Republic of Rwanda
Ministry of Health

Rwanda Biomedical Centre
Healthy People, Wealthy Nation

HIV, STIs and Viral Hepatitis

Annual Report

2023/2024

Foreword

Each year, the Ministry of Health publishes a comprehensive annual report that meticulously documents national progress in controlling HIV, STIs, and Viral Hepatitis. This year's report presents a thorough analysis of activities, achievements, and challenges encountered from July 2023 to June 2024.

The report underscores the significant strides made through synergistic collaborations between the Government of Rwanda, Development partners, Civil Society Organizations, UN agencies, and other critical stakeholders dedicated to HIV response. Their concerted efforts have been instrumental in mitigating the impact of HIV, STIs, and Viral Hepatitis across the Nation.

Moreover, this report highlights the indispensable contributions of scientists, epidemiologists, and healthcare professionals. Their relentless dedication within various technical working groups, healthcare settings, and community advocacy roles has been pivotal in advancing our health objectives.

Despite the notable progress achieved over the past two decades in combating the HIV epidemic, this report emphasizes the urgent need for sustained investments and targeted interventions. Reducing new HIV infections among key populations, particularly adolescent girls, young women, and high-burden districts, remains a critical priority. Evidence-based strategies are essential to effectively address these challenges.

The report also delineates strategic priorities for the forthcoming fiscal year, providing a roadmap for the Government of Rwanda, its partners, and stakeholders. These priorities aim to guide the continued evolution of our HIV response strategy, ensuring that Rwanda remains on course to achieve the ambitious goal of ending AIDS by 2030.

Digitally signed by MOH(Minister)

Dr. Sabin NSANZIMANA
Minister of Health

Executive Summary

This report presents the key achievements of all actors in HIV/AIDS, STIs, and Viral Hepatitis response, from July 2023 to June 2024, as referred to as the reporting period. It covers essential areas of interventions in the fight against HIV/AIDS, STIs, and Viral Hepatitis, namely prevention, care and treatment, social impact mitigation, health system strengthening, financing HIV national response, and strategic information.

The national program prioritizes targeted testing. This year, the number of HIV tests conducted decreased from 2,283,301 to 2,072,366 tests. A high decrease was reported in HIV testing services (HTS). The overall HIV testing yield remained at 0.7%. The highest HIV testing yield of 4.1% was recorded among elicited partners of index cases who were reached and tested through partner notification services.

Rwanda embarked on the plan for the elimination of mother-to-child HIV transmission. From July 2023 to June 2024, 344,746 pregnant women were tested for HIV out of those who attended ANC visits. Of these, 1,151 pregnant women tested positive for HIV, translating into a positivity rate of 0.3%. Overall, 99.8% of pregnant women living with HIV received ART to reduce mother to child HIV transmission during the fiscal year 2023-2024.

Rwanda is implementing oral Pre-exposure prophylaxis (PrEP) among key populations and sero-discordant couples as part of the HIV prevention package. By June 2024, the number of female sex workers and men who have sex with men receiving PrEP had gradually increased to 12,187. In addition, during this fiscal year, 355,728 men were circumcised.

During this reporting period, people who were diagnosed with HIV were linked to HIV care and treatment services. By the end of June 2024, a total number of 222,604 were on ART and the overall retention rate was 94%. The overall viral load suppression was at 97%.

On the other hand, Rwanda is on course for Hepatitis B and C elimination and by June 2024, 773,693 and 719,277 were respectively screened for HBV and HCV; 11,463 and 15,639 were respectively HBs Antigen positive and HCV Antibody positive; 1,906 and 1,535 had detectable viral load for HBV and HCV respectively. The prevalence was 0.25%

and 0.21% for HBV and HCV respectively. In the end, 771 and 1,419 were respectively initiated on HBV and HCV treatment.

Alongside, 3,862,732 people were screened for other Sexually Transmitted Infections (STIs) with 209,817 (5%) who screened positive and treated. Of these, 6,127 (3%) were coinfected with HIV. Among the top syndromes we can highlight vaginal discharge (52%), urethral discharge in men (29%), pelvic inflammatory syndrome (11%) and genital ulcerations (8%).

Successful implementation to contain HIV, STIs and Viral Hepatitis and sustain the gains during this last fiscal year, is a sign of effective collaboration between the Government of Rwanda, development partners, united nations (UN) agencies, implementing partners, civil society organizations and beneficiaries towards targets set by the national strategic plan

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1. HIV PROGRAM OVERVIEW

The recent Rwanda Population-based HIV Impact Assessment (RPHIA), a national household-based study conducted in 2018–19, revealed a 0.4% decline in prevalence among adults aged 15–49 between 2014 and 2019. However, the HIV prevalence remains at 3% among adults aged 15-64, with a high prevalence peak of 7.4% among women aged 50-54 and 6.5% among men aged 55-59 years, resulting in the shift of the HIV epidemic to elderly people or those who are aging with HIV as a result of decreased mortality and antiretroviral treatment retention. In addition, the reported prevalence was higher among women (3.7%) than males (2.0%) in the adult population. The HIV incidence in Rwanda has decreased from 27 per 10,000 person-years in 2013-2014 to 8 per 10,000 person-years in 2018-2019.

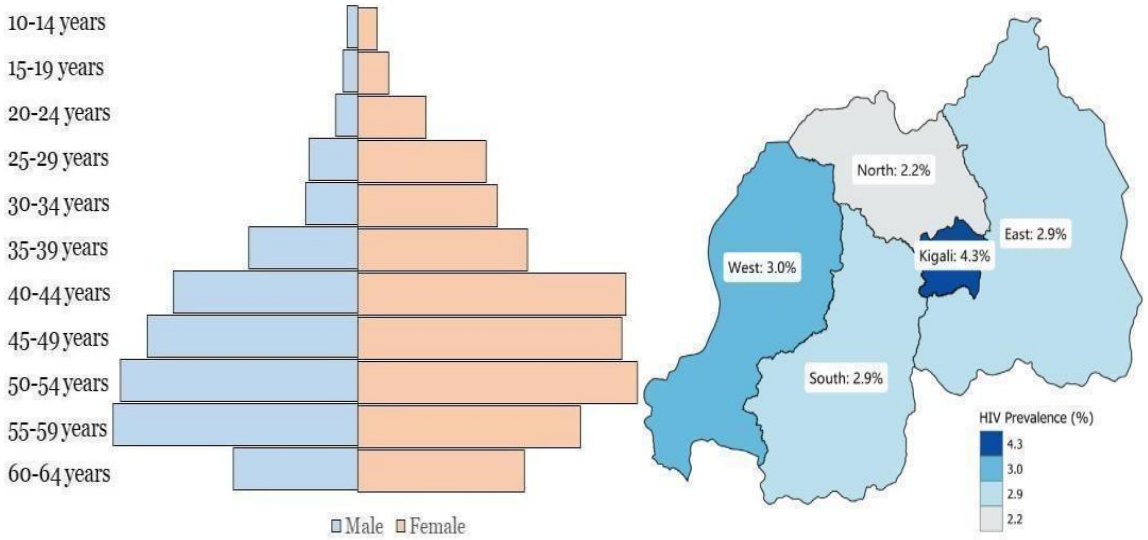


*Figure 1: **HIV prevalence by age category, sex and province***

Despite the low and stable prevalence of HIV in the general population, it remains significantly higher among key populations such as female sex workers (35.2%) and men who have sex with males (6.5%). HIV prevalence among FSWs declined from 51% in 2010 to 35.2% in 2023.

The HIV prevalence among the general population aged 15–49 years in Rwanda decreased from 3.0% in 2015 to 2.7% in 2019–2020, according to findings from demographic and health surveys (RDHS). Nonetheless, the peak of HIV prevalence

shifted from 40–44 years in 2015 to 45–49 years in 2019–2020. The cohort effect subsequently reflects the positive clinical outcome of ART retention and decreased mortality and comorbidities among people living with HIV.

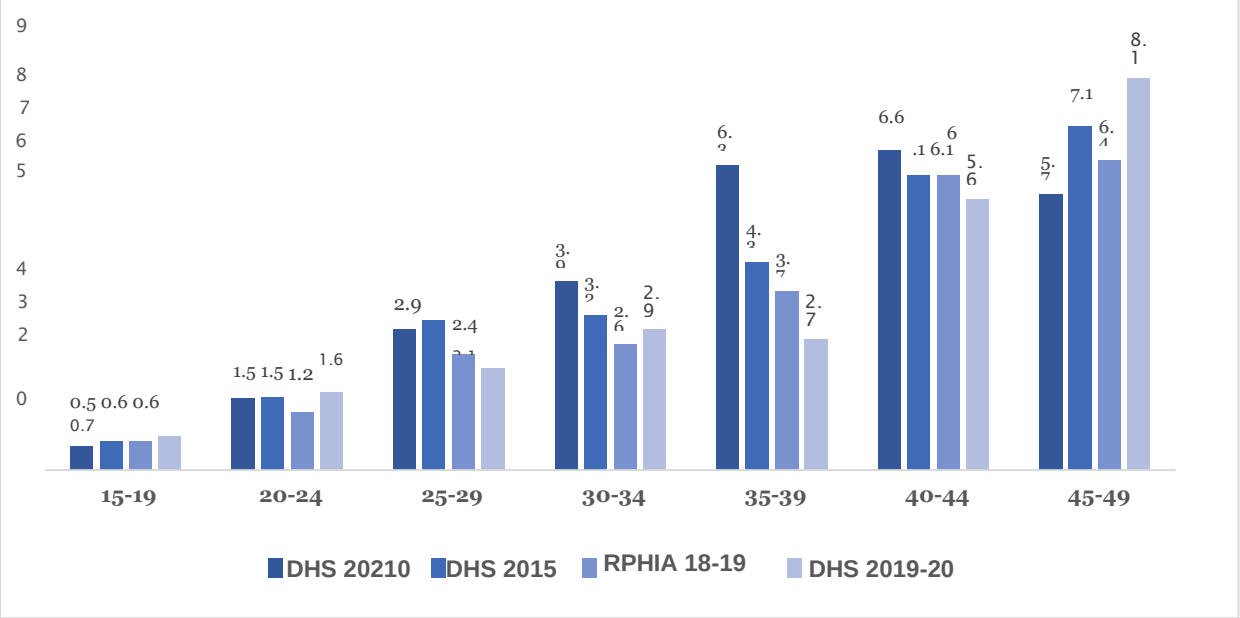


Figure 2: Trends in HIV prevalence by age and period

In the last decade, HIV services have been scaled up across the country. As a result, Rwanda has been internationally recognized for its effective response to HIV epidemic control. The Global UNAIDS report 2024, released in July 2023, ranked Rwanda as one of five African countries that achieved the 95-95-95 targets, with an estimated 96% of people living with HIV aware of their status, >98% receiving antiretroviral therapy, and >98% achieving viral load suppression. According to these estimates, Rwanda is on a path that will end AIDS by 2030. These achievements demonstrate Rwanda's dedication to ending the HIV/AIDS epidemic and improving the quality of life for the infected and affected population.

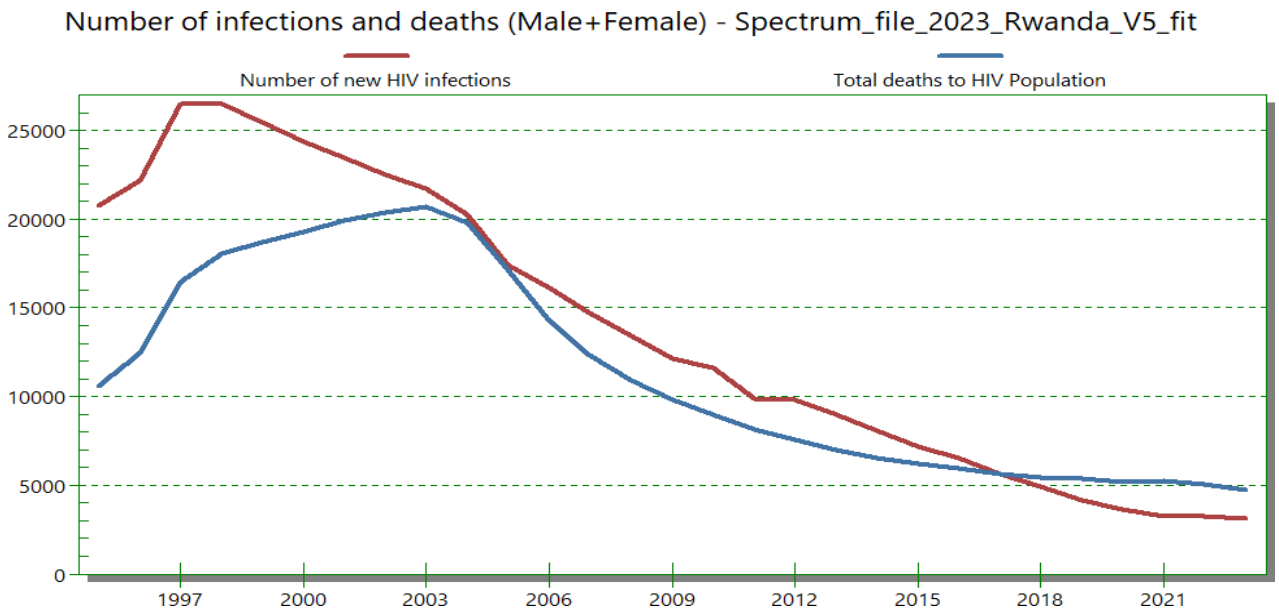


Figure 3: Trend of new infections and AIDS deaths from 1997 -2021 (source: EPP Spectrum 2022)

Rwanda has put efforts into biomedical interventions for HIV prevention. Male circumcision has increased from 13% in 2010 to 56% in 2020 and the mother-to-child HIV transmission rate has stabilized below 2% from facility-based prevention of mother-to-child transmission programs.

2. HIV PREVENTION

2.1. Introduction

Rwanda's commitment to HIV prevention is evident through its robust national programs and community initiatives. This report provides an overview of the efforts undertaken in 2023-2024 to reduce HIV transmission and improve the lives of those affected by the virus.

To meet the global target of ending AIDS by 2030, the National HIV Prevention Program coordinated efforts across various sectors, ensuring a unified approach to HIV prevention. Regular training and capacity-building workshops were conducted for healthcare professionals and community workers.

2.2. Objectives and goals of the HIV prevention program

The objectives and goals aim to create a comprehensive and effective response to the HIV epidemic. These objectives and goals typically include:

Objectives

- **Reduce New Infections:** Decrease the incidence of HIV through effective prevention strategies.
- **Increase Awareness:** Educate the public about HIV transmission, prevention, and treatment.
- **Promote Safe Practices:** Encourage behaviors such as safe sex to minimize risk.
- **Expand Testing and Diagnosis:** Increase access to and uptake of HIV testing services.
- **Support At-Risk Populations:** Provide targeted interventions for high-risk groups, such as sex workers, men who have sex with men (MSM), and vulnerable populations.

Goals

- **Universal Access to Prevention Tools**: Ensure widespread availability of condoms, PrEP, and other preventive measures.
- **Stigma Reduction:** Combat stigma and discrimination associated with HIV/AIDS.
- **Strengthen Health Systems:** Improve healthcare infrastructure and capacity to support HIV prevention efforts.
- **Community Engagement:** Involve communities in the design and implementation of prevention programs.
- **Sustainable Impact:** Develop long-term strategies for sustained reductions in HIV transmission rates.

2.1.2. The target population

Programs are tailored to address the specific needs and challenges faced by these groups to effectively reduce HIV transmission. Those groups include:

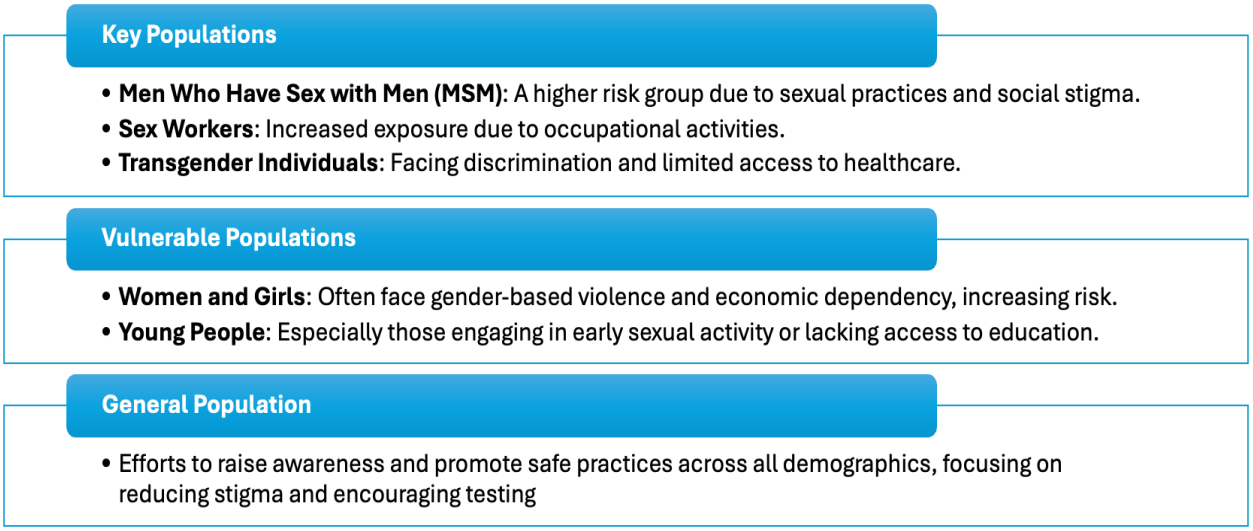


Figure 4: Key population program

2.3. HIV Testing Services (HTS)

Rwanda is committed to reducing HIV transmission and improving the health outcomes of people living with HIV. Comprehensive HIV Testing Services (HTS) are a cornerstone of this effort, enabling early diagnosis, timely treatment, and prevention of further transmission. HTS encompasses a range of services designed to reach different populations and ensure high-quality testing, counseling, and linkage to care. These services are tailored to meet the diverse needs of the population and are implemented through various channels.

HIV testing services are integrated into a comprehensive range of HIV-related interventions, including medical male circumcision (VMMC), post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), prevention of mother-to-child transmission (PMTCT), and the screening and management of sexually transmitted infections (STIs). These testing services provide a vital platform for healthcare providers to share health information, educate, and offer guidance on behavior change. Additionally, they enhance awareness about HIV/AIDS and are essential in broadening outreach efforts to engage hard-to-reach populations and boost the demand for HIV-related services.

From July 2023 to June 2024, health facilities performed 1,979,852 HIV tests across the country, with an overall positivity yield of 0.67 %. The highest, at 3.43%, was recorded from index testing.

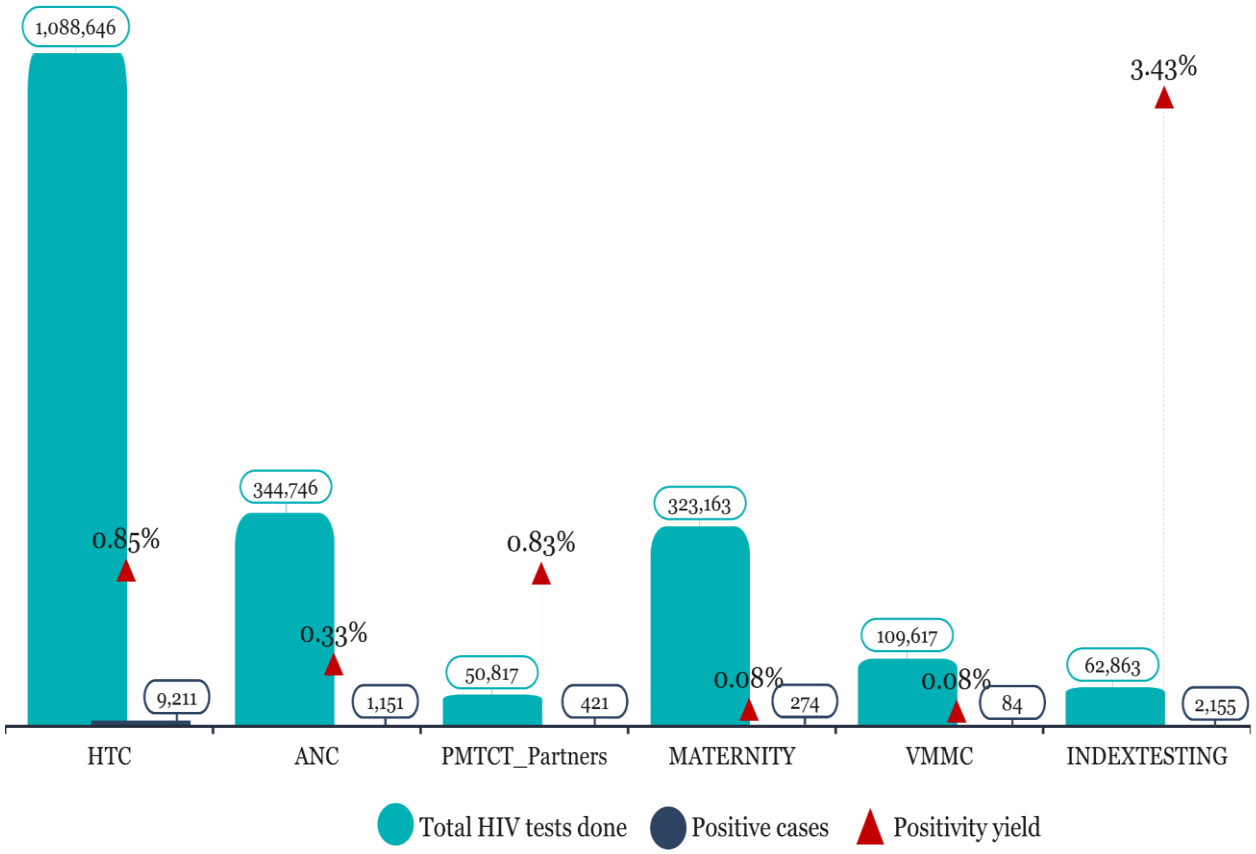


Figure 5: HIV testing and positivity yield different entry points

The figures below represent a comprehensive overview of HIV positivity yields across all provinces and districts in the country. The maps use varying shades to indicate HIV positivity yields, with darker areas representing districts that have highest positivity yields. This visualization aids in redirecting efforts towards more focused testing approaches for high-risk populations. Notably, HIV testing outcomes revealed that the City of Kigali had the highest yield at 1.1%. Conversely, the Northern and Western provinces exhibited the lowest testing yields, recording 0.54% and 0.57% respectively.

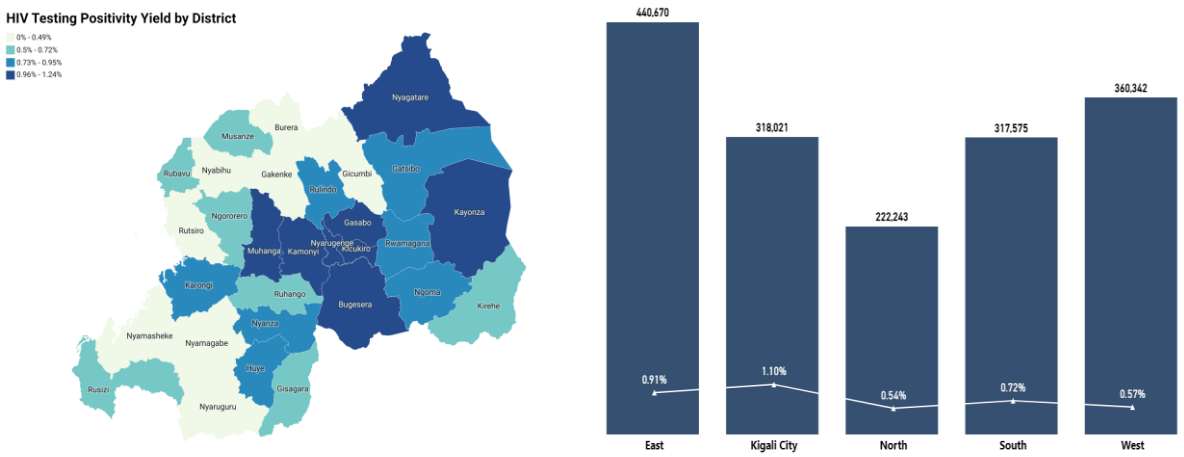


Figure 6: HIV testing yield in HTC by Districts from July 2023-June 2024 *Figure 7:HIV testing yield in HTC by Provinces from July 2023-June 2024*

The figure below highlights the trends in HIV testing, positivity rates, and the effectiveness of targeted testing strategies over the five fiscal years. The decline in the number of tests conducted in the subsequent years is reflecting changes in testing strategies, resource allocation, and the shift in focus to more targeted testing. And the increase in positivity yield suggests that although fewer people were tested in the later years, the testing strategies have become more focused and targeted towards higher-risk populations.

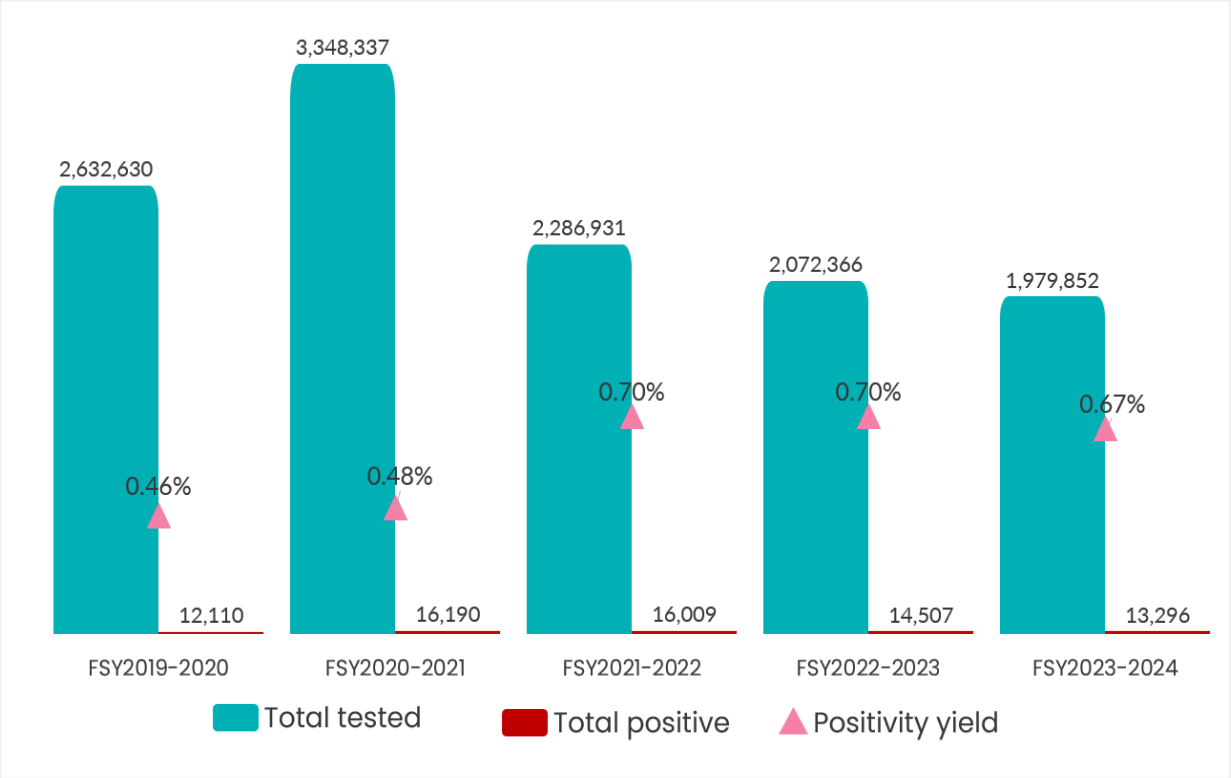


Figure 8: Trend of Total HIV Tests done and Positivity yield for the last 5 years (HMIS)

2.4. Case-based surveillance (CBS)

Case-based surveillance (CBS) is an innovative HIV testing approach designed to identify people living with HIV (PLHIV) who are unaware of their status. This method employs active case finding techniques, primarily utilizing index testing and recency testing strategies. The primary goal of CBS is to expand HIV testing coverage and identify previously undiagnosed cases within the population.

In its early stages, CBS implemented a voluntary partner notification process. Trained

healthcare providers would engage with index clients (those already diagnosed with HIV) and individuals from high-risk populations. These providers would sensitively inquire about the sexual partners and family members of these individuals. If the index client consented, the provider would then extend HIV testing services to the identified contacts. This approach aimed to create a network of testing opportunities stemming from known HIV-positive individuals.

As the program progressed, there was a significant scaling up of index testing and partner notification services. This expansion was implemented across all health facilities nationwide, marking a substantial increase in the program's reach and effectiveness. Enrollment of index clients in CBS increased steadily: from 8% at the end of June 2020, to 21% in end of June 2021, and 31% in end of June 2022. The widespread adoption of these services allowed for a more comprehensive approach to HIV case finding throughout the country.

In the next phase of the CBS rollout, the focus shifted to prioritizing newly identified HIV-positive individuals. Particular attention was given to those who had documented risk factors for HIV transmission. This targeted approach aimed to concentrate resources on individuals most likely to benefit from early intervention and treatment, as well as those who might be at higher risk of transmitting the virus to others.

More recently, the scope of CBS has broadened to include clients who are already established on antiretroviral therapy (ART). This expansion serves two primary purposes. Firstly, it aims to exhaust all possibilities for active case finding, ensuring that no potential cases are overlooked. Secondly, it facilitates the longitudinal follow-up of clients, allowing for better monitoring of treatment adherence and overall health outcomes for PLHIV.

The impact of these strategic implementations and expansions has been significant. The number of index cases enrolled in CBS has seen an exponential increase. From a baseline of 96,372 individuals (representing 47% of eligible PLHIV) in June 2023, the program has grown to include 198,216 index cases by June 2024. This remarkable growth means that CBS now encompasses 95% of all PLHIV above 18 years of age.

2.4.1. Index testing and partner notification services

Index testing and partner notification services are vital strategies in Rwanda's HIV program. By ensuring that the sexual partners and children of people diagnosed with HIV

are tested and linked to care, so that we can continue to make significant progress in reducing HIV transmission and improving the health and well-being of our population.

This approach focuses predominantly on identifying and locating the sexual partners, social networks, and biological children of an HIV-positive person referred to as an index client. Partner notification, on the other hand, is a voluntary program in which counselors and/or healthcare professionals inquire about the sexual relationships among clients on ART and newly diagnosed, also known as "index clients." During partner notification and services, healthcare providers are looking for information on their sexual partners and family members. If the index clients agree to share information about their sexual relationships, they are invited to a health facility and offered a voluntary HIV test.

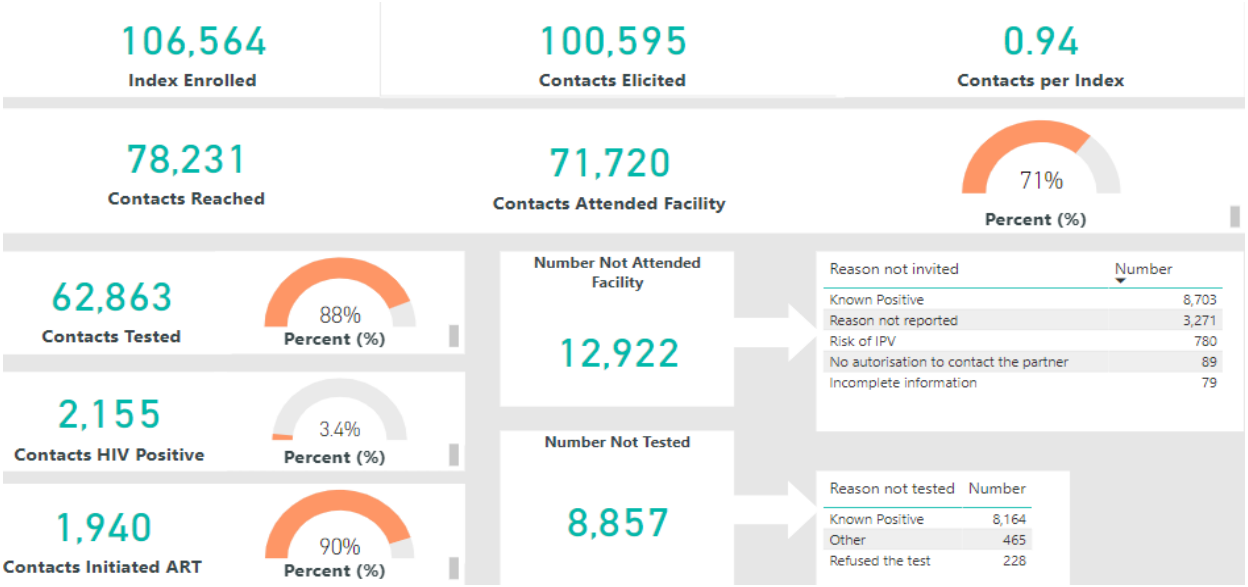


Figure 9: Index testing cascade (July 2023–June 2024)

The figure below illustrates the testing results during this reporting period. Out of 62,863 contacts tested, 2,155 were diagnosed as HIV-positive. Notably, the data reveals a significantly higher positivity yield among females aged 15-24, with rates reaching 5% and 8%, surpassing those of their male peers in the same age group.

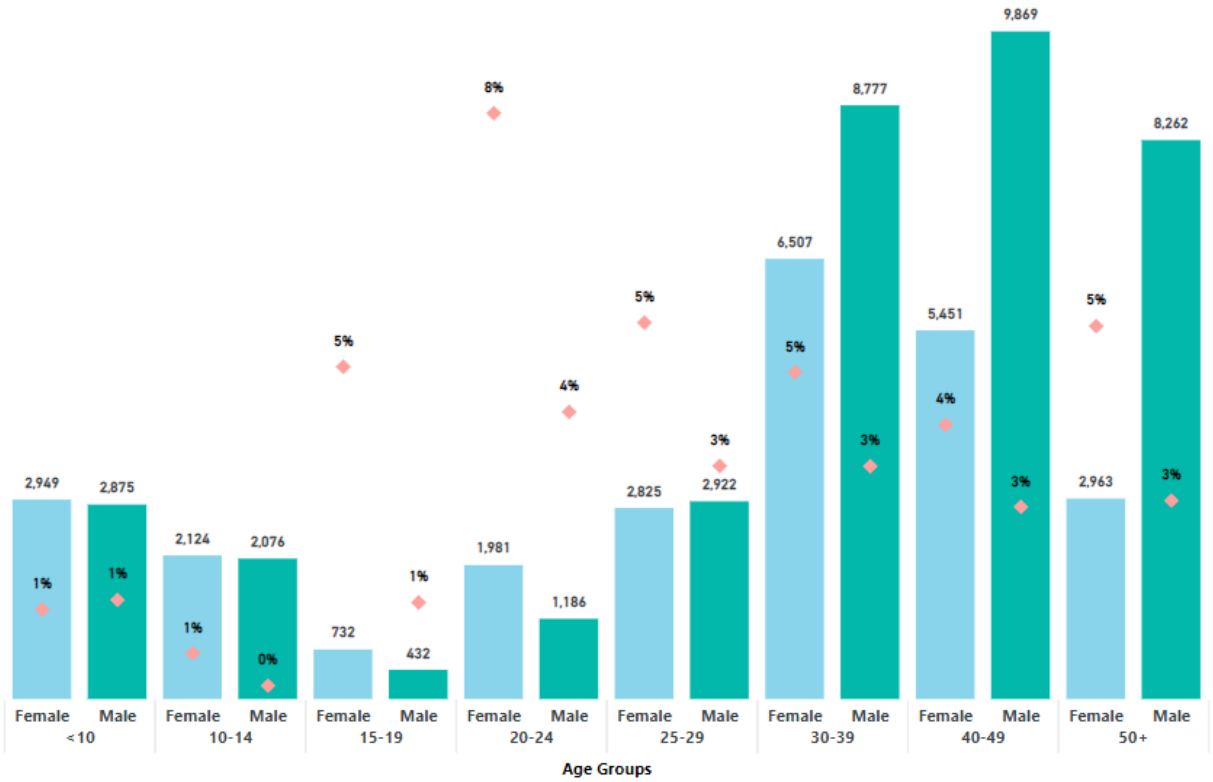


Figure 10: Number of contacts tested by age, sex and positivity rate.

