REPUBLIC OF RWANDA

ANNUAL REPORT ON HIV AND AIDS

July 2009- June 2010

March 2011

Acknowledgements

This report was developed through the collaboration of various partners involved in the National Response to HIV in Rwanda.

The RBC-CNLS would like to take this opportunity to thank all stakeholders who participated in providing the necessary information on the progress in implementing the National Strategic Plan for the period of July 2009 to June 2010.

Through the Monitoring and Evaluation Technical Working Group, the RBC-CNLS was able to collect the information from MOH, RBC-TRACPlus, RBC-NRL, RBC-CNTS, RBC-CAMERWA, CDLS and EDPRS Sectors.

We are grateful for the technical support received from different partners such as WHO, UNAIDS, MEASURE Evaluation in compiling this report.

Executive Summary

The 2009-2010 Annual Report on HIV presents a comprehensive picture of the results and progress on the implementation of the strategies and activities articulated in the National Strategic Plan on HIV and AIDS 2009-2012 commonly referred to as the NSP. The report presents consolidated information against the output achievements in the first year of implementing the five year strategy.

The collection of data for this report was guided by the Monitoring and Evaluation Technical Working Group in the CNLS. Information on achievements and challenges was gathered by each of the NSP outputs from both government agencies and nongovernmental partners supporting the national response to HIV and AIDS.

The NSP clearly articulates the results that are expected from the implementation of the five year strategy. The country made great progress during the reporting period and amongst some of the key achievements are summarized under the three impact areas below.

Impact 1: The incidence of HIV in the general population is halved by 2012

- **2,000,000** Rwandans received well coordinated HIV prevention messages through a number of successful prevention campaigns including the World AIDS Day campaign under the theme "*Condom as a means of dual protection. Let's talk about it, let's access it, let's use it: a fundamental right for all*."
- District Hospitals and Health Centers providing PMTCT services increased from 377 to 382 during the period 2009-2010 increasing coverage to 82 per cent of all health facilities in the country.
- HIV prevention education was successfully integrated into schools' curricula during the reporting period via the Rwanda National Curriculum Development Center
- **A minimum package of HIV services for all at-risk groups at the district level** including MSM, FSW and drafted the minimum package for other most at-risk groups
- In total, **47,922 high-risk people were tested for HIV by mobile VCT** from July 2009 to June 2010 under the supervision of TRAC Plus reaching 27, 879 men and 20, 043 women.
- The use of the Decision Makers Program Planning Tool (DMPPT), which estimates the overall cost and impact of MC adopted as a national HIV prevention strategy. A pilot program in two districts (Nyanza and Musanze) has been initiated as a first step in scaling up services.

Impact 2: Morbidity and mortality among people living with HIV are significantly reduced (HIV Care and Treatment)

- By the end of the reporting period, TRAC Plus reported that **70% of health facilities were offering the full package of HIV services**: VCT, PMTCT, and ART integrated services, **marking a 28% increase from baseline** values at the end of 2008.
- New OI and STI guideline were updated according to new evidence, disseminated to all facilities, and are now being used by all service providers who were also trained on the guidelines.
- **125,784 PLHIV were supported in 2009 to access health insurance**.

- **2,869 new HIV-positive individuals were enrolled in the national care and treatment program** which brings the **cumulative total to 159,103 HIV-positive individuals** enrolled by June 2010.
- The number of **adult patients on ART increased from 68,520 patients (end June 2009) to 83,041 patients (June2010)**. In addition, the number of **children on ART increased from 5,894 children (end June 2009) to 7,111 children by the end of June 2010**.
- TRAC Plus reports that 98% of adults are currently under a first-line ART regimen, while 2% are currently under a second-line regimen.

Impact 3: People infected and affected by HIV have the same opportunities as the general population HIV Impact mitigation

- The Global Fund specifically supported 18,350 OVC with school fees in 2009 and PEPFAR-funded NGOS supported approximately 10,000 OVCs. Other HIV implementers reported supporting 6,103 OVC for educational support during the reporting period.
- In 2009, the CNLS in collaboration with UNAIDS conducted an assessment of the Rwandan legal environment as it relates to HIV in an attempt to bridge the gap between international obligation and national practice as implemented in the domestic legal system include a scarcity of resources for the creation and operation of enforcement mechanisms, and generally a low level of legal expertise which is part of the legacy of Rwanda.

Further action

- Strengthen HIV prevention programs in light of the incidence
- Look at combination HIV prevention interventions
- Reinforce PMTCT to reduce the MTCT rate to 2%
- Implement effective prevention strategies for MARPS
- Continue to encourage inter sectoral collaboration

Contents

Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Ante-natal consultations
ART	Anti-retroviral therapy
BCC	Behavior Change Communication
BSS	Behavioral Sentinel Surveillance
CAMERWA	Centrale d'Achat des Médicaments Essentiels du Rwanda (Central Agency for Procurement of essential Medicines)
CBO	Community based organization
CCM	Country coordinating mechanism
CDLS	Comité de District de Lutte contre le Sida (district AIDS Control committee)
CHW	Community health worker
CNLS	Commission Nationale de Lutte contre le Sida (National AIDS Control Commission)
CSO	Civil society organization
CT	Counseling and Testing
DHS	Demographic and Health Survey
DOTS	Directly observed treatment – short course
EDPRS	Economic Development and Poverty Reduction Strategy
EID	Early Infant Diagnosis
FBO	Faith based organization
FOSA	Formation Sanitaire (Health Facility)
FP	Family Planning
GBV	Gender based violence
GF/MAP PMU	Global Fund / MAP Project Management Unit
GIPA	Greater involvement of people living with HIV and AIDS
GLIA	Great Lakes Initiative against AIDS
HBC	Home Based Care
HCC	Health Communication Center
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
IEC	Information, Education, Communication
IGA	Income generating activity
IMCI	Integrated Management of Childhood Illnesses
LNGO	Local NGO
M&E	Monitoring and Evaluation
MAP	Multi-sectoral AIDS Project
MARP	Most at risk population
MCH	Maternal Child Health
MDG	Millennium Development Goals
MIGEPROF	Ministry of Gender and Family Promotion
MINAFET	Ministry of Foreign Affairs
MINALOC	Ministry of Local Government, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning

MINEDUC	Ministry of Education
MINIYOUTH	Ministry of Youth
MISPOC	Ministry of Sport and Culture
MOT	Modes of Transmission
MSM	Men who have sex with men
NCBT	National Center for Blood Transfusion
NGO	Nongovernmental organization
NIS	National Institute of Statistics of Rwanda
NSP	National Strategic Plan for HIV and AIDS
OI	Opportunistic Infection
OVC	Orphans and vulnerable children
PBF	Performance based funding
PEP	Post exposure prophylaxis
PEPFAR	Presidential Emergency Plan For AIDS Relief
PIT	Provider Initiated Testing
PLHIV	People living with HIV / AIDS
PMTCT	Prevention of mother to child transmission of HIV
PWD	People with disabilities
RCLS	Réseau des confessions religieuses dans la lutte contre le Sida (Network of Faith Based Organizations against AIDS)
RH	Reproductive Health
RRP+	Réseau Rwandais des personnes vivant avec le VIH (Rwandan Network of people living with HIV)
RWANARELA	Rwanda Network of Religious Leaders living with AIDS
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infection
TBA	Traditional birth attendants
ToT	Training of Trainers
TRAC Plus	Treatment and Research AIDS Centre
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UP	Universal precautions
UPHLS	Umbrella des personnes handicapées dans la lutte contre le Sida (Umbrella of people with disabilities in the fight against AIDS)
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YFS	Youth friendly services

1 Introduction

The Annual Report on HIV and AIDS 2009-10 captures the main achievements and progress to date in the implementation of the multi-sectoral HIV response in Rwanda, as outlined in the National Strategic Plan on HIV and AIDS 2009-12 (NSP). The NSP serves as the guidance document for all HIV implementers in the country, indicating key national results that should be achieved through the delivery of high quality HIV services in both health facilities and community settings. Following the Three Ones framework, the NSP clearly describes the roles and responsibilities of all actors and stakeholders in the HIV response at the international, national, and decentralized levels, indicating key strategies to guide implementation.

1.1 Purpose of Annual Report on HIV and AIDS 2009-10

This report is meant to serve as the overall reference document for the HIV response in Rwanda, providing the most comprehensive data on progress in NSP implementation and achievements against NSP results and targets. By widely disseminating this document through the dissemination mechanisms outlined in the NSP Monitoring and Evaluation (M&E) Plan, it is anticipated that all stakeholders may use this document as a source document when describing or citing achievements in the national HIV response for the period commencing on1 July 2009 and ending on 30 June 2010.

1.2 Organization of Annual Report on HIV and AIDS 2009-10

This Annual Report is largely a narrative report, describing progress in the implementation of key strategies by all HIV actors in the country for the reporting period. As such, the report is primarily organized according to the three Impact Results outlined in the NSP 2009-12:

- The incidence of HIV in the general population is halved by 2012.
- Morbidity and mortality among people living with HIV are reduced.
- People infected and affected by HIV have the same opportunities as the general population.

In the NSP, each Impact Result is further organized into outcome results, intermediate results (for the HIV Prevention Impact Result), and output results. At each result level, performance and success indicators have been selected to measure progress. Impact and outcome results are higher level results obtained and measured at the population level. These changes take several years to detect through population-based surveys and other research studies, and thus are beyond the purview of this report. Nonetheless, some data are available to report against the NSP and these data are reported in the section on NSP Indicators in ANNEXES A, B, and C.

Output results represent program-level results and describe the changes expected in the national program through the implementation of the national response. For each output result in the NSP, key strategies for implementation from 2009-12 are described. As such, this report is organized at a secondary level by output result under each impact result. Narratives describe the achievements of HIV actors in the country according to these strategies. As described above, each output result also includes national and program-level indicators and annual targets. Program-level indicators are typically divided according to the community-based and facility-based HIV response. Results against stated indicators and targets for all Output Indicators are included in ANNEXES A, B, and C.

2 Results and Progress on Implementation of Key Strategies by NSP Output Result

2.1 Impact 1: The incidence of HIV in the general population is halved by 2012

2.1.1 Output 1.1.1.1. General population reached by comprehensive HIV prevention programs

This output seeks to ensure that all members of the Rwandan population are informed about HIV and STI prevention, and the existence of key services such as family planning, HIV testing and condoms. During the reporting period, all partners worked together to provide HIV prevention services to the general population according to the key strategies outlined in the NSP. The main strategies involved increasing the coverage of community education and outreach activities targeting the general population and providing information, education, and communication (IEC) services to the community with the aim of increasing knowledge within the community about HIV modes of transmission and methods of prevention.

As regards to community education and outreach, HIV implementers reported **1,195,900 people aged 15-49 reached through routine community outreach activities** with at least one HIV information, education, or behavior change communication message during the reporting period. It is important to note that this figure represents people reached, and not individuals, thus the final number is subject to some data quality issues, particularly around double counting. Nonetheless, this represents a major achievement in the delivery of community-based HIV education and outreach.

In terms of IEC events and national sensitization campaigns, the largest IEC event held each year is the three-month campaign organized around *World AIDS Day* on December 1. In addition, CNLS maintains a *physical and digital library* of HIV IEC materials for the community, manages a toll-free *informational hotline* service to provide comprehensive HIV information to the community, and conducts ongoing mass media campaigns through a *weekly radio program* and other mass media campaigns. Detailed descriptions of these major IEC initiatives are provided below.

World AIDS Day 2009 and other community education and outreach activities

Each year, the largest community education event held in Rwanda is the 3-month campaign around World AIDS Day (WAD). In 2009, an estimated 2,105,600 **people were reached by IEC sensitization activities as part of the World AIDS Day campaign** conducted between December 2009 and February 2010. The campaign's theme was "*Condom as a means of dual protection. Let's talk about it, let's access it, let's use it: a fundamental right for all*." The event involved a broad range of partners including the network of faith based organizations, civil society organizations, Global Fund implementing organizations and beneficiaries, associations and cooperatives, the One UN Family, and NGOs (AHF, PSI-Rwanda, World vision).

In collaboration with the CNLS and MINISANTE, PSI/Rwanda supported World AIDS Day 2009 through the development and placement of several mass media events. Four celebrity singers were engaged to spread the condom messages: "Let's talk about it, let's access it, let's use it: a fundamental right for all". On December 1st 2010, a concert was held at the Amahoro Stadium and

mobile VCT was conducted outside the concert event, testing over 1,100 people. 120 Billboards flexis were placed around Kigali with four separate messages from each of the singers. Additionally, radio spots were aired on radio stations with songs and messages from the four stars.

