COUNTRY PROGRESS REPORT

RWANDA

Submission date 2012-03-30

NARRATIVE REPORT

List of Acronyms

ACT	Artemisine Combination Therapy
AIDS / SIDA	Acquired Immuno-Deficiency Syndrome
ANC / CPN	Ante Natal Care
ARH	Adolescent Reproductive Health
ART / V	Anti-Retroviral Treatment / Drugs
BCC	Behavioural Communication and Change
CAMERWA	Central Drug Purchasing Agency in Rwanda (ED)
CBC	Communication for Behaviour Change
CBHI	Community Based Health Insurance schemes (= Mutuelles)
CBO	Community Based Organisations
CDC	Centre for Disease Control
CDLS	Commission District de Lutte contre le SIDA
CHW	Community Health Worker
CNF	Conseil National des Femmes
CNLS	National AIDS Commission / Commission National de Lutte contre le SIDA
CNTS	National Blood Transfusion Centre / Centre National de Transfusion Sanguine
CPAF	Common Performance Assessment Framework (used for GBS and SBS donors)
CSO	Civil Society Organisations
DHS+	Demographic and Health Survey (+ = with HIV testing, done in 2005 and 2010)
DOTS	Directly Observed Treatment Scheme / Short Course
DP	Development Partners
EDPRS	Economic Development and Poverty Reduction Strategy
ESP	School of Public Health (SPH)
FBO	Faith Based Organisation
FSW	Female Sex Worker
GBV	Gender Based Violence
GFATM	Global Fund for AIDS, TB and Malaria (=GF)
GOR	Government of Rwanda
HIV / VIH	Human Immuno-Deficiency Virus

HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
MC	Male Circumcision
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MIFOTRA	Ministry of Public Service, Skills Development and Labour
MIGEPROF	Ministry of Gender and Family Promotion
MIJESPOC	Ministry of Youth, Sport and Culture
MINAFRA	Ministry of Infrastructure
MINALOC	Ministry of Local Administration, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education, Science, Technology and Research
MOH / MINISANTE	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
NCBT	National Centre for Blood Transfusion
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NISR	National Institute of statistics Rwanda
ONUSIDA	Organisation des Nations Unis pour le SIDA (UNAIDS)
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV and AIDS (see PVVIH)
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNLS	Programme National de Lutte Contre le SIDA
PW	Pregnant Women
PWD	People with Disabilities
RBC	Rwanda Biomedical Centre
RTT	Resource Tracking Tool
RWF	Rwandan Franc
SGBV	Sexual and Gender Based Violence
SPH	School of Public Health

SPIU	Single Project Implementation Unit
STI	Sexually Transmission Infections
SW	Standard Workload
SWAp	Sector Wide Approach
TB	Tuberculosis
THE	Total Health Expenditure
TRAC	AIDS Treatment and Research Center (Centre de Recherche sur le SIDA)
TRAC +	Centre for Infectious Disease Control (CIDC)
UNFPA	United Nations Fund for Family and Population
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
YFC	Youth Friendly Centre
WB	World Bank
WHO / OMS	World Health Organisation

Table of Contents

I. Status at a glance

I. Country Progress Report process and stakeholder participation

The Rwanda Biomedical Center, Institute of HIV/AIDS, Disease Prevention and Control (IHDPC) was the leading institution in the development of this country progress report. The whole process engaged all relevant partners from public and civil society sectors to gather relevant contributions.

The information included is drawn from the following documents validated by the Government of Rwanda: The 4th Demographic and Health Survey, 2010; National Annual Report on HIV & AIDS, 2010-2011; Universal Access Report, 2011; Behavioural and Biological Surveillance Survey among female sex workers, 2010; Behavioural Surveillance Survey among youth, 2009, Behavioural and Biological surveillance Survey among Truck Drivers 2010, and Exploring HIV Risk among MSM in Kigali, Rwanda, 2009, National Strategic Plan for HIV AIDS(2009-2012) and the EDPRS report on lessons learned 2008-2011 .

Data for the Country Progress Report indicators were collected in March 2012. Indicator 6.1 and the funding matrix were filled using the National Health Accounts (NHA) report from fiscal year 2009/2010 with additional spending assessments through contact with major donors. The work for indicator 6.1 was guided by the expertise of a technical working group consisting of representatives from the Global Fund Country Coordinating Mechanism, Rwanda Biomedical Center, the Health Financing Unit in the Ministry of Health, the School of Public Health, Clinton Health Access Initiative, UNAIDS and the Technical working group on HIV AIDS led by Rwanda Bio-Medical Centre .

The National Policy Index (NPI) Part A was filled in a meeting held on 23rd of March 2012 by government institutions working on HIV AIDS. The NPI part B was filled by Civil Society organisations in a stakeholders meeting held on the 15th of March 2012.

Throughout the process of developing the report, the One UN HIV theme group has been involved from planning through data collection and validation.

Rwanda's Country Progress Report 2012 has been validated by the government of Rwanda, civil society representatives and development partners through an inclusive and open stakeholders meeting held on the 27th of March 2012. The comments and suggestions raised in this meeting have been incorporated in the final report submitted.

I.2. Status of the epidemic

HIV prevalence among the general population aged 15-49 years in Rwanda is 3.0%, as ascertained by the 4th Rwanda Demographic and Health Survey (RDHS) 2010; this is the same prevalence as found in the Rwanda Demographic and Health Survey in 2005. HIV prevalence is higher among women (3.7%) than men (2.2%) and higher in urban areas (7.1%) than in rural areas (2.3%).

While the overall prevalence of HIV in Rwanda found in the RDHS 2010 is similar to the patterns observed in the RDHS 2005, some changes in distribution by age and gender have occurred. Notably, among women, prevalence increased in those aged 25-29 (3.4% to 3.9%) and 35-39 (6.9% to 7.9%), while decreasing for those aged 30-34 (5.9% to 4.2%). This observation is likely due to factors including HIV transmission patterns, as well as survival and aging of those living with HIV.

Knowledge and behaviour related to HIV risk show encouraging trends but room for improvement. Approximately half of those surveyed in the RDHS 2010 demonstrated comprehensive knowledge about HIV transmission and prevention (55.5% of women and 51.6% of men), with slightly lower knowledge among young people aged 15-24; 52.6% of women and 47.4% of men in this age group demonstrated comprehensive knowledge. Uptake of HIV testing has increased, with 37.7% of men and 38.6% of women having received results of an HIV test within the past 12 months according to the RDHS 2010, more than triple in comparison with the 11.0% of men and 11.6% of women testing and receiving results according to the RDHS 2005.

The prevalence of multiple sexual partnerships were found in the RDHS 2010 to be decreasing for men in Rwanda: 3.9% of men and 0.6% of women aged 15-49 reported having had more than one sexual partner in the past 12 months, compared to 5.1% of men and 0.6% of women in the RDHS 2005. However, only 27.5% of men and 28.9% of women with multiple sexual partnerships reported using a condom during their last sexual intercourse. Among men, engaging in multiple sexual partnerships is most common in the 30-39 age group, while among women multiple partnerships are most common among those aged 20-24. Concurrent (overlapping) sexual partnerships within the past 12 months were reported by 3.1% of men and 0.4% of women in the RDHS 2010, marking the first DHS measurement of this indicator in Rwanda.

According to the 2011 National Annual Report on HIV & AIDS, the HIV positivity rate among women attending sites for prevention of mother to child transmission (PMTCT) in Rwanda was 1.9% in the period July 2010 – June 2011 (a decrease from 2.6% in the period July 2009 – June 2010). Of those pregnant women testing positive for HIV during this period, 98% received antiretroviral therapy for PMTCT. These successes follow the implementation of a new PMTCT protocol by the Rwanda Ministry of Health in 2010, the increase in geographical accessibility of HIV services as well as strong leadership and community involvement.

By June 2011 the HIV annual report showed that 96,123 people were receiving antiretroviral therapy in Rwanda, including 7,597 infants and children less than 15 years old and 88,526 adults were reported. With an estimated number of 105190 people eligible for ARV treatment in 2011 (HIV Epi Update-median 2010), 91% of HIV-positive individuals eligible for ARV therapy are receiving this treatment.

Data remain relatively scarce on the most at-risk populations, including sex workers, men who have sex with men and people who inject drugs. However, a number of recent studies have examined the characteristics of these populations, providing valuable data for this report.

I.3. Policy and programmatic response

Rwanda's National Strategic Plan on HIV (NSP, 2009-2012) guides the HIV work in the country carried out by all sectors and partners. The allocation of funds to civil society and government entities to work to achieve the targets in the NSP are coordinated to align with the plan. The Country Coordinating Mechanism (CCM) for the Global Fund to Fight HIV, TB and Malaria are using a national strategic application (NSA) to ensure that the funds spent are going to support the fulfilment of the NSP. The goals of the current NSP are by June 2013: (1) halving the incidence of HIV in the general population; (2) reducing morbidity and mortality among people living with HIV; (3) ensuring people infected and affected by HIV have the same opportunities as the general population.

In the last two years, Rwanda has made progress in all these areas and has advanced the policy and programmatic response to take into account new evidence in the field of HIV and AIDS and new knowledge about the epidemiological specificities of Rwanda.

There is no data on HIV incidence in the general population in Rwanda but this measurement is planned to take place in 2012. The Government has developed minimum service packages for HIV prevention to key groups at high risk and vulnerable populations and these are being implemented in 2012. In addition to these prevention programs, Rwanda has launched an initiative to eliminate mother to child transmission of HIV and a campaign to circumcise 2 million men by 2013 as an additional strategy to prevent HIV transmission.

Reduction of mortality and morbidity has been achieved through increased geographical coverage of ARV services, increased local capacity to do CD4 counts thereby realising treatment need and treatment failure quicker, higher degree of TB and HIV co-management and more active management of co-infection and co-morbidity. To respond to the limited number of Medical Doctors, 500 nurses were trained and certified to prescribe ARVS 1st line through task shifting policy adopted and implemented in Rwanda since 2010; in the same period US Department of Health and Human Services (HHS) issued a policy to transition HIV clinical services programs funded by President's Emergency Plan for AIDS Relief (PEPFAR) to host-country partners. The Rwanda Ministry of Health coordinated a successful process to phase out transition of PEPFAR/HHS-funded health facilities from international partners to Rwanda MOH in collaboration with Health Resources Services Agency (HRSA) and CDC.

To further mitigate the effects of HIV and to ensure a positive prevention environment, stigma and discrimination has been high up on the agenda and a report on the experiences of people living with HIV was launched in early 2011; in addition same sex sexual activities were removed from the penal code since 2009.

The policy framework is strong in Rwanda and a National Accelerated Plan For Women, Girls, Gender Equality And HIV was launched in 2010 and is under implementation.