From July 2023 through June 2024, partner notification services were used to identify and test contacts, and the results of this process are displayed in the accompanying figure below, encompassing family members, sexual partners, and social networks. The data demonstrate varying HIV positivity yields among these different contact categories, with social networks exhibiting the highest rate in comparison to sexual partners and family members. These partner notification services, implemented through index testing, primarily aim to improve the efficiency of HIV testing efforts. This goal aims to ensure that 95% of people living with HIV are aware of their status, aligning with the first target of the UNAIDS by 2030.

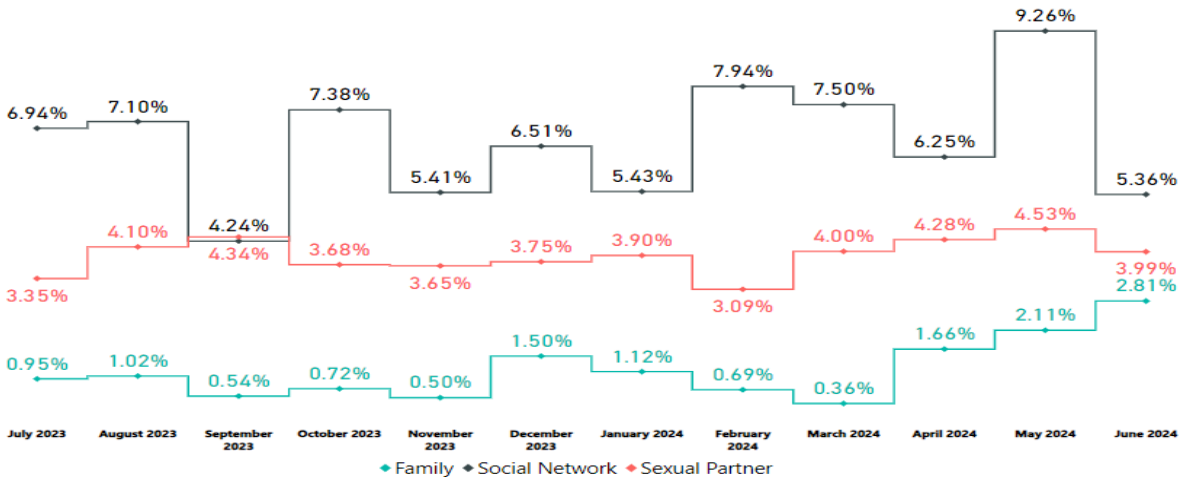


Figure 11: Trend in positivity rate by contact type (July 2023-June 2024)

2.4.2. HIV recency testing

As Rwanda progresses toward epidemic control, surveillance of newly diagnosed persons ensures that interventions target those at highest risk of acquiring or transmitting HIV infection. Recency testing is one of the approaches that we have tapped into to identify recent HIV infections, defined as those acquired within approximately the last one year. Recent HIV-1 infection (RTRI) rapid test has been incorporated into routine HIV testing services that facilitates the establishment of a surveillance system to quickly detect, monitor, and characterize recent infections among newly diagnosed HIV cases. Data from a recent infection surveillance system contribute to data-driven approaches to finetune a country's programmatic response through prioritized programming and resource allocation.

HIV recency testing surveillance serves multiple essential functions. It helps understand how HIV is transmitted, identifies hotspots for new HIV infections, helps describe behaviors that contribute to ongoing HIV transmission, and optimizes the use of data to inform effective prevention interventions.

Changes in recent infection hotspots have been observed over the last 3 years, with a higher number of recent infections increasing in Eastern Province while in other provinces the number decreases or remains the same. Many clusters of recent infections were identified around the major national roads.

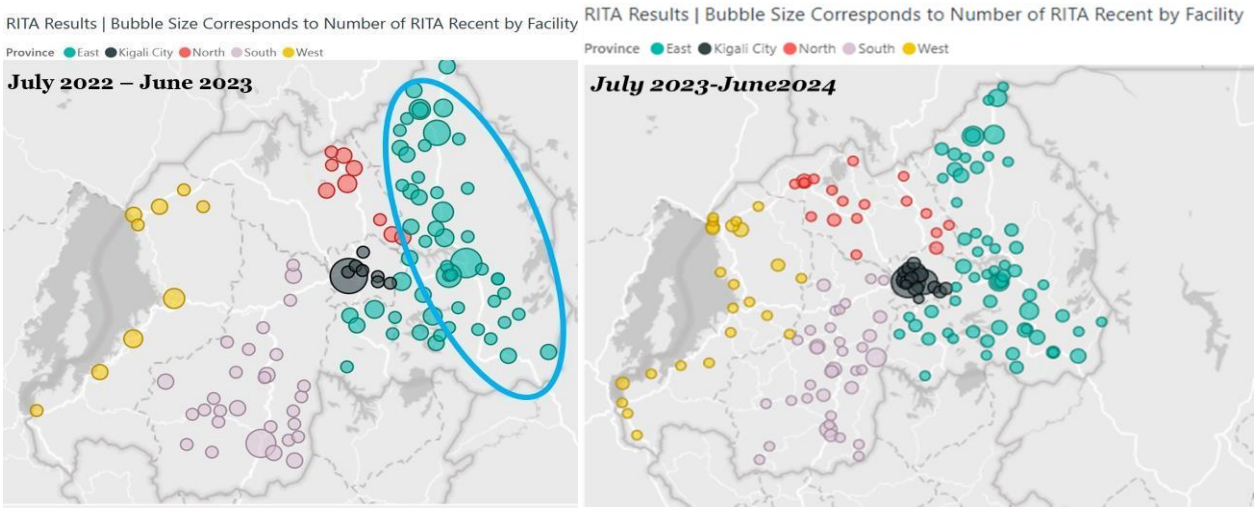


Figure 12: RITA Recent infections patterns by location and time

Recency testing approaches;

Two testing approaches in the laboratory network modes in Rwanda are currently used:

- **Centralized HIV recency testing:** Since 2021, the national program has successfully implemented HIV Recency testing in all District Hospitals across the country.
- **Point-of-care testing (POCT):** Performed at 78 different sites across the country including 13 Hub, with the plan to increase the number of POC by focusing on sites with high numbers of recent infections. The national program has improved the quality of these services through constant quality control checks and proficient testing activities.

The map below shows HIV recent infections by province. The highest number of cases of recent HIV infection observed in Eastern Province has triggered program responses such as awareness campaigns in identified hotspots within that province.

Overall, 9,588 out of 12,097 newly diagnosed HIV diagnosed persons were tested through the rapid test for recent infections (RTRI). Among the 756 who were tested recent on RTRI,756 were tested for viral load to eliminate the bias of prior exposure to ARVs. Of those tested for viral load, 315 were confirmed as recent infections, while 441 were reclassified as long-term infection, the latter representing potential people living with HIV already on ART who repeat HIV testing.

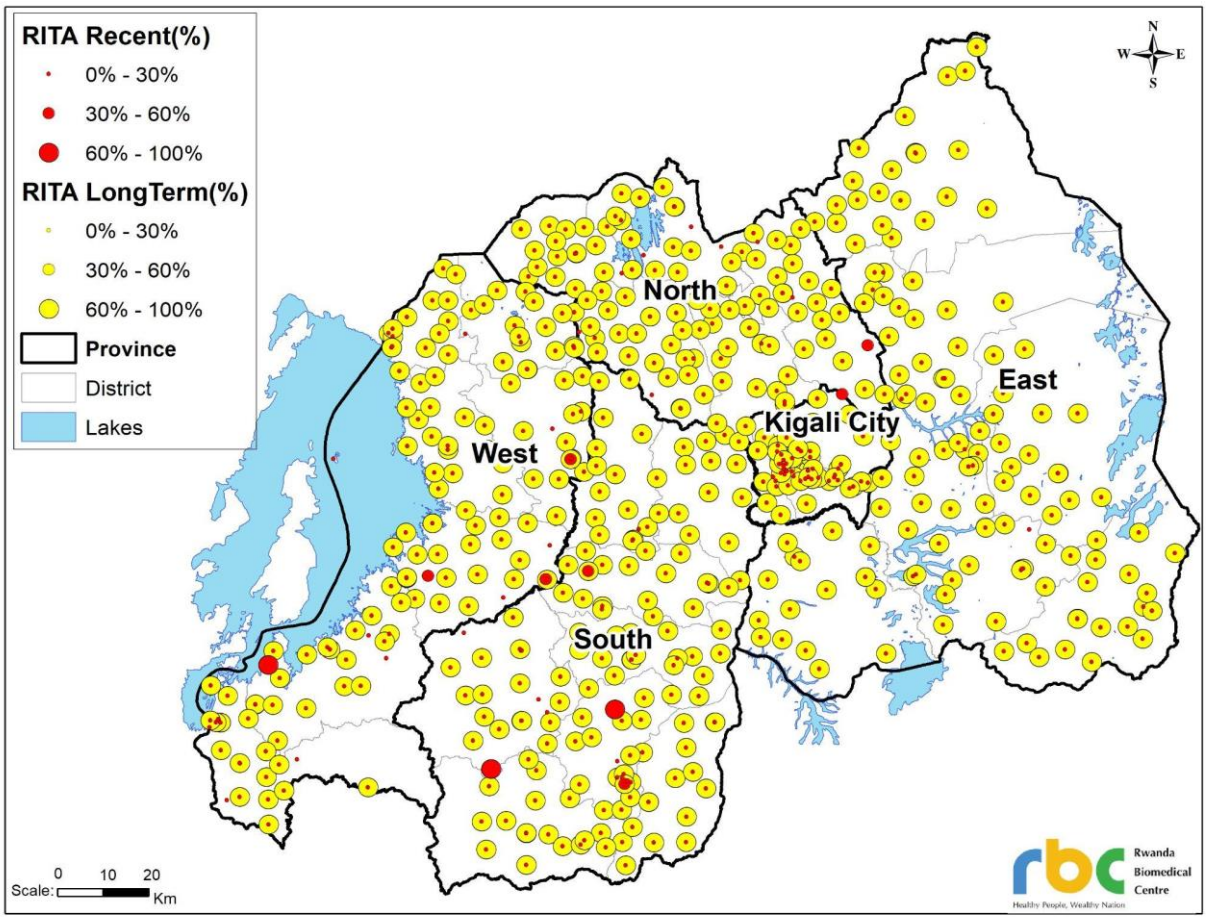


Figure 13: Distribution of Recent and long-term infections across Rwanda, July 2023-June 2024

HIV recency testing is critical for the surveillance of new infections and their geographical spread across the country. The figures above show that females aged 15-30 years have a higher rate of positive results compared to males in the same age range. Additionally, this figure below highlights the significant number of recent infections among females in this age group.

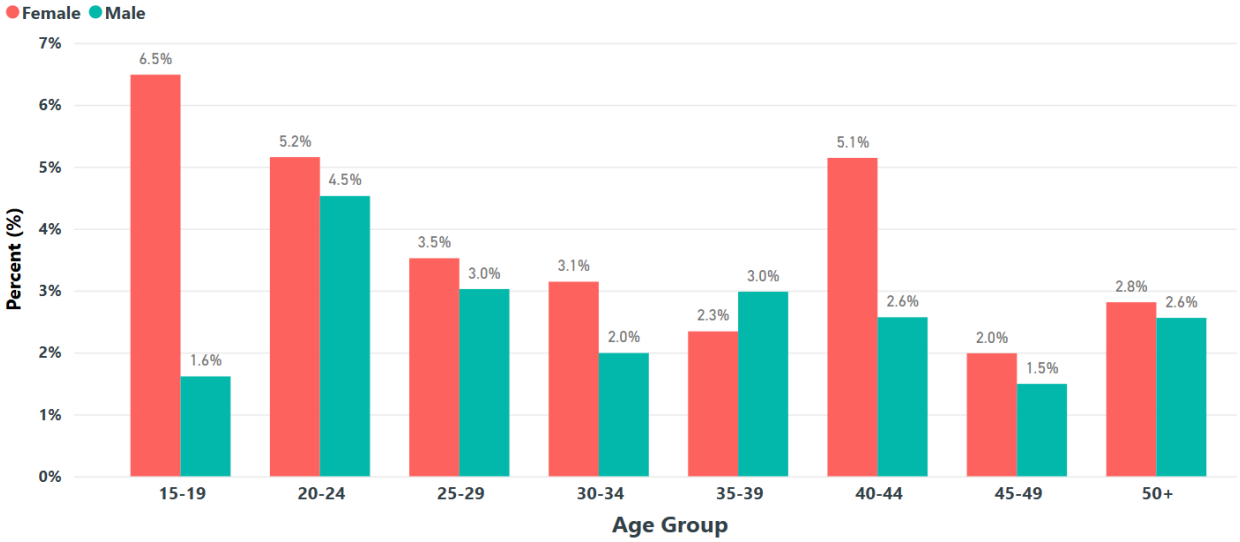
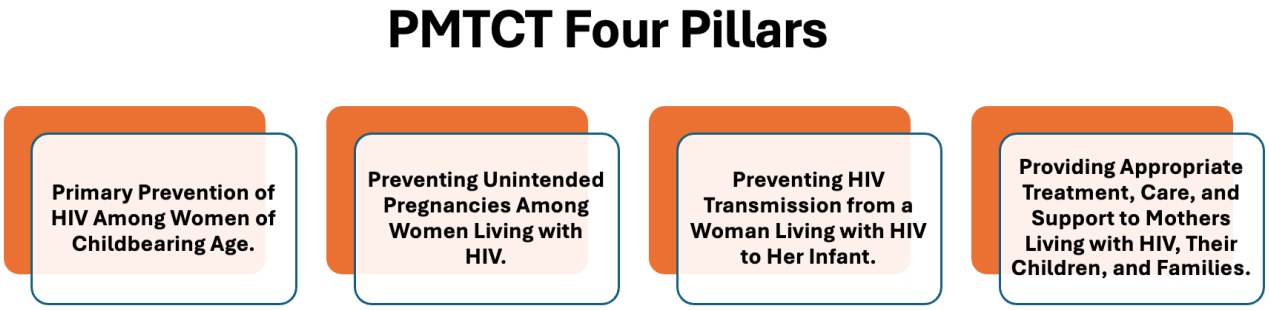


Figure 14: Number of recent cases by age and sex (July 2023-June 2024)

2.5. Prevention Mother to Child Transmission (PMTCT)

Rwanda maintained a strong commitment to eliminating HIV transmission from mother to child. The PMTCT Program has shown a notable progress on decreasing mother to child HIV transmission since inception, the Programmatic data has shown a decrease of MTCT Rate at less than 2% since 2015 to Date. On the basis of the four pillars of PMTCT, a comprehensive package of services is provided to prevent HIV transmission from mother to child.



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

HIV testing and continuum of care for pregnant women with HIV are crucial components of preventing mother-to-child transmission (PMTCT) and ensuring the health and well-being of both the mother and the child, and HIV testing is systematically provided to all pregnant women and their partners with unknown and Negative HIV status at their first antenatal care visit. Thus, those tested HIV positive are linked to the PMTCT Program and Start the Option B+ to prevent mother-to-child HIV transmission.

Between July 2023 and June 2024, a total of 349,244 pregnant women attended their first antenatal care (ANC) visit. Of these, 4269 were already known to be HIV positive. Out of the remaining women, 344,746 were tested for HIV. Among those tested, 1151 were newly diagnosed with HIV, resulting in a positivity rate of 0.33%. A total of 99.9% of All PW Eligible for HIV testing were tested for HIV in ANC July 2023-June 2024.

From July 2019 to June 2024, the HIV prevalence among pregnant women who attended antenatal care visits decreased from 2.26% to 1.55%, respectively. During this fiscal year, the HIV prevalence among all women tested in ANC is approximately 1,55%. All women who were not tested for HIV during ANC or those who received negative results were again tested in maternity during labor or at the time of delivery. Out of a total of 323,163 pregnant women who were tested for HIV during labor or delivery, 274 tested positives for HIV. Among all women who tested positive for HIV during both ANC and maternity, 99,8% of them received ART to prevent the transmission of HIV to their babies.

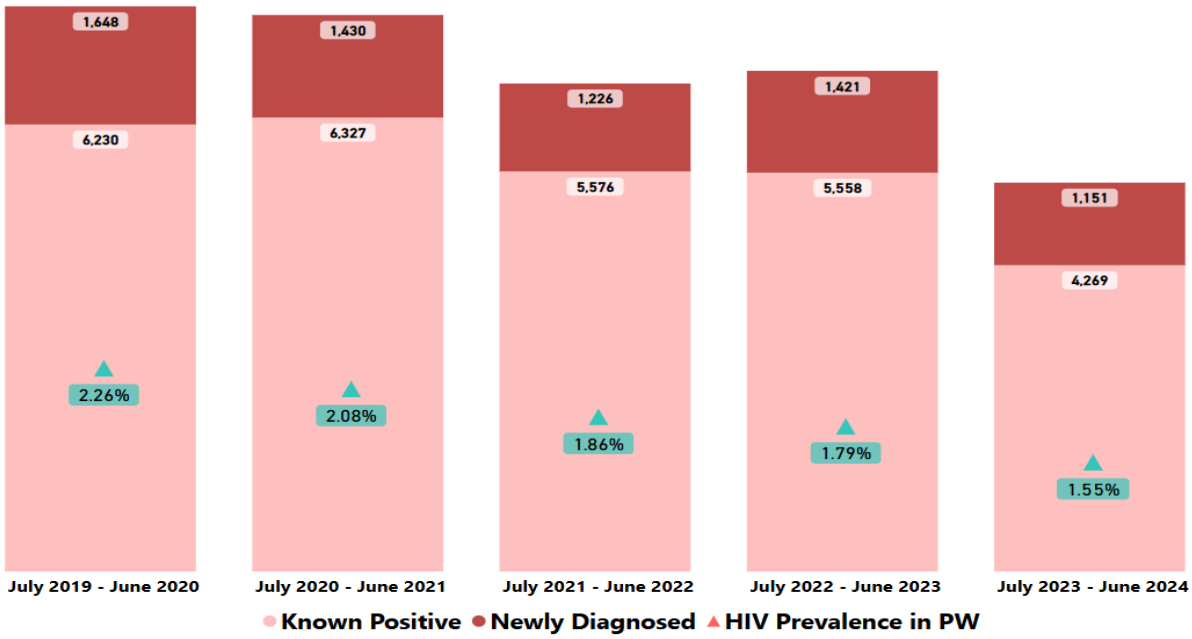


Figure 15: Trend of HIV prevalence in ANC among Pregnant women from 2019-2024

2.5.2. Triple Elimination of mother-to-child-transmission of HIV, Syphilis and Hepatitis

The Triple Elimination initiative in Rwanda aims to drastically reduce mother-to-child transmission (MTCT) of HIV, syphilis, and hepatitis. Implemented since 2023, this

strategy seeks to enhance maternal and child health outcomes by ensuring low transmission rates of these three infections. Rwanda's health facilities are now comprehensively screening pregnant women for HIV, syphilis, and hepatitis B virus (HBV) in Antenatal Care.

Specific guidelines and a surveillance system are being developed to monitor at-risk women and track infant outcomes. In the current fiscal year, 344,746 pregnant women were screened for HIV, with a 0.33% positivity rate. For syphilis, 326,756 women were screened, with 3,619 confirmed positive, showing a 1.04% prevalence rate. For HBV, 202,618 women were screened, and 3,661 had detectable viral loads, with 404 starting treatments.

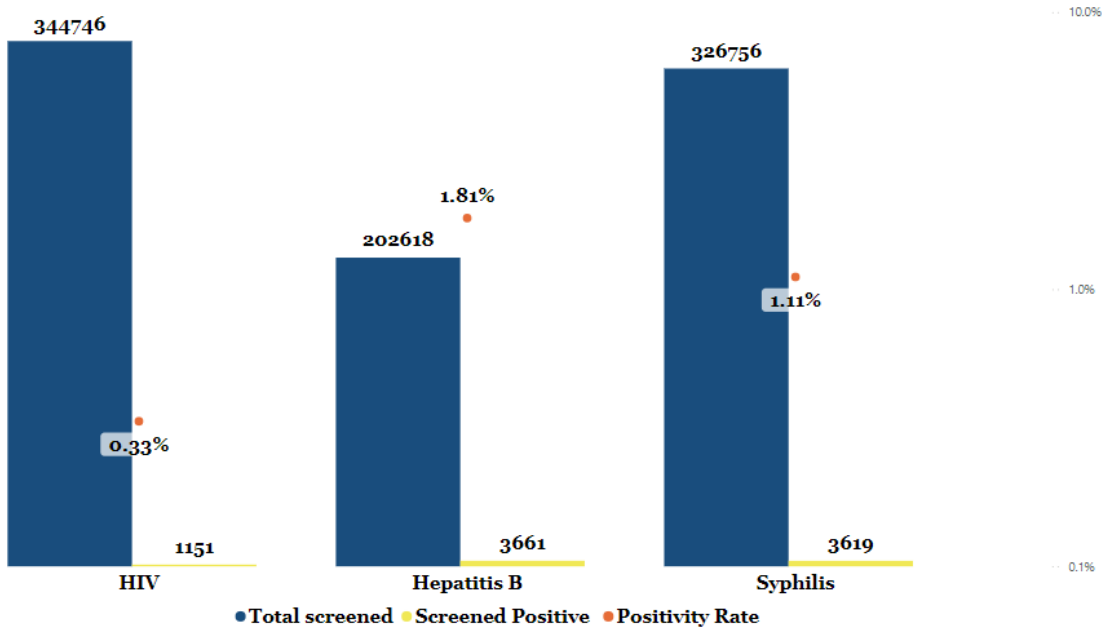


Figure 16: HIV, Syphilis and Hep B infection Among pregnant women, July 2023 - June 2024

2.5.3. Follow-up of HIV-exposed Infants

Follow-up of HIV-exposed infants is a critical component in the prevention of mother-to-child transmission (PMTCT) of HIV. This process involves regular monitoring and healthcare interventions to ensure early detection and treatment if the infant acquires HIV. Here are the key elements involved in the follow-up of HIV-exposed infants:

Children of HIV infected mothers have to be enrolled in the program at birth in the maternity or postnatal ward. Although the ideal enrollment age is at birth or within the first six weeks, children can theoretically be enrolled up to 24 months old, in this fiscal

year 100% of All Children who were born from HIV Positive mothers were enrolled in the PMTCT Program. when HIV infection can be ruled out by a rapid antibody test. A rapid PCR test confirms a positive antibody result. HIV-exposed infants undergo scheduled testing at specific intervals (6 weeks, 9 months, 18 months, and 24 months) to ensure timely diagnosis and prompt initiation of antiretroviral therapy (ART) for those who test positive. Among 5467 children who were born from HIV-positive Women in Maternity July 2023 to June 2024, 27 (1%) tested HIV positive at 6 weeks 5(0.1%) at 9 months 23(0.4%) at 18 months and 2 (0.03%) at 24 months

This year, we included children born to HIV-positive mothers who completed their two-year follow-up during the current reporting period. A total of 4,104 children were included in the analysis, with an overall mother-to-child transmission (MTCT) rate of 0.9% at 24 months. This cohort demonstrates that 99.1% of HIV-exposed infants were free of HIV at 24 months, reflecting a significant decrease in the MTCT rate and showing a decreasing trend over time.

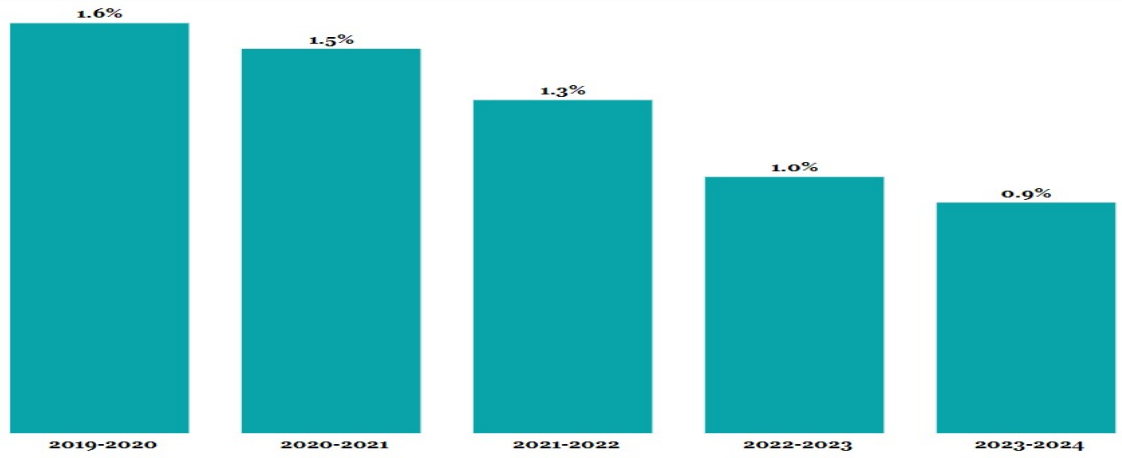


Figure 17: Trend of HIV MTCT rate from 2019-2024

2.6. Voluntary medical male circumcision (VMMC)

Voluntary Medical Male Circumcision (VMMC) is recognized as a key HIV prevention strategy, and Rwanda has implemented VMMC programs since 2008 to reduce HIV transmission rates. The Ministry of Health (MOH), through the Rwanda Biomedical Centre, in collaboration with other implementing partners, has scaled up the service throughout the country in all health facilities.

Through comprehensive strategies, including widespread availability, education, and

adherence to safety standards, Rwanda has made considerable progress in its VMMC program; as a result, in DHS 2019-2020 ,56% of men reported being circumcised, the below map show district in highest percentage of men and those with lowest percentage of men circumcised.

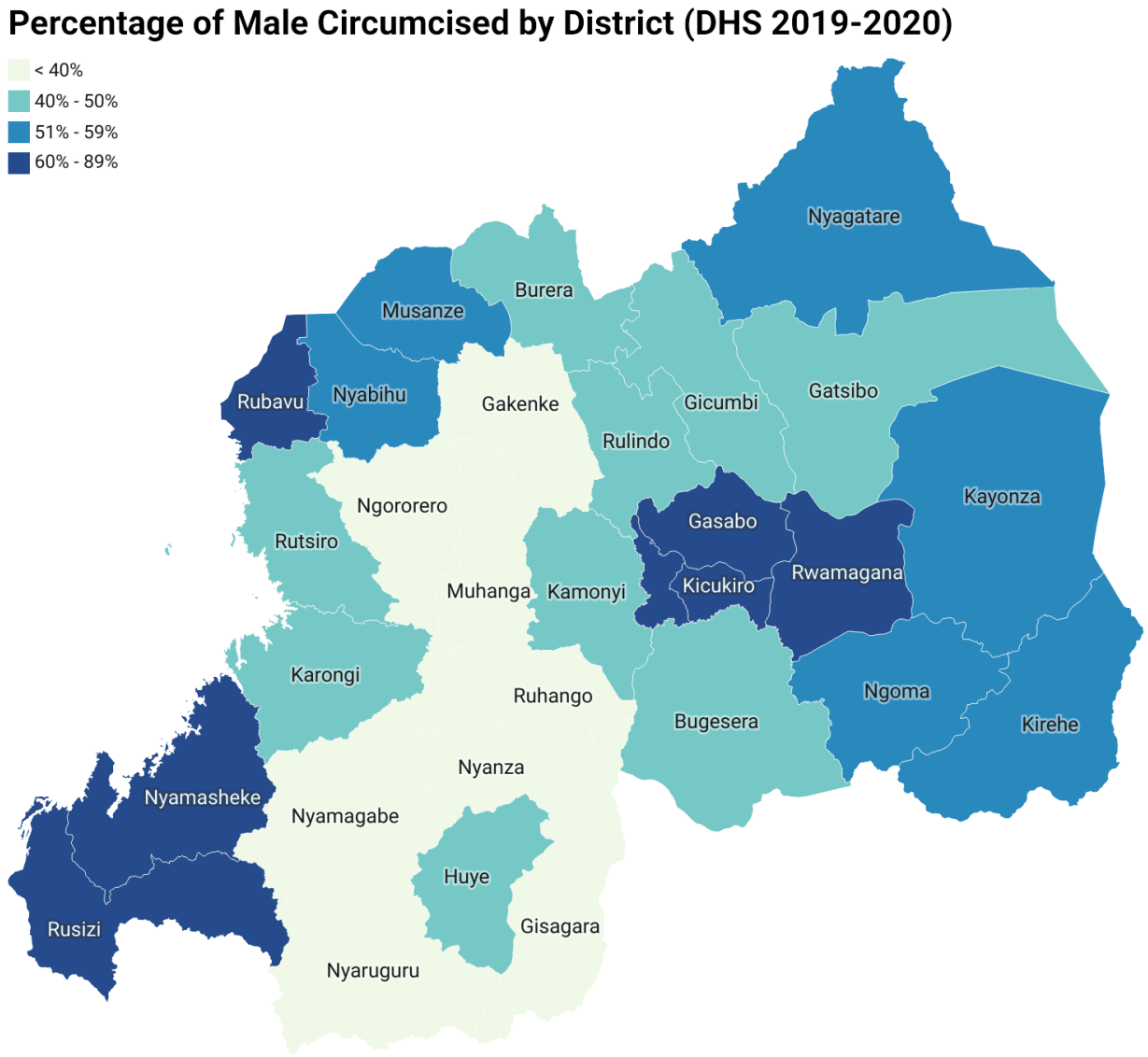


Figure 18: Percentage of male circumcised by District (DHS2020)

Since then, substantial efforts have been made across the country, aligned with the HIV national strategy plan, to increase VMMC prevalence and ensure the program's sustainability. Key activities included capacity building of healthcare providers, mentorship and campaign activities in various districts.

Between July 2023 and June 2024, a total of 355,728 males were circumcised. Among these, 355,338 underwent surgical circumcision, while 390 were circumcised using a medical device (Morgan Clamp).

As illustrated in the map below, the districts of Nyabihu, Gicumbi, Gatsibo, Rwamagana, and Nyamasheke reported higher numbers of circumcisions compared to the districts of Kicukiro, Rulindo, Burera, Ruhango, Muhanga, and Rusizi.

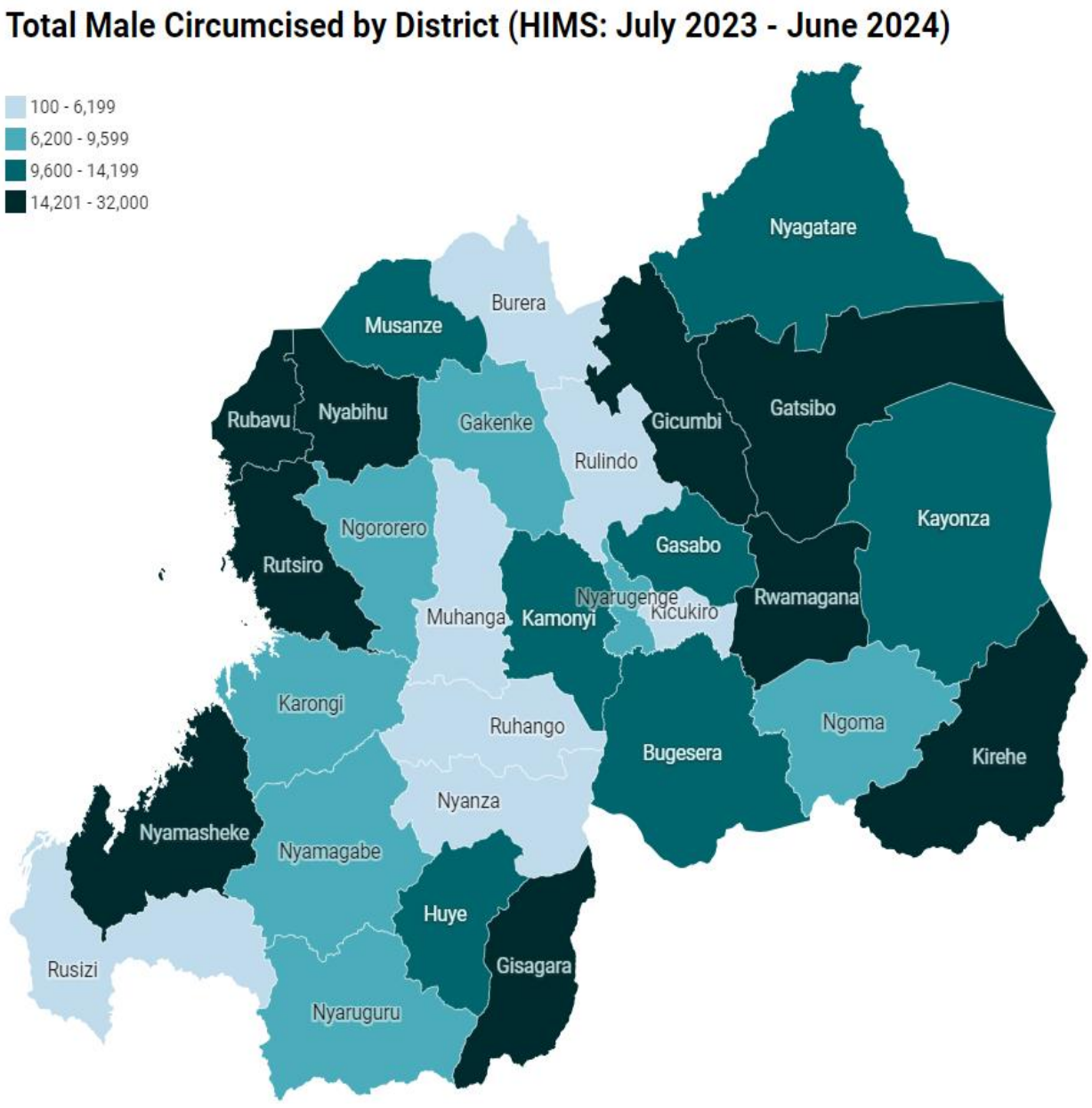


Figure 19: Total male circumcised per district (HMIS 2023-2024).

