.8% to 3.1%. This suggests that fewer new infections are being detected in the general population, pointing to progress in controlling the epidemic. Index testing, however, has continued to show the highest returns, peaking at 1.07% in 2022, which highlights its strength in finding undiagnosed cases by tracing contacts of people already living with HIV. On the other hand, ANC, maternity, partners of pregnant women, and VMMC consistently recorded very low yields of less than 1%, reflecting the impact of prevention programs and lower infection

levels in these groups. Together, the results show the importance of focusing on strategies like index testing that are more targeted and effective in identifying people who might otherwise remain undiagnosed.

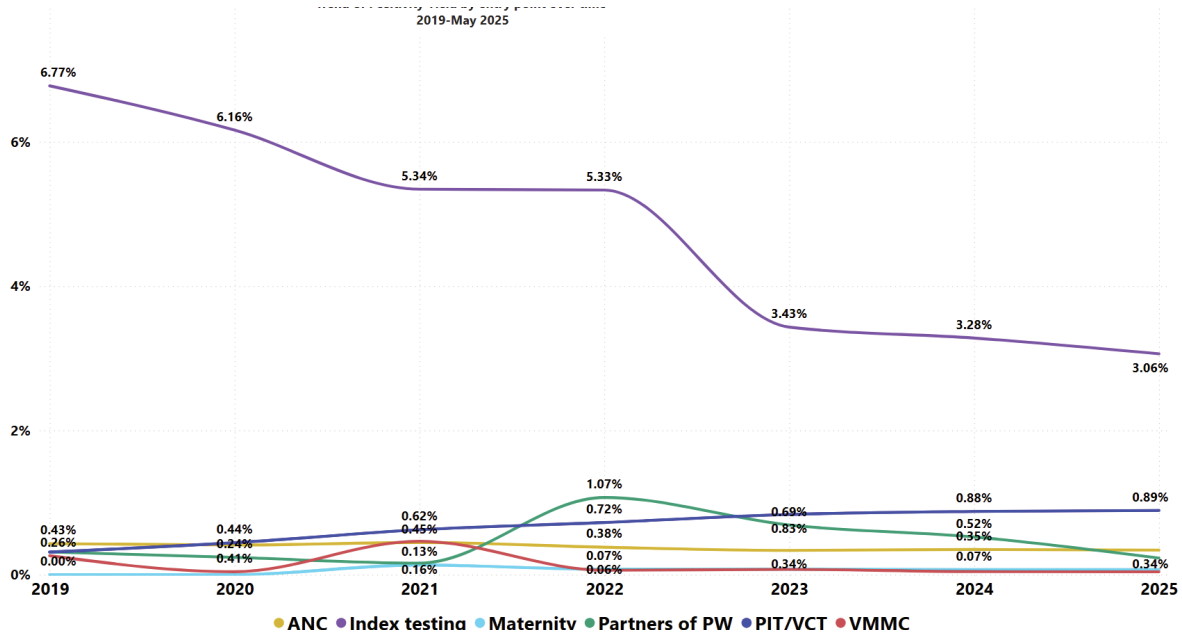

Figure 7: Trend of HIV testing Positivity yield by different entry points for the last 7 years

2.4 Case-based surveillance

Rwanda's Case-Based Surveillance (CBS) is a data-driven system that ensures people living with HIV (PLHIV) aged 18 and above are identified, linked to services, and continuously monitored throughout their care. It focuses on those unaware of their status, newly diagnosed individuals in high-risk situations, HIV-exposed infants identified through family testing, and index clients on ART requiring ongoing follow-up.

2.4.1 Active Case-Finding Strategies

Active case finding under Rwanda's Case-Based Surveillance (CBS) is a proactive approach that targets undiagnosed HIV cases by focusing on high-risk groups, especially contacts of confirmed cases. Using strategies such as index testing and recency testing, CBS enables early detection, timely linkage to care, and tailored interventions for individuals and communities most at risk. Once a case is identified, the system records detailed demographic and clinical data to guide both individualized treatment and program-level decision-making, ensuring that newly diagnosed clients are promptly initiated on treatment and monitored for adherence and viral suppression.

Beyond individual management, CBS serves as a critical public health tool. The real-time data it generates provides valuable insights into HIV transmission patterns, highlights high-burden populations, and informs resource allocation. This evidence-driven approach allows health

authorities to refine prevention strategies, strengthen follow-up systems, and reduce new infections, thereby improving outcomes and the overall well-being of people living with HIV nationwide.

2.4.1.1. Index testing and partner notification services

Index testing and partner notification are central to Rwanda's HIV control strategy, enabling early detection and rapid linkage to care among partners, children, and sexual contacts of people with HIV. This approach has helped the country surpass its national target, with 96% of people living with HIV already diagnosed—well ahead of the 2030 goal.

Key Achievements

From July 2024 to June 2025, CBS testing cascade enrolled 28,631 index clients, from whom 37,659 contacts elicited a slight drop of contact to index ratio observed related to extensive reach of index enrollment. Among the contacts elicited, 32,391 (85%) were successfully reached, and 30,609 (88%) attended a health facility. HIV testing uptake remained high, with 28,778 contacts tested (94%), resulting in 1,128 new HIV-positive diagnoses with a positivity yield of 3.9%. While the positivity yield has decreased compared to previous years, this reflects the growing effectiveness of CBS interventions in detecting cases earlier and reducing undiagnosed HIV. Importantly, ART initiation performance was strong, with 1,094 (97%) of newly diagnosed contacts starting treatment promptly. The CBS testing cascade has consistently linked individuals with unknown HIV status to testing services and ensured both newly diagnosed and previously diagnosed clients are retained in care and treatment.

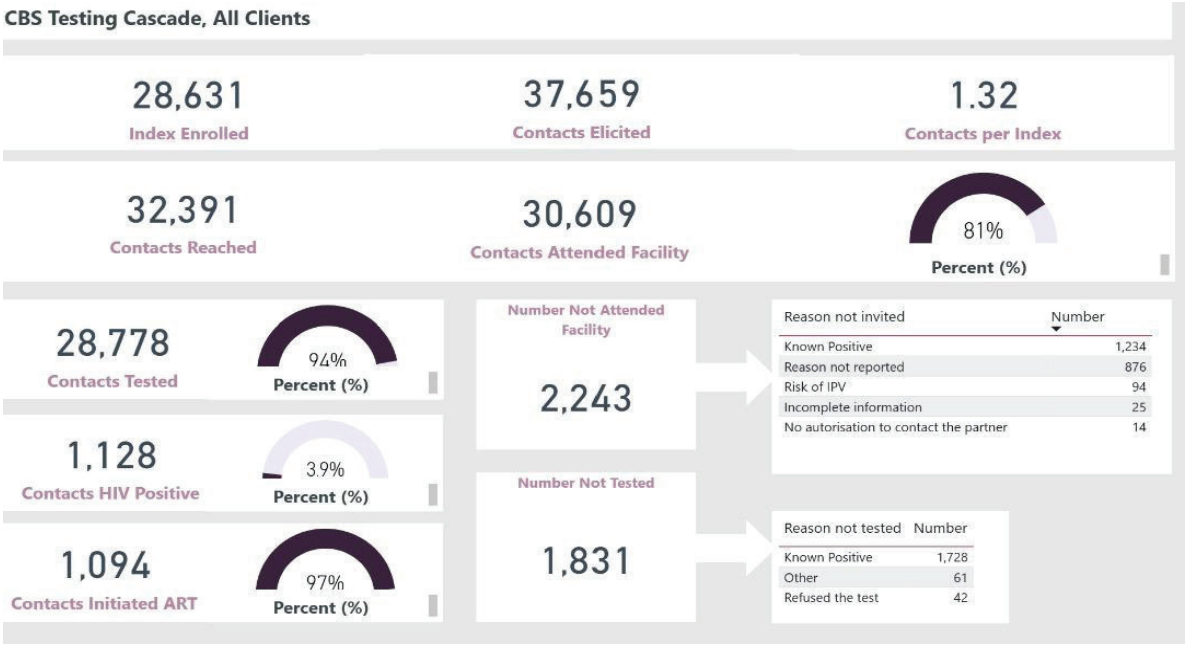

Figure 8: CBS index testing cascade (July 2024-June 2025)

During the reporting period, most index clients were enrolled among adults aged 25–49 years, with females consistently outnumbering males across age groups. Married individuals accounted for the largest share of clients, followed by those who were single or co-habiting, while widowed

and divorced clients represented smaller proportions. The majority of index clients were identified through provider-initiated testing and counselling (PITC), with fewer enrolled through VCT, ANC, labor and delivery, or transfer-in. Geographically, Kigali City and the Eastern Province contributed the highest proportions of enrolled clients, while the Northern Province recorded the lowest.

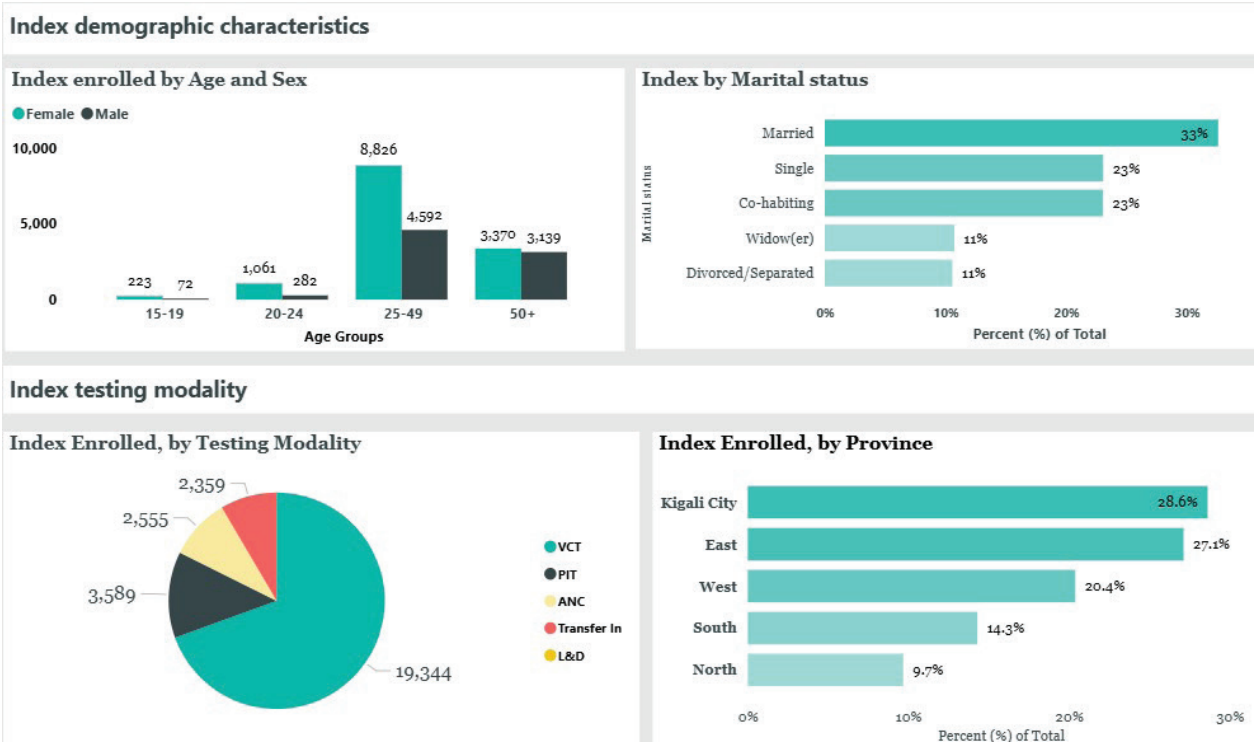

Figure 9: Characteristics of index clients enrolled in CBS (July 2024-June 2025)

The distribution of contacts elicited by age and sex shows that the highest numbers were reported among adults aged 30-39 years and 40-49 years, with men outnumbering women in both categories. Among those aged 50 years and above, males also represented the majority. In contrast, the number of contacts elicited was lowest among adolescents aged 15-19 years, while children under 10 years accounted for a modest share, with slightly more females than males in this group. Overall, contact elicitation was concentrated in adults of reproductive age, particularly men between 30 and 49 years.

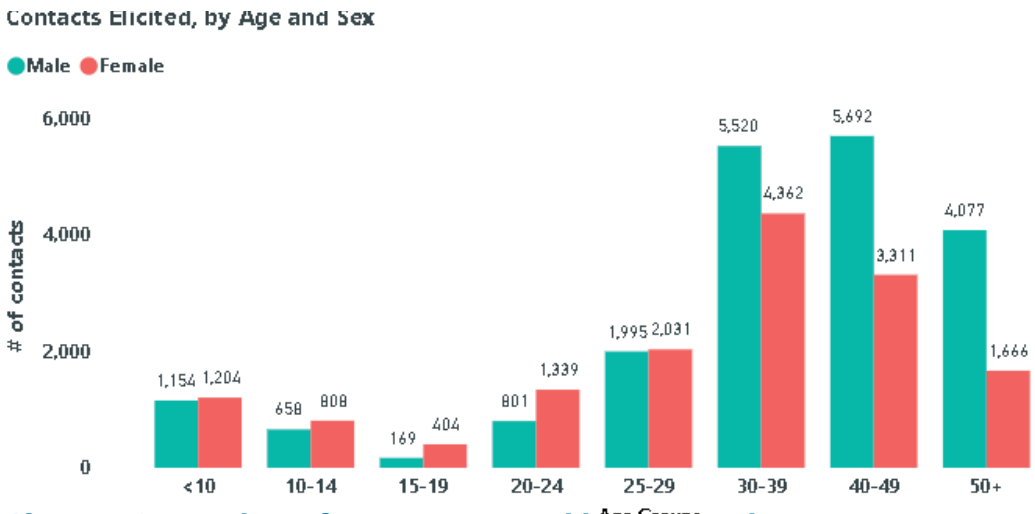

Figure 10: Number of contacts tested by age, and sex

Family testing

From July 2024 to June 2025, HIV positivity in family contact testing remained low and stable at about 1–1.5% for most of the year, but rose sharply from March, reaching 6.0% in June 2025. This surge, supported by the LIFT UP program that was designed to trace and identify untested children under 15 years of age living with parents or caregivers who are PLHIV. highlights a shift toward more targeted testing that identifies higher-risk contacts more effectively.

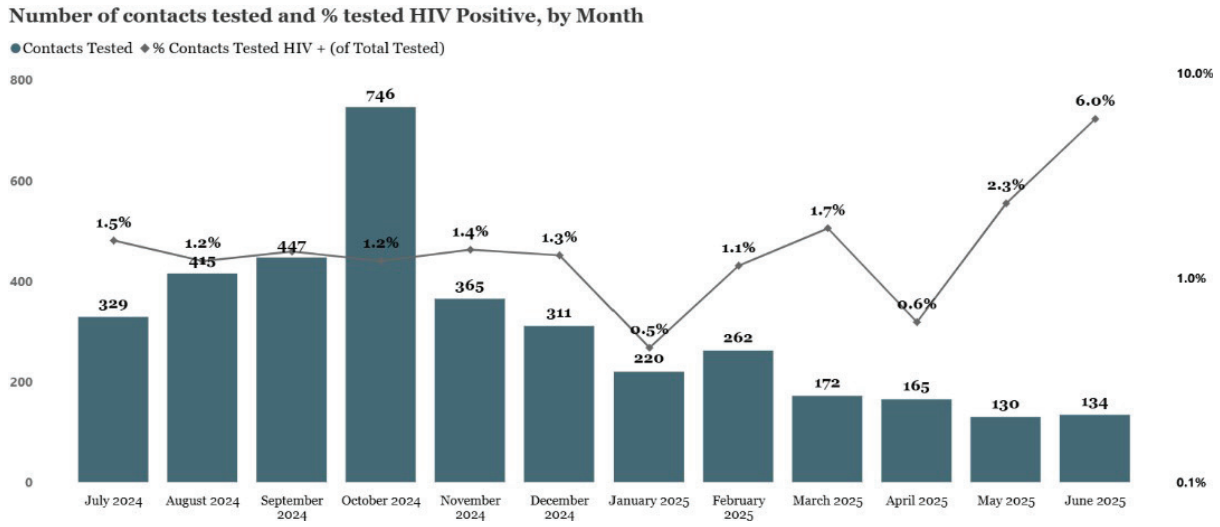

Figure 11: Trend in positivity rate among family testing (2024-2025)

Partner notification services

The chart shows the number of sexual partners tested for HIV by age and sex. Testing was highest among adults aged 35–39 years and 50+ years, with women consistently representing a larger share than men across all age groups. Among younger groups, testing numbers were lowest in those aged 15–19 years. HIV positivity rates remained relatively low overall but were slightly higher in older age groups, particularly among men aged 50 years and above.

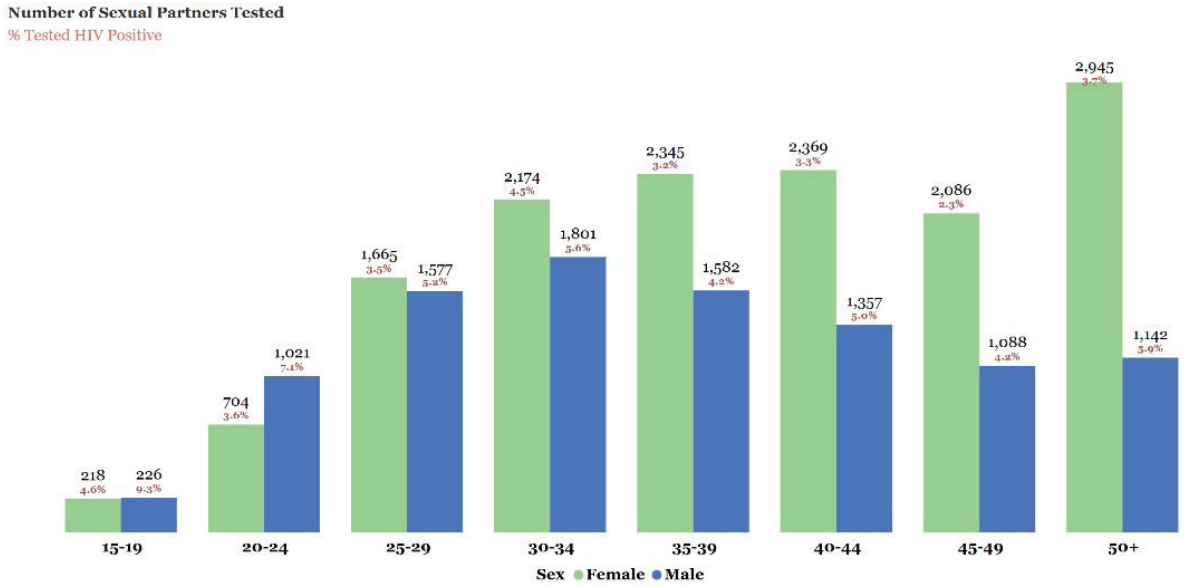

Figure 12: Tests done and positivity rate in PNS (July 2024-June 2025)

Social network services

The chart illustrates the number of social network contacts tested for HIV by age and sex. Testing was most frequent among adults aged 40–44 years, followed by those in the 25–39 year and 20–24 year, with females consistently outnumbering males across all age categories. Testing was lowest among adolescents aged 15–19 years. HIV positivity was generally higher in younger females, especially those aged 15–24 years, and among older adults aged 45 years and above, highlighting important age- and sex-specific vulnerabilities within social networks.

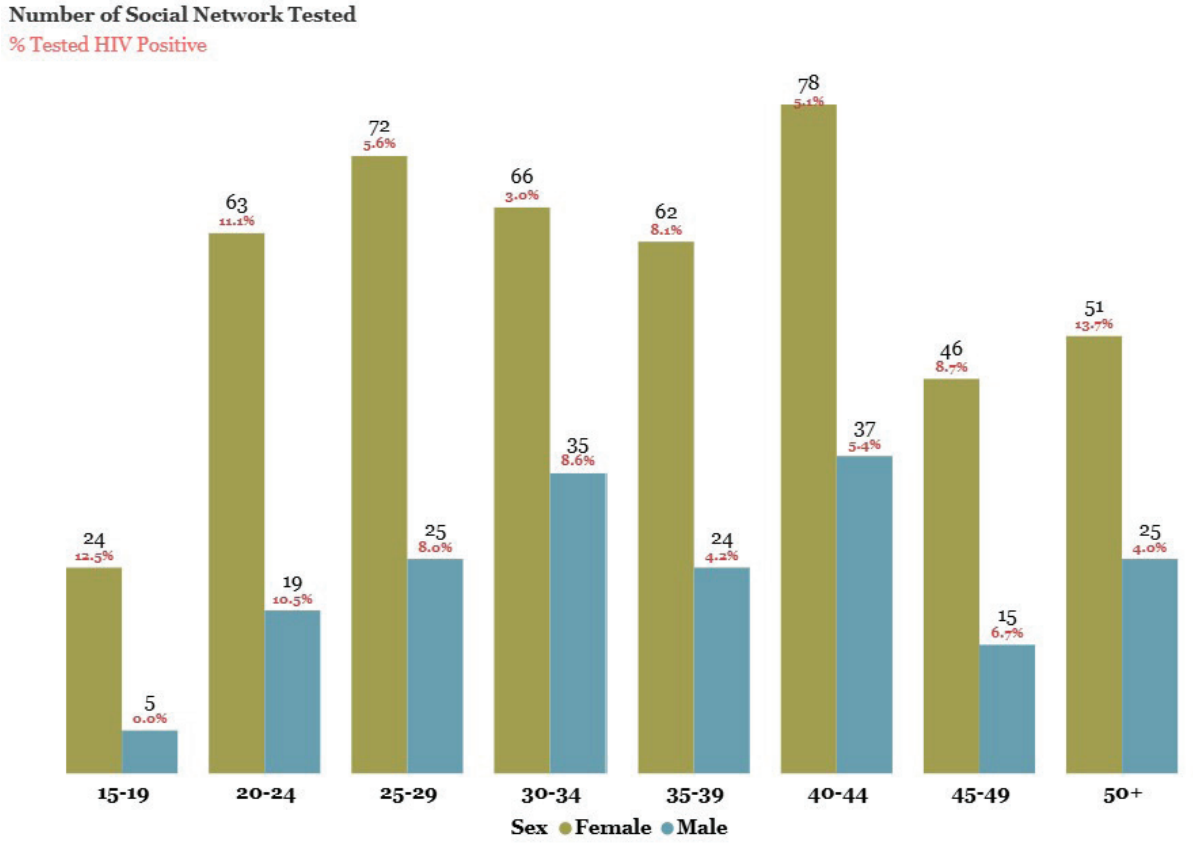

Figure 13: Tests done and positivity rate in SNS (July 2024-June 2025)

2.4.1.2. HIV recency testing

HIV recency testing (RITA) distinguishes recent from long-standing infections and has been integrated into Rwanda's routine testing since 2018 to guide targeted interventions. The figure shows that recent infections are disproportionately higher among adolescent girls and young women, especially those aged 15–29 years, while cases among men are fewer and more evenly distributed across age groups.

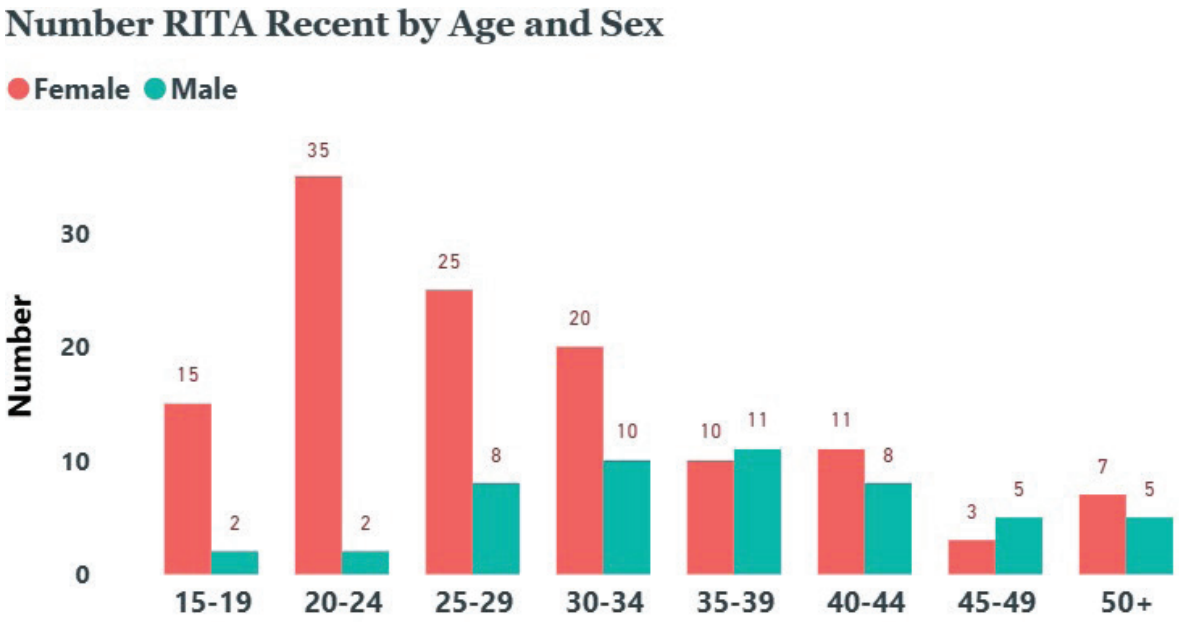

Figure 14: Recent cases by age and sex (July 2024-June 2025)

Capacity building and mentorship

In total during the reporting period, 243 healthcare providers were trained through centralized training and by on-site training. Additionally, mentorship activities reached 64 health facilities across the country, strengthening HIV case-based surveillance, recency testing, and active case finding.

Gaps and challenges

- Gaps in reaching high-risk and geographically remote populations, limiting timely case detection and service access.
- Stigma, self-stigma, and fear of disclosure among key populations, hindering participation in partner notification, family testing, and social network strategies.
- High staff turnover and limited refresher training, reducing availability of skilled personnel for specialized services such as index and recency testing.
- Weaknesses in data management systems, including fragmentation, poor integration, incomplete case tracking, duplicate reporting, and reporting delays.
- Difficulty in reaching some contacts due to migration, remote locations, or inaccurate information.
- Logistical delays in distributing testing commodities, disrupting service continuity in certain facilities.

Lesson learned

- High-yield strategies such as index testing, partner notification, family testing, and social network approaches are critical for early case identification and prompt linkage to care.
- Community engagement and stigma reduction remain essential to improve service uptake, especially among marginalized and high-risk groups.
- Skilled workforce development through continuous training, mentorship, and supportive supervision is necessary to maintain service quality and address staff turnover.
- Integration of real-time data systems across facilities is key to eliminating duplicate reporting, improving surveillance accuracy, and strengthening contact tracing and linkage outcomes.

2.5 Prevention of Mother to Mother-to-Child Transmission (PMTCT)

Rwanda has demonstrated strong commitment to eliminating mother-to-child transmission (MTCT) of HIV since launching the PMTCT program in 1999. The program has averted numerous pediatric infections, improved maternal outcomes, and expanded to all health facilities, including private clinics. MTCT rates have remained below 2% for the past decade, thanks to interventions such as lifelong ART, decentralization of services, close follow-up of mothers and infants, rigorous viral load monitoring, retention strategies, and continuous training of health providers to ensure quality care.

PMTCT program is guided by four pillars (1) primary prevention of HIV among women of childbearing age (2) prevention of unintended pregnancies among women living with HIV, (3) prevention of HIV transmission from mothers living with HIV to their infants (4) provision of appropriate treatment, care, and support to mothers, children, and families. The program continues to drive Rwanda toward the goal of eliminating mother-to-child HIV transmission.