Overview of Global AIDS Progress Reporting data

Indicator	Age or other disaggregation criteria	Women	Men	Indicator definition	Sources
Target 1: Halve sexual transmission of HIV by 2015					
1.1 Young people: Knowledge about HIV prevention	*overall*	52.6%	47.4%	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	RDHS 2010 (Tables 13.3.1, 13.3.2; pp180-181)
	15-19	49.3%	43.5%		
	20-24	56.3%	52.4%		
1.2 Sex before the age of 15	*overall*	3.8%	11.3%	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	RDHS 2010 (Table 13.15; p202)
	15-19	4.8%	13.3%		
	20-24	2.8%	8.8%		
1.3 Multiple sexual partnerships	*overall*	0.6%	3.9%	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	RDHS 2010 (Tables 13.8.1, 13.8.2; pp189-190)
	15-19	0.3%	0.4%		
	20-24	0.9%	3.2%		
	25-49	0.6%	5.8%		
1.4 Condom use at last sex among people with multiple sexual partnerships	*overall*	28.9%	27.5%	Percentage of women and men aged 15-49 who had more than one partner in the last 12 months who used a condom during their last sexual intercourse	RDHS 2010 (Tables 13.8.1, 13.8.2; pp189-190)
1.5 HIV testing in the general population	*overall*	38.6%	37.7%	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	RDHS 2010 (Tables 13.10.1, 13.10.2; pp194-195)
	15-19	27.3%	23.9%		
	20-24	47.2%	41.7%		
	25-49	39.9%	42.7%		
1.6 HIV	*overall*	1.6%	0.4%	Percentage of young people aged 15-24 who are living with HIV	RDHS 2010

prevalence in young people					(Table 14.3, p211)
1.7 Sex workers: prevention programmes	*overall*	-	-	Percentage of sex workers reached with HIV prevention programmes	Data not available
	<25	-	-		
	≥25	-	-		
1.8 Sex workers: condom use	*overall*	83.2%	-	Percentage of sex workers reporting the use of a condom with their most recent client	Behavioural and Biological Surveillance Survey Among Female Sex Workers, Rwanda, 2010 (Table 6, p25)
	<25	85.3%	-		
	≥25	81.3%	-		
1.9 HIV testing in sex workers	*overall*	89%	-	Percentage of sex workers who received an HIV test in the past 12 months and know their results	Behavioural and Biological Surveillance Survey Among Female Sex Workers, Rwanda, 2010 (Table 11, p30)
	<25	88.9%	-		
	≥25	89.7%	-		
1.10 HIV prevalence in sex workers	*overall*	50.8%	-	Percentage of sex workers who are living with HIV	Behavioural and Biological Surveillance Survey Among Female Sex Workers, Rwanda, 2010 (Table 12, p31)
	<25	42.1%	-		
	≥25	57.7%	-		
1.11 Men who have sex with	*overall*	-	-	Percentage of men who have sex with men reached with HIV prevention programmes	Data not available
	<25	-	-		
	≥25	-	-		

men: prevention programmes						
1.12 Men who have sex with men: condom use	*overall*	-	52.3%	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (from a qualitative study in Kigali)		Exploring HIV Risk among MSM in Kigali, Rwanda, 2009 (pp25-26)
	<25	-	-			
	≥25	-	-			
1.13 HIV testing in men who have sex with men	*overall*	-	42.4%	Percentage of men who have sex with me who received an HIV test in the past 12 months and know their results (from a qualitative study in Kigali)		Exploring HIV Risk among MSM in Kigali, Rwanda, 2009 (p29)
	<25	-	-			
	≥25	-	-			
1.14 HIV prevalence in men who have sex with men	*all*	-	-	Percentage of men who have sex with men who are living with HIV		Data not available
	<25	-	-			
	≥25	-	-			
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015						
2.1 People who inject drugs: prevention programmes	-		-	-	Number of syringes distributed per person who injects drugs per year by needle and syringe	Data not available

				programmes	
2.2 People who inject drugs: condom use	-	-	-	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	Data not available
2.3 People who inject drugs: safe injecting practices	-	-	-	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	Data not available
2.4 HIV testing in people who inject drugs	-	-	-	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	Data not available
2.5 HIV prevalence in people who inject	-	-	-	Percentage of people who inject drugs who are living	Data not available

drugs				with HIV	
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths					
3.1 Prevention of mother-to-child transmission	*Any type*	98.0%	-	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	National Annual Report on HIV & AIDS, 2011 (pp44-45)
	ARV as treatment/prophylaxis for eligible women	36.4%	-		
	Maternal triple ARV as prophylaxis	47.3%	-		
	Maternal AZT	14.4%	-		
	Single-dose NVP	0.0%	-		
3.2 Early infant diagnosis	-	70.0%		Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Universal Access reporting, 2011
3.3 Mother-to-child transmission of HIV (modelled)	-	-	-	Estimated percentage of child HIV infections from HIV-positive women delivering in the last 12 months	National Annual Report on HIV & AIDS, 2011

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015					
4.1 HIV treatment: antiretroviral therapy	*all*	82.4%		Percentage of eligible adults and children currently receiving antiretroviral therapy.	Universal Access reporting 2011; HIV & AIDS in Rwanda Epidemiologic Update, 2010
	<15	53.9%			
	>15	86.6%			
4.2 Twelve-month retention on antiretroviral therapy	*all*	-	-	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Data not available
	<15	-	-		
	>15	-	-		
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015					
5.1 Co-management of tuberculosis and HIV treatment	-	100%		Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	National Annual Report on HIV & AIDS, 2011 (Annex 7.3; p86-87; indicators F5-F6)
Target 6: Reach a significant level of annual global expenditure (between $22 billion and $24 billion) in low- and middle-income countries					
6.1 AIDS spending	-	See funding matrix		Domestic and international	National Health

				AIDS spending by categories and financing sources	Accounts, 2009-2010
Target 7: Critical enablers and synergies with development sectors					
7.1 Government HIV and AIDS policies	-	See NCPI reporting		National Commitments and Policy Instrument (NCPI)	NCPI
7.2 Prevalence of recent intimate partner violence	-	44.3%	-	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.	RDHS 2010 (Tables 17.7, 17.10; pp 246, 250)
7.3 Orphans' school attendance	*orphans*	83.8%	91.2%	Current school attendance among orphans and non-orphans (10-14 years old, primary	RDHS 2010 (Table 2.13; pp27-28)
	non-orphans	96.0%	96.2%		

				school age, secondary school age)	
7.4 External economic support to the poorest households	-	-		Proportion of the poorest households who received external economic support in the last 3 months	Data not available

II. Overview of the AIDS epidemic

II.1.Context

Rwanda is a small landlocked country in East Africa; it is bordered in the north by Uganda, south by Burundi, East by Tanzania and in the west by the Democratic Republic of Congo. It has an estimated population of 10.7 in 2011 (NISR, 2012) It is divided into four Provinces – North, South, East, West- and Kigali City and has 30 districts.

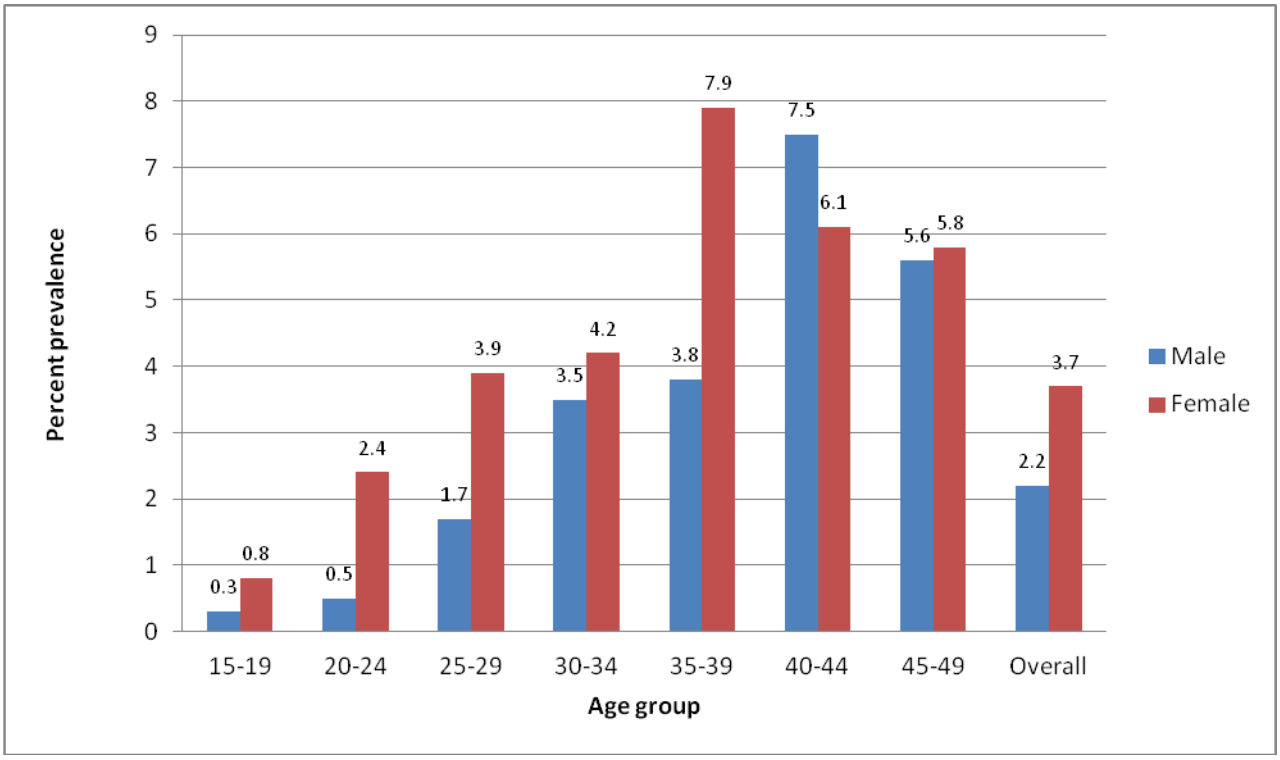
When the latest Country Progress Report from Rwanda was written in 2010, Rwanda was ranked 161 out of 179 countries on the Human Development Index (HDI), an index ranking countries depending on the health, education and standards of living of their populations. At that time, 57% of Rwandans lived below the national poverty line and 37% in absolute poverty. In the latest HDI report (2011) Rwanda is ranked 166 out of 187, scoring above average for the sub-Saharan region on health. At this same time 76.8% of the population is living on less than $1.25 a day. According to EICV (integrated household living conditions survey) assessing the level and pattern of poverty in Rwanda, a marked reduction in poverty has been achieved in the last 5 years (11.8 point percent between 2005/06 and 2010/11 (from (56.7% to 44.9% living under the national poverty line). This is a significant reduction over a five year period.)