The figure below illustrates trends of males circumcised by age group during the fiscal year 2022-2023 and 2023-2024. This year, males aged 15-19 years had the highest number of circumcisions compared to last fiscal year, while men aged 50 years and above still show up in low numbers to circumcision services even though there is a slight increase compared to last fiscal year.

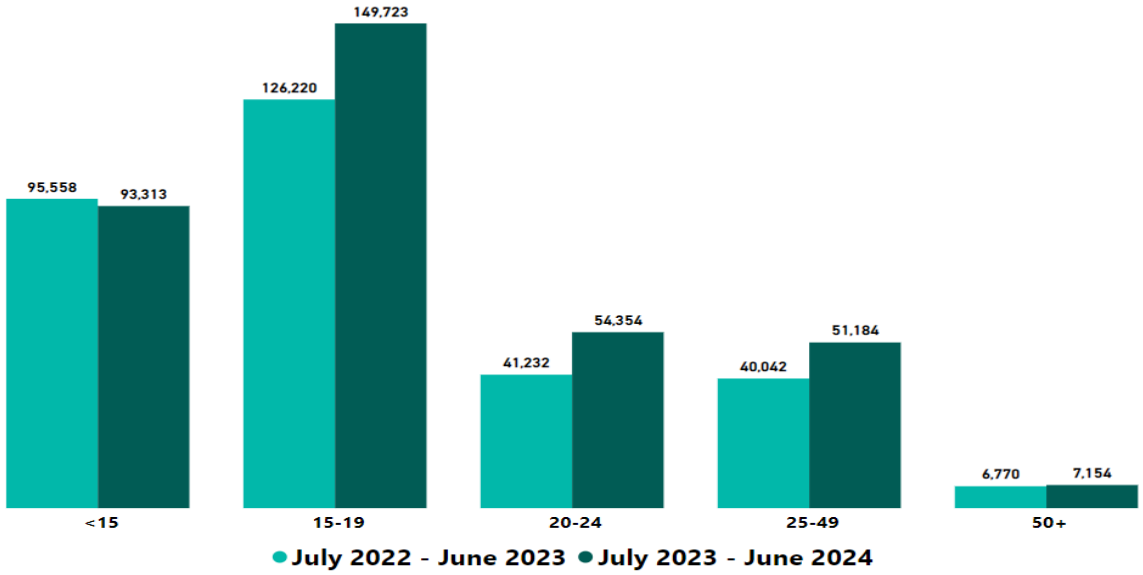


Figure 20: Number of VMMC performed by age group, July 23-June 24

The figure below presents data on the number of male circumcisions performed across five fiscal years (2019-2020 to 2023-2024), distinguishing between surgical circumcisions and medical device circumcisions. The number of surgical circumcisions has generally fluctuated over the years, with a peak in 2020-2021 (462,479) and a slight decline in subsequent years. Medical device circumcisions showed a significant drop after 2019-2020, decreasing from 53,794 to just 390 in 2023-2024.

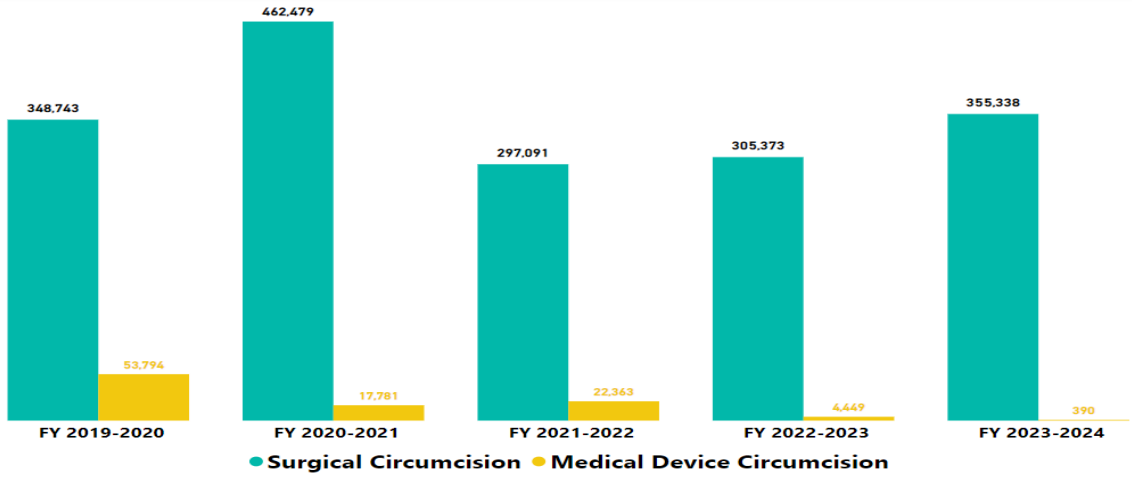


Figure 21: Trend of male circumcised for the last 5 years by either surgical or device methods (HMIS)

2.7. Condom programming

Over the past twenty years, Rwanda has seen a steady increase in condom use. Condom programming in Rwanda plays a vital role in the country's strategy to curb the spread of

HIV, other sexually transmitted infections (STIs), and unintended pregnancies. This comprehensive approach includes various key components to ensure condoms are accessible, available, and used effectively across the population. The program emphasizes leadership, coordination, partnerships, ensuring a stable supply, promoting access and demand, and establishing robust support systems for effective condom use.

Additionally, the condom program targets highly affected groups, such as sex workers, men who have sex with men, Adolescent Girls and Young Women (AGYW)and long-haul truck drivers. These targeted interventions involve distributing condoms in high-traffic areas frequented by these vulnerable populations.

During this fiscal year 2023-2024, a total of 29,794,225 condoms were distributed across Rwanda. Distribution channels included health facilities, social marketing, and condom kiosks. Additionally, peer educators played a significant role by distributing condoms during community outreach sessions.

Comparing these two fiscal years, there is a notable increase in condoms that were distributed in health facilities than in 2023-2024 attributed to enhancement in awareness on HIV services and various implementing partners distributing condoms in health facilities, also note a decrease in condom distributed in social marketing.

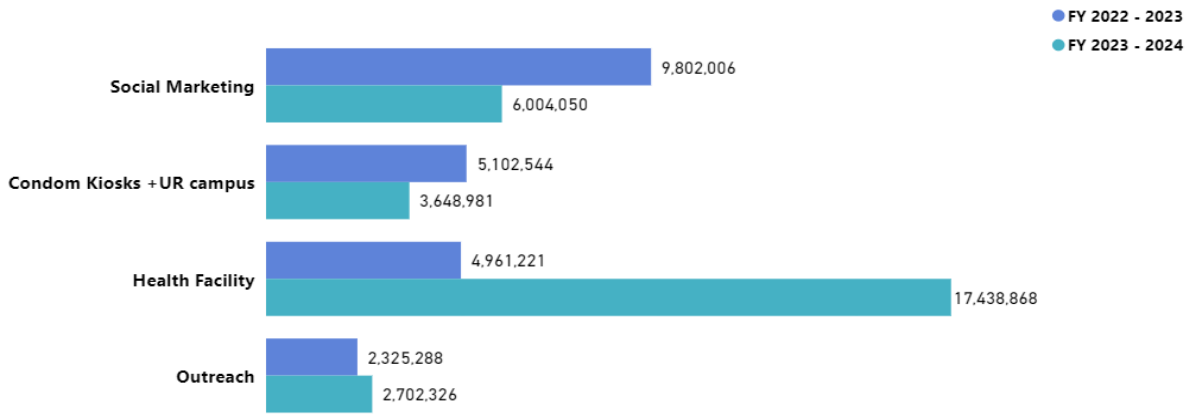


Figure 22: Condom distribution

2.8. Key Population

Key and priority populations play a crucial role in the spread of the HIV epidemic. Their vulnerability is shaped by individual attitudes, societal changes, various sexual orientations, and gender identities. Risky behaviors such as alcohol and drug use, unprotected sex, and transactional sex further heighten their risk. Additionally, factors like poverty, stigma,

discrimination, and limited access to support services exacerbate their susceptibility.

National HIV program, Key Population, includes men who have sex with other men (MSM), female sex workers (FSW), and clients of female sex workers and other priority populations. Health facilities receive specific training to provide services that are friendly to these groups at risk, such as HIV testing and counseling, condom distribution, and comprehensive HIV prevention messages.

The graphs below illustrate data for FSW who were followed at the health facility (HF) during the reporting period. It also shows the number of individuals who are HIV positive and those who are ART, according to HMIS program data.

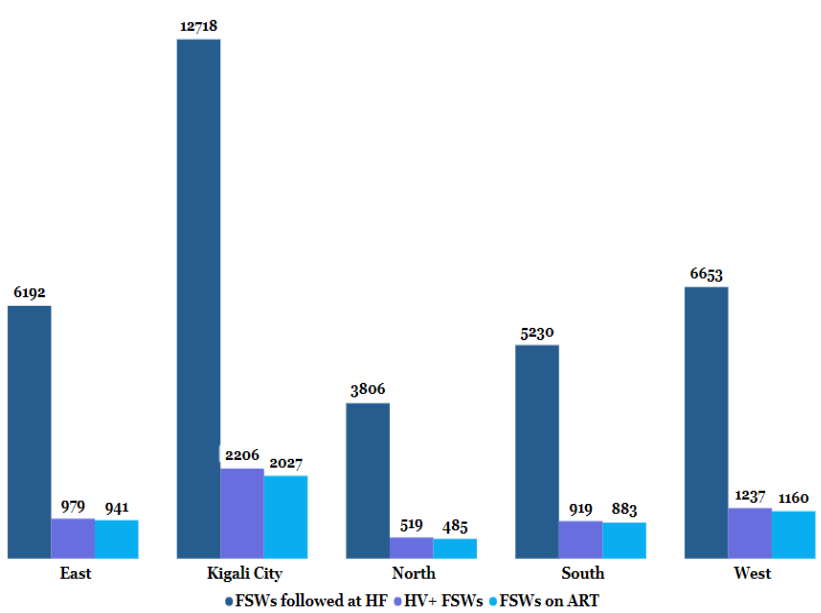


Figure 23: Distribution of FSWs per Province

The figure below provides a comprehensive overview of the number of Men who have Sex with Men (MSM) who are being followed at the health facility in each province. Additionally, it demonstrates those who have tested positive for HIV and those who are currently receiving Antiretroviral Therapy (ART). where Kigali City has the largest number of MSM being followed among the other provinces.

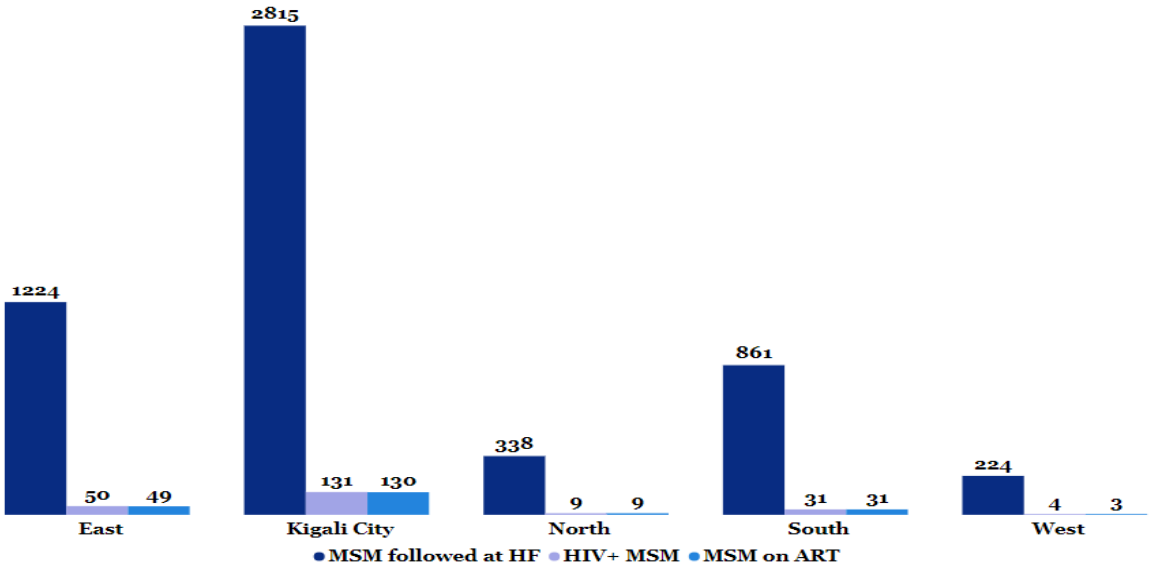


Figure 24: Distribution of MSM by Province

Progress towards 95-95-95 UNAIDS targets among KP (IBBSS)

Rwanda has made remarkable strides in addressing HIV/AIDS, particularly in reaching the 95-95-95 targets set by UNAIDS. These targets aim for 95% of people living with HIV to be aware of their status, 95% of those diagnosed to receive continuous antiretroviral therapy (ART), and 95% of those on ART to achieve viral suppression by 2030. Significant progress has been observed among Key Populations (KPs).

The graph below demonstrates Rwanda's significant progress towards the 95-95-95 UNAIDS targets among Key Populations. Through extensive outreach and testing programs, targeted interventions to reduce stigma, and comprehensive healthcare services especially among FSW as showcased during the recent IBBSS (2023), where there is still some progress to be made in MSM as illustrate during IBBSS (2021) to as to achieve the 1st 95.

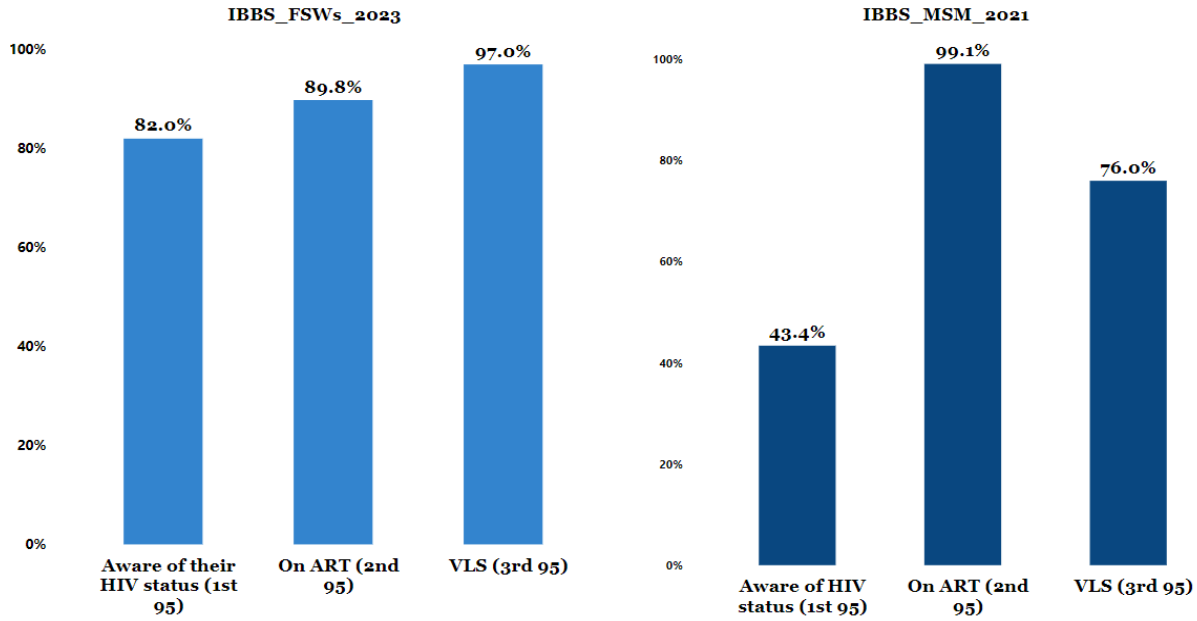


Figure 25: Progress towards 95-95-95 UNAIDS targets among Key Populations in Rwanda

2.9. Pre-Exposure Prophylaxis (PrEP)

Pre-Exposure Prophylaxis (PrEP) is a preventive strategy for individuals at high risk of acquiring HIV infection. Rwanda has been proactive in its efforts to combat HIV/AIDS and has integrated PrEP into its national HIV prevention programs.

The Ministry of Health through RBC in collaboration with implementing partners, has made significant efforts to ensure broad access to PrEP. The program in Rwanda is aimed at reducing new HIV infections among key and vulnerable populations, including FSW, MSM, sero-discordant couples, and other high-risk groups.

By the end of June 2024, the number of FSW and MSM receiving PrEP is 12,187 as shown in the below detailed graph.

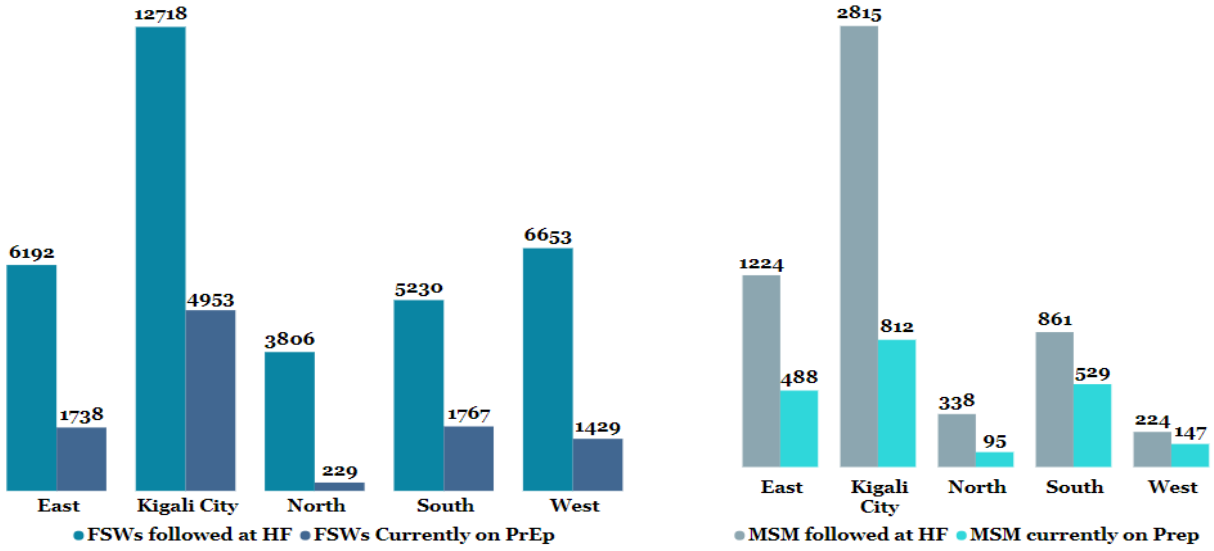


Figure 26: Key Populations currently enrolled on PrEP

Capacity Building of Health Care Providers on PrEP

Pre-Exposure Prophylaxis (PrEP) for HIV has been implemented in phases, targeting key populations and high-risk groups. These include female sex workers (FSWs), men who have sex with men (MSM), sero-discordant couples (SDCs), sexual partners of index clients, and adolescent girls and young women (AGYW) who are at a high risk of HIV infection. End June 2024, 312 Health facilities are trained and mentored in provision of PrEP and friendly services to KPs.

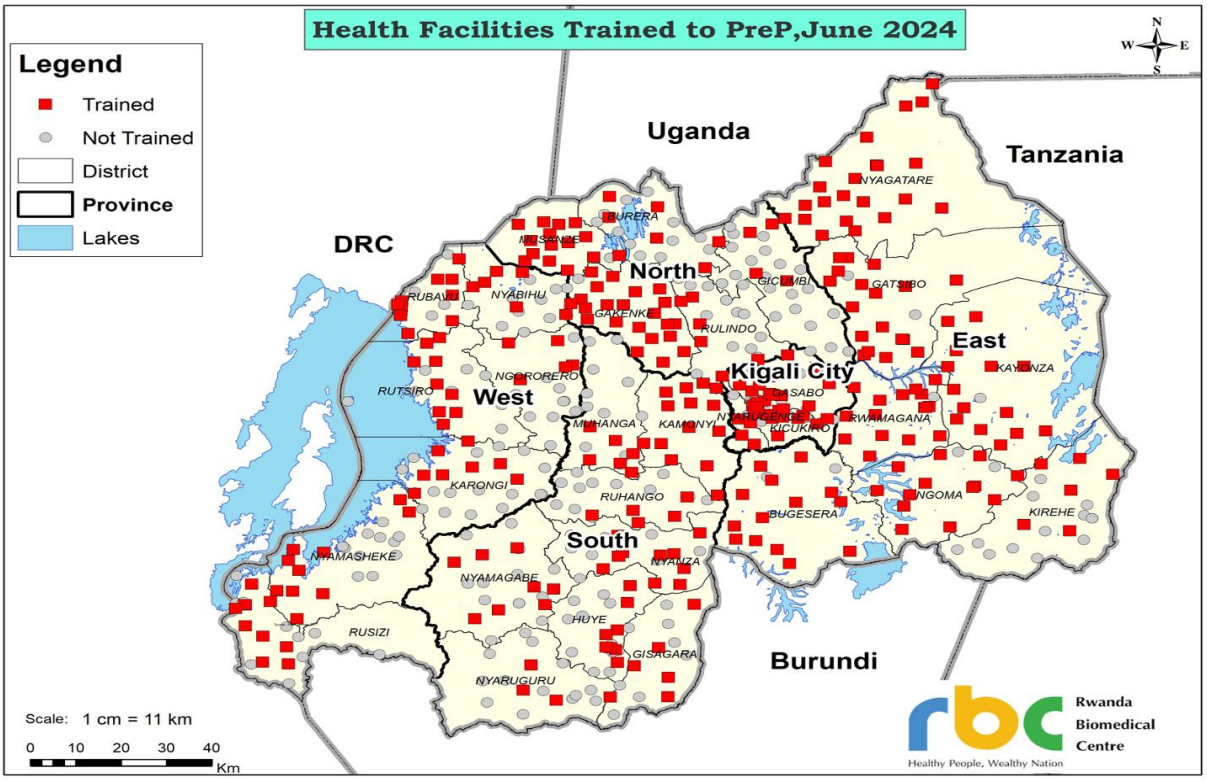


Figure 27: Health facilities trained on Prep, June 2024

2.10. Adolescent Girls and Young Women (AGYW)

Adolescent girls and young women (AGYW) are particularly vulnerable to the risk of acquiring HIV. In Rwanda, this group is recognized as a crucial priority population, leading the national HIV program to develop an extensive array of services specifically designed to meet their needs through the AGYW minimum package of services. The objective of the AGYW program is to decrease the rates of new HIV infections and unplanned pregnancies among adolescent girls and young women aged 10 to 24 in Rwanda.

Furthermore, the program aims to empower AGYW with knowledge about their sexual and reproductive health rights (SRHR) and to provide education on HIV/AIDS, sexually transmitted infections (STIs), prevention strategies, family planning, and mental health. Through engagement across multiple sectors, partners and implementers provided Adolescent Girls and Young Women (AGYW) with formal education, life skills training, Technical and Vocational Education and Training (TVET and support for economic strengthening to enhance their economic resilience. The main objective of the HIV prevention program aimed at AGYW is to gain a thorough understanding of their most vulnerable circumstances and improve their access to both biomedical and non-biomedical HIV prevention services.

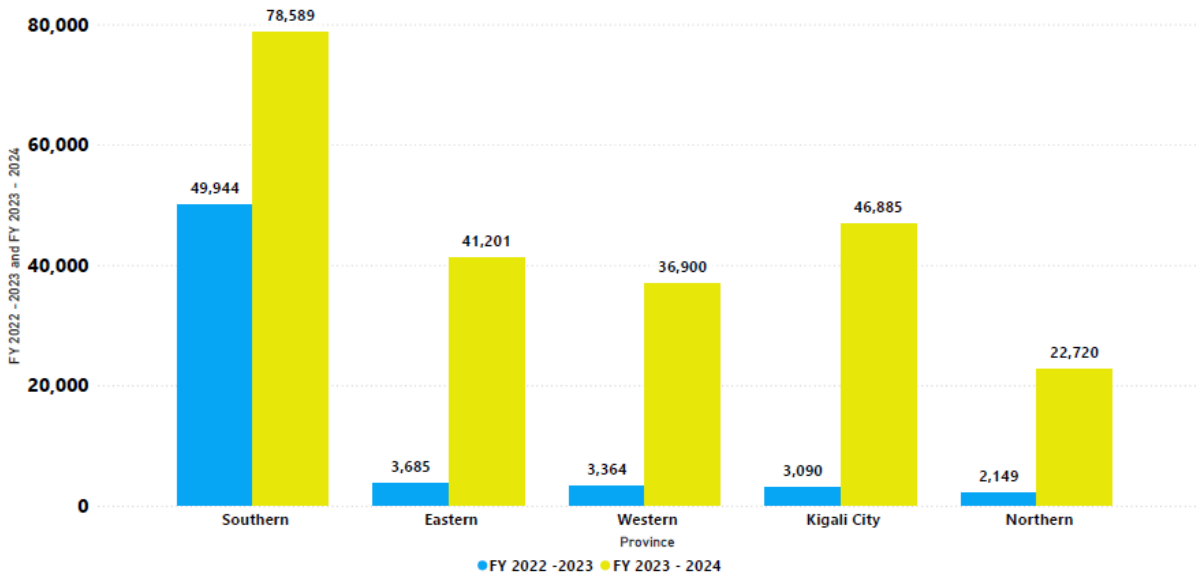


Figure 28: Enrollment and follow up of AGYW by Province

HIV positivity yield among high-risk adolescent girls and young women

The estimated HIV positivity rate among high-risk AGYW linked to healthcare facilities stands at (0.84%). This rate is notably higher in the Eastern province at (1.78%), while it is lowest in the Southern province at (0.34%) among AGYW who were tested for HIV.

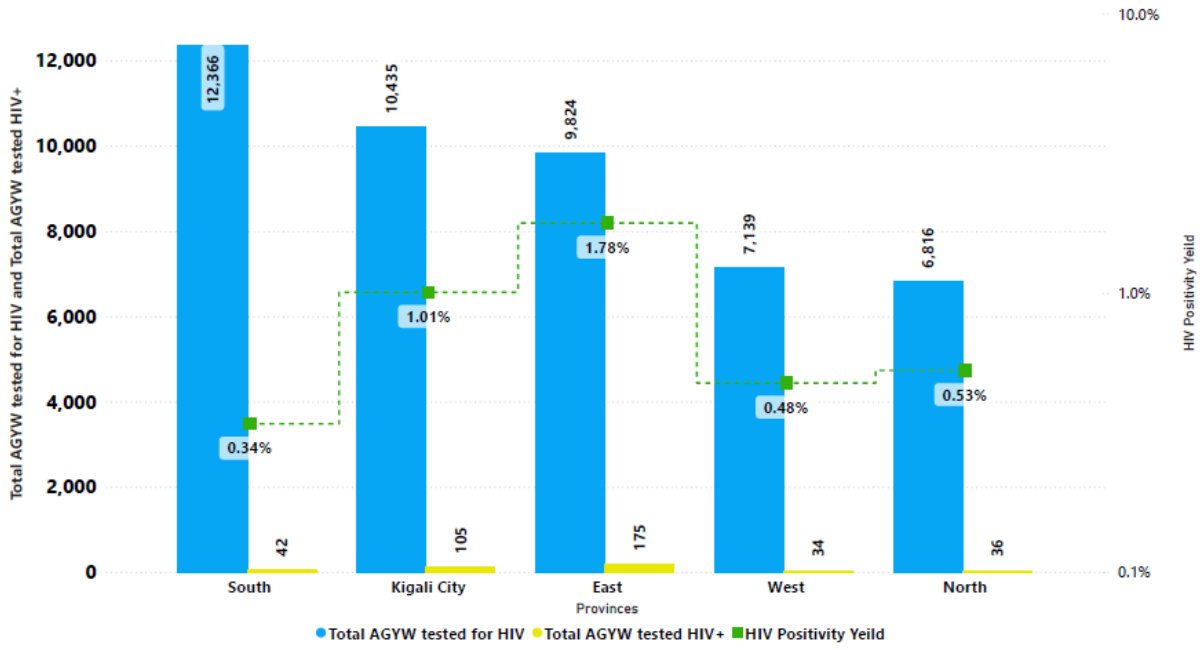


Figure 29: Positivity yield among AGYW by Province

Achieving UNAIDs Target among Adolescent girls and young women

UNAIDS 'target focuses on making sure that 95% of all people living with HIV know their HIV status and that 95% of those diagnosed and are on ART. This goal is especially important for adolescent girls and young women, as they are at higher risk of HIV infection. Knowing their status helps these young women access the support and treatment they need, which leads to healthier lives and communities. By achieving these targets, we can help reduce the number of new infections and provide better care, allowing young women to live full and healthy lives without the burden of HIV. The highlight on the initiative emphasizes the importance of education, testing, and treatment as key steps to combating the HIV epidemic in this vulnerable group.

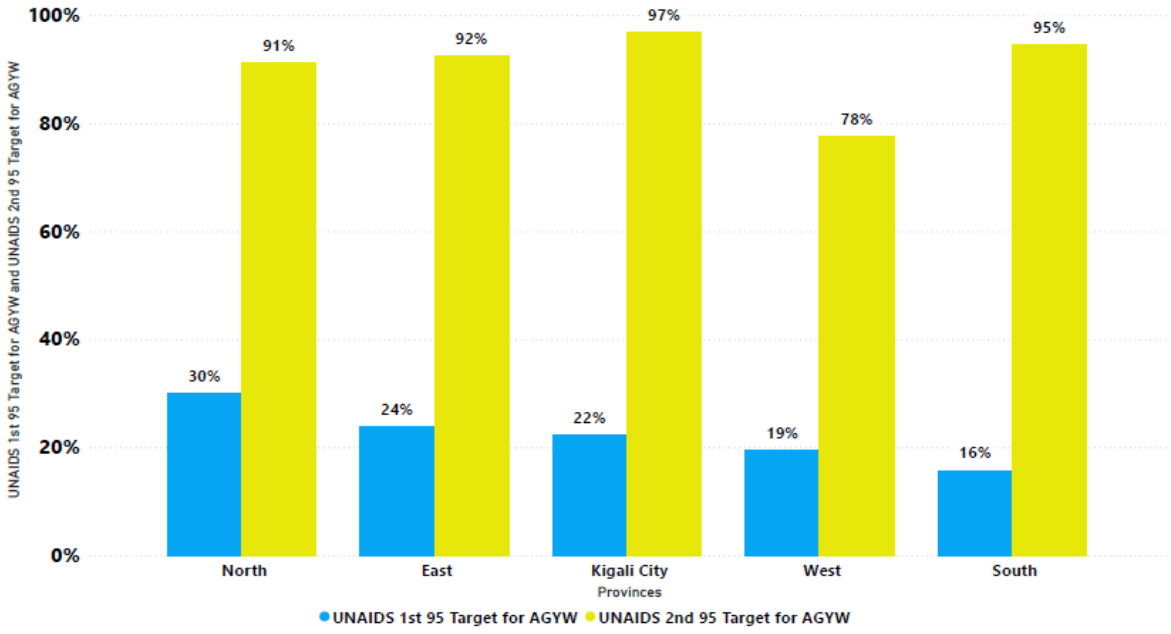


Figure 30: Achieving UNAIDs targets among AGYW

Outreach, service delivery, and education targeting AGYW and their male partners.

Community outreach initiatives are actively working to enhance awareness and mitigate stigma, alongside health education campaigns for adolescent girls and young women (AGYW) that highlight the advantages of comprehensive HIV prevention and sexual and reproductive health (SRH). Partnerships with community organizations and stakeholders have improved access to pre-exposure prophylaxis (PrEP services. Peer educators and mentors within the AGYW demographic have received training on comprehensive HIV prevention methods, SRH, voluntary medical male circumcision (VMMC) for their male partners, and prevention of mother-to-child transmission (PMTCT) services.

Efforts are being intensified to elevate the quality of care provided in both healthcare facilities and community settings, emphasizing the delivery of a complete minimum service package through the establishment of private and supportive consultation spaces for AGYW. Specific interventions are being rolled out to tackle particular healthcare issues faced by AGYW, which includes raising awareness by training a group of youth peer educators on HIV prevention and SRH.

2.11. Pre-exposure prophylaxis (PrEP) among AGYW and their male partners

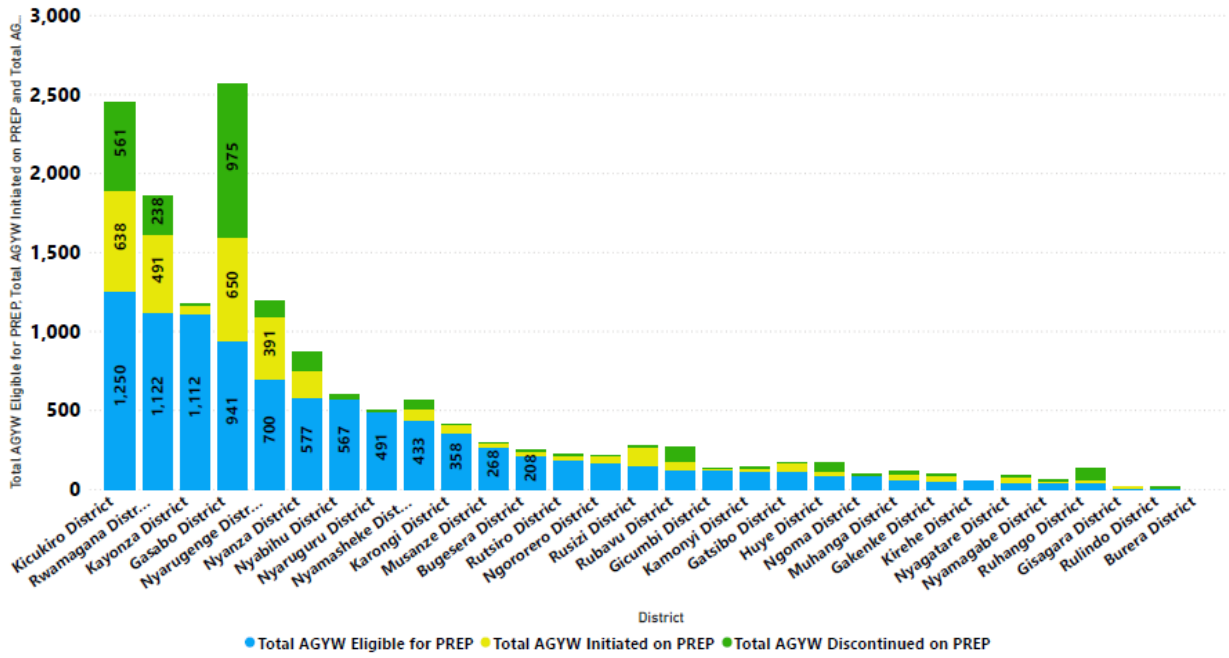


Figure 31: ***AGYW on PrEP from July 2023- June 2024.***

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

Rwanda is focused on advancing behavior change communication (BCC) initiatives. These efforts aim to alter personal behaviors and promote changes at the community and societal levels. BCC strategies are designed to address the underlying factors that influence the adoption and maintenance of positive behaviors, by promoting risk awareness and assessment and encouraging individuals to avoid risky actions.

