



FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS (UNGASS)

Final Report

In collaboration with all partners in the fight against HIV/AIDS in Rwanda

COUNTRY REPORTING FORMAT
Reporting period: January 2003 - December 2005
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Foreword

We have made substantial progress in our fight against HIV/AIDS in Rwanda. Of this we can be proud. This success in bringing this issue to the attention of Rwandans at all levels of the society, in mobilising our own resources as well as support from partners, has resulted in demonstrable gains. But HIV/AIDS is not a condition that allows us to rest on our laurels. We have more to do.

First, we must maintain the momentum we have reached, and this will require a stronger fight to consolidate the gains we have made. As with most programmes, the initial energy into a programme can dissipate with time, as fatigue sets in, as an asymptote of returns is reached. We cannot afford to relax, as it will cost us more in the long run – in terms of human lives destroyed, financial capacities eroded, and reduced standard of living. We must therefore ensure a balance across HIV prevention, treatment and mitigation.

Second, we need to build on the excellent collaboration that we have developed with partners. We have achieved so much together, but we have the potential to do even better by being more efficient. In this respect, we will encourage partners to support our national efforts with better alignment and integration of their activities within our vision, which has been developed to combat and minimise the effect of HIV/AIDS within our country context. The lack of harmonisation among partners is one of the barriers we need to overcome, as it dilutes synergies to achieve common objectives.

We are in a new phase of the epidemic, in which we need to recognise that external support cannot continue indefinitely. We must therefore look carefully at sustainability issues in programmes we have initiated with partner support, and continue to further integrate HIV into the broader development framework for poverty reduction.

Finally, in the spirit of ‘three ones for the three big’ campaign, we must improve the link and the synergy found in the response for HIV with other major killing and debilitating diseases, notably malaria and tuberculosis.

« Merci pour le bon travail. La lutte continue, mais ensemble nous ferons de cette épidémie une histoire du passé. »

Commission Nationale de Lutte Contre le SIDA
(National AIDS Control Commission) |
Rwanda

Acknowledgements

This report has been made possible by the strong collaboration between the National AIDS Control Commission (CNLS) and UNAIDS in Rwanda.

Several institutions have been instrumental in collecting, reviewing, analysing and validating the information reported here. All key mandated government authorities and implementing HIV/AIDS programmes have been supportive and forthcoming with information for this reporting exercise done by CNLS: Ministry of Health (TRAC, National Reference Laboratory), Ministry of Finance and Economic Planning (Budget Department, Institute of National Statistics), Ministry of Education, Ministry of Gender and Family Protection and Ministry of Local Affairs. The Central Bureau of Public Expenditure (CEPEX) at the Ministry of Finance and Economic Planning assisted to understand financial flows from other bilateral partners such as DfID, the Belgian Cooperation, France, the German Cooperation, the Italian Government and Lux Development that are centrally reported.

Civil society national umbrella organisations that coordinate efforts of different strategic components: -Umbrella of Network of People Living with HIV/AIDS (RRP+); Forum of Non-government Organisations; Umbrella of Religious and Faith-based organisations and the Umbrella of the Private Sector (APELAS) - participated in an assessment of national efforts to attain the UNGASS goals. The Umbrella for the Public Sector and APELAS provided support to assess the workplace indicator.

Partner institutions that have been working alongside government and support government efforts with human, financial and technical resources were approached for support to understand financial resource flows. While not every single such agency was contacted, the support that partners have been providing to the Rwanda programme is acknowledged here. The support of the United States Government Group (CDC, PEPFAR, USAID), Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM), and the United Nations system (FAO, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WFP, WHO) and the World Bank Multisectoral HIV/AIDS Programme (MAP)- at different stages of data collection is acknowledged.

Special mention and recognition is given here to the work undertaken by the National M&E Technical Working Group, led by CNLS, and the Steering Committee for UNGASS, which provided input at each critical stage of this exercise and to the Consultant who assisted with the indicators, particularly the financial reporting aspect.

This is the third progress report on the 2001 UNGASS promises to fight HIV and AIDS in Rwanda. The first report assessed whether institutional structures have been put in place and the second assessed whether key policies have been put in place. This report provides a complete report of all the 2001 UNGASS promises. It is dedicated to the pioneers who are applying themselves to reduce HIV and AIDS and its effects in Rwanda.

Acronyms

Acronym	Sigle	English	Francais
ADB	BAD	African Development Bank	Banque Africaine de Développement
AIDS	SIDA	Acquired Immuno-Deficiency Syndrome	Syndrome d'Immunodéficience Acquise
ANC	CPN	Ante-natal Care	Consultation PréNatale
ART	ART	Anti-retroviral (Viral) Therapy	<i>Thérapie d'Anti-retroviral</i>
ATRACO	ATRACO	<i>Association of Public Transporters</i>	Association des Transporteurs en Communs
BNR	BNR	National Bank of Rwanda	Banque du Nationale du Rwanda
BRALIRWA	BRALIRWA	Rwanda Breweries	Brasserie et Limonaderie du Rwanda
CAMERWA	CAMERWA	<i>Central Purchasing of Essential Medicines in Rwanda</i>	Centrale d'Achat des Médicaments Essentiels au Rwanda
CARE	CARE	Concerned Americans for Relief Everywhere	Concerned Americans for Relief Everywhere
CDC	CDC	Centers for Disease Control	Centre de contrôle des maladies
CDLS	CDLS	<i>District AIDS Control Commission</i>	Commission de District de Lutte contre le Sida
CEPEX	CEPEX	Central Public Investment and External Finance Bureau	Bureau Centrale des Investissements Publiques et des Finances Externes
CHU/CHK	CHU/CHK	Centre Hospitalier Universitaire/Centre Hospitalier de Kigali	Centre Hospitalier Universitaire/Centre Hospitalier de Kigali
CHUK	CHUK	Centre Hospitalier Universitaire de Kigali	Centre Hospitalier Universitaire de Kigali
CNJR	CNJR	<i>National Youth Council in Rwanda</i>	Conseil National de la Jeunesse du Rwanda
CNLS	CNLS	<i>National AIDS Control Commission</i>	Commission Nationale de Lutte contre le Sida
CPLS/CULS	CPLS/CULS	<i>Provincial / Urban AIDS Control Commission</i>	Commission Provinciale/Urbaine de Lutte contre le Sida
CRIS	CRIS	Country Response Information System	Country Response Information System
CRS	CRS	Catholic Relief Services	Catholic Relief Services
CTS	CTS	<i>Blood Transfusion Centre</i>	Centre de Transfusion Sanguine
DDC	CDC	<i>District Development Committee</i>	Comité de Développement Communautaire
DfID	DfID	Department for International Development (UK)	Département du Royaume Uni pour le développement international
DHS / RDHS	EDS	Demographic and Health Surveys	Enquête Démographique et de Santé
FAO	FAO	Food and Agricultural Organisation	<i>Organisation mondiale pour l'alimentation et l'agriculture</i>
FAWE	FAWE	Forum for African Women Educationalists	
FRw	FRw	Rwandese Francs	Francs Rwandais
FY	FY	Fiscal/Financial Year	Exercice fiscal
GIPA	GIPA	Greater Involvement of People Living with Aids	Greater Involvement of People Living with Aids
GTZ	GTZ	German Technical Cooperation	Agence de coopération technique Allemande
HBC	HBC	Home-based care	<i>Soins ambulatoires</i>
HCR	HCR	United Nations High Commission for Refugees	<i>Haut Commissariat pour les Réfugiés</i>
HIV	VIH	Human Immunodeficiency Virus	Virus d'Immunodéficience Humaine
ICT	ICT	Information and Communication Technology	<i>Technologie de l'information et de la communication</i>
IEC	IEC	Information Education Communication	Information Education Communication
IMPACT	IMPACT	Project Implementing AIDS Prevention and Care	Projet Implementing AIDS Prevention and Care
KAP	CAP	Knowledge, Attitudes and Practices	Connaissances, Attitudes et Pratiques
M&E	S&E	Monitoring and Evaluation	Suivi et Evaluation
MAP	MAP	Multisectoral AIDS Project (World Bank)	<i>Projet multisectoriel du Sida</i>
MIFOTRA	MIFOTRA	<i>Ministry of Public Sector, Professional Training for Jobs and Professions</i>	Ministère de la Fonction publique, de la formation professionnelle, du Travail et des métiers

MIGEPROFE	MIGEPROFE	Ministry of Gender and Family Promotion	Ministère du Genre et de la Promotion de la Famille
MIJESPOC	MIJESPOC	Ministry of Youth, Sports and Culture	Ministère de la Jeunesse, des Sports et de la Culture
MINAGRI	MINAGRI	Ministry of Agriculture, Animal Husbandry and Forestry	Ministère de l'agriculture, de l'élevage et des forêts
MINALOC	MINALOC	Ministry of Local Government, Community Development and Social Affairs	Ministère de l'administration locale, du développement communautaire et des affaires sociales
MINECOFIN	MINECOFIN	Ministry of Finance and Economic Planning	Ministère des Finances et de la Planification Economique
MINEDUC	MINEDUC	Ministry of Education, Science, Technology and Scientific Research	Ministère de l'éducation, science, technologie et recherche scientifique
MINISANTE	MINISANTE	Ministry of Health	Ministère de la Santé
MoU	MoU	Memorandum of Understanding	<i>Memorandum of Understanding</i>
MSF	MSF	Médecins Sans Frontière	Médecins Sans Frontière
MTR	MTR	Joint Mid-Term Review of the National Multisectoral Plan for HIV/AIDS 2002-2006	<i>Revue Conjointe à Mi-Parcours du Plan National Multisectoriel de la réponse au VIH/SIDA 2002-2006</i>
NCDC	NCDC	National Curriculum Development Centre	<i>Centre National du Développement du Curriculum</i>
NGO	ONG	Non-Governmental Organisation	Organisation Non-Gouvernementale
NMP	PNM	National Multisectoral Plan	Plan National Multisectoriel
NRL	LNR	National Reference Laboratory	Laboratoire Nationale de Référence
OAFLA	OPDAS	Organisation of African First Ladies Against HIV/AIDS	Organisation des Premières Dames d'Afrique contre le SIDA
OI	IO	Opportunistic Infection	Infection Opportuniste
OVC	OVC	Orphans and other Vulnerable Children	<i>Orphelins et autres enfants vulnérables</i>
PACFA	PACFA	Protection And Care of Families Against HIV/AIDS	Protection et prise en charge des familles contre le VIH/SIDA
PEPFAR	PEPFAR	President (Bush)'s Emergency Plan For AIDS Relief	<i>Plan d'urgence du Président (Bush) contre le SIDA</i>
PLACE	PLACE	Priorities for Local AIDS Control Efforts	
PLWHA	PVV	People Living With HIV/AIDS	Personnes Vivants avec le VIH
PMTCT	PTME	Prevention of Mother-To-Child Transmission	Prévention de la transmission du VIH de la mère à l'enfant
PNILT	PNILT	National Integrated Programme for the Control of Leprosy and Tuberculosis	Programme National Intégré de Lutte contre la Lèpre et la Tuberculose
PSI	PSI	Population Services International	<i>Population Services International</i>
PSF	PSF	Projet San Fransisco	Projet San Fransisco
RDHS-II, III	RDHS-II, III	Rwanda Demographic and Health Surveys Round II, III	Enquête Démographique et de Santé Rwandaise II, III
Reseau	RRP+	Network of Associations of People Living With HIV/AIDS	Réseau Rwandais des Personnes Vivant avec le VIH/SIDA
SIS	SIS	Health Information System	Système d'Information Sanitaire
STI	IST	Sexually Transmitted Infections	Infections Sexuellement Transmissibles
TB	TB	Tuberculosis	Tuberculose
TRAC	TRAC	Treatment and AIDS Research Center	Centre de traitement et recherche sur le SIDA
TRACNet	TRACNet	Information System for Monitoring HIV/AIDS medical component at TRAC	Système d'Information pour le suivi de composant medical du VIH/SIDA au TRAC
TWG	TWG	Technical Working Group	<i>Groupe de Travail Technique</i>
UN	NU	United Nations	Nations Unies
UNAIDS	ONUSIDA	Joint United Nations Programme on HIV/AIDS	Programme commun des Nations Unies sur le VIH/SIDA
UNDP	PNUD	United Nations Development Programme	Programme des Nations Unies pour le Développement

UNFPA	FNUAP	United Nations Fund for Population Activities	Fonds des Nations Unies pour la population
UNGASS	UNGASS	United Nations General Assembly Special Session on HIV/AIDS	Session extraordinaire de l'Assemblée générale des Nations Unies sur le VIH/SIDA
UNICEF	UNICEF	United Nations Children's Fund	Fonds des Nations Unies pour l'enfance
UNIFEM	UNIFEM	Organisation des Nations Unies pour la femme	Organisation des Nations Unies pour la femme
USAID	USAID	United States Agency for International Development	Agence des Etats Unis pour le développement international
USD	USD	United States Dollars	Dollars américains
USG	USG	United States Government	Gouvernement des Etats Unis
VCT	VCT	Voluntary Counselling and Testing	Dépistage et conseil volontaires
VCTI	VCTI	Integrated Voluntary Counselling and Testing	Dépistage et conseil volontaires (Intégré)
WFP	PAM	World Food Programme	Programme Alimentaire Mondial
WHO	OMS	World Health Organisation	Organisation Mondiale de la Santé

I. STATUS AT A GLANCE

Table 1.