Voluntary counseling and testing was widely performed at the community level in conjunction with these sensitization activities. Mobile VCT services were organized throughout the campaign and general VCT services were provided in all health facilities. Notably, TRAC Plus reports that the number of tested people during these events represents approximately one third of all people tested through mobile VCT during the reporting period.

Political leaders actively participated in the WAD campaign, from the village to national level, through village and cell leaders, community health workers, officers in charge of social affairs at sector levels and other opinion leaders. They were trained on condom promotion, its use and availability in all parts of the country during various meetings including public demonstration on the proper use of condom. Messages on condoms and slogans used for sensitization through various channels (Mass media, hotline, banners, booklets, leaflets, billboards, newspapers, community mass events) were developed and disseminated throughout the country., CNLS in collaboration with two radio stations (Radio 10, Radio Contact FM) and Rwanda Television (TVR)produced several live radio programs during the campaign . During these radio and TV programs, presenters discussed issues related to the theme of the campaign.

CNLS Documentation Center

As it has been earlier mentioned, CNLS also manages a Documentation Center in order to provide the general population with routine information about HIV and AIDS through physical and digital libraries, and the CNLS website. By the end of 2009, the digital library contained over **1,200 primary source documents and other informational resources** related to HIV. The digital library is available to the public via the CNLS website. The physical library is located on the ground floor of CNLS office and provided free HIV resources reached to over 12,600 people, with approximately 7,560 people visiting the online resource center in the reporting period.

SOS/SIDA: HIV Information Free Hotline

The CNLS also operates a toll-free hotline (dial “3334” or “3335” from any mobile phone; or “18” from any landline) to provide HIV-AIDS related information by answering questions from the general population. During 2009-2010 year, the **Hotline answered 123,148 calls**, where the operators provide advice and orientation when needed. During this year, a compilation of the most frequently-asked questions was conducted and organized into a brochure in conjunction with TRAC *Plus* in order to inform the general population on the most common misconceptions identified via the hotline.

Mass Media IEC Activities

During the reporting period, CNLS also produced a weekly radio program entitled “*Tega amatwi vumve ubeho*” which means, “Listen and Live” in English. The Radio program is aired on Radio Rwanda every Saturday.

CNLS, in collaboration with the Ministry of Youth and with technical and financial support from PSI-Rwanda organized another mass media campaign called “*Sinigurisha*”, or “I am not for sale” in

English, throughout the country. Billboards, radio and TV programs were used to disseminate messages against cross-generational sex.

2.1.2 Output 1.1.1.2. Women aged 15-24 are at reduced risk of HIV infection

Though youth in general are reached through interventions outlined under Output 1.1.1.1 as part of activities targeting the general population, it is recognized that youth have particular HIV risks that are unique to their age group, with young women particularly vulnerable to HIV acquisition. As such, this output specifically outlines strategies aimed at working with women aged 15-24 years in order to better understand the risk factors that are related to their higher vulnerability to HIV and to develop appropriate responses to their specific needs. Besides **research initiatives**, the main achievements described below underscore activities that specifically target young women with appropriate messages and services. The strategies include support to outreach activities via **anti-AIDS Clubs** targeting in-school and out-of-school youth, **national mass media and sensitization events** targeting young women, the extension of **youth-friendly services** targeting young women, and improvements in providing youth with comprehensive **HIV education in schools**.

Research to better understand the vulnerabilities of women

A behavioral surveillance survey (BSS) among youth aged 15-24 years was conducted during the reporting period. This BSS is conducted on a routine basis every 2-3 years and is meant to consistently collect data on HIV knowledge, attitudes, behaviors, and practices among youth in order to analyze key trends over time. In general, the data suggest that youth's comprehensive knowledge of HIV and STIs is showing some signs of improvement. However, these short-term gains in knowledge have not yet been translated into longer-term changes in risk behavior. In terms of knowledge, youth's comprehensive HIV knowledge did not significantly increase since the last Youth BSS conducted in 2006 (from 11% in 2006 to 19% in 2009), though some positive changes in some knowledge indicators, including knowledge of abstinence and condom use as HIV prevention methods, were noted with proper condom use increasing from 72% in 2006 to 84% in 2009. Even though results suggested that current IEC campaigns are effective in changing some areas of HIV knowledge in youth, there was no evidence to suggest that these changes in knowledge are translated into changes in risk behavior. When analyzing key trends between the results of the 2006 Youth BSS and the 2009 Youth BSS, the data show no significant changes in key risk behaviors, including age of sexual debut or recent condom use at last sex.

Anti-AIDS Clubs

PSI, MINIYOUTH and CNLS worked tirelessly during the reporting period to involve many development partners in reaching girls in and out of school through anti-AIDS clubs. In primary schools, the establishment of "girls' rooms" were encouraged as a safe area for girls to confidentially discuss their particular challenges and issues. In addition, Girls Forums have been developed in all schools where a trained teacher advises girls about reproductive health. For out-of-school youth, anti-AIDS Clubs have been reached with capacity-building support provided by partners. In total, HIV implementers reported reaching **210,029 out-of-school youth** aged 15-29 and **178,510 in-school youth** aged 15-29 with HIV information, education, communication or behavior change communication through HIV youth clubs (club anti-SIDA) throughout the reporting period. Implementers report that girls constitute a majority of membership in these groups.

National mass media and sensitization campaigns

CNLS and partners made significant progress in reaching young women during the reporting period through numerous mass media and sensitization campaigns. In general, the National IEC/BCC technical working group (TWG) reported that they approved and oriented 34 different messages and IEC materials targeting girls during the reporting period. Important progress was also made during the reporting period to reach women aged 15-24 as part of the *SINIGURISHA* national campaign targeting community education around the HIV risks of cross-generational sex.

In addition to billboards, distribution of written materials, and public service announcements via the radio stations, partners organized several other community-level events in support of the campaign. Field visits were undertaken in higher learning institutions (KHI, INATEK, ISAE-Busogo, ULK Gisenyi, NUR) to talk about cross-generational sex as a contributing factor to the spread of HIV. These educated young people were interested to play the role of peer educators and transmit the message to their friends who are out of school.

Extension of youth friendly HIV prevention and reproductive health services

Rwanda currently offers youth-friendly HIV prevention and reproductive health services in fourteen districts through Youth Friendly Centers. The role of youth friendly centers is to provide youth with correct information regarding HIV prevention: awareness on STI, Family Planning, Gender-based violence prevention, condom promotion, access to VCT services, and reproductive health services to help them adopt safe behaviors. These centers also propose different activities for socio-economic promotion of youth, such as vocational trainings and IGAs. Using the youth friendly centers known as DUSHISHOZE Centers, out-of-school youth were reached by HIV prevention services.

Integration of sexual and reproductive health and HIV prevention component into schools' curricula

HIV prevention education was successfully integrated into schools' curricula during the reporting period via the Rwanda National Curriculum Development Center which ensured that all schools curricula are understood and effectively used by teachers via several supervisory activities including regular visits to schools, training seminars to orient teachers, periodic reviews, research and evaluation of curricula. Specifically, HIV/AIDS and STI prevention education have been integrated in the national curricula of primary and secondary schools during the reporting period. These curricula are available on the NCDC web site (www.ncdc.gov.rw).

2.1.3 Output 1.1.1.3. Sex workers are reached by comprehensive prevention programs

Recent evidence suggests that female sex workers constitute a key driver of the HIV epidemic in Rwanda. During the reporting period, CNLS and UNFPA produced a broad overview of the extent to which HIV interventions for sex workers are available in different districts by suggesting that more needs to be done to ensure that sex workers have access to comprehensive HIV services in each district.

To this end, significant achievements were made in improving the delivery of standardized and comprehensive HIV services to female sex workers at the district level, notably; the national technical working group on HIV prevention endorsed **the minimum package of HIV services that should be available to sex workers at the district level**. The minimum package includes services according to the following categories: to reduce their personal risk of HIV transmission and acquisition, improve their access to condoms, provide voluntary and non-stigmatizing access to health and social services to all sex workers, improve the environment for sex work interventions,

and increasing participation of sex workers in planning, implementation, monitoring and evaluation of HIV services for sex workers.

Conduct research to improve understanding of vulnerability and needs of sex workers

The 2010 Female Sex Worker (FSW) Behavioral Surveillance Survey (BSS) provided important information on HIV knowledge, attitudes, behaviors, and practices among a nationally representative sample of 1,338 FSW in 2010. The overall prevalence of HIV infection among FCSW was 51%. The HIV prevalence increased with age, 35% in the 15 to 19 years of age compared to 63% in the 40 years of age or more. The highest HIV prevalence was observed among FCSWs working in Kigali at 56%. HIV prevalence was lower among FCSWs having another type of employment or source of income compared to those who did not (47% vs. 53%, respectively). HIV prevalence among married FCSWs living with their husband was only 33% compared to 59% among those who were separated but not cohabiting with a sexual partner. Those who reported having had HIV comprehensive knowledge had lower HIV prevalence compared to those who did not (44.3% vs. 54.1%, respectively).

Comparing trends from 2006 to 2010, an increase in comprehensive HIV knowledge from 18% in 2006 to 22% in 2010 was observed. However, some misconceptions still persist. The median age of respondents' first paid sexual act remained the same, with a reported median age of 19 years in both surveys. The proportion of FCSW who reported having consistently used condoms in the month prior to the survey rose from 28% in 2006 to 35% in 2010. At the same time, the proportion of FCSW who reported having used a condom during their last sexual act with a paying client dropped from 84% in 2006 to 80% in 2010.

Progress in implementation of Minimum Package of Services to FCSW

Significant progress was made in the reporting period to reach FCSW with comprehensive HIV services according to the minimum package endorsed by the national technical working group on HIV prevention. In total, HIV implementers reported **reaching 3,035 female sex workers with HIV prevention interventions** in the reporting period. Progress on specific strategies and minimum services activities are provided below.

Concerning community-based outreach and HIV education, HIV implementers trained FCSW on health issues in general and on HIV knowledge in particular, with special emphasis on peer education, and received sensitization tools to improve their behavior change communication. Sex workers comply with the national policy to form cooperatives, and most of them have agreement certificates from Rwandan Cooperative Agency (RCA). Some of these cooperatives received funding that enabled them to achieve impressive results which were witnessed by the parliament social sub-commission. In terms of the facility-based delivery of HIV services for sex workers, 22 nurses were trained in STI screening and management for sex worker-friendly treatment, and in partnership with TRAC Plus, 61 trainers were trained from all Districts in Rwanda.

2.1.4 Output 1.1.1.4: Other vulnerable and most at risk populations are reached with comprehensive prevention programs

In addition to Female Sex Workers, other at-risk populations and vulnerable groups are believed to be associated with high levels of HIV risk behavior and are thus specifically targeted for comprehensive HIV services in the NSP. These groups include men who have sex with men (MSM), people with disabilities (PWD), prisoners, mobile workers, and refugees.

During the reporting period, the national technical working group on HIV prevention endorsed **the minimum package of HIV services that should be available to all at-risk groups at the district level** including MSM, FSW. It equally drafted the minimum package for other most at-risk groups. The minimum packages for each group include services to reduce their personal risk of HIV transmission and acquisition, improve their access to condom and post exposure prophylaxis, provide voluntary and non-stigmatizing access to health and social services to all populations, improve the environment for interventions with marginalized groups, and increasing the participation of at-risk groups in the planning, implementation, monitoring and evaluation of HIV programs.

TRAC Plus and PSI made notable progress during the reporting period in reaching at-risk groups through mobile VCT efforts targeting HIV transmission "hot-spots". In total, **47,922 high-risk people were tested for HIV by mobile VCT** from July 2009 to June 2010 under the supervision of TRAC Plus reaching 27, 879 men and 20, 043 women. It was noted that in mobile VCT the number of men tested is higher than women (58.2% and 41.8%). This differs from what was observed when considering all people tested at health facilities where the number of women tested (54.6%) is higher than men (45.4%). The prevalence of HIV in mobile VCT is 6%. Specific progress according to each risk group is provided below.

Men who have sex with men (MSM)

An exploratory study on MSM was conducted in Kigali during the reporting period with 98 MSM aged between 18 and 52 years participating in the study. The results suggest that MSM in Kigali are at higher risk for HIV infection compared to the general population and that they require specific HIV/STI prevention services and support. For example, condom use was reportedly low among the study participants, with nearly one third of participants reporting that they had never previously used a condom with a male or female sexual partner. In addition, a high proportion of study participants engaged in commercial and/or transactional sex and a majority of study participants reported relatively high levels of alcohol consumption. Respondents expressed a need for psychosocial services and safe sex tools such as condoms and lubricants.