This increase in economic development has been accompanied by achievements in population health: the life expectancy at birth has increased from 41 in 1998 to 55 in 2009 (according to the World Bank) and the total fertility rate has decreased from 6.1 in 2005 to 4.6 in 2010. (DHS, 2010) Among key indicators for child health, infant mortality has decreased from 73 per 1000 in 2005 (RDHS, 2005) to 50 per 1000 in 2010 (RDHS, 2010), and under-five mortality has decreased from 133 per 1000 to 76 per 1000 in the same years. (RDHS, 2005; RDHS, 2010) These are substantial gains in this period of time.

II.2.HIV prevalence

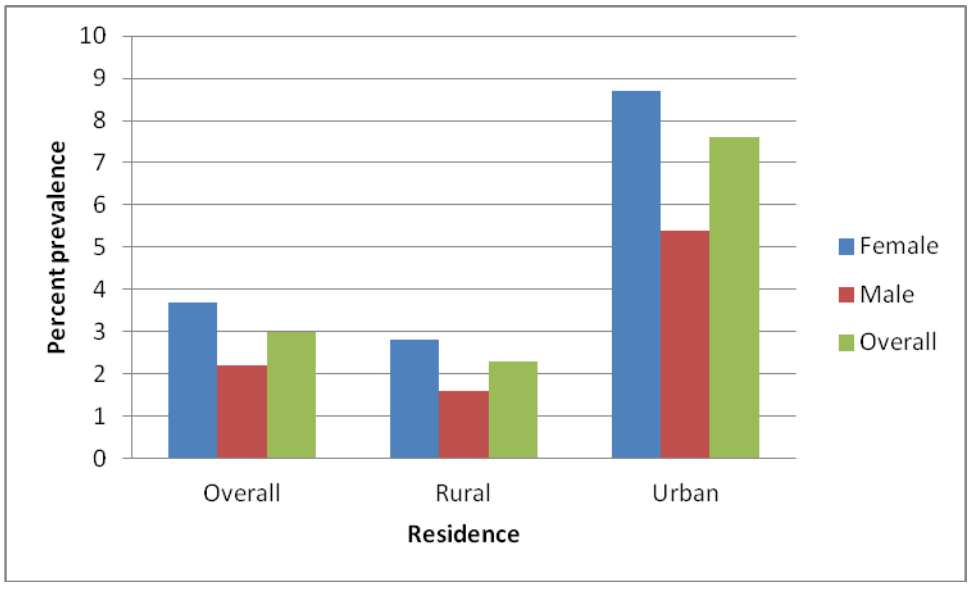
HIV prevalence in Rwanda has remained stable over the last five years. In the DHS with HIV testing carried out in 2005, the national prevalence was measured to be 3.0% in people between 15 and 49. (DHS, 2005) In the most recent population-based survey, the 2010 DHS, this is still the case. HIV prevalence is higher among women than among men (3.7% compared to 2.2%). The highest HIV prevalence is among women aged 35-39 (7.9%) and among men aged 40-44 (7.3%). (Figure 2.1). (DHS, 2010)

Figure 2.1: HIV prevalence, disaggregated by age and gender (RDHS, 2010)



HIV prevalence varies widely between urban and rural areas, urban areas having a total HIV prevalence of 7.6% (8.7% in women and 5.4% in men) and rural areas with a total prevalence of 2.3 (2.8% in women and 1.6% in men)(Figure 2.2) (RDHS, 2010)

Figure 2.2: HIV prevalence by place of residence, disaggregated by gender (RDHS, 2010)



The key populations in Rwanda at higher risk of HIV include female sex workers, men who have sex with men, truck drivers and prison inmates. Of these, female sex workers is the only group for which

the national HIV prevalence can be reported. In this group the prevalence of HIV is 50.8%, higher for women 25 years of age and older (57.7%) and lower for women under 25 years of age (42.1%). (TRAC+, 2010)

III. National response to the AIDS epidemic

III.1.Introduction

In 2011, Rwanda reorganised its institutional architecture to collect several separate governmental health agencies into the Rwanda Biomedical Centre (RBC). The two major actors at national level in the HIV field before the restructuring, the National AIDS Control Commission (Commission Nationale de Lutte Contre le SIDA) and Centre for Treatment and Research on HIV/AIDS, Malaria, TB and Other Epidemics (TRACPlus), became the Institute of HIV/AIDS, Disease Prevention and Control (IHDPC), serving as an integral part of RBC. RBC is further coordinating other health agencies including the referral hospital King Faisal, National Reference Laboratory (NRL), Health Communications Centre and the National Centre for Blood Transfusion, Medical Maintenance Workshop, Mental Health Division, the Pharmaceutical Laboratory (LABOPHAR), National Drugs Procurement Agency (CAMERWA), Vaccine Preventable Diseases and the Medical Research Centre.

Rwanda fully adheres to the "Three Ones" principles: the existence of one national coordinating body, one strategic national plan of action and one sole monitoring and evaluation framework. The framework of national strategies guiding the response is described below.

Vision 2020

The Government of Rwanda's guiding development strategy; it includes six pillars describing strategies for achieving the country's long-term development objectives, among which HIV/AIDS is clearly highlighted.

Economic Development and Poverty Reduction Strategy (EDPRS) 2008-2012

The current medium-term strategy for achieving Rwanda's Vision 2020 goals. The EDPRS provides the framework for multi-sectoral action on HIV and AIDS: the strategic plan for each of seven economic sectors that have a role to play in HIV response. The EDPRS encompasses all actors working in each sector, including private ventures and communities, with each sector under the leadership of a Government Ministry.

Health Sector Strategic Plan II (2008-2012)

Five-year plan outlining the goals and strategies for the entire health sector. The HSSP II aims to strengthen institutional capacity, to increase the quantity and quality of human resources, to ensure that health care is accessible to the entire population, to increase the availability and accessibility of drugs and to improve the quality of services in the fight against diseases.

National Strategic Plan on HIV and AIDS (NSP 2009-2012)

The reference document for all sectors, institutions and partners involved in the fight against HIV and AIDS. The NSP aims to make Universal Access to HIV prevention, treatment, care and support a

reality. The goals of the current NSP are, by June 2013: (1) halving the incidence of HIV in the general population; (2) reducing morbidity and mortality among people living with HIV; (3) ensuring people infected and affected by HIV have the same opportunities as the general population. The NSP includes indicators and targets, making it possible to track progress and follow up on commitments made. It is evaluated both at midterm and at the end of the cycle. The evaluation is the basis for new costing and prioritizations to reach the targets within the timeframe.

National Accelerated Plan for Women, Girls, Gender Equality and HIV (2010-2014)
Four-year strategy to accelerate actions to promote gender equality and reduce women's and girls' increased vulnerability to and risk of HIV. The plan aims to ensure that: women's and girls' equal access to HIV services is guaranteed by an evidence-informed HIV response; political commitment is matched by concrete actions and resources for women and girls; and rights of women and girls and their empowerment are protected and promoted in the context of HIV.

The EDPRS, NSP and the HSSP II are currently under review to prepare the next phase of strategic plans (starting between July 2012 and July 2013). The National Strategic Plan for HIV is closely aligned with the Economic Development and Poverty Reduction Strategy 2008-2012 (EDPRS) and Vision 2020. The multi-sectoral EDPRS includes the Health Sector Strategic Plan (HSSP II), on which the NSP for HIV is based.

III.2.Funding of the HIV response

○ HIV spending in Rwanda – A rapid assessment using NHA data (Fiscal year 2009/2010)

Methods and Assumptions

The data collected from the National Health Accounts (NHA) for HIV in 2009/10 were used to fill the financial matrix for the Rwandan Country Progress Report on HIV (2012). No primary data was collected, and the NHA data that were used had not yet been validated at the time of this assessment thus we recommend UNAIDS and WHO to facilitate countries to have a harmonized tool as it was recommended by MERG at Divonne les Bains in 2007 . Since the NHA does not break down the categories of spending in the manner required by the financial matrix used in the Global HIV and AIDS reports, some cross-walking (UNAIDS, 2009) and estimations were required. In some cases this meant that the detail of the type of prevention, or treatment, or mitigation activities could not be obtained, and so the spending was captured under "prevention not disaggregated", "treatment not disaggregated", and so on.

The data for the Rwanda National Health Accounts 09/10 was mostly taken from a Health Resource Tracking Tool (HRTT) managed by the Ministry of Health, Health Financing Unit. All actors in the Health Sector in Rwanda are required to report on their spending in the HRTT. It is estimated to capture more than 90% of all spending made on health from government, bilateral agencies, multilateral organizations, international NGOs and civil society organizations. ,This was the first year of data collection using HRT and a number of partners were reluctant to report using the tool despite many trainings and requests ; This situation affected the quality and completeness of the data.

When spending figures were not broken down from Health to HIV specific or from HIV in general to specific subcategories the following assumptions were made:

1. To estimate the spending by activities of the health centers and district hospitals in 2009/10, the breakdown between prevention and treatment activities that were found in the Global Fund report for the year 2010/11 were applied to the 2009/10 amounts. It is assumed that the percentages spent on prevention and treatment in 2010/11 would have been much the same. It was also assumed that the same proportions were found in health centers as in district hospitals. This probably underestimated the share spent on treatment in the hospitals and that spent on prevention in the health facilities.

2. To estimate the portion of the government's spending on health that went to HIV, the percentage of 21% was applied, which was taken from the Annual Financial Report on HIV expenditures (2010-2011). The reasoning behind this number is that that 21% of all spending captured in the HRTT was for HIV specifically.

3. To this amount of government spending, we applied the same proportional breakdown between prevention and treatment as were applied from the Global Fund report (2010/11), as described in point 1 above.

4. Community health insurance – the contributions from the members as out-of-pocket expenditure (OOPE) was omitted since we had no reliable data on HIV specific OOPE. The Global Fund contribution to the insurance program was assumed to be all for the purpose of HIV treatment, so 100% was captured. Given the immunity status of PLWA, it is recommended by national guidelines that they timely seek medical advice in case of any signs or symptoms. This definitely will include conditions that are related or not to HIV. For the government contribution, it was assumed that 21% was for HIV specifically, based on the rational in the Annual Financial Report on HIV expenditures (2010-2011), described in point 2 above. This amount was coded as government social security in the financial matrix. For all other external contributions to the insurance, 21% was also applied, assumed to be the portion that was for HIV treatment specifically.

Public and External Sources for HIV in Rwanda in 2009/10

In 2009/10, Rwanda spent almost US$173.6 million on HIV, sourced from public and external sources. Given the omission of OOPE and the contribution of the private sector, this is an underestimation of the total spending on HIV in the country. The total public contribution was US$16.6 million (9,6%% of the total), while the external sources were the largest contributors, totaling US$156.7 million (90.2% of the total).