(see Table 2 for detailed definitions)		2003	2004	2005	Source
National Commitment and Action indicators					
1	Actual Expenditure, Total 2003-2005 (US\$ millions)	7.7	40.3	78.5	2003: MTR. 2004-2005: various.
	Government Expenditure 2003-2005 (US\$ millions)	1.3	2.7	1.7	Budget Dept, MINECOFIN
2	Government policies	OVC drafted	OVC; ARV	National HIV/AIDS Policy; Workplace; Condom;	CNLS, MIGEPROFE
3	Life skills education in schools	See text	See text	See text	MINEDUC 27.12 /UNICEF
4	Work place policy (workers benefiting)	2000 public servants 45% large enterprises (>45 employees) have a policy	+490 targeted in private sector	+2660 targeted in private sector National policy available	CNLS 2003. WHO 2004, CNLS MTR 2005, MIFOTRA
5	STI (15-49) (percent seeking and getting care)	Total: 32 Female:27/ Male: 36	Total: 32 Female:27 / Male: 36	Total: 50 Female:49 / Male: 52	RDHS-II 2000, RDHS-III 2005
6	MTCT: ARV prophylaxis (percent mothers getting)	14.2%	20.1%	27.8%	MTR, UNGASS, TRAC 2005
7	HIV treatment: ART (number of patients)	4,189	8,355	19,058	2005: end Dec05, TRAC

8	School children affected	See text	See text	See text	
9	Blood safety (percent of transfused blood screened)	100	100	100	CTS
9.1	Number of quality control of PMTCT, VCT tests done	15,000	34,000	64,000	Nat'l Ref. Lab, UNGASS 2005

Knowledge and Behaviour indicators

10	Young knowledge on prevention (15-24)	Total: 22 Female:23 / Male: 20	Total: 22 Female:23 / Male: 20	Total: 52 Female:51 / Male: 54	RDHS-II 2000, RDHS-III 2005
11	Sex before age 15 (percent among 15-24)	Total: Female:/Male:	Total: Female:	Total: 6.6 Female:4.0 /Male: 13.1	RDHS-II 2000, RDHS-III 2005
12	Higher risk sex among young (15-24)	Total: 26 Female:10 / Male: 42	Total: 26 Female:10 / Male: 42	Total: 22 Female:15 / Male: 48	RDHS-II 2000, RDHS-III 2005
13	Young women and men's condom use (15-24)	Total: 39 Female:23 / Male: 55	Total: 39 Female:23 / Male: 55	Total: 30 Female:26 / Male: 41	RDHS-II 2000, Preliminary report of RDHS-III, 2005
14	Orphans' school attendance (10-14)	Total: 0.93 Female:0.94/ Male:0.91	Total: 0.93 Female:0.94/ Male:0.91	Expected March 2006	RDHS-II 2000, RDHS-III 2005

Impact indicators					
15	Reduction in prevalence (15-24)	Total: 1.5 Female: 2.5 /Male: 0.5	Prelim report, RDHS-III. 2005
15.1	Prevalence (15-49)	5.1	Rural: 2-4 Urban:7-11 [Total:5.3]	Rural: 2.2 Urban: 7.6 Total: 3.0 (CI 2.6-3.4)	2003: UNAIDS 2004: TRAC; [UNGASS] 2005: RDHS-III.
16	HIV treatment: survival	Not available	Not available	Not available	
17	Reduction in MTCT (see Table 2 for definition)	23.26	22.48	21.52	UNAIDS (base: TRAC PMTCT data)
	Percent infants+ born to mothers+	9.5	9.9	11.0	TRAC sentinel surveillance

Table 2. UNGASS indicators and definitions

Indicator		Standard Definition	Numerator	Denominator
National Commitment and Action indicators				
1	Actual Expenditure 2003-2005	<i>Amount of national funds disbursed by governments in low- and middle-income countries</i>	<i>Assessment of financial expenditure using either</i> 1. <i>National AIDS Accounts in the context of National Health Accounts.</i> 2. <i>Stand-alone National AIDS Accounts.</i>	
2	Government policies	<i>National Composite Policy Index Areas covered: prevention, care and support, human rights, civil society involvement, and monitoring and evaluation Target groups: people living with HIV and AIDS, women, youth, orphans, and most-at-risk populations</i>	<i>Assessment of progress in the development and implementation of national-level HIV/AIDS policies and strategies (use National Composite Index Questionnaires in focus group discussions)</i>	
3	Life skills education in schools	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	Number of schools with staff members trained in and regularly teaching life-skills-based HIV education	Number of schools surveyed.
4	Work place policy	Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes	Number of employers with HIV/AIDS policies and programmes that meet all of the above criteria.	Number of employers surveyed.
5	STI (15-49)	Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled	1. The number of respondents who reported symptoms suggestive of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care. [from a clinic, hospital, or private doctor; not personnel specifically trained in STI care]	Total number of respondents who reported symptoms suggestive of STIs in the last 12 months.
6	MTCT: ARV prophylaxis	Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Number of HIV+ pregnant women provided with ARV therapy to reduce the risk of MTCT in the last month	Number of women who gave birth in the last 12 months

	Indicator	Standard Definition	Numerator	Denominator
7	HIV treatment: ART	Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	Number of people with advanced HIV infection who receive antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards); it is calculated as follows: number of people receiving treatment at the start of the year, plus number of people who commenced treatment in the preceding 12 months, minus number of people for whom treatment was terminated in the preceding 12 months (including those who died).	Number of people with known advanced HIV infection (i.e. those in need of antiretroviral combination therapy)
8	School children affected	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Number of orphaned and vulnerable children who live in households that answered YES to at least one of questions 1, 2, 3 and 4. 1. Has this household received medical support, including medical care and/or medical care supplies, within the last 12 months? 2. Has this household received school-related assistance, including school fees, within the last 12 months? 3. Has this household received emotional/psychological support, including counselling from a trained counsellor and/or emotional/spiritual support/companionship, within the last three months? 4. Has this household received other social support, including socioeconomic support (e.g., clothing, extra food, financial support, shelter) and/or instrumental support (e.g., help with household work, training for caregiver, childcare, legal services) within the last three months?	Total number of orphaned and vulnerable children.

	Indicator	Standard Definition	Numerator	Denominator
9	Blood safety	Percentage of transfused blood units screened for HIV	Number of blood units screened for HIV in the last 12 months up to WHO or national standards.	Number of blood units transfused in the last 12 months.
10	Young knowledge on prevention (15-24)	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (Target: 90% by 2005; 95% by 2010)	Number of respondents who, in response to prompting, 1) correctly identify using condoms and having sex only with one faithful, uninfected partner[uninfected not specified] as means of protection against HIV infection and 2) who correctly reject the two most common local misconceptions about AIDS transmission or prevention[mosquitoes][sharing food] and 3) who correctly respond that a person who looks healthy may pass on HIV.	Total number of respondents age 15-24 years.
11	Percentage of young women and men who have had sex before the age of 15.		Number of respondents (aged 15–24 years) who report their age at sexual initiation as under 15 years.	Number of respondents aged 15–24 years.
11.1	Median age at first sex among young (15-24)			
12	Higher risk sex among young (15-24)	** Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	Number of respondents aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months.	Number of respondents aged 15–24 who report sexual activity in the last 12 months.
13	Young women and men's condom use (15-24)	** Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	Number of the respondents (aged 15–24) who reported having had a non-regular (i.e., non-marital and non-cohabiting) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner.	Number of respondents (15–24) who reported having had a non-regular sexual partner in the last 12 months
14	Orphans' school attendance	** Ratio of current school attendance among orphans to that among non-orphans, aged 10–14	1. Number of children who have lost both parents and are still in school. 2. Number of children, both of whose parents are still alive, who live with at least one parent and who are still in school.	1. Number of children who have lost both parents. 2. Number of children both of whose parents are still alive and who live with at least one parent.

Impact indicators				
	Indicator	Standard Definition	Numerator	Denominator
15	Reduction in prevalence (15-24)	**Percentage of young women and men aged 15–24 who are HIV infected (Target: 25% in most-affected countries by 2005; 25% reduction globally by 2010)	Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive	Number of antenatal clinic attendees (15–24) tested for their HIV infection status
16	HIV treatment: survival	Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	Number of adults and children continuously on antiretroviral therapy at 12 months after initiating treatment.	(a) Minimum survival: Total number of adults and children who initiated antiretroviral therapy in the therapy start-up group 12 months earlier, including those who have stopped antiretroviral therapy, those who have transferred out, and people lost to follow-up. (b) Maximum survival: Total number of adults and children who initiated antiretroviral therapy in the therapy start-up group 12 months earlier, excluding those who have stopped antiretroviral therapy, those who have transferred out, and people lost to follow-up.
17	Reduction in MTCT	Percentage of infants born to HIV infected mothers who are infected (Target: 20% reduction by 2005; 50% reduction by 2010)	weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving antiretroviral; the weights being the proportions of women receiving and not receiving antiretroviral, respectively. Expressed as a simple mathematical formula: Indicator score = $\{ T*(1-e) + (1-T) \} * v$	where: T = proportion of HIV-positive pregnant women provided with antiretroviral treatment v = mother-to-child transmission rate in the absence of any treatment e = efficacy of treatment provided T is simply national indicator #6. Default values of 25% and 50%, respectively, can be used for v and e. However, where scientific estimates of the efficacy of the specific forms of antiretroviral treatment (e.g., nevirapine) used in the country are available, these can be used in applying the formula. When this is done, the values of these estimates should be recorded.

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC

Prevalence: The most recent finding on HIV/AIDS prevalence is from the Rwanda Demographic and Health Survey (RDHS-III) of 2005, which provided an observed adult prevalence rate of 3.0 (95% CI 2.6 - 3.4) percent nationally, with marked variations between the sexes (2.3 males, 3.6 females) and by residence (2.2 rural, 7.6 urban).

In 2001, sentinel surveillance of women in antenatal care established prevalence rates of 13.5 percent from mostly urban sites. When adjusted for national representation, UNAIDS provided an estimate of 5.1 percent (CI 3.4 – 7.6) in 2003.

In 2004, the sentinel surveillance reported prevalence rates of 2-4% in rural areas and 7-11% in urban areas in 2004. These figures have been validated by the DHS 2005 (RDHS-III) results of 2.2 percent in rural areas and 7.3 percent in urban areas.

The Government of Rwanda plans, with partners, to provide a summary estimate that uses the different sources of information available and minimises typical biases of each of the different data sources. With this in mind, the Treatment Research and AIDS Centre (TRAC) and the National Institute of Statistics, in collaboration with key partners, will make estimates combining these different sources which will be presented prior to June 2006.

Trend: Published prevalence reports from different sources could suggest a decline in adult HIV prevalence. This apparent decline needs to be interpreted with caution, because there have been improvements in both measurement and estimation methods. The RDHS-III, for example, was nationally representative. Sentinel surveillance, however, relied more on data from urban and semi-urban sites in the late 1990s, but since 2002, has improved national coverage. Trend data from sentinel surveillance indicates a generally decreasing trend in prevalence from 1998 to 2003 especially among the urban sites (TRAC Sentinel Surveillance reports 2002, 2003). The 2004 TRAC sentinel surveillance report argues that a reduction in prevalence is debatable, however there is no evidence from all available sources to suggest that HIV incidence is increasing. UNAIDS models (EPP and Spectrum) have been refined in recent years, so UNAIDS reported rates of 12.8 percent in 1998 and 5.1 percent in 2004 have to be interpreted in light of the advances in measurement and estimation. In 2006, Rwanda will further improve its surveillance of the HIV epidemic by introducing new testing methods that will give an idea about the number of *recent* infections, especially among 15-24 year olds and primiparous women.

Geographic distribution: Although the HIV rates in rural area are clearly lower than in the urban area, Rwanda is a small country where movement is quite easy, and the country is therefore at risk of experiencing continued increase in prevalence amongst the 83% of the population that lives in rural areas from the ease of interaction between rural and urban populations. It is therefore necessary to continue to reinforce prevention, continuous and extended treatments efforts aimed at the urban as well as the rural populations.

Gender difference:

Fig. 1: Prevalence of HIV/AIDS by residence

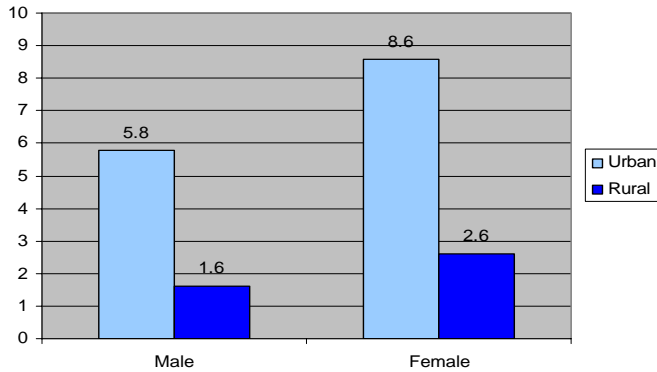
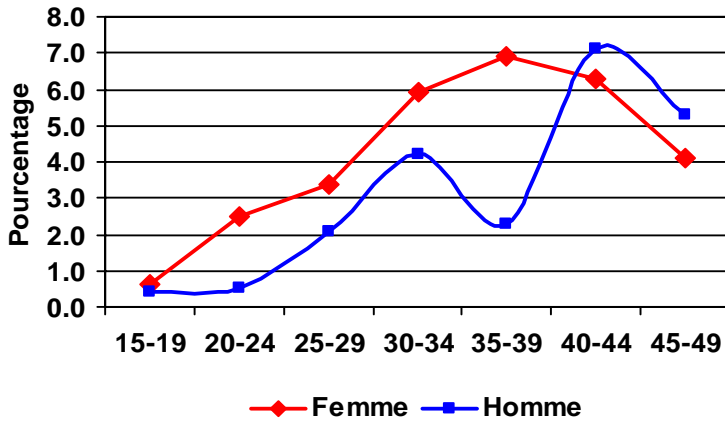


Figure 1 from the RDHS-III, 2005 shows that women are about 1.5 times more infected than males, with marked urban/rural differences.