A follow-up qualitative study was initiated during the reporting period with an aim to better understand the contributing factors to MSM HIV risk behavior and identify barriers and facilitators to their access to comprehensive HIV services. In terms of reach, no implementers reported directly reaching MSM with comprehensive HIV prevention services during the reporting period, though PSI reported reaching some MSM male sex workers through their mobile VCT efforts. Two implementers namely ICAP and PSI received funding for the implementation of HIV prevention, care and treatment programs targeting MSM, which should be available during the next reporting period.

People with disabilities

HIV implementers at the district level reported **reaching 15,788 people with disabilities with HIV prevention services** during the reporting period. The umbrella of people with disabilities in the fight against HIV and AIDS (UPHLS) developed different IEC materials and disseminated existing tools to different groups of PWDs. Guidelines for inclusion of PWDs in HIV programs were developed and disseminated to different groups with disabilities. A technical working group was set up with regard to integrate inclusion. 335Peer educators were trained on HIV/AIDS and different needs of PWDs depending on the type of disability (general information on HIV, STIs, condom use and negotiations, life skills, reproductive Health services, and VCT & PMTCT). Disability friendly outreach campaigns

were conducted by different organizations of people with disabilities (DPOs) with prevention messages; this was done both at central and decentralized levels as well as during events including during World AIDS Day events.

Different workshops over the course of the reporting period were organized in order to assist in the development of PWD-specific HIV services and to promote the involvement of PWD in their development. These included Training of 123 community volunteers on PWDS specific need and psycho social care of PWDs living with HIV/AIDS, training of 242 volunteers on Community palliative care, and training of 56 local authorities & national police trained on PWDs specific needs, GBV and HIV/AIDS. PWD made recommendations to different stakeholders focused on developing programs on disability and HIV/AIDS, adapting tools in HIV/AIDS to specific needs of PWD and including disability into nursing and pre-service training. TRAC Plus reports that 205 health facilities from 16 districts of the Eastern and Southern provinces and Kigali City received trainings in the reporting period on the delivery of specific services to PWD.

Prisoners and prison workers

Notable progress was made during the reporting period in improving the delivery of HIV services to prisoners and targeting prison workers with comprehensive HIV education. The **establishment of Anti-AIDS Clubs within prisons was performed in all 14 prisons** of Rwanda. However, trainings for peer educators took place only in two prisons. Until late June 2010, 120 peer educators in two prisons were trained on IEC/BCC on HIV/AIDS, access to HIV treatment and topics related to HIV and human rights (60 at Kigali Central Prison and 60 at Gisenyi prison).

After several technical meetings between members of the Steering Committee for Prisons, an advocacy meeting for availability of condoms in prisons and surrounding areas was held between the Minister of Internal Security and the Executive Secretary of CNLS. This topic remains sensitive and negotiations will continue through the draft document on the HIV Minimum Package to prisons expected to be validated during the next reporting period. Thus, the initiatives to define a minimum package of activities related to the prevention of HIV in prisons have been initiated. All prisons in Rwanda have VCT services (on Accreditation of TRAC Plus) and are supervised by district hospitals. HIV testing is done routinely in prisons that have laboratories with consistent supplies of commodities by CAMERWA via districts pharmacies. Between **July 2009 and June 2010, 28,095 prisoners were tested for HIV**.

Mobile populations and Refugees

HIV implementers reported **reaching 18,436 members of mobile populations with HIV services** during the reporting period. The CNLS-GLIA project was the biggest implementer of interventions targeting mobile populations, specifically truck drivers, fishermen, and refugees. The CNLS-GLIA project provided the key services including IEC/BCC, condom distribution and VCT in collaboration with the health facilities around the sites. Referral services between community educators and health centres in targeted zones were established. They particularly encouraged HIV& STI screening and treatment. Outreach via mobile VCT was organized in all sites.

Three health facilities were selected along the main road axes (Kigali-Rusumo, Kigali- Kanyaru and Kigali-Gisenyi) to facilitate the continuum of care for long distance truck drivers. Three Recreational Centres were set up and equipped to provide truck drivers with recreational and HIV IEC services, including condom distribution.

HIV implementers reported **reaching 4,766 refugees with HIV services** during the reporting period. In refugee camps, mobilization was mostly done through moderators (NGOs working in the refugee camps) while referral services oriented patients to Health centers for HIV& STI services. Apart from HIV clinical services provided by Health centres, there were also outreach activities to the sites through mobile VCT, condom use promotion and PMTCT.

2.1.5 Output 1.1.1.5. People living with HIV including sero-discordant cohabiting couples are provided with prevention services

Though HIV transmission is an extremely complex issue subject to biomedical, behavioral, social, and structural challenges, it is recognized that HIV is always transmitted from an HIV-positive individual to an HIV-negative individual, thus highlighting the importance of providing people living with HIV (PLHIV) and particularly HIV sero-discordant couples with comprehensive HIV prevention programs. To achieve our objectives, efforts were made on couple testing for HIV and data are provided in the section below.

Providing HIV services to PLHIV

HIV implementers reported **reaching 114,245 PLHIV with HIV prevention services** during the reporting period. At the community level, peer educators were selected and trained within 56 associations of PLHIV. IEC sessions were organized in associations. HIV implementers report that 1,389 people were sensitized on abstinence and being faithful, **3,004 people were reached with condom messages**, and **1,246 people were provided with family planning (FP) information**. Local authorities were actively involved in meetings and community works in schools and VCT sites. In the framework of increasing adherence, reference and linkages of PLWH with health services through the GIPA approach (Great Involvement of People Living with HIV and Aids), the Rwanda Network of PLWH was supported to conduct training activities for peer educators in different associations especially in the creation and/or reinforcement of linkages between traditional routine condom supply points (health facilities) and their respective communities. For reasons of ownership, trainings sessions also targeted opinion leaders like local authorities (The in charge of social affairs at the sector level), heads of health centers and CDLS coordinators.

Progress was also made to integrate family planning services into routine HIV services. Trainings at all level integrated the FP module; all providers working in HIV services are now trained in FP. HIV health facilities were equipped with materials and consumables used in FP according to FP services delivered at each level. FP services are now part of topics on which mentors emphasize during on site trainings and indicators on FP are now being reported on a monthly basis to central level through TRACnet.

In order to develop outreach work with PLHIV to minimize poor adherence and long term follow up, several sessions were given to the community during local meetings, community work (umuganda) in each village to sensitize the population on the importance of drugs and good adherence. Education on adherence is regular at HFs when patients come monthly for regular visits. A special focus was on children under 15years where after disclosure of their status, HFs organized monthly meetings on counselling and assessment of those children adherence by targeted children. All providers working in HIV services are trained on this practice.

Providing HIV services to HIV sero-discordant cohabiting couples

HIV implementers report **reaching 12,254 members of sero-discordant couples with HIV services** during the reporting period. From July 2009 to June 2010, **103,298 couples were tested for HIV,** and among them 4,170 were discordant (4.04%). A program for couple counselling among discordant couples was implemented since January 2010. Through this program the expected number of couples who come for VCT services will increase and the follow up of new discordant couples as well as the tracking of discordant couples tested previously will be done. TRACPlus in collaboration with PSF, the institution with expertise in couple HIV counseling and discordant couples, put in place a special program for couples counseling and discordant couples follow up.

Following development of tools to be used a pilot project started in all health facilities of Kigali since March 2010. CNLS in collaboration with other clinical partners developed a training plan that is currently implemented in the entire territory of the country. Currently, 276 counselors are trained in couples counseling and discordant couples follow up. This program will allow couples to get a real counseling so that those who become sero-discordant will be provided with a follow up. A specific tracking system was established for couples who had been tested previously.

2.1.6 Output 1.1.1.6. HIV infections resulting from sexual or gender-based violence are prevented

An integrated approach to manage Gender Based Violence (GBV) issues was adopted by the GoR, and structures were put in place right from the community to prevent GBV cases and establish community early warning systems where these cases occur. MINALOC and the National Police initiated anti-GBV clubs in all administrative cells and trained the Community Policing Committees on GBV all over the country. Local leaders, in this area, contributed to reduce gender-based violence. For example, **100 members of the police force were trained on the new GBV guidelines** including linkages with medical services.

35 District Hospitals are equipped with trained personnel and can refer GBV cases to the second level treatment sites. Health care workers have been extensively trained to manage GBV cases. 5 trainers at each District Hospital and around **250 Health Care providers were trained** (4 trainees at each Health Centers).

An additional **One Stop Centre** was initiated at Gihundwe Hospital and capacities of health care providers working both at Gihundwe hospital and Isange One Stop Centre in Kacyiru were continuously strengthened. 9 hospitals are piloting an integrated approach between clinical, police, and legal services, involving the community in response to GBV. ISANGE ONE CENTER was visited by African First Ladies who appreciated the initiatives of Rwanda.

Several campaigns against GBV have been conducted at the community level. The local NGO HAGURUKA taught women about their rights and increased awareness about an anti-GBV law published in 2009.

2.1.7 Output 1.1.1.7. Male and female condoms are available and accessible for all populations

CNLS and partners continued to promote the use of condoms as dual protection; both as a family planning and HIV prevention commodity; in the country throughout 2009. They equally advocated to make condoms accessible to the community at the decentralized level.

Currently, in Rwanda, there are two active condoms distribution chains at the national level: a **Social Marketing approach**, which ensures availability of condoms through the commercial sector with a

total market approach (shops, bars, youth centers and other sales outlets), and a **Public sector approach**, which ensures distribution of free condoms, with health facilities being the traditionally accepted final distribution points for condoms for purposes of both HIV prevention and Family planning.

Increase in social marketing of both male and female condoms

Establishing the number of other private sector entities involved in availing and selling different varieties of condoms on the Rwandan Market is complex. Activities conducted in year 2009-2010 focused on continued strengthening of private sector distribution networks, increased visibility for condoms at points of sale, in and around hot spots.

Prudence condom sales totaled 6,605,978 in the private sector and 3,471,578 in free distribution to the Department of Defense, VCT sites, and public sector. Direct private sector distribution focused on supporting the 37 direct wholesale customers with wholesaler promotion (where direct customers are intercepted and given information to increase product sales at the wholesaler), product promotion (where key messages are given to target consumers on market days and around large retail outlets), and rapid outlet creation (where a small quantity of product is sold to retailers, who are then given the list of wholesalers to strengthen the link between retail and wholesale).

The hot spot locations attracting high risk groups like commercial sex workers were of concern as regards HIV prevention. The slow rate of condom purchase in the open or public sale outlets due to the traditional misconception of "seeing a person buying a condom as a sex worker" raises public concern of HIV spreading. To address this issue, PSI Rwanda and partners agreed to place condom dispensers in all hot spot areas, firstly in Kigali.

Mobile video shows about condoms continued in various districts to educate the general public on correct and consistent condom use around and outside outlets, hot spots, and high risk areas. Twenty one sessions of mobile video shows – mainly for condom sensitization – were conducted, reaching 10,130 general populations.

In Musanze, 98 semi-whole sellers and retailers were trained on correct and consistent condom use in December 2009. In March 2010, 86 local Authorities and 63 shop owners in Gisagara District were trained on correct and consistent condom use. Twelve Rwandan Allied for Peace and Progress (RAPP) promoters were trained on Plaisir Hot Spot promotions in Gasabo District, which led to the recruitment of 33 blitzers from RAPP to promote Plaisir areas around hot spots.

Strengthening community based distribution initiatives of condoms to most at risk and other vulnerable groups

Under the coordination of CNLS, different partners including the UN family, International and Local NGOs, and the civil society participated in National WAD campaign and different activities in relation to promotion of condom use. There was a sharp increase in condoms distribution during the 2009 WAD campaign attributable to the efforts of the campaign. Over 2.105.600 people were reached during condom promotion and sensitization sessions conducted at the National level both at the central and Districts levels.

In the framework of increasing adherence, reference and linkages of PLWHA with health services through the GIPA approach (Greater Involvement of People Living with HIV and Aids), the Rwanda Network of PLWH was offered support to conduct training activities for peer educators in different

associations especially in the creation and/or reinforcement of linkages between traditional routine condom supply points (health facilities) and their respective communities. For reasons of ownership, trainings sessions also included opinion leaders like local authorities (in charge of social affairs at the sector level), heads of health centers and CDLS coordinators.