Implementing BCC interventions involves a combination of approaches targeting risky behaviors and the epidemic's drivers. This requires enhancing access to, uptake of, and adherence to both behavioral and biomedical interventions. BCC and information

education and communication (IEC) programs seek to improve public awareness and understanding of HIV risks and vulnerabilities, leading to increased personal risk reduction and higher uptake of prevention services.

2.12.1. HIV Awareness

Increasing awareness about HIV is a key strategy in reducing new HIV infection. It's important for both the general population and specific target groups to be aware of available HIV prevention, care, and treatment services.

This fiscal year, multiple approaches were utilized to enhance awareness of HIV, sexually transmitted infections (STIs), and Viral Hepatitis prevention. These efforts included creating and broadcasting radio and television spots, distributing newsletters, and leveraging social media along with large-scale promotional campaigns.

2.12.2. Mass campaigns

HIV Prevention initiatives, such as campaigns, have been pivotal in greatly enhancing access to comprehensive HIV service packages for both the general population and key and priority populations, particularly those with limited access or utilization. Additionally, these campaigns have been essential in distributing extensive information on comprehensive HIV prevention methods.

Rwanda Biomedical Centre (RBC), through its division of HIV, STIs, Viral Hepatitis, and Other Viral Disease Control, organized and launched a national campaign mainly during the preparation of World AIDS Day 2023.

Ensuring the availability and accessibility of HIV prevention, care, and treatment services in Rwanda is essential for meeting the global goal of ending AIDS by 2030. In line with the "Every Voice Matters" theme, various speakers underscored the importance of community engagement in HIV prevention and impact mitigation. They highlighted the need for everyone to contribute to and participate in ending AIDS.

After the WAD celebration, HIV national program with its implementing partners participated in a Car free day run in Kigali to continuously raise awareness in the fight against HIV.

2.12.3. Youth Campaign

HIV/AIDS awareness campaigns targeting youth were conducted from May 7th to 18th in Eastern Province (Nyagatare, Gatsibo, Kayonza, and Rwamagana Districts).

It began in Rwamagana District, one of the districts with a high number of new HIV infections. Despite the availability of HIV/AIDS prevention services countrywide, the uptake among youth remains a challenge.

The awareness campaign was aimed at raising awareness about the disease in order to reduce its prevalence and increase the uptake of related services among young people.

2.12.4. Radio and TV shows to raise awareness.

During this last year, 2023-2024, public and private media houses were used to provide information and education on available HIV prevention services, including new strategies for HIV service delivery. During this reporting period, 735 DJ mentions, 5400 TV spots and 232,920 radio spots were aired.

2.13. Civil society organizations engagement

2.13.1. Background and Context

Despite the low and stabilized HIV prevalence in the general population, it remains substantially higher among key populations of female sex workers (35.5%) and men who have sex with men (6.5%). The trend of HIV prevalence among FSWs shows a decrease from 51% in 2010 to 35.5% in 2019. The decrease was seen mainly in 2015 in the city of Kigali and the southern province because of the implementation of facility-based key population HIV prevention programs. Contrarily, HIV prevalence among FSWs increased to almost 9% from 2010 (33%) to 2019 (42%), in the eastern province. (Source: IBBS in FSWs 2019 and MSM 2020.

To bridge the identified care gap, this year, 7 CSOs implemented the key population activities in SFR, MRO, ASOFERWA, HDI, FVA, SFH, and FXB in 18 districts of Rubavu, Ruhango, Muhanga, Kirehe, Kayonza, Bugesera, Karongi, Huye, Nyanza , Nyagatare , Gatsibo, Ngoma, Nyamasheke, Nyabihu , Rutsiro Kamonyi, Gakenke, Musanze and 10 CSOs implemented the AGYW program activities in HIV prevention and response; those CSOs are Imbuto Foundation, Bamporeze, We Actx for Hope, RDO, AVEGA, Access to Health, PACT/ACHIEVE, AEE, FXB, and DUHAMIC-ADRI, implemented in Gatsibo,

Nyagatare, Bugesera, Gicumbi, Ruhango, Kamonyi, Burera, Gakenke, Nyabihu, Kirehe, Ngoma, Gisagara, Rubavu, Nyamasheke, Rutsiro, Nyaruguru, Rulindo, Musanze, Rwamagana, Nyanza, Gasabo, Nyarugenge, Kicukiro districts under the coordination and oversight of the Rwanda NGO Forum on HIV/AIDS and Health Promotion (RNGOF on HIV/AIDS & HP). Supported AGYW are screened through selection eligibility criteria, putting AGYW at higher risk of acquiring HIV and having unwanted pregnancies. Furthermore, CSOs conduct outreaches, referrals, and linkages to health centers or other institutions for service provision, as well as airing radio series on community radios with messages targeting AGYW and beyond.

Looking at the effort made to control the HIV epidemic in Rwanda for the past 20 years, retaining the gains made and reaching the last miles remains a huge challenge for key populations and priority populations, such as sex workers and their clients, men who have sex with men, transgender persons, and vulnerable groups, including youth, especially adolescent girls and young women, and people who inject with drugs, who experience higher rates of HIV transmission despite substantial progress in reducing HIV prevalence and improving access to antiretroviral treatment (ART).

To reduce HIV incidence among key and priority populations, Rwanda has put in place preventive strategies through the Rwanda HIV National Strategic Plan (NSP) 2018-2024. Civil society organizations, working closely with communities, have been engaged to support government efforts to achieve set goals. Various strategies were put in place by CSOs to implement their activities in alignment with the NSP 2018-2024 and contribute to achievement of the global targets by 2030.

2.13.2. Activities and achievements by indicators

CSOs have implemented different key activities such as: Annual advocacy meeting on KPs' rights to health; mapping/tracing of key populations; a quarterly stakeholders' coordination meetings on key population issues; quarterly meetings with peer educators of FSW and MSM; conducted supervision in form of field visits to beneficiaries/service users i.e Key and Vulnerable Populations (KVPs); outreach campaigns on radio stations , community dialogues, outdoor campaigns, capacity building; produced and distributed IEC materials.

In total, during this reporting period, 77,195 FSWs were identified and 53% were referred to HFs for different HIV services, whereas 7,655 MSM were identified and 35 % were referred to HFs. For the benefit of key populations, condoms, lubricants, self-test

kits, and IEC materials were distributed. Targeted awareness was raised through radio and TV talk shows.

Indicators on services and interventions for FSWs

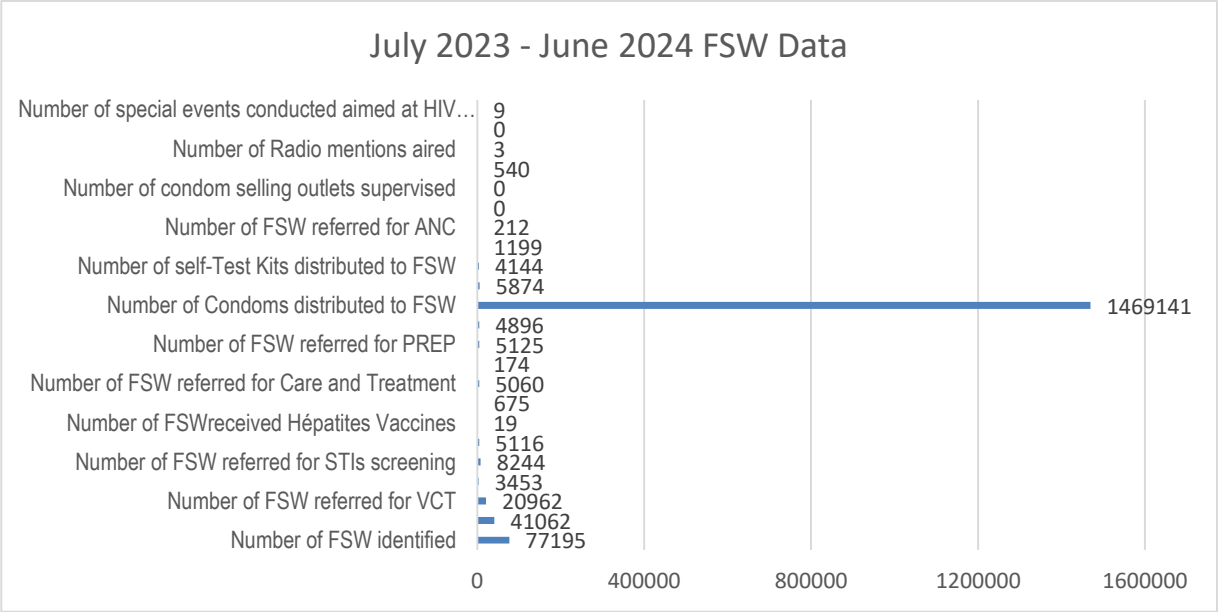


Figure 32: Indicators on services and interventions for FSWs

Indicators on services and interventions for MSM

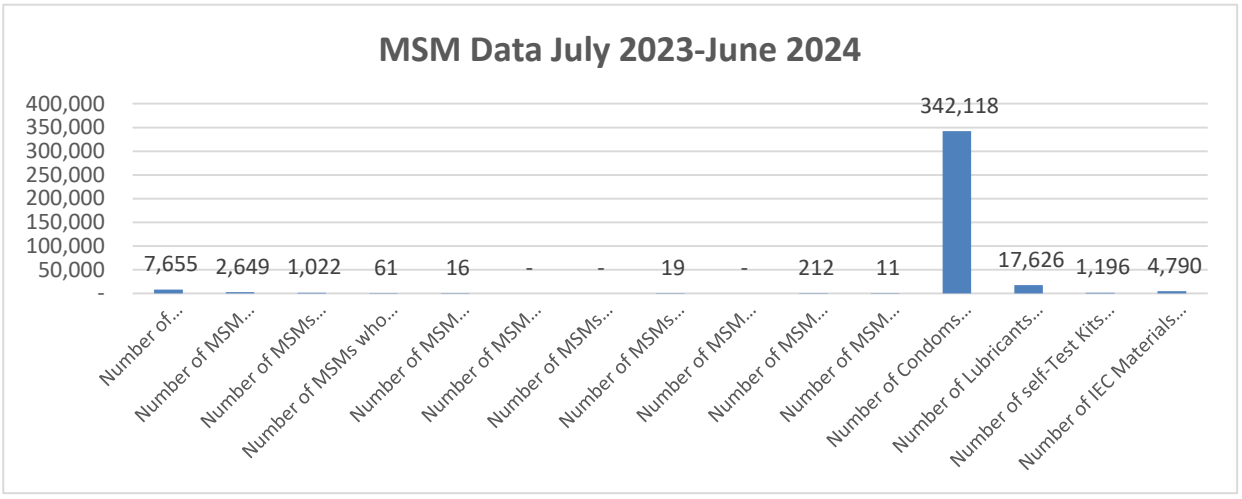


Figure 33: Indicators on services and interventions for MSM

Indicators on services and interventions for AGYW

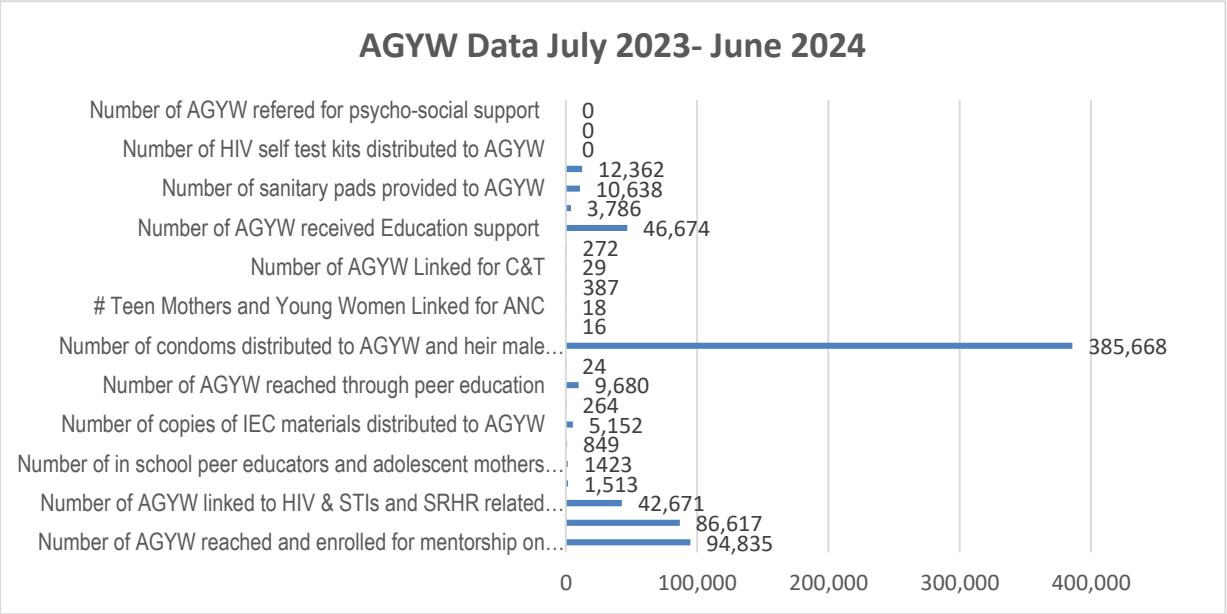


Figure 34: Indicators on services and interventions for AGYW

2.13.3. Key achievements

2.13.4. Key Populations

During this reporting period, 1,156 stakeholders have been reached. 77,195 FSWs and 7,655 MSM were identified through 1,962 hotspots that were newly identified. 24 different quarterly coordination meetings including 20 at Decentralized and 4 at National level were conducted, and 103 Health facilities were reached. 843 peer educators from FSW and MSM were involved in data collection, 43 radio series dramas were produced and aired; and 20,392 IEC materials were produced and distributed.174 MSM and transgender key informants were supported; 780 teen mothers and FSWs living with HIV were reached and referred to HFs for different HIV services. Continuous capacity building was conducted through supervision and mentorship.

2.13.5. Vulnerable / Priority Population (AGYW)

94,835 AGYW were reached in 24 districts and were enrolled for mentorships and education on SRHR, HIV/AIDS, STIs, TB, FP, life skills. Among them, 46,674 were provided with education support, 3,786 provided with TVET support and sanitation materials, and 12,362 AGWY were supported in economic strengthening and financial support to generate income and run businesses, 86,617 young women were reached

through outreaches and provided with the awareness campaigns and 385,668 condoms were distributed to their male partners, 2,272 peer educators in school, out-of-school and adolescent mothers were trained across 24 districts with a task to mentor the AGYW on SRHR, HIV/AIDS, STIs, TB, FP and SRHR.

5,152 IEC materials were distributed to the AGYW and in the community to raise awareness on HIV and unintended pregnancies, 5 radio drama series and spots were aired on 5 Radio stations: RC Musanze, Huye, Gicumbi, Izuba radio, and KT radio, in order to sensitize adolescents and youth to seek services on HIV prevention and FP at health centers. During this year, 264 supervisions were done in the community and at health centers to identify the challenges faced by the service users, peer educators and the project implementation in general. There was harmonized/ developed and disseminated Community-led monitoring and reporting tools for integrated HIV and SRHR services for AGYW.

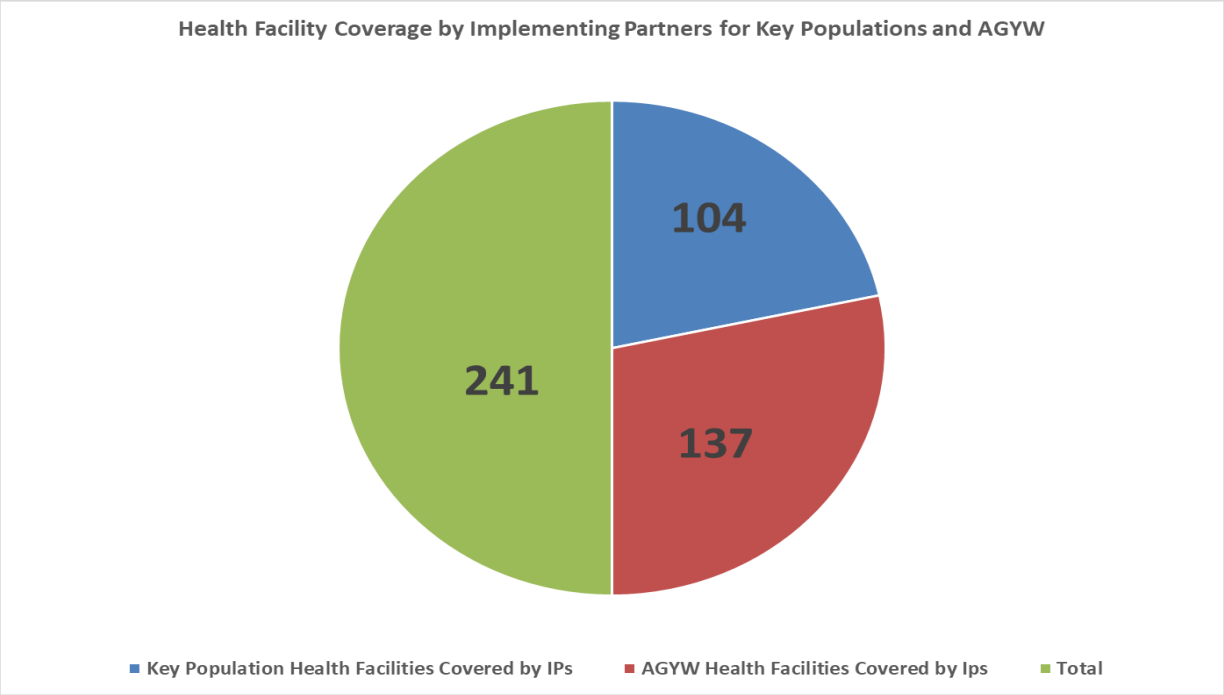


Figure 35: Health facility coverage by IP for KP and AGYW

2.13.6. Community-Led Monitoring (CLM)

Throughout the reporting period of the fiscal year 2023-2024, Under the support of the Global Fund, RNGOF on HIV/AIDS & HP in collaboration with the Rwanda Biomedical Centre (RBC) and other stakeholders designed, developed and are looking to pilot and implement an integrated CLM model for HIV, TB and Malaria to get feedback from

service users notably PLHIV, Key and Vulnerable populations/high risks groups of HIV, TB and Malaria services in a routine and systematic manner that will translate into action and change.

The primary goal of the developed integrated community led monitoring (iCLM) model in Rwanda is to strengthen the delivery of HIV, TB and malaria services amongst key and vulnerable populations (high risk groups) for HIV, TB and Malaria by empowering and facilitating communities to challenges and barriers to their access to and quality preventive and curative services, and the timely resolution of the same to facilitate improvements on the same.

The specific goals of the CLM are:

- To capacitate and empower KVPs and HRGs, institutions and networks to utilize service users' feedback to identify and resolve challenges to quality HIV, TB and malaria health services in Rwanda

- To assess the accessibility, availability, affordability and quality of HIV, TB and Malaria services delivered health facility and community level by the ministry of health through the HIV, TB and malaria programs, and by CSOs.
- To promote data collection and use, and accountability mechanisms amongst communities, community led and civil society organizations in Rwanda.
- To strengthen community and stakeholder engagement, and advocacy to in the resolution of challenges affecting the AAAQ of HIV, TB and malaria services at facility and community level in Rwanda

Key Results from CLM are:

- Accountability: Holds both government and non-governmental service providers responsible for meeting the needs of the communities affected by HIV, TB and Malaria.
- Community ownership: Strengthens community engagement and a sense of ownership in health initiatives, leading to more sustainable solutions.
- Improved service delivery: Identifies gaps and weaknesses in the health system, informing targeted improvements.
- Equity and access: Highlights human rights and gender-related barriers to accessing services, ensuring no one is left behind.
- Resource management: Monitors budgets and helps prevent stock outs of

essential medical supplies, commodities and management of infrastructure.

Key Achievements in CLM

- Designed/developed CLM Model and tools
- Conducted a series of capacity-building workshops for 60 Civil Society Organizations and 15 Community-Led Organizations working with key populations such as Female Sex Workers, Men who have Sex with Men, People Who Use or Inject Drugs (PWUD/PWID), transgender individuals, and adolescent girls and young women in Rwanda. 360 Peer Educators (PEs) of FSWs, 180 Peer Educators (PEs) and 320 Peer Educators (PE) of AGYW were trained on CLLM
- The training was designed to strengthen their capacities in understanding:
  - The CLM Concept and Principles
  - The use of data in advocating for improved services for Key Population (KPs)
  - The role of CSOs and service users in CLM implementation

Through these CLM trainings, civil society organizations, community-led organizations, and key populations increased their knowledge and technical capacity to gather, analyze, secure, use, and own data. They further pledged to use the knowledge gained through the implementation of interventions targeting key populations to improve HIV service delivery.

2.13.7. Partnerships and Collaboration

Strengthened partnerships and collaboration with community Radios including RC Musanze, Huye, Gicumbi, Izuba radio, and KT radio in order to sensitize adolescents and youth to seek services on HIV prevention and FP at health centers, engage local leaders, healthcare providers and peer educators at the decentralized level, and the public and Development Partners (DPs) at the national level, has been a key enabler to community engagement in HIV response during the current fiscal year.

Activities and achievements by indicators

CSOs have implemented different key activities such as: an annual advocacy meeting on KPs' rights to health; mapping/tracing of key populations; a quarterly stakeholders' coordination meeting on key population issues; a quarterly meeting with peer educators of FSW and MSM; conducting supervision; and producing IEC materials.

In total, during this reporting period, 60,460 FSWs were identified and 78.1% were referred to HFs for different HIV services, whereas 13,818 MSM were identified and 49.7% were referred to HFs. For the benefit of key populations, condoms, lubricants, self-test kits, and IEC materials were distributed. Targeted awareness was raised through radio and TV talk shows.

Key achievements

During this reporting period, 1,156 stakeholders have been reached. 21,992 FSWs and 2,897 MSM were identified through 1,962 hotspots that were newly identified. Different quarterly coordination meetings were conducted, and 103 Health facilities were reached. 843 peer educators from FSW and MSM were involved in data collection, 33 radio series dramas were produced and aired; and 22,201 IEC materials were produced and distributed.174 MSM and transgender key informants were supported; 780 teen mothers and FSWs living with HIV were reached and referred to HFs for different HIV services. Continuous capacity building was conducted through supervision and mentorship.

90,706 AGYW were reached in 24 districts and were enrolled for mentorships and education on SRHR, HIV/AIDS, STIs, TB, FP, life skills, among them, 46,674 were provided with education support, 2,445 provided with TVET support and sanitation materials, and 10,638 AGWY supported in economic strengthening and financial support to generate income and run businesses, 86,617 young women were reached through outreaches and provided with the awareness campaigns and 370,968 condoms were distributed to their male partners, 2,272 peer educators in school, out-of-school and adolescent mothers were trained across 24 districts with a task to mentor the AGYW on SRHR, HIV/AIDS, STIs, TB, and FP. 5,152 IEC materials were distributed to the AGYW and in the community to raise awareness on HIV and unintended pregnancies, 20 radio series and spots were aired on 5 Radio stations: RC Musanze, Huye, Gicumbi, Izuba radio, and KT radio, in order to sensitize adolescents and youth to seek services on HIV prevention and FP at health centers. During this year, 195 supervisions were done in the community and at health centers to identify the challenges faced by the peer educators and the project implementation in general. Harmonized/ developed and disseminated Community-led monitoring for integrated HIV and SRHR services for AGYW.

3. CARE AND TREATMENT

3.1. Introduction

The health of people living with HIV (PLHIV) relies on access to treatment and care for the virus. It is of the utmost importance that individuals living with HIV start antiretroviral therapy (ART) as soon as possible after diagnosis. This will drastically cut down on HIV-related deaths and illnesses, improve quality of life, increase survival rates, and stop the spread of the virus, including mother-to-child transmission (MTCT).

By accomplishing the UNAIDS 95-95 objectives, Rwanda has significantly reduced the spread of HIV and put an end to the AIDS epidemic. The main goals for 2023 and 2024 were to improve and expand people-centered differentiated service delivery (DSD) to more groups of PLHIV and to stress that pediatric dolutegravir (pDTG) is the best HIV treatment for children living with HIV. Care and treatment interventions that focused on crucial activities like mental health, enhancing the ability of healthcare professionals to manage advanced HIV disease, and providing services for non-communicable diseases (NCDs) ensured comprehensive care. Other activities that were highlighted included clinical mentorships, quality improvement techniques, psychosocial care and support, and activities that were in accordance with controlling the HIV epidemic.

3.1.1. Objectives of HIV care and treatment

HIV care and treatment aim to limit HIV-related morbidity through holistic health care delivery to all PLHIV and has the following objectives and goals:

a. Objectives:

- Increase ART coverage for all PLHIV across all age groups and maintain a retention rate above 95%.
- Maintain viral load suppression above 95% among all PLHIV on ART.
- Enhance capacity building to ensure consistent, high-quality service delivery across all health facilities nationwide.
- Strengthen the community of people infected and affected by HIV to ensure they have equal opportunities as the general population.

b. Goals:

1. Ensure timely linkage and retention in care for newly diagnosed individuals by
   - Enhancing the "Treat All" policy implementation, recommending ART initiation for all people living with HIV regardless of clinical stage or CD4 count.
   - Strengthening communication between testing entry points and ART services to ensure same-day enrolment, enhanced counseling, and mentorship of healthcare providers.
2. Optimize ART coverage and retention:
   - Maintain a high rate of retention on ART using safe drugs with fewer side effects and long-acting ART.
   - Enhance and scale up pediatric centers of excellence to support optimal treatment outcomes for children and adolescents living with HIV.
3. Enhance psychosocial well-being and patient-centered care:
   - Provide comprehensive psychosocial support and adherence counseling.
   - Address inequities in access to HIV services among children and adolescents.
   - Promote community-led monitoring to empower PLHIV and key populations for advocacy and improved service quality.
4. Integrate NCDs and mental health within HIV services:
   - Implement regular screening protocols for non-communicable diseases (NCDs) and mental health conditions in all HIV care settings.
   - Provide comprehensive management and follow-up care for PLHIV diagnosed with NCDs or mental health conditions, ensuring seamless integration with their HIV treatment plans.
5. Integrate nutritional support within HIV services:
   - Conduct nutritional assessments and provide counseling during each health facility visit.
   - Ensure nutritional rehabilitation for eligible PLHIV and their families based on national guidelines.
   - Strengthen coordination with other health programs to enhance nutritional support.
6. Improve socioeconomic status for people infected and affected by HIV:
   - Transition support from orphans and vulnerable children to the most vulnerable children for effective coverage and sustainability.
   - Provide socio-economic support services, reduce stigma and discrimination, and promote human rights for PLHIV.

3.2. ART Coverage among PLHIV

Over the course of five years, from 2019 to 2024, Rwanda has experienced notable progress in antiretroviral therapy (ART) coverage among people living with HIV (PLHIV). In June 2020, the number of PLHIV on ART reached 201,629, indicating a coverage of 87.2%. By June 2024, this figure increased to 222,604 PLHIV, reflecting a significant rise in coverage to 96.9%. The adoption of the "Treat All" strategy in June 2016 played a crucial role in this increase, as it mandated that all individuals who tested HIV-positive were linked to care and initiated on ART, regardless of their CD4 count.

This ongoing improvement in ART coverage demonstrates HIV national program unwavering commitment to enhancing access to life-saving treatment for all individuals living with HIV. Different strategies implemented during this period have significantly contributed to the reduction of mortality among those infected with HIV, ensuring that more individuals benefit from timely and effective care.

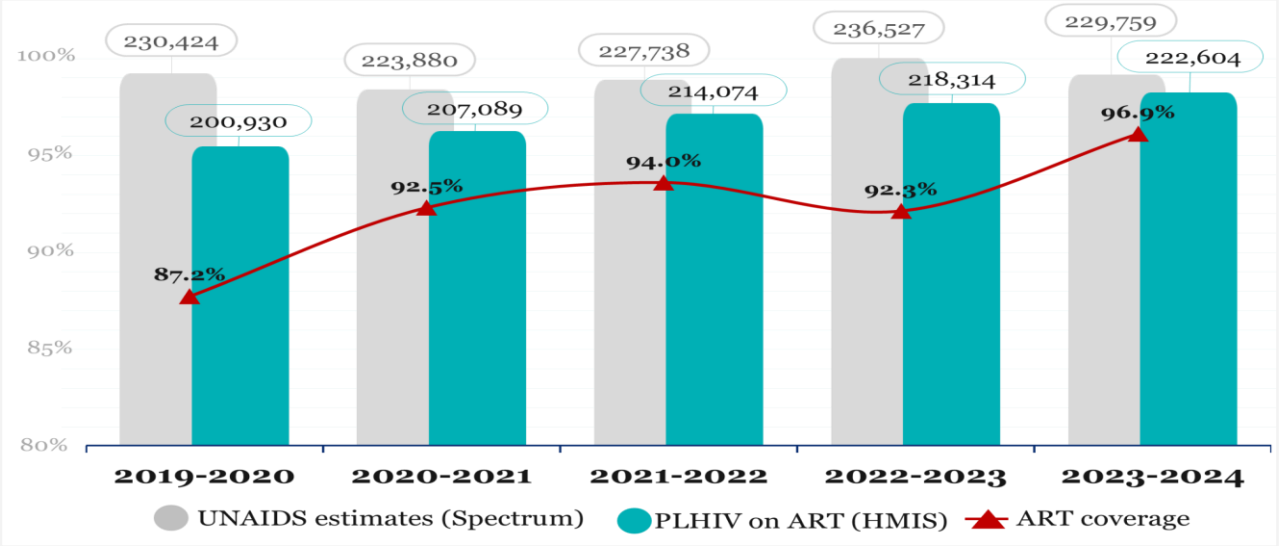


Figure 36: Trend of ART Coverage from July 2019 to June 2024

Despite significant efforts by the national HIV program to achieve epidemic control and meet global HIV targets, as highlighted in the recent UNAIDS 2023 report, which identifies Rwanda as one of five African countries to have attained the "triple 95" targets, a notable disparity persists among children, adolescents, and young adults compared to adult populations concerning these benchmarks. Specifically, ART coverage among children living with HIV (CLHIV) under 15 years of age has demonstrated gradual improvement, increasing from 60% in July 2021 to 76% by June 2024 (Figure 28). Likewise, ART coverage among adolescents and young adults, aged 15 to 24 years old, has risen from 84% in 2021 to 87% during the same period.

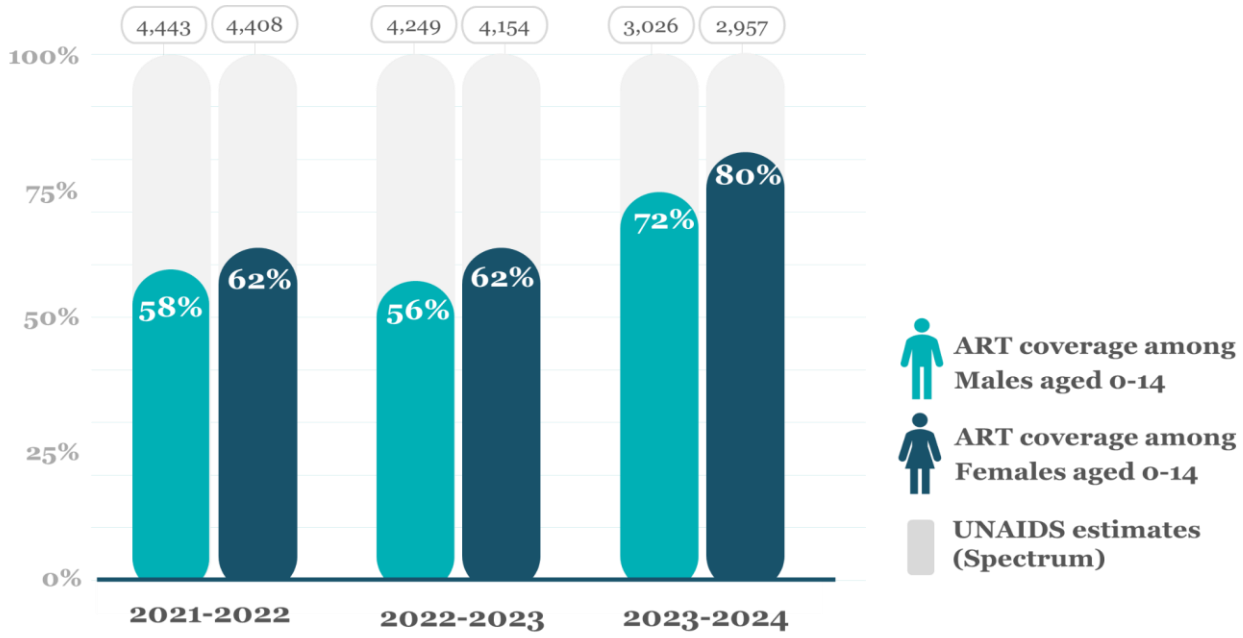


Figure 37: Trends of ART Coverage among Children aged 0-14 years from FY21-22 to FY23-24

To bridge these disparities, targeted strategies such as the LIFT UP initiative have been proposed and will be implemented to enhance HIV diagnosis among children. This initiative focuses on identifying children aged 0-14 years born to mothers living with HIV who are at high risk for HIV infection, facilitating their linkage to health facilities for testing and, if positive, enrolling them in care and treatment. Additionally, the provision of youth-friendly services has also been established to improve access to treatment and care for these vulnerable populations, with the overarching goal of diminishing the aforementioned gap.

The global trend regarding HIV/AIDS indicates that the epidemic disproportionately affects more women compared to men. In the Eastern and Southern regions of Africa, the prevalence of HIV among women remains notably higher, with women representing 59% of all people living with HIV (PLHIV) in these areas. In Rwanda, by the end of June 2024, a total of 222,604 individuals were enrolled on antiretroviral therapy (ART) and care, with females comprising the majority at 63% (140,972 out of 222,604), while males accounted for 37% (81,632 out of 222,604). This gender disparity is often attributed to various socio-economic, cultural, and biological factors that heighten women's vulnerability and exposure to HIV. Additionally, women's healthcare-seeking behavior tends to be more proactive, enhancing their access to HIV care compared to men, who according to different studies may exhibit poorer healthcare-seeking behaviors (Figure 29).