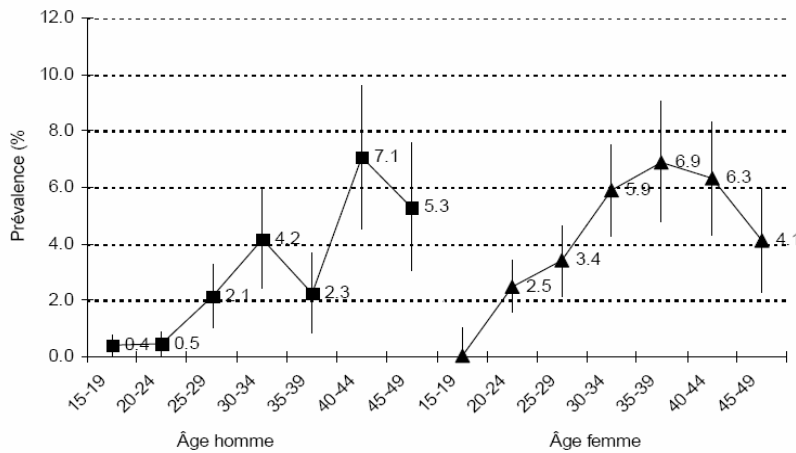
Age difference: Figure 2 below shows the expected general trend of increasing prevalence by age and gender. The low prevalence observed among males 35-39 years old is not fully understood yet.

Fig. 2: Prevalence of HIV/AIDS by quintile age group



The RDHS-III results in Figure 2 are shows that men have lower prevalence rates rising in parallel until age 30-34. The low rate among men aged 35-39 is not explained yet. Women have the highest rates among 35-39 year olds. For men, the observed peak is among 40-44 year old men.

Figure 3. Prevalence of HIV by age and sex, with 95% confidence limits



Source: RDHS-III, Preliminary Report. 2005.

High risk groups: A recent PLACE¹ study (2005) of high transmission foci throughout the country shows that age of sex debut is less than 20 years, with important urban-rural differences in the selected sites. For youth aged 15-19, 57 percent males and 60 percent females in urban areas started sexual relations, compared with 44 percent males and 47 percent females in rural sites studied. Likewise, use of condom is still low. During the last sexual intercourse, 75 percent males and 71 percent females in urban areas reported condom use, compared to 21 percent males and 13 percent females in rural sites. Quantitative information about other high risk groups such as refugees and prisoners are not readily available.

III. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

Since 2003, Rwanda has made significant progress in revising strategies to fight HIV/AIDS. The national response is characterized by a multisectoral, multidisciplinary, decentralized and community-based approach. Multiple coordinating bodies have been created in the past three years at national and decentralized levels. To better monitor the effectiveness of these structures, measures to operationalise and harmonize standard operating procedures have been put in place, e.g. mapping of activities of all implementing agencies, who now sign memoranda of understanding (MoU) with the National AIDS Control Commission (CNLS). The Commission is currently finalizing a guiding document on coordination mechanisms in the country.

At the end of 2004, the National AIDS Control Commission (CNLS) in collaboration with partners conducted a joint mid-term review of the Multisectoral National Plan which was planned to be implemented within the programme cycle 2002-2006. The review came out with important recommendations for programmatic change, which resulted in the revision of the National Strategic Framework and the development of the National Policy on HIV/AIDS. Both documents were finalised at the end of 2005 and are now awaiting legislative adoption.

Policy developments: Several key policy statements have been developed and clarified, particularly involving new aspects of the epidemic after the multisectoral national plan 2002-2006 was made. Key policy statements have been developed for OVC (2003-4), for ARV (2004), for HIV/AIDS in the workplace, and for condoms (2005). In addition, a national HIV/AIDS policy document encompassing all policies was drafted in 2005.

The OVC policy defines mechanisms for socio-economic support of the estimated 1,264,000 children below 18 identified in the 2002 General Population Census² as orphans. This estimate represents about 30 percent of children, one of the highest in the world. The breakdown by type is as follows:

- Maternal orphans:	170,000
- Paternal orphans:	799,000
- Double orphans:	183,000
- Don't know ³	112,000

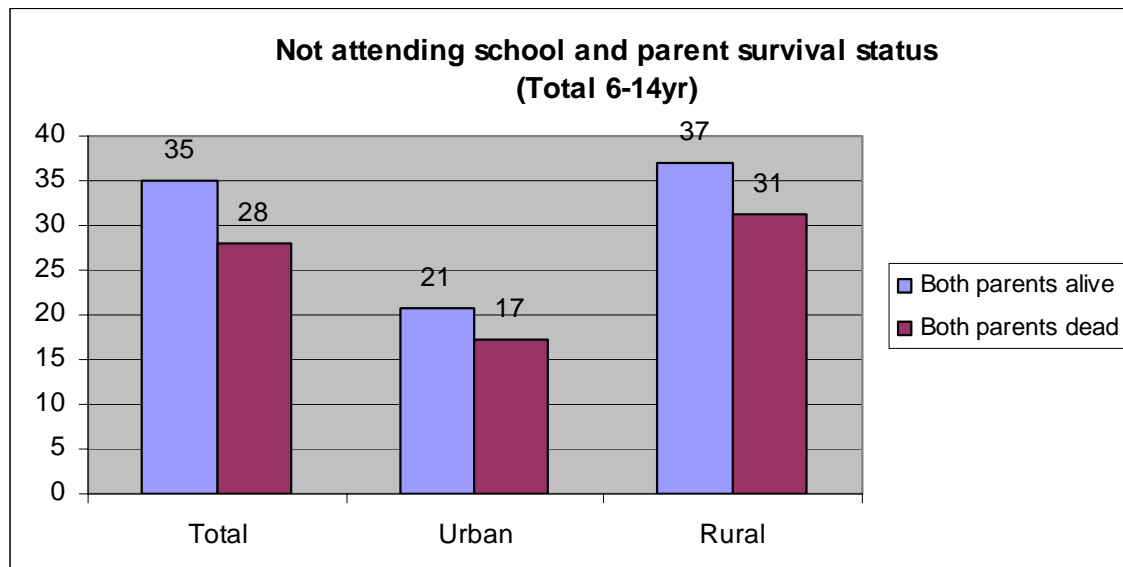
¹ Priorities for Local AIDS Control Efforts. This is a study that uses foci of high transmission points to assess behaviour that favours transmission of HIV/AIDS and allows local decisions on action to take.

² According to *Children on the Brink, 2004*, there are 810,000 orphans below 18, but in the country the figure used is that of the Census.

³ Children under the "Don't know" category are included as orphans. It may be that some of them are not technically orphans, but in practice they are living as such.

An analysis of the breakdown of children of primary school going age shows that while there are differences between urban and rural children, double orphans are no more likely than children with both parents alive to miss out on primary schooling (see Fig 4 below). This is presumed to be the effect of government policy on free access to primary education. At higher levels of education, the State provides for orphans of the genocide, who include some AIDS orphans.

Figure 4



Source: General census 2002 data.

The ARV policy developed in 2004 was in the form of a Ministerial Decree allowing vulnerable people free access to ARV, and payment for ARV on a sliding scale depending on family resources. This Decree followed successful negotiations between Government and pharmaceutical companies to reduce the cost of ARV from approximately \$400 to \$100 in 2003 alongside global advocacy efforts by UNAIDS and Clinton Foundation in particular. In 2003, the average monthly cost of ARV at the Kigali University Referral Hospital (CHUK) reduced further from 34,000 FRw (\$63) to 10,000 FRw (\$18) per month⁴.

In 2005, a National HIV policy document has been compiled after review of existing policies. Two key policies were developed: HIV/AIDS in the workplace and a condom policy. The workplace policy outlines access of employees to care and support (including ARVs) and the conduct of employers vis-à-vis employees that are HIV positive. This policy will be debated in 2006 by Government and others, notably trade unions, but is expected to be adopted. Evidence from the private sector shows that more employees are being targeted for ARV access. In 2004, 490 employees were targeted. This figure rose to 2660 in 2005.⁵ All workers are covered by a law on Social Security (for recruitment and social benefits), and each Government Ministry has an HIV/AIDS Focal Point attached to promote integration of HIV/AIDS within the Ministry. A key informant interview of seven of the largest employers revealed that all are making efforts to address HIV/AIDS in the workplace, though it is difficult to quantify at the current time, how many workers are actually benefiting from ongoing efforts.

⁴ MTR 2004.

⁵ MIFOTRA 2005 report

The condom policy defined Government position for equity of access, market approach, integration of a reproductive health package. Access to condoms has not been ideal, given different strategies for prevention measures supported by different stakeholders and partners. Faith-based organizations do not promote condom use among youth, on moral grounds. This is given currency by conditions attached to funds from key partners, notably under PEPFAR. The faith-based organizations have agreed with Government that they will take a neutral stance with respect to condoms – neither promoting nor dissuading promotion of condoms.

Rwanda has been successful in raising funds to implement programmes to fight HIV/AIDS. This is largely a result of high level commitment on the part of the government. In the last UNGASS report, it was estimated that from a base of 6.7 million USD in 2002, a total of 102 million USD was *mobilised* for 2003 and 2004. Table 3 below is indicative of the *expenditure* patterns from 2003 to 2005. In 2003, government accounts report that 7.7 million USD was spent by institutions and from major funding partners on HIV/AIDS programmes. For 2004, reports from central government accounts and directly obtained from funding agencies, showed a total of 40.3 million USD spent. The expenditure nearly doubled in 2005, to 78.5 million USD. For both 2004 and 2005, the increase in expenditure was due to intensive efforts by the main partners (PEPFAR, Global Fund, World Bank-MAP and the UN System).

Table 3. Indicative expenditure in the HIV/AIDS sector, USD, 2003-2005.

INSTITUTIONS	2003	2004	2005
	US Dollars	US Dollars	US Dollars
Government spending	1,324,112	2,733,159	1,705,474
USA - PEPFAR		15,696,394	46,817,474
Global Fund	932,160	6,452,330	7,597,300
World Bank / MAP	767,040	5,122,799	9,960,387
UN System:	555,073	4,259,113	7,772,545
CNLS/UNDP PROJECT	234,473	392,907	414,595
UNICEF		999,473	1,329,261
WFP		2,216,733	4,427,658
UNFPA	320,600	480,500	702,500
WHO		431,250	431,250
Other UN		169,500	467,282
Bi / Multilateral donor support:	4,130,000	5,590,000	4,690,000
Belgium	490,000	580,000	660,000
France	0	810,000	630,000
Italy	280,000	0	0
Germany	1,020,000	1,080,000	0
United Kingdom	2,340,000	2,350,000	2,810,000
African Development Bank/ADB	0	770,000	590,000
TOTAL	7,708,385	40,285,045	78,543,180

SOURCE: Direct reports for Government expenditure from CEPEX/ Budget Department in the Ministry of Finance and Economic Planning. Direct reports from MAP, Global Fund, CNLS/UNDP, PEPFAR, UN Agencies and Government. Remaining from CEPEX Donor Matrix reports

Notes on methodology and interpretation of financial reports in Tables 3-6:

Financial reports have been obtained directly for Government expenditures recorded at the Central Public Investment and External Finance Bureau (CEPEX) in the Ministry of Finance and Economic Planning for the specified calendar years. Expenditures from the largest funding partners (PEPFAR, MAP and Global Fund) have also been directly obtained from these agencies for calendar years specified. Costs have been allocated to the framework of the National AIDS Spending Accounts to the best of the ability of reporting officers and through consensus. Some agencies working in broad areas that are cross-cutting in objective found it difficult to assign their activities to the narrowly defined functional areas. With improved frameworks of reporting, this will become easier to do.

Caveats:

Government expenditure does not include operational costs for health facilities.

Expenditures have not been uniformly reported. PEPFAR funding report includes technical assistance, both “short” and “long-term,” and costs out-of-country; other bi-lateral and multilateral assistance is what goes through the national accounts.

Terms as they have been used:

“Allocation” applies to funds that have been earmarked and blocked from funding sources to be used for specific activities within a specified time frame.

“Burn rate” applies to the proportion of budget disbursed that is actually spent (with receipts).

“Committed” may have been used interchangeably with “allocation.”

“Disbursement” applies to funds that have been paid into accounts to be ready for payment of costs related to implementation.

“Expenditure” applies to funds that have been paid out for service delivery.