CNLS in collaboration with the Community Health Desk-MCH-MoH and the Family planning TWG, integrated condoms into the community health basket, considered in counseling as dual protection through condom use and distribution at the community level. The Family Planning technical working group is currently considering scale up in other Districts that are not piloted for the CBD program.

There are no specific legal barriers for distribution of condoms in schools and or institutions of higher learning. CNLS is working with higher learning institutions in promoting HIV/Aids prevention programs through anti AIDS clubs. With the recent need to promote HIV prevention workplace programs in all schools, there is need to identify and build capacity of HIV/Aids focal points for schools to support them in getting condoms from supply points at each District level.

Based on results of the recent 2010 BSS the rise in condom use is one of the biggest achievements in HIV prevention in the country. Ensuring that sufficient quantities are distributed to the general population is still a big challenge to contribute to achievement of the National target of reducing the incidence of HIV by half by 2012. While results from these surveys based on recent efforts show that there is increased awareness and need for more condoms, there is an urgent need for commitment to purchase and avail enough quantities of the needed products to meet the increasing demand for prevention of new HIV infections, STIs and unwanted pregnancies among the general population and other vulnerable groups.

Strengthen initiative for promotion of female condom use

In a bid to ensure equal access to HIV prevention services for women, CNLS in collaboration with the Federation of Rwandan Women LWH/A supported 17 cooperatives from 12 sectors in 5 provinces to conduct training sessions on empowering women to negotiate condom use and on counselling, with special emphasis on the use of female condoms. In addition, linkages for supply of condoms between health facilities and potential condom suppliers at the community level and or at workplaces are gradually reinforced.

Expanding distribution of condoms in the private sector

During the reporting period, CNLS in partnership with private sector, CNLS, PSI and the chair person of Hotel associations undertook promotion of and advocacy for the availability of condoms in hotels, motels, lodges and bars through advocacy meetings at different levels and press conferences where heads of different institutions participated. Advocacy for condom availability at the workplace was also undertaken and 70 condom vending machines were distributed to different Hotels. With the support of the Ministry of Youth and the National Youth Council there are condoms in youth centers and youth clinics.

Strengthening of linkages between HF and CSO/CBOs for the distribution of condoms

CNLS in collaboration with the Community Health Desk-MCH-MoH and the Family planning TWG, integrated condoms into the community health basket, considered in counseling as dual protection through condom use and distribution at the community level. The Family Planning technical working group is currently considering scale up in other Districts that are not piloted for the CBD program.

Forty-one percent of clients received injections, 32% received condoms, 25% received oral contraceptive pills, and 2% received Standard Days Method. It has been recommended to scale up CBD/CBP to 11 other districts, save for condoms that will be provided in all the uncovered districts.

CNLS initiated active condoms distribution at the Decentralized level through creation of a link between the traditional routine condoms supply points e.g. District pharmacies, health facilities and the HIV/Aids community based groups including CHWs' groups, associations and/ or cooperatives for prevention of HIV and PLWH. CBOs were identified to support condom promotion and distribution. A quarterly estimate of both male and female condoms was established based on needs of each identified community based group. In total, about 4 million and 400,000 pieces of male and female condoms were estimated. An initial 2.9 million condoms were dispatched to Districts for a quarterly distribution with the support of the community groups but unfortunately, the estimated female condoms were not available at the central Store and the ones available at the District level were not enough.

2.1.8 Output 1.1.2.1. Newborn boys, adolescents and adults have increased access to circumcision

High coverage of male circumcision proved to be effective in reducing heterosexual transmission of HIV infection by 60 per cent. Strategies that are under this output aim to ensure that circumcision is promoted among adult males in order to increase the prevalence of circumcision. In addition, although circumcision of newborn boys will not contribute to the result of reduced sexual transmission of HIV during the period covered by this NSP; it is nonetheless an important long-term strategy for reducing susceptibility to HIV infection in the Rwandan population.

Advocacy and Research on Male Circumcision Integration

A Male Circumcision Study was conducted to provide baseline evidence regarding MC Knowledge, Attitudes, and Practices (KAP) in the general population and guide message development and communication plans for male circumcision and medium and long term strategic program planning for effective MC services scale up. In general, circumcision is well known among men who participated in the study. Considering the definition of circumcision as a removal of the foreskin, 72% of respondents were right. 49.8% of respondents don't want to go for MC (those who said no and those who don't know combined). Kigali city has the highest prevalence with 52.5% and the Southern Province has the lowest prevalence, 4.2%. Rusizi District has the highest prevalence in Rwanda (71%) while almost for 63.3% of circumcised men; the procedure was performed by a health care provider. Others were circumcised by Muslims (16.1%) and traditional circumcisers (9.3%).

The use of the Decision Makers Program Planning Tool (DMPPT), which estimates the overall cost and impact of MC in different scale up scenarios, was implemented during the reporting period and demonstrated that a total of 2 million circumcisions will need to be carried out over and above the existing base line to enable Rwanda to achieve a 25% reduction in new HIV infections by 2015. Advocacy was conducted with MOH for the involvement of nurses in the practical exercise of surgery in the field of Male Circumcision. Discussions resulted in a consensus that nurses, with minimum qualification of a high school diploma, are entitled to participate in the surgery of male circumcision once they have been trained.

Promotion and provision of male circumcision for adolescents and adults

The only group that has been targeted so far by a structured program providing male circumcision services is the military. The scaling up of interventions to other target groups is dependent on the adoption of a National MC operational plan that is yet to be finalized. A pilot program in two districts (Nyanza and Musanze) has been initiated as a first step in scaling up services.

Output 1.1.3.1. Increased awareness of STI symptoms and demand for STI treatment

As it is stipulated in its mission, CNLS and its partners collaborate with TRAC Plus and Health facilities in sensitizing the general population to be aware of different STIs and to go for STIs diagnosis and treatment. To be able to achieve this goal, the BCC national strategic plan 2005-2009 proposed the integration of STIs awareness in all prevention messages. In 2009-2010, all educative publications and messages addressed the issue of STIs. CNLS and all its Behavior Change Communication partners complied with this practice. World Relief Reproductive Health manual can serve as a model. Specific results in relation to this output are included as part of results reported under Output 1.1.1.1 describing community education targeting the general population, including STI awareness.

2.1.9 Output 1.1.3.2. Increase availability and accessibility of high quality STI treatment

In all 427 out of 451 health facilities provide STIs diagnosis and treatment of STIs. Guidelines for the diagnosis and treatment of STIs were developed and disseminated to all health facilities. Diagnostic and treatment algorithms were developed and disseminated. The STIs management was integrated in the HIV prevention and care training of Trainers and providers. The M&E tools and indicators were defined and integrated in the National M& E System through TRACNet. Specific at-risk groups (e.g: FSW, youth age between 15-24 years…) were also identified and specific STI prevention packages focusing on those groups will soon be implemented .

2.1.10 Output 1.2.1.1. Increased availability and accessibility of PMTCT services

The number of **District Hospitals and Health Centres providing PMTCT services increased from 377 to 382** during the period of 2009-2010. By the end of the reporting period, MOH achieved 72% coverage, which is a significant step towards the NSP coverage target of 90% by 2012. In addition, training of health care providers was done and laboratory equipment, supplies and consumables were availed to health facilities where PMTCT services were introduced.

In terms of male involvement in PMTCT, the percentage of **partners of pregnant women attending PMTCT services counseled and tested for HIV in Rwanda increased from 73% in June 2008 to 84% in June 2010**, according to the mid-term review of the PMTCT National plan. This was achieved by mobilizing the communities on couples ANC through local authorities/CHWs, including ANC male attendance in community PBF and by improving adherence of families to community health insurance schemes. According to the 2010 PMTCT symposium report, among all PMTCT sites, 343 (86.6%) sites collected DBS sample in 2009 and 417 (98.5%) sites in 2010. The **percentage of HIV infected women giving birth at Health facilities increased from 48% in2005 to 77% in 2009**.

2.1.11 Output 1.2.1.2. All HIV positive pregnant women complete the full PMTCT program

Rwanda continues to achieve high levels of coverage of women attending and completing the full PMTCT program. The percentage of HIV-positive pregnant women who received ARV prophylaxis according to the existing guidelines was estimated at 68% in 2009. In all PMTCT sites, pregnant

women tested HIV-positive are enrolled in care and followed up for treatment. This included provision of Cotrimoxazole prophylaxis and WHO clinical staging on the same day and return within one week for CD4 count and analyses. ART treatment is initiated for these women according to national guidelines. This activity is done in collaboration with CHWs in charge of maternal health including sensitization and follow up for their adherence.

Reinforce linkages between health facilities and community

PMTCT related services are offered in the community by families, community health workers, local leaders, peer support groups, CBOs and NGOs. At the family level, spouses accompany their pregnant wives for the first ANC and when husbands are not available, community health workers accompany pregnant mothers for the first ANC. Women who have not had husbands they are given letters by local leaders to introduce them to health facilities. This is done to reinforce couple counseling and testing. Home visits to PLHA were done by social workers from health facilities whenever there is a need. These home visits include some practical demonstrations especially regarding nutrition and infant feeding. Community health workers sensitize and deliver PMTCT messages during meetings or other events like "UMUGANDA" (community work) at the end of every month.

Output 1.3.1.1. Blood-borne HIV transmission in clinical environments is reduced

During the reporting period Progress has been made in order to ensure that proper waste disposal mechanisms are available and used within all health facilities. Notably, MOH reports 90 safe final disposal methods, 5 modern incinerators, 15 DeMonfort incinerators, and 70 separated waste pits. In addition, the Revision of National Post-Exposure prophylaxis protocol has already been completed and distributed; it is used by health providers. All care providers that were exposed to HIV have been tested and received ART prophylaxis.

2.1.12 Output 1.3.1.2. All blood donated for transfusion is screened for HIV

The National Blood Transfusion Centre (CNTS) regularly collected blood from volunteer donors to supply the blood bank. This blood is tested for HIV, Hepatitis B and C and Syphilis. The blood bank is supplying the district hospitals for blood transfusion. No blood transfusion is done in Health Centres.

2.1.13 Output 1.3.1.3. Blood-borne HIV transmission outside clinical environments is reduced

In all mass sensitization events people were made aware of blood exposure risks, although at clinical facilities, these risks are maintained very low by the national blood transfusion Centre (CNTS).

Impact 2: Morbidity and mortality among people living with HIV are significantly reduced

2.1.14 Output 2.1.1.1. People living with HIV systematically receive Opportunistic Infection prophylaxis and treatment according to need and national guidelines

2.1.15 Output 2.1.1.2. People living with HIV and STIs receive treatment for STIs

In order to reduce morbidity among PLHIV it is important to assist them in preventing them from the acquisition of opportunistic infections (OI) or other sexually transmitted infections (STI), and quickly and efficiently diagnose and treat opportunistic infections in a facility setting if acquired. Though Outputs 2.1.1.1 and 2.1.1.2 are separate in the NSP to preserve the causal chain of the results framework, these output results require similar strategies from an implementation perspective. As such, the progress in implementation of these two output results will be provided below. To date progress focuses on **increasing the availability** of services in all facilities, **revising and implementing national guidelines**, **and improving financial access** to services among PLHIV.

Increasing service availability in a healthcare setting

By the end of the reporting period, TRAC Plus reported that **70% of health facilities were offering the full package of HIV services**: VCT, PMTCT, and ART integrated services, **marking a 28% increase from baseline** values at the end of 2008. OI and STI drugs and lab commodities are now part of national procurement and are distributed to HFs under the routine activities of CAMERWA. In addition, during the reporting period, 703 biotechnologists were trained for skills development in HIV, TB, hematology and biochemistry to improve service delivery of services.

Revising and implementing national guidelines on OI and STI

New OI and STI guideline were updated according to new evidence; disseminated to all facilities, and are now being used by all service providers. To ensure this process, integrated training on national guidelines was conducted at the national level and sessions on new diagnostic and treatment protocols for OIs were conducted in all District Hospitals (DH). Through a Training of Trainers (TOT) approach, decentralized trainings are currently ongoing in order to train all health care service providers in the country. Trainers of each DHs trained health providers from their catchment areas on new protocols. In addition, integrated supervision from central level to DHs is done regularly by a multidisciplinary team and DHs experiencing problems receive special mentorship. It is important to note that OIs is one of the topics targeted by supervision.

Improving financial access to OI treatment to PLHIV

Some implementers are supporting a health Insurance project aimed at providing health insurance to vulnerable groups especially PLHIV. Implementers report that **125,784 PLHIV were supported in 2009 to access health insurance**.