When adjusting for total population size in 2009 (10.6 million), Rwanda spent on average approximately US$16.40 per person for HIV in 2009/10 comprising medical and non medical prevention and control of the epidemic.

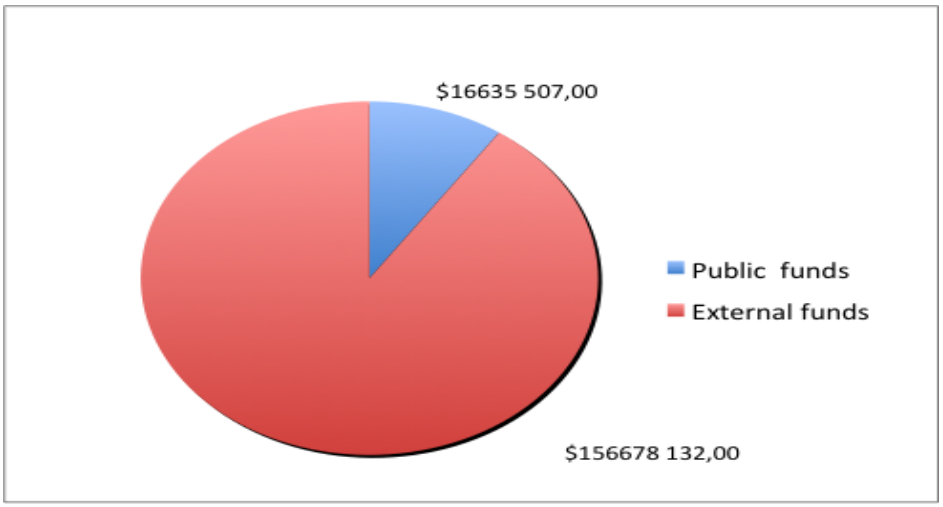
Of the external sources, the multi-laterals contributed a total US$67.4 million or 38.8% of the total spending on HIV, and 43% of the total external funds, in 2009/10. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) made the largest contribution among multilaterals of US$63.6

million (40.6% of total funding for HIV). Other multilaterals included the European Commission and the UN Agencies, contributing 1.7% and 2.8% respectively of the total HIV funding.

The total bi-lateral contributions made up 44.8% (US$77.9 million) of the total spending on HIV in 2009/10. The Government of the United States of America (USG) was the largest contributor, with US$74.2 million sourced through the President's Emergency Plan for AIDS Relief (PEPFAR), making up 42,7% of total HIV spending in the country, and 95.3% of all the bilateral aid. Other bilateral aid came from: Belgium (2.8% of bilateral funds) and Switzerland (1.3% of bilateral aid) and others which were aggregated together in the NHA data and hence could not be labeled separately.

There were a few international foundations – such as CARITAS, Clinton Foundation, Red Cross, and others that were aggregated together – funding various HIV activities in Rwanda. These were relatively small contributions, but together contributed US$10.9 million (6.3%) of the total HIV spending in 2009/10.

Key Sources of HIV Funding in Rwanda (US$, 2009/10)



Breakdown of Sources of HIV Activities in Rwanda (USD, 2009/10)

	USG 2009/10
Total Public Sources	**16 635 507**
Total Bilateral	**77 854 492**
USG	74 192 977
Germany	4 994
Switerzerland	1 010 486
Belgium	2 184 870
Other bilats	461 165
Total Multilateral	**67 389 878**
Global Fund	63 649 284
UN Agencies	1 917 394
European Commission	1 148 033
Other Multilats	675 167
Total International Foundations (not-for-profit)	**10 927 765**
Caritas	667 304
Red Cross	1 155 141
Clinton Foundation	1 365 508
Other international foundations	7 739 812
Total International for-profit	505 997
Total External	156 678 132
Total Spending on HIV	**173 621 081**

HIV Interventions in Rwanda

Most of the HIV funds in Rwanda were spent on treatment activities. In 2009/10, a total of US$86.4 million (50% of total funds) went to treatment, followed by prevention activities at US$49.2 million (28%), then program management and co-ordination receiving US$19.2 million (11%). We could not report on other items under this section especially for OVCs, HR, and social protection as the breakdown didn't give accurate figures matching with the language in country plans, strategies and laws .We advice UNAIDS for futures reports to adopt a methodology that permits capturing of expenditure as per national strategy and classification.

Please refer to the financial matrix for further detail.

HIV Prevention

Knowledge and behaviour change

Youth

Approximately half of all young people (aged 15-24) in Rwanda can both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission (termed 'comprehensive knowledge about AIDS' in the DHS methodology). Comprehensive knowledge about HIV is more common in young women than young men (52.6% vs. 47.4%) and increases with age for both men and women. For young women, 56.3% of 20-24 year-olds compared with 49.3% of 15-19 year-olds have comprehensive knowledge about HIV; for young men, 52.4% of 20-24 year-olds compared with 43.5% of 15-19 year-olds have this knowledge.

Among young people aged 15-24, 3.8% of young women and 11.3% of young men reporting having had sex before the age of 15. Within this age group, those aged 15-19 more frequently reported sexual debut before 15 years than those aged 20-24 (4.8% of girls and 13.3% of boys aged 15-19,

compared with 2.8% of women and 8.8% of men aged 20-24). (DHS, 2010) This might be interpreted as a trend toward earlier sexual debut now than five years ago. However, 2005 DHS, 15.3% of young men between 15-19 years old and 5.2% of young women the same age reported having had sexual intercourse before 15 years of age, more than in the current 2010 DHS. (DHS, 2005) This suggests that fewer young Rwandans have sex before the age of 15 now than five years ago. Overall, the median age for debut of sexual activity is high: the median reported age at sexual debut for women is 20.7 years among the women aged 25 to 49 years old, while for men in the same age group the median is roughly one year older at 21.9 years. Efforts to delay sexual debut has been successful as measured by these metrics. (DHS, 2010)

One of the three goals for Rwanda's National Strategic Plan on HIV has been to halve the HIV incidence in the general population. This has been approached through various programs targeting the population in general and youth in particular. Through anti-AIDS clubs in schools, and services specifically targeting youth out of school, the Government has trained peer-educators and developed prevention packages, information and educational materials. During 2010 the Government, in partnership with development partners, implemented a campaign to inform youth about the phenomenon of "sugar daddies," encourage young people to avoid these high-risk relationships.

The Ministry of Education has had an HIV focal person hired with the support of One UN for the past several years, supporting the Ministry in developing a school curriculum on sexual education including knowledge and skills related to HIV and sexually transmitted diseases.

Sex workers

In 2011 former CNLS (now RBC/IHDPC) developed minimum packages for HIV prevention programs targeting sex workers. The implementation of these packages is planned for 2012 and 2013. A key tool for the planning and distribution of HIV services to sex workers is improving knowledge on the characteristics of the sex worker population in Rwanda. To ascertain the size of this population, a study was carried out in 2011 using the novel network scale-up methodology. The study estimates that there are 25,000 - 45,000 female sex workers in Rwanda, a finding in agreement with prior estimates made using participatory mapping and capture-recapture methodologies. (RBC/IHDPC, 2012)Data on the size of the hidden population of sex workers will allow for better planning of services, and with an improved understanding of the environment and practices associated with sex work in Rwanda, services targeting this group can be more strategic, appropriate and of high effectiveness.

In 2010, 80% of all female sex workers reported that they used a condom with their most recent client. (TRACPlus, 2010)This is lower than the 84% who replied in the affirmative to the same question in 2006 (TRACPlus, 2006) although slightly higher than what was reported in 2000 (81.8%) (TRACPlus, 2000)However, female sex workers who reported having consistently used condom in the last 30 days rose from 28% to 33%. (TRACPlus, 2010)Female sex workers under the age of 25 are more likely to have used a condom at last sex with a client (85.3%) than sex workers 25 years of age and older (81.3%) according to the 2010 study. This is positive, especially if younger female sex workers persist with higher condom use as they age into the older group.

For sex workers, the HIV prevention service package includes peer education programs to increase knowledge on HIV and STIs, promotion of condom use, raising awareness of gender-based violence, referral to reproductive health services, PMTCT and encouragement of voluntary testing and counselling. Government strategies for sex workers have in some cases been implemented by non-governmental organisations who have been providing free condoms and who have paid Mutuelle de Santé (health insurance) for approximately 1,000 female sex workers and their children (Ministry of Health, 2011). HIV testing in female sex workers has increased dramatically over recent years: in 2006, 65.3% had received an HIV test and learned their results in the last 12 months, and in 2010 that proportion had increased to 86.6%. (TRACPlus, 2006) (TRACPlus, 2010)

Men who have sex with men

Engaging in same-sex sexual activities is not an offence in Rwanda, and any sort of discrimination is legally prohibited in Rwanda. A reliable estimate of the number of men who have sex with men does not exist, and Rwanda does not report a percentage of men who have sex with men who are reached by HIV prevention services. In 2011, a study measuring the size of key populations for the HIV response in Rwanda set out to estimate the number of MSM in Rwanda. However, due to reporting and information biases related to the stigmatisation of MSM, the estimated MSM population size (<100 - 4,700) was noted in the study report to very likely be a large underestimate.