Table 4. Expenditures on HIV/AIDS, by origin of financing agent, in US Dollars, 2003

REPORTING TO UNGASS
 DECEMBER, 31, 2005
Expenditure on HIV and AIDS
2003

MANDATORY (as agreed in the UNGASS DoC)
RECOMMENDED (Components of the total figure to be reported)
OPTIONAL

Functions	ORIGIN OF THE SOURCES by FINANCING AGENT									
	PUBLIC				INTERNATIONAL					
	Total USD \$	Central (National)	Sub- national	Development Bank Reimbursable	Other bilateral agencies	USA-PEPFAR	Multilaterals			Development Banks Grants (non- reimbursable)
UNDP/CNLS +UNFPA							MAP	Global Fund		
TOTAL	7,708,385	1,324,112			4,130,000		555,073	767,040	932,160	
1. Prevention	752,266	0					320,600	347,266	84,400	
2. Care and Treatment	1,161,948	754,249						196,558	211,141	
3. Orphans and Vulnerable children	0									
4. Program Management costs	1,259,377	462,360					89,015	223,216	484,786	
5. Incentives for Human Resources	0									
6. Social Mitigation	151,833								151,833	
7. Community development and enhanced environment	28,871						28,871			
8. Research (not operations)*	107,503	107,503								
9. Other country defined activities Not Elsewhere Classified	116,587						116,587			

Table 5. Expenditures on HIV/AIDS, by origin of financing agent, in US Dollars, 2004

REPORTING TO UNGASS
 DECEMBER, 31, 2005
Expenditure on HIV and AIDS
2004

MANDATORY (as agreed in the UNGASS DoC)
RECOMMENDED (Components of the total figure to be reported)
OPTIONAL

Functions	ORIGIN OF THE SOURCES by FINANCING AGENT									
	PUBLIC				INTERNATIONAL					
	Total USD \$	Central (National)	Sub- national	Development Bank Reimbursable	Other bilateral agencies	USA-PEPFAR	Multilaterals			
UN Agencies							MAP	Global Fund	Development Banks Grants (non- reimbursable)	
TOTAL	40,285,044	2,733,159			5,590,000	15,696,394	4,690,363	5,122,799	6,452,330	
1. Prevention	3,643,595						1,043,436	1,697,763	902,396	
2. Care and Treatment	5,121,825						85,761	2,616,756	2,419,308	
3. Orphans and Vulnerable children	584,421						584,421			
4. Program Management costs	6,496,426	2,733,159					579,321	808,280	2,375,666	
5. Incentives for Human Resources	0									
6. Social Mitigation	2,971,693						2,216,733		754,960	
7. Community development and enhanced environment	156,691						156,691			
8. Research (not operations)*	24,000						24,000			
9. Other country defined activities Not Elsewhere Classified	0						0.00			

Table 6. Expenditures on HIV/AIDS, by origin of financing agent, in US Dollars, 2005

REPORTING TO UNGASS
 DECEMBER, 31, 2005
Expenditure on HIV and AIDS
2005

MANDATORY (as agreed in the UNGASS DoC)
RECOMMENDED (Components of the total figure to be reported)
OPTIONAL

Functions	ORIGIN OF THE SOURCES by FINANCING AGENT								
	PUBLIC				INTERNATIONAL				
	Total USD \$	Central (National)	Sub national	development bank and reimbursement	Bilaterals		Multilaterals		
Other Bilateral Agencies					USA-PEPFAR	UN Agencies	MAP	Global Fund	
TOTAL	78,543,179	1,705,474			4,690,000	46,817,474	7,772,545	9,960,386	7,597,300
1. Prevention	14,244,002	0				11,003,542	1,227,089	1,335,852	677,519
2. Care and Treatment	30,456,403	1,058,775				20,874,493	302,663.31	5,357,445	2,863,026
3. Orphans and Vulnerable children	5,471,014					2,963,712	490,393.74	2,016,908	
4. Program Management costs	19,140,385	642,219				11,975,727	1,215,503.96	1,250,181	4,056,755
5. Incentives for Human Resources	0								
6. Social Mitigation	4,427,658						4,427,658.00		
7. Community development and enhanced	109,237						109,236.65		
8. Research (not operations)*	4,480	4,480							
9. Other country defined activities Not Elsewhere							0.00		

The pie charts below show the proportional allocation of funds that partners reported that they had expended for the HIV/AIDS sector in 2004 and 2005.

Figure 5.

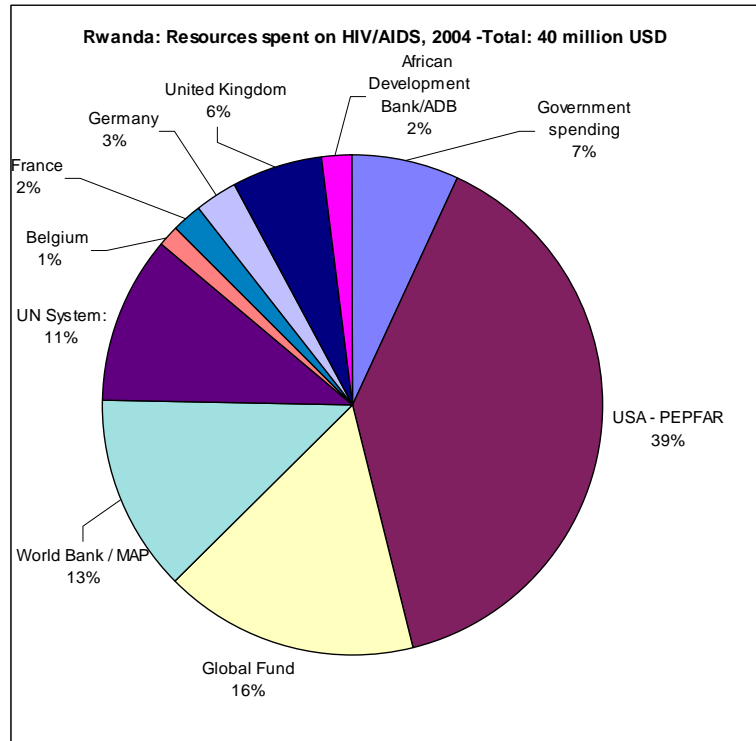
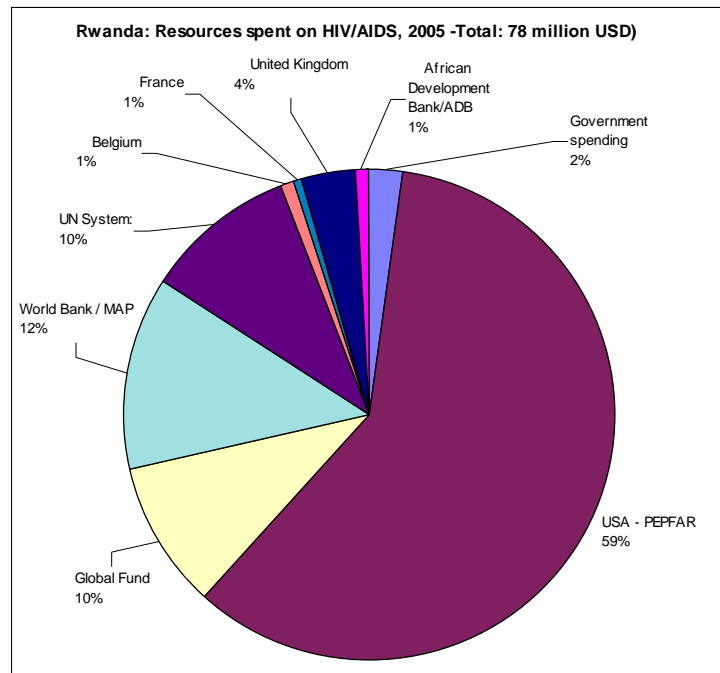


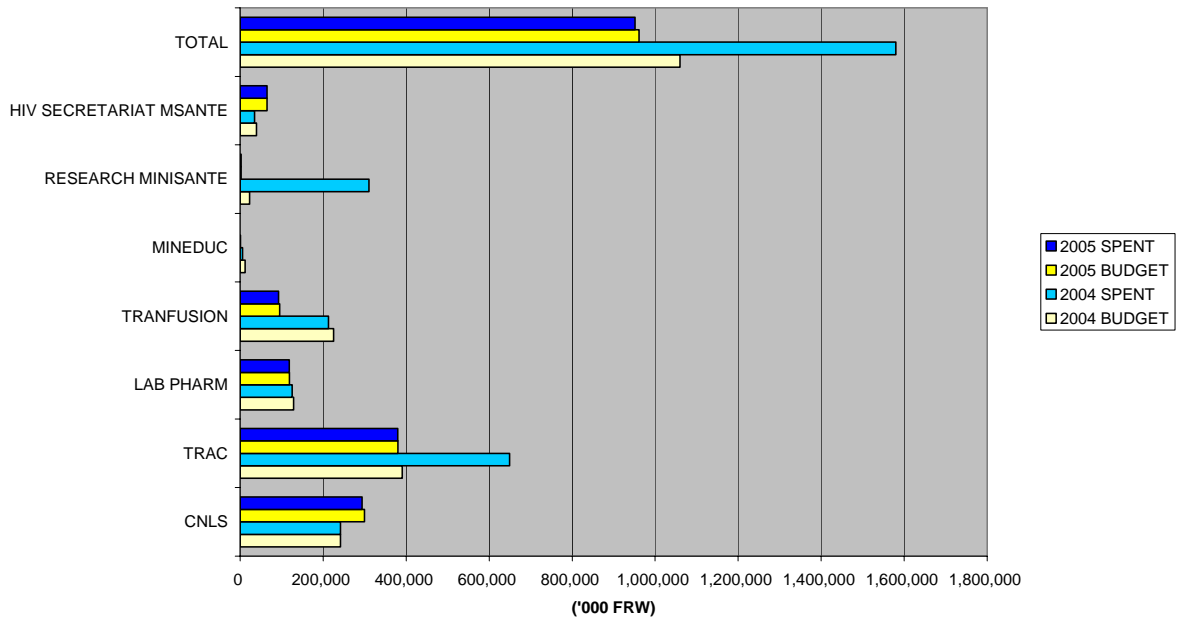
Figure 6.



Note: Bilateral funds reported here are from CEPEX Donor Matrix reports. All other funds have been reported directly by the agencies represented

Figure 7.

Government Institution Expenditures, 2004-2005



Note: operational cost of health facilities are not included in the Government expenditures reported.

Other important institutional and contextual changes occurred in 2005. The Government has taken decisive measures to improve service delivery to Rwandans. The hitherto top-heavy bureaucratic structures on government have now been replaced with a shift of human resources to newly reorganised and consolidated districts. The old structures have now been replaced with 4 provinces (East, West, North and South) and Kigali Municipality, and 30 districts which have direct reporting lines to the central level. CNLS is now decentralised to these 30 districts. CNLS and the umbrella organisations will now focus more on coordination and less on implementation, and are assisting to clarify the role of partners. CNLS itself underwent a reorganisation in the first half of the year, and cost-saving measures were taken without overlooking efficiency.

The national response to the epidemic is reflected in five strategic components of the National Strategic Framework (NSF). These are: (1) strengthening preventive measures against HIV/AIDS transmission; (2) Assuring that the national response to HIV/AIDS is adapted to Rwanda’s evolving socio-economic and health conditions by using surveillance and research results; (3) Improving HIV/AIDS-related treatment for persons infected and affected by HIV/AIDS; (4) Reducing the detrimental affects of HIV/AIDS on national (micro/macro) socio-economic conditions and (5) Coordination of the Multi-sector response for increased cost-effectiveness.⁶

⁶ The wording used to describe the strategic axes is as has been proposed in the revised strategic framework 2005-2009 plan that is yet to be officially adopted. However, the strategic axes maintain the same general orientation.

Prevention

The first National Strategic Framework of 2002-2006, the prevention strategy focused on eight areas: promoting low-risk behaviour through IEC and BCC; promoting VCT and prompt treatment of STIs and TB; promotion of voluntary and confidential counselling and testing; prevention of accidental transmission; promotion of condom use; promotion of blood safety in transfusions; prevention of mother-to-child transmission and promotion of transregional interventions to prevent cross-border transmission.

In 2005, a National Prevention Plan 2005-2009 has been elaborated. This Plan seeks to prevent the spread of HIV/AIDS through four main strategies: behaviour change among targeted groups; behaviour change among health care providers; medical prophylaxis, and an enabling cultural environment. In particular, there is greater attention to youth, to individual responsibility to break the chain of transmission, and to quality and equity in health care delivery. This Plan will be revised in 2006 to be adapted to the current national and global realities.

Prevention among Youth

There is high level commitment and support for youth programmes in Rwanda. More emphasis is being placed on youth because 67 percent of the population is aged below 24 years. There are an estimated 1,250,000 orphans and vulnerable children aged below 18 years (Census 2002). Comprehensive knowledge about prevention of HIV/AIDS has improved among youth aged 15-24. In 2000, 22 percent of youth had comprehensive knowledge⁷ about transmission of HIV (23 percent among females and 20 percent among males). In 2005, this level of knowledge has increased to 52 percent (51 percent among females and 54 percent among males).

A UNICEF and CARE International Knowledge, Attitudes and Practices (KAP) study in 2002⁸ on a sample of 726 people (teachers in primary school and teacher-training centres, the girls and boys at school, the parents and headmasters of school centres) from 5 provinces (Butare, Kibuye, Ruhengeri, Umutara, and Kigali) . The study found that: most of the cultural practices that could have a positive influence in the fight against HIV/AIDS were mentioned by interviewees. However, many teachers lacked elementary knowledge of HIV/AIDS issues in Rwanda. More than 80% admitted to be asked questions, in their work as teachers, they were not able to answer; more than 10% of teachers had false or erroneous information regarding HIV transmission modes and prevention; HIV/AIDS was not part of the curricula but many teachers told pupils about it; most people interviewed (63.1%) were against teaching about the condom in primary school; and more than 20% of teachers still stigmatized PLWHA.