2.1.16 Output 2.1.1.3. People living with HIV and tuberculosis receive appropriate treatment for TB

As HIV and TB co-infection constitutes the majority of the disease burden of HIV co-infection, significant progress was made in supporting the full integration of these two services. According to TRACNet data, in the first semester 2010, 251/328 (76%) HIV care and treatment clinics reported that 94% of new enrolled HIV patients were screened for TB with 2, 5% (314/12580) of those screened testing positive for TB. All healthcare providers working in ART services in all sites are trained in TB diagnosis and treatment. During the reporting period, these “one stop” services

became operational in all sites providing ART services. TB screening in PLHIV is now done as part of routine enrollment procedures in the national HIV care and treatment program for new patients, and at each follow-up visit for those enrolled for more than 6 months.

2.1.17 Output 2.2.1.1. HIV+ people are identified in order to initiate treatment

In order to reach the ambitious targets for ART coverage set forth in the NSP, it is not only necessary to ensure that all identified PLHIV enrolled in the national care and treatment program are transitioned to treatment in a timely manner, but also to ensure that PLHIV who have not yet been identified as HIV-positive in a counseling and testing setting are identified and enrolled in the national care and treatment program. As a result, during the reporting period, significant progress was made to identify new HIV-positive individuals for enrollment in the national care and treatment program. According to TRAC Plus, during the reporting period **2,869 new HIV-positive individuals were enrolled in the national care and treatment program** which brings the **cumulative total to 159,103 HIV-positive individuals** enrolled by June 2010.

Following the introduction of the new algorithm for HIV testing, registers and reporting tools were revised accordingly and VCT indicators were defined and introduced into the national reporting system. From July 2009 to June 2010, 66 new trainers received an integrated training (prevention, care and treatment) and 83 care providers received a refresher course on new prevention and care and treatment guidelines in conjunction with the new guidelines. At the end of June 2010, 419 health facilities offered voluntary counseling and testing services, and among them were 13 prisons.

Another important strategy for increasing the number of Rwandans who know they are HIV-positive is through provider-initiated testing (PIT). Voluntary counseling and testing initiated by providers (PIT) started in 2008. Only 5 health facilities offered PIT services in 2008. By the end of June 2010, all health facilities are able to initiate HIV testing to clients coming for other services to the health facilities and 203 trainers were trained on PIT in the whole country with an average of 4 trainers at every District Hospital.

2.1.18 Output 2.2.1.2. Improved HIV exposed infant follow up according to national guidelines

By the end of the reporting period, TRAC Plus reported that **84% of known children born to known HIV-positive mothers received an HIV test at 18 months**, representing a **9% increase from baseline** values reported at the end of 2008. Home visits to PLHIV were conducted primarily by social workers from health facilities and focused on supporting HIV exposed infants. The home visits include some practical demonstrations especially regarding nutrition and exposed infant follow up and feeding. Community health workers sensitize and deliver PMTCT messages during meetings or other events like “UMUGANDA” at the end of every month. In addition, a program was launched during the reporting period to promote advocacy and community mobilization at all levels for increased HIV prevention and uptake of PMTCT services through the PMTCT acceleration plan 2010-2012.

2.1.19 Output 2.2.1.3. Coverage of facilities offering ART is increased

Ensuring geographical coverage to ART for all PLHIV in the country is critical to reducing morbidity and mortality among PLHIV. Much progress was made during the reporting period to increase the availability and coverage of ART services. Notably, the number of **adult patients on ART increased from 68,520 patients (end June 2009) to 83,041 patients (June2010)**. In addition, the number of **children on ART increased from 5,894 children (end June 2009) to 7,111 children by the end of**

June 2010. TRAC Plus reports that 98% of adults are currently under a first-line ART regimen, while 2% are currently under a second-line regimen.

The coverage of health facilities offering ART also increased from 217 to 295 throughout the country during this period. In conjunction with this increase in ART coverage, trainings of providers were conducted with representatives from all HFs in collaboration with trainers at district level: 655 providers have been trained from July 2009 till June 2010.

Strengthen the supply and distribution of drugs and commodities

Support to strengthen quantification, forecasting and supply planning of all health supplies for CPDS and other programs was conducted during the reporting period. The national quantification committee members were trained to acquire skills needed for the annual quantification exercise forecasting the national needs in health commodities including the ARVs, OI drugs, consumables and laboratory reagents. Three staff in charge of commodities management from different institutions (CAMERWA, TRAC Plus, NRL) attended training on quantification and procurement planning at ESAMI (East-Southern Africa Management Institute). In addition, the stock inventory and tracking management was also ensured on a monthly basis in order to maintain the stock levels between the minimum and maximum stock levels at both central level and peripheral levels.

Strengthen and support the LMIS of a better medicines supplies, vaccines and lab consumables management (MACS + SAGE) for the central and district level

The availability of medicines mostly depends on effective logistics system used to manage essential logistics data used for planning, forecasting and quantification. Without reliable data, the procurement of health commodities will be affected, with potential risks of ending up with enormous expiries or stock outs. A harmonized form that was developed will be used across all programs for reporting data on the usage of medicines at health facilities, and would be used as a requisition form at the same time. All health commodities logistics data would be easily captured, validated, managed and used for quantification, resupply, supply planning and other decision making. Training for District Pharmacy managers and Laboratory managers in District Hospital was a success. Standard Operating Procedures Manual which supports those forms in their implementation has also been revised and validated in the same workshop.

Ensure the establishment of active distribution of medicines supplies, vaccines and lab consumables from the central level to district pharmacies and H

The first phase of active distribution roll-out ended in March 2010 with 5 districts pharmacies and the second one added five other district pharmacies. By July 2010 a total of 10 district pharmacies were actively distributing the HIV medicines from central level to health facilities.

Task Shifting

A training curriculum for task shifting was developed and a guide to nurses was developed and is now available at all sites. During the 1st phase of task shifting, 2 nurses at each HF with HIV services were trained, 856 nurses in total were trained. After the training of nurses in task shifting, trainers passed through mentorship under DHs supervisions before validation and accreditation of nurses as prescribers.

2.1.20 Output 2.2.1.4. Quality standards for ART are maintained

Ensuring high quality standards for ART is an essential strategy to ensure that treatment regimens are effective. The National Reference Laboratory (NRL) began implementing plans to improve the

national quality-control program, including strengthening transport mechanisms for specimens and proficiency panels to twenty three district hospitals.

During the period of reporting, the pilot study was conducted in 15 sites, before undertaking scaling-up with the 28 remaining sites. Evaluation of pilot phase was necessary to inform planning for the expansion phase. The Workflow at NRL has been adapted to sample transportation schedule. This includes duty rosters, sample reception, sample processing and reporting of results.

In addition, currently 38 District hospitals are equipped with FACS count Machines for CD4. During this reporting period, 51,395 CD4 tests, 9,819 DNA PCR tests, 10,833 viral load tests, and 58,775 QA/QC HIV tests were carried out. NRL equally received, on a monthly basis, 5% of HIV negative and 10% of HIV positive specimens for quality control. Regular feedback was made by NRL.

Additional proficiency panels for external quality control were received from CDC Atlanta and South Africa (NHLS), the WHO regional quality control program (WHO/QASI) for PCR CD4 and HIV serology tests. Similarly the NRL sent specimens to the same institution for quality control checks. In order to assist the National Reference Laboratory in its activities which increase overtime, 20 additional staff and one Technical Assistant were recruited through the Global Fund Project to support NRL.

Establish and enforce a national quality standard

TRACPlus M&E unit is establishing continuous quality improvement approaches that are implemented via mentorship and formative supervision. TRAC PLUS together with its partners, harmonized tools for quality of care that will be soon disseminated to all sites. Quality indicators were selected; and will be monitored periodically and areas of improvement will be identified and aggressively addressed.

Strengthen the M&E system to identify and trace patients lost to follow up

From March to 18th September 2009, TRAC Plus/HAS Unit conducted an activity of tracking people living with HIV and exposed children lost to follow up in all ART/PMTCT health facilities of Rwanda. A total of 314 health facilities were visited. The results of the activity will be used in the next reporting period to strengthen the overall M&E system.

2.1.21 Output 2.3.1.1. People living with HIV receive psychosocial support and community support including palliative care

Home visits are made regularly to patients on treatment in order to ensure their strict adherence. Particularly patients who miss a regularly scheduled appointment are visited and counseled on adherence by social workers. Besides home visits conducted routinely by community health workers, some NGOs also provide home-based care services to PLHIV. HIV implementers reported **conducting 6,762 home visits to PHIV** during the reporting period.

Integrate psychosocial support and mental health in the routine follow up of the HIV patients

The integration of mental health and HIV is one of the main focuses to respond to psychosocial needs of HIV positive patients. Training modules and mental health screening tools targeting HIV-positive patients were developed and validated by the National Technical Working group on HIV care and treatment. Since December 2009, a pilot program has been initiated and the Neuropsychiatric referral hospital has been reinforced. A pool of 30 national trainers has been trained. In a bid to decentralize services, another group of trainers from 9 district hospital (25 people) was also trained.

Provision of psychosocial support to PLHA

Psychosocial support to both individual and group counseling was reinforced through implementation of systematic individual counseling of all HIV-positive patients who were newly enrolled in care and treatment. Another aspect was the reinforcement of disclosure counseling for children and adolescents and follow-up in support groups. In total, 265 health facilities provide special counseling and psychosocial services for children and adolescents (disclosure counseling and support groups). Pre-ART Education and preparation is now done in about 95% of cases who start antiretroviral treatment.

For adherence monitoring and assessment, an integrated mentorship program was initiated as part of task shifting for nurses and as an integrated part of routine for both psychosocial and clinical consultation in 51 health facilities. These mentorships helped also in the training of health care providers for screening of psychosocial problems that need special attention and support.

2.1.22 Output 2.3.1.2. People living with HIV receive nutritional support according to needs

The integration of nutritional services at health facility is done through trainings of health workers and supervision of nutrition activities in HIV services. During the reporting period, 10 sessions of training at the decentralized level were conducted in all 5 provinces: 160 health providers from health centers were trained in Nutritional care and support for PLWHA. A training of trainers was conducted: 43 nutritionists from district hospitals were trained in nutritional care and support particularly in monitoring and evaluation of nutrition activities.

There is a program providing individual food ratio for ART clients with moderate malnutrition during six months. In addition, clients received nutrition counseling and education. Health workers from 137 health facilities were trained in food for ART program. This program is being implemented in 137 health centers with ARV services for 14,707 beneficiaries by June 2010.

Apart from food supplementation and nutrition counseling, clients on ART are being sensitized on production and consumption of animal proteins; they are participating in demonstration Gardens session in order to gain practical advice and to incorporate fruits and vegetables into their diet.

2.2 Impact 3: People infected and affected by HIV have the same opportunities as the general population

2.2.1 Output 3.1.1.1. Increased skills and education for infected and affected persons (including child household heads)

During the reporting period, several HIV partners + conducted trainings and seminars to strengthen economic opportunities, improve food security and offer nutrition services for PLHIV and their families. HIV implementers reported **1,301 PLHIV received capacity-building trainings in support of income generation activities**. Trainings were also conducted to increase the capacity of government officers (Social Affairs & Education Officers) in 30 districts to manage and monitor OVC services, as measured by a score of 80% in the district OVC service Provision monitoring tool.

With the collaboration of the National Decentralization Implementation Secretariat (NDIS), trainings were organized by RALGA and MCC-funded projects in order to harmonize district authorities' capacities. Field visits to officers were led by the CDLS team to supervise the Internal Saving and Lending Groups (ISLG) trainings.

A TOT was conducted in Cooperative Development for CSOs and pre-cooperatives in market opportunities identification and organizational development progress was monitored for pre-cooperatives in 30 districts. Technical and vocational training (TVET) Institution assessments were conducted in 30 Districts for TVET candidates with a view to expand TVET partnerships—thereby increasing youth (ages 15 to 24) opportunities for enrollment—in the coming school year and supporting potential internship and apprenticeship opportunities for currently enrolled TVET students.

2.2.2 Output 3.1.1.2. Creation of employment opportunities for infected and affected persons (including child household heads)

Through CNLS partners, this activity is implemented in 30 districts. Partners reported that 1,866 PLHIV received support to initiate income-generation activities during the reporting period. The trainings are still going on with Rwanda Cooperatives Agency and CDLS partners in order to acquire cooperatives status. During the reporting period, 217/853 associations registered in all Districts were transformed into cooperatives. This activity is provided by only CHF in 20 Districts covered by HIGA UBEHO. Other 10 districts are coved by CRS IBYILINGIRO and RRP+, the national network for people living with HIV and AIDS.