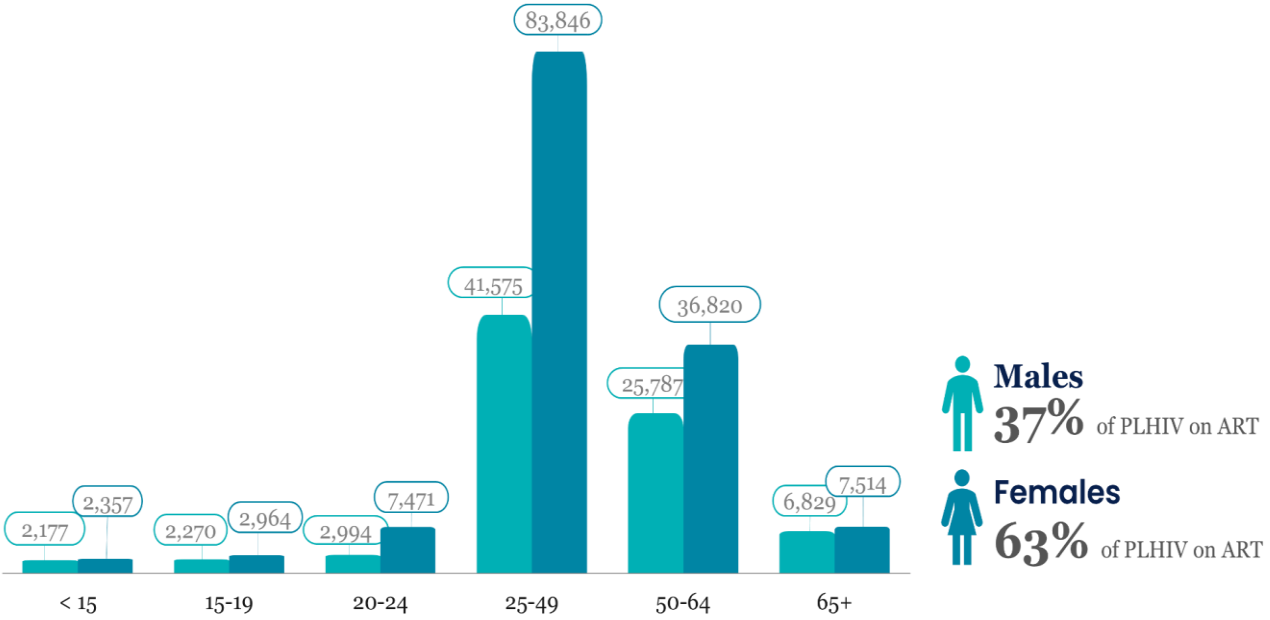


Figure 38: ART distribution by age category and gender at the end of June 2024

The city of Kigali exhibits the highest prevalence of individuals living with HIV (PLHIV), representing 26.6% of the total PLHIV population, equivalent to 59,357 out of 222,604 individuals. This is followed by the Eastern Province, which comprises 22.6% of the PLHIV population, accounting for 50,357 individuals. Conversely, the Northern Province demonstrates the lowest prevalence, with only 10.6%, or 23,877 individuals, out of the total population of PLHIV. (Figure 30).

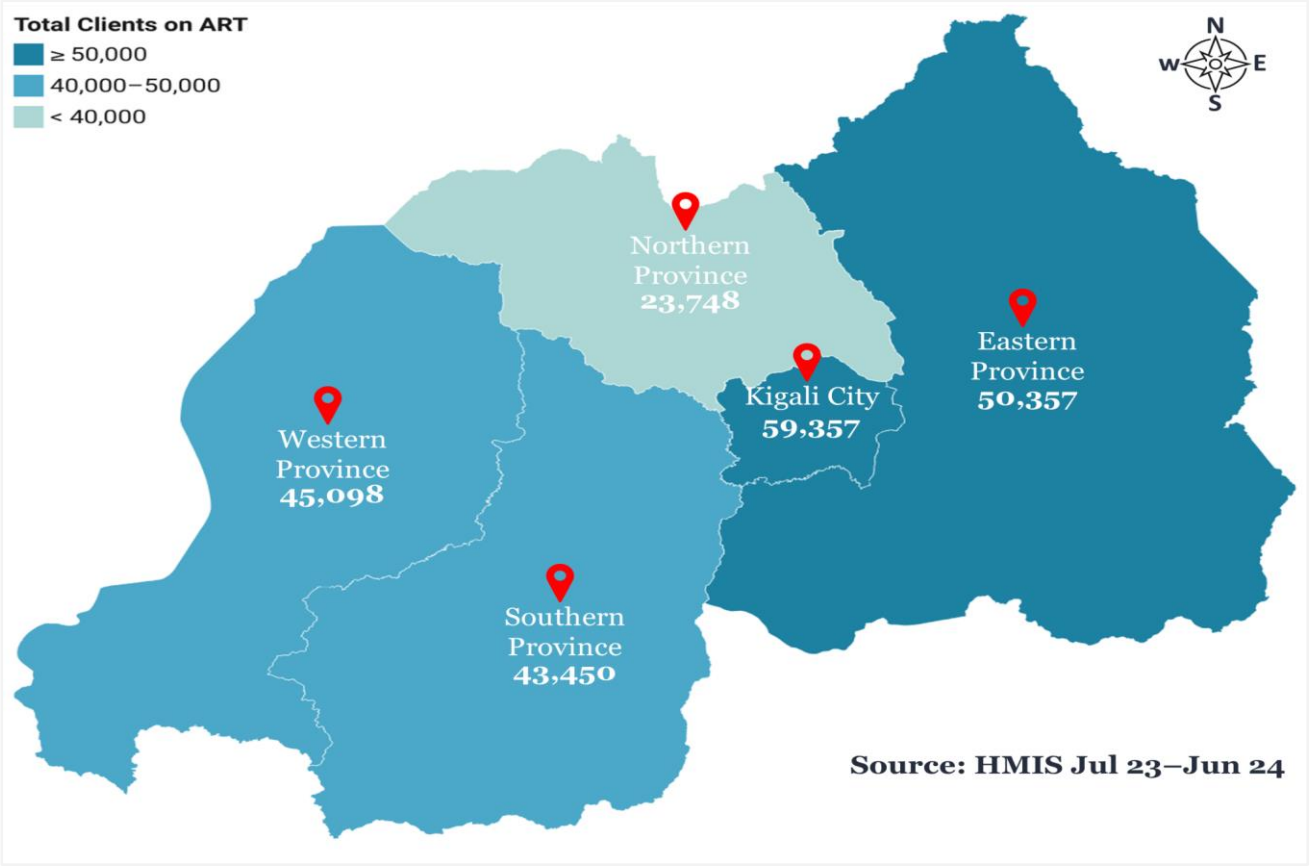


Figure 39: ART distribution by Province, June 2024

Among CLHIV under 15 years of age who are receiving antiretroviral therapy (ART), 95.33% (5,020 out of 5,266) are on first-line treatment, while 4.63% (244 out of 5,266) are prescribed second-line treatment, and a negligible 0.04% (2 out of 5,266) are on third-line treatment. In the population of individuals living with HIV aged 15 years and older, 97.15% (211,150 out of 217,338) are also on first-line treatment, with 2.80% (6,096 out of 217,338) receiving second-line treatment, and again, only 0.04% (92 out of 217,338) on third-line treatment. (Figure 31). These trends in regimen distribution showcase the significance and effectiveness of the DTG-based first line regimen particularly TLD accounting for 87.3% of all PLHIV on ART by June 2024.

Figure 40: ART distribution by lines and age category, June 2024

3.3. Linkage and Retention in Care and Treatment

The World Health Organization recommended the 'Treat All' strategy of initiating all individuals tested HIV positive on ART, irrespective of their CD4 count and clinical staging. Timely and effective linkage to care and treatment has been identified as key to improved health outcomes and the success of the universal test and treatment interventions for linkage to care. Continuous engagement of clients in care during antiretroviral treatment is a critical element of HIV care interventions and is closely associated with optimal individual and public health outcomes and cost effectiveness.

In addition to maximizing the health advantages of therapy and limiting secondary spread, this proactive strategy effectively prevents further HIV transmission. Rwanda's HIV care and treatment program has strengthened its testing entry point and ART service communication techniques to facilitate the linkage and initiation of newly diagnosed positive clients into ART. Practices including same-day ART initiation, intensive counseling upon enrollment, and efforts of retracing individuals that are lost in care to re-engage and adhere to care whilst ensuring that friendly services and person-centered care is at the core of service delivery particularly for individuals likely to interrupt treatment.

Retention in care is a spectrum of continuum care packages, from diagnosis of HIV infection to lifelong services. By the end of June 2024, a total of 589 health facilities,

including public hospitals, health centers, and private facilities, were equipped to offer comprehensive antiretroviral treatment, thereby facilitating optimal retention in care.

The figure below shows the retention rates among women and men after one year of ART initiation, with lower retention rates recorded among males within the 20-24 years age group. According to RBF retention data in a sample size of over 5,392 individuals initiated on ART between July 2022 and June 2023, the overall retention rate was 94%, with retention rates of 95% among females and 91% among males.

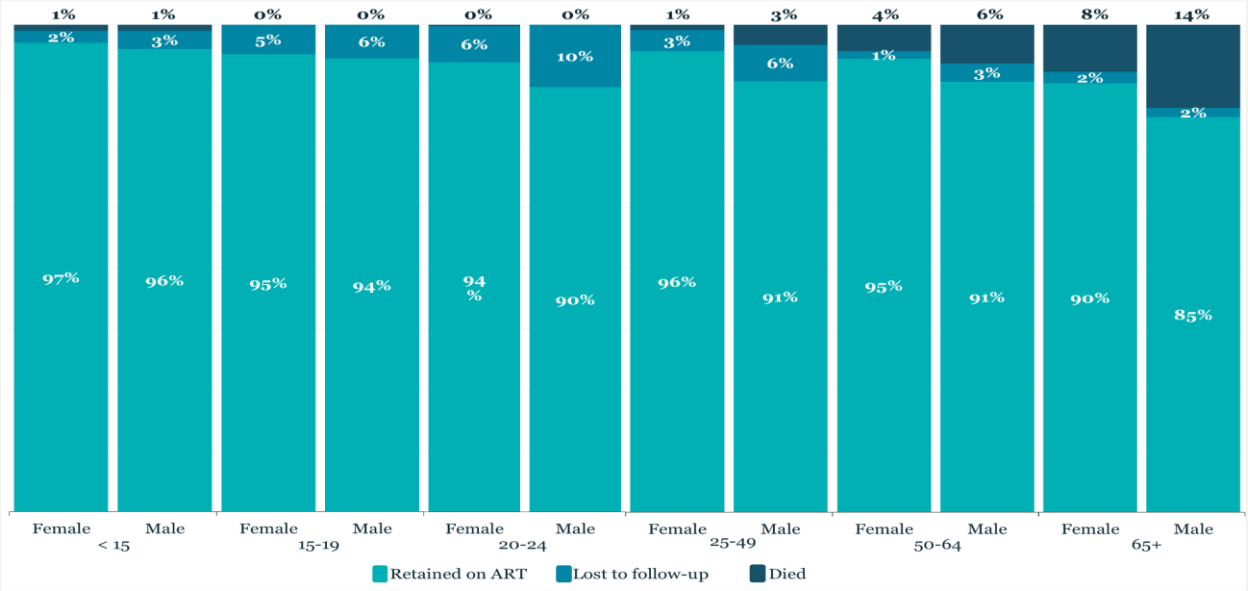


Figure 41: Retention after one year of treatment

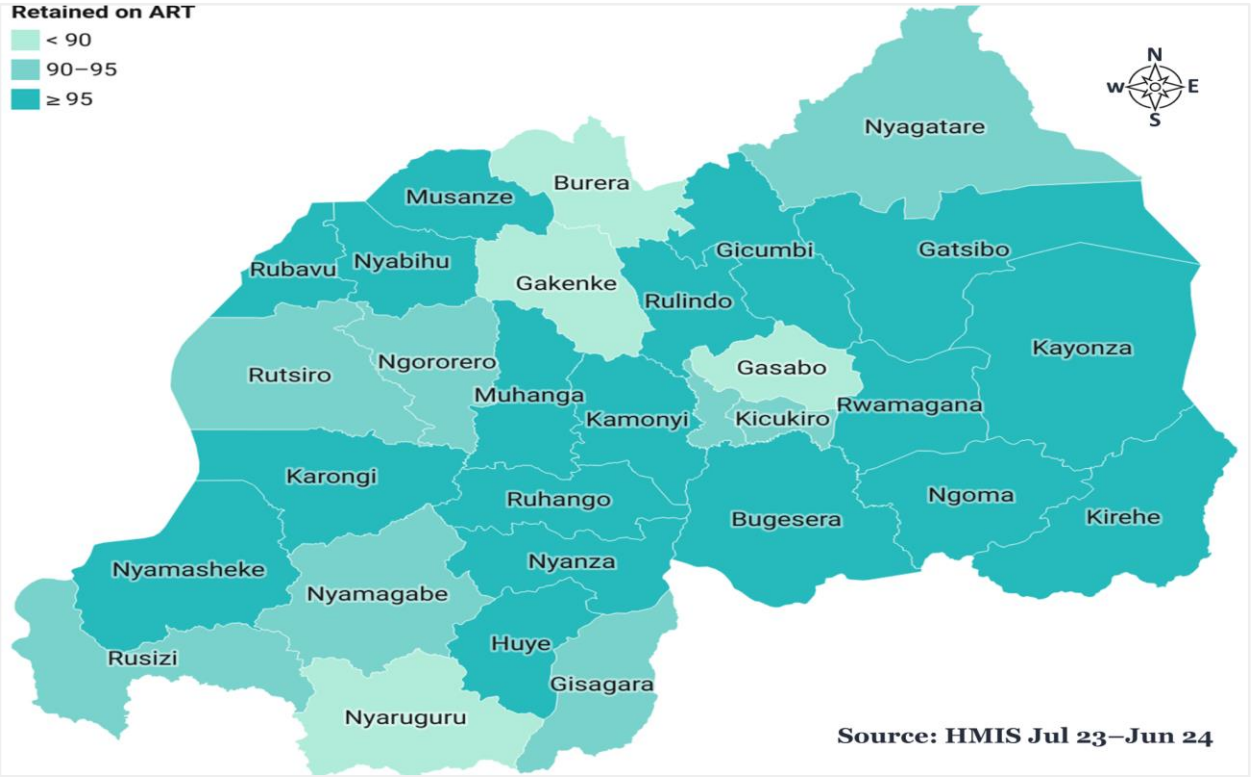


Figure 42: Retention after one year of treatment by District

3.4. Differentiated Service Delivery (DSD)

Following the ever-evolving global guidance to reach ambitious prevention, testing, and treatment targets, the number of PLHIV accessing HIV services keeps increasing while decreasing funds. Therefore, Rwanda resorted to leveraging DSD models to close gaps in program quality. DSD has delivered practical solutions towards a person-centered approach that considers the needs and expectations of diverse groups of PLHIV to enable high-quality service delivery. In order to enable health care providers to offer high-quality services to those who are most in need, a crucial component of this strategy has been evaluating the eligibility criteria for clients who have been established on ART versus those who have not, in order to establish the frequency of clinical, psychosocial, and ART visits.

Compared to 79% in the previous fiscal year, 87% of all PLHIV on ART as of June 2024 were registered in less-intensive models. The share for 6 multi-month models (6-MMD) is 61% and 25% for 3-MMD. The number of PLHIV in more-intensive models (1-MD) otherwise known to require more intensive clinical and psychosocial services due to increased risk associated with treatment interruption decreased from 21% to 13% indicating significant program milestones (Figure 42).

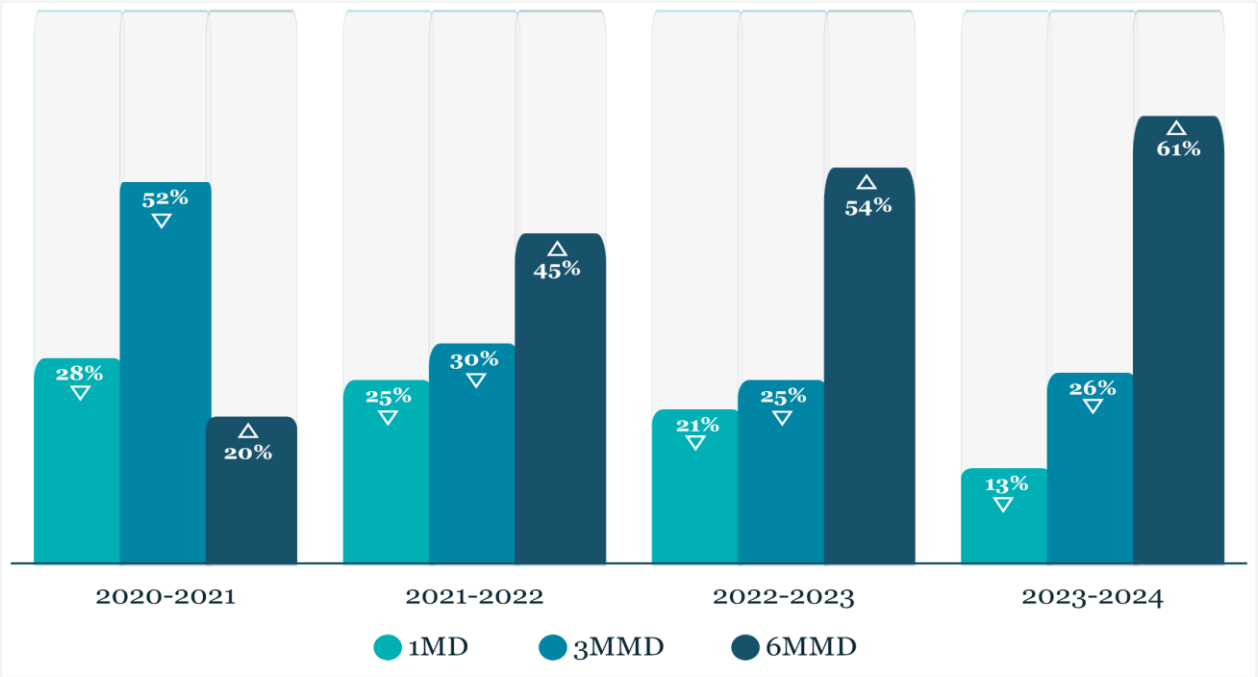


Figure 43: Trends in the scale-up of DSD model categories from July 2020 to June 2024

3.5. Viral Load Testing and Monitoring

To optimize the effectiveness of ART, the most significant predictor of an early and long-lasting response to ART is viral load monitoring, which should be assessed in all people living with HIV on a frequent basis. Repeat viral load testing while not on ART is optional for patients who don't adhere to treatment for whatever reason. Viral load is one of the eligibility criteria for DSD. In order for a client to be categorized as established on ART (stable), they must have a suppressed viral load (<200 copies/ml in the context of Rwanda), which renders them eligible for less-intensive services. Allowing focused, more-intensive services to PLHIV with unsuppressed VL and risk of HIV disease progression.

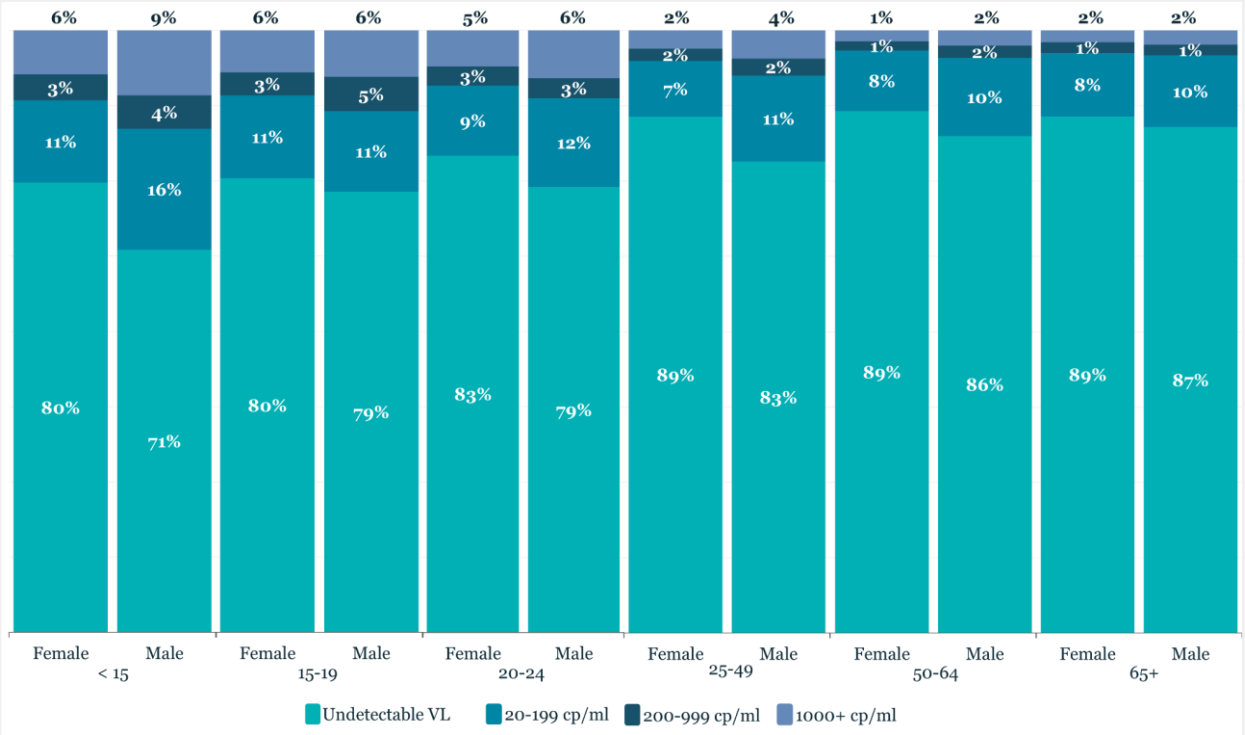


Figure 44: Viral load suppression among PLHIV on ART by sex and age June 2024 (source: VLSMS & LIS)

Through a variety of treatments aimed at enhancing adherence among age groups that have previously experienced subpar treatment outcomes, the program set high goals to optimize treatment outcomes. As of July 2024, 87% of PLHIV are in less-intensive models (receiving 3 to 6 multi-month ART and bi-annual clinical visits), showcasing a significant achievement of VLS among PLHIV across the board. Between July 2023 and June 2024, most viral load tests, 96% (181,459 out of 189,904), had successful suppression below 200 copies/ml, with 87% (164,449 out of 189,904) having undetectable levels, and those under 1000 copies/ml were 97% (184,833 out of 189,904). Nevertheless, a significant disparity remains among male children under 15 years old

who are on antiretroviral therapy (ART). For this group, the rate of viral load suppression (below 200 copies per milliliter) falls under 90%.

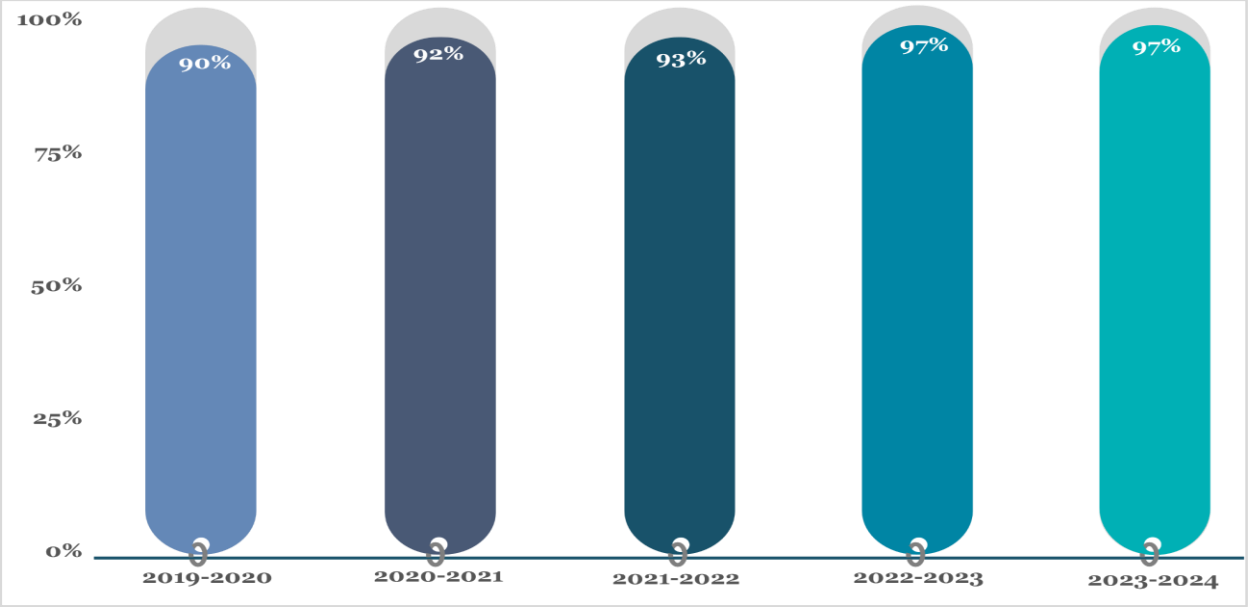


Figure 45: Trends of viral load suppression (<1000cp/ml) among PLHIV on ART from July 19 to June 24

3.6. Movements in HIV service

In the fiscal year 2023-2024, there was a 1.9% increase in the total number of people living with HIV enrolled in care and treatment, rising from 218,314 in June 2023 to 222,604 in June 2024. This growth reflects a net increase driven by several factors, such as targeted HIV testing (Index testing), the initiation of new clients on ART regardless of their CD4 count, and efforts to reconnect previously lost-to-follow-up cases. During this period, a total of 11,631 individuals were newly initiated on ART. However, there were also challenges, with 3,987 individuals lost to follow-up and 1,699 deaths reported. On a positive note, 2,019 individuals were retraced back into care, highlighting ongoing efforts to improve retention and support for PLHIV. Overall, the data indicates a concerted effort to enhance access to and continuity of HIV care.

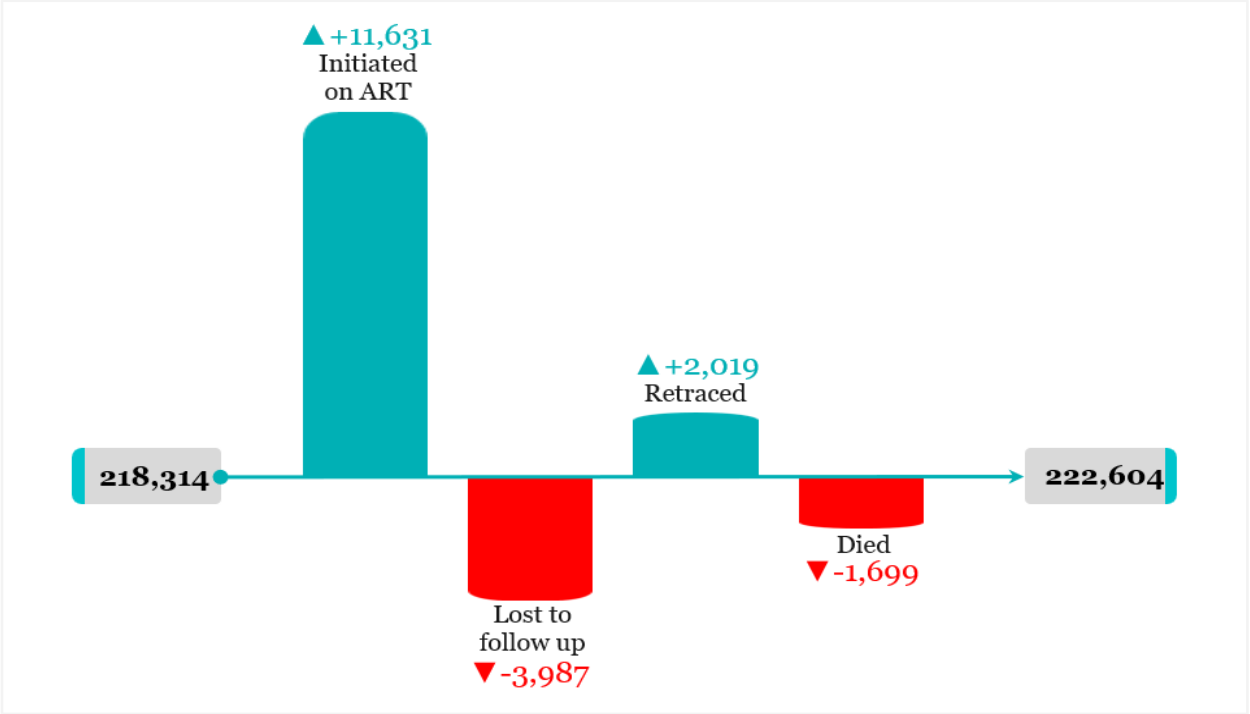


Figure 46: Recipient of care movements from July 2023 to June 2024

3.7. Integration of other services into HIV-differentiated ART models

3.7.1. Mental health

Integration of mental health into HIV care has been a crucial development in improving the overall well-being of individuals living with HIV. This integration aimed to address the complex interplay between HIV and mental health and social factors that can affect the overall health outcomes of PLHIV.

During this year, we conducted training of trainers on screening and referral for management of Mental health issues along with other NCDs, where 37 Medical Doctors and nurse mentors participated in this training, Clinical mentorship and follow-up of special cases in Rwamagana, Rubavu and Nyagatare districts. Furthermore, in collaboration with stakeholders, two research projects were conducted, one was the "Assessment of depression and anxiety disorders among adolescents and young people living with HIV in urban area of Rwanda and continuity of HIV services in rehabilitation centers" and the other was the "Prevalence of Mental Health Disorders and Their Associated Risk Factors Among People Living with HIV in Rwanda" This will lead us to develop tailored interventions to address the mental health needs for this population effectively.

3.7.2. TB/HIV Integration

The risk of developing active TB among PLHIV is 19 times higher than among people without HIV. Following the 2021 political declarations on AIDS; ensure that 90% of PLHIV receive TB preventive therapy (TPT) and reduce TB-related deaths among PLHIV by 80%. Rwanda embarked on use of differentiated service delivery models for testing and treating TB. Leveraging from an already established one stop shop model, TPT was fully scaled up in July 2020 starting with high HIV and TB prevalent districts depending on TPT drug availability. As of June 2024, all districts have been trained and provided with the necessary skills and commodities to integrate TPT into HIV service delivery. An estimated 96% (213,307/222,604) of PLHIV have been initiated on TPT, with significantly high completion rates of 95.8%. Having maximized TPT coverage for PLHIV on ART moving forward the program will embark on ensuring that all incoming newly diagnosed clients are linked immediately to effective TPT regimens.

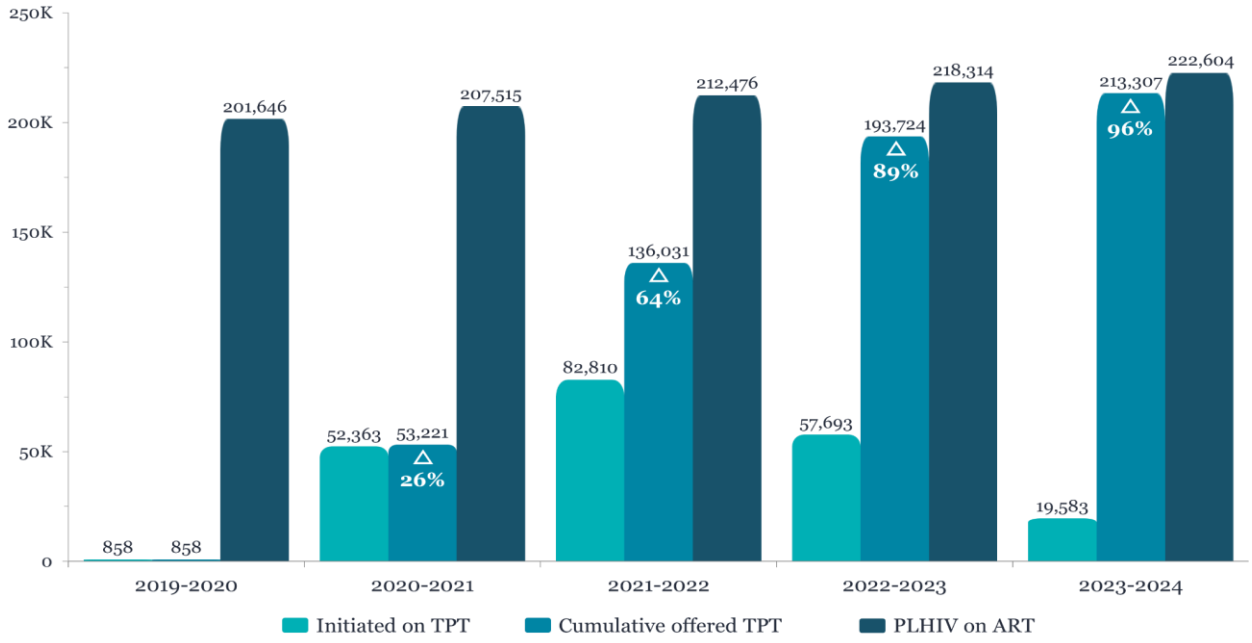


Figure 47: The trend of TPT coverage among PLHIV from July 2019 to June 2023

3.7.3. NCDs/HIV Integration

Aging with HIV significantly increases the risk of developing non-communicable diseases (NCDs) such as hypertension, cardiovascular disease, and diabetes. In Rwanda, 34% of people living with HIV (PLHIV) are over the age of 50. Consequently, the program's focus has recently shifted to addressing the knowledge gap surrounding the intersection of HIV and NCDs.

The HIV Care and Treatment Unit, in collaboration with the Surveillance Unit, identified at-risk populations and conducted an NCD study targeting PLHIV in Rwanda. The goal of this study was to determine the prevalence of major NCDs among this group. Preliminary results revealed that 24.2% of participants had raised blood pressure, compared to 16.8% in the general population. Additionally, 17.2% of the women screened were HPV positive. These findings underscore the additional risks HIV poses in the development of NCDs among PLHIV.

In response, the HIV program has partnered with multiple stakeholders to develop straightforward protocols for the screening, prevention, and management of NCDs, particularly hypertension and diabetes. A training of trainers was conducted, involving 37 trainers from the East and North of the country, focusing on the screening and referral for managing hypertension, diabetes, and mental health among PLHIV within HIV services. This initiative aims to enhance early detection and management of NCDs in this population.

Looking ahead, the NCD and HIV divisions plan to scale up HIV/NCD integration, starting with districts experiencing the highest disease burden, to ensure early screening and timely interventions, ultimately improving the quality of life for PLHIV.

3.8. Psychosocial Care Support among PLHIV

As part of Rwanda's comprehensive HIV treatment program, significant emphasis has been placed on adherence counseling and psychosocial support, recognizing these as essential components in managing HIV/AIDS and helping people living with HIV (PLHIV) adjust to a lifelong condition.

In response to gaps identified among children, adolescents, and young adults living with HIV—totaling over 4,534 children under 15 years old and 15,699 individuals aged 15-24—ninety-nine peer educators focused on these age groups were trained. This training utilized the Community Adolescent Treatment Supporters (CATs) project model to provide effective psychosocial support.

Moreover, to combat stigma and discrimination against adolescents living with HIV in schools, 535 educators were trained on delivering HIV-friendly services, ensuring they can support adolescents, particularly those in boarding schools. Additionally, targeted psychosocial mentorship and rehabilitation activities were conducted across various locations, addressing the psychological and social challenges that affect adherence to care and treatment for PLHIV.