Life skills for the youth: The national response was to address issues in HIV/AIDS and gender education and allow the voices of the young to be heard, especially through communication materials and peer education programmes. In schools, anti-AIDS programmes (trainer of trainers in 16 schools were carried out). In 2003, the government, with support from UNICEF, trained 60 people from teacher training colleges and the National Curriculum Development Centre (NCDC). A civic education manual was developed for Rwanda primary schools, which included a module on HIV/AIDS.

⁷ The number of respondents age 15-24 years. who, in response to prompting, 1) correctly identify using condoms and having sex only with one faithful uninfected partner as means of protection against HIV infection and 2) who correctly reject the two most common misconceptions

⁸ "Life skills, gender, sexuality and HIV/AIDS in education", UNICEF and CARE International. 2002

In 2004, 10,000 copies of the first teacher’s guide for civic education (for grades 4-6) were printed and distributed nationwide in both English and French.

A review of the national primary school curriculum was started in 2005, to integrate HIV programmes to include more on anti-AIDS clubs and other youth organised activities. These activities are reflected in the increased indicative budget of 2004-2005 from \$77,000 in 2004 to \$155,000 in 2005 by UNICEF alone.

Prevention through Individual Responsibility: the Individual

In 2005, Rwanda national AIDS campaign message under the global theme to Stop AIDS: keep the promise, was “individual responsibility to break the chain of transmission.” These individual responsibilities revolve around knowing one’s status, and having the necessary knowledge and capacity to take appropriate action to prevent the spread of HIV/AIDS.

Counselling and testing: The evolution of VCT sites has been remarkable (150,000 in 2003, 340,000 in 2004 and 640,000 in 2005) and may be found throughout the country. The response to accepting HIV testing is high, following a high demand. At the moment, 100 percent of all the pregnant women who attend ANC clinics are tested. Greater attention is being put to promoting HIV testing among the youth, among couples, and for families to have access to family planning options to suit the family context.

World AIDS Day messages since 2003 have promoted VCT with increasing importance. In 2003, a national campaign against stigma advocated for VCT as a tool to the reduce fear of knowing one’s status; in 2004, VCT was promoted as a means to access drugs, and in 2005 as a means for individual responsibility to break the chain of transmission. In the just-concluded RDHS-III which included testing for HIV, out of 5,837 women and 4,548 men sampled, 97 percent of the women and 95 percent of the men voluntarily agreed to give blood samples. The availability of services has been the main contributory factors for this development. However, the demand for testing has still to be matched with an increase in the quality and number of human resources who provide care and treatment.

Treatment of sexually transmitted diseases: To reduce the risk of HIV transmission, it is important to treat and contain the spread of sexually transmitted infections. Between 2003 and 2005, the reported number of STI cases has increased (see Table 7). There are modest increases among all the STIs reported here, but not to the extent of increased reporting observed for HIV/AIDS. The observed increase for HIV/AIDS may be due to several factors: real increase in availability of services, increased reporting, increased demand for accountability or demonstration of results in the HIV/AIDS sector given the large resource in-flows, among others.

Table 7. Reported sexually transmitted diseases from 2002-2004

	2002	2003	2004
Conjunctivitis (gonococcal)	601	911	972
Urethritis	8436	9185	11436
HIV/AIDS	4167	6598	12741
Genital Ulcer Women	4580	4936	5883
Genital Ulcer Men	4681	5739	5904

Source: SIS, December 2005.

In 2000, RDHS-II reported that among respondents aged 15-49, 32 percent (27 percent among females and 36 percent among males) reported symptoms suggestive of STIs in the last 12 months and sought care at a service provider (i.e. from a clinic, hospital, private doctor). The RDHS-II did not seek to specify if the provider was specifically trained in STI care. RDHS-III data shows that overall, 50 percent (49 percent females and 52 percent males) sought care from a service provider. This is a positive trend that can be useful for intervention in prevention of HIV/AIDS.

Prevention of mother-to-child transmission (PMTCT): The number of sites that offer PMTCT has expanded significantly in the past two years. There are currently 160 sites offering PMTCT services up from 120 in 2004, and 56 in 2003⁹. According to TRAC surveillance reports, a cumulative 138,000 pregnant women have accessed PMTCT services as at end Oct. 2005.

Table 8. Trends in the PMTCT programme.

	Spectrum estimation for total population 15-49		PMTCT programme monitoring data								
	Pregnant women	HIV+	ANC		TESTED		HIV+		NVP		Act. Cov
			#	%	#	%	#	%	#	%	
2001	355,554	18,949	13,146	4	11,478	87	1,782	16	952	53	5.0
2002	363,128	19,587	42,869	12	34,944	82	3,107	9	1,547	50	7.9
2003	368,926	20,138	50,575	14	41,856	83	3,505	8	2,866	82	14.2
2004	373,382	20,596	119,496	32	95,475	80	6,405	7	4,141	65	20.1
2005	377,000	20,735	198,234	53	178,054	90	8,632	5	5,756	67	27.8

Source: 2001-2004 data: TRAC Epidemiological bulletin. Oct.2005.

2005 data: ANC attendance (RDHS-III), Number on NVP – TRAC. End Dec 2005.

Note: grey-shaded cells are estimations and extrapolations.

From Table 8 above, the actual coverage of pregnant women in need of ARV prophylaxis has been steadily increasing. In 2003, 14 percent of all pregnant women who would require prophylaxis are estimated to have received NVP. This figure increased to 20 percent in 2004 and to 28 percent in 2005.

Condom accessibility: In Rwanda PSI and UNFPA are the leading agencies in condom marketing and distribution, however, there are still a number of traditional negative practices which hinder its utilization. In a recent nationally representative study of male condom accessibility carried out by CNLS in collaboration with PSI and GTZ,¹⁰ of 5045 persons aged 15-49 years old, the key findings were that: cost was not perceived as a barrier; neither was knowledge about where to get a condom, even though there was an urban/rural gradient (88% urban vs. 45% rural respondents knew of a place near their home to obtain a condom.

The study leads to the conclusion that condoms have not been adequately accessible to the population and suggests that the reasons are related more to stigma related to HIV/AIDS and condoms in general. For example, urban dwellers are more comfortable to speak with their friends about condoms - 78% urban vs. 60% rural. With respect to buying condoms, 53%

⁹ VIH au Rwanda. Bulletin Epidemiologique. TRAC. Oct. 2005.

¹⁰ Male Condom Accessibility Survey carried out by CNLS, with collaboration from PSI and GTZ. June 2005

thought they could be considered promiscuous and 51% were ashamed to be seen buying a condom. Men could purchase more easily than women, and there was a gradient according to marital status, with married women being least able to purchase. (According to this study, between 25 and 30 percent of the respondents thought anyone who needed condoms, or single men, or the sexually promiscuous could get them. About 12 percent thought married men could get them, and about 2 percent thought married women or single women could buy (male) condoms. Finally, 41% thought that rumours about condoms discourage use. These findings suggest that condoms are perceived to be used outside the confines of marriage and therefore seen as a tool of promoting promiscuity.

In response to these findings, the National AIDS Control Commission, in collaboration with partners, developed a National Condom Policy and its operational plan to guide the agencies that intervene in the area of ensuring access and use of condom in the country (2005).

Prevention through Individual Responsibility: health service providers

Injection safety and management of medical waste¹¹

The Government is taking steps to improve injection safety and management of medical waste. Since mid 2004, when a baseline survey was carried out, two districts (Nyagatare and Rwamagana) were selected as pilots to improve medical waste management and injection safety. In 2005, the programme is expanding to six other districts: Gahini, Kiziguro, Kabutare, Gakoma, Nyanza and Kibilizi. The programme will reach national coverage by 2007. A national policy on injection safety and prevention of nosocomial infections and the management of medical waste is under development. In 2005, a Medical Waste Management Plan was prepared, and is being implemented with MAP financing.

Blood safety and quality assurance

Measures have been taken to safeguard blood supplies for transfusion. The Blood Transfusion Centre reports 100 percent screening of transfused blood.

Table 9 below shows the evolution of HIV/AIDS and other STI prevalence in the blood samples that were quality-controlled.

Table 9: Evolution of mean seropositive rate since 2002

Infection	Year				Rate in the general population in 2003
	2000	2001	2002	2003	
HIV	1,6	1,2	1	1,1	11
Hepatitis B	2,9	3,2	3,1	2,7	10
Hepatitis C	2,1	1,9	1,7	3,1	3,5
Syphilis	0,7	0,5	0,9	0,7	...

Source: MINISANTE 2003 report.

Other quality measures have been put in place. The National Reference Laboratory has a policy to carry out external (national and international) quality controls on 10 percent of all negative test and 10 percent of all positive tests on HIV testing. There was a substantial increase in the number of quality control tests carried out between 2002 and 2003, indicating the increase in demand for testing. A total of 15,000 quality control tests were carried out in 2003, 34,000 in 2004 and 64,000 in 2005.

¹¹ Enquete sur les pratiques d'injection au Rwanda. Juillet – Aout 2004. MINISANTE/JSI. Kigali.

Treatment, Care and Support

The Government of Rwanda has made steady progress in provision of care, treatment and support to people infected and affected by HIV/AIDS. The number of ARV sites has increased from 16 in 2003 to 31 in 2004 and to 83 at the end 2005.

The national strategic orientation in this domain is three-fold: increase access to high quality care and treatment at health facilities; increase access to high quality care and treatment within the community level; and assure that HIV/AIDS-related care and treatment is sustainable.

The number of people in need of treatment by end 2005, according to WHO 3 by 5 Report 2005, was 39,000. The number of people on ARV increased substantially over years from 3206 in 2003 to 8,991 in 2004 doubling to 19,058 (6985 males and 12,073 females) in 2005 (TRAC December 2005 Report). The December achievement marks access to approximately 50 percent of persons in need of ARV, an achievement of the 3 by 5 goals.

To ensure access to treatment and to ARV by the poor and vulnerable (especially women and children), the Government released a Ministerial Decree establishing guidelines for the distribution of ARVs in 2004. Among other articles, this Decree allows for free access to ARV to poor vulnerable affected persons and a token amount of money on a sliding scale based on family wealth, in a family approach to ensure that women and children are not left out.

In addition, the government has continued to provide support to initiate a common basket for procurement of ARVs from CAMERWA. To date, the main agencies funding ARV are The Global Fund, MAP, PEPFAR, MSF, BRALIRWA, National Bank of Rwanda.

In the past two years, the Treatment Research AIDS Center, TRAC, in collaboration with partners has developed national protocols for HIV/AIDS care and treatment, and subsequently conducted training to service providers at facility levels. More clinicians and health service delivery facilities are increasingly tracking individual patients to promote adherence to proper treatment regimen. With this development also, is a concurrent effort to monitor drug stocks and have an early warning system for stock outs.

Therapeutic nutritional support for PLWHA who are on ARV treatment has mixed reception, since this has a potential of creating dependency. MIGEPROFE, however, sees nutritional support as an integral part of support for vulnerable children. While it increased substantially the estimated cost of the programme, the actual cost of feeding the children was considered reasonable. Programmes are being implemented by WFP, FAO and UNICEF and partners to support people living with HIV/AIDS and children in particular. WFP has provided support of 6.6 million USD for provision of food for HIV programmes (PMTCT, IGA activities, refugee camps and ARV nutritional support) over the period 2004-2005. PEPFAR reports provision of services to 29,682 OVC in 2005¹², MAP – 25,634 children; UNICEF – 50,000 OVC-services from 2004-2005. Global Fund reported providing support to 971 children at a cost of FRw 61 million by end 2005. The count of children at national level is not yet mutually exclusive. CNLS is in the process of consolidating and promoting the concept of a minimum package of service delivery for OVCs. Typical services offered are: access to health insurance schemes (“mutuelles”); school fees and hidden costs for school education; shelter, including construction and rehabilitation; nutritional support; psychosocial support and income generation support.

¹² PEPFAR Annual Programme Results FY 2005 (Oct 1-Sept30 2005)

Knowledge and behaviour change

Knowledge on individual items for the two most common modes of transmission, correctly identifying two most common misconceptions, and correctly identifying one locally held belief regarding AIDS is high, and has increased on all measured items in the last five years. RDHS-III findings compared to RDHS-II are that, among 15-24 year olds:

85% vs. 72% knew that having sex only with one faithful uninfected partner can prevent HIV infection and prevent the spread of AIDS

82% vs. 63% knew that the use of condoms can prevent infection with, and the spread of HIV/AIDS

89% vs. 68% knew that one cannot become infected by sharing food with someone who has AIDS

80% vs. 60% knew that AIDS cannot be transmitted by mosquito bites

83% vs. 64% knew that a healthy-looking person can have the AIDS virus

In 2000, 22 percent youth aged 15-24 had comprehensive knowledge about prevention of HIV/AIDS. The status of comprehensive knowledge has increased in 2005, with 52 percent demonstrating comprehensive knowledge.

Sexual debut: RDHS-II reported that the median age at first sex was 20.8 years (Female 20.8, Male 20.6). RDHS-III found that this was 19 years for females, and 18 years for males, an apparent drop for both sexes. Calculation of median age at first sex among 15-24 year olds has to exclude the group 15-19, since there is a very low proportion of youth in this age group that has commenced sexual activity.

Higher risk sex and condom use among youth: In 2000, a total of 26 percent (10 percent females and 42 percent males) aged 15-24 self-reported having higher risk sexual behaviour¹³ (RDHS-II). These reports have increased to 15 percent among females and 48 percent among males according to RDHS-III, even though the combined rate has fallen to 22 percent. Preliminary estimates of condom use from the RDHS-III conducted in 2005 suggest that 40 percent of females, compared to 69 percent of males used condoms during their last sexual encounters. While this level of use is an increase over levels reported in 2000 (39 percent total; 23 percent females, 55 percent males), condom use among this population will need to rise to meet the increased report of higher risk sex trend if abstinence does not increase.