2.5.1 PMTCT Objectives for 2024-2025 year

- Reinforce integration of PMTCT services into routine maternal, newborn, and child health care of public health facilities and at least 70% of private health facilities, thereby reducing the remaining gaps in PMTCT service coverage.
- Ensuring that all health facilities providing antenatal and delivery services implement routine screening, treatment, and monitoring for HIV, syphilis, and hepatitis B in line with national triple elimination guidelines.
- Ensuring exposed infants receive timely testing and ARVs prevention according to

national guidelines, and maintain uninterrupted availability of testing materials in health facilities through capacity building and strengthening communication and coordination.

Key achievement within PMTCT program

2.5.2 HIV testing and continuum of care

HIV testing services are a vital component in PMTCT. In Rwanda, all pregnant women and their male partners with unknown or negative HIV status are systematically offered testing during their first antenatal care visit, enabling early detection and timely intervention. Mothers who test positive are immediately enrolled in a program and initiated on lifelong antiretroviral therapy (ART) to reduce the risk of HIV transmission to their infants. Male partners who test positive are enrolled into care and started on lifelong ART.

In the fiscal year 2024-2025, the data from health facilities with PMTCT services showed that a total of 364,665 pregnant women attended their first antenatal care (ANC) visit. Of these, 4,156 were already known to be HIV positive. Out of the remaining women, 358,839 were tested for HIV. Among those tested, 1233 were newly diagnosed with HIV, resulting in a positivity rate of 0.34%. About 99.5% of All Pregnant women eligible for HIV testing were tested for HIV in ANC 2024- 2025. The ART coverage for pregnant women who were positive in ANC was 99.9%. A persistent challenge is the low involvement of male partners in ANC services. Only 190,904 male partners were tested for HIV in ANC, of whom 435 tested positives among which 225 male partners had pregnant partners who are HIV negative in ANC. This depicts the importance of male involvement and testing in ANC. From July 2020 to June 2025, the HIV prevalence among pregnant women who attended antenatal care visits decreased from 2.08% to 1.48%, respectively.

All women in labor or at delivery were offered HIV testing and counseling if they were not already known to be living with HIV. Out of 325,803 pregnant women tested during labor or delivery, 243 were newly diagnosed with HIV of which 65% were aged 25 years old and above while 25% aged 20-25 years old. Among all women who tested positive, 99.9% were immediately initiated on ART to prevent mother-to-child transmission and to improve their own health. During the reporting period, 131 pregnant women living with HIV delivered at home where 88% were aged above 25 years and above, posing a high risk of mother-to-child HIV transmission.

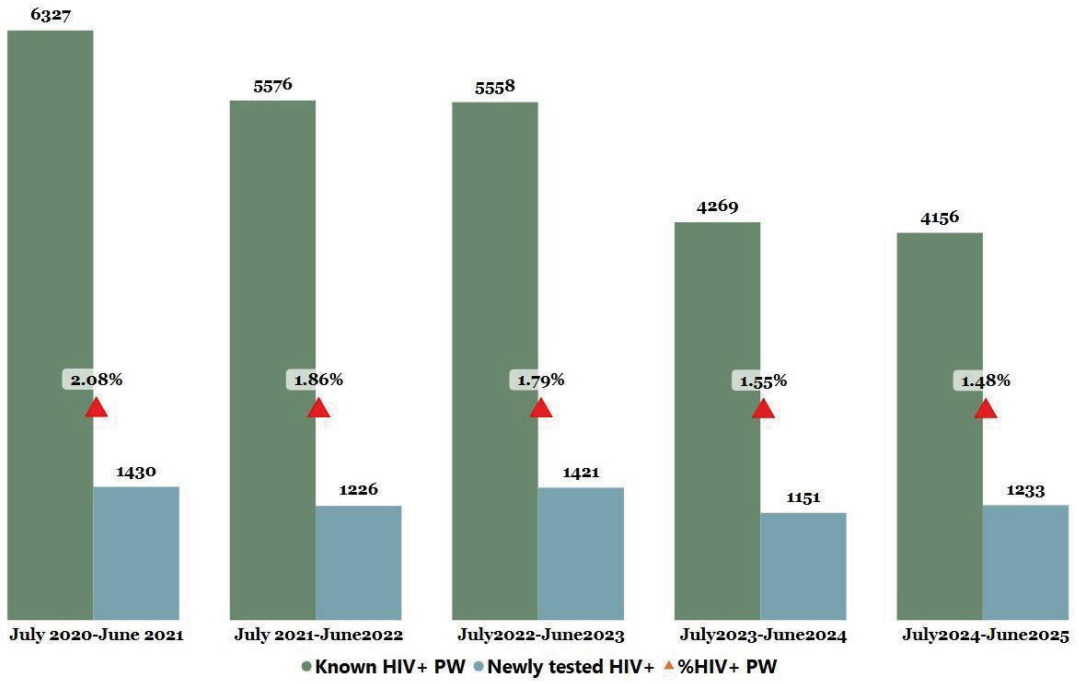

Figure 15: Trend of HIV prevalence in ANC among Pregnant women from 2020-2025

2.5.3 Triple Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B

Rwanda continues to demonstrate unwavering commitment to the Triple Elimination Initiative for syphilis, HIV, and hepatitis B, which aims to reduce mother-to-child transmission (MTCT) of these three diseases in alignment with global elimination goals. Launched in 2023, the initiative seeks to improve maternal and child health outcomes by sustaining very low transmission rates. All pregnant women attending antenatal care (ANC) are screened for HIV, syphilis, and hepatitis B virus (HBV). Those who test positive receive timely and appropriate treatment, while infants exposed at birth are provided with prophylaxis for HIV, vaccination for hepatitis B, and close follow-up to prevent infection.

In the 2024-2025 fiscal year, notable progress was achieved:

- Hepatitis B: A total of 316,334/364,665 (86.7%) pregnant women were tested during ANC visits. Among them, 290 (0.09%) had detectable viral loads, and 146 were initiated on treatment per eligibility criteria, in line with national guidelines which recommend treatment initiation for patients with viral load >2,000 IU/ml.
- Syphilis: Out of 340,024/364,665 (93.2%) pregnant women tested, 3,533 (1%) were diagnosed positive, and all were promptly initiated on treatment.
- HIV: A total of 358,839 pregnant women were tested, with 1,233 identified as HIV-positive.

Throughout the year, efforts were strengthened by introducing new indicators to enhance monitoring of the Triple Elimination Initiative. The figure below presents the proportion of pregnant women tested during ANC for the three diseases, along with the corresponding positivity yield.

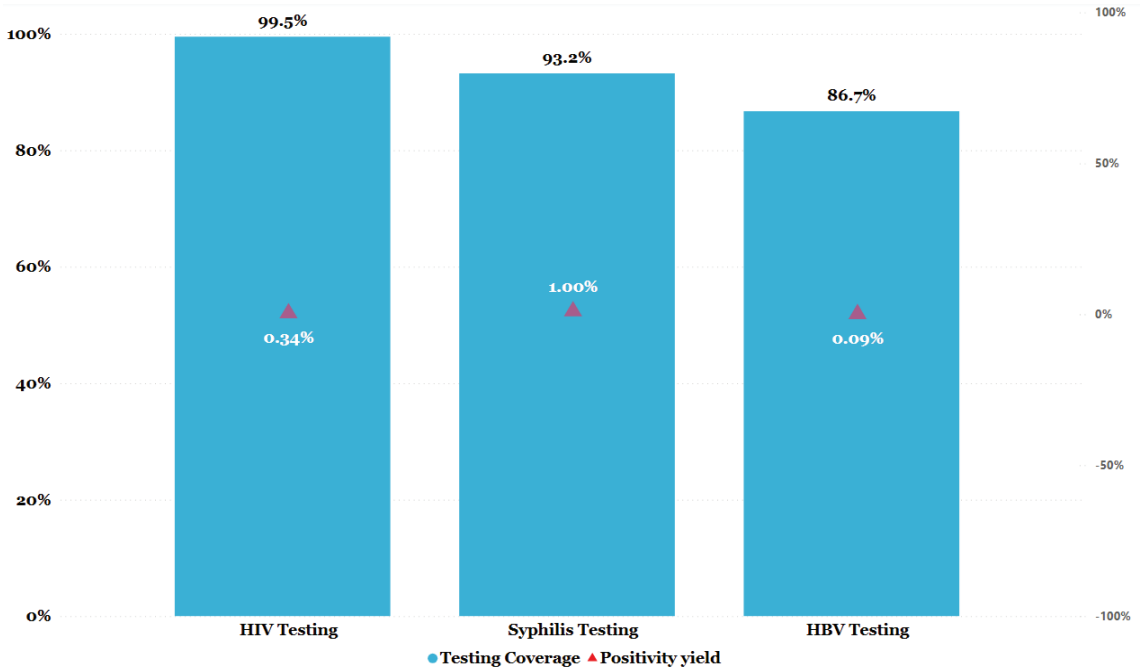

Figure 16: Proportion of PW tested for HIV, HBV and Syphilis in ANC and the positivity yield.

2.5.4 Follow-up of HIV-exposed Infants

Tight follow-up of HIV-exposed infants plays a vital role in preventing mother-to-child transmission (PMTCT) of HIV. This process involves regular monitoring to early detect exposed infant seroconverting and promptly initiate treatment. In Rwanda, most follow-up of HIV-exposed infants occurs on monthly basis at primary health care, particularly health centers, with a smaller proportion taking place in private facilities. Everyone HIV-exposed is enrolled in the PMTCT program immediately after birth before discharge from the maternity or postnatal ward.

In the 2024–2025 reporting period, mother-to-child transmission (MTCT) rates were assessed among infants who had completed full 24-month follow-up within the program, totaling 4,026 HIV-exposed infants.

The overall mother-to-child transmission (MTCT) rate was 1.1%, with stage-specific rates of 0.3% at 6 weeks, 0.3% at 9 months, 0.3% at 18 months, and 0.1% at 24 months. While transmission rates remain consistently low across follow-up stages, analysis against the five-year trend shows a slight increase, rising from 0.9% in the previous year to 1.1% in the current reporting period. This upward shift, though modest, underscores the importance of sustained vigilance and targeted interventions to maintain progress toward elimination goals.

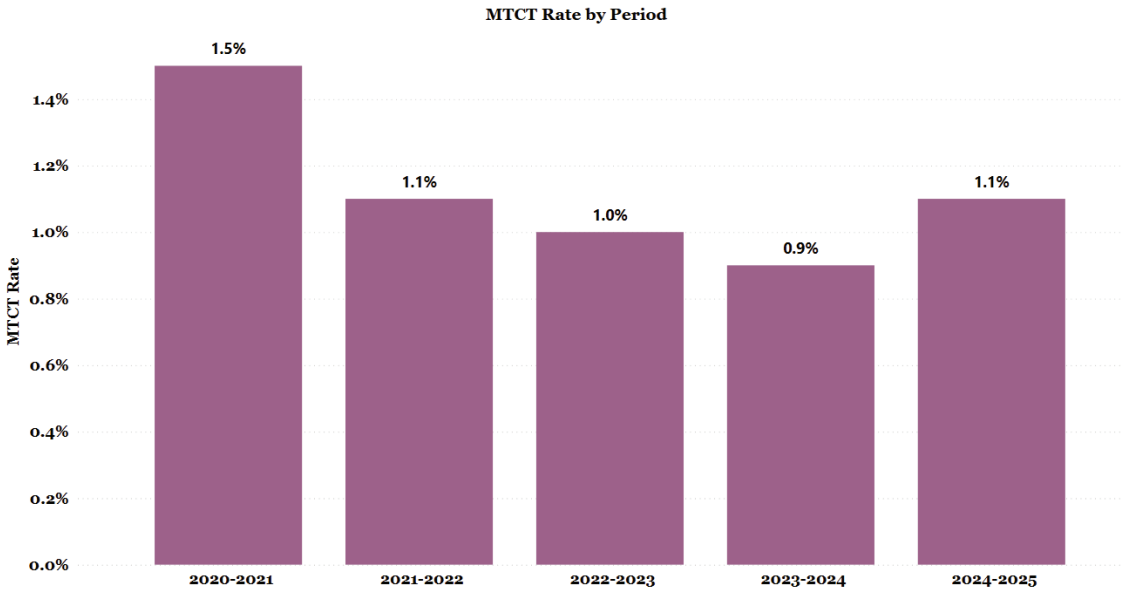

Figure 17: Trend of HIV MTCT rate from 2020 to 2025

Capacity building & mentorship during FY 2024-2025

During the reporting period, 386 new and untrained healthcare providers (HCPs) from public health facilities and 27 from private facilities received training, while mentorship was conducted across 165 health facilities.

Lesson learnt and challenges

- The PMTCT program in Rwanda has integrated HIV, syphilis, and hepatitis screening into routine maternal and child health services and decentralized care to primary health facilities, demonstrating strong effectiveness in preventing mother-to-child transmission.
- The adoption of new monitoring indicators under the Triple Elimination Initiative has strengthened progress tracking and informed targeted interventions. These indicators will help us to bridge the gap regarding application for triple eliminations
- Moving forward, sustained funding, targeted interventions, and continued innovation remain critical to achieving full elimination.
- Despite these gains, challenges persist, including stock-outs of HIV test kits for exposed infants, low male partner involvement in ANC, and home deliveries among HIV-positive women.
- Limited participation of some private facilities, unaddressed treatment gaps for pregnant women with low-level HBV viremia, and high turnover of healthcare providers without

structured skills transfer undermine program continuity and quality.

- Financial constraints and budget cuts have slowed integration of PMTCT services into private clinics and delayed key studies needed to reinforce HIV testing in ANC and support evidence-based integration of PMTCT into vaccination programs.

2.5.5 PMTCT Targets & Strategies for FY 2025-2026

Targets

- PMTCT program aims to re-enforce implementation of the triple elimination initiative (HIV, syphilis, and hepatitis B) across all facilities, ensuring that: 100% of pregnant women attending ANC receive screening for all three diseases, all infected mothers receive timely and appropriate treatment. Ensure all exposed infants receive appropriate prophylaxis and tight follow up, vaccine and ensure accurate reporting to monitor progress.
- Ensure progress and planning on the enhanced testing in ANC and during vaccination with regards to available funding
- Integration of PMTCT services to private clinics and ensure continued service delivery in private health facilities
- Ensure progressive reduction in mother-to-child transmission rate to below 1%
- Application to Elimination of HIV, Hepatitis B, and Syphilis

Strategies

- Ensure an uninterrupted supply of Testing Kits and medication to the health facilities and early communication when occurred for timely action
- Enhance Facility-Level Capacity building through Mentorship and training
- Ensure continuous professional development and capacity building in PMTCT services delivery through e-learning
- Regular monitoring on the program progress through quality data assurance quarterly
- Reinforce HIV and PMTCT services into private health facilities by providing training and mentorship and ensuring appropriate reporting

2.6 Voluntary medical male circumcision (VMMC)

Voluntary Medical Male Circumcision (VMMC), endorsed by WHO and UNAIDS, remains a cornerstone of Rwanda's HIV prevention strategy, reducing female-to-male HIV transmission risk by about 60%. The program has strengthened service delivery through task-shifting, infection prevention, and demand-generation approaches, ensuring broad access while upholding safety and quality. In FY 2024–2025, Rwanda achieved 88.7% of its target of 374,885 circumcisions, with success attributed to prioritization of high-demand provinces and the introduction of a new device-based method, expanding safe options for boys and men. These achievements provide a strong foundation for further progress in the coming year.

Key achievements in VMMC programs

2.6.1 Circumcision Uptake by Province

During the reporting period, 332,804 adolescent boys and men received VMMC services nationwide. Uptake was highest in the Western Province 33.5% and Eastern Province 26.2%, while the Northern and Southern provinces contributed around 16.7% and 16.6%, and Kigali City recorded the lowest share at 7.0%. Strong performance in the West and East reflected effective mobilization and service accessibility, whereas lower uptake in Kigali and the North highlighted reduced demand and lifestyle barriers. These trends point to the need for targeted demand-creation and strategic resource allocation to ensure more balanced coverage across provinces.

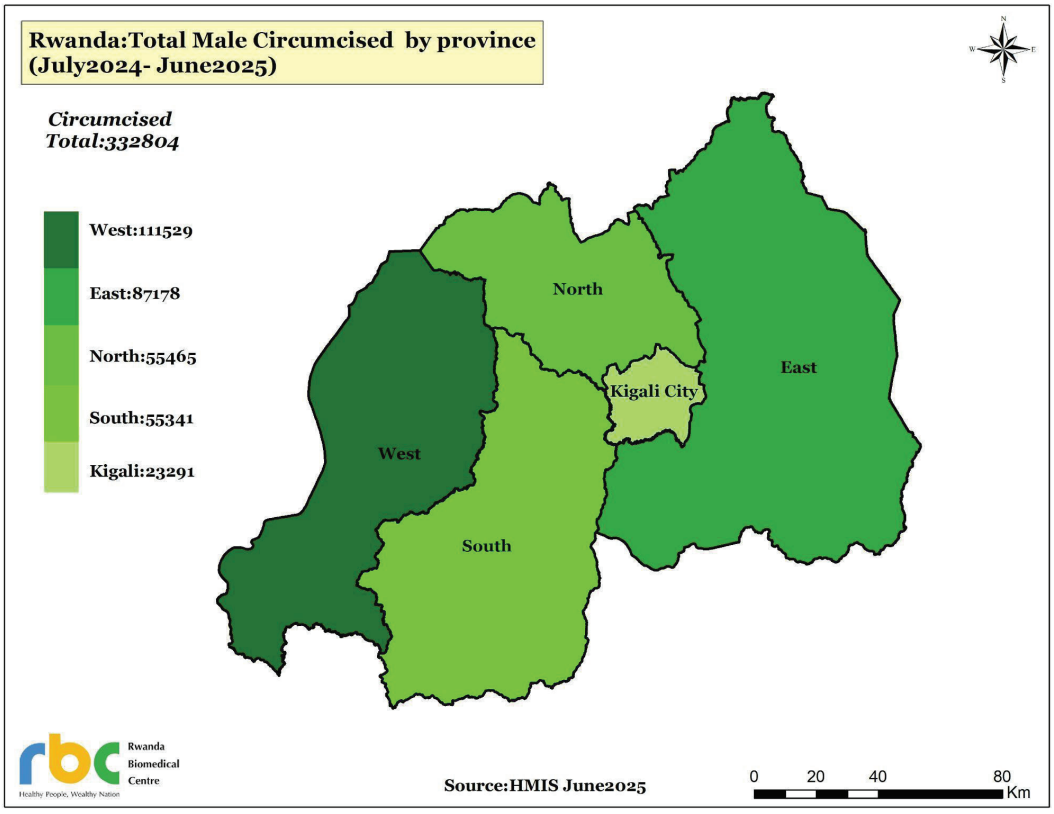

Figure 18: Total male circumcised per province (HMIS 2024-2025).

2.6.2 Circumcision Coverage by Age Group

Surgical circumcision dominates across age groups, peaking among males aged 15–19 years (38.1%) and those under 15 years (30.4%), while medical device use remains negligible (≤0.48%). Uptake declines sharply with age, falling to 15.8% among men aged 20–24, 13.4% for those aged 25–49, and 1.5% for those aged 50 and above. This age-skewed pattern indicates that there is a need for targeted strategies to increase coverage among older men, particularly those aged 40 years and above.

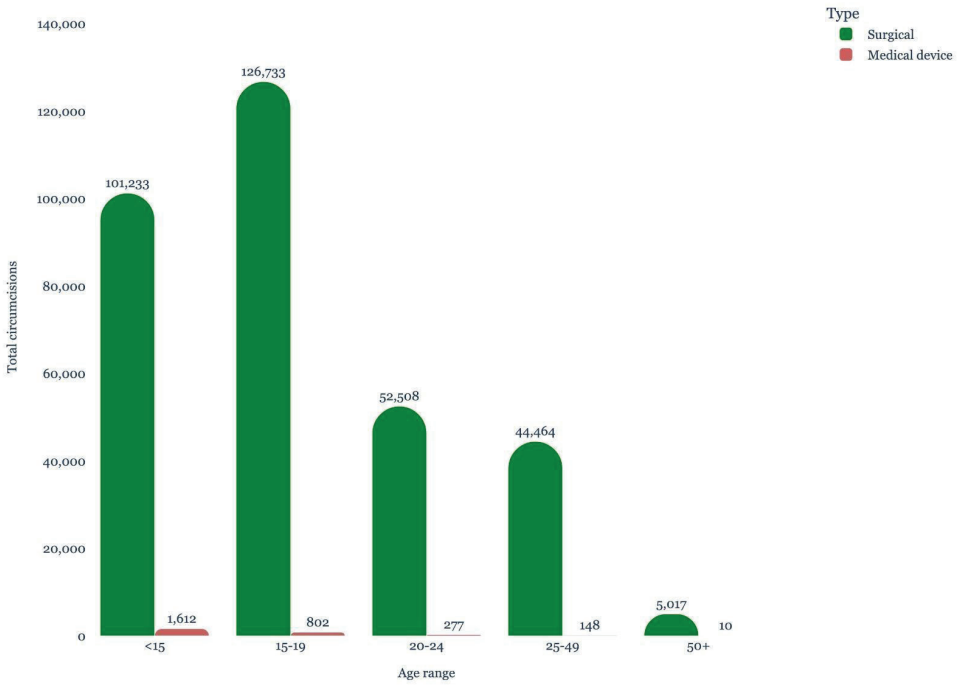

Figure 19: Number of VMMC performed by age group, July 24-June 25

2.6.3 Five-Year Performance Progress in VMMC

Over the past five fiscal years, the VMMC program has maintained strong performance, with surgical circumcision consistently accounting for the vast majority of procedures nationwide. While annual figures show minor fluctuations, overall service delivery has remained within a high and stable range. Device-based circumcision has contributed only a small fraction of the total, with past fluctuations largely attributable to the phase-out of the pre-Pex device.

In FY 2024–2025, the introduction of the Shang Ring device, complementing the Morgan Clamp, which is used exclusively for newborns aged 60 days and below contributed to the observed increase in device-based procedures during this reporting period. Although still in the early stages of scale-up, the Shang Ring offers an opportunity to diversify service delivery, expand client choice, and potentially increase uptake among eligible age groups.

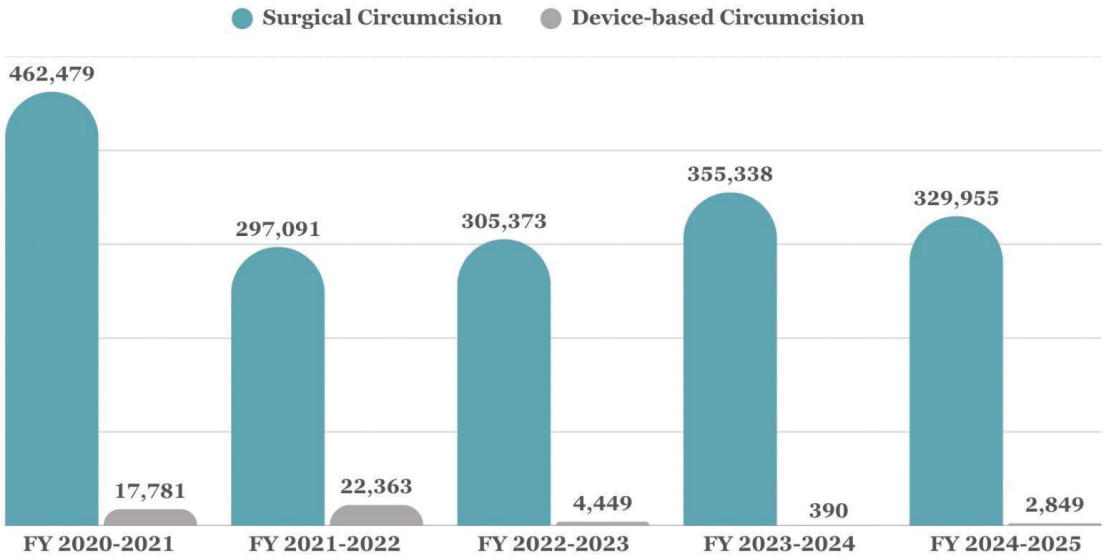

Figure 20: Trend of male circumcised for the last 5 years by surgical and device methods (HMIS)

Capacity building and mentorship in VMMC

During the reporting period, a total of 79 healthcare providers from various districts were trained on the use of the new Shang Ring device. In addition, 11 district hospitals received mentorship focused on quality improvement and the reporting of adverse events.

Lessons learned & challenges in VMMC program

- Service delivery innovations such as the Shang Ring method diversified options and attracted new clients, including older men.
- Integration with other health initiatives and community events boosted visibility and uptake.
- Challenges in Shang Ring rollout included limited trained providers and logistical constraints, slowing scale-up.
- Targeted mobilization with locally tailored messaging proved effective in high-demand provinces, particularly among adolescents and young adults.
- Low uptake among men aged 40+ persisted due to age-specific concerns, myths, and misconceptions.
- Workforce instability: high turnover of trained providers, lack of refresher training, and attrition in rural/high-demand areas, disrupted service delivery and created gaps.

2.6.4 Targets & Strategies in VMMC

Targets of Fiscal Year 2025-2026

The national VMMC program aims to circumcise 412,373 adolescent boys and adult men across all provinces. This target reflects the program's commitment to accelerating HIV prevention efforts, increasing coverage among priority age groups, and maintaining momentum toward national and global HIV epidemic control goals.

Strategies to Achieve the Target.

To achieve this target, the program will implement a multi-pronged approach that combines demand creation, service expansion, supply chain strengthening, capacity building, and data-driven decision-making. Demand creation will focus on intensified community mobilization and targeted outreach to high-yield age groups and underserved areas. For men above 40 years, the program will implement tailored strategies, including:

- Workplace and community-based awareness designed to reach men in formal and informal employment settings.
- Engagement of peer champions and community role models to normalize VMMC among older men.
- Focused health education sessions that address myths, misconceptions, and age-specific concerns related to circumcision and recovery.
- Integration of VMMC promotion into broader health check-up services commonly accessed by older men (e.g., NCD screenings).

Service delivery will be expanded by increasing the number of operational sites, extending service hours, and optimizing provider allocation to meet both seasonal and regional demand. Continuous availability of circumcision kits, devices, and related commodities will be ensured to prevent any service interruptions. Provider capacity will be enhanced through refresher training and targeted mentorship on both surgical and device-based methods, including scaling up the use of the Shang Ring device alongside existing techniques. Furthermore, real-time data collection, monitoring, and feedback systems will be strengthened to identify and address performance gaps promptly, ensuring high-quality service delivery in line with national standards

2.7 Condom programming

Condom programming remains a central pillar of Rwanda's HIV prevention strategy, contributing simultaneously to the reduction of STIs and unintended pregnancies. The program integrates reliable commodity supply with behavior change interventions, ensuring condoms are both accessible and consistently used. Distribution is strengthened through robust supply chain

management, expanded access points, including health facilities, retail outlets, and targeted community outreach, and demand creation efforts such as health education, social marketing, and peer-led initiatives. Priority is given to populations at higher risk, including sex workers, men who have sex with men, adolescent girls and young women, and mobile groups like truck drivers, with distribution strategically positioned at border posts, entertainment venues, and transport hubs. However, recent years have seen a decline in distribution volumes since FY 2020-2021, largely due to fluctuations in procurement funding, underscoring the need for sustained investment to preserve these gains.