In September 2009, CNLS supported 8 cooperatives to successfully participate in Rwanda's annual Business Expo. Participating cooperatives generated 1,448,700 RWF (~$4,911) in sales during the two-week event. CHF/Rwanda, CARE and CRS also provided key support to Rwandan Partner Organizations (RPOs) in the form of coaching and monitoring, including: monitoring of Junior and Farmer Field School Abahuza training; holding gender mainstreaming reflective practice sessions with RPO staff; and support to Positive Deviant Health Abahuza training.

In 2009, CNLS started discussions with Rwanda Development Board (RDB) to help new emerging cooperatives to develop their business plan and market research in order to facilitate their integration in East African Community. CHF also organized, in the Southern Province (Kamonyi District), training for new cooperative in research market for beans in order to produce in accordance with market needs.

2.2.3 Output 3.1.1.3. People infected and/or affected by HIV (including child household heads) have access to credit (individually or collectively)

Create a guarantee fund for cooperatives formed by people infected and affected by HIV

Over the 2004-2008 period, an estimated three billion four hundred million Rwandan Francs (3,400 million Rwfs), or approximately six million USD were injected into income generating activities initiated by people infected / affected by HIV and AIDS. However, funds offered by donors to various projects are limited in time and in economic impact for beneficiaries, hence the need to consider more long-term solutions. The HIV National Strategic plan proposed a guarantee fund to facilitate access to credit for cooperatives recognized by CNLS. The establishment of a guarantee fund aims at eliminating the scattering of funds for income generating activities by putting them in a common fund. It should lead to sustainability of projects initiated by CNLS cooperative partners whose members would first be trained on savings, loan management and entrepreneurship. A study was conducted to advise CNLS on the appropriate strategies to prepare the establishment of this guarantee fund.

Create partnerships and alliances with financial institutions

The Guarantee fund study shows us how we can select the partnering bank for the management of the guarantee fund. The criteria to choose the financial institution will include the coverage of the national territory, experience in managing guarantee funds admitted in a bank, time spent on handling requests made by cooperative, interest rate, etc. This will be done as soon as the favorable conditions for the Guarantee fund will be met.

2.2.4 Output 3.1.1.4. Households of persons infected/affected by HIV have food security

There is no specific strategy targeting PLHIV for food production. It is assumed that PLHIV benefit from improvements in food production along with the general Rwandan population. Crop production continued to follow a broadly upward trend in 2009/10. Production statistics show that total agricultural output increased from approximately 7 to 10 million MT and that this has a positive impact on food security in Rwanda, measured in terms of availability. Production has exceeded consumption for the last three agricultural seasons, for the first time since 1994.

In addition, nutritional education sessions were organized for cooperatives created from PLHIV associations. In some nutritional promotion programs, the strategy of positive deviance is used. The principle of this approach is to identify families whose children are well nourished and use them as a model to other households with similar socio-economic status. In general, HIV implementers reported that **1,684 PLHIV were supported for food-security initiatives** during the reporting period.

During 2009, particular attention was put on technical instruction on kitchen garden in order to provide supplement food to the vulnerable families. Catholic Relief Service provided technical assistance to PLHA in 20 Districts. RRP+ also received financial support from Gardens for Health International (GHI), a non–profit organization, to support an integrated, communal approach to simultaneously target malnutrition and HIV&AIDS in Rwanda.

2.2.5 Output 3.2.1.1. Increased percentage of OVC have minimum package of services

Improve management and coordination transparency of OVC program

The Ministry of Gender and Family Promotion (MIGEPROF) in collaboration with its partners has been working to find a solution for Orphans and other vulnerable children identification and to come up with integrated framework which will facilitate easy data exchange among ministry and partners.

The last identification has been conducted in July and August 2008 all over the country and has shown some challenges. To overcome those challenges MIGEPROF during the preparation of the new OVC identification has developed OVC identification materials and guidelines with three out of six criteria related to the situation of children infected or affected by HIV and AIDS. The identification is planned for the next reporting period.

Create a database at all levels starting from village to national level

MIGEPROF working with their stakeholders have started the design, development and piloting a comprehensive electronic database to track OVC services provision in the districts. This database will reduce duplication of efforts by making it easier for district officials to monitor vulnerable individuals receiving services, levels of support and the geographic coverage of services being provided by different organizations. The firm experienced in this activity has been recruited and Project technical appraisal finalized. MIGEPROF partners have committed to work together by providing initial data, thus National ID project will provide all data regarding children under eighteen years. MIGEPROF, in partnership with USAID/Higa Ubeho will pilot the database in 2 districts in the next reporting period.

There is an OVC subcommittee at district level. Under the coordination of CDLS, this committee takes part in the planning, coordination, monitoring and evaluation of all activities targeting OVCs at district level. Note that there is a plan to strengthen those committees next year. The coordination of OVC activities at district level has been reinforced in the way that 10 districts have recruited and equipped staff in charge of OVCs' activities. In 2009, CNLS organized the 5th Annual National Pediatric Conference on children infected and affected by HIV and AIDS in Rwanda, around the 4 programmatic areas which are HIV Primary Prevention, Prevention of Mother-to-child HIV Transmission, Pediatric HIV Care and Treatment, Protection of children infected or affected by HIV. The theme of the Conference was, "Count down to 2015 targets for children and HIV- Achieving Millennium Development Goal (MDG) 6". 70 children delegates of the parliament of children from 30 districts of the country attend this conference.

Provision of package of support to OVC

Many activities were conducted during the reporting period to provide support services to OVC and their families. The school fees for OVCs have been provided at secondary schools, The Global Fund project Round 7 for OVC components as well as the CHF and all other stakeholders has contributed to this area. **The Global Fund specifically supported 18,350 OVC** with school fees in 2009 and **PEPFAR-funded NGOS supported approximately 10,000 OVCs**. **Other HIV implementers reported supporting 6,103 OVC for educational support** during the reporting period. HIV implementers also supported children in primary education with materials and other related costs. Through national and international adoption, MIGEPROF has made the analysis of all requests for adoption and the identification of the child to be adopted in partnership with CALCUTA ORPHANAGE.

In terms of support to shelter and housing, **decent houses have been constructed for 2,227 marginalized families and vulnerable population**. Through Global Fund funding, MIGEPROF provided support to Earlier Childhood Development Centers (ECDC) in the 10 Districts where GF operates. Financial support to Orphanages, street children centers and centers for children living with disabilities were also supported. This year, the vocational training was a target intervention, where vulnerable youth and adolescents received courses in woodwork, handcraft, sewing, construction etc. The graduated OVCs in vocational training were supported to begin professions with start-up kits of supplies.

The Child Protection Committee (GBV/CPC) was created in each district. An advocacy and elaboration of various policies aimed to reinforce protection against violence like GBV policy, land law, etc. at operational level community policing was established as a means to prevent violence within the community. OVC and other vulnerable people received psychosocial support at different levels. Health facilities are the main institutions that provided that kind of support and community health workers (CHW) and other caregivers are the ones who contributed to the psychosocial services delivery at the community level. HIV Implementers reported **providing 1,840 OVC with psychosocial support** during the reporting period.

The specific interventions made by our partners supported community-based health insurance project through the creation of income generating activities especially for those regrouped into cooperatives and other projects like VUP Umurenge. This facilitated access to basic health care to vulnerable children and families through payment of health coverage schemes (mutuelles). HIV implementers at the community level reported **supporting 2,756 OVC for health-related needs** during the reporting period.

2.2.6 Output 3.3.1.1. The rights of people infected and/or affected by HIV are assured in legal framework

In 2009, the CNLS in collaboration with UNAIDS conducted an assessment of the Rwandan legal environment as it relates to HIV in an attempt to bridge the gap between international obligation and national practice as implemented in the domestic legal system. The assessment was designed as a quality assurance device using the benchmarks contained in the international guidelines on HIV/AIDS & Human Rights, and ultimately aims to promote an enabling environment for responding effectively to the HIV epidemic through promoting respect for human rights in the context of HIV and AIDS at the national level.

The Rwandan audit revealed that the challenges faced by the Rwandan legal system as a whole are also a feature of legal regulatory framework concerning HIV/AIDS that include a scarcity of resources for the creation and operation of enforcement mechanisms, and generally a low level of legal expertise which is part of the legacy of Rwanda.

The national organization “Fight against the AIDS Scourge” (FAAS) through trainings supported the legal education for lawyers on rights of PLHIV in order to assist them in different cases related to their rights. With the Bar Association, lawyers have taken the commitment to provide assistance to the vulnerable by provision of legal counseling to PLHA and OVC. FASS trained some communities regarding awareness for PLHA on their rights. It was also the campaign to raise public awareness of PLHA rights.

2.2.7 Output 3.3.1.2. People living with HIV and AIDS and orphans and vulnerable children have access to legal aid services

In 2008, the Ministry of Justice initiated MAJ (Maison d'Acces à la Justice) on High Court level in order to facilitate the access to justice for PLHIV and OVC by providing assistance and advice in justice cases. The National Police also started the programme ISANGE STOP centre for protection against GBV and documenting cases of stigma and discrimination for vulnerable people and particularly for PLHIV and OVC.

2.2.8 Output 3.3.1.3. Increased acceptance of persons infected/affected in the community

In collaboration with RRP+, CNLS continued its actions in protecting people infected and affected by informing the general population on the HIV ways of getting infected and ways of non-contamination. To help the general population to learn about the rights of people living with HIV, a 56 pages booklet was produced in May 2010 giving testimonies about the lives of PLHIV. CNLS has also advocated for PLHIV in centralized and decentralized political institutions to maintain the steps ahead in fighting stigma and discrimination among PLHIV or affected people. This had a big impact, and now many discordant couples continued to live as usual and employers are being more supportive in many public and private sector institutions.

2.2.9 Output 3.3.1.4. Increased self-acceptance of people infected and/or affected by HIV

Psychosocial and community activities focus on the development of palliative care policy and guidelines and home visits as well. Recently, a national palliative care policy that includes HIV has been approved. Home visits to track lost to follow up are done in all health facilities providing ART services even if budget located to this activity is very low.

2.3 Coordination of the National HIV Response

CNLS facilitated the integration of priorities of the National Strategic Plan in the Action Plans of Partners, both at the national and decentralized levels. The coordinating body of HIV response organized three major national conferences which are namely the Fifth National Conference of Exchange and Research, the Fifth Annual Pediatric Conference on HIV and AIDS and the Fourth Partnership Forum on HIV and AIDS. The Elaboration of the 2010 UNGASS Report on activities carried out in the area of HIV and AIDS was produced through the CNLS coordination

Implementing partners in area community prevention and impact mitigation areas are coordinated by District AIDS Control Committee (CDLS) in terms of Planning, Monitoring and Evaluation and Reporting. A database is available at RBC-CNLS (CNLSNet) for the management of routine data from CDLS. These data are reported on 11 community-based indicators and include data on community prevention and impact mitigation.

Coordination of clinical activities at the district level is provided by the district hospitals that send their reports to TRACPlus. The TRAC *Plus* HIV and STI Unit (HAS) coordinates the response of the health sector to HIV/AIDS and STIs, including HIV clinical prevention programs (counseling and testing, PMTCT, male circumcision and prevention among PLWHA), Prevention, care and treatment programs for STIs; HIV Comprehensive care and support (prevention and treatment of opportunistic infections, antiretroviral therapy, psychosocial care, community-based and home-based care, nutritional support, and TB/HIV co-infection); Epidemiological surveillance and research on HIV/AIDS and STIs; and the monitoring and evaluation of HIV, AIDS and STI prevention care and treatment programs. Coordination of clinical activities by the TRACPlus is jointly and in close collaboration with the CNTS and the NRL respectively in charge of the activities of blood transfusion and Laboratory activities.

2.4 National Monitoring and Evaluation Plan on HIV and AIDS

Rwanda's M&E system is organized around 12 essential components which outline a comprehensive framework incorporating all M&E-related tasks. The twelve components are further organized into three broad areas with sub-components in each area. This framework ensures the organization of a robust M&E system that will meet the needs of all stakeholders.