¹³ The proportion of respondents who have had sex with a non-marital, non-cohabiting partner in the last 12 months.

IV. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE GOALS/TARGETS

Three targets were specified for three core indicators in the Declaration of Commitment. The targets for “percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission” and the “percentage of HIV-infected infants born to HIV-infected mothers” are applicable in every country, including those with concentrated or low prevalence epidemics. The target for the “percentage of young people aged 15-24 who are HIV-infected” applies only to countries that have high prevalence epidemics for the year 2005 and to all countries for 2010.

Table 10. UNGASS indicators with pre-defined targets

Indicator	Target	Target	Baseline	Baseline Year [Ref]	Achievement
	2005	2010			2005
Knowledge among youth aged 15-24:	90%	95%	Total: 22 Male: 20 Female: 23	2000 [1]	Total: 52 Male: 54 Female: 51
Percentage of young people aged 15-24 who are HIV-infected	25%	25% reduction	Female: 4.5	2003 [2]	Total: 1.5 [3] Female: 2.5 Male: 0.5
Percentage of HIV-infected infants born to HIV-infected mothers (PMTCT programme data)	20% reduction	50% reduction	23.26	2003 [4]	21.52 [4]

Sources: [1] RDHS-II, 2000, [2] Sentinel surveillance report. TRAC, 2003, [3] RDHS-III [4] TRAC/UNAIDS

From the results in Table 1, and Table 10 above, comprehensive knowledge among the youth has substantially improved, but has not been attained.

Among young people aged 15-24, sentinel surveillance data from 2003 indicated that 4.5 percent of women aged 15-24 were HIV-positive. The RDHS-III of 2005 observed 2.5 percent among women in the same age group in the general population. The data reported for achievements in 2005 are not really comparable, since the baseline is from sentinel surveillance data, and the 2005 status is from the RDHS-III (general household survey), but they both show very low levels of infection among women in this age group.

For PMTCT, programme monitoring reports show that the percentage of infected infants born to HIV-infected mothers has increased from 9.5 percent in 2003 to 9.9 percent in 2004, to 11.0 percent in 2005. The PMTCT programme data also shows that there has been an increase in the number of pregnant women seeking care and provided with Nevirapine for prevention of infection to newborns - 14.2 percent in 2003, 20.1 in 2004 and 27.8 in 2005. Using these proportions in an (International) M&E Reference Group for AIDS formula that also takes into account HIV transmission rate in the absence of any treatment and efficacy of treatment provided, there has been an estimated 7.5 percent reduction in the proportion of infants born with HIV as a result of ARV treatment for PMTCT between 2003 and 2005¹⁴. Although this is below the 20 percent target (see Table 10), the trend is in a positive direction. In other words, fewer children are getting infected from their mothers as a result of the observed PMTCT intervention. It should also be noted that there has been an increase in the numbers of infants tested postpartum (at the recommended age of 18 months) for testing.

¹⁴ See Table 2 for the definition of Indicator 17 and the formula used to calculate this indicator

Prevention

VCT and PMTCT: The increase in the acceptance of testing has still to be matched with an increase in the quality and number of human resources who provide care and treatment. (see Section I).

Behaviour change among health care providers: The new strategic framework 2005-2009 includes an expected result of behaviour modification among health personnel to reduce transmission of HIV/AIDS. To achieve this, health service providers will need reinforced capacity – sufficient knowledge and skills and a conducive environment (policy guidance, financial, administrative, logistical support) for effective operations. Health workers are also expected to be more proactive in providing services, such as for STIs, and for care and support of people infected and affected by HIV/AIDS, using a family approach. The national shift to performance-based financing of the health institutions could be the catalyst for this, however, as this is only just beginning. The challenge will be to ensure equity in providing opportunities for support. In addition to existing traits of hard work and long-suffering, health workers have to apply higher hygienic standards to reduce nosocomial infections. For example, hand-washing must increase, and more attention paid to the disposal of medical waste. Another challenge is for health workers to reach their catchment populations. The prevailing culture must be oriented more towards prevention, which is a challenge for the national response in general. Finally, there is a need for communities to increase the level of their participation with public spiritedness.

Youth knowledge and behaviour change: The RDHS-III results indicate that there is a possible widened gap in the comprehensive knowledge of HIV/AIDS prevention between males and females. What are the underlying factors, and how best can young males, who have higher risky behaviour be influenced to take the necessary precautions to prevent the spread of HIV/AIDS?

CNLS is currently promoting a strategy to increase individual responsibility to break the chain of transmission. Different segments of the population have different communication needs, and require targeted messages. This requires investment in communication strategies that are often expensive, but pay off in the long run, as demonstrated by the private sector. How can these communication strategies be implemented?

Care and Treatment

Decentralisation, scaling up and human resources: The poverty reduction strategy in Rwanda has a fundamental component to reduce layers of administration for public service delivery. This translates to devolution of authority to sub-national level. At the end of 2005, this plan was set into motion, drastically reducing staff at central level ministries to a skeletal structure, and moving human resources out to newly created district administrations consolidating previous health districts and administrative districts. This shift has come at a time of rapid scale up of service delivery to provide better access to health care (notably access to ARVs) and other public services. These scaling up efforts require resources if quality and equity in service delivery are to be maintained. The greatest challenge is that of the numbers and quality human resources available. In 2005, there were 4.2 doctors working fulltime, supported by 1.3 doctors working part-time, 61.6 clinical officers, 43.9 enrolled nurses and 6 laboratory technicians per 100,000

population.¹⁵ For the medium term, the national plan is to decrease the staff at central level, and to increase the capacity of the available human resource to be more efficient at sub-national levels. For example, Government has recently decided to release all medical doctors who were working in the public services on duties other than provision of care and treatment and to re-allocate them in health facilities all over the country. Partners have already taken steps to meet these training needs. It was estimated that about half of all (health) districts had received training for managing opportunistic infections, and for HIV/AIDS and counselling¹⁶. A standardised training package is under development, and will be used to guide capacity building efforts. The challenge will be to meet these needs in a timely and sustained manner.

In spite of concerns about equity, more efficient service delivery operations are likely to receive more resources, and should not be penalised in favour of poorer performing units. This market strategy approach is just beginning for the public sector, and will need to be monitored to identify and to provide specific support to weaker units to keep pace with a certain minimum standard of operation.

Sustained support: Some good initiatives that have been implemented during the 2003-2005 period risk discontinuation when partners who helped with resources pull out their resources. A challenge will be to determine which critical areas of support need to be jointly supported by partners. One area being proposed is support for the complete establishment of a national system for district-level monitoring and evaluation of the response to include civil society interventions. Another area is to support universal access to ARVs while forcing the epidemic down to manageable concentrated pockets.

Behaviour change

Behaviour change among health personnel and among youth with respect to prevention has been discussed above. This section discusses other behaviour changes that would promote a healthier life style for people living with HIV/AIDS or at risk to get HIV/AIDS.

Provision of quality in health care delivery: The Government seeks to provide quality health care, as reflected in the national plan of action. The associated behaviour changes are discussed in the section above, under 'prevention'. With care and treatment, health staff are expected to foster better linkages with the communities they serve and take care out to the people who cannot come to the health facilities. Without including the cost of outreach services, this is a challenge, as the numbers of health staff is not enough to meet the needs of the communities they serve as a static unit. CARE International experience in MAP-funded provinces demonstrates positive partnership between the public sector and civil society to reach out to people living in difficult conditions, such as the bed-ridden ("grabataires").

Stigma vs. living positively with HIV/AIDS: The levels of self stigma associated with HIV/AIDS have reduced since ARTs became more accessible, as evidenced by people coming forward to be tested. However, there is still a large segment of the population that has not come to terms with the possibility of continuing to live with acceptance should their status be known. This is evidenced by the low levels of people, especially in higher socio-economic brackets, living openly with AIDS. One high ranking official went public in 2005 and received a standing

¹⁵ Services Availability Mapping, Ministry of Health. 2005.

¹⁶ Services Availability Mapping. Ministry of Health/WHO/UNAIDS. 2005

ovation during a nationwide question-and-answer session with people gathered at town halls. The underlying factors need to be more fully understood by more people for fears and attitudes to be modified.

Condoms or abstinence: As previously discussed, condoms are not widely seen as a device to safeguard health. Like AIDS in general, condoms are associated with promiscuity. Adolescents appear to be more open, but their use of condoms is still low compared with the rate of sexual activity. Communication messages promoting condoms are carefully done and not explicitly sexual; communication messages to youth emphasise abstinence. New communication messages are now promoting “EABC” (**E**ducation, **A**bstinence, **B**e Faithful, and **C**ondom Use [in the event that abstinence cannot be depended on]). Past messages based on ABC have been given and interpreted with an oversimplicity associated with a moral perspective. The new national condom policy calls for a neutral stance by faith-based organisations with respect to messages about condoms. The practical implementation of this by influential persons not aware of the public policy, have strong beliefs, or simply disagree, can delay the adoption of condom use to protect health. The influence of large sums of money for one position or the other also has a role to play, and this is a challenge of itself.

Care and support: The burden of HIV/AIDS on families is high. The challenge is to create a division of labour that allows PLWHA to receive palliative care that includes family members that are able, without seriously affecting the economic output by these supportive family members. Rwandese society is continuously seeking ways in which care and support can arrive at the family level. How can volunteers of all ages be incorporated to support this process? What roles can they play?

Health care seeking: More people need to seek health care with a view towards prevention of more serious conditions. This shift in behaviour (to seek prophylaxis for STIs, seek ANC, seek professional counselling) is linked to the faith people have in the health centres to provide quality care and treatment in a caring manner. This in turn depends on the capacity of the health centres and the staff running them, as well as on education for all.

Providing an increased multi-sectoral response. This needs to be strengthened, since the majority of partners are placing greater emphasis on a "health" weighted response.

Workplace interventions are still a challenge, though more workplaces have interventions, they are probably not comprehensive. The draft work place policy of 2005 will be validated in 2006. The challenge will be to assure its implementation and monitoring.

Assuring equity and equality in service delivery. Rwanda has promulgated laws for equity among citizens. Because of their cultural and economic status in society, women need to be empowered for greater financial independence. The HIV response to fight poverty through microcredit schemes benefits more women than men because the majority of associations are comprised of women. This also helps to equalise women's unequal economic status, however, eligible males are encouraged to join associations to benefit from such available support.

About half of all ARV patients are treated in urban areas, however, this is a function of the concentration of the epidemic in urban areas; furthermore, there has been a major expansion of ARV sites nationwide in the past two years. Finally, the role of men in antenatal services (especially for PMTCT) needs to be reviewed to include them more.

SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

Coordination

As mentioned in the contextual environment, as of 1 January 2006, the geo-administrative structures in Rwanda have changed from 12 Provinces including Kigali City and the 106 districts and towns to an amalgamated 5 provinces (4 provincial, and Kigali City), with a total of 30 districts. Therefore the government and development partners ought to review operationalisation to fit into this new administrative set-up, whose essence is to strengthen decentralised levels particularly the Districts and Sectors, bringing services closer to the people. CNLS will consequently, focus on the 30 new districts to coordinate the HIV response in the country.

With the shift in focus to the districts, the CNLS has, as from January 2006, placed one staff within the revised organisation structure of the District: for coordinating the HIV response. In view of coordination of community programmes at District level, and to ensure smooth data collection and data flow, the commission would need support from the development partners in providing capacity building programmes to personnel at the decentralised coordination level and the implementing agencies in planning and budgeting, and in monitoring and evaluation of the programmes.

To facilitate tracking of national response, and progress in implementation of programmes, support is needed to install data bases in all Districts and a network connection to link the Districts with the National AIDS Control Commission.

Research

The new strategic framework has placed emphasis on evidence-based programming and the use of research to guide decisions. Support will be needed from partners to assist capacity building among Rwandans to carry out good quality relevant research, from the planning, implementation, analysis and through to the publication and presentation stages. Support will also be needed from partners to increase a culture of use of literature.

Continued support for sustainability of programmes

An estimate of the cost of the new strategic plan, using default values from global data bases, is that the new strategic plan will require 332 million USD. This is about 66.6 million USD per annum for the next five years. For 2005, all partners reported expenditures totalling 78.5 million USD, above the mean amount. These figures need to be cautiously interpreted, as the national costed plan for 66.5m USD to scale up prevention, care and treatment did not include the additional high cost of technical support either at national or international level required to run these programmes. The current shortage of the required capacity at national level obliges external support, which is variable in cost, and makes this aspect difficult to estimate. Furthermore, the reported budgets do not include total amounts spent by regional and international bodies that are not directly accountable to Rwanda, spent in favour of programmes for Rwanda, and yet these costs contribute to the success of the national response. Finally, the pattern of expenditure in the future is difficult to determine since there were a lot of start-up costs in 2005. The distribution of estimated costs per strategic axe was 34 percent for prevention (Axe 1), 39 percent for treatment, care and support (Axe III), and 19 percent for social mitigation (Axe IV). The actual reported expenditure distribution pattern for 2005 was: 20 percent, 42 percent and about 5 percent for Axe I, III and IV respectively. As indicated, start-up costs for programme management and coordination may have taken up higher proportions than

a fully operational programme would cost. Some interventions cut across axes and may have been lumped under one axis instead of dividing arbitrarily among the axes. In any case, the current pattern reveals that more needs to be spent on prevention efforts.