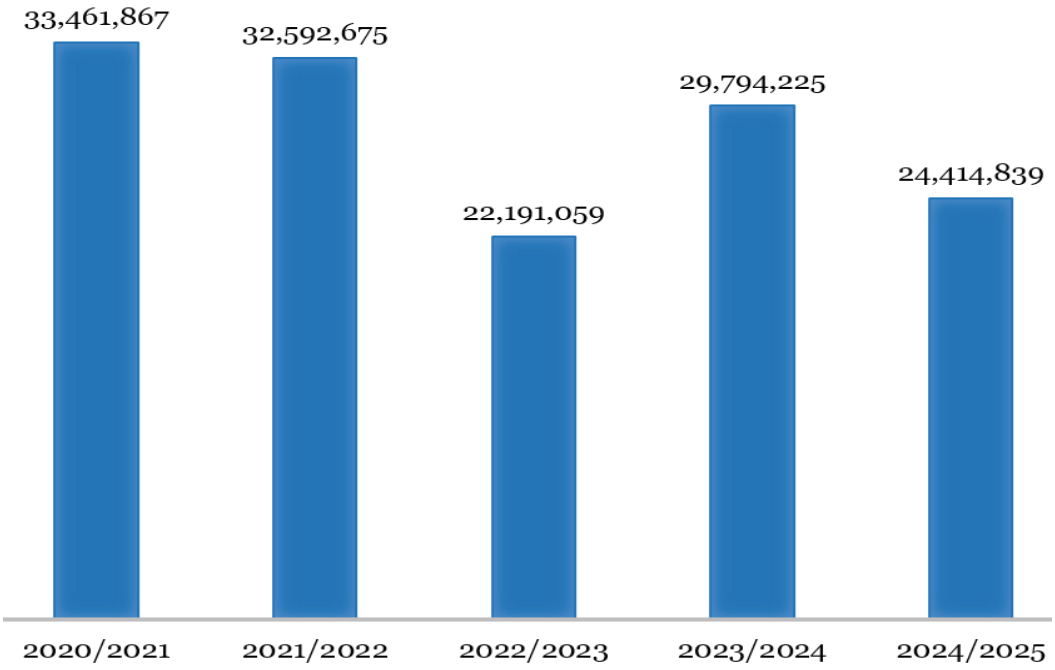

Figure 21: Trends in the number of condoms distributed over the past five years in Rwanda

From July 2024 to June 2025, a total of 24,414,839 condoms were distributed. Out of these, 17,145,962 were distributed through health facilities, 6,170,760 through condom kiosks and University campuses, and 1,098,117 through outreach activities.

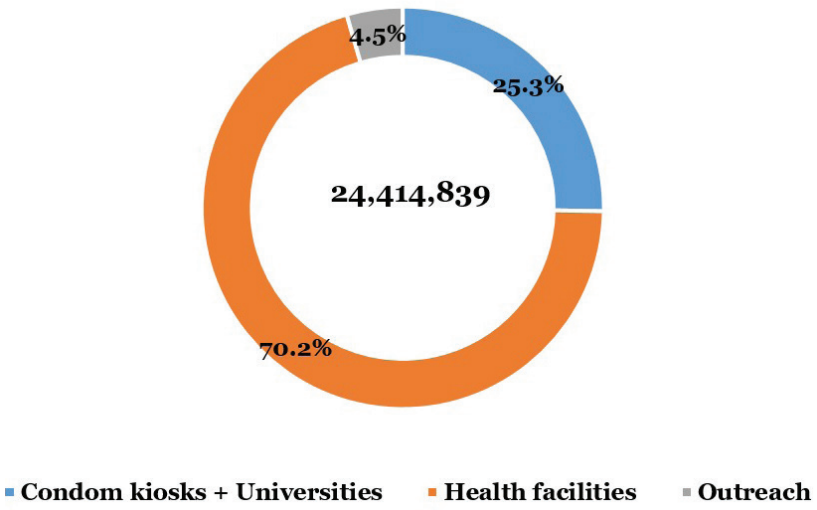

Figure 22: Condom distribution from July 2024 to June 2025

2.8 Key and priority populations

An effective HIV response requires prioritizing interventions for populations most affected by the epidemic. In Rwanda, key populations include female sex workers (FSW) and men who have sex with men (MSM), while priority populations include adolescent girls and young women (AGYW), adolescent boys and young men (ABYM), truck drivers, sero-discordant couples, and prisoners. These groups are supported with targeted prevention and treatment services such as HIV testing, PEP and PrEP, condom distribution and education, and access to care and treatment.

This section of the annual report highlights the services provided to key and priority populations, as well as progress made in FY 2024/2025 in line with the 2024-2027 National AIDS Strategic Plan to end AIDS by 2030. By strengthening community engagement and ensuring inclusive access to prevention and treatment, Rwanda continues to advance a comprehensive response that addresses the needs of those most at risk while reinforcing national commitments to epidemic control.

2.8.1 Key populations

2.8.1.1. Key Population Program Activities (July 2024 - June 2025)

From July 2024 to June 2025, several strategic interventions were implemented to ensure that key populations (KPs) in Rwanda continue to receive high-quality, KP-appropriate services. These services included access to HIV prevention information, pre- and post-exposure prophylaxis (PrEP and PEP), condom distribution, and sexually transmitted infection (STI) screening and treatment.

2.8.1.2. Capacity Building and supportive mentorship

To strengthen service delivery for key and priority populations, a total of 237 healthcare providers including HIV nurses, doctor mentors, nurse mentors, and data manager were trained on KP appropriate services, with a focus on delivering respectful, confidential, and non-discriminatory care to those at substantial risk of acquiring HIV. In addition, supportive mentorship was provided to 246 providers across 99 health facilities, offering on-site guidance to reinforce adherence to KP service delivery standards, improve quality of care, and address challenges encountered in daily practice.

2.8.1.3. Coordination and Experience Sharing:

Two biannual coordination and experience-sharing sessions were conducted with 46 Directors of Nursing and Midwifery from hospitals nationwide. These meetings provided a platform to:

- Discuss strategies to make health facilities more KP friendly, re-emphasize the critical

role of nursing leadership in ensuring the provision of high-quality HIV services, and

- Strengthen the accuracy and completeness of HIV data reporting through the Health Management Information System (HMIS).

2.8.1.4. Tools Revision and Standardization:

To improve efficiency and reduce the documentation burden for healthcare providers, existing KP and PrEP tools were revised. The revision resulted in the development of:

- A Key Population Register,
- A PrEP Register
- Standard Operating Procedures (SOPs) for PrEP services.

Previously, service delivery relied heavily on client files, where each KP client had an individual file. For sites with large KP cohorts, KP service provision required extensive time and effort to complete. The introduction of registers was therefore a significant improvement, as they allow providers to record client information in a streamlined manner, reducing time spent on documentation and enabling more time for direct service provision.

2.8.1.5. Key statistics on key populations in Rwanda

As of June 2025, about 39,406 key population members were following in health facilities in Rwanda with 35,995 (91.3%) of them being female sex workers. Program data shows that about 1 in 4 key population members is aged between 18 to 24 years. The data also shows that health facilities in Kigali city and Western province follow relatively higher numbers of sex workers, 11,275 and 9,515, respectively. However, relatively higher numbers of Men who have Sex Men are followed in Kigali city followed by health facilities in southern and eastern provinces. The below figure provides further details about distribution of key populations by age and province.

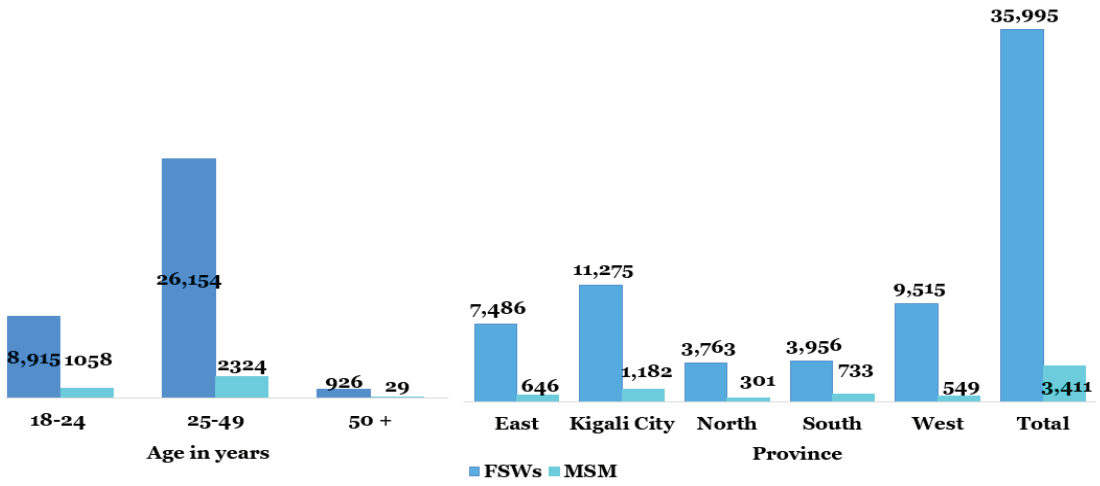

Figure 23: Distribution of key populations served in health facilities per Province and age distribution (HMIS data: June 2025)

2.8.1.6. Current HIV and STI burden among key population

Rwanda Biomedical Centre, in collaboration with its development partners conducts these surveys and alternates between surveys for Men who have Sex with Men (MSM) and Female Sex Workers (FSWs). The most recent is among FSWs and was conducted in April and May 2023, while the latest survey among MSM was in May and June 2024. The surveys revealed an HIV prevalence of 5.8% among MSM and 35.2% among female sex workers. Comparing the HIV prevalence rates from previous editions of the bio-behavioral surveys, there has been a gradual reduction in HIV prevalence among FSWs. Below figure provides further information on the HIV prevalence trends among MSM and FSWs in Rwanda.

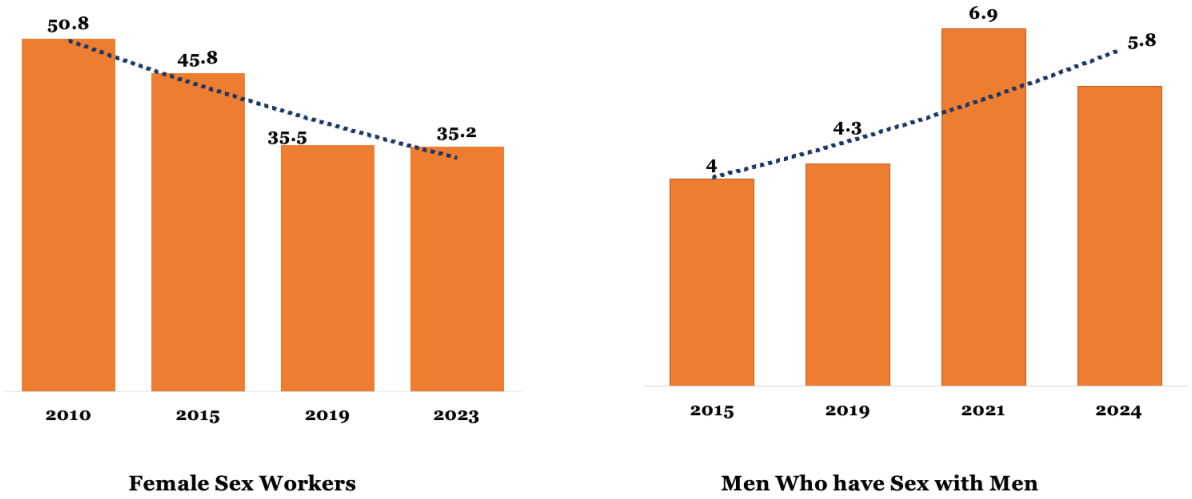

Figure 24: Trend of HIV prevalence among Female sex workers and MSM from 2010 to 2023 and from 2015 to 2024 respectively in Rwanda (BBS)

Key populations are disproportionately affected by HIV, as well as other sexually transmitted infections such as syphilis and viral hepatitis. Recent bio-behavioral surveys have reported varying prevalence rates of syphilis, Hepatitis B virus, and Hepatitis C Virus among MSM and FSWs. The prevalence of syphilis was found to be 25.5% among FSWs (BBS, 2023) and 5.8% among MSM (BBS2024). Additionally, the surveys revealed HBV and HCV prevalence rates of 0.5% and 2.1% among FSWs (BBS, 2023) and 1.5% and 1.65% among MSM (BBS, 2024), respectively. Overall, syphilis is the most prevalent sexually transmitted infection, particularly among female sex workers.

2.8.2 Pre-Exposure Prophylaxis

HIV Pre-Exposure Prophylaxis (PrEP) in Rwanda is available as oral pills and long-acting injectable cabotegravir (CAB-LA). Oral PrEP can reduce HIV risk by over 90% with consistent use, while CAB-LA, administered every two months, has shown even greater effectiveness due to better adherence. Since December 2024, clients have had access to both options, allowing more tailored and flexible HIV prevention strategies.

Since June 2021, the numbers of key populations on PrEP have been gradually increasing, with 8,772 in 2021, 10,372 in 2022, 10,789 in 2023, 12,187 in 2024, and 13,575 in 2025. While the number of Female Sex Workers on PrEP has been increasing from 8,550 in 2023 to 11,862 in 2025, the number declined among MSM from 2,239 in 2023 to 1,713 in 2025. These changes can be attributed to the frozen funding landscape of key population services, which halted services, especially those provided by community-based implementing partners.

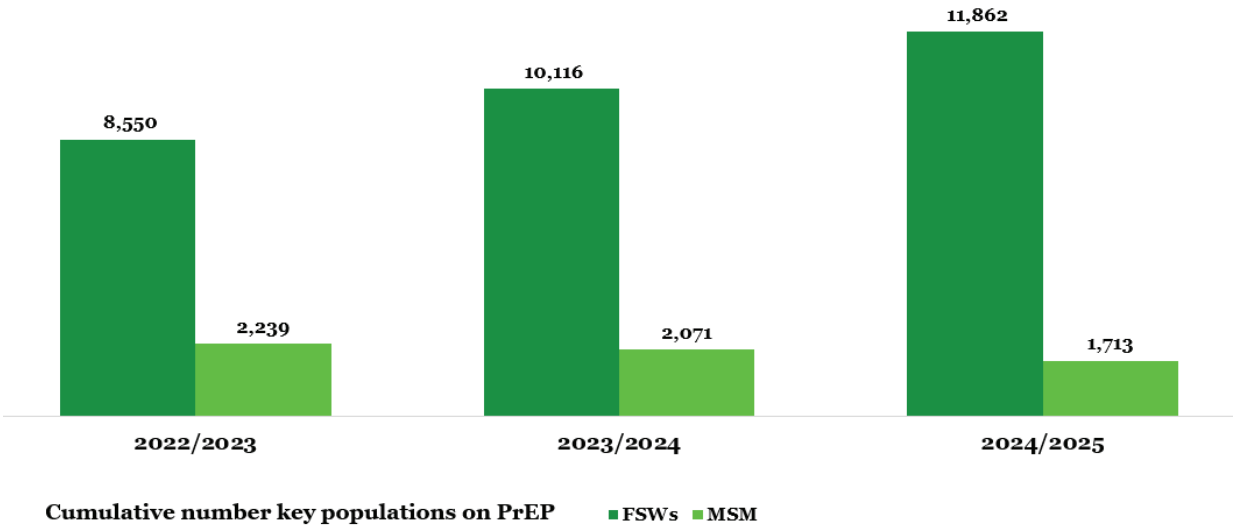

Figure 25: Total number of key populations enrolled on HIV Pre-Exposure prophylaxis, June 2023 to June 2025

2.8.2.1. Capacity Building of Health Care Providers on PrEP

Out of 595 health facilities (580 public and 15 private), 489 (82.2%) were trained to offer PrEP services. However, only 150 (30.7%) reported one or more clients followed in the PrEP program in June 2025. This is an indicator of low uptake of PrEP services among people at substantial risks. The low rates can be attributed to self-stigma, pill burden, and fear of taking daily oral pills. Injectable PrEP would be a better option for those with adherence issues.

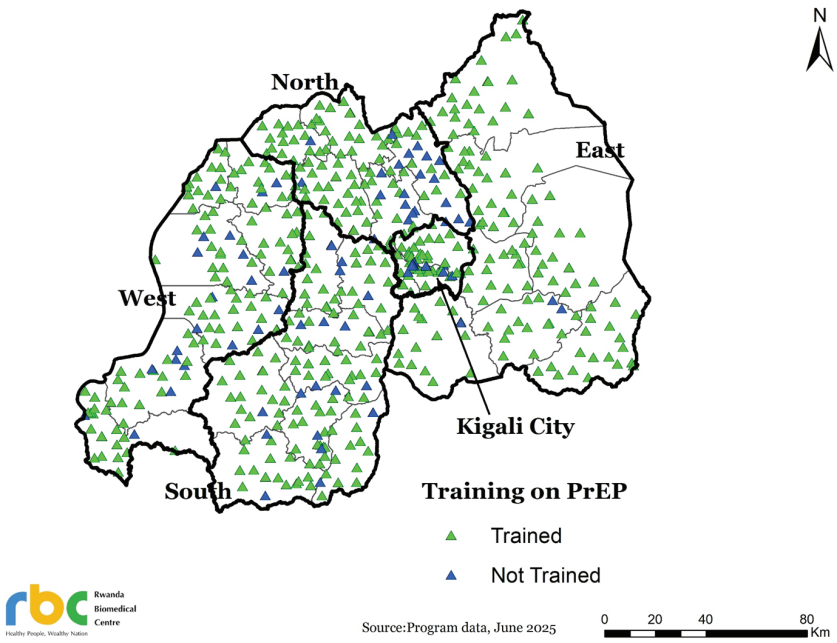

Figure 26: Health facilities trained on provision of HIV PrEp

2.8.2.2. Long Acting injectable cabotegravir pilot in Rwanda

Rwanda initiated the Long-Acting Injectable Cabotegravir (CAB LA) program in December 2024. The country received a donation of 8,775 CAB LA doses from PEPFAR in October 2024. From November 19-21, 2024, two pilot sites, Busanza and Gikondo Health Centers, were trained to offer CAB LA as an HIV PrEP option. The first injection took place on December 17, 2024, at Gikondo Health Center. As of June 30, 2025, 67 people at high risk of acquiring HIV were using CAB LA.

Since December 2024, CAB LA enrollments indicated a rapid increase in enrollment during the initial two months. However, issues arose related to the required commodities for enrollment, such as ALT and AST for liver function testing, causing a slowdown. The curve began to rise again in June 2025. Expanding the CAB LA rollout could potentially boost PrEP uptake, as more individuals may opt for the convenience of a two-month dosing schedule over daily PrEP dosing. Figure below provides further information on CAB LA new enrollments by month.

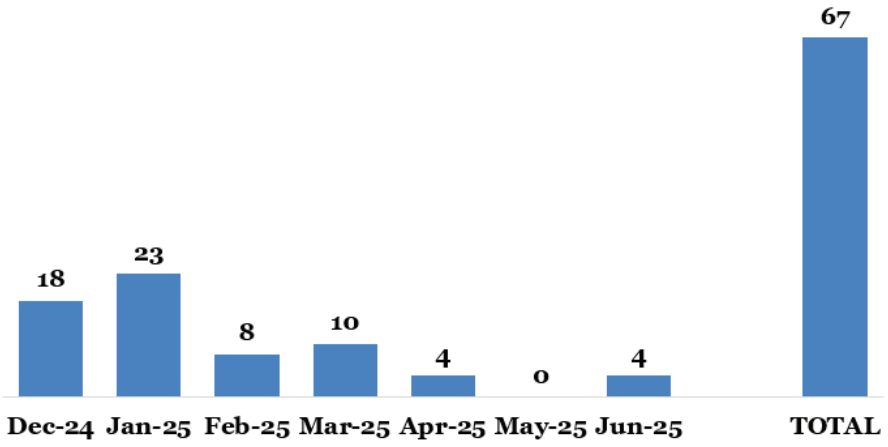

Figure 27: CAB LA New enrollments by month

Strategies for the upcoming FY 2025-2026

- Strengthen condom distribution by combining it with PrEP, focusing on high-risk groups and high-burden areas.
- Scale up new prevention methods, particularly long-acting injectable PrEP (CAB-LA) at high-volume sites.
- The program plans to initiate the phased introduction of LENACAPAVIR as part of the national HIV prevention portfolio, in alignment with emerging global recommendations and evidence on long-acting injectable PrEP options.
- Use digital tools (e-Buzima) to streamline services, cut duplicate testing, and expand key population-friendly care (esp. for FSWs & MSM).

2.8.3 Priority population

2.8.3.1. Adolescent Girls and Young Women

In 2024, 630,000 died from AIDS-related causes, mainly in sub-Saharan Africa, with over 210,000 adolescent girls and young women (AGYW) aged 15-24 acquiring HIV, about 570 daily (UNAIDS, 2024). In 2025, new guidelines are crucial as HIV prevention stalls, with 1.3 million new infections in 2024, disproportionately affecting key populations like sex workers, MSM, transgender individuals, drug users, prisoners, children, and youth. In Rwanda, according to the Rwanda Population-based HIV Impact Assessment (RPHIA, 2019), HIV prevalence was 0.4% and 0.6% among adolescents aged 15-19 years in men and women, respectively, while it was 3 times higher in females (1.8%) versus males (0.6%) aged between 20 and 24 years. This emphasizes the importance of focusing on AGYW as far as HIV prevention, SRH, and mental health are concerned, especially the prevention of further new HIV infections.

2.8.3.1.1. AGYW program strategic objectives and alignment with national HIV Strategic priorities.

- Establish a comprehensive mechanism to create an enabling environment for the successful implementation of friendly and high-quality differentiated services specifically tailored for AGYW, and their sexual partners.
- Enhance the knowledge, capacity, and skills of AGYW regarding their needs and rights through raising awareness.
- Improve access to quality-friendly health services for AGYW as defined by a minimum

package of services.

- Ensure health facilities and other implementing partners are providing friendly and high-quality services to AGYW.
- Reinforce social reintegration and referral systems for AGYW by strengthening community support structures.
- Strengthen evidence-based programming through the implementation of an effective and comprehensive monitoring and evaluation system, coupled with targeted research.

2.8.3.1.2. Target demographics, including vulnerability profiles

Globally, adolescent girls and young women (AGYW) aged 10–24 remain especially vulnerable, as they are more likely to drop out of school, marry early, and face poor health outcomes, with restrictive gender norms further limiting their access to health and social resources. Despite progress in HIV prevention, AGYW continue to encounter barriers to comprehensive HIV, sexual and reproductive health (SRH), and mental health services. In Rwanda, this vulnerability is further reflected in rising teenage pregnancy, which in FY2024–2025 increased to 8.7% among girls under 20 years and 2.2% among those under 18 years.

2.8.3.1.3. Partnerships and stakeholder engagement

Throughout the year, the AGYW program strengthened collaborations with multisector government ministries/institutions, non-governmental organizations, and community-based groups to enhance service delivery and reach. Government partners provided operation plan guidance, integration with national priorities, and technical support. NGOs contributed specialized expertise, resources, and innovative approaches, especially in identifying and linking AGYW to preventive services, as well as bridging the HIV comprehensive knowledge gap, while community groups ensured local ownership, cultural relevance, and direct mobilization of beneficiaries. These partnerships have created a coordinated network that amplified impact and promoted the sustainability of interventions for adolescent girls and young women.

2.8.3.1.4. Adolescent Girls and Young Women Program Reach and Coverage

The program equipped high-risk AGYW and ABYM with essential knowledge on safer sex, HIV testing, and treatment, while engaging male partners to share responsibility for prevention. By addressing socio-economic barriers to condoms and lubricants, we reduced AGYW's vulnerability and strengthened their ability to negotiate safer relationships. This year, the program's reach and impact grew stronger than ever, touching the lives of 209,759 adolescent girls and young women across 30 districts in Rwanda. Monitoring and evaluation data reveal a slight downward trend, especially on enrollment. The enrollment shifted with a decrease of 7.3% compared to last year, with community session attendance remaining consistently high, a testament to the trust and relevance the program has built.

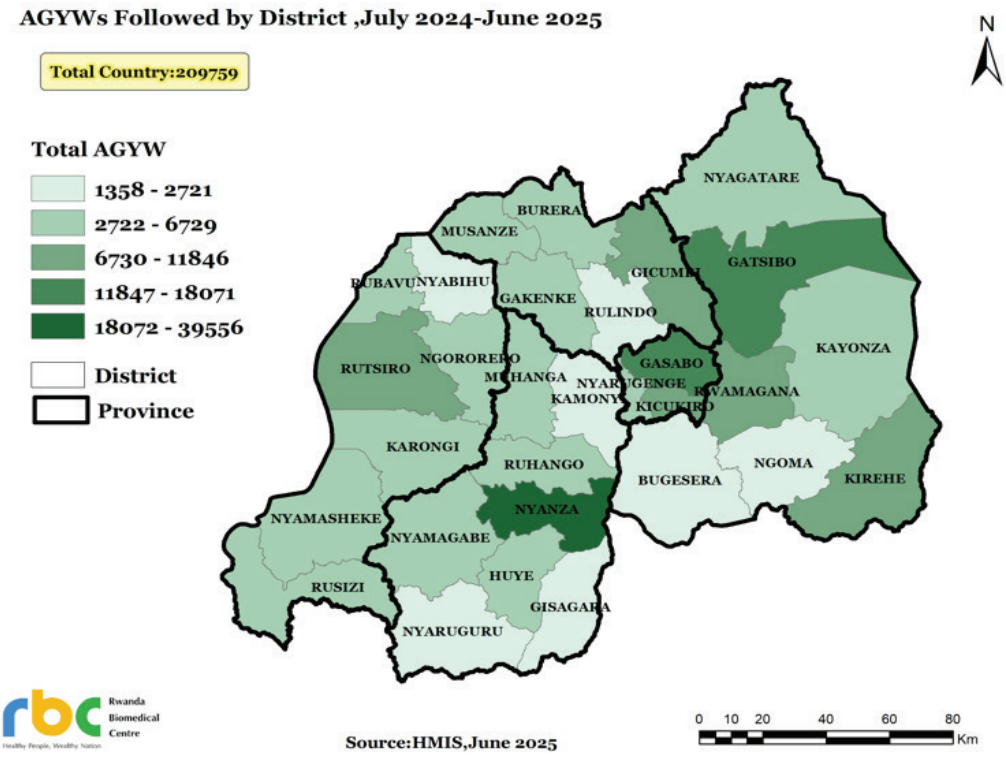

Figure 28: Total AGYWs followed in HFs by District from 2024-2025

Compared to previous years, the gains are evident; however, a quarterly cut of funding has slowed down the enrollment process from the community, especially in Kigali by a reduction of 31.4%and the Southern Province by 18.6%, hence hindering service uptake, participation in economic empowerment programs, and education retention. Overall, the year's data and stories combine to show a program that is not only growing in numbers but also deepening its impact, equipping AGYW with the knowledge, skills, and opportunities they need to thrive.