A qualitative study in 2009 using snowball sampling found that 52.3% of MSM in Rwanda had used a condom the last time they had anal sex with a male partner. In the same study population, 42.4% had received an HIV test in the past 12 months, a proportion comparable to the testing rate in the general population. (CNLS, 2009)

Condom use

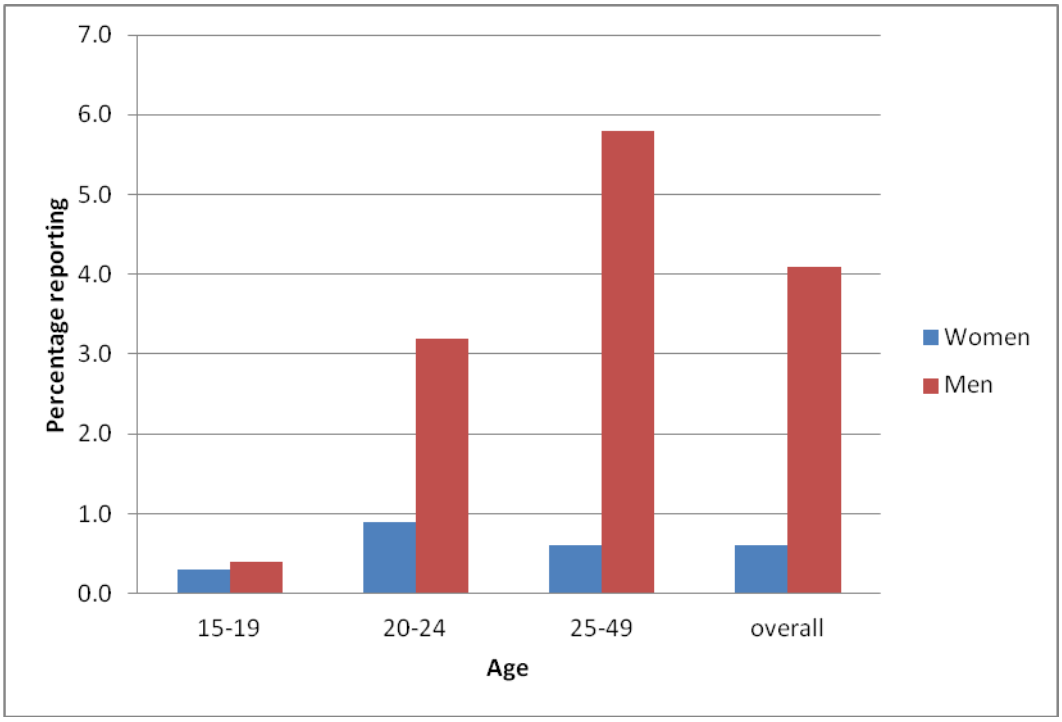
In 2010, 90.7% of women and 92.3% of men age 15-49 stated that people can reduce the risk of getting the AIDS virus by using condoms every time they have sexual intercourse. However, although this large majority of women and men know this to be an effective strategy to reduce the risk of contracting HIV, only 28.9% of women and 27.5% of men with more than one sexual partner in the last 12 months reported using a condom during their last sexual intercourse. (DHS, 2010)

A key strategy to decrease transmission of HIV in the last two years has been condom promotion and condom distribution, with both socially marketed condoms and free condoms increasingly accessible to the general population. In 2011, 700 condom vending machines were procured and installed across the country. Special attention has been put into making sure that condoms are available in HIV hot spots, such as bars, hotels and truck stops.

Multiple Sexual Partners

Having multiple sexual partners is fairly uncommon in Rwanda. The 2010 RDHS showed that in the past 12 months, 0.6% of women and 4.1% of men aged 15-49 had sexual intercourse with more than one partner (Figure 3.1). In youth aged 15-19, only 0.3% – 0.4% had multiple sexual partners in the last 12 months.

Figure 3.1: Percentage reporting two or more sexual partnerships in the past 12 months, disaggregated by age and gender (RDHS, 2010)

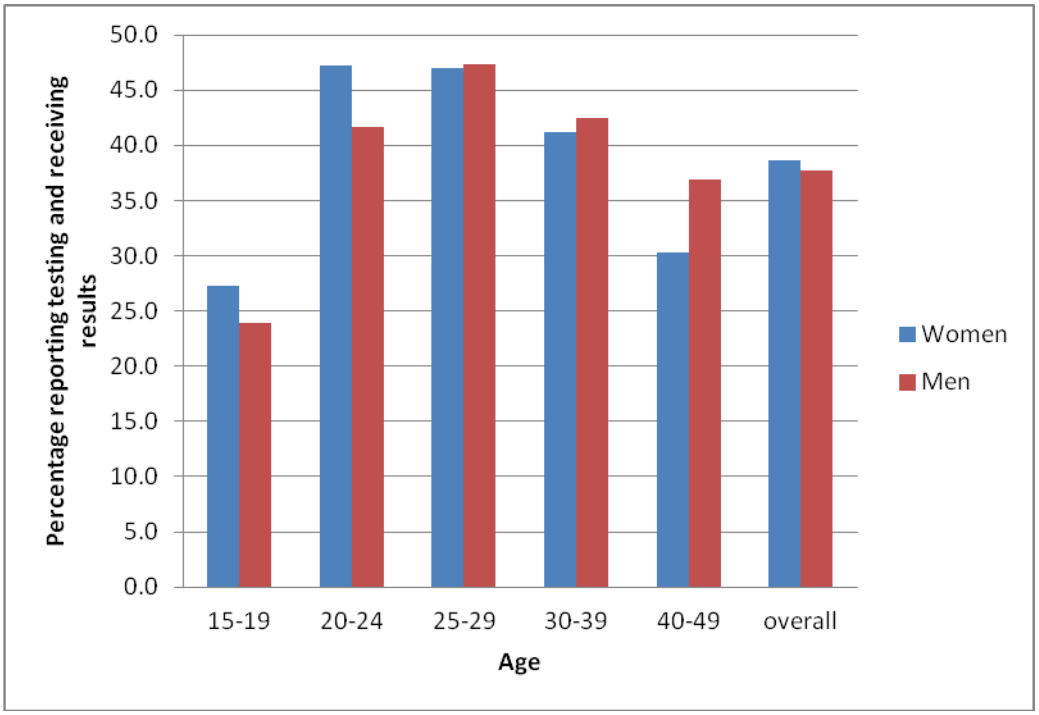


Clinical HIV prevention

HIV testing

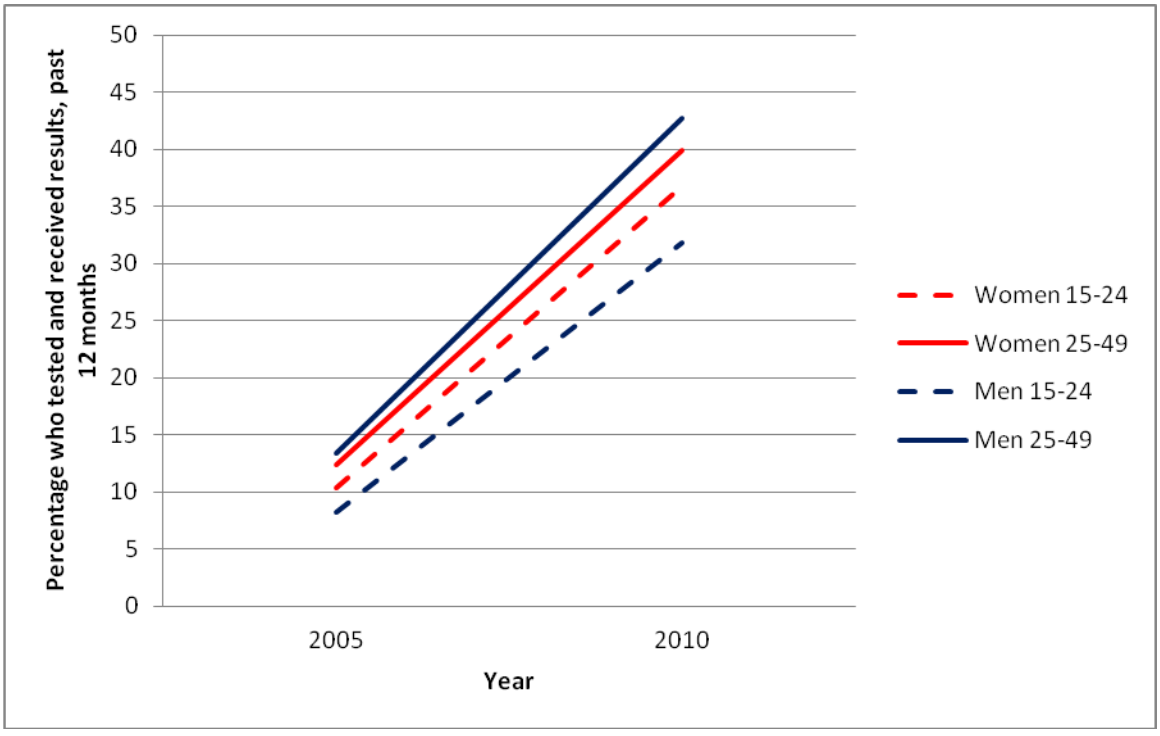
In the general population, 38.6% of all women and 37.7% of all men aged 15-49 have received an HIV test in the last 12 months and know their status. Testing practices were especially high in women aged 20-24, among whom 47.2% had received a test result, and in men aged 25-49 where 47.4% had received a recent test (Figure 3.2). (DHS, 2010). The Government of Rwanda has made it a priority to ensure prevention of mother to child transmission (PMTCT) of HIV is available to all women of reproductive age. One of the pillars of PMTCT is HIV testing during pregnancy, upon enrolment in ANC, and partner testing. Enhanced testing through PMTCT may contribute to the likelihood women aged 20-24 completed and received results from HIV testing.

Figure 3.2: Population percentage with results received from an HIV test in past 12 months, 2010 (RDHS 2010)



Uptake of HIV testing has increased substantially in Rwanda, across ages and genders. The current prevalence of results received from an HIV test within the past 12 months is more than three times the prevalence found in the RDHS 2005, when 11.0% of men and 11.6% of women reported having received results (Figure 3.3).

Figure 3.3: Changes in percentage completing HIV testing and receiving results, 2005 to 2010 (RDHS, 2005; RDHS, 2010)



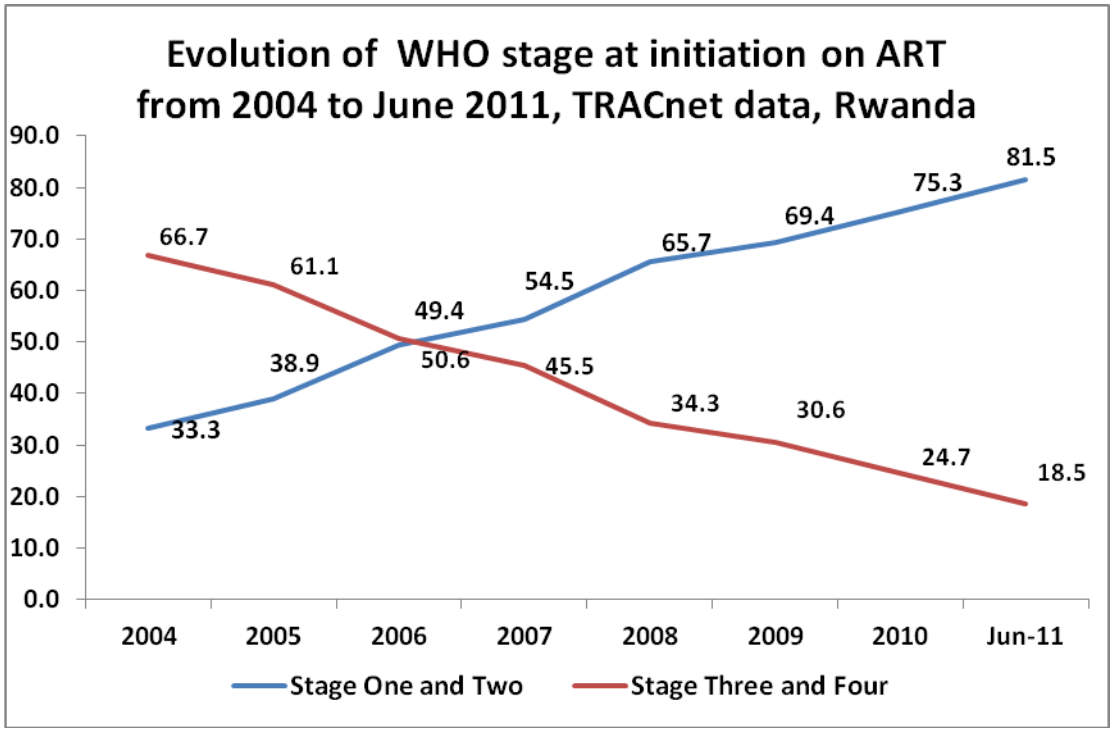
Prevention of Mother to Child Transmission of HIV (PMTCT)