2.4.1 Component 1: Organizational structures with HIV M&E functions

In this 1st component of the M&E area, a lot of works was done to strengthen the M&E system for all the community-based, civil society organizations and health facilities based structures. For the community-based M&E system, new terms of references were adopted with reviewed job description for the two CDLS Technical Assistants. Those ToRs were reviewed by CNLS and CDLS TAs in a workshop held at Kabgayi/Muhanga from 10th to 12th March 2010. Position of each TA /CDLS is clearly defined: the Coordinator of CDLS is in charge of planning, coordinating, monitoring and evaluating HIV activities done at the District level, and the Technical Assistant under the direct supervision of the Coordinator is in charge of integration of HIV in the Health sector. To support CDLS to fulfill its mandate and to be aligned to the new reform structures, CNLS had to review the MoU signed with Mayors of Districts in the fighting against HIV. The MoU was review but has not yet been signed between CNLS and Mayors of Districts. This exercise will take place in the next quarter. For technical support, while waiting for Single Streaming Fund to be available, MEASURE Evaluation project through the capacity building program supported CDLS with needed materials to enable them to achieve their Action Plans.

Regarding the civil society organizations, job description of M&E Officers and Districts Coordinators for Umbrellas were developed but have not been recruited because of lack of their salaries to be covered by SSF which was not signed at the period of the report. Searching for another alternative, only RRP+ had the technical and financial support from MEASURE Evaluation for the recruitment of the Junior M&E Officer through a joint M&E work plan as a way to support RRP+ to fulfill its M&E mandate.

2.4.2 Component 2: Human capacity for HIV M&E

On human capacity for HIV M&E staff, a 5-day training of trainers (TOT) was organized in July 2010 for master M&E trainers; the latter comprised of M&E staff from CNLS, TRAC Plus, MOH, and School of Public Health. There is a plan for those ToTs to facilitate planned trainings for M&E staff from different institutions (Umbrellas, EDPRS, CSOs …) in the coming year. There was also training for CDLS on the use of data collection and reporting tools aligned to the NSP 2009-2012 in order to be able to collect on the community indicators. In general, M&E staff from CNLS, MOH, TRAC Plus and other Health Institutions participated in international seminar, regional seminar and M&E Courses.

2.4.3 Component 3: Partnerships to plan, coordinate, and manage the HIV M&E system

To be able to plan, coordinate and manage the HIV M&E system, a PM&E TWG has a mandate to meet quarterly with different points on the agenda in order to fulfill the M&E of HIV activities. However, unfortunately, the group didn't have the opportunity to achieve their mission in this reporting period because of many changes in CNLS PCM&E department as the coordinating body of this group.

To reinforce the partnership between all HIV stakeholders, the planned annual meeting of umbrellas on experiences sharing of best practices and lessons learned was combined with an

annual meeting of HIV stakeholders. This partnership forum was an occasion for all HIV stakeholders in the fight against HIV to share experiences, to set up achievements and challenges in the achievement of the Universal access as one strategy of the HIV National Strategic Plan 2009-2012.

2.4.4 Component 4: National multi-sectoral HIV M&E plan

During this reporting period, the HIV M&E work plan and the operational plan were finalized at the same time and disseminated during the Partnership Forum. Indicators reference sheets were developed with all definitions, targets and measurement units to respond to HIV indicators in the HIV M&E Plan. Tools to collect data for community indicators were developed and TA/CDLS were trained on their use during Kabgayi workshop on data management and use. TA/CDLS disseminated those tools to implementers during their quarterly coordination and planning meetings. The process of aligning M&E plans of organizations to HIV national M&E plan had started during this quarter as for example RRP+ M&E Plan, and the activity is ongoing for other organizations.

2.4.5 Component 5: Annual costed national HIV M&E work plan

The HIV M&E work plan for June 2009 to July 2010 was costed during a workshop in September 2009, with the participations of different institutions concerned by the M&E Plan.

2.4.6 Component 6: Advocacy, communications, and culture for HIV M&E

In order to raise awareness on the culture of HIV M&E, a session on data use and dissemination was integrated in the Partnership Forum and the training for TA/CDLS was organized. The use of evidence from the joint review of the NSP 2006-2009 in the development of the HIV National strategic Plan 2009-2012 was presented as an example. Reports and documents from different workshops/conferences and studies were posted on CNLS Digital library and on the CNLS website. Exactly, 539 documents were collected from 52 institutions in fighting against HIV to be posted on the CNLS Digital library.

2.4.7 Component 7: Routine HIV program monitoring

An operational guide for planning, collecting and reporting data was developed for community level indicators and is used by TAs/CDLS. The next step will be to extend it and update it at the national level. A harmonized tool for data collection related to OVC was developed using CSI (Child Status Index). The tool was used for identification of OVC during the reporting period.

Regarding the health facilities M&E system, in December 2009, the Ministry of Health with technical support from MEASURE Evaluation developed a routine data quality audit (RDQA) tool that is contextualized to the Rwandan health sector situation. The tool was designed with a dual purpose of being used for health facility self assessment as well as data quality assessment. Following the development of the RDQA tool, 41 recruited District Hospital M&E officers and 40 data entry officers attended a five day training workshop on management of data and the use of the RDQA tool between December 2009 and February 2010. The training included a one-day exercise of the tool by the participants in nearby hospitals and health centers. Results so far from the RDQA assessments revealed the following causes of insufficient data quality in medical registries: inaccurate data transcription and recording errors and illegible handwriting in patient records and registers; lack of clear definitions for data items and guidelines for data collection; insufficient data checks; insufficient control over correction of detected data errors locally; and lack of a clear and coordinated plan for quality improvement.

Therefore, the MOH M&E Task Force set up a temporary team of trained central level staff in RDQA to conduct site visits to all health facility at least once in every four months to detect data inaccuracies that take place during the site data collection process and during the transfer of data to upper levels and identify their causes that should lead to developing immediate actions to improve data quality in addition to providing support to the District Hospital M&E officers.

TRAC Plus developed and distributed new M&E programmatic tools. These include registers, patient files and new indicators to be collected. The new developed ART registers collect the patient information related to the adherence and track the lost to follow up and missed appointments. The trainings were organized for health care providers and Districts M&E on the new developed M&E tools. DHs M&E officers were trained on how to generate and disseminate feedback on programmatic data to HCs and conduct data quality assessment. The data managers and M&E officers from DHs were also trained on DQA and they perform corrections of all discordant data and send to partners new corrected reports. They are also responsible for improving completeness of information that is in registers and other tools.

2.4.8 Component 8: Surveys and surveillance

DHS 2010 protocol was developed and finalized in June 2010, and submitted to the National Research Committee. The study itself is planned to begin in the next year.

2.4.9 Component 9: National and sub-national HIV databases

National database was updated in order to include data on eleven community indicators collected by TAs/CDLS at districts level. TAs CDLS had a session on data entry of those indicators in the database as a part of their capacity building on data management.

But the evidence was that the updated database didn't have a solid structure to avoid duplication and other mistakes in data entry and was not user friendly. It was concluded that there was a need to restructure the National HIV Database and this will be done in the coming year.

2.4.10 Component 10: Supportive supervision and data auditing

In October 2009, supervision visits were organized in 30 Districts where CNLS staff, districts authorities, partners and beneficiaries met to discuss on achievements, challenges and solutions for HIV response at District level. Those supervisions were done in terms of meetings at districts headquarters and field visit to beneficiaries.

2.4.11 Component 11: HIV evaluation and research

Regarding the HIV evaluation and research agenda, a research conference was held from 2nd to 3rd November 2009 with the theme, "HIV Prevention Based on evidence" where more than 300 participants both national and international attended.

For strengthening the functioning of the research committee monthly meetings of National Research Committee were held, but there were no research protocols to review. In all, 16 research protocols were approved from Jun 2009 to July 2010.

An electronic inventory of all HIV/AIDS studies and research already conducted in Rwanda were done where all researches in the area of HIV and AIDS which were reviewed by the National Research Committee are listed and updated accordingly.

Regarding studies, a quantitative study to know the situation of MSM in the country was conducted and the results were disseminated. The protocol of the qualitative study on HIV risk among MSM was also developed, but the study will be conducted in next year. Consultative meetings with different stakeholders were conducted on the IDU study to be conducted next year.

2.4.12 Component 12: Data dissemination and use

As it has been already mentioned, the 2008 review findings of the HIV & AIDS NSP were disseminated during the Partnership Forum and this also was also done for TAs/CDLS during their training on data management and use at Kabgayi. Studies, research projects and reports of conferences and workshops were disseminated through hard copies sent to partners or soft copies posted on the CNLS website.

All reports from districts or partners were analysed and feedback sent to them with recommendations for their next activities. Concerning UNGASS report, all consultations were done and data were collected at national and decentralized level. The report showed tremendous progress made by Rwanda in the fight against HIV. The validation and dissemination of the UNGASS report were done during a workshop held in March 2010.

3 ANNEX A: HIV PREVENTION INDICATORS

3.1 NATIONAL INDICATORS

Number	Indicator	Baseline	*Actual Value (June 2010)*	Target by 2012
1.1a	Percentage of most-at-risk populations (female sex workers, truck drivers, men who have sex with men, prisoners) who are HIV-infected	FSW: baseline 2009 Truck drivers: baseline 2009 MSM: baseline by 2010 Prisoners: baseline by 2010	*BSS 2010:* FSW: 51% Truckers: No data MSM: no data Prisoners: no data	Prevalence remains stable at baseline levels (reduction in incidence and AIDS-related mortality)
1.1b	Percent of discordant couples that remain discordant after enrolment to couples' counseling and testing at 12, 24, 36 months	Baseline by 2009	No data	90% at 36 months
1.1.1a	Percentage of women and men aged 15-49 who reported using a condom the last time they had high risk sexual intercourse	*RDHS 2005:* 26% women 15-24 20% women 15-49 40% in men 15-24 41% in men 15-49	*BSS 2009:* 38% women 15-24 52% in men 15-24	60% in women 15-24 and 15-49 75% in men 15-24 and 15-49
1.1.1b	Percentage of young women and men aged 15-24, and 18-24, who have had sexual intercourse before the age of 15, and 18, respectively	*RDHS 2005:* **Before age of 15:** 4% women 15-24 13% in men 15-24 **Before age of 18:** 18% women 18-24 27% men 18-24	*BSS 2009:* **Before age 15:** 6% women 15-24 13% men 15-24 **Before age of 18:** 27% women 18-24 43% men 18-24	**Before age 15:** No target **Before age 18:** 12% women 18-24 18% men 18-24
1.1.1c	Percentage of population aged 15-49 who had more than one sexual partner in the past 12 months	*RDHS 2005:* 0.6% women 15-49 5.1% in men 15-49	No data	Stabilize at <5%

1.1.1d	Percentage of sero-discordant cohabiting couples reporting consistent and correct condom use during reporting period	Baseline by 2009	No data	50% increase from baseline
1.1.1e	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Baseline by 2009	*MSM Exploratory Study (N=99)* 50% last sex with boyfriend; 51% last casual male partner	50% increase from baseline
1.1.1f	Percentage of female sex workers reporting condom use during last sex with a client	*BSS 2006:* 86.6%	*BSS 2010:* 80%	93%
1.1.1g	Percentage of other most-at risk populations reporting condom use during last sexual intercourse with non-married non-cohabitating partner	*BSS 2006:* 82% in Truck drivers	No data	90% (Truck drivers)
1.1.1.1a	Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	*DHS 2005:* 51% women 15-24 54% women 15-49 54% men 15-24; 58% men 15-49	*BSS 2009:* 12% women 15-24 14% men 15-24	70% in men and women aged 15-24 and 15-49
1.1.1.1b	Number of couples who have received couples HIV counseling and testing and who know their results in the last 12 months	*TRAC Plus 2008:* 101,139 couples tested	*TRAC Plus 2011:* 10,514 couples	200,000 couples tested per year by 2012
1.1.1.3a	Percentage of sex workers reached with HIV prevention programs	*Baseline by 2009 (Triangulation)*	*No data*	60%
1.1.1.3b	Percentage of sex workers who both	*BSS 2006: 36.2%*	*BSS 2010: 22%*	70%

	correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission			
1.1.1.4a	Percentage of other most at risk populations reached with HIV prevention programs (disaggregated by population)	*Baseline by 2009 (Triangulation)*	*No data*	60% in other most at risk populations
1.1.1.4b	Percentage of other most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by population)	*BSS 2006: Truck Drivers: 39.1%* *Other baselines to be obtained*	*No data*	70% in other most at risk populations
1.1.1.5	Percentage of those testing positive for HIV receiving complete prevention package	*TRAC Plus 2008: 5%*	*No data*	80%
1.1.1.6a	Percentage of health facilities with post-exposure prophylaxis (PEP) available	*SPA 2007: 28%*	*TRAC Plus:* *65%* *(308 / 471)*	100%
1.1.1.6b	Percentage of women presenting at health facilities reporting rape who receive PEP according to national guidelines	*Baseline by 2009*	*TRAC Plus:* *Overall: 83%* *Occupational: 94%* *Rape/Sexual assault victims: 76%* *Other: 86%*	100%
1.1.1.7a	Total number of condoms available for distribution nation-wide during the last 12 months	*Rwanda RHC 2009: Approximately 15,000,000 condoms*	*No data*	26,000,000 condoms
1.1.1.7b	Percentage of young women and men aged	*DHS 2005:*	*No data*	60% in women