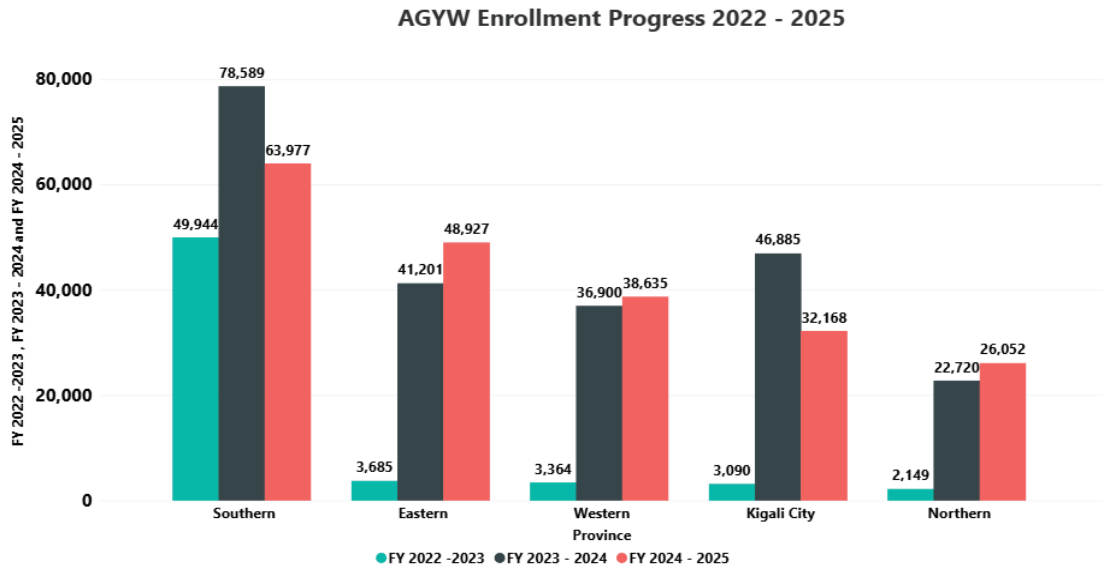

Figure 29: Trend of high-risk AGYW Enrolled at the health facility 2022-2025

Key Achievements

2.8.3.1.5. HIV prevention communication, information, and demand creation for male sexual partners for AGYW/comprehensive sexuality education for AGYW and ABYM,

In 2025, the program increased HIV prevention efforts by improving communication and demand generation for AGYW's male sexual partners, as well as extending comprehensive sexuality education for both AGYW and adolescent boys and young men (ABYM). These campaigns raised awareness, sharpened risk perception, and increased uptake of HIV prevention services among young people, resulting in better relationships and more informed decision-making.

Program performance data show both improvement and rising issues. AGYW enrollment peaked in the South 63,977 and East 48,927, with significant involvement also recorded in the West 38,635, Kigali City 32,168, and North 26,052. HIV testing closely tracked these enrollment patterns; nevertheless, positive results revealed spatial variations. The West 11.97%, East 11.55%, and Kigali City 11.97% had the highest yields, while the South had the lowest at 5.23%, while having the largest enrollment rates. These findings show that the program has a significant impact in high-priority population areas, while also emphasizing the need for more focused HIV prevention and treatment spending in provinces where the pandemic is still concentrated. Progress against key indicators reflects tangible change. HIV testing with linkage-to-care is improving. Educational retention remained strong, with most in-school AGYW staying enrolled. In economic empowerment, young women completed vocational training and transitioned into income-generating activities.

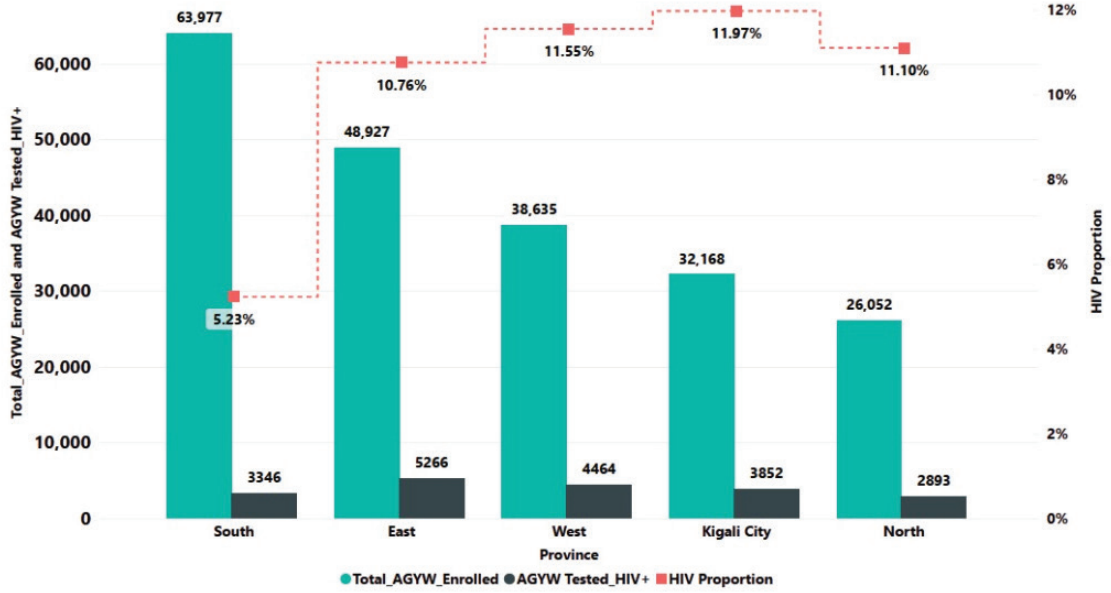

Figure 30: AGYWs enrolled in the program and proportion of HIV positive July 2022-June 2025

2.8.3.1.6. Pre-Exposure Prophylaxis Prep Programming for High-Risk AGYW

Rwanda National HIV Guidelines recommend PrEP as an additional prevention measure for key and priority populations. AGYW are at a disproportionately high risk of HIV infection due to factors like gender-based violence, limited decision-making power in sexual relationships, and lack of access to comprehensive sexual education. Pre-exposure prophylaxis (PrEP) is an effective prevention method.

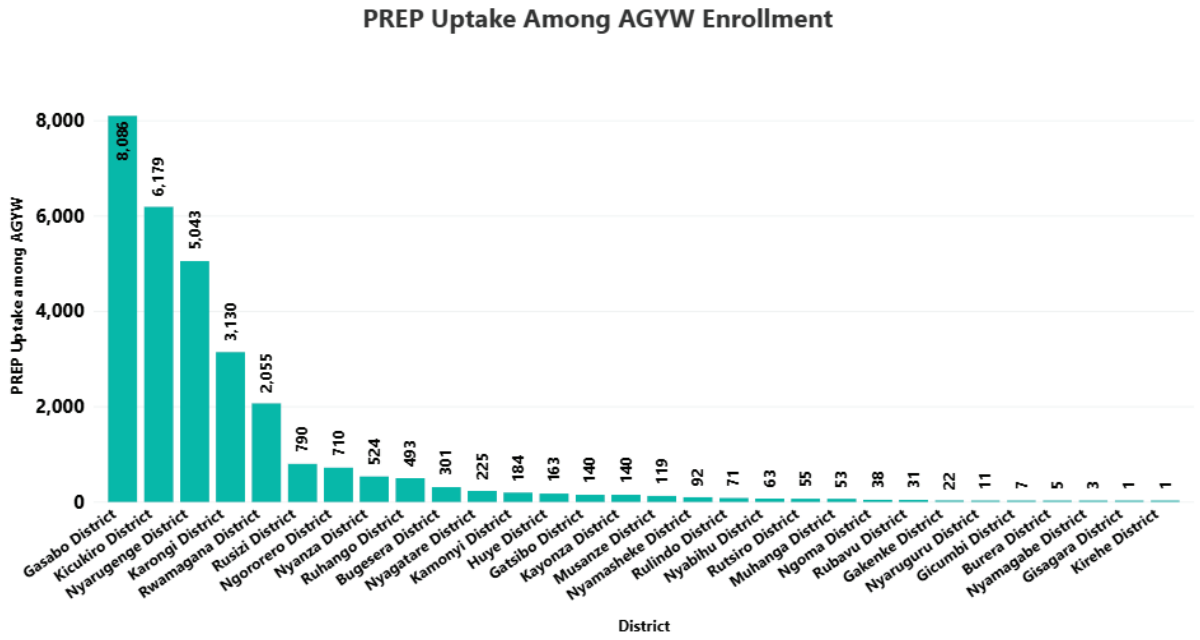

Figure 31: AGYWs enrolled on PrEp by District July 2022-June 2025

The pattern in PrEP uptake among AGYW between July 2024 and June 2025 demonstrates both the rapid expansion of services and the difficulties in maintaining demand over time. Following a slow start in July and August, uptake increased considerably in September to 3,810 initiations, the highest monthly performance due to increased demand generation and service availability. Uptake was continuously above 3,000 during November, indicating strong momentum. However, uptake began to decline progressively in December, stabilizing around 2,600-2,700 through March 2025 before decreasing further to a low of 1,957 in May. These findings illustrate the program's potential to immediately mobilize and reach AGYW at scale, as well as the relevance of ongoing communication, service accessibility, and follow-up assistance in maintaining high PrEP uptake levels. Moving forward, deliberate investments in distinctive demand development, ongoing engagement of male partners, and integration of PrEP services into broader SRH platforms will be crucial for maintaining momentum and addressing prevention coverage gaps.

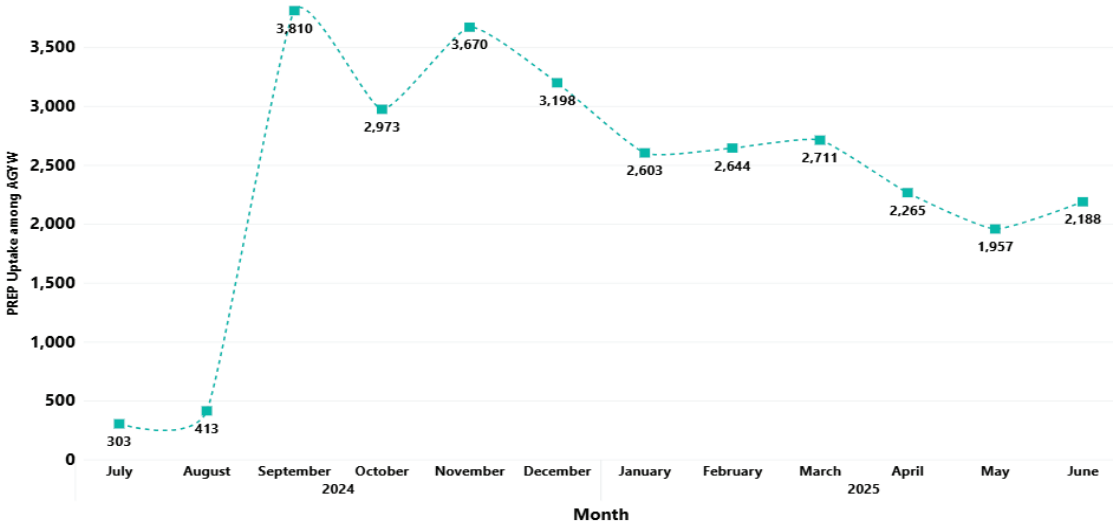

Figure 32: Trend of AGYWs enrolled on PrEp July 2024-June 2025

Table 1: Adolescent Girls and Young Women (AGYW) Challenges and Mitigation Strategies

Key Challenge	Impact	Mitigation Strategy	Progress
1. Funding Cuts to DREAMS/PEPFAR Program	Reduced community service reach and limited AGYW support.	Private sector engagement, and donor advocacy.	Core services We cut for dreams to 0%; partial funding was secured from partners and government-led multisector engagement.
2. Shortfall in 5-Year AGYW Operational Plan Funding	Slower program rollout and risk to sustainability.	Adopted phased implementation.	Phased rollout in 3 of 5 priority provinces.
2. Limited Nationwide Scalability	Proven models have not expanded nationally due to capacity and resource gaps.	Documented best practices, built local capacity via ToT, and integrated AGYW services into national systems at a multisector engagement.	13 master trainers certified; best practice briefs shared; AGYW indicators embedded in the national M&E framework.

2.8.3.1.7. Adolescent Girls and Young Women (AGYW) Program Capacity Strengthening and Sustainability

Over the past years, the program strengthened local capacity by equipping healthcare and local community staff, community leaders, and peer mentors with skills in mentorship, program management, and AGYW gender-responsive service delivery. These investments have laid the groundwork for lasting change, with HIV, SRH, PMTCT, and mental health programs and community leaders now actively championing AGYW rights and peer mentors sustaining safe spaces beyond direct program oversight. Sustainability efforts gained momentum through health policy integration. Looking ahead, the program aims to scale into underserved districts, enhance service quality through digital outreach, and tailor interventions for younger adolescents and hard-to-reach communities, ensuring the momentum built this year translates into deeper and broader prevention impact.

2.8.3.2. HIV sero-discordant couples

HIV sero-discordancy occurs when one partner is HIV-negative while the other is HIV-positive. The risk of HIV transmission is higher when the HIV-positive partner has a detectable viral load. However, the Undetectable = Untransmissible principle confirms that individuals with HIV who achieve viral suppression cannot transmit the virus to their partners.

In Rwanda, sero-discordant couples receive comprehensive services, including counseling, routine viral load monitoring, condom promotion, and options like pre-exposure prophylaxis (PrEP) for prevention. Condom use is strongly recommended even for those on PrEP. Moreover, only HIV-negative partners of non-virally suppressed HIV-positive partners are initiated on PrEP.

The number of sero-discordant couples in care rose to 24,684 in FY 2024–2025, with 23 seroconversions recorded, up from 14 the previous year.

2.9 Human Rights and Gender Equity

As an essential component of the HIV response, we are committed to advancing gender equality and human rights. We persisted in tackling structural barriers, stigma, and cultural norms that impede access to prevention and treatment in 2024–2025, particularly for key and priority populations. Gender-based violence, early marriage, economic dependency, and low educational attainment make AGYW especially susceptible. Addressing these disparities is not only morally required but also essential for lowering HIV transmission and promoting health equity in communities. At the same time, discrimination and rights violations among key populations and priority populations have decreased, improving access to necessary care and friendly service delivery.

Over the past year, we made notable progress. Expanded HIV testing and sexual and reproductive health services enabled more key and priority populations to access prevention and

treatment services. In contrast, peer-led outreach and inclusive service delivery fostered trust and increased participation among AGYW, MSM, and FSW. Our efforts in strengthening social protections, gender-based violence response, and community engagement have created safer environments for vulnerable groups. Moving forward, we aim to build on these achievements by scaling community-driven initiatives, improving rights-based data monitoring, and pushing policy reforms to dismantle structural barriers. Guided by the principle that health is a human right, the Division is committed to ensuring no one is left behind in the fight against HIV.

2.10 HIV awareness, targeting people at high risk of acquiring HIV infection.

2.10.1 HIV Awareness

Rwanda continues to position HIV awareness as a cornerstone of its prevention strategy, using large-scale communication campaigns to improve knowledge, reduce stigma, and encourage health-seeking behavior. In FY 2024–2025, these efforts leveraged mass media and high-profile events to promote testing, care adherence, and consistent engagement across urban, peri-urban, and rural communities.

Objectives

- Increase public awareness of HIV prevention methods, including condom use, PrEP uptake, and VMMC services.
- Promote regular HIV testing and early linkage to care for individuals who test positive.
- Mobilize communities to participate in HIV prevention and testing activities during high-profile events.
- Strengthen knowledge and motivation for adherence to antiretroviral therapy (ART) and retention in HIV care and treatment programs to improve health outcomes and reduce transmission risk.

Key Activities Implemented

2.10.1.1. Mass Media Campaigns

During the reporting period, the program implemented a comprehensive mass media strategy to expand the reach and impact of HIV prevention messaging nationwide. This included designing and disseminating targeted communication content through 8 national radio stations and 8 television channels, ensuring consistent coverage across both urban centers and remote rural communities.

The broadcasts featured a mix of informative talk shows, expert interviews, and community testimonials to address knowledge gaps, counter misinformation, and encourage uptake of HIV services. In addition, short, engaging video and audio spots were produced and aired at peak

listening and viewing times to reinforce critical messages. These spots promoted consistent condom use, highlighted the availability and benefits of pre-exposure prophylaxis (PrEP), emphasized the role of voluntary medical male circumcision (VMMC) in reducing HIV transmission risk, and underscored the importance of regular HIV testing and strict adherence to treatment for people living with HIV. By leveraging diverse media formats and strategically timing broadcasts, the campaign maximized audience engagement, ensured message consistency, and reached key population segments with tailored, evidence-based information to drive positive health behaviors.

2.10.1.2. World AIDS Day (WAD) Commemoration

On 1st December 2024, Rwanda commemorated World AIDS Day (WAD) under the theme *"End AIDS: My Responsibility"*, in a national-level event that brought together participants from government, civil society, healthcare institutions, and community-based organizations. The celebration was marked by a community *Umuganda* activity, during which trees were planted to symbolize growth, resilience, and the nation's long-term commitment to ending AIDS.

As part of efforts to engage and educate young people, the event also featured a live concert that combined entertainment with targeted HIV prevention messaging, aiming to increase awareness and encourage positive health-seeking behaviors among youth. To ensure nationwide reach, live radio and television broadcasts covered the proceedings, while coordinated community mobilization activities in districts hosting WAD-linked outreach amplified visibility and participation at the grassroots level.

3.Civil society organizations engagement

Background

During the 2024/25 fiscal year, Civil Society Organizations (CSOs) continued to fill critical service delivery gaps in Rwanda's HIV response, reaching key and priority populations in line with national priorities. Under the coordination of the Rwanda NGOs Forum on HIV/AIDS and Health Promotion, multiple CSOs (SFR, IMRO, HDI, , AHC, FXB, and WE ACT) implemented targeted interventions including Social Behavior Change Communication (SBC); Linkages; Capacity Building; IEC Materials; Condoms and Lubricants distribution; Lost to Follow up; stigma and discrimination at community level, advocacy and routine monitoring across 18 districts (Nyabihu, Gakenke, Musanze, Kirehe, Bugesera, Kayonza, Nyagatare, Ngoma, Gatsibo, Rubavu, Burera, Nyanza, Karongi, Gicumbi, Rutsiro, Nyamasheke, Rusizi, and Rwamagana) for key populations such as female sex workers and men who have sex with men, while others (Dream Village, Caritas Rwanda, Assoferwa, Imbuto Foundation, Bamporeze, and AEE) focused on adolescent girls and young women (AGYW) in 18 districts (Rwamagana, Kayonza, Kamonyi, Huye, Nyanza, Gisagara, Gicumbi, Ngororero, Burera, Nyagatare, Rubavu, Bugesera, Ngoma, Kirehe, Gatsibo, Musanze, Rulindo, and Ruhango). The Rwanda Network of People Living with HIV (RRP+) also played a nationwide role, supporting PLHIV across 547 health facilities with prevention, treatment adherence, stigma reduction, and youth engagement through peer-led and community-based approaches.

Beyond direct service provision, CSOs strengthened national response by addressing complementary issues. Profemmes Twese Hamwe led initiatives against sexual and gender-based violence (SGBV), while AIDS Healthcare Foundation (AHF) ensured consistent condom availability through CSOs, kiosks, and health facilities. They also promoted routine screening of vulnerable groups using risk-based tools, linked beneficiaries to specialized services like ISANGE One Stop Centres, and delivered community outreach through education sessions, referrals, and awareness campaigns. Strategic communication efforts, including radio programs and digital platforms, further extended their impact on prevention and support.

Despite national progress in reducing HIV prevalence, expanding ART, and achieving high viral load suppression, key and priority populations continue to face barriers in accessing prevention and treatment services. CSOs remain indispensable in bridging these gaps through inclusive, community-led interventions that complement government efforts. Their active engagement under the Rwanda HIV National Strategic Plan (2018-2024) has helped sustain the country's gains, while laying a foundation for reaching the 2030 global targets by ensuring no group is left behind.

3.1 Community Support for PLHIV - Peer Education

In this reporting period, Rwanda Network of People Living with HIV (RRP+) mobilized 4,724 peer educators (PEs) to support 166,522 recipients of care across 547 facilities. Clients were served through differentiated delivery 60% on six-month refills, 28% on three months, and 12% on monthly schedules. Peer groups were mainly adults (92%), with youth (6%) and female sex workers (2%). During the year, PEs conducted 44,183 education sessions, 199,003 home visits, and 26,534 referrals, while awareness campaigns reached about 750,000 people. Their psychosocial support helped 1,199 individuals return to care, boosting treatment continuity. Through education on adherence, viral suppression, TB prevention, family planning, stigma reduction, and mental health, PEs reinforced their vital role in sustaining Rwanda's HIV response.

3.2 Youth Engagement in HIV Response - Youth Ambassadors

In 2024-2025, Strategic Brand Ambassador Initiative (SBAI), led by RRP+, empowered youth as advocates for HIV prevention and stigma reduction. Youth ambassadors reached over 39,000 peers through school campaigns, sports events, and safe-space dialogues in five districts, while 18 YouTube sessions drew 41,000+ views and sustained online engagement. They promoted key HIV priorities testing, condom use, PrEP/PEP, viral suppression, TB co-infection, U=U, mental health, and support for sero-discordant couples. Through leadership, peer outreach, and media platforms, ambassadors became role models, inspiring informed health-seeking behaviors and inclusivity among young people.

3.3 Support for Children, Adolescents, and Young People Living with HIV

Dream Village supported 3,216 children, adolescents, and young people living with HIV across 12 health centers in Kigali. Viral load monitoring showed 2,711 suppressed, 231 unsuppressed, and 274 invalid results. Community Adolescent Treatment Supporters (CATS) engaged 2,364 participants in group activities, made 591 home visits, 181 referrals, and used 7,932 calls plus 2,125 texts to boost adherence, successfully tracing 72 clients back into care. In January 2024, 339 young people graduated after aging out of the program. Complementing this, an RRP+ pilot in four health centers tested new peer education modules on life skills, which improved mental health, strengthened confidentiality, and promoted youth-friendly services. Together, these interventions underscored the importance of structured, peer-led, youth-centered approaches for sustaining retention in HIV care.

3.4 Inclusive HIV Response for Persons with Disabilities

The Umbrella of Organizations of Persons with Disabilities in the Fight against HIV/AIDS & for Health Promotion (UPHLS) strengthened disability-inclusive HIV programming across 14 districts, reaching over 45,000 people with disabilities and hard-to-reach groups through tailored awareness. To build inclusive service delivery, UPHLS trained 250 peer educators, 180 youth representatives, 150 healthcare providers, and 60 disability focal points. Accessibility was expanded with 310 assistive devices and 15,000 IEC materials adapted into Braille, large print, and sign language. Psychosocial support was provided to 420 parents of children with disabilities living with HIV, while community outreach engaged more than 120,000 people. Renovation of eight health facilities further improved accessibility, reduced stigma, and enhanced provider capacity to serve persons with disabilities.

3.5 Faith-Based HIV Prevention and Advocacy

Rwanda Interfaith Council on Health (RICH) advanced HIV prevention and stigma reduction using a faith-based approach, reaching over 2 million people with HIV and reproductive health messages through faith-based media, religious leaders, religious youth movements and family structures. RICH trained 200 family commission heads to promote family-based approach for a sustainable HIV response by strengthening parent-child communication and integration of SRH and HIV education into pre- and post-marital counselling. RICH also trained 350 religious leaders on HIV prevention and community-led monitoring, while also providing supportive supervision in 15 districts, which enabled them to advance HIV response by reducing stigma, promoting adherence and retention on ART, raise community awareness, and strengthen accountability in the HIV response. In Mahama Refugee Camp, RICH in partnership with other stakeholders engaged 10,000 community members, tested 3,200 individuals for HIV, and reached 1,500 refugees with disabilities through targeted messages. These interventions promoted open dialogue, integrated prevention into faith teachings, and strengthened community ownership of the HIV response.

3.6 Comprehensive HIV Prevention and Care

The national HIV program in collaboration with AIDS Healthcare Foundation (AHF) expanded HIV prevention and treatment services across 11 districts, reaching over 45,000 people living with HIV (PLHIV) who are now receiving care and treatment. Viral load testing coverage reached 95.3%, with a 98.8% viral load suppression rate. AHF distributed 3.67 million condoms nationwide and tested 312,556 individuals for HIV, identifying 3,124 HIV-positive cases, of which 99% were successfully linked to care. Additionally, 58,796 men underwent voluntary medical male circumcision. Through the Back in Care (BIC) initiative, AHF successfully traced 3,348 clients who had dropped out of care, and 617 of them were re-initiated on antiretroviral therapy (ART). To reduce financial barriers, AHF financed health insurance for 67,904 people including PLHIV

and their family members and strengthened the capacity of health facilities by supporting 170 healthcare staff across the country. Comprehensive services also included cervical cancer screening for 2,650 women living with HIV, of whom 949 tested positives for HPV. A dedicated wellness clinic provided treatment for 469 women with reproductive tract infections, reinforcing AHF's commitment to holistic care for women and youth.

3.7 Community-Led Monitoring

With UNAIDS Rwanda support, community-led monitoring (CLM) was introduced in Kicukiro, Gasabo, Nyarugenge, and Rwamagana, bringing together RBC and a coalition of civil-society and other implementing partners, under the principle that service users should shape and assess service quality. Two pilots ran in parallel: RRP+ led CLM in 8 health facilities and 2 DREAMS safe spaces across three districts, namely Rwamagana (Nyagasambu HC), Gasabo (AVEGA HC, Remera HC, Gihogwe HC, Ndera HC, and DREAMS Safe Spaces at Groupe Scolaire Kagugu Catholique and Agateko Cell), and Kicukiro (Bethsaida HC, Gatenga HC, and Gikondo HC). While RNGOF implemented it in 10 facilities across Kicukiro and Nyarugenge. Both streams shared the goal of amplifying community voices and using evidence to drive improvements in HIV services.

3.7.1 CLM in Kigali City and Rwamagana District

In 2024, RRP+ and RNGOF rolled out community-led monitoring (CLM) across 20 health facilities and DREAMS safe spaces in Kigali districts, training more than 100 community monitors and master trainers, including PLHIV, youth, key populations, and persons with disabilities. Equipped with skills in ethics, data collection, and advocacy, monitors captured the experiences of diverse groups AGYW, FSWs, MSM, transgender people, and people with disabilities through over 1,200 interviews.

RNGOF on HIV/AIDS & HP used the iCLM Information System for community data management which allowed community monitors to use digital devices during data collection. This saved time for data entry while using paper based; data accuracy; data analysis and access to real time information and response.

By strengthening feedback loops and prioritizing client voices, CLM generated immediate fixes, like improved patient flow and communication, while also fueling advocacy for systemic changes in staffing, infrastructure, and commodity supply. The lesson was clear: when communities evaluate services, practical solutions emerge, and progress is accelerated toward closing the last mile of Rwanda's HIV response.

3.7.2 Integrated community-led monitoring (iCLM) for HIV, TB and Malaria

In 2024/25, with Global Fund support and in collaboration with Rwanda Ministry of Health, RBC, the Rwanda NGOs Forum on HIV/AIDS and Health Promotion and Tecjnical Funding Agencies, CSOs and Communities developed and validated the iCLM Model for HIV, TB and Malaria together with the iCLM Information System for community data management. The validated Model and Information System were piloted in 12 Health Facilities and to the points of service delivery at the community level in Rwamagana, Bugesera, and Gasabo districts. The model, developed through consultations and a stakeholder's national workshop, assessed the availability, accessibility, acceptability, and quality (AAAQ) of services at both facility and community levels. Twelve health facilities participated in the pilot, include Nyamata, Mayange, Gashora, and Ruhuha in Bugesera; Nzige, Mwurire, Rwamagana, and AVEGA in Rwamagana; and Kinyinya, Kagugu, Gikomero, and Gihogwe in Gasabo. A new digital iCLM system and mobile app replaced paper-based tools, allowing real-time feedback and stronger accountability.

Community monitors (265) were selected from PLHIV, key populations (MSM, FSWs), people with disabilities, and faith groups were trained by Master Trainers of iCLM for HIV, TB and Malaria and deployed alongside Health facility focal points, with oversight from district iCLM task teams. This approach ensured inclusive participation, systematic data collection, and continuous supervision, reinforcing community ownership and strengthening accountability in Rwanda's HIV, TB, and malaria response.