3.9. Nutrition Support

Malnutrition and HIV are closely intertwined, with each condition exacerbating the other. HIV can lead to malnutrition both directly and indirectly, while malnutrition can increase the risk of progressing to advanced stages of HIV. To prevent and treat malnutrition and its related consequences, nutrition care and support are provided through a comprehensive approach, including nutrition assessment, education, counseling, follow-up, referral, and direct nutrition support.

In the past fiscal year, 40 nutritionists from hospitals received refresher training on delivering nutrition services for people living with HIV. Additionally, 17 hospitals and their associated health centers were mentored on providing nutrition care and support. Over 53,530 PLHIV received Corn Soya Blend Plus (CSB+), and 2,337 PLHIV received Ready-to-Use Therapeutic Food (RUTF) from 46 hospitals and their health centers.

3.10. Community engagement and CSOs

Rwandan Civil Society Organizations (CSOs) play a crucial role in HIV/AIDS response, especially by serving as a bridge between clinical services and members of communities who are infected and affected by HIV/AIDS. Their involvement is essentially implemented in the community, where they complement the efforts of governments and healthcare systems in addressing the multifaceted challenges posed by the HIV/AIDS epidemic. For this year 2022/2023, 12 CSOs implemented community activities in HIV response; those CSOs are RRP+, AHF, UPHLS, Dream Village Organization, PACT, AEE, FXB, DUHAMIC, CARITAS, YWCA, RICH, and PROFEMME.

The community mobilization and CSO engagement in communities that reached 397,917 people (including 8,320 people with disabilities) contributed to greater knowledge of HIV/AIDS, changes in attitudes toward HIV risk behaviors, access to HIV/AIDS-related services, greater health-seeking behaviors that include HIV testing, and the uptake of HIV prevention methods among community members. This community mobilization targeted vulnerable populations at high risk, such as Orphans and Vulnerable Children, people with disabilities (PWDs), and discordant couples. The community mobilization used evidence-based training manuals such as SRHR, Life Skills, GBV/SGBV, TB, Parent-Adolescent Communication Manual, Disability and HIV Manual, and Community Adolescent Treatment Supporters Service Delivery Manual, facilitated by community volunteers and peer educators.

CSOs contributed to the care and treatment of PLHIV by providing peer educator's kits to 4,919 peer educators, and assistive devices to 92 PWDs living with HIV. CSOs provided referrals and linkages to their beneficiaries to health services as well as coordinated the stakeholders' consultative meeting to evaluate the community-led monitoring of DSDM, which reached 213 people. Also, CSOs contributed to HIV management by supporting 38 health facilities with 141,497 laboratory kits and reagents and providing psychosocial support and counseling sessions to 8,505 CAYLHIV through home visits and/or support groups.

Under the HIV impact mitigation pillar, CSOs contributed enormously by providing health insurance to 48,989 PLHIV and their families, providing nutrition support to 1,746 PLHIV; providing education support to 34,463 OVC infected or affected by HIV, provision of TVET support to 1,389 OVC infected or affected by HIV; provision of economic strengthening support to 27,013 people as well as provide training on parents-adolescent communication using Family Matter's Program given to 3600 people. Consider that CSOs conducted a capacity building of 32 umbrella constituencies (made of 288 PWDs, 60 religious denominations, and 162,000 PLHIV) to increase their engagement in community mobilization and advocacy on HIV services during Covid-19.

Furthermore, CSOs supported the health system strengthening efforts in building the capacity of health providers on HIV task shifting training provided to 78 nurses; facilitated training and supervision of community actors such as peer educators, and community volunteers to conduct HIV community monitoring reaching 123,923 people. Also, CSOs supported the renovation of the HIV clinic of Karambo HC and a building of waiting and IEC rooms at Matyazo HC. In order to support the workforce in health facilities, CSOs contributed to paying salaries for additional 170 Healthcare providers in 38 health facilities.

Among the challenges encountered, CSOs were limited in providing nutrition support to PLHIV but mostly among children living with HIV. PWDs are still facing challenges to access to health services while stigma and discrimination is still sensed among PWDs and PLHIV in their community and CAYLHIV at school. Through peer education models used by CSOs, beneficiaries receive close services from their peers which increase their health service uptake.

3.11. HIV-Related Commodities Supply Chain Management

Effective supply chain management is vital for any health system or program to deliver optimal performance levels and intended services. The management of antiretroviral medicines and other HIV-related commodities involves a series of activities to ensure that products are continuously available for clients in need. Throughout the last fiscal year, we supported the procurement of medical products for both prevention and treatment purposes. Collaborating with RMS and other implementation partners, we successfully procured the planned shipments, which enhanced commodity security.

During the integrated quantification exercises, we estimated the needs for HIV/AIDS, Viral Hepatitis, Tuberculosis, Malaria, Maternal and Child Health (MCCH), and other essential medicines. The forecasted needs for 2024-2028 and the supply plans for 2024-2025 were determined, and a comprehensive report was produced and approved for implementation. Additionally, we conducted quarterly supply plan reviews to assess forecasted commodity consumption against actual records. Based on these forecasts, we made necessary adjustments to ensure the optimal supply of health commodities.

We also performed monthly health commodity stock status reviews to monitor stock levels at central, district, and health facilities. By referencing the national min-max policy, we aimed to prevent both shortages and expiries, thus improving the efficient use of health products. To further enhance supply chain management, we conducted a nationwide training program for all store managers and RMS branch staff involved in medical commodities supply chain management. This training aimed to improve the skills and knowledge necessary for effective supply chain management.

3.12. Mentorship and Continuous Quality Improvement

Continuous education, and ongoing service improvement through clinical mentorship is necessary to ensure high-quality healthcare services delivery for people living with HIV/AIDS. Quality of care given to PLHIV and the general population is critical to the success and sustainability of HIV response. Enhancement of the quality of care provided to PLHIV was achieved through clinical mentorships, coordination meetings, experience exchange workshops, and monitoring of HIV related activities in health facilities through clinical mentorships and supportive supervisions in addition to the trainings provided to healthcare providers.

In all 47 hospitals and its catchment area public and private health facilities across the nation, clinical mentorships on HIV treatment, psychosocial care, mental health, supply

chain and nutrition services were provided by HIV program staff and partners as well as hospital clinical mentors in different sessions. As care and support options are necessary as part of the continuum of delivering effective healthcare, these clinical mentorships were able to assist clinical mentors and healthcare providers in screening and managing non communicable diseases and mental disorders among PLHIV according to their needs, conducting support groups for children and adolescents, and improving adherence counseling and support to PLHIV.

In order to achieve the objective of HIV elimination, quality improvement (QI) programs also served as the cornerstone of HIV care and treatment services. During FY 23-24, 40 healthcare providers (ART nurses and mentors) from 29 health facilities were trained on QI Principles and approaches to improve HIV services delivery. As of June 2024, 57 health facilities are implementing QI projects and received mentorship to empower their QI Committees and monitor QI Projects progress. An experience-sharing workshop for those 29 HFs, was conducted to provide a platform for sharing experiences between health facilities that are implementing QI projects in HIV services to allow them to learn from each other and discuss challenges that sites are facing during the implementation of the QI projects.

At those sites, QI projects played a role in improving the enrollment of clients in CBS and their retention.

4. VIRAL HEPATITIS AND SEXUALLY TRANSMITTED INFECTIONS

4.1. Introduction

Globally, the epidemic of Viral Hepatitis B and C draws attention where 254 million people live with hepatitis B and 50 million with hepatitis C in 2022 and 2.2 million new infections annually. Every year,1.3 million people die of Viral Hepatitis-related liver disease, liver failure and liver cancer which claim 3,500 deaths a day (WHO, 2024).

In Africa, chronic Viral Hepatitis affects over 70 million Africans (60 million with hepatitis B and 10 million with hepatitis C). Dying from Viral Hepatitis in Africa is becoming a bigger threat than dying from HIV/AIDS, malaria or tuberculosis with at least 200,000 deaths a year (WHO, 2023).

In Rwanda, an estimated prevalence of HBV and HCV infection was 0.36% and 0.48%

respectively in 2023 (RBC HIV and Viral Hepatitis annual report, 22-23). HIV prevalence is 3% according to DHS 2019/2020 with the highest prevalence in Kigali City (6%). Co-infection of HIV with Hepatitis B or C viruses (HBV or HCV) is associated with less spontaneous clearance, higher chronicity, and more rapid disease progression. The Ministry of Health and RBC put much effort in strengthening the prevention, diagnosis and treatment of Viral Hepatitis.

On the other hand, preventing other Sexually Transmitted Infections (STIs) is essential to mitigate several health consequences, including chronic disease, fertility problems, cancer and death. When primary and secondary prevention fail, curative healthcare is a priority, despite numerous barriers linked mainly to culture and other socio-behavioral factors. According to the Rwanda Demographic and Health Survey (RDHS) 2019-2020, 4.4% of women and 2.9% of men reported having had STI and/or STI symptoms in the past 12 months. The high prevalence of STIs may reflect multiple barriers to accessing quality STI prevention and control services, but also linked to the population socio-economic and behavioral factors. Without neglecting the priority given to the follow-up of STI cases through the expansion of public and private clinics in Rwanda, there is still a need to improve the capacity of health sector staff, health infrastructure, community awareness, as well as a continuous guidance on prevention, treatment and follow-up of STI cases.

Rwanda has invested a great effort in the design, implementation and expansion of a monitoring and evaluation system using DHIS2 and HMIS data reporting platforms, which has not only enabled the initial digitalization of hepatitis services, but has also helped the program to collate national data into a single national database used to monitor the progress towards hepatitis elimination and inform the program on needed interventions to continuously improve hepatitis services.

4.2. Training and mentorship on HBV, HCV and STIs management

Healthcare workers need continuous training and mentorship to provide equitable and quality healthcare services. In the current fiscal year, a number of staff and managers from various health facilities have been trained on the management of Viral Hepatitis and STIs. The following table shows the staff and managers trained on updated national Viral Hepatitis and STI guidelines, monitoring and evaluation, and hepatitis tools, to improve the quality of comprehensive service delivery, through continuous capacity building of healthcare providers.

The hepatitis B and C viral load testing shifted from the conventional to GeneXpert testing platform, which not only reduced test results turnaround time, but also reduced travels made by beneficiaries to the health facilities for viral load sample collection. In this context, laboratory managers, technicians and scientists from all public health facilities were trained on this new platform.

Additionally, the training also improved the management of Viral Hepatitis and STI data, using an electronic data recording system, and enhanced the skills and motivation of healthcare workers by providing them with effective technical support.

Table 1: People trained on Viral Hepatitis and STIs, 2023-2024

Type of healthcare providers trained	Total number
Laboratory managers, scientists and technicians	635
Medical doctor /Nurse mentors/nurse in charge of hepatitis	669
Store managers	595
RMS OPDO	30
Head of maternity services and EPI supervisors	208
Total	2,137

4.3. Management of Viral Hepatitis B

4.3.1. Hepatitis B prevention, care and treatment (June 2023-July 2024)

Public awareness of diseases is key for their control and elimination. In the current fiscal year, the population was continuously informed about Viral Hepatitis and STIs through radio, TV broadcasts, written press releases 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 773,693 people were screened for HBV, 11,463 of them (1.48%) tested positive for hepatitis B surface antigen (HBsAg), 1,906 (0.25%) had detectable viral load and 771 were eligible and initiated on HBV treatment.

4.3.1.1. Hepatitis B annual cascade of care (July 2023 - June 2024)

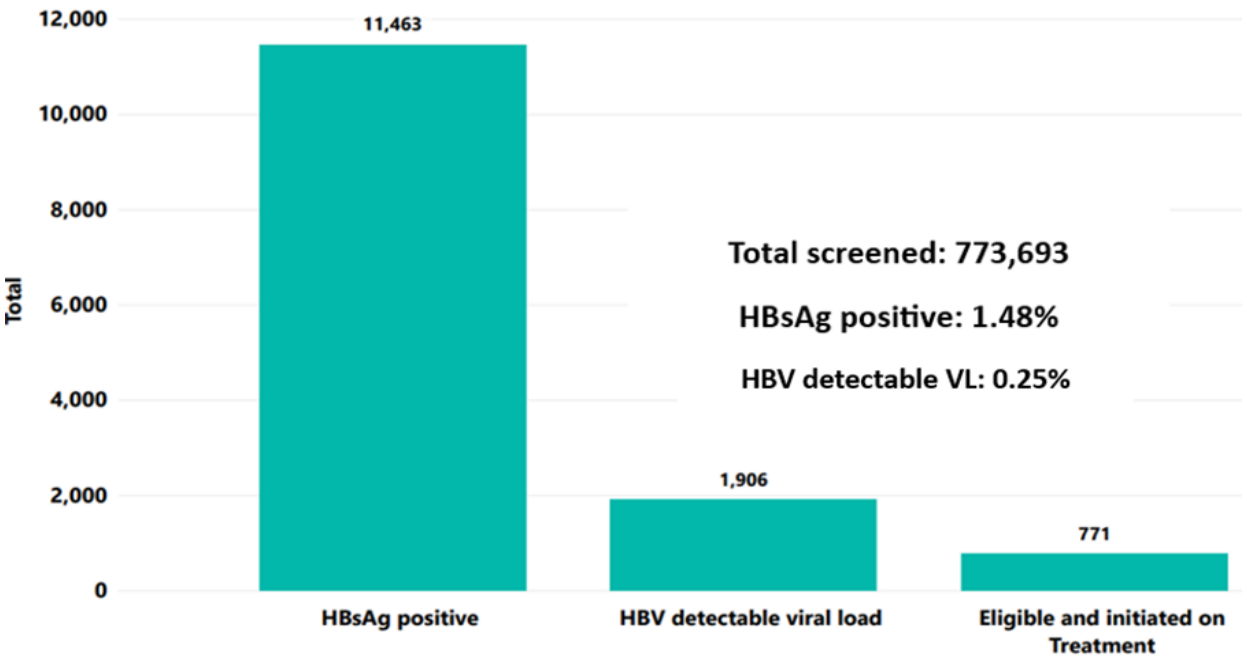


Figure 48: Hepatitis B cascade of care from July 2023 - June 2024

4.3.1.2. 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 Eastern Province screened the highest number of people (202,614), while the Northern Province screened less (106,279). The highest and lowest proportion of positive cases by viral load tests were observed in Kigali City (0.5%) and the Southern Province (0.16%) respectively.

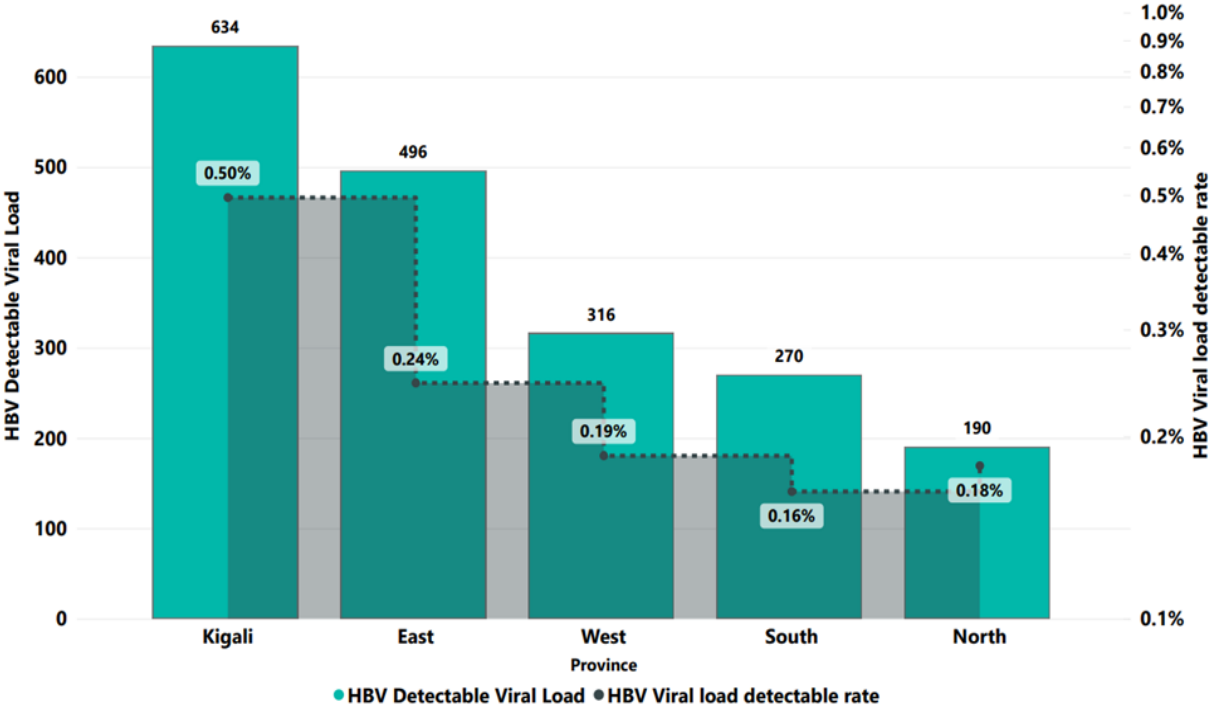


Figure 49: HBV prevalence by Province, July 2023 - June 2024

4.3.1.3. Hepatitis B infection by District

The map below shows that there is a relatively highest prevalence in Kicukiro district, varying between 0.47% - 1.05%. The following category of districts with a relatively high prevalence varying between 0.23% - 0.46%, are the districts located on the borders including Burera, Nyagatare, Kayonza, Ngoma, Bugesera, Rusizi, Nyamasheke. High prevalence in the districts located on the borders, suggest cross-border transmission.

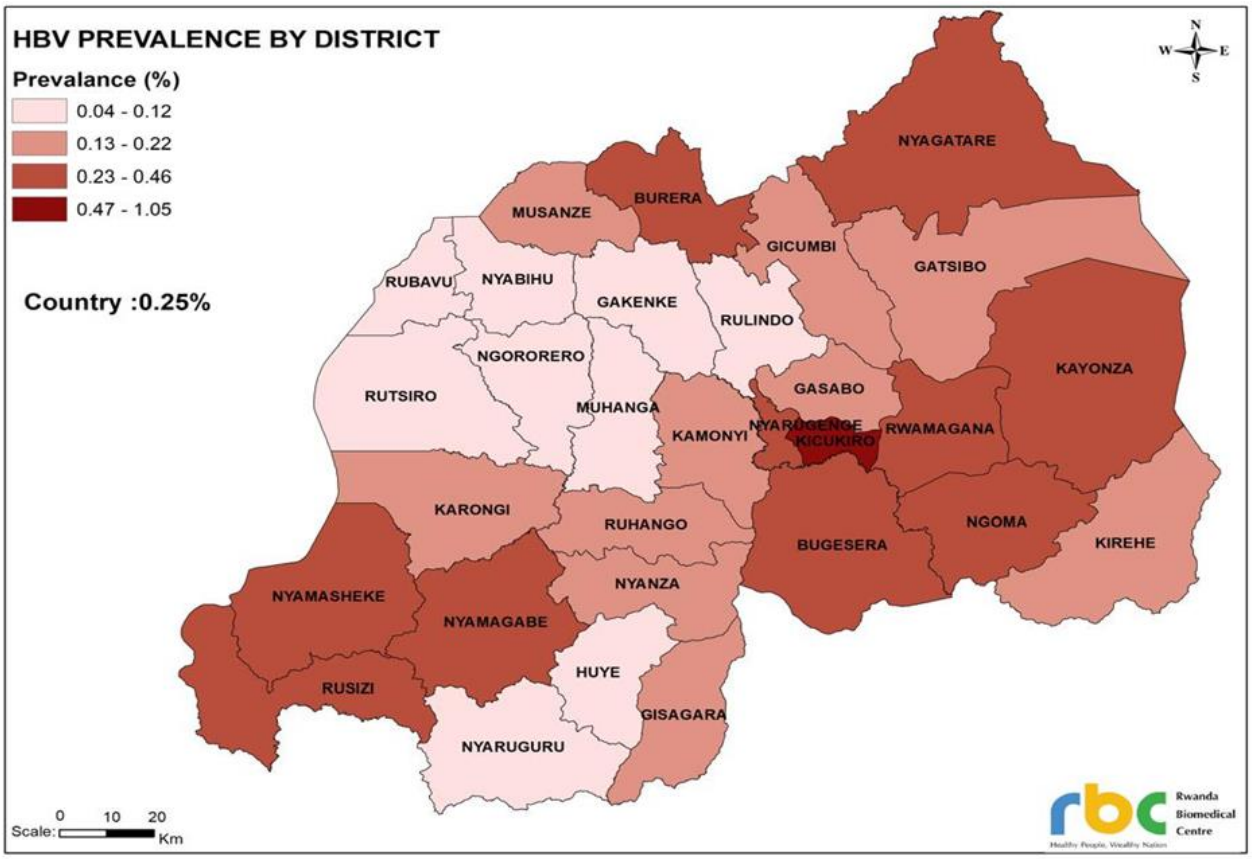


Figure 50: HBsAg positivity rate by District, July 2023 - June 2024

4.3.1.4. HBV infection in pregnant women

Rwanda's national HBV guidelines suggest that all pregnant women should be routinely screened for HBsAg at first contact and delivery, and followed up to determine whether they are infected and can benefit from treatment but also to prevent the transmission from mother to child. From July 2023 to June 2024, a total of 202,618 women were tested and 3,661 (1.8%) had detectable viral load and were initiated on treatment in line with eligibility criteria. In addition, a total of 329,891 babies out of 363,839 have been vaccinated (pentavalent vaccine third dose) with a coverage of 91% from July 2023- June 2024. A targeted HBV birth dose was offered to all babies born to infected mothers within 24 hours after birth.

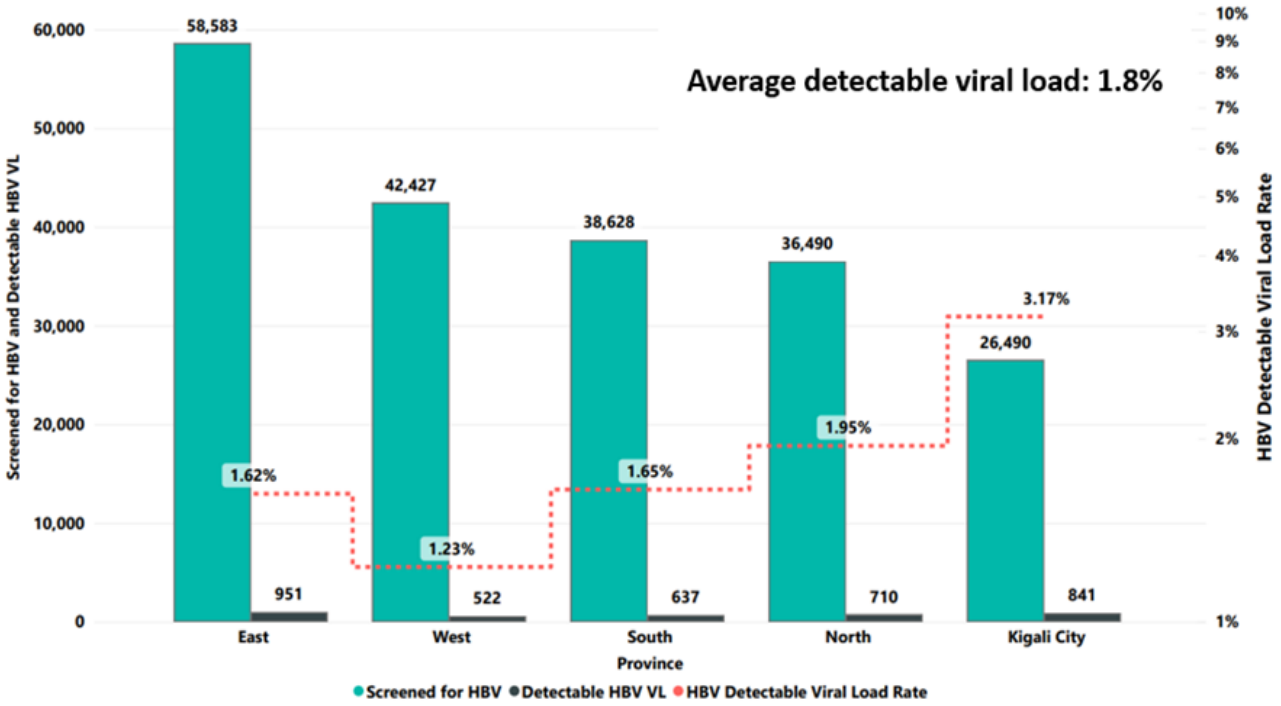


Figure 51: HBV infection in pregnant women

4.3.1.5. Hepatitis B and HIV coinfection

From July 2023 to June 2024, a total of 773,693 people were screened for HBV, 11,463 of them (1.48%) tested positive for hepatitis B surface antigen (HBsAg). Out of the 11,463 who tested HBsAg positive, 2062 (17.99%) were coinfected with HIV.

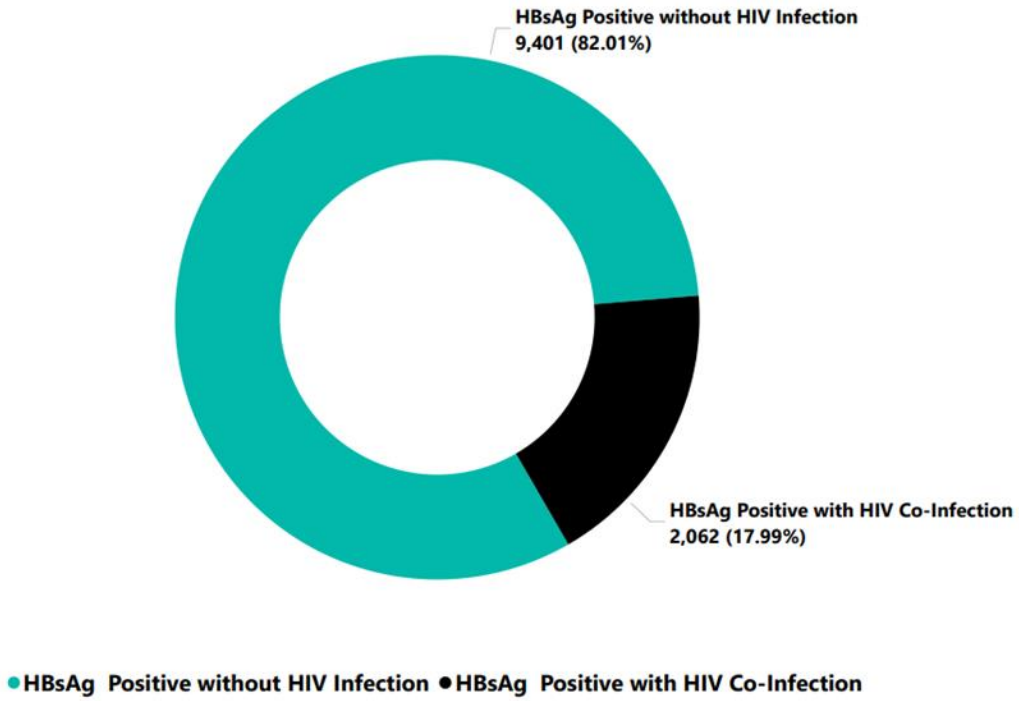


Figure 52: Hepatitis B and HIV coinfection

4.3.1.6. Hepatitis B vaccination

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 2023 to June 2024, a number of 329,891 babies out of 363,839 have been vaccinated (pentavalent vaccine third dose) with a coverage of 91%. A targeted HBV birth dose was offered to all babies born to infected mothers within 24 hours after birth.

4.3.2. Hepatitis B cumulative cascade of care, 2015-2024

With regard to the program's achievements in terms of HBV management, it is worth noting that almost six million people have been screened since screening services began in 2015, 149,975 have tested positive for HBsAg and 9,029 have been put on HBV treatment to date.

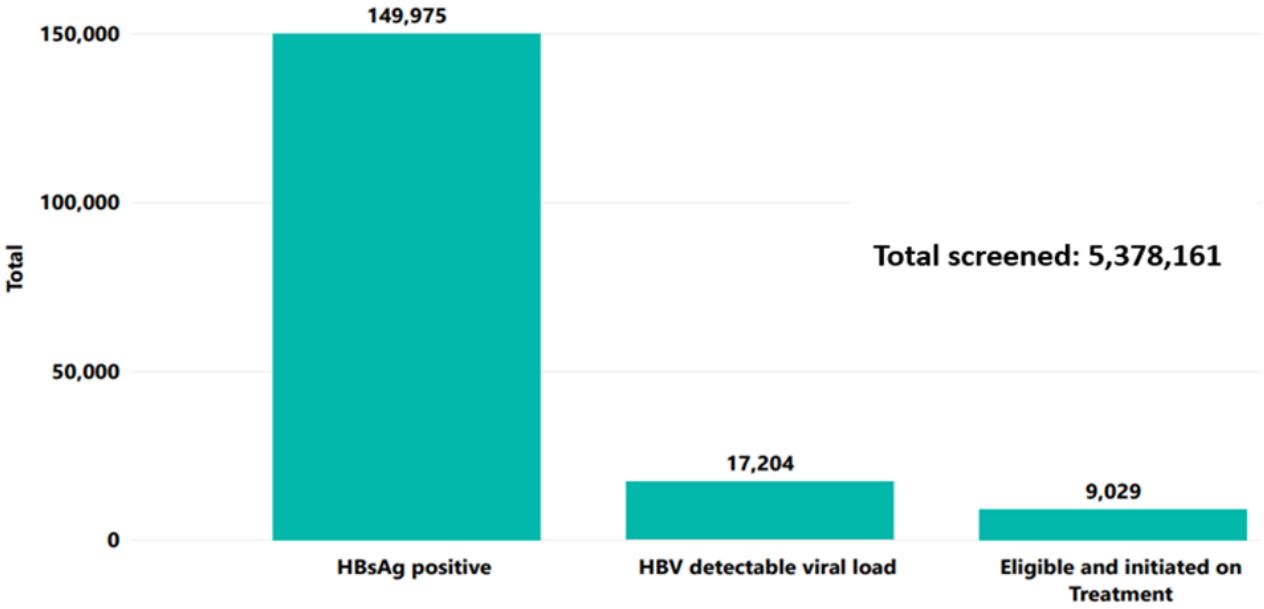


Figure 53: Hepatitis B cumulative cascade of care, July 2015 – June 2024

4.4. Management of Viral Hepatitis C

4.4.1. Hepatitis C awareness, testing and treatment

4.4.1.1. Hepatitis C annual cascade of care, 2023-2024

In the current fiscal year, 719,277 people were screened for HCV, 15,639 people were HCV antibody positive and 1,535 had a detectable viral load which implies a prevalence of 0.21%.

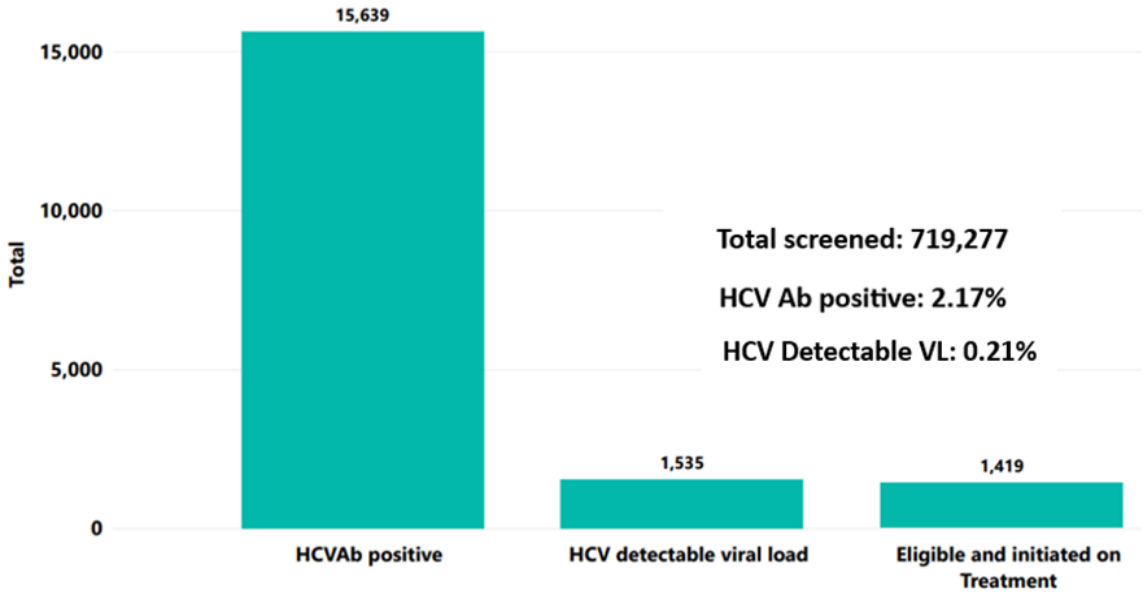


Figure 54: HCV cascade of care, July 2023 – June 2024

4.4.1.2. Hepatitis C positivity rate by District

Analysis of HCV virological prevalence, broken down by district, shows that Nyabihu in the Northern Province as well as Nyanza and Nyamagabe in the Southern Province, Karongi in the Western Province and Ngoma in the Eastern Province have the highest Prevalence. Similarly with HBV, these districts located on borders are the most affected and cross-border transmission could be one of the reasons.

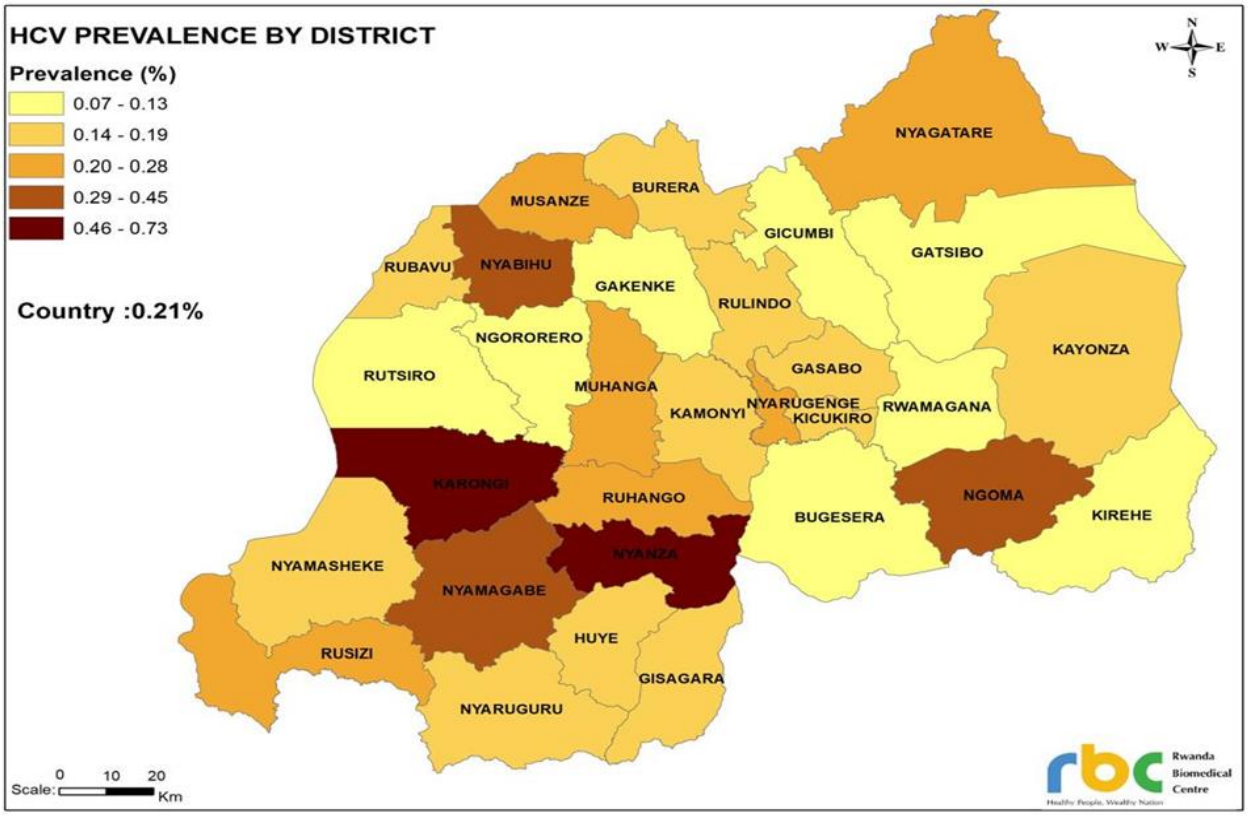


Figure 55: Prevalence of HCV per district

4.4.1.3. Hepatitis C positivity rates by Province

Analysis by Province shows that the Eastern Province tested the highest number of people, (183,008), while the Northern Province tested fewer (95,941), and the Southern Province recorded the highest proportion of HCV- detected viral load (0.27%).