Finally, the results of the RDHS-III, showing a lower prevalence, could cause some partners to shift resources elsewhere. This could cause problems for sustainability, and needs to be avoided.

VI. Monitoring and evaluation environment

In 2004, there was an influx of M&E technical support from key HIV and AIDS partners. This group has joined forces with the local M&E expertise to form a Technical Working Group which has been active for the major M&E activities undertaken in 2004 and 2005 with respect to HIV/AIDS. This group is expected to support capacity building efforts in 2006 and beyond.

Following the mid term review (MTR) of the multisectoral national plan 2002-2006 conducted in 2004, a revised plan for 2005-2009 was elaborated in 2005, incorporating aspects of care, support, treatment, monitoring and evaluation that were missing in the first plan. The national M&E system comprises several smaller systems monitoring different aspects of the epidemic. At the National AIDS Control Commission (CNLS), a monitoring and evaluation system for the non-health component of the epidemic is under development and is expected to be fully operational at the sub-national level (District) by mid-year 2006. The medical aspect of the epidemic and monitoring of patients and drug stock out is being undertaken through the TRACNet system at the Treatment and Research on HIV and AIDS Center (TRAC).

The following improvements have been realized to date: MoUs between CNLS and implementing partners has been established to assist with coordination of the response; CNLS is developing a database to monitor the national response; a piloting training on the use of the data base has been made to the monitoring agents at the District level. The second part of the training is planned for February 2006 when the agents will be trained also on the data collection format for community non-medical programme output indicators, a standardized tool that is currently being developed by the CNLS in collaboration with the National M&E technical working group (M&E TWG).

The new National Strategic Framework for HIV Control 2005-2009 was finalized in December 2005 for adoption in January 2006. CNLS in collaboration with M&E TWG and partners are now in the process of revising the National M&E Plan. Discussions are on-going to simplify the M&E framework and data flow, reduce the data collection burden for the indicators proposed so that they are feasible and useful for programme management decisions. These developments have been made possible through substantial technical and financial resource support from partners.

ANNEXES

- ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS
- ANNEX 2: National Composite Policy Index Questionnaire (through CRIS)
- ANNEX 3: National Return Forms for programme, knowledge, behaviour and impact indicators (through CRIS)

ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

The National M&E Technical Working Group, together with representatives from the coordinating umbrella organisations and other members of civil society formed a Steering Group for the UNGASS reporting process.

Steering Committee composition

CNLS (M&E, Research, Planning Units)

Civil society (RRP+)

CNLS key partners for M&E (PEPFAR, USAID, Tulane University, CDC, World Bank-MAP, Global Fund, UNDP, and UNAIDS).

The process started informally in October 2005 with the UNAIDS Task Force, which developed a proposal for support to the process. This proposal was reviewed and accepted by CNLS for a consultant to gather information, with particular emphasis on the financial aspect of the response and the policy environment.

A consultant was engaged after a competitive selection process, and started work in December 2005. The consultant carried out a literature review, and determined that there was a major risk of double counting if all implementing agencies were to be contacted. After consultation with the Steering Group, and given the limited time in which to complete this exercise, only major funding / strategic partners were to be contacted, in a 'light consultation' process.

Nearly half of all government ministries which have an HIV/AIDS programme were contacted. In addition, USG (PEPFAR, USAID, Impact, etc), World Bank-MAP, Global Fund, UN System were also contacted. Summary reports of financial reports are attached in Annex 3.

Two focus group discussions were carried out to determine a policy index. In a series of questions aimed at government officials, the Executive Secretary and staff members from CNLS, an external evaluator (the consultant), and UNAIDS went through Part A of the Policy Index Questionnaire.

In a second focus group meeting, representatives from all the civil society umbrella organisations went through Part B of the Policy Index Questionnaire, along with the consultant and representatives from CNLS and UNAIDS. The findings of the Policy Index Questionnaires are attached in Annex B.

Data was reviewed by the TRAC (health component) and the National Statistics Institute, the agency responsible for verification and validation of all data that is to be published, and the findings were presented at a workshop in mid January.

Edits were made, the final report submitted to UNAIDS at the end of January 2006. The indicators will be captured in CRIS and sent to UNAIDS for compilation of all global reports.

ANNEX 2: National Composite Policy Index Questionnaire

NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE PART A

I. Strategic plan

1. Has your country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?^{17*}

(Multi-sectoral strategies should include, but not be limited to, those developed by Ministries such as the ones mentioned below)

Yes

No

Not Applicable (N/A)

Period covered:

- 1.1 IF YES, which sectors are included?

Sectors included	Strategy/Action framework	Focal point/Responsible
Health	Yes <i>No</i>	Yes <i>No</i>
Education	Yes <i>No</i>	Yes <i>No</i>
Labour	Yes <i>No</i>	Yes <i>No</i>
Transportation	Yes <i>No</i>	Yes <i>No</i>
Military	Yes <i>No</i>	Yes <i>No</i>
Women	Yes <i>No</i>	Yes <i>No</i>
Youth	Yes <i>No</i>	Yes <i>No</i>
Others to specify*		
Public sector PLWHIV	Yes <i>No</i>	Yes <i>No</i>

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

Comments:

No comments

- 1.2 IF YES, does the national strategy/action framework address the following me areas, target populations and cross-cutting issues? (*Yes/ No*)

Programme	
a. Voluntary counselling and testing?	a yes __
b. Condom promotion and distribution?	b yes __
c. STI prevention and treatment?	c yes __
d. Blood safety?	e yes __
e. Prevention of mother-to-child transmission?	g yes __
f. Breastfeeding?	h yes __
g. Care and treatment?	
h. Migration?	i yes __
Target populations	j yes __
i. Women and girls?	k yes __
j. Youth?	l yes __

¹⁷ All questions bolded and with an asterisk are also relevant for the “Three Ones” monitoring at country level

k. Most-at-risk populations ¹⁸ ? 14 Categories: l. Orphans and other vulnerable children? Cross-cutting issues m. HIV/AIDS and poverty? n. Human rights? o. PLHA involvement?	m <u>yes</u> n <u>yes</u> o <u>yes</u>
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1.3 *IF YES*, does it include an operational plan? **Yes** *No*

1.4 *IF YES*, does the strategy/operational plan include:

- | | | |
|--------------------------------------|------------|-----------|
| a. formal programme goals? | Yes | <i>No</i> |
| b. detailed budget of costs? | Yes | <i>No</i> |
| c. indications of funding sources? | <i>Yes</i> | No |
| d. a monitoring and evaluation plan? | Yes | <i>No</i> |

1.5 Has your country ensured “full involvement and participation” of civil society in the planning phase?

Yes *No*

1.6 Has the national strategy/action framework been endorsed by key stakeholders?

Yes *No*

Comments: STRATEGY PLAN 2005-2009 REPLACED 2002-2006 AND HAS BEEN APPROVED AFTER CONSULTATION FORUM WITH DIFFERENT STAKEHOLDERS.

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

Yes *No* *N/A*

2.1 *IF YES*, in which development plan? a) * b) * c) *) other

Covering which of the following aspects? (*Yes/ No*)

	a)	b)	c)
HIV Prevention	yes		
Care and support	yes		
HIV/AIDS Impact alleviation	yes		

¹⁸ Most-at-risk populations are groups that have been *locally* identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, commercial sex workers, moto-taxi drivers etc)

Overall, how would you rate strategy planning efforts in the HIV/AIDS programmes?											
2005	Poor										Good
		0	1	2	3	4	5	6	7	8	9 10
2003	Poor										Good
		0	1	2	3	4	5	6	7	8	9 10
<p><i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: After 2003 for coordination Purposes the government created UMBELLA to coordinate HIV/AIDS activities in each sector : For instance in 2003 we had 3 umbrellas against 2005 we have 8 umbrellas Government commitment and partners on HIV/AIDS</i></p>											

II. POLITICAL SUPPORT

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

1. Does the head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year?

Head of government	Yes	No
Other high officials	Yes	No

2. Does your country have a national multi-sectoral HIV/AIDS management/coordination body recognized in law? (National AIDS Council or Commission)*

Yes	No	N/A
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2.1 IF YES, when was it created? Year: **2001**

2.2 Does it include?

Terms of reference	Yes	No
Defined membership	Yes	No
Including civil society	Yes	No
PLHIV	Yes	No
Private sector	Yes	No
Action plan	Yes	No
Functional Secretariat	Yes	No
Date of last meeting of the Secretariat	Date: EVERY MONDAY	

Comments:

Apart from having a functional secretariat, above it there is a Board of Commissioners who represent the sectors.

3. Does your country have a national HIV/AIDS body that promotes interaction between government, PLHIV, the private sector and civil society for implementing HIV/AIDS strategies/programmes?

Yes	No	N/A
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3.1 IF YES, does it include?

Terms of reference	Yes No
Defined membership	Yes No
Action plan	Yes No
Functional Secretariat	Yes No
Date of last meeting	Date: EVERY MONDAY

Comments:

4. Does your country have a national HIV/AIDS body that is supporting coordination of HIV-related service delivery by civil society organizations?

Yes No N/A

4.1 IF YES, does it include?

Terms of reference	Yes No
Defined membership	Yes No
Action plan	Yes No
Functional Secretariat	Yes No
Date of last meeting	Date: Twice a month

Comments:

Overall, how would you rate the political support for the HIV/AIDS programme?										
2005	Poor									Good
		0	1	2	3	4	5	6	7	8 9 10
2003	Poor									Good
		0	1	2	3	4	5	6	7 8 9 10	
<p><i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: Before 2003 there was government commitment. In 2005 it was reinforced through the following: Decentralisation of HIV/AIDS structures, establishing coordination structures for different civil society sectors (“umbrellas”), Government negotiations with international Pharmaceutical companies to lower ARV prices to increase the number of persons on ARV Treatment programmes</i></p>										

III. Prevention¹⁹

1. Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population?

Yes *No* *N/A*

- 1.1 In the last year, did you implement an active programme to promote accurate HIV/AIDS reporting by the media?

Yes *No*

Comments:

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

Yes *No* *N/A*

- 2.1 Is HIV education part of the curriculum in

primary schools **Yes** *No* secondary schools **Yes** *No*

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

Yes *No*

Comments: curriculum needs to be harmonised and extended to all schools particularly in private schools

3. Does your country have a policy or strategy to promote IEC and other preventive health interventions for most-at-risk populations?

Yes *No* *N/A*

- 3.1 Does your country have a policy or strategy for these most-at-risk populations?

Injecting drug users, including:	<i>Yes</i>	<i>No</i>	<i>N/A</i>
- Risk reduction information, education and counselling?	<i>Yes</i>	<i>No</i>	
- Needle and syringe programmes?	<i>Yes</i>	<i>No</i>	

¹⁹ Strategies/policies discussed under *Prevention* may be included in the national strategy/action framework discussed in I.1 or separate

- Treatment services?	Yes	No	
- If yes, drug substitution treatment?	Yes	No	
Men who have sex with men?	Yes	No	N/A
Sex workers?	Yes	No	N/A
Prison inmates?	Yes	No	N/A
Cross-border migrants, mobile populations	Yes	No	N/A
Refugees and/or displaced populations?	Yes	No	N/A
Other most-at-risk populations? <i>Please specify 14 Categories</i>	Yes	No	N/A

Comments:

Homosexuals are not among the most-at-risk groups in Rwanda. This is because this group is still small and they do not appear to have many partners. In our country it is also a hidden practice which makes it difficult to implement a strategy for them even if one were developed.

4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These commodities include, but are not limited to, access to VCT, condoms, sterile needles and STD drugs)

Yes No N/A

Do you have programmes in support of the policy or strategy?

A social marketing programme for condoms?	Yes	No
A blood safety programme?	Yes	No
A programme to ensure safe injections in health care settings?	Yes	No
A programme on ante-natal syphilis screening	Yes	No
Other programmes? <i>Please specify PMTCT, VCT programme for Teachers</i>		

Comments:

Overall, how would you rate policy efforts in support of prevention?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											
There have been huge increases in the number of VCT and PMTCT sites and services provided from 2003 to 2005.											

5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy?

(Check all programmes that are implemented beyond the pilot stage to a significant portion in both the urban and rural populations).