Key Achievements in the Pilot of iCLM Model and information system in 2024 -2025

- **Validation & Launch:**
    - Developed and validated the iCLM model, tools, and information system in both English and Kinyarwanda.
    - Introduced and piloted the model in **six districts** (Gasabo, Bugesera, Rwamagana, Gisagara, Rulindo, Rubavu) with strong collaboration between MoH, RBC, CSOs, district leaders, and communities.
- **Capacity Building & Staffing:**
    - Recruited staff to support pilot and implementation (2024–2026).
    - Trained **25 Master Trainers**, **265 community monitors**, and **12 health facility focal points** on iCLM, data collection, advocacy, and joint work planning.
- **Community Engagement & Governance:**
    - Formed **district task teams** including leaders, CSOs, and community reps to follow

up on issues identified by iCLM and advocate for improved HIV, TB, and malaria services.

  - Established the **iCLM Web Platform** for knowledge sharing and learning.

- **Partnership & Scale-up:**

  - Ensured strong multi-stakeholder collaboration and endorsed a **scale-up plan** for July 2025–June 2026 in two additional districts.

Key Challenges

- Funding gaps, limiting implementation and advocacy.
- Limited community capacity in health technology and lack of devices for data collection.
- Poor internet access in remote areas, affecting real-time monitoring and reporting.

4.CARE AND TREATMENT

4.1 Background

In 2024-2025, Rwanda's HIV care and treatment program continues to prioritize comprehensive, people-centered services that address the diverse needs of people living with HIV (PLHIV). While early initiation of antiretroviral therapy (ART) remains a cornerstone in reducing HIV-related morbidity and mortality, improving quality of life, and preventing further transmission, including mother-to-child transmission, the program's focus has expanded to strengthen adolescent-friendly services as a critical component of epidemic control.

A major milestone in this period has been the development and validation of the ATLAS (Adolescent, Test, Link, Adhere and Suppress) model - All Adolescents living with HIV: Test for HIV, Link to care and treatment, adhere to optimized ART, Suppress their viral load. This model is designed to ensure that adolescents receive tailored, holistic support from diagnosis through sustained viral suppression. Following provider training, ATLAS is now being piloted to refine its implementation and maximize its impact.

Building on achievements toward the UNAIDS 95-95-95 targets, the program also continues to enhance differentiated service delivery (DSD) for varied population groups, introduce pediatric Abacavir Lamivudine Dolutegravir (pALD) as the preferred fixed-dose combination for children, integrate mental health and psychosocial support, and strengthen the capacity of healthcare providers to manage advanced HIV disease. Additional priorities include integrating non-communicable disease (NCD) services into HIV care, implementing quality improvement initiatives, and sustaining clinical mentorships to ensure that all PLHIV receive comprehensive, high-quality care aligned with national and global strategies to end AIDS as a public health threat.

4.2 Objectives and goals of HIV care and treatment

HIV care and treatment aim to reduce HIV-related illness and death through comprehensive, people-centered services for all people living with HIV (PLHIV). Beyond consistent access to antiretroviral therapy (ART) for viral suppression, holistic care addresses physical, mental, and social well-being. This includes routine clinical monitoring, prevention and management of opportunistic infections, psychosocial support, nutritional counseling, sexual and reproductive health services, and efforts to combat stigma and discrimination. By integrating these services, HIV care improves adherence, enhances quality of life, and promotes long-term health outcomes.

Objectives:

- Achieve universal ART coverage across all age groups with retention above 95%.
- Maintain viral load suppression above 95% among all PLHIV on ART.
- Strengthen provider capacity to ensure high-quality, consistent service delivery nationwide.
- Empower and support communities affected by HIV to ensure equal opportunities for all.

Goals:

- Ensure timely linkage and retention in care for newly diagnosed individuals through full implementation of the "Treat All" policy and improved coordination between testing and treatment services.
- Optimize ART coverage and retention using safe, well-tolerated regimens, including long-acting ART, and by strengthening pediatric centers of excellence.
- Enhance psychosocial well-being and patient-centered care by providing comprehensive support, addressing inequities in access, and promoting community-led monitoring.
- Integrate non-communicable disease (NCD) and mental health services into HIV care through routine screening, management, and follow-up.
- Incorporate nutritional support into HIV services through regular assessments, counseling, and targeted rehabilitation.
- Improve socioeconomic well-being and protect the human rights of PLHIV by expanding support to the most vulnerable, reducing stigma and discrimination, and promoting inclusion.

4.3 Key achievement in 2024-2025

Building on Rwanda's HIV care and treatment objectives and goals, significant progress was achieved in sustaining universal ART access, maintaining viral suppression, expanding adolescent-friendly services, and integrating broader health interventions into HIV care. In this reporting year, the following milestones were results of a strong, coordinated effort that strengthened a comprehensive, people-centered response:

- ART coverage remained at 96.9%, with retention at 94% after one year of initiation.
- Viral load suppression (<200 copies/mL) was sustained above 95%.
- Pediatric Abacavir Lamivudine Dolutegravir (pALD) was rolled out as the preferred

regimen for children to improve treatment outcome among children living with HIV currently 29 districts are trained with one remaining and will be trained in the 2025/2026 fiscal year.

- The ATLAS adolescent model was finalized, validated, and piloted in 30 health facilities to provide tailored, adolescent-friendly services that strengthen linkage to care, support adherence, and improve viral suppression outcomes.
- Differentiated service delivery was expanded, with most (90%) clients receiving 3-6 months refills.
- Capacity building was strengthened through training and mentorship, with clinical mentorship sustained across all hospitals and further complemented by e-learning and tele-mentorship.

Key Challenges and Gaps in HIV Care and Treatment

- ART coverage among children and young adolescents (0-14 years) remains substantially lower at 75%, well below the 95% target.
- Persistent loss to follow-up is observed among adolescents and young adults (15-24 years), as well as among men aged 25-49 years.
- Timely viral load (VL) testing monitoring is at 88%, which remains suboptimal.
- The viral load suppression (VLS <200 copies/mL) rate among children, adolescents, and young adults under 25 years continues to lag behind the ≥95% benchmark.
- Youth-friendly services are being strengthened but still require significant scale-up to reach full national coverage.
- Occasional stock-outs of HIV commodities (including test kits and pediatric formulations) persist, disrupting service continuity and patient management.

Key Strategies

To address the identified gaps in the HIV care and treatment program, the national response will prioritize a set of targeted strategies aimed at improving ART coverage, retention, viral load monitoring, and overall quality of services. These strategies place particular emphasis on children, adolescents, and young adults, groups that continue to experience disparities in treatment outcomes, while also strengthening systems to ensure continuity of services for all clients.

- Strengthen family testing approaches and expand active case-finding efforts to

promptly link newly identified children (0-14 years) to care and initiate them on ART.

- Enhance retention support for newly initiated clients, particularly among high-risk (lost to follow-up) subgroups, through tailored interventions and dedicated assessments to better understand and address reasons for loss to follow-up.
- Scale up youth-friendly services within the ATLAS model to further engage young people, improve adherence, and ensure durable viral suppression.
- Optimize viral load (VL) testing coverage and cascade in general by strengthening systematic follow-up mechanisms for clients who miss VL tests and invalid samples which affect the number of VL test received versus to the number of VL tests done.
- Improve viral load suppression (VLS) among children and adolescents through optimized pediatric ART regimens, strengthened adherence counseling, psychosocial support, and family-centered approaches.
- Build capacity of health facility staff in stock management and reporting practices to prevent commodity interruptions and ensure timely responses to supply challenges.
- Strengthen supply chain systems by pursuing joint procurement with partner countries to overcome minimum order barriers, improve cost efficiency, and minimize pediatric ARV and test kit stock-outs.

4.4 ART Coverage among PLHIV

Rwanda has made remarkable progress in the HIV response and is among the countries that have successfully achieved the global 95-95-95 targets. These milestones demonstrate that 95% of PLHIV know their status, 95% of those diagnosed are receiving ART, and 95% of those on treatment are virally suppressed. Several approaches have been instrumental in reaching these goals, including the "Treat All" policy, which mandated immediate ART initiation for all individuals testing HIV positive regardless of CD4 count. Innovative models such as differentiated service delivery and multi-month dispensing have improved adherence and reduced the burden of frequent clinic visits. In addition, the LIFT-UP initiative was designed and implemented during this reporting period to strengthen the first and second 95s by actively identifying children and adolescents at risk of HIV infection. However, its roll-out has so far been limited to nine districts, and the final report is still pending.

During this reporting period, the number of PLHIV receiving ART increased from 222,604 in June 2024 to 229,275 in June 2025, across 597 health facilities providing HIV-related services, maintaining overall ART coverage at 96.9% (UNAIDS Spectrum estimates, denominator 236,538). This achievement reflects client dynamics, with 11,162 individuals newly initiated on ART and 1,987 retraced after being lost to follow-up. At the same time, the program recorded 3,258 individuals newly lost to follow-up and 1,683 deaths, highlighting ongoing programmatic

challenges in sustaining treatment continuity.

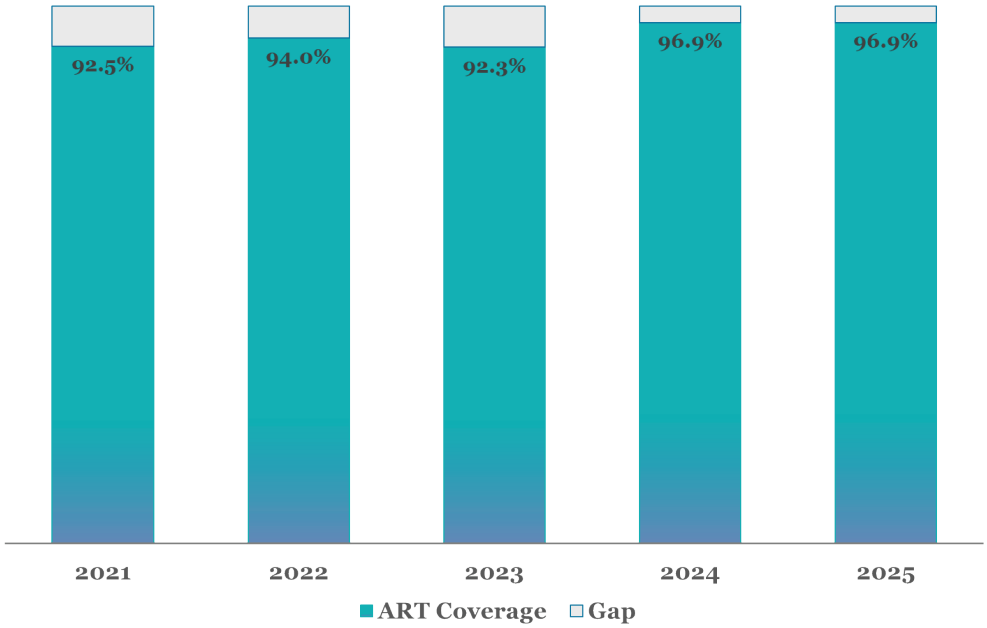

Figure 33: Trend of ART Coverage from 2021 to June 2025 (Source: RHMIS & Spectrum 2025)

Despite these advances, ART coverage among children and young adolescents (0–14 years) remains significantly lower at 75% (4,334/5,773), with 72% (2,094/2,907) among males and 78% (2,240/2,866) among females. This persistent gap is largely driven by undiagnosed children born to mothers living with HIV who are not identified through community or facility-based testing.

To close this gap, Rwanda will need to further strengthen family testing approaches and expand active inventory efforts, such as those piloted under LIFT-UP, to all districts. These strategies will be essential to ensure that undiagnosed children and adolescents are identified, promptly linked to care, and initiated on ART, thereby securing equitable progress toward sustaining the 95-95-95 achievements across all age groups.

The figure 34 below illustrates trends in ART coverage among children aged 0-14 years. As shown, coverage for children living with HIV steadily increased from 60% in July 2021 to 75% by June 2025, remaining below the target.

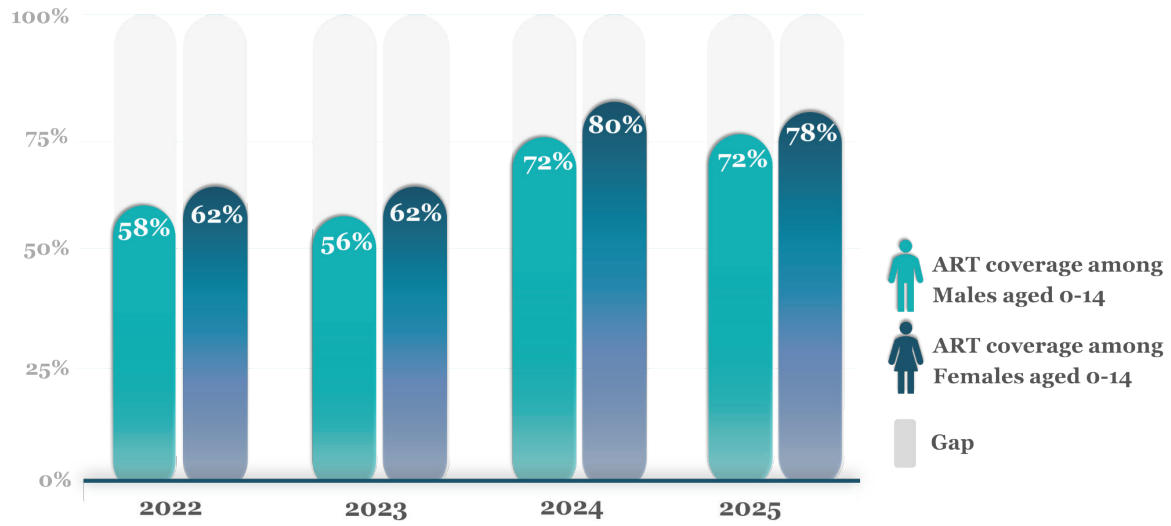

Figure 34: Trends of ART Coverage among Children aged 0-14 years from 2022 to 2025 (Source: RHMIS & Spectrum estimates)

Figure 35 presents the distribution of PLHIV on ART by sex and age category. The largest share is observed among adults aged 25–49 years, while a significant proportion, 35.4%, are aged 50 years and above, highlighting the aging profile of PLHIV in Rwanda. This trend underscores the importance of strengthening non-communicable disease (NCD) screening and management as an integral part of HIV service delivery to ensure comprehensive care for this growing population group.

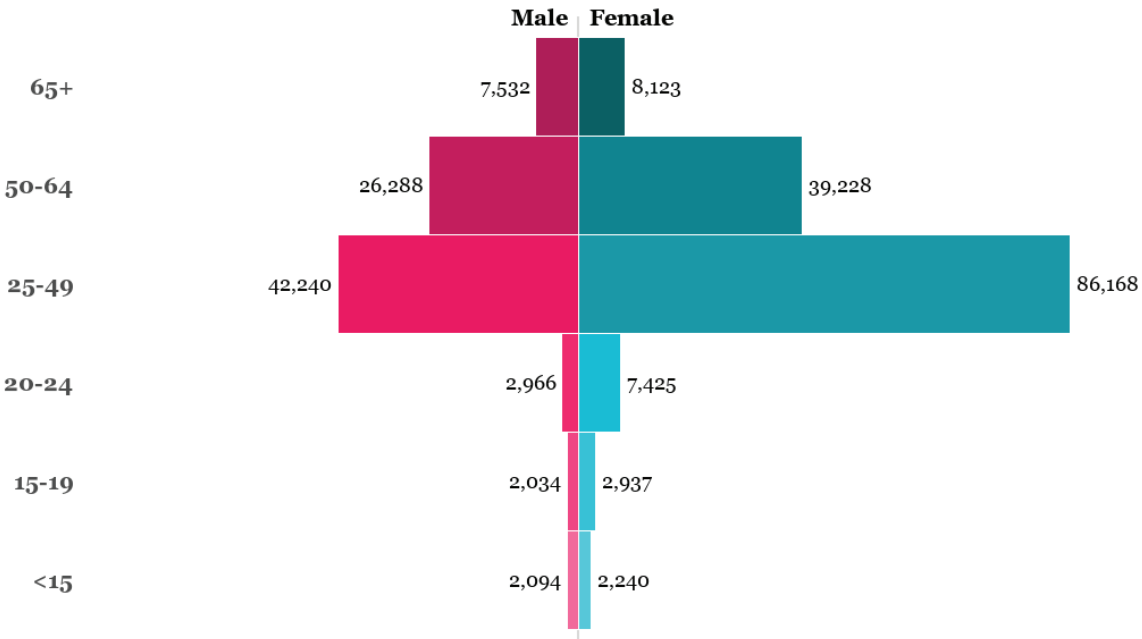

Figure 35: ART distribution by age category and gender at the end of June 2025 (RHMIS 2025)

Figure 36 shows the distribution of 11,162 individuals newly initiated on ART across Rwanda between July 2024 and June 2025, serving as a proxy for new HIV infections. The highest numbers were observed in Gasabo, Nyagatare, Kayonza, and Bugesera districts. However, this number is significantly higher than the national HIV incidence estimate of about 3,200 new infections per year, suggesting that reported ART initiations may include duplications, where people already on ART are retested and re-initiated as new cases.

This programmatic gap underscores the need for corrective strategies. In the short term, enhancing pre- and post-test counseling and strengthening screening at HIV testing points will help ensure that individuals already on ART are not misclassified as new cases. In the longer term, the implementation of an electronic system with a unique identifier linked to the national ID will be critical to prevent duplication, improve patient tracking, and ensure accurate reporting of new infections.

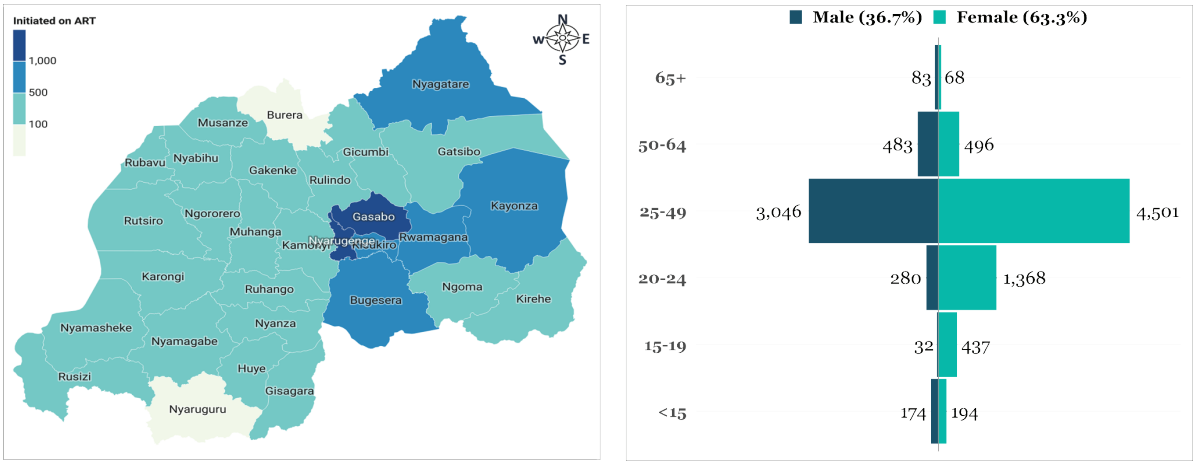

Figure 36: Geographic distribution of new ART initiations by district (left) and age-sex distribution of newly initiated individuals (right), July 2024-June 2025 (Source: RHMIS)

4.5 Linkage and Retention in Care and Treatment

Timely and effective linkage to treatment services, and sustained engagement of clients throughout the ART journey significantly increases viral suppression rates, reduces HIV-related morbidity and mortality, and improves the overall cost-effectiveness of HIV programs. Beyond individual benefits, the "Treat All" strategy also contributes to epidemic control by preventing onward transmission through rapid ART initiation and viral suppression. This part presents retention individual data of cohorts of 7,521 people initiated on ART between July 2023 and June 2024, and tracks their outcome after one year of ART initiation.

Key programmatic measures include same-day ART initiation, intensive counseling at enrollment, active tracing of clients lost to follow-up, and structured re-engagement mechanisms. During

this reporting period, the program achieved an overall retention rate of 94%, with 4% of clients lost to follow-up and 2% recorded as HIV-related mortality. These results demonstrate Rwanda's strong performance in sustaining engagement in HIV care and treatment.

The key gap observed is a higher proportion of loss to follow-up among adolescents and young adults aged 15-24 years, and among men aged 25-49 years (figure 37), alongside limited knowledge of the underlying drivers of disengagement. Addressing these challenges will require enhanced retention support for newly initiated clients, particularly in high-risk subgroups, and dedicated assessments to better understand the reasons for loss to follow-up.

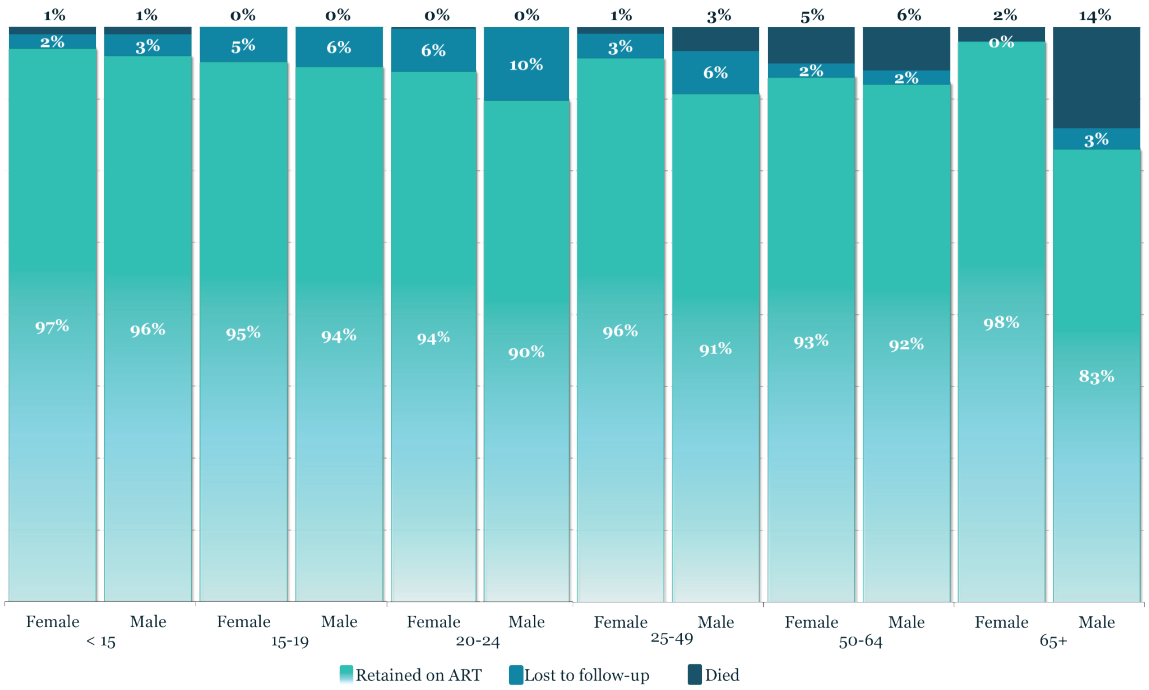

Figure 37: Retention after one year of treatment by age and sex, June 2025 (RHMIS)

4.6 Differentiated Service Delivery (DSD)

Differentiated Service Delivery (DSD) is a client-centered approach that adapts HIV services to the specific needs and circumstances of people living with HIV (PLHIV). In Rwanda, DSD is structured around four models: facility-based individual models, facility-based group models, community-based individual models, and community-based group models. These models are categorized into more-intensive approaches, where clients receive monthly refills and frequent follow-up, and less-intensive approaches, where clients who are established on ART may receive refills every three or six months depending on clinical and programmatic criteria. This approach ensures that those who need closer monitoring receive it, while those who are established on treatment benefit from reduced visits and longer refill intervals.

As a best practice, the 2022 national HIV treatment guidelines expanded eligibility for less-intensive models, allowing more clients established on ART to transition to multi-month dispensing. To facilitate implementation, during this reporting period, extensive training and

mentorships were conducted with healthcare providers, strengthening their capacity to deliver DSD consistently across health facilities.

By June 2025, notable progress had been achieved in scaling up less-intensive models (figure 38): 65% of clients established on ART were accessing six-month multi-month dispensing (6-MMD), while 25% were on three-month dispensing (3-MMD). Only 10% remained in one-month dispensing (1-MD), reserved for newly initiated on ART and individuals at higher risk of treatment interruption who require closer clinical and psychosocial follow-up.

However, community-based DSD models are not functioning uniformly across health facilities. The absence of a well-defined, standardized package for community models has led to variability in implementation and challenges in ensuring their effectiveness. To address this, the program will need to establish clear community-based service packages to promote harmonized implementation and guarantee both efficacy and sustainability.

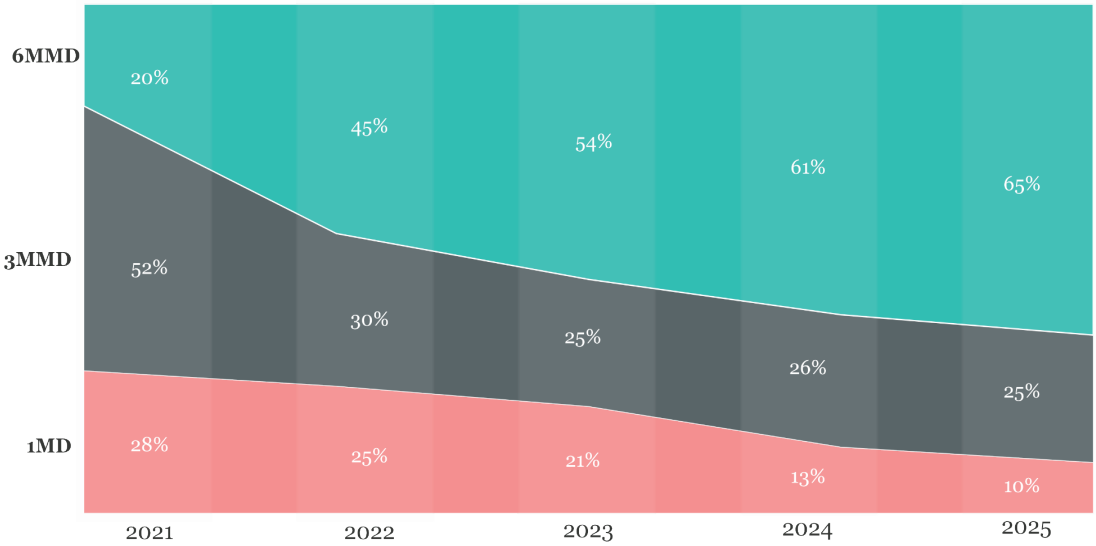

Figure 38: Trends in the scale-up of DSD model categories from 2021 to 2025 (source: RHMIS)

4.7 Viral Load Testing and Monitoring

Viral load (VL) testing is the cornerstone of ART monitoring, as it is the most reliable predictor of treatment success and long-term viral suppression. The World Health Organization (WHO) defines viral load suppression (VLS) as fewer than 1,000 copies/mL, whereas Rwanda uses a lower threshold of fewer than 200 copies/mL.

During this reporting period, the VL testing cascade showed that 88% of eligible clients received a viral load test. Among those with results, 96% achieved VLS using the <200 copies/mL threshold (Figure 41). Within this group, 87.3% had undetectable VL, while 97.6% had <1,000 copies/mL. Since 2022, VLS (<200) has improved steadily, increasing from 93% to 96% by June 2025 (Figure 43). This progress has been enabled by Rwanda's strong laboratory network,

improved sample transport systems, integration of viral load testing into routine care, and robust adherence support. It has also been strengthened through collaboration with different partners to enhance community support groups and peer education, which play a critical role in improving treatment literacy, adherence, and overall engagement in care.