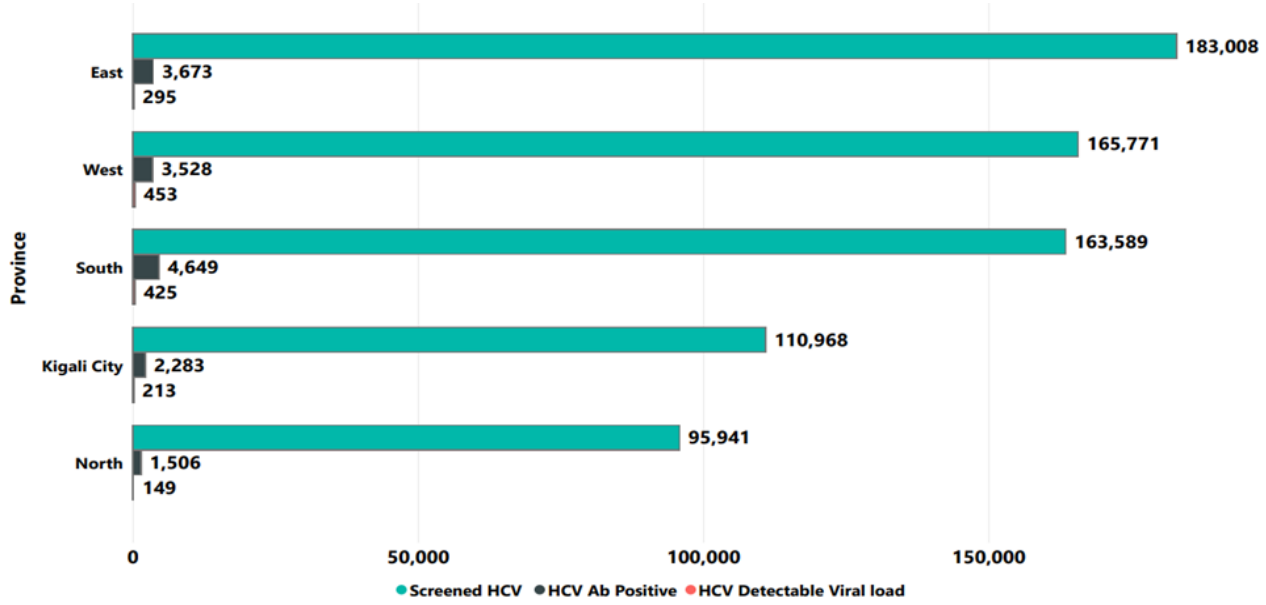


Figure 56: HCV positivity rate by Province, July 2023 – June 2024

4.4.1.4. Hepatitis C cumulative cascade of care, 2015-2024

Since the beginning of the HCV management in 2015, 8,285,780 people have been tested for HCV in Rwanda. Of the 172,748 people with positive HCV antibodies, 64,923 (37.5%) had a detectable viral load and were eligible for treatment.

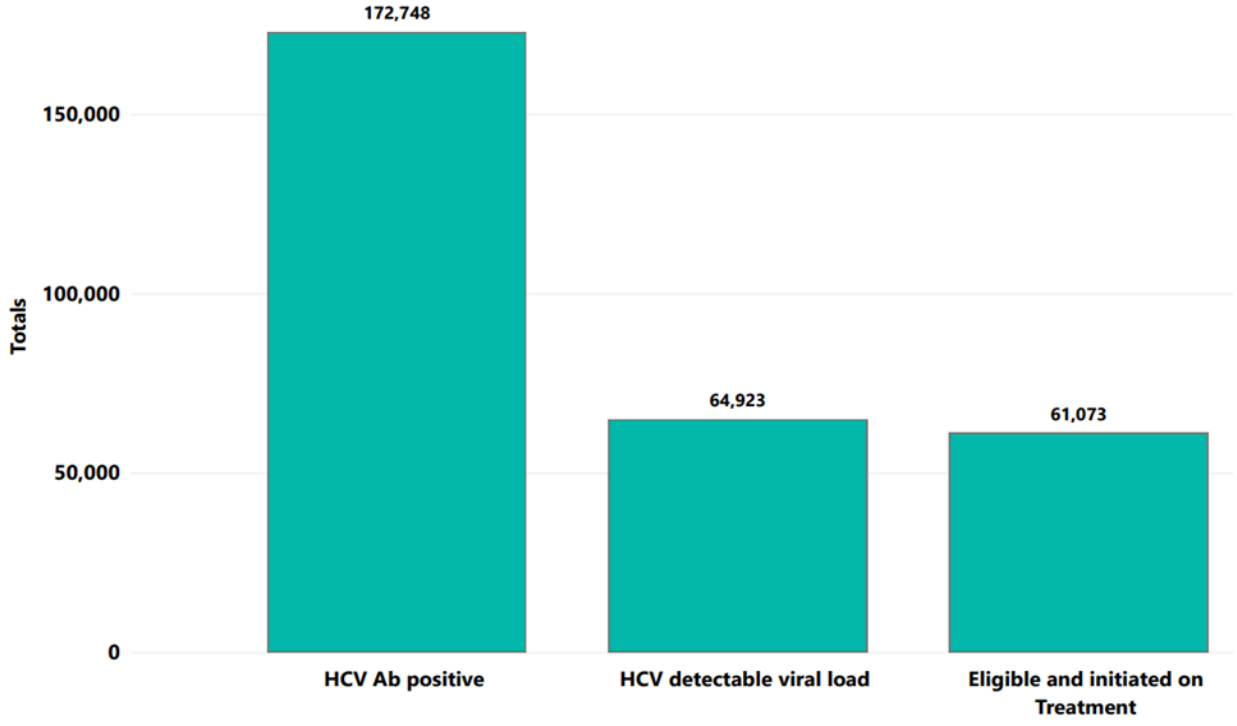


Figure 57: Hepatitis C cumulative cascade of care from July 2015 - June 2024

4.5. Management of sexually transmitted infections

4.6. STIs awareness, testing and treatment

STI management is a cornerstone in the fight against HIV and HBV, as they share similar modes of transmission. Rwanda has adopted systematic screening of all people visiting health facilities in order to increase the unmet need for STI-related services, mainly due to cultural barriers and stigma. Five syndromes have been adopted from WHO for oral screening, physical examination, treatment and reporting. From July 2023 to June 2024, 3,862,732 people have been screened for STIs, of whom 209,817 (5%) had one or more STI signs and/or symptoms, were confirmed positive and initiated on treatment. The Western province recorded the highest number of screened people (1,151,305) and the lowest number was recorded by the City of Kigali, 415,603, the latter having the second highest positivity rate after the Eastern Province, which is not surprising given that HBV and HIV are also widespread in the Eastern Province and Kigali City.

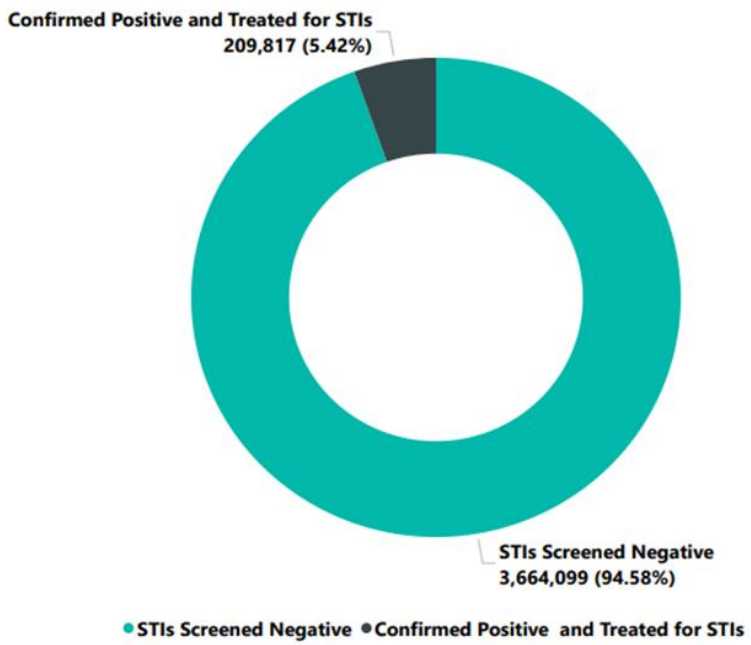


Figure 58: Number of screened people, confirmed positive and treated, July 2023-June 2024

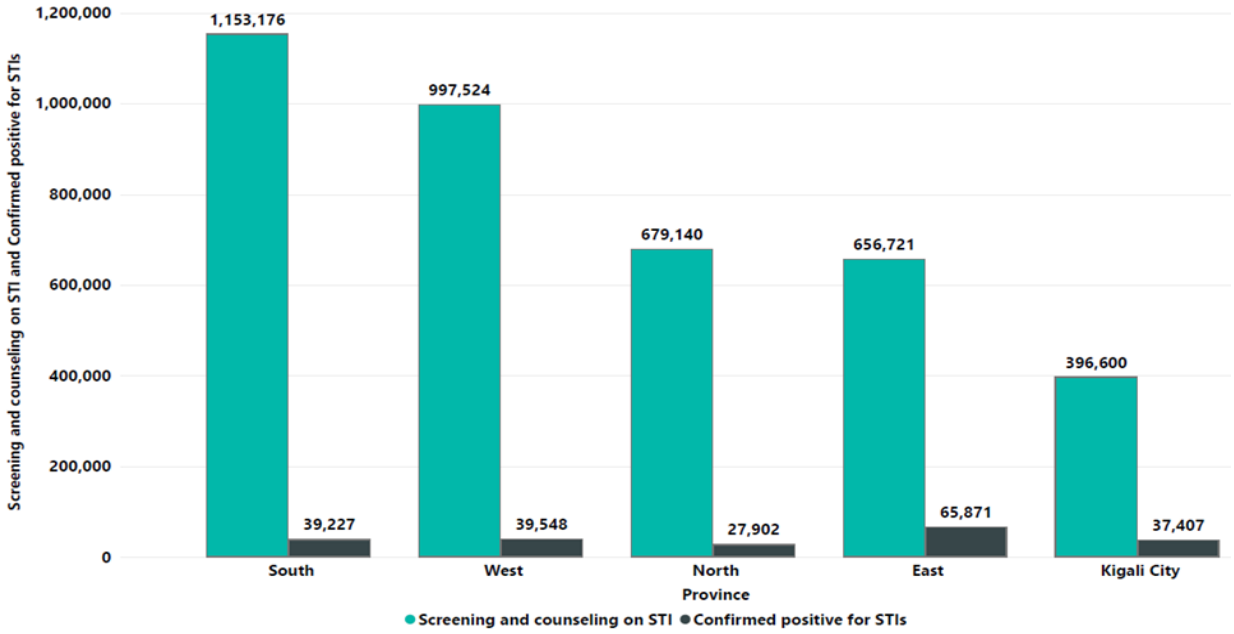


Figure 59: STIs screening and positivity rates by Province, July 2023 - June 2024

4.6.1. STI screening and positivity rates by age group

The graph below shows that the mostly affected age groups are 20-24 years with a prevalence of 7.5%, followed by the age group 25-49 years with a prevalence of 5.9%.

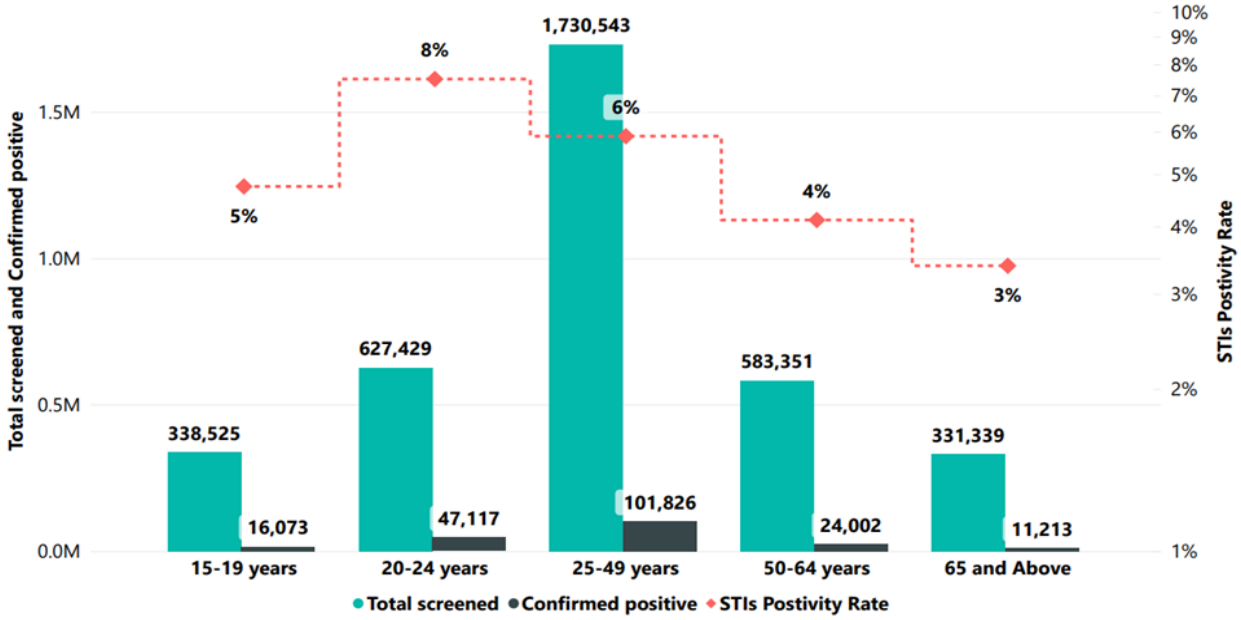


Figure 58: STI screening and positivity rates by age group

4.6.2. STIs syndromic management

In terms of syndromic management, vaginal discharge tops the list, followed by urethral discharge in men, the latter reflecting a possible spread of STIs, requiring greater awareness and better treatment.

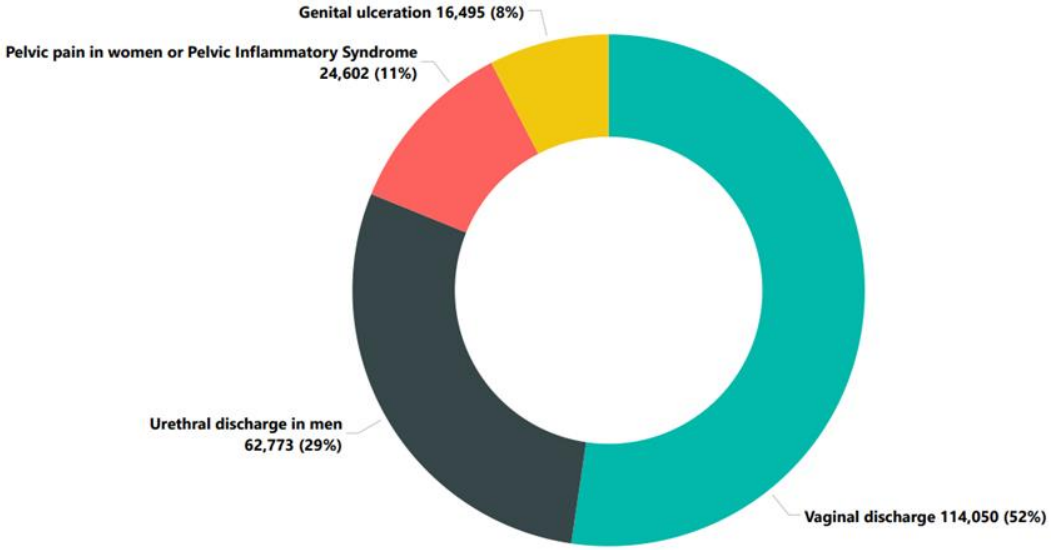


Figure 60: STI infection per syndromes

4.6.3. HIV and STIs coinfection

Among the 209,817 people who were confirmed STIs positive from July 2023 to June 2024, HIV coinfected people were 6,127 (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.

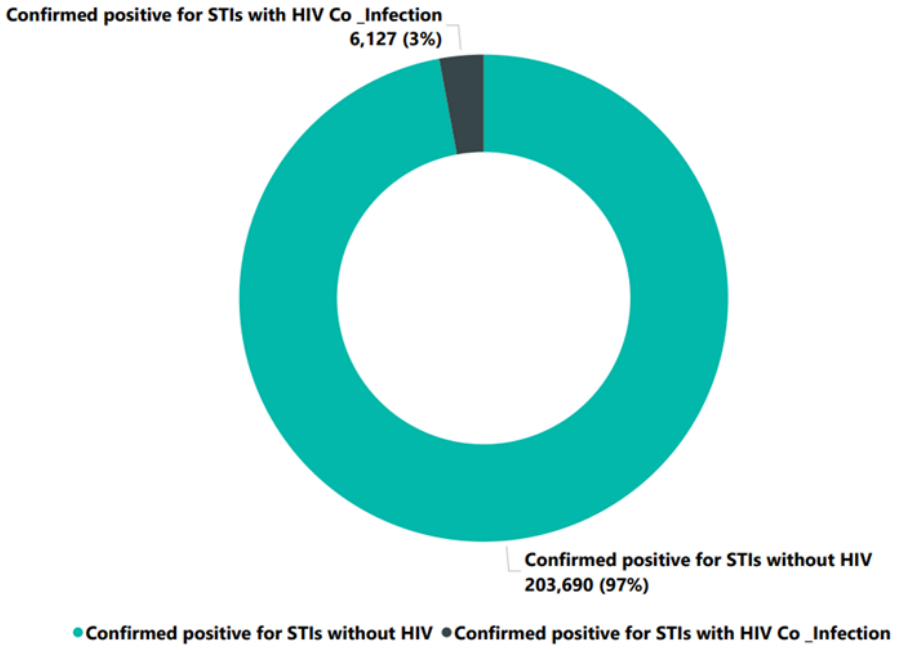


Figure 60: HIV and STIs coinfection

4.6.4.STIs cumulative cascade of care 2015-2024

From 2015, a lot of people have been counselled and screened for STIs and on average, around 4-5 million people are screened every year. From July 2023 to June 2024, 3,862,732 people have been screened for STIs, of whom 209,817 (5%) have been confirmed STIs positive and treated.

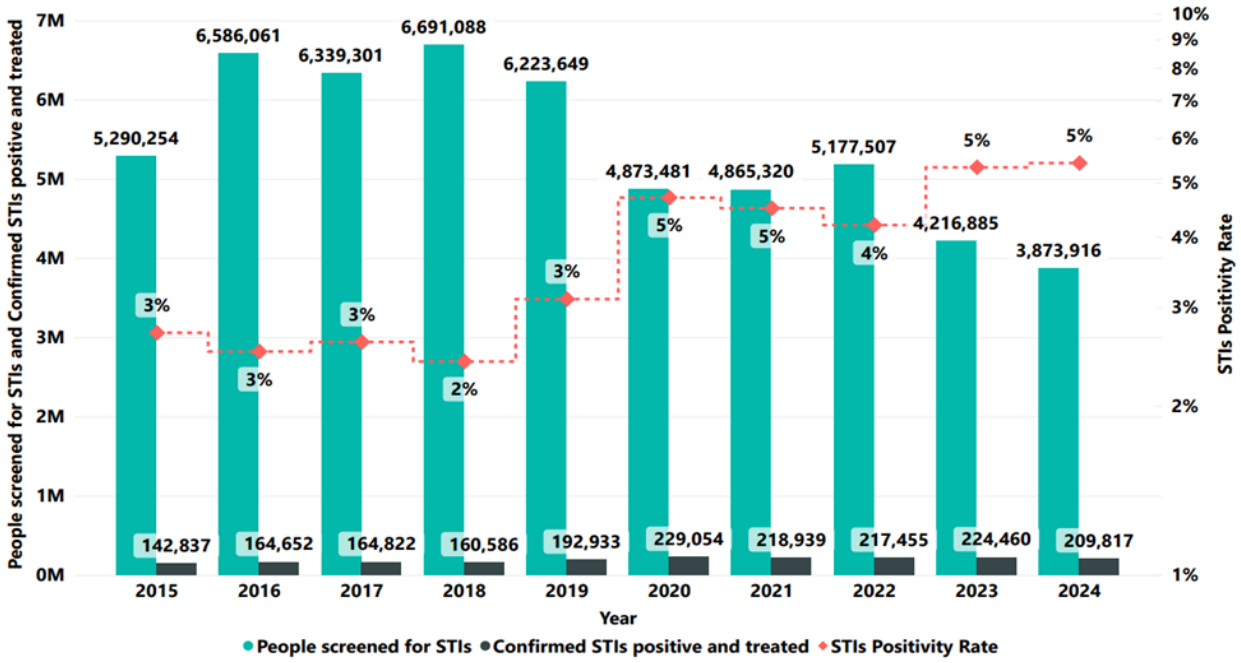


Figure 61: Individuals diagnosed and treated for STIs, 2015-2024

4.6.5. Monitoring and Evaluation

For surveillance and data management, the electronic information system namely Rwanda Health Management Information System (HMIS) and District Health Information Software 2 (DHIS2), are used and regularly updated to capture hepatitis and STIs management data. Meetings were regularly organized with health facility managers, medical doctors, head of maternity services, EPI supervisors, nurses, data managers and laboratory technicians to verify the quality of data and inform about the update of data management systems.

5. STRATEGIC INFORMATION

5.1. Introduction

Strategic information provides the critical evidence that policymakers, program directors, and line managers need to make informed decisions to improve programs. Strategic information plays three roles: to understand the epidemic and the extent of change resulting from interventions; to track and gauge the health sector's response to HIV, notably the health system inputs, intervention coverage, quality of services, outcomes and impact to inform program improvement, ensuring quality and a maximal return on resources invested and helping to identify bottlenecks and opportunities.

Strategic information plays a significant role in monitoring the progress toward UNAIDS target 95-95-95 by building the information system to collect and store health data, ensuring data quality, and promoting research and surveillance for evidence.

The national HIV responses are currently using passive and episodic surveillance methods that include participatory surveillance, surveys and community-based reporting systems. These include the HIV and Syphilis Surveillance (HSS), the Integrated Behavioral and Biological Surveillance Survey (IBBSS) among key populations, size estimations of high-risk groups of HIV infection, HIV drug resistance surveillance, Sexually Transmitted Infections (STIs) surveillance, and the Demographic and Health Surveys (DHSs).

Strategic information plays a significant role in monitoring the progress toward the NSP and the 95-95-95 UNAIDS targets by building information systems to collect and store health data, ensuring data quality, and promoting research and surveillance for evidence.

Several health information systems have been put in place to routinely collect, store, and produce analytics on different interventions and the quality of services to support decision-making. Rwanda is moving to digitize its entire health system by 2024. In this framework, Rwanda is establishing the health information exchange and interoperability between the Electronic Medical Record (EMR), the DHIS-2, the laboratory information systems, and the national unique ID database to facilitate the electronic return of results to the health facility, deduplication of client records and to facilitate the sharing of health data across health facilities. Parallel to these efforts, it is necessary to establish community-led structures and mechanisms to be used by communities to enable community members and community-based organizations to interact, coordinate and deliver their responses to the challenges and needs affecting their communities.

Following UNAIDS recommendations, Rwanda is in the first stages to initiate and operationalize community-led monitoring (CLM), an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organizations of people living with HIV, networks of key populations, other affected groups, or other community entities. The country has high expectations to improve the responsiveness, equity, and quality of HIV services.

Research is an important tool assisting disease control programs and aligning with national priorities. Research activities will continue to happen to inform the HIV program.

5.2. Health information systems

Several health information systems are put in place to routinely collect, store, and produce analytics on different interventions and the quality of services to support decision-making.

District Health Information System-version 2 (DHIS-2): is a free and open-source health management data platform developed by the health information systems program (HISP) and the university of Oslo to monitor patient health and improve disease surveillance. DHIS-2 is used to aggregate statistical data collection, validation, analysis, management, and presentation. In Rwanda, all health facilities use the DHIS-2 platform to record the electronic case report forms (eCRF) for index testing and to report the monthly aggregated data program under the health management information system (HMIS) module.

Electronic Medical Records (EMR) database: EMR is an individual-level database of HIV-infected patients' follow-ups, served at 60% of health facilities and 65% of patients on ART across all districts of Rwanda. It collects data from the initiation of ART until death.

Laboratory Information system: Stores laboratory data and supports laboratory management. The system is expanded to all district-level laboratories to develop a national electronic network of laboratories.

Viral SMS is a real-time data transmission of captured VL request forms and return of test results to health facilities as well as generating information (Dashboard) for monitoring the quality of lab service delivery and the quality of program performance.

To strengthen the electronic information system, he Rwanda Health Management Information system has been upgraded to reflect new HIV guidelines as well as refresh end users on changes, regarding Electronic Medical Records (EMR), ARV nurses and data managers were trained on the upgraded Open-MRS and HMIS version which included new HIV guidelines and a new reporting framework. This initiative was operationalized by initiating an integrated health information system that synchronizes data entry and reporting across various health databases to reduce transcription errors,

eliminate data capture errors, and reduce the time spent in reporting.

5.3. Monitoring and evaluation systems

Monitoring and Evaluation (M&E) focused on availability and use of M&E tools as well as the functionality of information systems. Full M&E systems consisting of at least a data manager, planning M&E officer, and community health workers' supervisor, were available in 88% of DHs. Regular (quarterly) data review and validation reports were found in 86% of the DHs. The Ministry of Health and RBC lead Monitoring and Evaluation(M&E) activities of HIV programs across health facilities and community level. Which is critical for assessing national effectiveness of national HIV response. The routine monitoring of facility-based HIV services is already well established through a series of published standard operating procedures guiding the collection and management of HIV data. However, routine monitoring can be improved to document the quality-of-service delivery at health facilities.

The community-based monitoring system needs to be strengthened, specifically to monitor interventions targeting key populations and vulnerable groups. Health facility information is collected through various registers on a daily basis at the time-of-service delivery Each facility reports on monthly aggregate data to be entered into HMIS, which uses the DHIS 2 platform. Furthermore, Electronic Medical Records (EMR) need to be scaled to cover all health facilities across the country and linked together to improve data accuracy.

At the health facility level, the Ministry of Health (MOH) and the Rwanda Biomedical Center (RBC) have established a Monitoring and Evaluation (M&E) framework led by district health officers to systematically collect and analyze data on HIV prevention, treatment, and care service delivery. Health facilities are equipped with standardized tools and guidelines to ensure accurate and consistent data reporting. Regular training and capacity-building initiatives are conducted to enhance the skills of healthcare providers in data management and utilization. At the community level, M&E efforts focus on tracking the impact of HIV interventions, such as awareness campaigns, testing, and linkage to care services. Both at the central and decentralized levels, RBC and MOH utilize health information systems to compile and analyze data from health facilities and communities. These systems facilitate real-time monitoring, enabling timely decision-making and resource allocation. Better M&E planning and coordination have contributed to improving overall system performance at central and decentralized levels. However, high turnover is causing instability of M&E staff, and for community-based

M&E systems, support is needed in the dissemination of finalized M&E tools and the continued training of local partners. The frequency and quality of supervisory visits from central to decentralized levels have to improve, as well as follow-up after supervision visits.

The HIV M&E system is primarily divided between health facility-based and community-based, components of monitoring and evaluating the national HIV response, and is decentralized from national to district levels. The health facility-based components of the M&E framework are led by MoH and RBC at the national level and district health officers at the district level. Better M&E planning and coordination have contributed to improve overall system performance at central and decentralized levels.

Routine monitoring is well improved to document the quality-of-service delivery at health facilities. The community-based monitoring system needs to be strengthened, specifically to monitor interventions targeting key populations and vulnerable groups. Health facility information is collected through various registers daily at the time-of-service delivery. Each facility reports on monthly aggregate data to be entered into HMIS, which uses the DHIS 2 platform. Further, Electronic Medical Records (EMR) need to be scaled to cover all health facilities across the country and linked together to improve data accuracy.

5.4. HIV Data monitoring and reporting

HIV data monitoring and reporting are integral to the national HIV response, guided by established procedures for accurate and systematic data collection. Health facilities across the country document HIV testing, treatment, and care data through standardized registers and electronic systems, with monthly reports submitted into health information systems via DHIS-2 platform. Community-based monitoring complements this by tracking outreach efforts and interventions targeting high-risk groups. Data quality is maintained through rigorous validation processes, regular audits, and targeted both mentorship and training for health workers. Technological advancements, including the expansion of Electronic Medical Records (EMR) and mobile health (mHealth) tools, further enhance data accuracy and real-time reporting.

The routine monitoring of facility-based HIV services is well established through a series of published standard operating procedures guiding the collection and management of HIV data. Accurate, timely, accurate and accessible health care data play a vital role in the health care economic planning, development, and maintenance of health services.

Following the revision and changes made in the National HIV guidelines, version 2020, some HIV, STIs, and Viral Hepatitis indicators were also revised and/or incorporated into HMIS to align with the national HIV guidelines. The indicators related to DSDM, DTG optimization, AGYW program, TPT initiation, PrEP program, and Viral load monitoring were revised, incorporated, and disaggregated by age and sex.

Routine monitoring will be improved to document the quality-of-service delivery at health facilities. The community-based monitoring system needs to be strengthened, specifically to monitor interventions targeting key populations and vulnerable groups. Health facility information is collected through various registers daily at the time-of-service delivery. Each facility reports on monthly aggregate data to be entered into HMIS, which uses the DHIS 2 platform. Further, Electronic Medical Records (EMR) need to be scaled to cover all health facilities across the country and linked together to improve data accuracy.

A total of 584 health facilities submits their monthly reports on 13 core national indicators in HMIS that provide minimum necessary information for national-level monitoring and response to the HIV epidemic: STIs and Viral Hepatitis focusing on ensuring data quality.

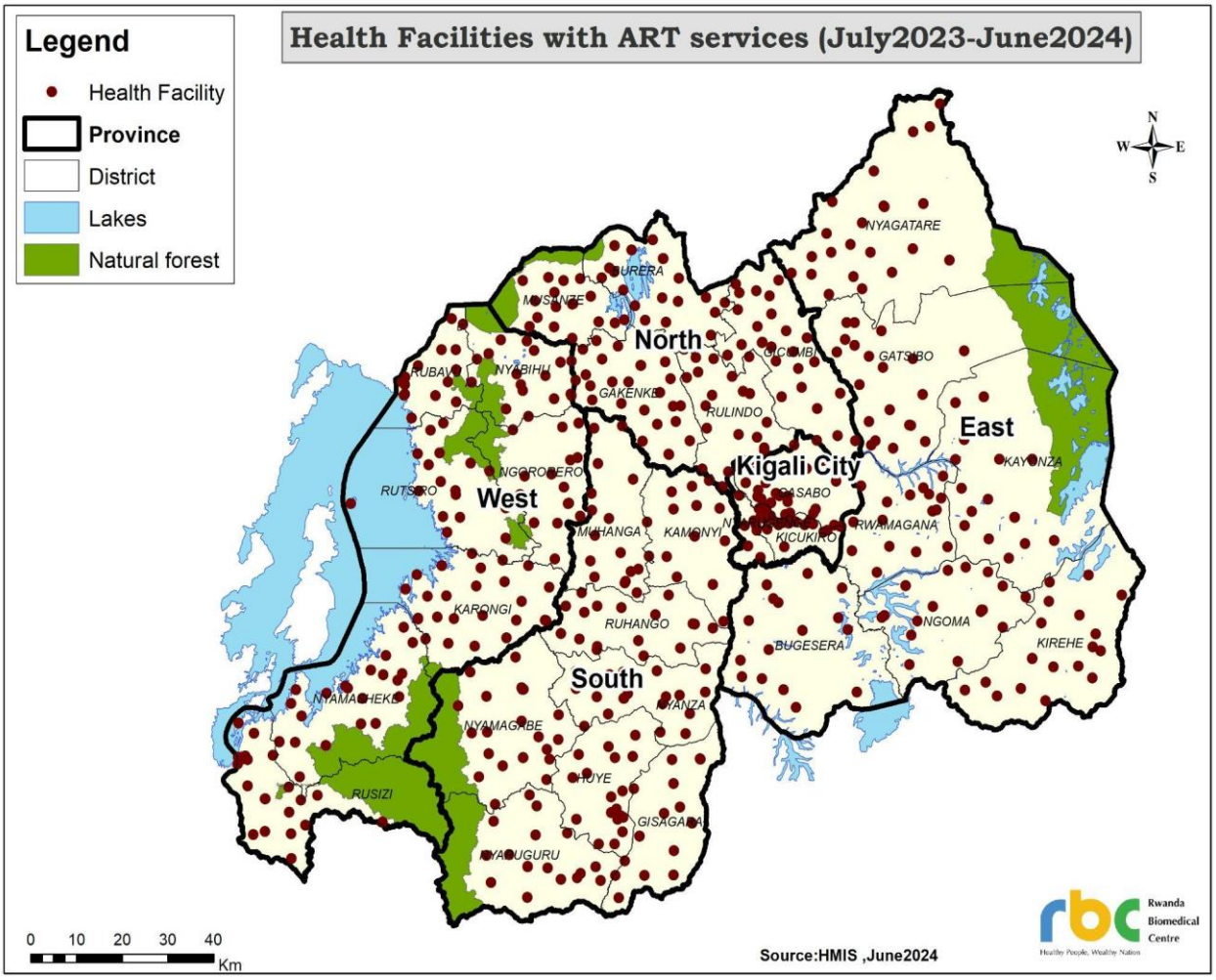


Figure 62: HF with ART services by June 2024

5.5. HIV data flow

Care providers gather HIV data daily at health facilities through registers and electronic systems, capturing details on testing, treatment, and care. Data managers ensure that data collection forms are available to care providers before the 28th of the month in which the data is being collected. Data is aggregated monthly by care providers and compiled by data managers at both health centers and hospitals. This data is reported into the Health Management Information System (HMIS) by the 5th of each month, where it is consolidated using the DHIS 2 platform for comprehensive analysis. Hospital data managers are responsible for ensuring that the data from health facilities within their catchment area is reported in a timely manner, and that it is complete and accurate.