	15-24 who report they could get condoms on their own	*37% in women 15-24* *73% in men 15-24*		80% in men
1.1.2a	Prevalence of male circumcision among adolescent and adult men (disaggregated by age [10-19, 20+])	*Intermediate DHS 2007/8:* *15% in males 15-59*	*BSS 2009: 16% in men aged 15-24*	50% in men 10-19; 30% in men 20+
1.1.2b	Proportion of males born in the last 12 months circumcised at a health facility	*Not available*	*No data*	50% of newborn males in 2012
1.1.2.1	Percentage of health facilities with staff who can perform male circumcision	*SPA 2007: 21% of health facilities*	*No data*	80%
1.1.3	Percentage of people reporting symptoms suggestive of STIs and seeking treatment from clinical services (disaggregated by sex)	*DHS 2005:* *12% in women; 14% in men*	*No data*	60% in men and women
1.1.3.2	Percentage of health centers and hospitals offering STI treatment that have capacity to test for syphilis	*SPA 2007: 40%*	*No data*	100%
1.2	Percentage of HIV+ children born to known HIV+ mothers [at 6 weeks, 5 months and 18 months]	*TRAC Plus 2008:* *3.2 % at 6 weeks* *2.8% at 5 months* *7.2% at 18 months*	*TRAC Plus:* *2.6% at 6 weeks* *No data at 5 months* *2.4% at 18 months*	2% at 18 months
1.2.1	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	*TRAC Plus 2008: 56%*	*TRAC Plus:* *74%*	90%
1.2.1.1	Number and percentage of health facilities that provide all four items from minimum PMTCT package	*SPA 2007: 35% of all health facilities (68% among all health facilities offering any*	*80%*	60% (90% of all health facilities offering any PMTCT services)

		PMTCT services)		
1.2.2	Percentage of women of reproductive age attending HIV care and treatment services with unmet need for family planning	*TRAC plus and FHI 2009: 18%*[1]	*No data*	<10%
1.2.2.1	Percentage of health facilities offering integrated family planning services as part of ART	*Baseline by 2009*	*TRAC Plus: 92% (371/404)*	80%
1.3	Percentage of donated blood units screened for HIV in a quality assured manner	*100%*	*100%*	100%
1.3.1.1a	Percentage of people in the general population reporting that last injection was given with a syringe and needle taken from a new, unopened package	*DHS 2005:* *94.7% in women* *89.4% in men*	*No data*	100%
1.3.1.1b	Percentage of health facilities with safe final disposal methods for sharps and infectious waste	*SPA 2007:* *92% for sharps waste* *88% for infectious waste*	*TRAC Plus: 20%*	100%

3.2 COMMUNITY-BASED PROGRAM INDICATORS

D1	Number of people in the targeted population reached through community	*No baseline*	1,195,900 people aged 15-49	

[1] Assessment of Family Planning and HIV Integrated Services in 5 Countries. This is an aggregate result for five countries (including Rwanda). No Rwanda-specific baseline.

	outreach with at least one HIV information, education, or behavior change communication message			
D2	Number of youth reached with HIV information, education, communication or behavior change communication through HIV youth clubs (club anti-SIDA)	*No baseline*	210,029 out-of-school youth aged 15-29 178,510 in-school youth aged 15-29	
D3	Number of Most-at-risk populations reached by HIV prevention interventions	*No baseline*	3,035 Female commercial sex workers 15,788 people with disabilities 4,643 people in uniform 114,245 PLWHA 67 prisoners 4,766 refugees 18,436 transporters 12,254 people in Sero-discordant couples	Percentage increase on baseline figures
D4	Number of district level implementers with the minimum capacity to deliver quality HIV prevention services to MARPs	*No baseline*		100%
D5	Percentage of health facilities that offer referral services for victims of sexual or gender-based violence	*No baseline*	*63%* *(247/395)*	100%
D6	Number of condom points of sale in the district	*No baseline*	*787*	50 per administrative sector

4 ANNEX 2: HIV CARE AND TREATMENT INDICATORS

4.1 NATIONAL INDICATORS

Number	Indicator	*Baseline*	*Actual Value (June 2010)*	Target by 2012
2.1	Percentage of people enrolled in HIV care and treatment who receive cotrimoxazole prophylaxis in the last 12 months	*Baseline by 2009*	*No data*	85% in adults and children
2.1.1.1	Percentage of hospitals and health centers offering full package of HIV services (VCT, PMTCT, ART)	*TRAC plus 2008: 43%*	*TRAC Plus: 70%*	100%
2.1.1.3	Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings (at the end of the reporting period)	*TRAC Plus 2008: 59% during 6 month reporting period*	*TRAC Plus: 67% (1,916/2,865)*	80%
2.2	Percentage of adults and children eligible for ART receiving it (disaggregated by treatment initiation eligibility criteria [CD4 <200, CD4 <350])	*77% in adults [CD4 <200]* *80% in children [CD4 <200]*	*TRAC Plus:* *83% in adults (75,930/91,400) [CD4 <350]* *53% in children (7,111/13,500) [CD4 <350]*	CD4 <200: 90% in adults CD4 <350: 70% in adults 90% in children
2.2.1.1a	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	*DHS 2005 (last 12 months): 11.6% in women 15-59 ; 11% in men 15-49*	*BSS 2009: 50% in youth aged 15-24*	35% (last 12 months)

		BSS 2006 (ever tested): 12.6% in girls 15-24; 11.3% in boys 15-24		
2.2.1.1b	Percentage of pregnant women who were tested for HIV and know their results	*75% (estimation based on model)*	*TRAC Plus: 69% (287,888/414,799)*	90%
2.2.1.1c	Percentage of partners of pregnant women in ANC who were tested for HIV in the last 12 months and who know their results	*TRAC Plus 2008: 78%*	*TRAC Plus: 84%*	90%
2.2.1.1d	Percentage of health facilities offering Provider-Initiated treatment (PIT)	*Not available*	*No data*	90%
2.2.1.2	Percentage of children of HIV+ mothers who received an HIV test at 18 months	*TRAC plus 2008: 75%*	*TRAC Plus: 84%*	90%
2.2.1.4	Percentage of viral load suppression after 12 months of treatment	*Baseline by 2010*	*No data*	70%
2.3	Percentage of adults who received follow-up adherence assessment and counseling as part of psychosocial support package	*Baseline by 2010*	*No data*	90%
2.3.1.1	Number of PLHIV who received at least one home visit and/or palliative care service in last 12 months	*Baseline by 2009*	*No data*	22,000
2.3.1.2	Number of people living with HIV benefiting from nutritional support in the last 12 months	*Baseline by 2009*	*No data*	42,000

4.2 COMMUNITY-BASED PROGRAM INDICATORS

D7	Percentage of ART sites with an affiliated community-based organization supporting PLWHA	*No baseline*	*12%*	100%
D8	Number of PLWHA visited by community health volunteers	*No baseline*	*5,045 at Health Centers;* *1,717 at district hospitals*	

4.3 FACILITY-BASED PROGRAM INDICATORS

F1	Total number of new patients enrolled in the care and treatment program	*No baseline*	*2,869*	
F2	Cumulative total number of patients enrolled in the care and treatment program	*No baseline*	*159,103*	
F3	Number of HIV-positive patients who receive prophylactic cotrimoxazole	*No baseline*	*No data*	
F4	Number of new HIV-positive patients to whom TB screening was done in the past month	*No baseline*	*1,918*	
F5	Number of new HIV-positive patients to whom TB screening was positive in the past month	*No baseline*	*248*	
F6	Number of HIV-positive patients assisted by the care and treatment services who have started TB treatment (including TB sufferers	*No baseline*	*10 PLWHA under 15 years;* *74 PLWHA aged 15+*	

	newly enrolled)			
F7	Number of new patients who started ART during the last month	*No baseline*	*1,572*	No target
F8	Cumulative total number of patients who are currently under ART	*No baseline*	*83,041*	
F9	Percentage of HIV-positive patients under first line regimen	*No baseline*	*98%*	
F10	Percentage of HIV-positive patients under second line regimen	*No baseline*	*2%*	
F11	Number of patients to whom CD4 count was done in the last 6 months	*No baseline*	*No data*	
F12	Number of STI cases treated in the past month	*No baseline*	*2,534*	
F13	Number of cases of opportunistic infections treated, excluding TB, in last month	*No baseline*	*2,341*	
F14	Number of HIV-positive clients (aged 15 years or above) to whom cervix cancer was detected	*No baseline*	*No data*	
F15	Number of HIV-positive children with severe malnutrition at the level of care and treatment services	*No baseline*	*201*	

F16	Number of HIV-positive children (under 5 years) who have received nutritional or treatment supplements	*No baseline*	*149*	
F17	Number of HIV-positive patients with malnutrition who have received treatment or nutritional supplements	*No baseline*	*962 patients under 15 years;* *3,934 patients aged 15+*	

5 ANNEX 3: HIV IMPACT MITIGATION INDICATORS

5.1 NATIONAL INDICATORS

Number	Indicator	*Baseline*	*Actual Value (June 2010)*	Target by 2012
3.1	Percentage of PLHA who have gone at least one day without food	*Rwanda Stigma Index 2008: 59% (58% females, 62% males)*	*No data*	<20%
3.1.1.1	Percentage of PLHA who have no formal education	*Rwanda Stigma Index 2008: 16.8% (19% females, 12% males)*	*No data*	<5%
3.1.1.2	Percentage of PLHA who are unemployed or not working at all	*Rwanda Stigma Index 2008: 20.4% (21% females, 20% males)*	*No data*	<10%
3.1.1.3	Percentage of cooperative members applying for credit who accessed credit mechanism per year	*Baseline by 2009*	*No data*	70%
3.2	Percentage of OVC aged 0-17 whose households received free basic external support in caring for the child	*DHS 2005: 12.6% at least one type of support; 0.2% all types of support*	*No data*	30% at least one type of support 10% all types of support
3.2.1.1a	Percentage of OVC who meet national	*Baseline by 2009*	*No data*	100%

	criteria for vulnerability that are in district registers			
3.2.1.1b	Current school attendance among orphans and non-orphans aged 10-14	*DHS 2005: Lost both parents: 70.1% in boys; 78.8% in girls* *Non-OVC: 88.1% in boys, 90.1% in girls*	*No data*	>90% in boys and girls
3.3	Percentage of PLHA who report fear of being physically harassed and/or threatened	*Rwanda Stigma Index 2008: 36% (32% female, 37% male)*	*No data*	<15%
3.3.1.1a	Laws are protective of the rights of persons infected/affected by HIV	*Baseline by 2009*	*No data*	Yes
3.3.1.1b	System for officially documenting cases of stigma and discrimination exist	*No*	*No data*	Yes
3.3.1.2	Number of PLHIV receiving legal aid when needing it	*Baseline by 2009*	*CNLS: 409*	[process only]
3.3.1.3	Percentage of population expressing accepting attitudes in relation to people living with HIV	*RDHS 2005: 46.1% in women 15-49; 51.0% in men 15-59*	*No data*	90% in men and women
3.3.1.4	Percentage of people living with HIV and AIDS who confronted, challenged or educated someone who was stigmatizing and/or discriminating them	*Rwanda Stigma Index 2008: 50%*	*No data*	90%

5.2 COMMUNITY-BASED PROGRAM INDICATORS

D9	Number of PLWHA who received secondary support services	*No baseline*	*1,866 received support for income-generating activities* *1,301 received capacity-building trainings;* *4,851 received support to purchase health insurance (mutuelle de santé)* *1,684 received support for food security initiatives*	
D10	Number of associations and cooperatives of PLWHA per district	*No baseline*	*853 associations* *271 cooperatives*	
D11	Number of OVC receiving services as part of the National Minimum Package of services	*No baseline*	*2,756 received health services* *2,616 received nutritional support* *6,103 received educational support* *1,001 received support for shelter* *1,127 received support for*	

	legal and social protection *1,840 received psychosocial support* *2,388 received support for their families/caregivers*	