Nevertheless, two major gaps remain. First, while 88% VL testing coverage is relatively high, it still falls short of the ≥95% target. The other one is the VLS (<200) rate among children, adolescents, and young adults under 25 years which remains below 95% (Figure 39), reflecting ongoing vulnerabilities in these groups. Furthermore, when considering viral suppression as a proportion of all clients eligible for VL testing, overall population-level suppression appears lower than suggested by the cascade, underlining the need to further improve VL coverage to ensure that all eligible clients benefit from viral load monitoring and subsequent clinical action. Improved VL coverage will require enhanced VL monitoring systems that allow facilities to track all clients due for VL testing and strengthen appointment management, an area the program aims to support through targeted capacity building. To address low VLS among children, adolescents, and young adults under 25 years, Rwanda is rolling out optimized pediatric ART regimens such as the combined ABC+3TC+DTG (pALD), now available nationwide, alongside continuous mentorship, both in person and via telementor ship, for appropriate prescribing and clinical support. At the same time, youth-friendly services within ATLAS models are being scaled up to better engage young people, improve adherence, and ensure durable viral suppression.

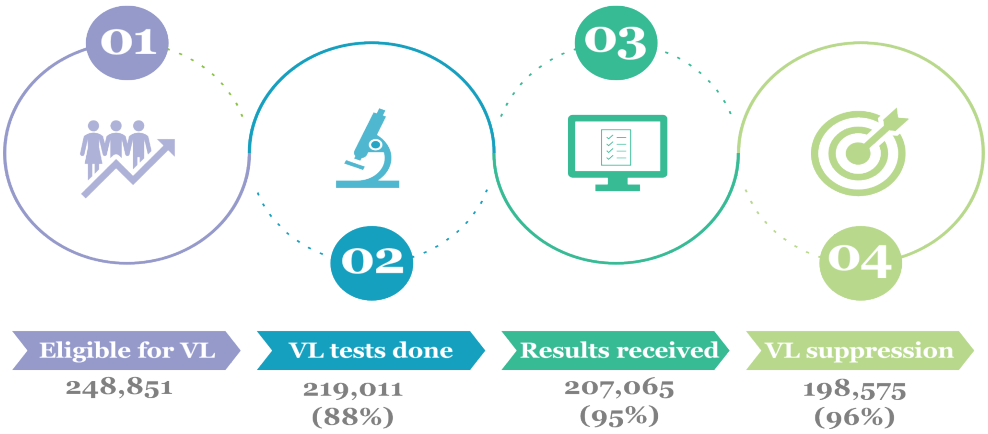

Figure 39: Viral load testing cascade from July 2024 to June 2025 (Source: RHMIS, VLSMS & LIS)

Viral load suppression (VLS <200 copies/mL) remains below 95% among children, adolescents, and young adults under 25 years, highlighting persistent gaps in these age groups. In contrast, VLS among adults aged 25 years and above is consistently at or above 95%, as illustrated in the following figure.

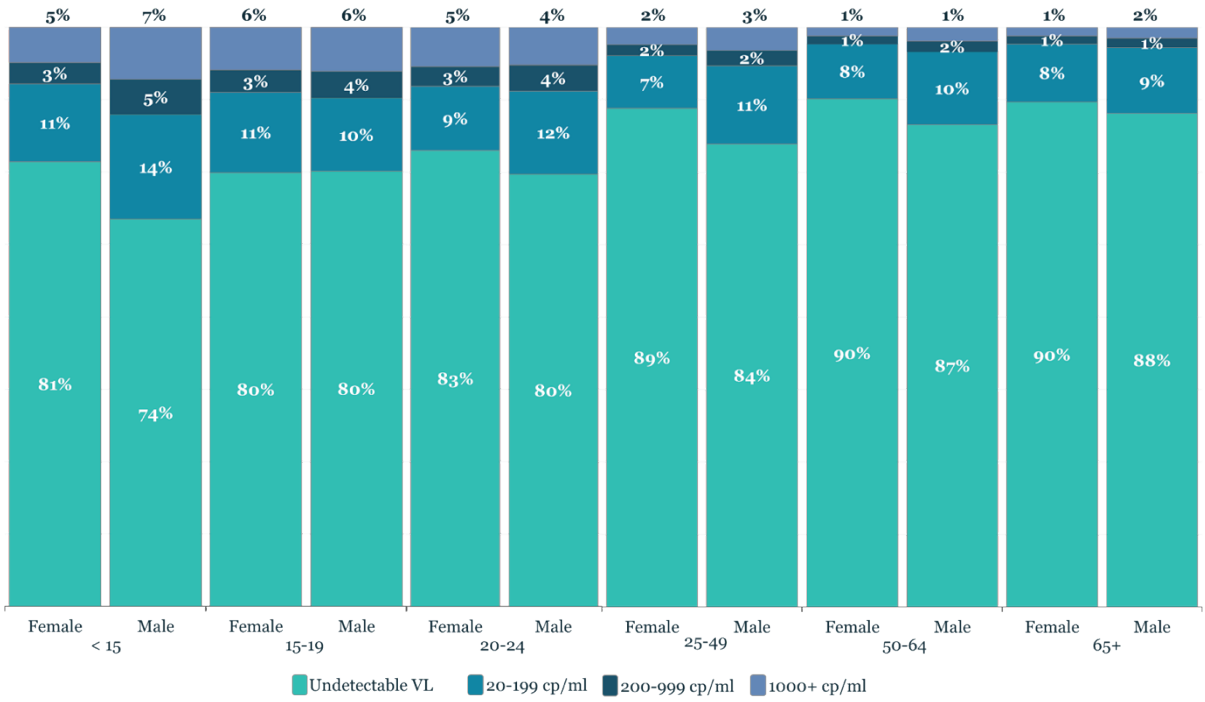

Figure 40: Viral load suppression among PLHIV on ART by sex and age June 2025 (source: VLSMS & LIS)

The figure below illustrates trends in VLS (<200 copies/mL) in Rwanda between 2022 and 2025. The data show a steady improvement from 93% in 2022 to 96% in 2024, which was then sustained in 2025.

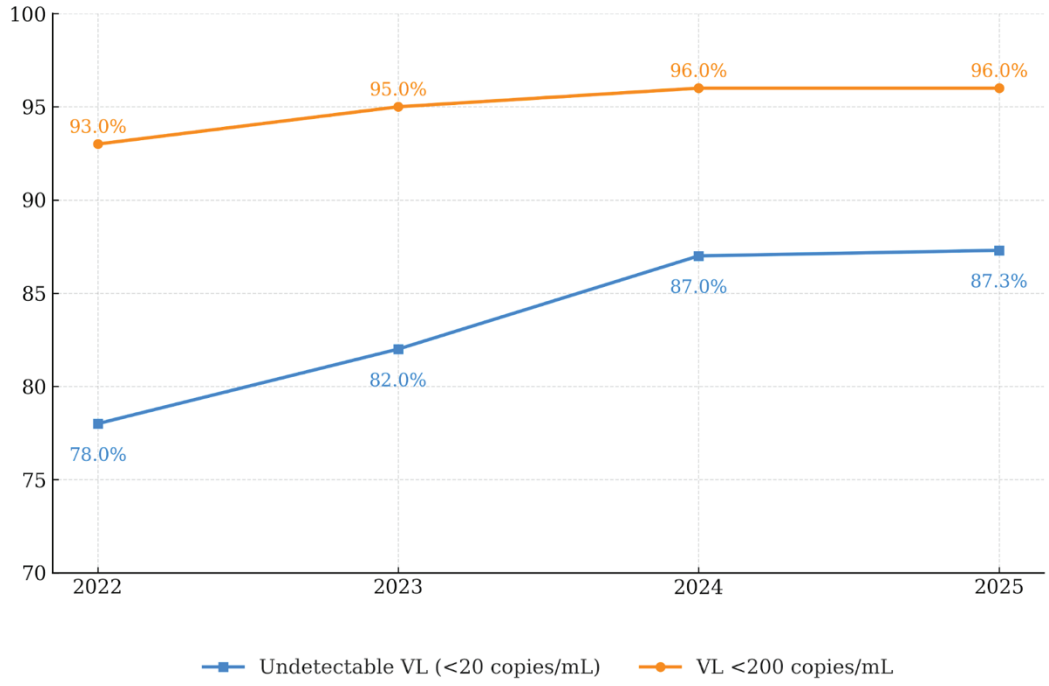

Figure 41: Trends of viral load suppression in Rwanda, 2022 - 2025

4.8 Youth-friendly services in HIV care and treatment

Recognizing the unique needs of adolescents and young people, the HIV program has prioritized the strengthening of youth-friendly services to enhance treatment outcomes and improve retention in care. Adolescents often face challenges related to stigma, disclosure, adherence, and transitioning into adult services, making tailored approaches essential for achieving national and global HIV targets.

During the reporting period, significant progress was made in this area. The adolescent model of care was finalized and approved by the Technical Working Group (TWG) and institutional leadership, marking an important milestone in formalizing adolescent-specific HIV services. In collaboration with stakeholders and partners, a series of capacity-building initiatives were conducted, including training of healthcare providers (HCPs) and peer leaders to strengthen skills in delivering youth-centered HIV care.

To translate this model into practice, piloting was initiated in 30 health facilities, providing an opportunity to test feasibility, acceptability, and effectiveness in real program settings. Looking ahead, a comprehensive assessment is planned for the coming year to generate evidence on outcomes and lessons learned, which will guide the scale-up of the adolescent model nationwide. This phased approach is expected to ensure that adolescent-friendly services are institutionalized, sustainable, and responsive to the needs of young people living with HIV.

4.9 Integration of other services into HIV-differentiated ART models

4.9.1 TB-HIV management

People living with HIV face a substantially elevated risk of developing active tuberculosis (TB), approximately 19 times higher than individuals without HIV, making TB one of the leading causes of morbidity and mortality within this population. Recognizing this, Rwanda has prioritized the integration of TB and HIV services as a cornerstone of its national HIV response. In line with the 2021 global political declaration on AIDS, which called for at least 90% of PLHIV to receive TB preventive therapy (TPT) and an 80% reduction in TB-related deaths among PLHIV, the country has strengthened HIV service delivery to incorporate systematic TB prevention and care. All health facilities that provide HIV services are equipped with the necessary skills and resources to systematically screen for TB at initiation and at every clinic visit, while ensuring access to TPT.

By the end of the reporting year, 98.3% (225,372/229,275) of PLHIV on ART had been initiated on TPT, reflecting substantial progress toward both global and national targets. However, based on HMIS data, TPT coverage among newly initiated individuals on ART was relatively low at 62.2%, largely because this indicator was newly introduced into the reporting system. To address this, the program conducted verification through chart reviews (patient registers

and files), which showed an improved coverage of 80.0% (8,928/11,162) between July 2024 and June 2025. As this indicator is still new in the reporting system, significant improvement is anticipated in the coming period through targeted mentorship.

During the same period, 1,097 TB cases were reported among PLHIV, representing 13% of all TB cases nationally. This marks a reduction from 18% in 2021, underscoring the impact of strengthened TB/HIV integration. Males accounted for 66% of all reported cases, and most cases occurred among PLHIV already on ART (745 cases) compared to those newly initiated on ART (352 cases), emphasizing the importance of continued vigilance in routine screening, prompt diagnosis, and timely treatment to mitigate TB-related morbidity among PLHIV.

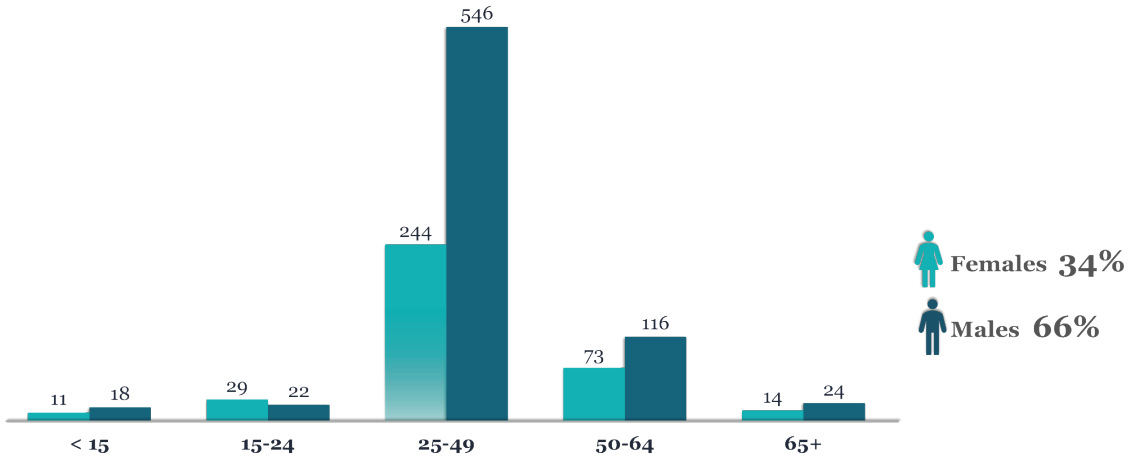

Figure 42: Distribution of TB Cases Among PLHIV by Sex and Age, July 2024 - June 2025

Geographic distribution of TB cases among PLHIV shows marked variation across provinces (Figure 45). The highest burden was observed in health facilities located in Kigali (39%), followed by the Eastern Province (23%), while the Northern Province accounted for only 7% of cases, representing the lowest burden nationally.

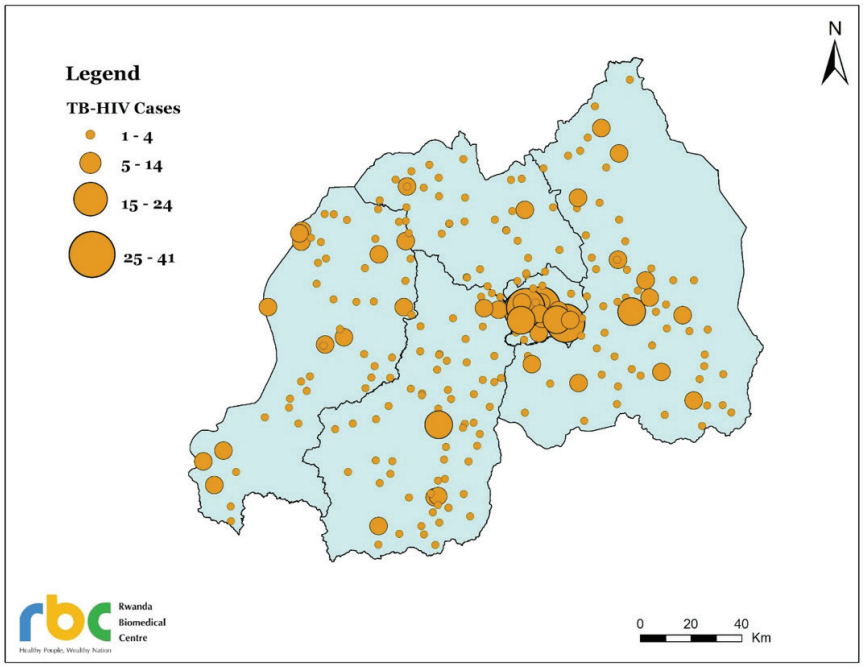

Figure 43: Distribution of TB Cases Among PLHIV by Health facilities, 2024 -2025

4.9.2 Mental health

Incorporating mental health services into HIV care has been an important advancement in supporting the overall well-being of people living with HIV. This approach recognizes that HIV, mental health, and social factors are closely connected, and that addressing them together can lead to better health outcomes for PLHIV.

During this year, we conducted Clinical mentorship to build and strengthen the capacity of healthcare providers to deliver comprehensive, patient-centered services that address both physical and psychological needs. Through this mentorship, providers were equipped with practical skills to screen for common mental health conditions among people living with HIV, enhancing providers' ability to offer appropriate management within HIV care settings and to make timely referrals for specialized mental health support when necessary.

Furthermore, in collaboration with stakeholders, one paper on "Prevalence of Mental Health Disorders and Their Associated Risk Factors Among People Living with HIV in Rwanda" was published, and another study on "Assessment of Depression and Anxiety Disorders Among Adolescents and Young People Living with HIV in Urban Areas of Rwanda and Continuity of HIV Services in Rehabilitation Centers," presented in IAS 2025. The findings from both studies will enhance the development of targeted interventions to address the mental health needs of PLHIV effectively.

Despite the progress made, several challenges persist; stigma and discrimination surrounding both HIV and mental illness continue to discourage disclosure and limit help-seeking behaviors. Staff turnover among healthcare providers trained in mental health screening remains high, particularly in rural areas, undermining continuity of services. Referral pathways between HIV care and specialized mental health services are often insufficient.

To address these challenges, several strategies are being implemented; Community peer support groups and sensitization activities are being expanded to reduce stigma and promote health-seeking behavior, task-shifting and ongoing mentorship programs to strengthen the capacity of non-specialist healthcare providers to screen, identify, and manage common mental health disorders, simple and validated screening tools are being integrated into HIV service packages to facilitate early detection, referral and feedback systems between HIV clinics and mental health facilities are being reinforced to improve continuity of care. In addition, partnerships with civil society organizations, peer lead programs, and social workers are being scaled up to close gaps in psychosocial support and ensure that services are accessible at the community level.

4.9.3 Psychosocial Care Support among PLHIV

As part of Rwanda's comprehensive HIV program, adherence counseling and psychosocial support remain central to effective care. Adherence counseling ensures that people living with HIV understand the importance of taking ART consistently to maintain viral suppression, prevent resistance, and reduce transmission. Beyond reminders, it addresses barriers such as stigma, side effects, and socio-economic challenges.

To close gaps among children, adolescents, and young adults, 30 health facilities were trained and equipped with youth-friendly services under the national adolescent model. In addition, 250 educators received training to deliver HIV-sensitive, youth-friendly services, helping to reduce stigma in schools and foster inclusive, supportive environments for adolescents.
Outside school settings, psychosocial mentorship and rehabilitation programs were expanded to address psychological and social barriers to adherence, improving retention, outcomes, and well-being for PLHIV.

Persistent challenges remain, particularly for children and adolescents who face adherence difficulties, limited caregiver support, weak disclosure, and overstretched psychosocial providers. To address these, family-centered approaches are being strengthened through caregiver training, linkages to social protection and livelihood support, and the scale-up of peer networks with continuous capacity building. At the same time, advocacy is pushing for HIV-sensitive school policies, refresher training for educators, and integration of psychosocial support into community structures such as peer leaders and youth clubs to ensure sustainability.

4.9.4 Nutrition Support

Nutrition is a fundamental component of the holistic care and well-being of PLHIV, given the relationship between HIV and nutritional status. The chances of malnutrition are high among PLHIV due to nutrient malabsorption, loss of appetite, and frequent opportunistic infections. Conversely, adequate nutrition supports immune function, enhances the effectiveness of ART, promotes faster recovery from illness, and improves overall quality of life. Recognizing this interplay, Rwanda's HIV program integrates nutrition into routine care through a comprehensive package of services that includes nutrition assessment, individualized counseling, client education, regular follow-up, referral to specialized services when needed, and provision of direct nutritional support.

In the last fiscal year, significant strides were made to strengthen the delivery and monitoring of nutrition services at the facility level. A total of 610 healthcare providers received targeted mentorship, delivered both in-person and through telementor ship platforms, focusing on practical skills for nutrition service provision, accurate reporting, and integrating nutrition care within HIV treatment plans. Through this strengthened capacity, 73,798 PLHIV were supported with

Corn Soya Blend Plus (CSB+), a fortified supplementary food designed to prevent and address moderate malnutrition, while 2,994 PLHIV with severe acute malnutrition received Ready-to-Use Therapeutic Food (RUTF) distributed through 46 hospitals and their associated health centers. These interventions not only address immediate nutritional needs but also contribute to improved treatment adherence, reduced morbidity, and better long-term health outcomes for PLHIV.

4.10 HIV-Related Commodities Supply Chain Management

A reliable supply chain is the backbone of the HIV program, ensuring that essential antiretroviral medicines and related commodities are consistently available for prevention, care, and treatment. Effective supply chain management within the HIV response involves careful forecasting, timely procurement, efficient distribution, and strong monitoring systems, all of which are vital to guarantee uninterrupted access for people living with HIV.

During the fiscal year 2024–2025, significant progress was achieved in strengthening the HIV supply chain. Integrated quantification exercises were conducted to estimate commodity needs for HIV and Viral Hepatitis for 2025–2029, and supply plans for 2025–2026 were finalized, approved, and set for implementation. In collaboration with RMS and implementing partners, the program successfully supported the procurement of HIV-related medical products for both prevention and treatment, thereby reinforcing the reliability of service delivery across the country.

However, challenges persist in maintaining a fully efficient supply chain. Occasional stockouts of HIV commodities continue to be reported, affecting continuity of care. At health facility level, expiries remain a concern, often linked to inadequate stock management. Discrepancies between stock quantities reported in the system and physical counts on the ground hinder accurate national planning and timely decision-making. Additionally, procurement difficulties for some commodities persist due to minimum order quantity requirements, which may lead to overstocking or shortages.

To mitigate these challenges, the program has prioritized several strategies. Capacity building of health facility staff is ongoing to improve stock management and reporting practices. Joint procurement with partner countries is being pursued to overcome minimum order barriers and achieve cost efficiency. Moreover, monitoring and accountability mechanisms are being strengthened to ensure closer alignment between reported data and actual stock, thereby enabling more effective national-level supply chain oversight for the HIV program.

4.11 Mentorship and Continuous Quality Improvement

Continuous education and service improvement through clinical mentorship remain essential for delivering high-quality care to PLHIV. Quality of care is a cornerstone of Rwanda's HIV response, critical to its success and sustainability.

In 2024-2025, significant progress was achieved through capacity-building interventions, including clinical mentorship, performance review meetings, and routine monitoring. These were complemented by targeted onsite training for providers. Mentorship sessions were conducted in all 47 hospitals and their catchment facilities, focusing on ART, VL suppression (especially in children and adolescents), NCDs, AHD, psychosocial care, supply chain, and nutrition. Delivered by program staff, partners, and hospital mentors, these efforts strengthened provider capacity and aligned stakeholders on service delivery priorities.

Quality improvement (QI) offered a structured framework to identify service delivery challenges, analyze root causes, and implement practical, sustainable interventions. Integrating QI into HIV services improved adherence, accelerated VL suppression, reduced incidence, and enhanced client satisfaction, advancing the global goal of ending the epidemic.

During the reporting period, 128 facilities-initiated QI activities and developed 131 projects in areas such as VL testing coverage, sexual partner testing, CBS follow-up, NCD screening, HEI follow-up, and clinical monitoring. Of these, 47 projects were completed, while 84 remained in progress.

Despite these achievements, frequent turnover of trained staff continues to undermine continuity of mentorship and QI activities. A strategy has been set to institutionalize hospital-based mentors, integrate QI into routine supervision, and strengthen e-learning and telementor ship platforms to sustain skills and practices across facilities.

5.VIRAL HEPATITIS AND SEXUALLY TRANSMITTED INFECTIONS

5.1 Background

In Rwanda, recent estimates indicate a prevalence of 0.25% for hepatitis B and 0.21% for hepatitis C (RBC HIV and Viral Hepatitis Annual Report, 2023-2024). This was the result of Rwanda biomedical center's strong measures to strengthen prevention, diagnosis, and treatment services for viral hepatitis. These efforts have included the development and scale-up of a robust monitoring and evaluation system utilizing the District Health Information System (DHIS2) and the Health Management Information System (HMIS) platforms to track progress and improve service delivery nationwide.

Rwanda has made significant strides in the fight against Hepatitis C, with a strong national commitment to its elimination as a public health threat. Since the launch of the National Hepatitis C Elimination Plan in 2018, spearheaded by the Ministry of Health in collaboration with key partners, the country has focused on prevention, widespread screening, affordable treatment, and community awareness. Key achievements include the integration of Hepatitis services into the national health system, mass screening campaigns targeting high-risk populations such as people living with HIV, incarcerated individuals, and older adults

Conversely, overlooking other Sexually transmitted infections (STIs) have serious long-term consequences, including chronic pain, infertility, ectopic pregnancy, neonatal complications, and an increased risk of HIV acquisition. Globally, more than one million new curable STIs occur daily, amounting to approximately 374 million new cases each year among adults aged 15-49 years. This staggering figure excludes the many cases of viral STIs such as herpes simplex, HPV, and HIV, which also present a significant disease burden. Despite their high prevalence, many STIs are asymptomatic, making detection and treatment challenging. This leads to persistent transmission within communities. Women, especially in low- and middle-income countries, bear a disproportionate burden due to biological susceptibility and social factors that limit their access to healthcare services. Preventing other sexually transmitted infections (STIs) is crucial to mitigate health consequences, including chronic diseases, fertility problems, cancer, and death. Rwanda has invested in a monitoring and evaluation system to improve health sector staff, infrastructure, community awareness, and continuous guidance on prevention, treatment, and follow-up of STIs cases. Syndromic management, increased screening, and public awareness campaigns have contributed to improved positivity rate, but challenges remain in reducing prevalence, particularly among high-risk populations.

5.2 Objective & Goals

- Reduce the incidence and prevalence of STIs and viral hepatitis through prevention, early diagnosis and treatment.
- Decrease morbidity and mortality associated with untreated or advanced infections.
- Improve access to quality healthcare services for screening, diagnosis, treatment, and follow-up of STIs
- Promote awareness, education and behavior change to reduce risk factors for STIs transmission.
- Strengthen surveillance, data management and reporting systems to inform policy and intervention strategies.

Key Achievements

5.3 Training and mentorship on HBV, HCV and STIs management

Healthcare providers require training and mentorship to ensure the delivery of high-quality healthcare services and equitable. During this fiscal year, a number of staff and managers from various health facilities publics and privates have received training and mentorship on the management of Viral Hepatitis and STIs. The training and mentorship aim to enhance the quality of comprehensive service delivery by continuously building the capacity of healthcare providers.

The training also strengthened the management of Viral Hepatitis and STIs data through the use of an electronic data recording system and data reporting. Furthermore, it improved healthcare workers' skills and motivation by equipping them with effective technical support.

The table below shows the number of staff and managers trained on updated national guidelines on Viral Hepatitis and STIs management as well as data quality review meetings.

Table 2: People trained on Viral Hepatitis and STIs, 2024-2025

Peoples trained	Number
Head of health centers	390
Health care providers and data managers	1032
Total	**1422**

5.4 Management of Viral Hepatitis B

5.4.1 Hepatitis B prevention, care and treatment (June 2024-July 2025)

The national program continued to scale up prevention, diagnosis, treatment, and monitoring of hepatitis B virus (HBV) infection in alignment with the WHO elimination targets. Public awareness of diseases was key for their control and elimination. In the current fiscal year, the population was continuously informed about viral hepatitis and STIs through radio and TV broadcasts and live chats to answer questions from the public, resulting in increased demand for health services and behavior change, as well as demand for screening, as shown in the following figure: a total of 741,534 people were screened for HBV, 7411 of them (1.0%) tested positive for hepatitis B surface antigen (HBsAg), 1922 (0.26%) had detectable viral load and 829 were eligible and initiated on HBV treatment with 93% treatment coverage.