The central level team reviews and verifies the data in the system, providing feedback to data managers between the 9th and 11th of the month. Data managers, in collaboration with care providers, then conduct cross-checks and audits, making any necessary corrections by the 15th. Finally, by the 16th of the month, the central level shares the finalized data with stakeholders and partners for their use.

Every data manager, working at both health center and hospital levels, is tasked with distributing forms to the appropriate services on the 28th of each month, subsequently collecting them after completion. This collected data is promptly entered into the Health Management Information System (HMIS) and must be finalized no later than the 5th of the following month.

At the hospital level, individual data managers are entrusted with verifying the completeness and accuracy of data within their designated catchment areas. In the event of any discrepancies or issues, the data manager at the corresponding health facility is responsible for resolving them from the 5th to the 8th of the month.

Between the 9th and the 11th, a central team takes over the task of reviewing the data. They meticulously analyze the information and, if needed, send comments to the data managers at the hospital level. These insights are then conveyed to the health centers, ensuring that any remaining concerns are addressed by the 15th end of the day, at which point the system is closed for that period.

Starting on the 16th, the central team actively shares the finalized data with various departments and stakeholders, facilitating a transparent and efficient flow of information. This structured process ensures that all parties involved have timely access to accurate data, fostering informed decision-making across the healthcare system.

5.6. Supportive supervision and data auditing

RBC conducts integrated supervision visits, employing both qualitative and quantitative data collection activities at the district level and (2) DHs conducts supervision visits to district-level HIV implementers. Other supervisory visits include visits to community-based activities. These supervisory visits are jointly conducted on a quarterly basis by RBC central level staff and district level staff in charge of health monitoring. Subsequently, the findings are shared to further improve the quality of HIV reported at the community level.

Supportive supervision of the implementation of key HIV program are conducted under partners supported and implemented by multiple stakeholders, resulting in different mentorship models used among various stakeholders at different levels

At the national level, a bi-annual data audit was conducted by RBC to assess the completeness and accuracy of district-level reporting and the degree to which national-level tools and formats are being respected both by district-level HIV implementers and

by Health Facilities. The accuracy of data reported via HMIS from the district level to the national level and from the service delivery level to the district level is guaranteed by biannual data quality assessments. Ensuring that the most accurate information will be used to inform evidence-based decision making requires improving the quality of data collected.

In the newly established integrated supervision system, all health services are assessed in a common supervision visit. There are two principal levels of supervision in the facility-based system: (1) RBC conducting integrated supervision visits, employing both qualitative and quantitative data collection activities at the district level and (2) DHs conducting supervision visits to district-level HIV implementers. Other supervisory visits include visits to community- based activities. These supervisory visits are jointly conducted on a quarterly basis by RBC central level staff and district staff in charge of health monitoring. A bi-annual data audit was conducted by RBC to assess the completeness and accuracy of district-level reporting and the degree to which national-level tools and formats are being respected both by district-level HIV implementers and districts.

5.7. Coordination of HIV Partners in Response

Activities under Coordination of HIV Partners in Response include activities to strengthen technical working groups involved in the implementation and management of the HIV system by improving linkages between the national and decentralized levels for M&E. The Planning, Monitoring, and Evaluation Technical Working Group continues to provide overall guidance and technical assistance to the implementation of the national M&E system. The working group is primarily responsible for developing and implementing the integrated HIV M&E annual work plan each year. It meets quarterly to review progress on implementation of the annual work plan, and to perform additional tasks as required.

The Rwanda health system implements a decentralized approach to HIV control, involving collaboration with line ministries, sectors, and the private sector. The Ministry of Health coordinates technical working groups, with the HIV division leading the coordination. The updated National Specific Plan (NSP) involves various actors, including civil society organizations, private sector partners, and government institutions.

The overall implementation framework in the Rwanda health system is based on a decentralization of services and their subsequent coordination to the lowest administrative level. Further, HIV control requires the multi sectoral approach beyond the health system. In this regard, the ministry of health works closely with the line ministries and sectors as well as the private sector to ensure the equity of services and the community outreach and engagement.

Technical working groups met regularly in working sessions and workshops under the coordination of the HIV division, which led the entire coordination, with the participation of several other divisions and units within the Ministry of Health. Various actors were involved in all phases of the development of this updated and revised NSP alongside different partners and stakeholders, including civil society organizations, private sector partners, and other government institutions.

5.8. Surveys and research

5.8.1. Integrated biological, behavioral, survey and surveillance among male who have sex with in Rwanda (ongoing)

The primary goal of the study was to assess the risk of HIV infection, sexually transmitted diseases, Viral Hepatitis B and C, and risky behaviors among men who have sex with men (MSM) in Rwanda in 2024, to enhance program planning. The study is now on the stage of data cleaning, analysis and report writing, then after the report will be published.

5.8.2. Non-communicable diseases study among people living with HIV (PLHIV) in Rwanda: Tackling the double burden.

This study was conducted in two arms with the main objectives to determine the prevalence of major Non-Communicable Diseases (NCDs) including Diabetes mellitus, Hypertension, Cervical Cancer, and Asthma among people living with HIV and to explore risk factors and estimate the NCD-related mortality among PLHIV in Rwanda. The study was conducted in 115 study sites and covered a sample size of 7,449 PLHIV aged 15 years and above for arm 1 and arm 2 consisting of a retrospective data analysis of PLHIV who died from 2020 to 2023. The preliminary results showed that 24.2% of participants had raised blood pressure, women screened HPV positive were 17.2%, while 1.1% of study participants had raised random blood sugar and 1.1% were on Asthma treatment. For arm 2, retrospective data of 6,038 died PLHIV were collected and the analysis is undergoing.

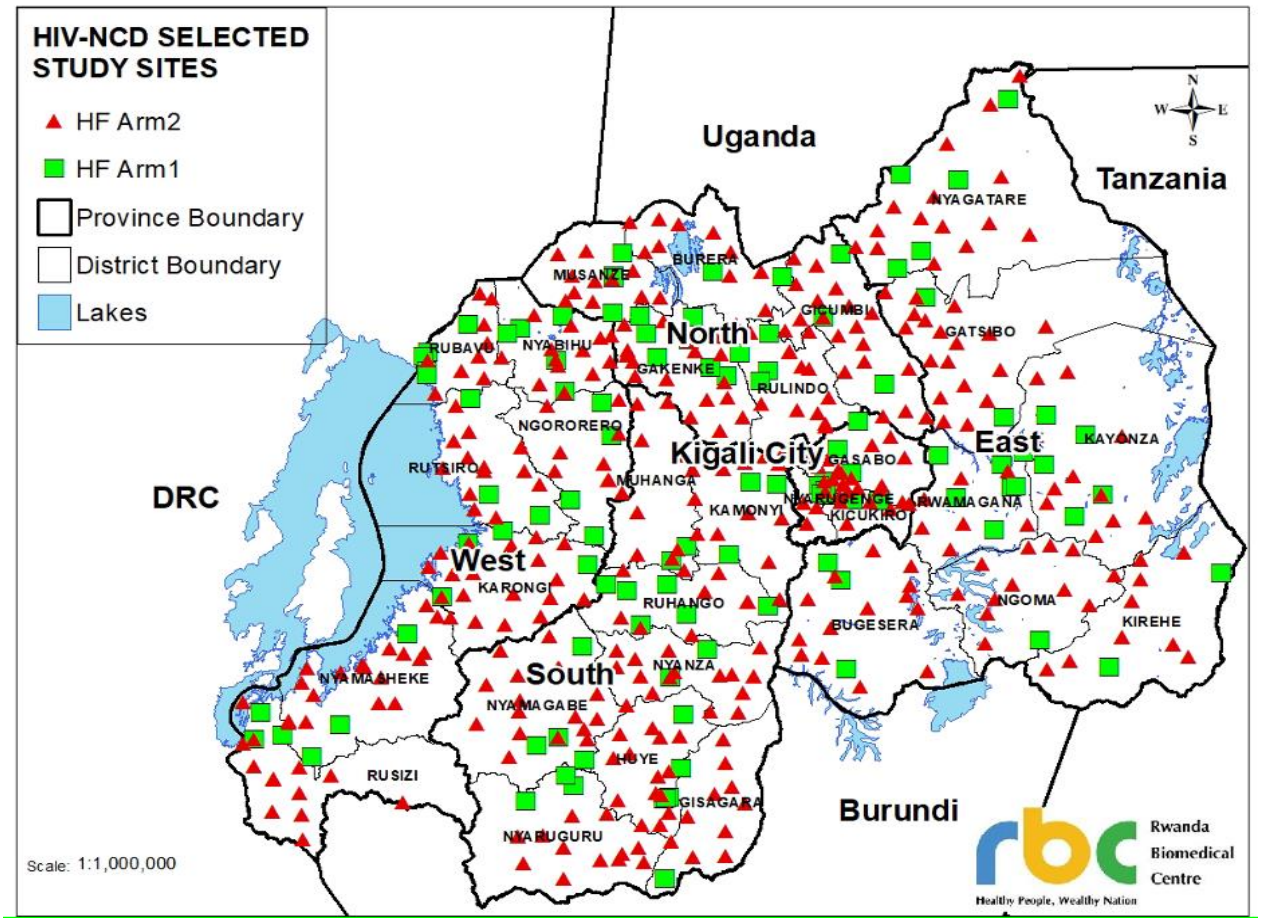


Figure 63: Map of selected health facilities for both arm 1 and arm 2.

5.8.3. Cyclical acquired HIV-drug resistance (CADRE) study among PLHIV (Ongoing survey)

In order to maximize the long-term efficacy of first-line ART, ensure the sustainability of ART programs, improve patient outcomes, and reduce the transmission of resistance, the primary goals of this study are to evaluate and track drug resistance among PLHIV on a DTG-based regimen. Every health facility/hub in the nation is participating in the study, which encompasses all PLHIV with a detectable viral load (VL) greater than 1000 copies/ml who have been on a DTG-based ART regimen for at least six months.

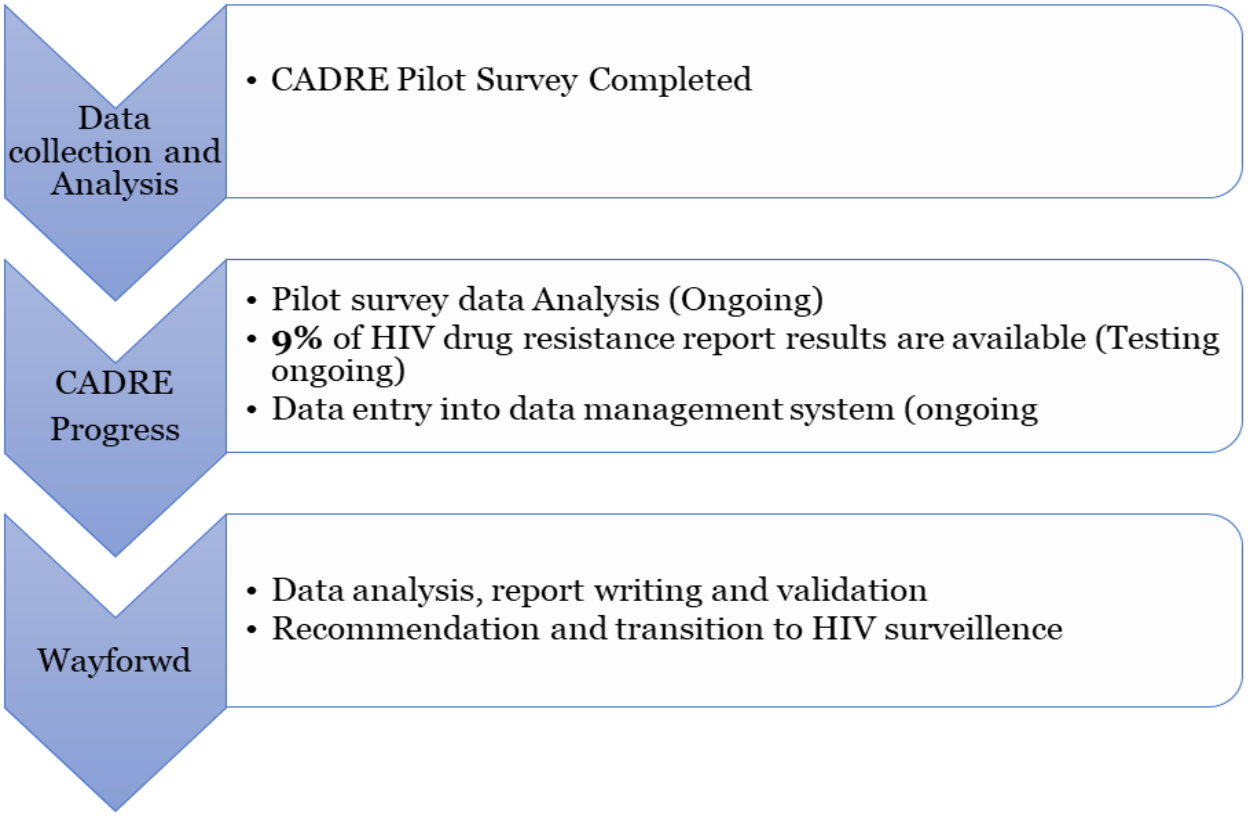


Figure 64: CADRE survey progress

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

The main objective of this study is to estimate the seroconversion rate among lactating mothers and to measure the vertical transmission rate from the newly infected mothers. The study was conducted in 28 health centers (Phase 1) and it will be expanded in 175 selected health facilities country wide. In general, 15,100 children were received at the health facility for vaccination from March to September 2023. Of them 9,821(62.4%) of their mothers accepted to participate in the study and to be tested for HIV. In total, 11 mothers tested HIV positive and 3 children tested HIV positive yielding HIV seroconversion rate during breastfeeding period of 11.2 per 10,000 and MTCT rate of 3 per 10,000 during breastfeeding. The study findings showed a MTCT rate of 3 per 10,000 during breastfeeding period. These findings do not represent the entire national level as the data were collected from a sub-set (28 HFs with n=9821) of the total HFs to be covered in Arm-2.

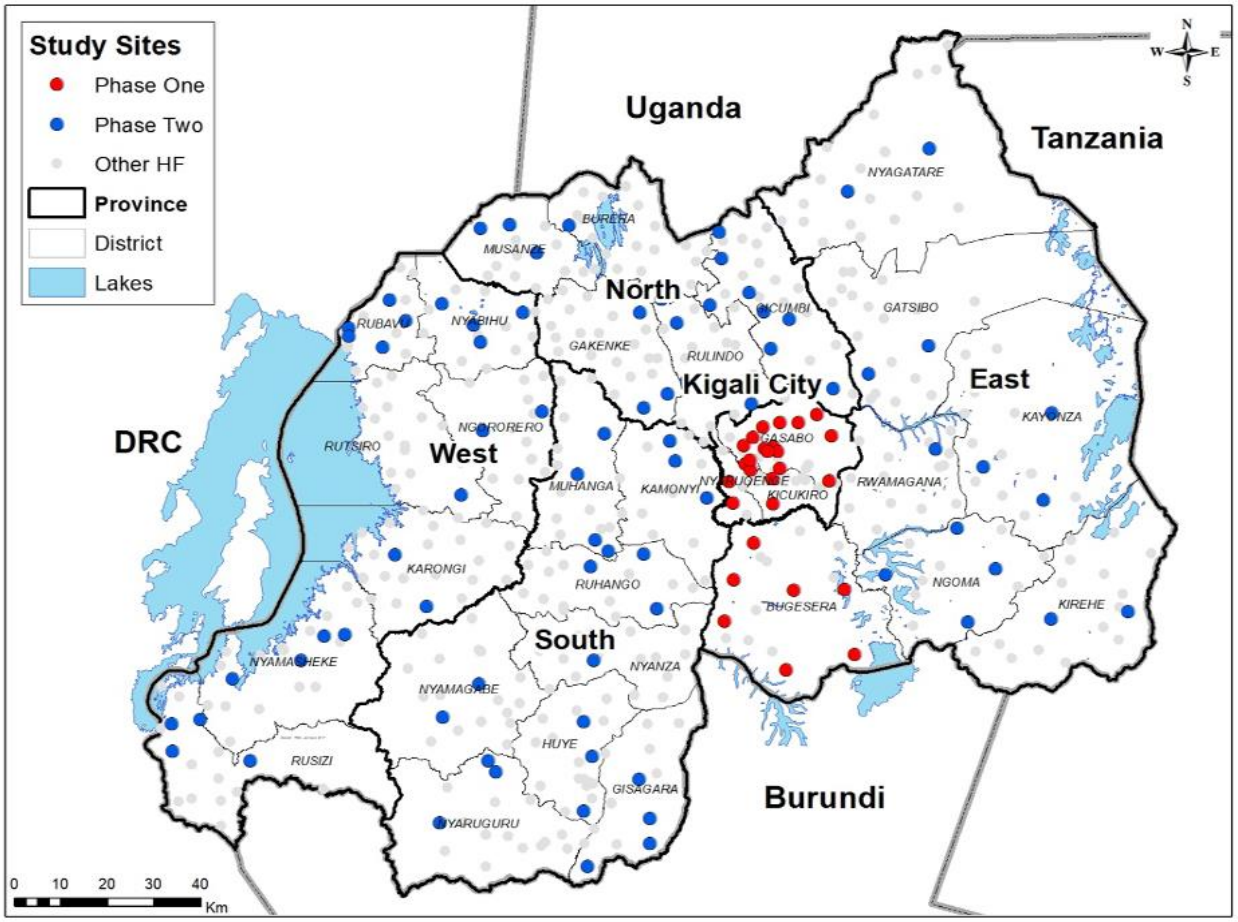


Figure 65: 28 Health Facilities eligible for the study survey in Bugesera district and City of Kigali. Red dots refer to 28 HFs locations (Arm-2, Phase-1) while the blue dots correspond to the remaining HFs to be enrolled in the study (Arm-2, Phase-2).

5.8.5. Assessment of HIV PMTCT service outcomes and associated missed opportunities in Rwanda Arm 1 & 2.

This study was conducted in two arms with the aim to investigate the rate of MTCT of HIV, associated missed opportunities along the PMTCT services cascade and measure the coverage of syphilis services among pregnant women in Rwanda. The study included the public, government-assisted and private health facilities delivering PMTCT services in Rwanda between July 2016 and June 2020. Out of 285 health facilities selected to be part of the study, 283 (99.3%) participated in the study. The findings of Arm1 revealed that 8,231 (84.2%) mothers included in the study knew they were HIV positive prior to their first ANC visit while 1,545 (15.8%) mothers who reported being HIV negative or with unknown status tested HIV positive at their first ANC visit. At 6 weeks, 9, 18 and 24 months, 0.5%, 0.2%, 0.1% and 0.1% of the HIV-exposed infants respectively tested HIV positive. The number of lost-to-follow ups increased over time, from 6.6% at 6 months to 20.8% at 24 months, and from 0.7% at 6 weeks to 16.0% at 24 months, in HIV positive mothers and their babies, respectively. Overall, Arm1 identified 1,266 children LTFU among those who would have completed the PMTCT follow-up at the time of data

collection. The second arm of the study (Arm2) concentrated on tracing mother-infant pairs that were lost throughout the PMTCT service cascade. Of the results, 765 (60%) could be located, whereas 511 (40%) could not be tracked. Of those who could not be located, 3.5% self-transferred to other health facilities, 2.5% relocated abroad, 0.7% of mothers and 1.7% of children passed away, 8.8% could not be found after changing their phone number or location, and 23.1% had no data source accessible.

5.9. E-Learning and Innovation

Three (3) workshops against Five (5) planned, were conducted to develop courses from various programs, and performed system upgrades to adopt recent versions of technologies. Therefore, 32 new courses were developed, allocated CPD credits and uploaded on eLearning platform while 18 courses are still under production.

The upload of new content on the eLearning platform was followed by a piloting phase with intention to fetch feedback from learners. This phase involved two courses, namely, the PMTCT and the Management of Latent TB infection in Rwanda. 115 learners have enrolled in the two courses, 19 learners have completed and got certified. There are more courses which are being attended by learners, such as MCCOD (2285 learners), Hypoxemia Screening and Oxygen Therapy (354 learners).

5.9.1. Tele mentorship program

Since the start of this program, 29 sessions were conducted based on the annual calendar of Telementorship sessions and 930 participants have attended the session. 33 spokes (hospitals) and 3 hubs were established and equipped, in terms of ICT Infrastructure and furniture for video conference rooms, to host Tele Mentorship sessions.

5.9.2. Priorities for the next year

The following are the priorities for the future:

- Mobilization of the Health sector to consume the content available on the platform.
- Monitoring of the eLearning uptake
- Upgrade and update of the platform to facilitate friendly utilization.
- Reinforce the capacity of central and decentralized level in analyzing and using data.

6. ANNEX

6.1. FINANCING HIV RESPONSE: FISCAL YEAR 2023-2024

6.1.1. Introduction

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

- Government resources, which includes revenues generated from taxes and non-taxes, loans, grants, donations – reported as Government contribution/ budget allocation and part is allocated as earmarked transfers.
- Development partner contributions through sector budget 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 2023-2024.

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 and UN agencies (One UN) contribution.

HIV/AIDS Expenditures in Rwanda FY 2023/2024 by Sources of Financing

The Global Fund for AIDS, TB and Malaria (GFATM) contributed the budget of USD 88,971,510.20 for the FY 2023/2024; the United States Government (USG contribution for the FY 2023/2024, is USD 64,563,538. The Government of Rwanda contributed the budget of USD 20,492,692.25 and the One UN with USD 623,072. Hence, the total contributions to the National Strategic Plan for the FY 2023/2024 were USD 174,650,812.45

Table 2: Global fund contribution to National Strategic Plan for the FY 2023/2024

Source of funding for NSP/HIV	Opening balance in USD	Initial approved budget for FY 2023-2024 in USD	Approved Budget FY 2023-2024 in USD (incl.opening balance)	Actual Expenditures FY 2023-2024 in USD	Variance in USD	Budget performance rate
Global Fund for AIDS, TB, and Malaria	28 100 071.51	60 871 438.69	88 971 510.20	87 207 608.44	1 763 901.76	98%
USG PEPFAR			64 563 538.00	64 563 538.00	-	100%
One UN			623 072.00	623 072.00	-	100%
GoR			20 492 692.25	19 257 709.17	1 234 983.08	94%
Grand Total	**28 100 071.5**	**60 871 438.69**	**174 650 812.45**	**171 651 927.61**	**2 998 884.84**	**98%**

*The total Global Fund contribution of USD 88,971,510.20 includes USD 28,639,934 related to C19RM activities.

Regarding expenditures in connection to the FY 2023/2024, the Global Fund for AIDS, TB and Malaria (GFATM) spent USD 87,207,608.44, the United States Government spent USD 64,563,538; the Government of Rwanda spent USD 19,257,709.17 and the UN agencies spent USD 623,072 as planned in National Strategic Plan.

The overall total expenditure for HIV NSP was USD 171,651,927.61 which represents 98% of the allocated budget.

Government contribution to HIV/AIDS National Strategic Plan FY 2023/2024

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 III implementation and different disease program strategic plans serve as guiding documents. The planning phase also uses the disease burden and services utilization data from HMIS to inform an effective resource allocation. The expenditure was then extracted and analyzed based on the disease burden.

Table 3: GoR contribution to NSP per MTEF chapter, FY 2023/2024

MTEF Chapter	Approved Budget for FY 2023-2024 in USD	Committed Amount FY 2023-2024 in USD	Budget Balance end June 2024 in USD	Performance rate in %
21 Compensation of employees	12,419,980	11,194,574	1,225,406	90%
22 Use of goods and services	3,113,430	3,161,594	(48,164)	102%
25 Subsides	414,836	414,804	32	100%
26 Grants	1,024,932	1,006,349	18,583	98%
27 Social assistances	1,446,808	1,426,631	20,178	99%
28 Other expenditures	160,060	159,329	731	100%
33 Inventory	68,801	68,497	304	100%
34 Fixed tangible non-financial Assets	1,843,846	1,825,931	17,915	99%
Total	**20,492,692**	**19,257,709**	**1,234,983**	**94%**

From the above table, the approved budget for the financial year 2023/2024 of USD 20,492,692 a total of USD 19,257,709 has been effectively spent by different budget entities with 94% of budget execution rate.

The medium-term expenditure framework (MTEF) chapter with the highest budget execution rate was Use of goods and services WITH 102% followed by Inventory; Other expenditures; subsides all with 100%, Fixed tangible non-financial assets and social assistance both with 99%, then grants with 98% the latest with low budget execution rate compared to others MTEF chapter is Compensation of employees with 90%.

Table 4: GoR contribution to NSP per budget agencies, FY 2023/2024

As reflected in the table below, the revised budget is USD 20,492,692 whereas the expenditure is USD 19,257,709. The type of budget agencies with the highest budget ceiling is Districts hospitals with USD 9,07 Millions, RBC with USD 4,2 million and Ministry of Health with USD 4,06 million.

Table 4: GoR contribution to NSP per budget agencies, FY 2023/2024

Budget Agency	Approved Budget for FY 2023-2024 in USD	Committed Amount FY 2023-2024 in USD	Budget Balance end June 2024 in USD	Performance rate in %
CHUB	731,721	731 721	-	100%
CHUK	965,564	965,564	-	100%
Districts	9,075,369	7,878,721	1,216,648	87%
HNN	400,928	400,928	-	100%
MOH	4,068,858	4,035,906	32,952	99%
RBC	4,242,135	4,283,085	(40,949)	101%
RMH	788,907	788,764	143	100%
RWANDA FDA	219,209	193,021	26,189	88%
TOTAL	**20,492,692**	**19,257,709**	**1,234,983**	**94%**

The Global Fund contribution

For the Global Fund contribution, the total approved budget C19RM inclusive is USD 88,971,510.20 for the financial year 2023-2024. During this financial year, the expenditure was USD 87,207,608.44 . Hence, the total budget execution rate for FY 2023/2024 was 98%. This total variance of USD 1,763,901.56 representing 2% will be used during the coming fiscal year 2024-2025 before end June 2024 as it is mainly in connection to C19 RM balance.

Table 5: GF budget execution per budget entities, FY 2023/2024

Budget Agencies	Opening balance	Approved budget in USD	Revised Budget in USD	Actual expenditures in USD	Variance	Budget performance rate%
CHUB		36,845	36,845	33,409	3,435.90	91%
CHUK		71,035	71,035	65,286	5,748.90	92%
MoH		2,283,545	2,283,545	2,071,268	212,276.86	91%
MoYA		300,726	300,726	257,581	43,144.81	86%
NCDA		381,785	381,785	346,182	35,603.00	91%
RBC	28,100,072	29,089,208	57,166,242	57,489,355	323,113.06	101%
RCS		34,184	34,184	21,086	13,097.89	62%
RMH		34,177	34,177	23,263	10,914.02	68%
RNP			23,038	23,038	-	100%
Grand Total	**28,100,072**	**32,231,504**	**60,331,576**	**60,330,467**	**1,108.33**	**100%**

From the above table, out of the approved budget of USD 60,331,576, a total of USD 60,330,467 has been effectively spent by different budget entities and this represents 100% of budget execution rate. The type of budget entity with the highest budget ceiling is RBC with USD 57,1 millions, MOH with 2,2 million, etc.

The type of budget entity with the highest budget ceiling is RBC with USD 57,1 millions, MOH with 2,2 million, etc.

Table 6: GF Grant expenditure per cost category, FY 2023/2024

GF Cost categories	Opening balance in USD	Budget approved for FY 2023-2024 in USD	Revised budget FY 2023-2024 in USD	Actual Expenditures for FY 2023-2024	Budget balance 30 June 2024 in USD	Performance in %
1.0 Human Resources (HR)		8,927,398	8,927,398	8,922,143.24	5,254	100%
2.0 Travel related costs (TRC)	3,978,885	3,042,262	7,021,147	7,019,263.67	1,108.33	100%
3.0 External Professional services (EPS)		282,707	282,707	282,541	166	100%
4.0 Health Products - Pharmaceutical Products (HPPP)		8,939,960	8,939,960	8,934,699	5,262	100%
5.0 Health Products - Non-Pharmaceuticals (HPNP)	7,130,231	7,574,789	14,705,019	14,728,516	(23,497)	100%
6.0 Health Products - Equipment (HPE)		121,287	121,287	121,216	71	100%
7.0 Procurement and Supply-Chain Management costs (PSM)	929,373	1,173,247	2,102,620	2,101,382	1,237	100%
8.0 Infrastructures	12,795,583		12,795,583	12,788,052	7,531	100%
9.0 non-health equipment (NHP)	19,497	152,230	171,727	171,626	102	100%
10.0 Communication Material and Publications (CMP)	791,471	306,512	1,097,983	1,097,337	647	100%
11.0 Indirect and Overhead Costs	583,355	1,027,652	1,611,007	1,610,060	947	100%
12.0 Living support to client/ target population (LSCTP)	1,871,677	683,459	2,555,136	2,553,632	1,504	100%
13.0 Payment for results						
Grand Total	**28,100,072**	**32,231,504**	**60,331,576**	**60,330,467.44**	**1,108.33**	**100%**

For the normal grant budget, out of the approved budget of USD 60,331,576, USD 60,330,467.44 has been effectively spent which represents 100% of the total budget including the opening balance from for the Fiscal Year starting 01st July 2022 to 30th June 2023. The variance of USD 1,108.33 will be used to cover the unpaid invoices,where goods were delivered within the reporting period and invoices received after payment deadline. The table above indicates that the cost category with the highest ceiling budget

is for acquisition of Health Products/Non Pharmaceutical followed by Infrastructures and then Health Products/Pharmaceutical products.

Table 7: C19 RM expenditures for Fiscal Year 2023/2024

GF Cost Category	Approved budget in USD	Revised Budget in USD	Actual Expenditures in USD	Variance in USD	Budget performance Rate in %
1.0 Human Resources (HR)	346,871	-	-	-	-
2.0 Travel related costs (TRC)	6,377,852	1,100,525	1,100,525	-	100%
5.0 Health Products - Non-Pharmaceuticals (HPNP)	705,045	8,661,456	8,661,456	-	100%
6.0 Health Products - Equipment (HPE)	4,327,957	5,277,470	5,277,470	-	100%
7.0 Procurement and Supply-Chain Management costs (PSM)	135,739	178,020	178,020	-	100%
8.0 Infrastructure (INF)	1,721,573	1,721,573	859,568	862,006	49%
9.0 non-health equipment (NHP)	9,808,508	8,575,402	7,674,614	900,788	89%
10.0 Communication Material and Publications (CMP)	1,418,998	733,683	733,683	-	100%
11.0 Indirect and Overhead Costs					
13.0 Payment for results	3,797,390	2,391,805	2,391,805	-	100%
Total	**28,639,934**	**28,639,934**	**26,877,141**	**1,762,794**	**94%**

For the C19RM grant budget, out of the approved budget worth USD 28,639,934, the total of USD 26,877,141 has been effectively spent which represents 94% of budget execution. The remaining balance of USD 1,762,794; representing 4% of total budget will be spent in the coming FY 2024-2025.

The USG/PEPFAR contribution

From 1st July 2023 to 30th June 2024, the US Government contribution was USD 64,563,538 to the National HIV response in Rwanda and this budget was spent 100%.

ONE UN Contribution

The One UN developed several flagship programs to fund HIV activities implemented from July 2023 to June 2024. The total budget for the Fiscal Year 2023-2024 is USD

623,072. This was used as a planned funding level for ONE UN.

KEY PERFORMANCE INDICATORS

Table 8: Key performance indicators

Indicators	Data Source	Results by July 2023–June, 202	Targets		
			2024-2025	2025-2026	2026-2027
HIV Prevalence (15 -64)	DHS 2020	2.7%		2.5%	
HIV Incidence	RPHIA, 2018 -	0.08%			0.068%
HIV Prevalence among female sex workers	IBBS_FSWs, 2023	35.2%			32%
HIV prevalence among Men having ex with Men	IBBSS, 2021	6.5%		5%	
Number HIV tests conducted	HMIS	1,979,852	NA	NA	NA
HIV sero-positivity rate (Overall)	HMIS	0.67%	NA	NA	NA
a. *VCT/PIT*	HMIS	1,088,646 (0.85%)	0.7%	0.7%	0.7%
b. *ANC Women*	HMIS	344,746 (0.33%)	0.3%	0.3%	0.3%
c. *ANC-among male partners*	HMIS	50,817 (0.83%)	NA	NA	NA
d. *VMMC*	HMIS	109,617 (1.5%)	NA	NA	NA
e. *Maternity*	HMIS	323,163 (0.08%)	NA	NA	NA
f. *Index testing*	HMIS	62,863(3.43%)	4%	4%	4%
Percent of HIV infected pregnant wome in PMTCT	HMIS	1.5%	NA	NA	NA
Pregnant women who received ART to reduce mother to child transmission	HMIS	99.8%	>98%	>98%	>98%
Percentage of exposed infants who are HIV-free by 24 months	Cohort data (health facility registries)	99.1%	>99%	>99%	>99%
Number of medical male circumcision performed according to national standards.	HMIS	350,460	374,885	412,373	453,610
Surgical circumcision	HMIS	350,044 (99,8%)	NA	NA	NA
Medical Device circumcision	HMIS	416 (0.2%)	NA	NA	NA
Prevalence of male circumcision (Proportion of males circumcised among male population)	RDHS 2019-2020	56%			60%
Number of female sex workers followed at health facility	HMIS	34,599	NA	NA	NA
Number of HIV negative female sex workers on PrEP	HMIS	10,116	NA	NA	NA
Percent of adults and children retained on treatment 12 months after ART initiation	Cohort da (health facility	94%	95%	95%	95%

	registries)				
Percent of adults and children currently receiving ART (ART coverage)	HMIS &EPP spectrum, 202	226,813/229,759 (98.7%)	93%	94%	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%	>97%	> 97%	>97%
Number of new clients initiating ART	HMIS	12,171	NA	NA	NA
Number of condoms distributed	HMIS	29,794,225	NA	NA	NA
Number of People screened for HCV	HMIS	719,277	NA	NA	NA
Number of people with HCV RNA positive	HMIS	15,639	NA	NA	NA
Number of people-initiated HCV treatment	HMIS	1,419	NA	NA	NA
Number of People screened for HBV	HMIS	773,693	NA	NA	NA
Number of people screened for HBV positive	HMIS	1,906	NA	NA	NA
Number of people screened for STIs	HMIS	3,873,916	NA	NA	NA
Number of people confirmed with at least one STI.	HMIS	209,817	NA	NA	NA

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