Rwanda's program for prevention of mother-to-child transmission has been very successful in preventing new HIV infection in infants. In 2011, the First Lady of Rwanda launched a campaign to eliminate mother-to-child transmission of HIV and the National Strategic Plan for HIV set the goals of PMTCT to reach 2% transmission from HIV-positive women to their children. The National Strategic Plan for HIV also set the goal of at least 90% of pregnant women receiving antiretroviral therapy to reduce the risk of MTCT. As well as national government-led scale-up, One UN has been working in two model districts in the reporting period to show how virtual elimination of MTCT could be achieved. Currently, 98% of all pregnant HIV-positive mothers receive antiretroviral treatment (Ministry of Health, 2011). 36.4% of all pregnant HIV-positive women received ARVs as treatment due to their clinical status, 47.3% received triple-dose ARVs only as prophylaxis for mother-to-child transmission of HIV, and 14.4% received maternal zidovudine as prophylaxis (Figure 3.4). No pregnant HIV-positive women received single-dose nevirapine, as this is no longer a treatment option in Rwanda, per WHO recommendations. In the nationally validated 2010 HIV/AIDS Epidemiologic Update (using EPP Spectrum data from 2009), it was estimated that 68% of pregnant HIV-positive women received ARV treatment. This number differs from the 98% reported in the National Annual Report, which is explained by a difference in denominators employed in calculation of ARV coverage: the National Annual Report used the number of women testing positive for HIV in PMTCT for the denominator, while the Epidemiologic Update relied on an estimate derived from modelling population data.

Care, treatment and support

Antiretroviral therapy

The early initiation of antiretroviral therapy according to WHO classification has been a priority for the national program . In 2011, 81.5% of patients starting ART were in stage I&II WHO and 18.5% were in stage III&IV. This has been a dramatical improvement since 2004 as seen in the figure below. (TRACnet). This resulted into a significant reduction of mortality and morbidity among people living with HIV AIDS in Rwanda.



Evolution of WHO stages at initiation of Anti retrovirals in Rwanda 2004-2011(June)

As of June 2011, 96123 people were receiving antiretroviral therapy in Rwanda . This total included 7597 infants and children aged 0-14(3840 female and 3757 male), as well as 88 526 aged 15 years and older (55036 female and 33490 male). In the HIV and AIDS in Rwanda 2010 Epidemiologic Update, it is estimated that there were 105 190 people eligible for antiretroviral therapy in 2011: 90 460 aged 15 years or greater and 14 730 aged 0-14 years (EPP, 2010, medium bounds). Using these data, it is calculated that 91.4% of HIV-positive individuals eligible for antiretroviral therapy in Rwanda are receiving it.

HIV-TB co-management

Facility-based program reporting in the 2011 National Annual Report on HIV & AIDS 2011 (Ministry of Health, 2011) shows that 67.2% of patients newly enrolled in care and treatment (20 961 out of 31 199) received screening for tuberculosis during the period July 2010 – June 2011. Among those screened, 880 patients were diagnosed with TB and all of them received anti-TB treatment. The component of improving TB-HIV integration and management is one of the most successful: 97% of all TB patients registered from July 2010 to June 2011 were tested for HIV. The prevalence of HIV was 30% and 98% of all co-infected cases received Cotrimoxazole preventive treatment.

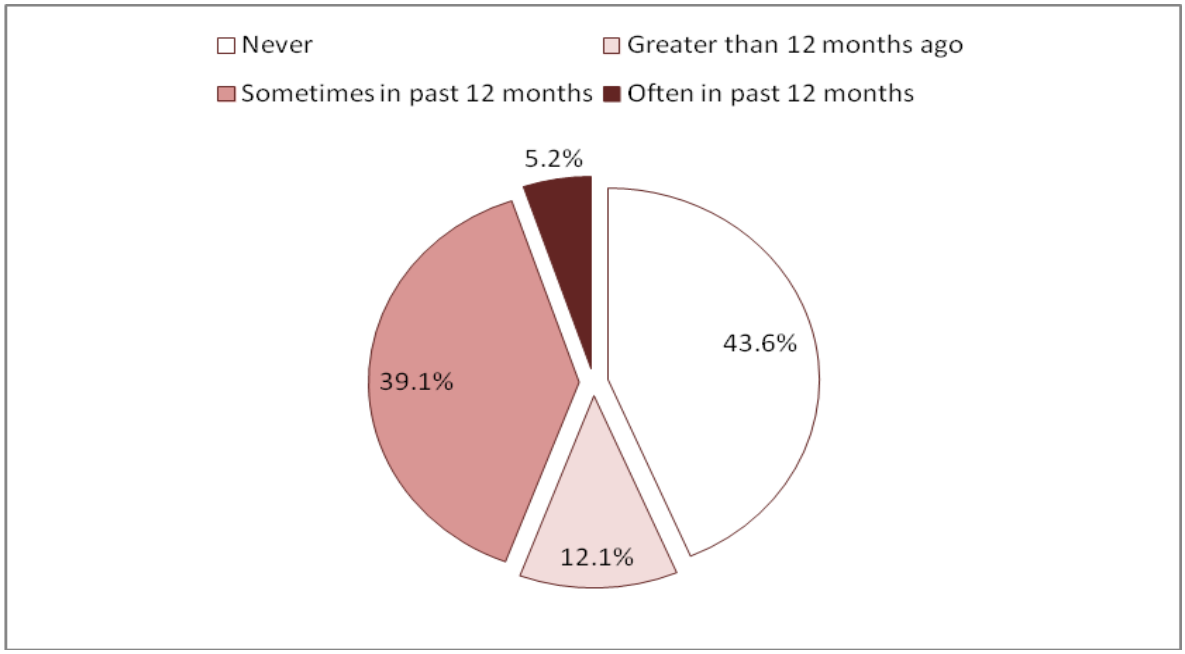
Impact alleviation

Intimate partner violence

The 2010 Rwanda DHS quantified the experience of intimate partner violence among women. Of ever-married women surveyed, 56.4% reported the experience of physical or sexual violence by an intimate partner. Among those women reporting IPV, 78.5% (or 44.3% of all women) reported

experiencing IPV within the past 12 months, while 9.2% of women reporting IPV (5.2% of all women) reporting experiencing IPV "often" during the past 12 months (Figure 3.5).

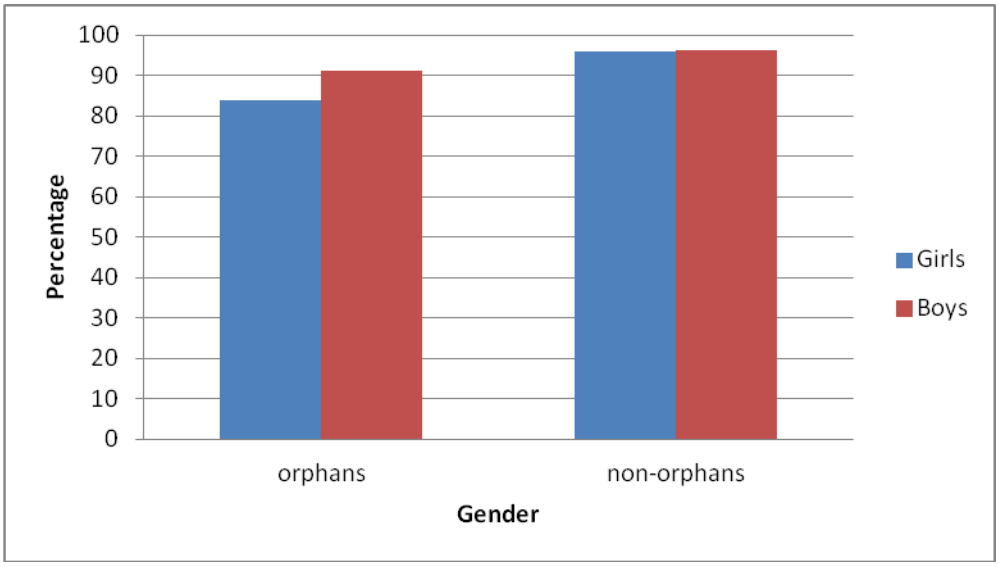
Figure 3.5: Experience of intimate partner violence among ever-married women (RDHS, 2010)



School attendance

The 2010 Rwanda DHS examined the proportion of children aged 10-14 who were attending school. Among non-orphans (defined as living with at least one parent and both being alive), school attendance was found to by high, and with little observable gender difference: 96.0% of non-orphan girls and 96.2% of non-orphan boys were attending school. However, among orphans (both parents deceased), school attendance was lower, especially among girls: 83.8% of orphaned girls and 91.2 % of orphaned boys were attending school (Figure 3.6).

Figure 3.6: School attendance among orphans and non-orphans, aged 10-14 years (RDHS, 2010)



National Commitments and Policy Instrument data and trend analysis

Civil society organizations held a stakeholders' meeting to reach consensus on reporting for the National Commitments and Policy Instrument (NCPI) Part B.

During the stakeholders' meeting, three subgroups worked on different sections of the NCPI. The subgroups were small enough to allow for free discussion on the rating and in most cases the answer was decided unanimously. In the cases where a unanimous score could not be reached, voting by a show of hands was used to reach an agreement. All answers were then explained and agreed upon again by the whole group in a plenary session.

After the National Validation meeting CSO met again and reworked some of their answers and the final results are shown in the table below and in the annex. Two separate attendance lists for the two meetings are attached in the annex.

In Table 3.2, the ratings provided by civil society organizations are displayed in comparison to previous years.