5.4.2 Hepatitis B cascade of care (July 2024 - June 2025)

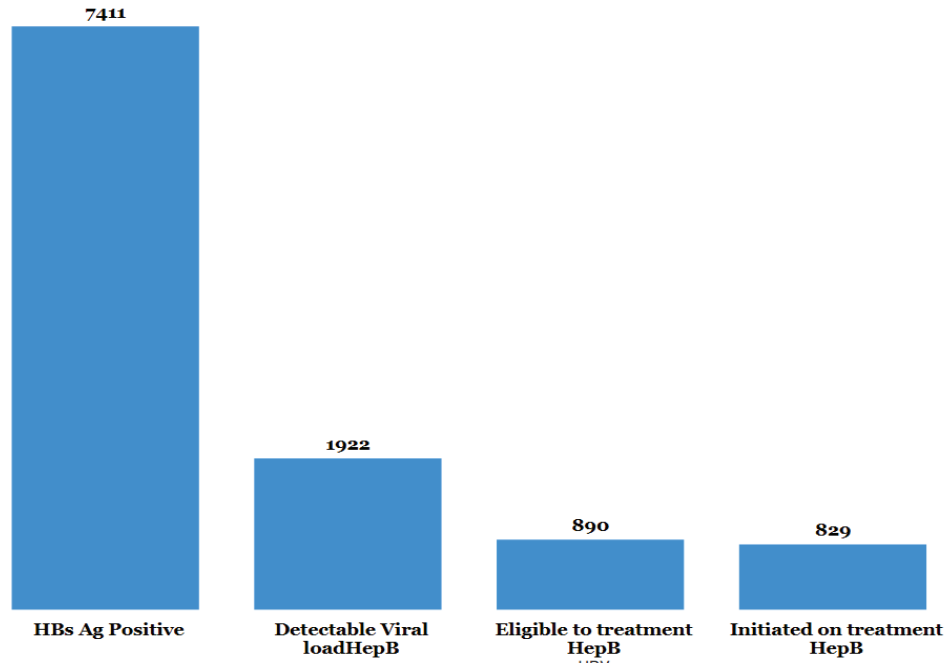

Figure 44: Hepatitis B cascade of care from July 2024 - June 2025

5.4.3 Hepatitis B infection by Province

In the context of hepatitis B infection distribution across the country, aiming at targeting interventions and improving disease management, the analysis of hepatitis B cascade of care by Province, showed that the Western Province screened the highest number of people (194,877), while Kigali city screened less (92,747). The highest and lowest proportion of positive cases by viral load tests were observed in Eastern province (0.33%) and Southern Province (0.19%) respectively.

5.4.4 Hepatitis B infection by District

The map below shows the districts with highest positivity rate including Nyagatare, Kirehe, Burera, Nyamasheke, Rusizi and Nyarugenge with the rate varying between 0.35% - 0.6%. This showcases high prevalence in cross-borders districts and the city of Kigali where Gasabo and Kicukiro districts are among the second with other districts on cross-borders where their positivity rate varies between 0.25-0.34%. The high prevalence in the districts located on the borders, suggest cross border Transmission.

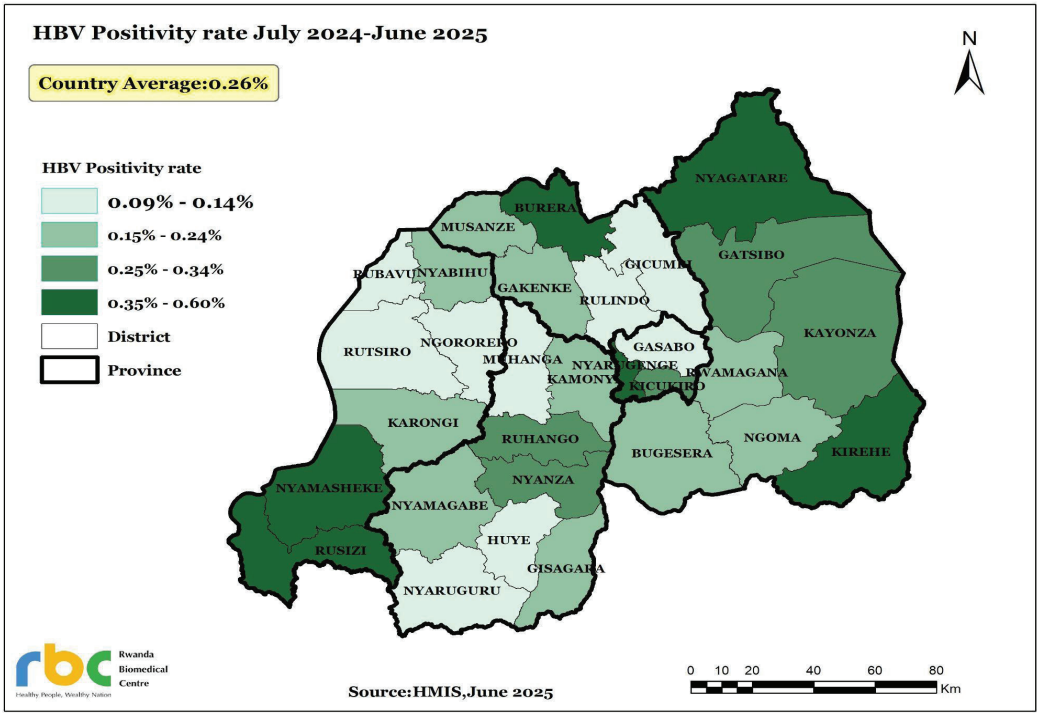

Figure 45: HBsAg positivity rate by District, July 2024 - June 2025

5.4.5 Hepatitis B vaccination

The national immunization program continued to prioritize universal infant vaccination against HBV, with sustained high coverage for the three-dose primary series. Infant immunization against HBV has been in place since 2002 in Rwanda, and the national coverage reached 99% in 2020 (Rwanda DHS, 2019-2020). Subsequently, more than 7,000,000 individuals including children and adults benefited from this service from 2002. From July 2024 to June 2025, a number of 324,078 babies out of 338,475 have been vaccinated (pentavalent vaccine third dose) with a coverage of 96%. A targeted HBV birth dose vaccine was offered to all babies born to infected mothers within 24 hours after birth. On top of routine childhood immunization, targeted adult vaccination campaigns were conducted among high-risk populations. Rwanda is planning to initiate Universal Birth Dose early next year.

5.5 Management of Viral Hepatitis C

5.5.1 Hepatitis C awareness, testing and treatment (June 2024-July 2025)

Significant progress was made in preventing new HCV infections, continued to focus on early detection, linkage to care, and sustained treatment, in line with national hepatitis C elimination targets. In the current fiscal year, 770361 people were screened for HCV, 10571 people were HCV antibody positive and 1348 had a detectable viral load which implies a prevalence of 0.17%.

5.5.2 Hepatitis C positivity rates by Province

Analysis by Province shows that the Western Province tested the highest number of people, (188,443), while the Kigali city tested fewer (95,608), the Southern Province recorded the highest proportion of HCV-detected viral load (0.24%) and the Northern Province with the lowest proportion of HCV-detected viral load (0.12%).

5.5.3 Hepatitis C positivity rate by District

The map below presents the positivity rate across different districts in Rwanda where Nyanza, Huye and Nyamagabe districts in Southern province, Ngoma district in Eastern province and Karongi district in Western province have the highest positivity rate varying between 0.26-0.31%.

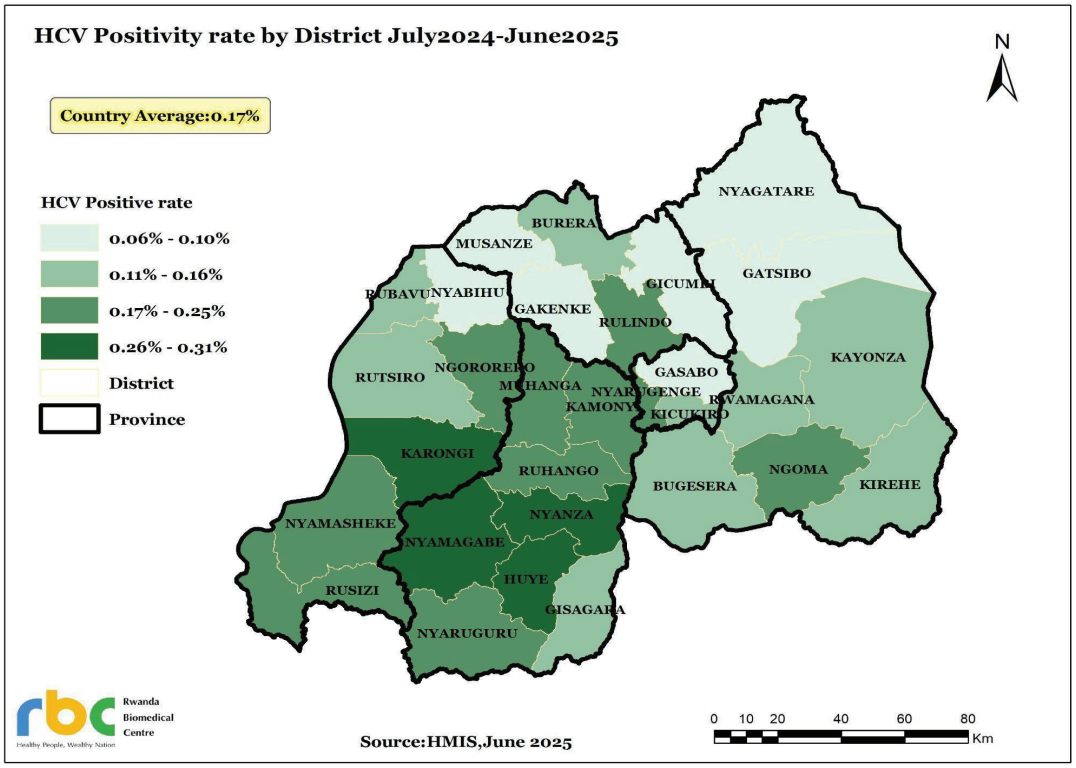

Figure 46: Positivity rate of HCV per district

Lessons Learned

During this fiscal year, HCV self-testing was introduced among high-risk populations in the context of HCV micro elimination, the first round was initiated from April 2025 in all prisons and rehabilitation centers with 49,992 people self-screened and 1744 were positive. The second round started in September in refugee camps across the country. Hepatitis C Self-testing is becoming an increasingly valuable tool in global efforts to eliminate the disease. This practice helps to reach many people and reduce the time for testing. Self-testing breaks down barriers such as stigma, fear, or discrimination, especially in marginalized communities.
This year hepatitis B immune globulin (HBIG) was also introduced and administered to exposed neonates in addition to HBV birth dose vaccine as a passive immune-prophylaxis.

5.6 Management of sexually transmitted infections

5.6.1 STIs awareness, testing and treatment

STIs management continues to play a critical role in the fight against HIV and HBV, given their shared transmission pathways and STIs increase their transmission risk. Rwanda maintained systematic screening for all individuals attending health facilities aiming to overcome cultural stigma and meet the growing need for STIs-related services. Five syndromes have been adopted from WHO for oral screening, physical examination, treatment and reporting. Between July 2024 to June 2025, a total of 3,624,551 individuals were screened for STIs, of whom 206,292 identified as having one or more STIs signs and/or symptoms, were confirmed positive and initiated on treatment with a positivity rate of 5.7%.

5.6.2 STIs screening and positivity rates by Province

The Western province had the highest number of people screened (1,029,800), while Kigali city recorded the lowest number (366,385), The latter being the second with highest positivity rate after Eastern province which is not surprising given that HBV and HIV are also widespread in the province and Kigali City.

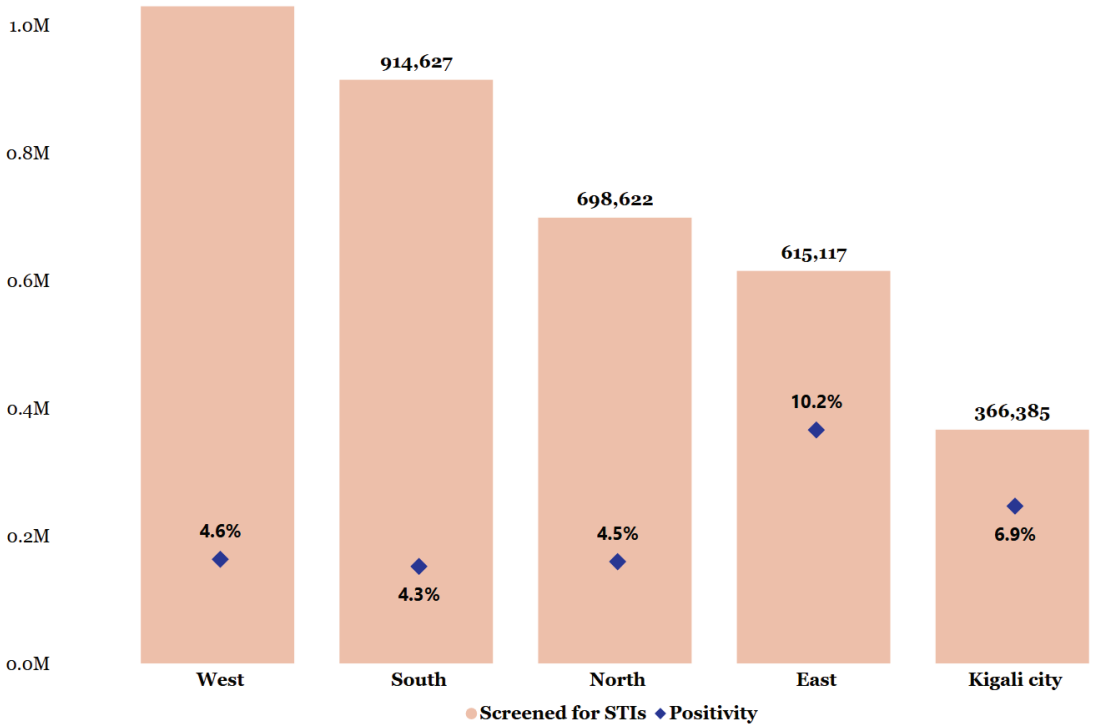

Figure 47: STIs screening and positivity rates by Province, July 2024 - June 2025

5.6.3 STIs screening and positivity rates by age group

The graph below shows that young women (20-24 years) are the most affected with a positivity rate of 7.5%, followed by the age group 25-49 years with a positivity of 7.3%.

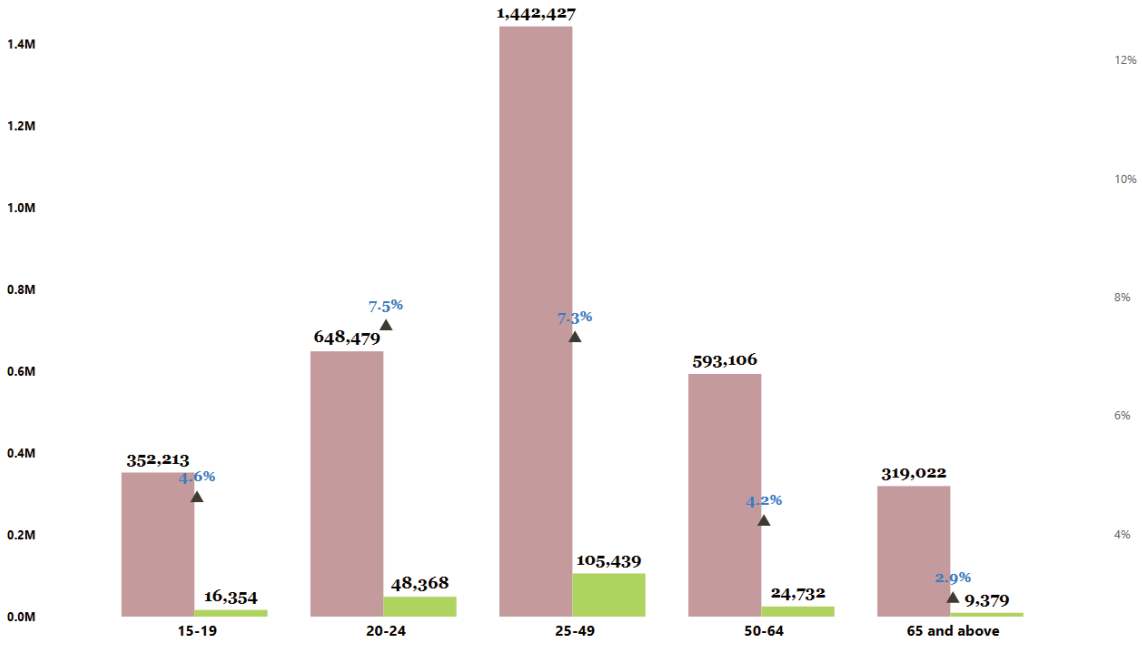

Figure 48: STIs screening and positivity rates by age group

5.6.4 STIs syndromic management

In terms of syndromic management, Urethral discharge among men tops the list (42.3%), followed by Vaginal discharge (37.4%). The former reflects a concern about a possible spread of STIs as most STIs in men are asymptomatic which require greater efforts in awareness and better treatment.

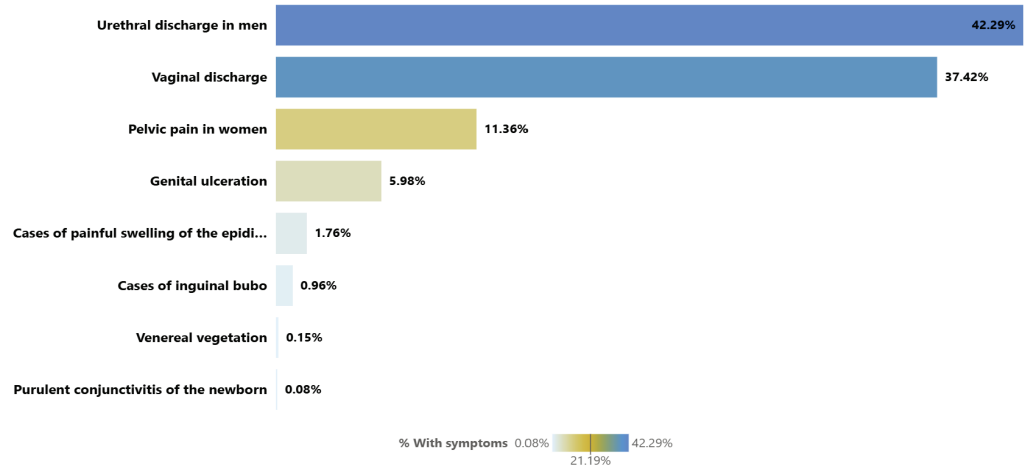

Figure 49: STIs infection per syndromes

5.6.5 HIV and STIs coinfection

Among the 206,292 people who were confirmed STIs positive from July 2024 to June 2025, HIV coinfected people were 6401 (3%). The coexistence of HIV and STIs is frequent as they are commonly transmitted via the same sexual route and STIs may increase the risk of transmission of HIV and vice-versa.

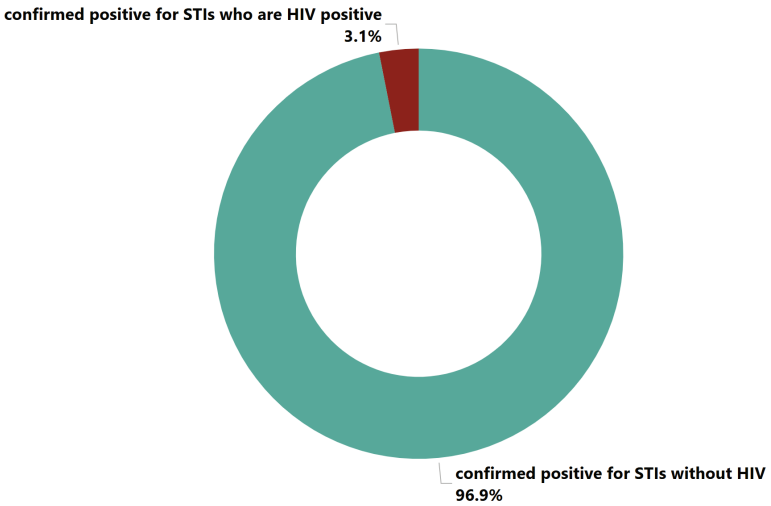

Figure 50: HIV and STIs coinfection

5.6.6 STIs cumulative cascade of care 2021-2025

From 2021, a lot of people have been counselled and screened for STIs and on average, around 4 million people are screened every year and confirmed cases have been treated. From July 2024 to June 2025, 3624551 people have been screened for STIs, of whom 206292 (5.7%) have been confirmed STIs positive and treated.

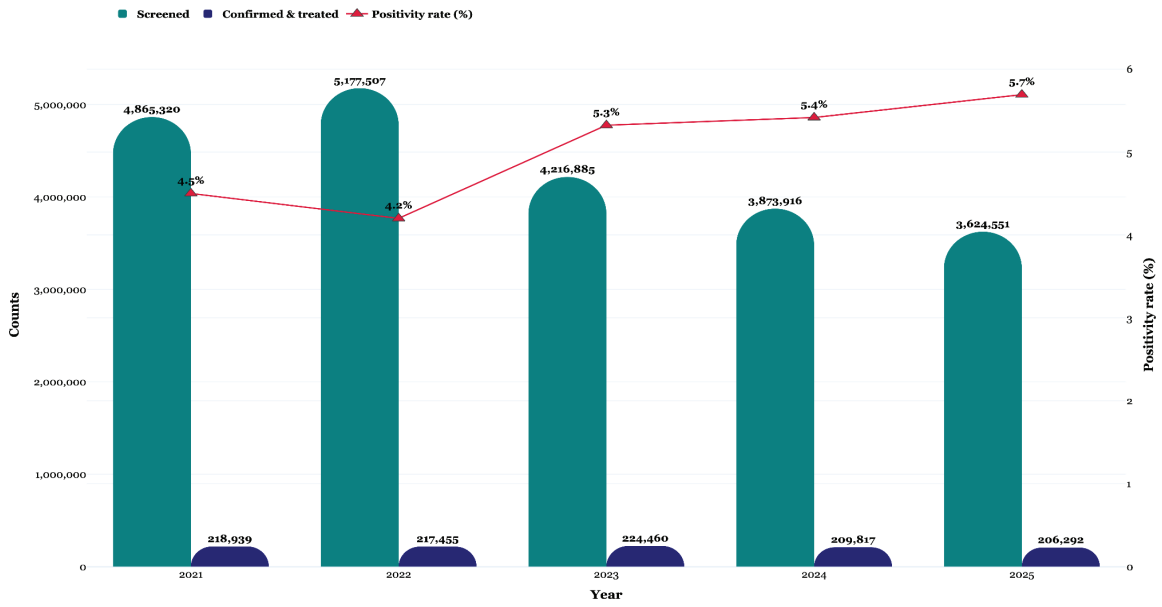

Figure 51: Individuals diagnosed and treated for STIs, 2021-2025

5.6.7 Targets & Strategies for FY 2025-2026

STIs and viral hepatitis B & C

- Apply for Hepatitis C elimination validation
- Accelerate testing uptake of hepatitis B and syphilis among pregnant women
- Ensure hepatitis B Birth dose and adult catch up vaccinations
- Sustain viral hepatitis B and C screening among high-risk populations
- Early diagnosis of STIs and viral hepatitis infections
- Increase VL uptake among people screened positive
- Ensure timely linkage of eligible beneficiaries to treatment
- Regular monitoring of data completeness and accuracy

5.6.8 Monitoring and Evaluation for viral hepatitis and STIs

Rwanda has invested a great effort in design, implementation and expansion of a monitoring and evaluation system using HMIS (Health Management Information System) and DHIS2(District Health Information Software 2) data reporting platforms, which has not only enabled digitalization of hepatitis services, but has also helped the program to collect national data into a single national database used to monitor the progress towards hepatitis elimination and STIs prevention for informing the program on needed interventions to continuously improve STIs services. For surveillance and data management, the electronic information systems are used and regularly updated to capture hepatitis and STIs management data. The review meetings were regularly organized with health facility managers, medical doctors, head of maternity services, nurses in charge of viral hepatitis program, data managers and laboratory technicians to verify the quality of data and inform about the update of data management systems.

6.STRATEGIC INFORMATION

6.1 Background

Strategic information serves as essential evidence for policymakers, program leaders, and managers to make informed decisions that strengthen programs. It plays three key roles: (1) to provide a clear understanding of the HIV epidemic and measure changes resulting from interventions; (2) to monitor and assess the health sector's response covering system inputs, service coverage, quality, outcomes, and impact to guide program improvement, ensure quality, and maximize the value of invested resources; and third, to pinpoint challenges and opportunities for more effective action.

Strategic information is vital for tracking progress toward Rwanda's HIV NSP and UNAIDS 95-95-95 targets by strengthening health information systems, ensuring data quality, and supporting research and surveillance. Current surveillance relies on passive and episodic methods, including HIV and Syphilis Surveillance (HSS), the Integrated Behavioral and Biological Surveillance Survey (IBBSS) among key populations, size estimations, HIV drug resistance and STI surveillance, and Health Surveys (DHS).

Rwanda is advancing full health system digitization, establishing interoperability between the Electronic Medical Record (EMR), DHIS-2, laboratory information systems, and the national ID database to streamline data sharing, result reporting, and client record deduplication. Alongside these efforts, Rwanda is initiating community-led monitoring (CLM) to enhance accountability, responsiveness, equity, and quality of HIV services, led by networks of people living with HIV, people at high risk of HIV, and other groups. Research will continue to align with national priorities and inform HIV program improvements.

6.2 Health information systems

Rwanda has established several electronic systems to routinely collect, store, and analyze health data for better decision-making and service delivery:

District Health Information System (DHIS-2): An open-source platform developed by HISP and the University of Oslo, used nationwide to capture, validate, analyze, and report aggregated health data. It supports disease surveillance and monthly reporting under the Health Management Information System (HMIS).

Electronic Medical Records (EMR): Patient-level database covering about 40% of facilities. It tracks HIV-infected patients from ART initiation until death.

Laboratory Information System (LIS): Manages laboratory data and supports national lab networking, rolled out to all district-level laboratories.

VLSMS: Enables real-time transmission of viral load (VL) requests and test results, with dashboards for monitoring laboratory service quality and program performance.

To strengthen these systems, Rwanda upgraded HMIS and EMR platforms (OpenMRS), aligning them with updated HIV guidelines and reporting frameworks. Health workers, including ARV nurses and data managers, were trained on the upgrades. The integration of these platforms allows synchronized data entry and reporting, reducing errors, improving accuracy, and saving time.

6.3 Monitoring and evaluation systems

Monitoring and evaluation systems is a structured process for tracking progress, measuring results, and using evidence to improve projects, programmers', or policies. In 2024–2025, M&E efforts continued to center on two pillars: the consistent use of standardized M&E tools and the reliability of health information systems. The Ministry of Health (MoH) and the Rwanda Biomedical Center (RBC) provided overarching leadership for HIV program M&E across facility and community settings, ensuring accountability for the effectiveness of the national response.

6.3.1 System organization and capacity

District hospitals maintained functional M&E teams that included a data manager, a planning/M&E officer, and a community health workers' (CHW) supervisor. Routine data review and validation were institutionalized, with quarterly reports produced by district hospitals. District health officers led implementation of the national M&E framework, supported by continuous capacity-building for providers on data quality and data use.

6.3.2 Facility-based monitoring

At the point of service, facilities recorded activities in standardized registers every day. These data were aggregated each month and submitted to the Health Management Information System (HMIS) on the DHIS2 platform. Established standard operating procedures (SOPs) guided data collection, management, and reporting.

6.3.3 Community-based monitoring

Community M&E tracked the reach and outcomes of key HIV interventions, awareness, testing, linkage, and retention. Strengthening remains a priority for interventions focused on key populations and other vulnerable groups, including improving the completeness, timeliness, and systematic use of community-level data.

6.3.4 Governance, supervision, and coordination

Improved planning and coordination between central and decentralized levels contributed to stronger overall system performance. Nonetheless, high staff turnover created instability in M&E positions. There is a continued need to disseminate finalized M&E tools widely, provide ongoing training for local partners, and increase both the frequency and quality of supportive supervision from central to district levels, with clearer follow-up actions after visits.