	2003	2005
a. A programme to promote accurate HIV/AIDS reporting by the media.	a. <u>no</u>	a. <u>yes</u>
b. A social marketing programme for condoms	b. <u>yes</u>	b. <u>yes</u>
c. School-based AIDS education for youth	c. <u>yes</u>	c. <u>yes</u>
d. Behaviour change communications	d. <u>yes</u>	d. <u>yes</u>
e. Voluntary counselling and testing	e. <u>yes</u>	e. <u>yes</u>
f. Programmes for sex workers	f. <u>yes</u>	f. <u>yes</u>
g. Programmes for men who have sex with men	g. <u>no</u>	g. <u>no</u>
h. Programmes for injecting drug users, if applicable	h. <u>no</u>	h. <u>no</u>
i. Programmes for other most-at-risk populations	i. <u>yes</u>	i. <u>yes</u>
j. Blood safety	j. <u>yes</u>	j. <u>yes</u>
k. Programmes to prevent mother-to-child transmission of HIV	k. <u>yes</u>	k. <u>yes</u>
l. Programmes to ensure universal precautions in health care settings	l. <u>yes</u>	l. <u>yes</u>
m. Others; Prevention of HIV/AIDS through Youth reproductive health Education, income generating projects for sex workers		

Overall, how would you rate the efforts in the implementation of HIV prevention programmes?										
2005	Poor									Good
		0	1	2	3	4	5	6	7	8
2003	Poor									Good
		0	1	2	3	4	5	6	7	8
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: 2003 had generalised prevention strategies unlike in 2005 which has a specific prevention strategy for each most at Risk group</i>										

IV. Care and support²⁰

- Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

Yes

No

N/A

- Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

	2003	2005
HIV screening of blood transfusion	Y	Y
Universal precautions	Y	Y
Treatment of opportunistic infections (OI)	Y	Y
Antiretroviral therapy (ART)	Y	Y
Nutritional care (still low)	Y	Y
STI care	Y	Y
Family planning services (still weak: cultural bottleneck)	Y	Y
Psychosocial support for PLHIV and their families		
Home-based care (still low)		
Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)		
Cotrimoxazole prophylaxis among HIV-infected people	<i>low</i>	Mandatory in treatment guidelines
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)	<i>y</i>	Y
Other: (<i>please specify</i>)		

Comments:

Treatment that respects family approach where men, women and children can be addressed. In 2003 the figures tripled from 400 of children on ARV to 1265 in 2005 source: TRACNET

Overall, how would you rate the efforts in care and treatment of the HIV/AIDS programme?											
2005	Poor									Good	
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor									Good	
	0	1	2	3	4	5	6	7	8	9	10

²⁰ Strategies/policies discussed under *Care and Support* may be included in the national strategy/action framework discussed in I.1 or separate

*In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: **At end 2003 there were 8375 People on ARV. By the end of Oct 2005 there were 17090, representing app. 66% of people in need of ARV. Source: TRAC EPP/SPECTRUM data estimations. 2003 the figures tripled from 400 of children on ARV to 1265 in 2005. Source: TRACNET***

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

Yes

No

N/A

3.1 IF YES, Is there an operational definition for OVC in the country? Yes, No

IF YES, please provide definition: **The Prime Minister’s Office in Charge of Gender and Family Promotion is in charge of the care and support of OVCs. The Government defines “OVC” as follows:**

“A vulnerable child is a person under 18 years exposed to conditions, which do not permit him/her to fulfil her/his fundamental rights for her/his harmonious development.

An orphan child is a child who has lost one or both parents.”

Source: National Policy for Orphans and Other Vulnerable Children. Ministry of Local Government, Information and Social Affairs. Rwanda, 2003.

3.2 Which of the following activities have been implemented under OVC programmes?

	2003	2005
School fees for OVC	YES	YES
Community programmes	NO	YES
Other: <i>(please specify)</i>		

Comments:

Overall, how would you rate the efforts to meet the needs of OVC?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference Due to the genocide of 1994, Rwanda has a high number of OVCs. Appromoximately ¼ of the total population. The Government put in place in 1998 National assistance fund for survivors of Genocide of which OVC is a component. This is funded by 5% of the previous domestic revenue generated through taxes.</i>											

V. Monitoring and Evaluation^{21*}

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

Yes *No* *In progress* *Years covered:*

1.1. IF YES, was it endorsed by key partners in evaluation?

Yes *No*

Comments:

The national M&E plan is under revision to make it consistent with the new revised strategic framework 2005- 2009. More support will be required to make it fully operational at decentralised levels, in terms of human resource capacity, technical support, and support to analyse and utilise the data obtained to improve programme delivery.

1.2. Was the M&E plan developed in consultation with civil society, PLHIV?

Yes *No*

2. Does the M&E plan include?

- data collection, analysis, reporting and information feed back

Yes *No*

- well defined standardized set of indicators

Yes *No*

- guidelines on tools for data collection

Yes *No*

- a data management plan

Yes **No in progress**

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

Yes *No* *In progress* *Years covered: 2005-2009 – under development*

3.1 If yes, has funding been secured?

Yes **No**

²¹ The whole M&E section is relevant for the “Third One”

4. Is there a Monitoring and Evaluation functional Unit or Department?

Yes *No* *In progress*

IF YES,

Based in NAC or equivalent? **Yes** *No*

Based in Ministry of Health? **Yes** *No*

Elsewhere? **TRAC** **Yes** *No*

The epidemic is monitored at two institutions. The Treatment AIDS and Research Center (TRAC) monitors the health/medical aspects of the epidemic through the National AIDS Control Commission. The National AIDS Control Commission is charged with monitoring all other aspects of the epidemic.

4.1 If yes, are there mechanisms in place to ensure that all major implementing partners submit their reports to this Unit or Department?

Yes *No*

Comments:

4.2 Is there a full time officer responsible for monitoring and evaluation activities of the national programme?

Yes full time *Yes part-time* *No M&E officer*

4.3 *IF YES*, since when? : Year 2001

5. Is there a committee or working group that meets regularly coordinating M&E activities, including surveillance?

Yes regular *Yes irregular* *No* *Date last meeting:*

5.1 Does it include representation from civil society, PLHIV?

Yes *No*

6. To what degree (*Low to High*) are UN, bi-laterals, other institutions sharing M&E results?

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

Comments:

In 2005, two studies were carried out namely National prevalence from RDHS-III 2005 and the PLACE Study. The Multisectoral action plan 2005-2009 is fed with the information from the two studies. In addition, the Ministry of Health implemented a facility-wide survey that has provided a baseline of services available in all public health facilities throughout the country, that will help an understanding of efforts required for scaling up HIV/AIDS programmes.

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

- At national level? **Yes** No
- At sub-national level? **Yes** No
- Including civil society? **Yes** No

Overall, how would you rate the monitoring and evaluation efforts of the HIV/AIDS programme?												
2005	Poor							Good				
	0	1	2	3	4	5	6	7	8	9	10	
2003	Poor							Good				
	0	1	2	3	4	5	6	7	8	9	10	
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: There was increased involvement of an M&E working group. The Joint Mid-term Review concluded in Jan. 2005 it was the first joint review involving participation of wide partners, and demonstrated the importance of M&E.</i>												

Part B administered to representatives from the governments' primary partners including non-governmental organizations, bilateral agencies, and UN system organizations. This part covers three broad areas with a particular focus on policy *implementation* for the last topic:

1. Human rights
2. Civil society involvement (*new section*)
3. Prevention
4. Care and support

The section on civil society participation has been developed based on lessons learnt from 2003 reporting. It was felt that the full involvement and participation of the civil society in the design, planning, implementation and evaluation of HIV/AIDS programmes was not sufficiently assessed in the previous reporting.

The overall responsibility for collecting information related to the National Composite Policy Index lies with National governments, through their National AIDS Councils (NAC) or equivalent, with support from UNAIDS and partners.

Responses to most questionnaires' categories often require more explanation than just a *yes* or *no*. There is a space in the questionnaire, under "*comment*", that should be selectively used to shortly explain why, for example, a particular policy has not been implemented, or if it has been implemented what difficulties there have been in particular areas. For example, if sex work HIV prevention education is given in re-education camps, it will be important information to be mentioned. Qualitative analysis of the comments will be performed. If a section or question is *not relevant* for a specific country, the response "non applicable" should be used and explanation provided (when appropriate).

The 2006 NCPI asks respondents to provide both a score for 2003 and 2005 to be able to measure change over time. Such comparison is required for the specific questions on implementation and for the overall rating.

PROPOSED STEPS FOR DATA GATHERING

1. Designation of two technical coordinators for the study (one for each part)

Technical coordinators (preferably from the NAC (or equivalent) for Part A and a person outside the government for Part B) should be given responsibility to undertake the desk review and carry out specific interviews for this indicator. This person should ideally have a monitoring and evaluation background and may request the assistance of a national consultant with a similar background. It is strongly recommended that civil society representatives be part of the survey team for Part B.

2. Designation of a technical working group led by the NAC or equivalent (4 to 6 members)

Composition: representatives from the government (key line ministries and officials at sub-national level), NGOs, UN and bilateral agencies.

Role: Agree on (1) the process and timeline; (2) the selection of best respondents for each section; (3) the final results from both parts.

3. Selection of key informants for each section

- *Strategic Plan and Political Support*: the Director or Deputy Director of the National AIDS Programme or National AIDS Council;
- *Monitoring and Evaluation*: officers of the National AIDS Council or equivalent, Ministry of Health and HIV focal points of other ministries
- *Human rights*: Experts such as the Ministry of Justice officials, human rights commissioners, and representatives of human rights NGOs or legal aid centres/institutions.
- *Civil society participation*: representative sample of major civil society organizations working in the area of HIV/AIDS
- *Prevention and care and support sections*: major implementing agencies in those areas.

4. Data gathering

Each section should be completed by desk review and by interviewing the two or three people most knowledgeable about that topic.

5. Data entry, analysis and interpretation

Once both sections are filled out, the technical coordinators need to carefully review similar questions and check whether there are any discrepancies between the government and other counterparts' responses. If such is the case, a meeting with members of the working group should be organized to discuss and address those issues before the final consensus meeting on the UNGASS national report. This stage may require additional selected consultations and more documents to review. Validated data are entered into the CRIS, and analysis and interpretation done by both coordinators.

6. Consensus workshop organized by the NAC (or equivalent)

UNAIDS secretariat strongly recommends that NAC or equivalent organize a one-day broad consultation forum to discuss and endorse the major findings of the UNGASS national report, including this section on policy development and implementation.

PART B – NATIONAL COMPOSITE POLICY INDEX

II. Civil society participation

Key informants from the civil society provided information on the involvement of civil society in the implementation of UNGASS. Civil society was represented by the 3 biggest umbrellas: NGOs Forum (with 80 NGOs members), Pro-Femmes, an Umbrella of 43 women's organisations; RRP+ (representing 800 associations of PLHA) and APELAS (a federation of 14 companies from the private sector).

1. To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?

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

Consensus on rating : 7

Explanation: The civil society organisations think that high top leaders, business and highly educated people have not joined the National network of PLHA, which means that political commitment is not as high as it could be otherwise.

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

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

Consensus on rating: 8

Explanation: The key informants acknowledged the involvement of civil society in all processes of the development of National strategic planning and mid-term review.

3. To what extent the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports?

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

Consensus on rating: 8

III. Prevention

1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy?

(Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).

	2003	2005
A programme to promote accurate HIV/AIDS reporting by the media.	a. _____	a. <u> x </u>
A social marketing programme for condoms	b. <u> x </u>	b. <u> x </u>
School-based AIDS education for youth	c. <u> x </u>	c. <u> x </u>
Behaviour change communications	d. <u> x </u>	d. <u> x </u>
Voluntary counselling and testing	e. <u> x </u>	e. <u> x </u>
Programmes for sex workers	f. _____	f. <u> x </u>
Programmes for men who have sex with men	g. <u> N/A </u>	g. <u> N/A </u>
Programmes for injecting drug users, if applicable	h. _____	h. <u> x </u>
Programmes for other most-at-risk populations*	i. <u> x </u>	i. <u> x </u>
Blood safety	j. <u> x </u>	j. <u> x </u>
Programmes to prevent mother-to-child transmission of HIV	k. <u> x </u>	k. <u> x </u>
Programmes to ensure safe injections in health care settings	l. <u> x </u>	l. <u> x </u>

* Please define

Refugees, widows, genocide survivors, youth, orphans and vulnerable children, PLHA

Overall, how would you rate the efforts in the implementation of HIV prevention programmes?										
2005	Poor									Good
		0	1	2	3	4	5	6	7	8
2003	Poor									Good
		0	1	2	3	4	5	6	7	8
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:										
Explanation: For 2003 the rating is 6, and 8 in 2005 because in 2003, most of the activities were about sensitisation and IEC. From 2004 to 2005, more attention has been given to PMTCT and VCT. In addition, a national BCC strategy has been developed and a strategy on prevention has also been adopted.										

IV. Care and support

- Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

	2003	2005
HIV screening of blood transfusion	X	x
Universal precautions	X	x
Treatment of opportunistic infections (OI)	X	x
Antiretroviral therapy (ART)		x
Nutritional care		
STI care	X	x
Family planning services	X	x
Psychosocial support for PLHA and their families	X	x
Home-based care		x
Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)		x
Cotrimoxazole prophylaxis among HIV-infected people	X	x
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)		x
Other: (please specify)		

Palliative care associated with cotrimoxazole prophylaxis is not systematically applied. Only drugs to treat related infections are given to the patient. PEP is available only in medical settings

Overall, how would you rate the care and treatment efforts of the HIV/AIDS programme?										
2005	Poor									Good
	0	1	2	3	4	5	6	7	8	9
										10
2003	Poor									Good
	0	1	2	3	4	5	6	7	8	9
										10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>										
<p>In 2003: consensus on rating is 2 while in 2005 it is 9</p> <p>Explanation: high level advocacy was for general public to acquire access to ARV treatment because only rich people could afford it in 202. In 2004 and 2005 advocacy produced significant results, first of all through PMTCT programs, and now in 2005 ARV is accessible to the most needy. A policy on ARV distribution allows the poorest to access to free ARV treatment.</p>										

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

Yes X

No

N/A

- 2.1 Which of the following activities have been implemented under the OVC programmes?

	2003	2005
School fees for OVC		X
Community programmes		X
Other: (please specify) Medical health insurance schemes (“Mutuelles” de Sante)		

Comments:

Overall, how would you rate the efforts to meet the needs of OVC?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											
<p>Consensus on rating: 2003 - 3 2005 - 8</p> <p>Explanation: there is now a family approach to HIV/AIDS responses, and attention has been given to the payment of school fees to more of the most vulnerable children.</p>											

ANNEX 3: National Return Forms for programme, knowledge, behaviour and impact indicators (through CRIS)

To be captured in CRIS and onfowarded electronically to UNAIDS.