Table 3.2: National Commitments and Policy Instrument (NCPI) ratings, as provided by civil society organizations in stakeholders' meetings (15 and 27 March, 2012) – refer to Annex 3 for details

	2008	2010	2012
Civil society involvement			
Civil society contribution to political commitment and national strategy/policy formulation	4/5	5/5	5/5
Civil society involvement in planning and budgeting process for the National Strategic Plan	4/5	5/5	5/5
Inclusion of services provided by civil society in national HIV strategy	4/5	5/5	5/5
Inclusion of services provided by civil society in national HIV budget	4/5	4/5	5/5
Inclusion of services provided by civil society in national HIV reports	4/5	4/5	5/5
Civil society inclusion in developing national M&E plan	-	4/5	5/5
Civil society participation in national committee/working group for coordination of M&E activities	-	5/5	5/5
Civil society participation in data use for decision-making	-	-	4/5
Diversity of organizations represented by civil society	5/5	5/5	5/5
Access to adequate financial support	3/5	3/5	4/5
Access to adequate technical support	3/5	4/5	4/5
Efforts to increase civil society participation	8/10	9/10	9/10
Political support and leadership			
Has the Government involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation? **(NB: 'Yes/No' question)**	Not assessed in 2008 NCPI	Not assessed in 2010 NCPI	Yes
Human rights			
Rating of policies, laws and regulations in place for human rights in relation to HIV	8/10	8/10	9/10

Rating of effort to implement existing human rights related policies, laws and regulations	8/10	8/10	8/10
Prevention			
Efforts in implementation of HIV prevention programmes	8/10	8/10	9/10
Treatment, care and support			
Efforts in implementation of HIV treatment, care and support programmes	8/10	8/10	10/10

IV. Best practices

World AIDS Campaign in Rwanda

The commemoration and cerebrations of the World AIDS Day has been a great occasion for mass campaigning in Rwanda, starting on the fist of December every year since 2001. It is a campaign involving political leaders from the highest national level to the decentralized entities. Members of parliament, ministers and local authorities visit the people in their respective constituencies and share key messages on the theme of the year that has been adopted by the steering committee for the World AIDS Campaign Rwanda.

When the campaign starts it is launched with a big national event gathering all partners, the campaign then lasts over 3 months during which a variety of activities are conducted under supervision of districts HIV control commissions in collaboration with members of the civil society. All the activities on district level are supported by funds from the national government, development partners, UN Group and US Government.

In a bid to reduce the incidence of HIV as stipulated in its development policy documents, Rwanda invested a lot of effort in the promotion of condom use for a period 2 consecutive years (2009-2010) which resulted to remarkable increase knowledge, reduction in stigma attached to condom use and increase in the distribution of condoms.

The themes for the years were:

1. “Condom as a means of dual protection. Let’s talk about it, let’s access it, let’s use it: a fundamental right for all!” 2009
2. “Protecting oneself and others against HIV is everyone’s responsibility. I choose to use Condoms” 2010

During these National campaigns, key national figures including Minsters of Youth, Health, Gender and Culture and sports as well as over 50 Parliamentarians were involved to bolster the campaign in demystifying the taboos around condom use, especially in all Universities and Institution of Higher learning and sensitization of the general population at the village level in all the 30 Districts countrywide during the monthly community cleaning (UMUGANDA) as their contribution to the World AIDS Day Campaign events.

The following year efforts were devoted to targeting youth aged 15-24 years as a vulnerable population with the theme titled “Youth – Let’s join our efforts to protect oneself and others against HIV for a brighter future” was launched on December 1st 2011. The message on reproductive health and behavior change was delivered to youth in all secondary schools countrywide and youth out of schools at village level through community work commonly known as UMUGANDA (a monthly

community work and meeting held the last Saturday every month at village level). During the campaign the campaigners reached more than 1 million school students.

Other achievements include the following:

- Press Conferences, live Radio programs through National Radio Station, commercial and Community Radio stations with many frequencies.
- Newspapers covered all events with special editions
- Advertisement passed on Rwanda TV, Radio stations and news papers
- Partnership with Parliamentarians (members of Rwanda Network of Parliamentarians on Population and Development) helped to provide a special messages on HIV prevention to the population
- Collaboration with faith based organization members from the Network of Religious in fighting HIV (RCLS)

After the campaign described above, the government participated in a commercial national trade fair to show and distribute Behaviour Change Communication materials to the visitor. This is also done on a smaller scale in province trade fairs.

During the campaign, youth and the general population have the opportunity to get Voluntary Counseling and Testing for HIV, share testimonies from PLWHIV and hear best practices from peers.

Male Circumcision

In 2009 the prevalence of male circumcision was estimated to be 12% in Rwanda (I-DHS, 2007).

Male Circumcision (MC) has been launched as an additional HIV prevention strategy that aims to reach 2 million men by June 2013. This involved a cascade training of health care providers in district hospitals (DH), health centers and private clinics to improve quality and quantity of MC services provided to clients. As of March 2012, the training according to the MC operational plan involved:

Master trainings of 31 surgeons and post-graduates in collaboration with Rwanda Surgical Society.
National Training of Trainers from DH by these master trainers: Each of the 41 district hospitals had one medical doctor and one nurse trained as a Trainer of Trainers. These 82 participants were trained to continue with the cascade trainings at health center (HC) level and in private clinics.

Decentralized trainings are ongoing with DH training in affiliated Health Centers: 340 health centers out of 447 health centers in the country have completed trainings on Male Circumcision as an additional HIV prevention strategy. Training of all 447 health centers is planned to be complete by May 2012 and so far 30,000 male circumcisions have been carried out as part of the HIV prevention strategy.

According to the MC communication plan, 5400 Community health workers have been trained to increase in-depth knowledge on MC; motivate eligible men to go for MC; motivate women to support MC decision of partners and sons; provide accurate information to men and women and address misconceptions. Information education communication materials on MC were given to the participants to use in their communities for MC advocacy activities. Communication tools and materials developed to aid the provision of MC services include: Posters (men & couples), Information booklets (men/women), take home materials (post-operative information, booklets, key holders), flipchart (for counselling), t-shirts (Publicity), media information sheet, radio spots on all local radio stations, Rwanda Television (Girubuzima program).

With TRACNet, a web based reporting system for Health Facilities, MC indicators such as number of MCs performed, complications etc. are constantly monitored and reported monthly for follow up.

Early Infant Diagnosis

Without antiretroviral treatment (ART), fifty percent of HIV-infected infants born to HIV-infected mothers die before their second year. Delay in obtaining HIV DNA polymerase chain reaction (PCR) test results impedes early infant diagnosis (EID) and early ART initiation. To shorten this delay, in 2010, Voxiva developed an EID notification system using SMS-based technology collaboratively with the Rwanda Ministry of Health and CDC, financed by PEPFAR.

EID notification is built on Rwanda's existing national web-based HIV-reporting system, TRACnet. HIV-exposed infant dried blood spot specimens and standard maternal and child demographic forms are collected from health facilities and transported to National Reference Laboratory (NRL), where HIV DNA PCR is performed. NRL staff enters PCR results and demographic data into the system, which issues text messages and emails to two recipients at the originating health facility. Automated reports are generated to provide basic statistics and performance indicators, including turnaround time.

Out of 597 health facilities in Rwanda, 416 are collecting DBS/PCR samples (70%) and EID results notification operates in all 416 health facilities performing DBS (100%). As of December 31, 2011, NRL received 14,437 specimens and 14,437 results were sent to health facilities, of which 457 (3.2%) tested HIV positive. HIV results were provided to caregivers within 6 days on average compared to 90 days at baseline. Transport of samples from health facilities to the NRL improved from 33 days at baseline to 8 days. Overall time from sample collection to caregiver notification has decreased from 144 days to 20 days.

The EID notification system has reduced time to HIV diagnosis among HIV-exposed infants in Rwanda. Since earlier ART initiation is associated with improved survival, further evaluation of the impact of Rwanda's EID notification system on timing of ART initiation and survival among HIV-infected infants is warranted.

The establishment of the single project implementation unit (SPIU) in the Ministry of Health

Motivated by the desire to ensure effective, efficient and results-oriented management of project funds, the Government of Rwanda (Cabinet of 11/02/2011) adopted the principal of the of a Single Project Implementation Unit (SPIU) in each Budget Agency (Ministries, autonomous and semi-autonomous public agencies). With regard to that, the Ministry of Health has already established its SPIU, which is functional since 10 March 2011 (Ministerial Instruction No 20/52 of 10/03/11 on the establishment of a Single Project Management Unit (SPIU) in the Ministry of Health) with a staff working previously for the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) and World Bank Project Management Unit. To date, a Procedures Manual for the overall management and monitoring and evaluation of health sector development projects has been developed and approved by the MOH General Senior Management Meeting. The SPIU/MOH operates under the direct supervision of the Ministry of Health. With this new development in the project management, the following are expected:

a. Reduced transaction costs by sharing functions that are valid for any kind of health sector development project;

b. Reduced time that is spent in team recruitment for the newly starting project;

c. Reduced number of extensions formerly requested due to delays normally registered in the project start;

d. Reduced staff turnover since the core team for project implementation is retained and recycled depending on the emerging projects;

e. Simplified coordination and reporting system, thus helping to capture all projects into the National Development Budget;

f. Reduced number of project management units (PMUs) and PMU project bank accounts;

g. Coordinated supervision missions conducted by Development Partners, PR and SPIU;

h. Harmonized interventions and unit costs, as well as averted duplications across projects and donors.

With the support of the Ministry of Finance and Economic Planning (MINECOFIN), key development partners (DPs) were informed of this new arrangement, and a considerable number of them – the first one being the Centers for Disease Control and Prevention (CDC) of the Department of Health and Human Services (DHHS) of the Federal Government of the United States of America (USG) – have already shown their willingness and readiness to channel their funds through the SPIU. During the financial year 2010/2011, the SPIU portfolio was composed of the East Africa Public Health Laboratory Networking (EAPHLN) Project, funded by the World Bank, along with another four on-going projects funded by the Global Fund.

At the moment, the Ministry of Health has initiated the process of transferring to the SPIU other project funds from GAVI, the Rockefeller Foundation, GTZ, CTB, and the Swiss Agency for Development and Cooperation. With regards to the 2003 Rome Declaration on Harmonization, the 2005 Paris Declaration on Aid Effectiveness and the 2006 Rwanda Aid Policy: the Ministry of Health will continue discussions with other health sector development partners on how to support this new structure of the Rwandan Government for the management of public projects.

Virtual Elimination of Mother to Child Transmission of HIV (high level leadership and community level involvement)

Rwanda and its partners in the fight against HIV and AIDS are committed to the Elimination of MTCT (EMTCT) by 2015. With an ambitious target of reducing MTCT below 2% by 2015, we are here describing the High Level political commitment and mobilization activities organised from national to local level leaders as well as community involvement for EMTCT.