6.4 HIV Data monitoring and reporting

HIV data monitoring and reporting are central to Rwanda's national HIV response, guided by standard operating procedures that ensure accurate, timely, and systematic data collection. Health facilities record HIV testing, treatment, and care data daily in standardized registers and electronic systems, with monthly aggregate reports submitted to the HMIS via the DHIS-2 platform. Community-based monitoring complements facility reporting by tracking outreach to key and high-risk populations.

Data quality is reinforced through validation processes, regular audits, and mentorship for health workers, supported by the expansion of EMR to improve accuracy and real-time reporting.

Following the 2022 revision of national HIV guidelines, several HIV, STIs, and Viral Hepatitis indicators such as those related to DSDM, DTG optimization, AGYW, TPT, PrEP, and viral load monitoring were updated, incorporated into HMIS, and disaggregated by age and sex.
Currently, 595 health facilities report monthly including 25 private health facilities on 13 core national indicators that form the basis for national-level monitoring of HIV, STIs, and Viral Hepatitis programs.

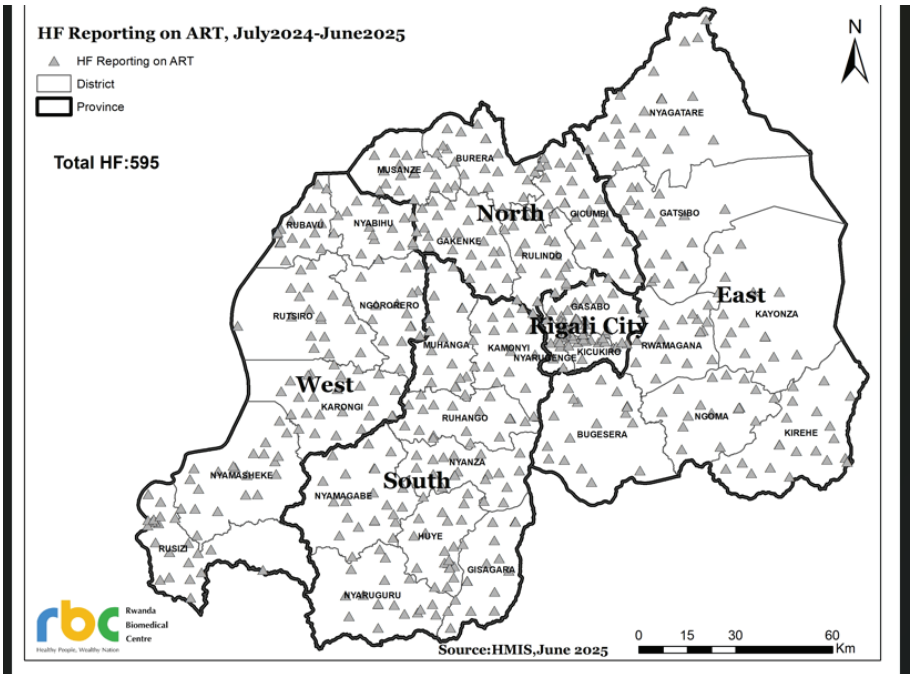

Figure 52: HF with ART services by June 2025

6.5 HIV data flow

HIV data is collected daily by health care providers at health facilities using registers and electronic systems, capturing information on testing, care and treatment. By the 28th of each month, data managers distribute data collection forms to health care providers, who complete them and return them to the data manager for data entry into the Health Management Information System (HMIS). All data must be entered and finalized in HMIS by the 5th of the following month.

From the 5th to the 8th, hospital data managers check the completeness and accuracy of data from all facilities in their catchment area, and any issues are resolved with the relevant health facilities. Between the 9th and 11th, the central level team reviews the data in HMIS, analyzes it, and sends feedback to hospital data managers, who work with health care providers to make corrections by the 15th when this data system closes automatically.

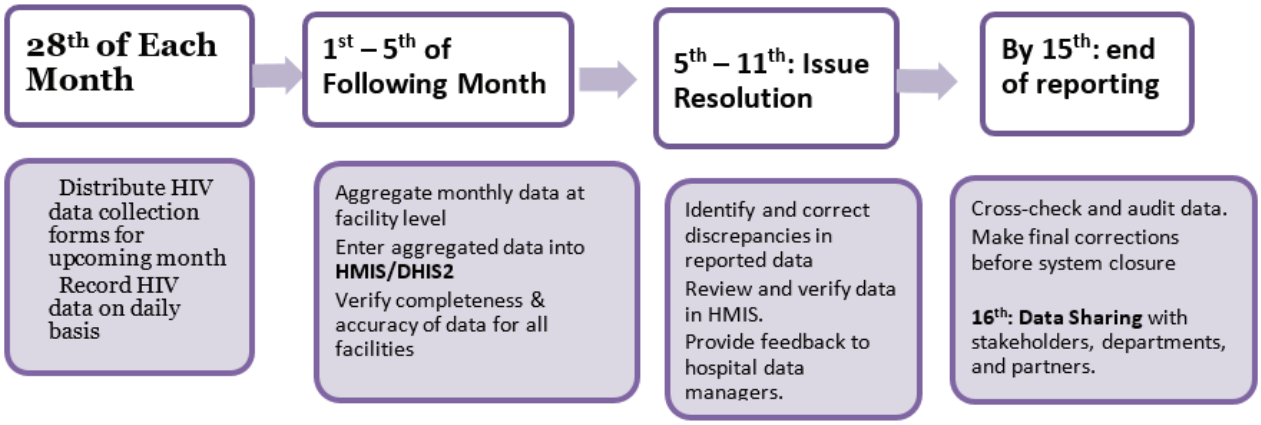

Figure 53: HIV data reporting process

On the 16th of each month, the central team finalizes and shares the verified data with different units, stakeholders and partners. This structured process, with clearly defined roles and timelines, ensures timely reporting, high-quality data, and informed decision-making at all levels of the healthcare system.

6.6 Supportive supervision and data auditing

Rwanda Biomedical Center (RBC), in collaboration with hospital data managers, conducted an integrated supportive supervision and data quality assessment in 225 health facilities. The activity involved 45 hospital data managers under the supervision of RBC staff, targeting healthcare providers (HCPs) and data managers working in HIV services.

The supervision covered both facility-based HIV programs, using qualitative and quantitative data collection methods. It aimed to improve data quality, ensure adherence to national tools and formats, and strengthen the consistency of HIV indicator reporting.

Key finding

The capacity of healthcare providers and data managers has been enhanced through improved skills in data review, verification, and correction, as well as a stronger understanding of HIV indicator definitions. This has led to more consistent reporting across source documents and digital systems, integration of new PMTCT and STIs indicators into routine reporting (with accurate data captured from July 2024), and correction of previously missing or erroneous data on HTC, index testing, key populations, AGYW, enrolment and ART, viral load, viral hepatitis, and STIs. These efforts have significantly strengthened the reliability of HIV data to support evidence-based decision-making and program performance. However, challenges remain, including difficulties retrieving historical Hepatitis data due to poor record-keeping, frequent turnover and lack of appointed data managers, missing VL results for hepatitis clients in some areas, internet interruptions during data correction, and limitations in the VL monitoring register design, which prevents capturing all eligible clients for testing.

6.7 Coordination of Partners in HIV Response

From the beginning, Rwanda adopted the "three ones" principle in its AIDS response: a single national coordinating body, one strategic plan, and one monitoring system. NGOs aligned their activities with national priorities, streamlining HIV service delivery and facilitating the eventual transition of programs to the Ministry of Health management.

Rwanda's main HIV development and funding partners include PEPFAR and the Global Fund, alongside support from UN agencies, bilateral partners, international NGOs, and foundations. These partners provide both financial and technical assistance to strengthen policy and program implementation.

Development partners collaborate closely with the government to set national targets, engage in joint planning, and submit annual budgets and reports to ensure accountability and effective use of resources. Monitoring and evaluation are centralized under the Rwanda Biomedical Centre's HIV Division, with all partners using common reporting tools.

6.8 Surveillance and research

6.8.1 HIV Surveillance for Key Population

The Rwanda Biomedical Center conducted Bio-Behavioral Surveillance (BSS) surveys to track sexual behaviors and HIV prevalence among key populations, including FSWs MSM and people who inject drugs (PWID), in line with the National Strategic Plan. BSS, initiated in 2000 for FSWs and 2015 for MSM, are repeated surveys that allow comparison across years to inform HIV and STI prevention and treatment programs.

Integrated Behavioral and Biological Surveillance Survey among MSM in Rwanda, 2024

RBC through HIV, STIs, Viral Hepatitis and OBBI Division conducted a fourth edition of Bio-behavioral survey and Population Size Estimation among MSM in Kigali City and four provinces to estimate HIV, syphilis, and Hepatitis B and C prevalence among MSM. The study collected behavioral data through questionnaire administration and HIV, syphilis, and Hepatitis B testing.

Key Findings:

The survey enrolled 3,757 MSM with a median age of 25. Consistent condom use in the past 30 days was reported by 24%, ranging from 37% in the South to 9% in the East. PrEP use varied with 18-29% having ever taken it and 35-78% reporting use in the last six months. The prevalence of HIV, syphilis, and hepatitis B was 5.8%, 5.9%, and 1.6%, respectively. HIV prevalence among MSM increased from 4.0% in 2015 to 5.8% in 2024. Syphilis prevalence declined from 4.0% in 2015 to 2.4% in 2021 but rose again to 5.9% in 2024. Hepatitis B prevalence dropped from 4.2% in 2021 to 1.6% in 2024, while hepatitis C prevalence increased from 0.7% in 2021 to 1.6% in 2024. The study also estimated a total of 29,048 MSM nationwide, with the highest concentration in the South province (7,666) and the lowest in the East province (4,230).

Mapping and size estimation of people who inject drugs (PWID) and determination of their risks to HIV and Viral Hepatitis infections in Rwanda

In October 2024, RBC in partnership with the Rwanda NGOs Forum on HIV/AIDS and Health Promotion and other stakeholders, conducted a national study to estimate the size of people who inject drugs (PWID) and assess their risks for HIV and viral hepatitis. The six-month study, carried out in ten districts, reached 1,114 participants and estimated the PWID population in Rwanda at about 3,418 individuals.

Results indicated a high HIV prevalence of 12.3%, along with notable HBV (2.6%) and HCV (3.0%) rates. Risk behaviors were common, including needle sharing (23.6%), low use of sterile needles (34%), and low condom use (67.8%). More than a quarter of participants reported experiencing an overdose, yet only 1.9% were aware of overdose reversal medications.

Significant service gaps were identified, including low awareness of available treatment programs, poor hepatitis testing uptake, and high levels of mental health challenges. These findings highlight the urgent need for harm reduction interventions, expanded access to services, and integrated support systems for PWID.

6.8.2 Non-Communicable Diseases study among people living with HIV in Rwanda: Tackling the double burden

NCDs study among PLHIV was conducted in two arms: (1) a cross-sectional survey to assess the prevalence of major NCDs: Diabetes, Hypertension, Cervical cancer, and Asthma among PLHIV, and (2) a retrospective analysis of mortality data among PLHIV who died from 2020 to 2024. Arm 1 was conducted in 115 sites and enrolled 7,449 PLHIV aged 15+, while arm 2 analyzed records of 7,636 deceased PLHIV across the country.

Arm 1 key findings: The overall prevalence of NCDs was 29%, meaning nearly one in three participants had at least one NCD.

- Hypertension was the most common NCD, affecting 24.2% of participants.
- Cervical cancer lesions were reported in 17.2% of women screened.
- Diabetes and asthma had relatively low prevalence rates (1.1% each).
-

Arm2 key findings: Data on 7,636 deceased PLHIV were collected from health facilities nationwide. Among these, analysis was conducted on 2,627 individuals with recorded underlying causes of death in the CRVS system. Findings showed that 25% of deaths were HIV/AIDS-related, while 30% were attributable to NCDs.

6.8.3 HIV seroconversion rate among pregnant and breastfeeding mothers and related vertical transmission rate in Rwanda. Arm 2_Pahes 1.

The primary objective of this study was to estimate the HIV seroconversion rate among lactating mothers and assess the vertical transmission rate from newly infected mothers. Phase 1 was implemented in 28 health centers, with plans to scale up to 175 facilities nationwide.

Data collection involved two steps:

- **Initial Visit**: Mothers attending health facilities for child vaccination were interviewed and tested for HIV. Infants of mothers who tested positive were also tested.
- **Follow-up Visit**: After 24 months of breastfeeding, mother-infant pairs were invited back for re-testing.

Key Findings:

- **Initial testing:** Among 9,821 breastfeeding mothers tested, 13 (≈0.13%) were newly diagnosed with HIV, and 3 transmitted HIV to their infants.
- **Follow-up testing**: Of 3,816 mothers who returned for re-testing after 24 months, 13 were newly diagnosed, but none transmitted HIV to their children.

Conclusion:

These results highlight the importance of routine and repeat HIV testing throughout the breastfeeding period, as timely detection and treatment can prevent vertical transmission and support eMTCT efforts.

6.9 E-Learning and Innovation

During the reporting period, one major eLearning workshop was organized with the overall goal of strengthening and expanding Rwanda's digital HIV training portfolio. The workshop was designed not only to update existing training modules but also to develop new content and refine operational tools and Standard Operating Procedures (SOPs) to improve the quality and efficiency of eLearning delivery. This initiative was part of ongoing efforts to build the capacity of healthcare providers and ensure that they remain equipped with up-to-date knowledge and skills in HIV prevention, care, treatment, and related health services.

The workshop brought together course developers, subject matter experts, and instructional designers who collaborated closely to create new content aligned with national HIV program priorities. As a result, 13 courses were developed during this session. These courses are currently under technical review to ensure accuracy, quality, and compliance with programmatic standards before their final release. The newly developed courses include:

1. HIV Care and Treatment for Children and Adolescents
2. Quality Improvement in HIV Health Care Services
3. Laboratory Information Management System (LIMS)
4. HIV Case-Based Surveillance (CBS)
5. HIV Testing Services
6. Minimum Package of HIV Services for Key Populations
7. HIV Data Quality Management

8. Updated Course on Hepatitis B and C Management
9. Minimum Package of HIV Prevention Services for Adolescent Girls and Young Women (AGYW)
10. Monitoring of Viral Load in People Living with HIV (PLHIV)
11. Early Infant Diagnosis of HIV
12. Bacteriology Analysis
13. HIV Care and Treatment for Children and Adolescents (duplicate module designed with different delivery approaches)

In addition to the above, nine other courses have already completed the production stage and are now ready for upload onto the eLearning platform. These will be rolled out to learners in the coming period to expand access to high-quality, accredited training materials. Once uploaded, these courses will contribute directly to improving healthcare workers' knowledge, competencies, and adherence to national HIV guidelines, thereby enhancing service delivery across the country.

This effort highlights the government and its partners' commitment to digital innovation in health workforce training. By investing in updated modules and new learning content, the eLearning platform will continue to serve as a central hub for continuous professional development (CPD), ensuring that providers remain informed about emerging evidence, new technologies, and evolving best practices in HIV care and other critical health areas.

7. CONCLUSION

During the 2024-2025 fiscal year, HIV response in Rwanda remained strong, with ART coverage sustained at 96.9%, retention at 94%, and viral load suppression beyond 97%, among the highest globally. Mother-to-child transmission was maintained below 2%, and the positivity rate dropped at 0.6% affirming the effectiveness of Rwanda's prevention and treatment programs. These outcomes demonstrate resilience and efficiency of the Rwanda National HIV Program.

Despite these achievements, important gaps and challenges remain. Key populations, adolescents, and young women continue to face barriers to accessing and utilizing available prevention measures, timely testing, treatment initiation, and retention in care. Challenges such as self- stigma, and sub national disparities persist, requiring tailored strategies.

Furthermore, the anticipated reduction in external funding underscores the urgency of building domestic financing mechanisms and strengthening health system resilience to ensure continuity of HIV services.

To maintain progress and accelerate toward epidemic control, Rwanda must adopt key strategies: (i) Develop and adopt innovative financing approaches to ensure sustainability of HIV services delivery, (ii) Integrate HIV services with broader health priorities (SRH, TB, hepatitis, and NCDs) to maximize efficiency and ensure sustainability, (iii) Strengthen community-led responses, which have proven critical in prevention, adherence, and accountability, (iv) Prioritize focused interventions for high-burden populations, including AGYW, MSM,FSW and key geographic areas at sub-national level, (v) Leverage innovations such as digital health tools, case-based surveillance, and long-acting prevention and treatment options.

Ending AIDS as a public health threat by 2030 in Rwanda will require bold action to secure sustainable financing while maintaining the people-centered, evidence-driven approaches that define Rwanda's success. The HIV response has shown resilience; the challenge now is to safeguard and scale these gains in a climate of constrained resources.

8.ANNEX

8.1 FINANCING HIV RESPONSE: FISCAL YEAR 2024-2025

Introduction

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

- Government resources, which includes revenues generated from taxes and non-taxes, loans, grants, donations – reported as Government contribution/ budget allocation and part is allocated as earmarked transfers.
- Development partner contributions through sector budget and project support. On the budget, the donor funds are indicated in the development budget. These include the Global Fund for HIV & AIDS, TB and Malaria, PEPFAR and contributions 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 data collection for the contribution of these sources is conducted on an annual basis. Therefore, the report is focused on funding sources where data were available as at the time of reporting as explained above.

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

The Ministry of Health and the Rwanda Biomedical Centre in collaboration with its partners worked on the financial data reported in HIV/AIDS annual report 2024-2025.

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

HIV/AIDS Expenditures in Rwanda FY 2024-2025 by Sources of Financing

The Global Fund for AIDS, TB and Malaria (GFATM) contributed the budget of USD 69,503,947 for the FY 2024-2025; the United States Government (USG) contribution for the FY 2024-2025, is USD 48,301,314. The Government of Rwanda contributed the budget of USD 12,829,570. Hence, the total contributions to the National Strategic Plan for the FY 2024-2025 were USD 130,634,831.

Table 3: Global fund contribution to National Strategic Plan for the FY 2024-2025

Source of funding for NSP/HIV	Initial approved budget for FY 2024-2025 in USD	Revised Budget FY 2024-2025 in USD	Actual Expenditures FY 2024-2025 in USD	Variance in USD	Budget performance rate in %
Global Fund for AIDS, TB, and Malaria	69,503,947	69,503,947	63,455,685	6,048,262	91%
USG PEPFAR	48,301,314	48,301,314	43,711,724	4,589,590	90%
GoR	12,671,136	12,829,570	12,447,425	382,145	97%
Grand Total	**130,476,397**	**130,634,831**	**119,614,834**	**11,019,997**	**92%**

The total Global Fund contribution of USD 69,503,947 includes USD 33,045,560 related to C19RM activities. Regarding expenditures in connection to the FY 2024-2025, the Global Fund for AIDS, TB and Malaria (GFATM) spent USD 63,455,685; the United States Government spent USD 43,711,724; the Government of Rwanda spent USD 12,447,425. The overall total expenditure for HIV NSP was USD 119,614,834 which represents 92% of the allocated budget.

Government contribution to HIV/AIDS National Strategic Plan FY 2024-2025

The GoR funds are allocated to different health programs during the annual planning and budgeting process, which entails sectoral consultations to discuss prioritization and budget allocation between the Ministry/ RBC and decentralized levels based on HSSP V 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.

Table 4: GoR contribution to NSP per MTEF chapter, FY 2024-2025

MTEF chap	Approved budget for FY 2024-2025 in USD	Actual expenditures for FY 2024-2025 in USD	Balance in USD	Performance in %
21 Compensation of employees	7,418,017	7,249,676	168,341	97.7%
22 Use of goods and services	2,878,717	2,821,415	57,302	98.0%
25 Subsides	353,771	352,814	957	99.7%
26 Grants	916,964	887,017	29,946	97%
27 Social assistance	1,013,954	892,108	121,846	88%
28 Other expenditures	170,218	166,481	3,737	98%
33 Inventory	61,535	61,535	-	100%
34 Fixed tangible non-financial Assets	16,395	16,379	16	100%
Total	**12,829,570**	**12,447,425**	**382,145**	**97%**

From the above table, the approved budget for the financial year 2024 -2025 of USD 12,829,570 a total of USD 12,447,425 has been effectively spent by different budget entities with 97% of budget execution rate. The medium-term expenditure framework (MTEF) chapter with the highest budget execution was Compensation of employees with USD 7,249,676 followed by Use of goods and services with 2,821,415 followed by social assistance with USD 892,108. As reflected in the table below, the budget is USD 12,829,570 whereas the expenditure is USD 12,447,425. The type of budget agencies with the highest budget ceiling is Districts hospitals with USD 3,962,313; Ministry of Health with USD 3,672,240 and RBC with USD 1,711.717.

Table 5: GoR contribution to NSP per budget agencies, FY 2024-2025

Budget Agency	Budget for FY 2024-2025 in USD	Actual expenditures in USD	Balance in USD	Performance rate in %
CHUB	761,532	761,532	-	100%
CHUK	1,072,177	1,072,177	-	100%
Districts	3,962,313	3,726,142	236,171	94%
HNN	300,878	426,427	-125,549	142%
MINISANTE	3,672,240	3,485,806	186,435	95%
RBC	1,711,717	1,707,210	4,508	100%
RMH	837,881	837,881	-	100%
RWANDA FDA	510,833	430,252	80,581	84%
Total	**12,829,570**	**12,447,425**	**382,145**	**97%**

The Global Fund contribution

For the Global Fund contribution, the total approved budget C19RM inclusive is USD 69,503,947 for the financial year 2024-2025. During this financial year, the expenditure was USD 63,455,685. Hence, the total budget execution rate for the FY 2024-2025 was 91%. This total variance of USD 6,048,262 representing 9% will be used during the coming fiscal year 2025-2026.

Table 6: GF budget execution per MTEF Chapter, FY 2024-2025

MTEF Chapter	Approved budget for FY 2024-2025 in USD	Actual expenditures for FY 2024-2025 in USD	Variance	Performance rate in %	Comments
22 Use of goods and services	25,394,205	26,647,806	-1,253,601	105%	This overspend was due to procurement of blood reagents and was covered by internal and overspending request
26 Grants	5,088,853	5,596,364	-507,511	110%	Overspend was covered by internal reallocation
27 Social assistance	109,583	94,006	15,578	86%	
28 Other expenditures	3,865,746	1,190,488	2,675,258	31%	Using C19 RM to support Local NGOs activities
37 Machinery and Equipment	2,000,000		2,000,000	0%	This variance is related to matching fund not yet implemented
Total	**36,458,387**	**33,528,664**	**2,929,723**	**92%**	

From the above table, out of the approved budget regular grant of USD 36,458,387; a total of USD 33,528,723 has been effectively spent by different budget entities and this represents 92% of budget execution rate. The type of budget entity with the highest budget ceiling is RBC with USD 32,6 millions, MOH with 3,3 million as indicated by the table below:

Table 7: GF budget execution per Budget Agency, FY 2024-2025

Budget Agency	Approved budget for FY 2024-2025 in USD	Actual expenditures for FY 2024-2025 in USD	Variance	Performance rate in %
CHUB	31,323	31,670	- 347	101%
CHUK	60,128	60,794	-666	101%
MOH	3,340,550	1,693,723	1,646,827	51%
MINIYOUTH	261,346	238,445	22,902	91%
NCDA	140,603	142,153	-1,550	101%
RNP	20,905	20,905	0	100%
RBC	32,550,318	31,287,408	1,262,910	96%
RCS	23,535	23,561	-26	100%
RMH	29,678	30,007	-329	101%
Total	**36,458,387**	**33,528,664**	**2,929,723**	**92%**

Table 8: C19 RM expenditures per MTEF Chapter for Financial Year 2024-2025

MTEF Chapter	Approved budget for FY 2024-2025 in USD	Actual expenditures for FY 2024-2025 in USD	Variance in USD	Performance rate in %	Comments
22 Use of goods and services	8,698,952	8,730,831	-31,879	100%	
28 Other expenditures	4,570,884	6,582,656	-2,011,772	144%	Overspend was covered by internal reallocation
36 Building and Structures	5,142,176	3,485,400	1,656,777	68%	
37 Machinery and Equipment	14,633,548	11,128,134	3,505,414	76%	
Total	**33,045,560**	**29,927,020**	**3,118,540**	**91%**	

For the C19RM grant budget, out of the approved budget worth USD 33,045,560, the total of USD 29,927,020 has been effectively spent which represents 91% of budget execution. The remaining balance of USD 3,118,540; representing 9% of total budget will be spent before 31st December 2025.

The USG/PEPFAR contribution

From 1st July 2024 to 30th June 2025, the US Government contribution was USD 48,301,314; to the National HIV response in Rwanda and this budget was spent with 43,711,724 represents 90%.

8.2 KEY PERFORMANCE INDICATORS

Table 9: Key performance indicators

Indicators	Data Source	Results 2024-2025	Targets		
			2024-2025	2025-2026	2026-2027
HIV Prevalence (15 -64)	DHS 2020	2.7%		2.5%	2.5%
HIV Incidence	RPHIA,2019	0.08%			0.068%
HIV Prevalence among female sex workers	IBBS_FSWs, 2023	35.2%			32 %
HIV prevalence among Men having sex with Men	IBBSS_MSM 2024	5.8%		5%	5%
Number HIV tests conducted	HMIS	1,987,601	NA	NA	NA
HIV sero-positivity rate (Overall)	HMIS	0.62%	NA	NA	NA
a. VCT/PIT	HMIS	8354/936168(0.89%)	0.7%	0.7%	0.7%
b. ANC Women	HMIS	1,233/358,839(0.34%)	0.3%	0.3%	0.3%
c. ANC-among male partners	HMIS	435/190,904(0.22%)	NA	NA	NA
d. VMMC	HMIS	42/94492(0.04)	NA	NA	NA
e. Maternity	HMIS	243/325,803(0.34%)	NA	NA	NA
f. Index testing	HMIS	2,494/81,395(3.06%)	4%	4%	4%
Percent of HIV infected pregnant women in PMTCT	HMIS	0.34%	NA	NA	NA
Pregnant women who received ART to reduce mother to child transmission	HMIS	99.9 %	>98%	>98%	>98%
Percentage of exposed infants who are HIV-free by 24 months		98.9%	>99%	>99%	>99%

Number of medical male circumcision performed according to national standards.	HMIS	332,804/374,885 (88.7%)	374,885	412,373	453,610
Surgical circumcision	HMIS	329,955	NA	NA	NA
Medical Device circumcision	HMIS	2,849	NA	NA	NA
Prevalence of male circumcision (Proportion of males circumcised among male population)	RDHS 2020	56%	60%	60%	60%
Number of female sex workers followed at health facility	HMIS	35,995	NA	NA	NA
Number of HIV negative female sex Workers on PrEP	HMIS	11,862	NA	NA	NA
Percent of adults and children retained on treatment 12 months after ART initiation	HMIS	94%	95%	95%	95%
Percent of adults and children currently receiving ART (ART coverage)	HMIS	229,275 (96.9%)	95%	95%	95%
Percent of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml)	VLSMS&LIS	97.6%	97%	97%	97%
Number of new clients initiating ART	HMIS	11,162	NA	NA	NA
Number of condoms distributed	HMIS	24,414,839	NA	NA	NA
Number of People screened for HCV	HMIS	770,361	NA	NA	NA
Number of people with HCV RNA positive	HMIS	1,348	NA	NA	NA
Number of people-initiated HCV treatment	HMIS	1,054	NA	NA	NA

Number of People screened for HBV	HMIS	751,781	NA	NA	NA
Number of people screened for HBV positive	HMIS	8,842	NA	NA	NA
Number of people screened for STIs	HMIS	362,4551	NA	NA	NA
Number of people confirmed with at least one STI.	HMIS`	206,292	NA	NA	NA