Strategic directions to achieve elimination of mother to child transmission of HIV include among others (i) Commitment and leadership, (ii) Technical guidance, (iii) Integration, (iv) Equitable access, (v) Promotion and supportive health systems, (vi) Measurement and (vii) Collaboration. The above strategies were used to mobilise central agencies, local authorities and community towards achieving EMTCT.

The First Lady of Rwanda endorsed EMTCT and officially launched a national Initiative for the Elimination of Mother to-child Transmission of HIV on May 12th 2011 at Ruhuha health center. The President of the Republic and the First Lady also advocated before world leaders at the High Level Meeting on HIV&AIDS in New York (June 8-10), showcasing the Rwandan model for EMTCT.

In the framework of the FLAME (First Ladies Action for Elimination of Mother to Child Transmission of AIDS) campaign, 18 journalists and parliamentarians were sensitized and equipped to mobilize community to address key behavioural bottlenecks (social and cultural norms, believes and misconceptions) to EMTCT. Additional strategies were used during the campaign to mobilize the general population on EMTCT as follows; talk-shows led by parliamentarians in collaboration with local authorities and health facility managers were organized in seven sites; meetings were organized at four sites at the provincial level under the leadership of governors, these meetings gathered 1296 participants; messages on EMTCT were shared during monthly community work "Umuganda" in all 30 districts of the country and finally, on 3rd June 2011, a national advocacy day was dedicated to EMTCT during which sensitisation events were organized in all the 381 PMTCT sites.

Rwanda has established high level leadership and has mobilized of communities towards Elimination of Mother-to-Child Transmission of HIV (below 2 % transmission) by 2015.

Task shifting

In resource-limited settings(Rwanda), serious healthcare worker shortages that contribute to weaken health systems exist alongside the drive to scale up ART and other HIV services to reach those in need. To bridge this gap, specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health.

It is evident that Rwanda was facing the challenge of having few health providers as the number of people on or needing ART increases, requiring long-term care and more staff to improve quality in HIV services. People who are eligible to ART were waiting for Medical Doctors to be initiated on treatment and this situation should not help in the improvement of quality of care to all health facilities, offering HIV services, around the country. Task shifting involves the rational redistribution of tasks among health workforce teams.

Given the scope of the situation in Rwanda and in the line of scaling up HIV services including ART, the delegation of healthcare tasks from higher-trained professionals to lesser-trained professionals was one of the solutions to meet the growing demand for services.

Task Shifting (change the roles and responsibilities of healthcare workers) was an urgent option for HIV/AIDS management in Rwanda in line with the WHO global recommendations and guidelines on task shifting propose the adoption or expansion of a task shifting approach as one method of strengthening and expanding the health workforce to rapidly increase access to HIV and other health services.

- By adopting this strategy, Rwanda has trained nurses to offer some activities which were offered by doctors, among them: ART first line prescription and the follow up of HIV infected or HIV

exposed patients, early identification of therapeutic failure in patients on ART, identification and management of side effects, STIs and TB screening , use of new patient files and registers

V. Major challenges and remedial actions

V.1. Progress made on key challenges reported in 2010

Alignment of partners

The Alignment of Partners to achieve effective implementation of the NSP 2009-2012 was raised as an issue in the UNGASS report from 2010.

In 2005, a Memorandum of Understanding was written between Development Partners and the Ministry of Health for a Sector-Wide Approach to Health (SWAp). It has been signed by 12 Development Partners. The partners in the health sector meet once a month and collaborate around issues of common and national concern. These partners are participating in Joint Health Sector Reviews with the Government twice a year. All activities carried out by the development partners are aiming at supporting the fulfilment of EDPRS and implementation of the Health Sector Strategic Plan.

To further align and coordinate the partners, since 2011 Global Fund Financial support in Rwanda is dispersed through a National Strategic Application using the Government as the Main Recipient of Global Fund funding and managing the support through the Single Project Implementation Unit in the Ministry of Health. This ensures that all Global Fund allocations are going to support the National Strategy in HIV, Malaria and/or TB.

In addition to these two coordinating mechanisms, the Government of Rwanda has recently begun to limit the amount of sectors that a single Development Partner can support. This allows fewer actors in each EDPRS sector and an easier interaction between Government and partners. It also allows the partners to focus more of their resources and time on key areas where they hold special expertise.

Bridging the funding gap

The financial gap was raised in the 2008 UNGASS report and remained an identified challenge in 2010. Although spending on HIV and AIDS is high in Rwanda compared to other areas in the health sector there is still a shortage of funds, especially for the support of vulnerable populations and for mitigating the effects of HIV. Donor programs providing nutritional support to people living with HIV and income-generating activities have been cut during the reporting period and the funding to support orphans and vulnerable children is still insufficient. In this report we have not been able to report on household support to the poorest quintile but since Rwanda still has a large portion of the population living below both the national and the international poverty line, the need for economic and social support is widespread and does not only include families infected with or affected by HIV.

Full geographic coverage of HIV prevention services

The challenge of reaching high-risk groups and youth with prevention services has been addressed in many ways in the last two years. RBC/IHDPC (former CNLS) has developed minimum packages for

sex workers, prison inmates and men who have sex with men, and these packages are currently under implementation. As previously mentioned, Rwanda has also moved forward in terms of mapping the size and characteristics of these groups to better respond to their needs. Prevention services have in some cases been offered in mobile clinics and mobile Voluntary Counselling and Testing (VCT) to reach geographically or socially hard-to-reach populations. Both Family Health International (ROADS project) and the Great Lakes Initiative on HIV and AIDS (GLIA) have been providing prevention services to populations at high risk at truck stops and border crossings.

Strengthening coordinating bodies

A challenge raised in the 2010 HIV update was HIV mainstreaming and the institutional changes on the way for CNLS and TRACPlus. As described in this report, this reorganisation is now completed and both CNLS and TRACPlus are incorporated in the Rwanda Biomedical Center. This has made the coordination of the HIV response more coherent, the link between research and programming tighter and the alignment of partner support easier. Involvement of non-health EDPRS sectors are still sometimes challenging. The Ministry of Education has a focal person for HIV and takes HIV issues into account especially in forming the sexual and reproductive education curricula. The Ministry of Gender and Family Promotion has been actively involved in the HIV response through the development and implementation of the National accelerated Plan for Women, Girls, Gender Equality and HIV. Further mainstreaming of HIV will be possible through the ongoing development of the new Health Sector Strategic Plan (HSSP III), coming into effect in 2012.

Decentralization

A challenge raised in 2010 was the need for increased capacity of the CDLS and district implementers to coordinate, monitor, report and actively contribute to decision-making on fund allocation. To make this possible, the Government has conducted trainings of District Health Professionals and establishment of district-based monitoring and reporting systems. At the time of writing, the districts are testing a new Health Management Information System aimed to allow them to better track their own allocations and spending in the health filed, including for HIV. In this way they can clearly identify funding gaps, create reports, make funding requests and compare their spending to other districts.

PMTCT Quality of Care

The scale-up of PMTCT has been successful in Rwanda but challenges now lie in assuring the quality of services, enrolment and minimize loss to follow up. PMTCT services are still being improved, for example to include more male involvement and a higher percentage of male testing and male partner support, to ensure more women receive at least four antenatal visits, and to increase the percentage of pregnant HIV-positive women who receive ARVs. The Government performed a six week evaluation study together with UNICEF in 2011 to measure the quality of services.

Needs of orphans and vulnerable children

This was raised as one of the challenges in 2010 and it still is at this time. In 2009 Rwanda had an estimated 1 350 000 orphans and vulnerable children 0 – 17 years old. (NSP, 2009) MIGEPROF reports that these children have a harder time accessing education, they suffer psychological distress and they have poorer living conditions than other groups in the country. This remains a challenge for the Government.

Addressing GBV

Brought up as a challenge in 2010, this remains a challenge. As seen in the recent RDHS 2010, experience of gender-based violence is still widespread in Rwanda and the efforts to support women who have experienced or are experiencing GBV (education of health care staff, opening of one stop centres for GBV, post exposure prophylaxis for victims) needs to be complimented by prevention efforts and programs addressing the underlying causes of GBV.

V.2. Current Challenges in the HIV response

Knowledge and protective behaviours, especially in high risk groups

The Truck Driver BSS from 2010 show that on many questions on HIV knowledge and prevention strategies truck drivers as a group know less now than they did in 2006. Only 30% of respondents knew that HIV-positive women can take ARVs to protect their infant from contracting HIV during pregnancy and labour, 17% less than the result in 2006. Truck drivers, as well as other migrant workers, are at especially high risk of contracting HIV through their sexual practices and it is a challenge to make sure that they have the knowledge to adopt protective behaviours for themselves and for their partners.

Flatlining HIV prevalence in youth, with significant difference between boys and girls

The particular vulnerabilities of young girls, combined with increased difference in the HIV prevalence in young girls compared to young boys, represent a challenge requiring ongoing monitoring and actions.

High HIV prevalence in female sex workers

As recent studies show, HIV prevalence is 51% among sex workers, this populations needs to access care and treatment. Sex worker targeted prevention and condom use for clients are major hallenges faced by the current HIV interventions.

Social support and nutritional services to PLWHIV

People living with HIV in Rwanda receive ARVs free of charge when clinically indicated, but social support and nutritional services are not accessed as desired.

Delayed disbursement of donor support

The Government implementation of HIV programs are facing delay due to the time between funding commitment and disbursement of funds from government partners. Annual planning is hampered by lag times of several months between commitment of funds and those funds being available for the implementer.

Remedial actions planned for achievement of agreed targets

The issues raised in this report are well known to decision makers in Rwanda and many of them are priorities in the current National Strategic Plan on HIV. The NSP is currently undergoing a mid-term review and all targets are followed up on to assess the progress, remaining steps required and to estimate the cost associated with the actions needed to reach the targets. With this review and priority setting for the remaining year of the current Strategic Plan in Rwanda, the country is expecting to achieve most of its targets.

VI. Support from the country's development partners

Key support

Rwanda is a country of highly skilled health and public health practitioners, also benefitting from the financial and technical support of development partners. The two majority funders of the HIV response are the Global Fund and PEPFAR, and in addition to those, a number of international foundations and organisations, bilateral agencies and the UN are supporting the process of policy and program development. On Government request, Rwanda has been a pilot country for the UN reform ("One UN"); UN Agencies will continue to work with a shared Country Action Plan for HIV and provide joint support to the Government.

Actions needed by the development partners

The development partners must sustain their support for HIV prevention, care and treatment, social support and mitigation in Rwanda, and commit to working with the Government in setting and achieving targets in the new National Strategic Plan (taking effect in 2013). To better support the Government, development partners should continue joint planning and coordination and continue to report budgeting and spending as well as submitting annual plans and reports. This facilitates Government planning and monitoring of the use of development partners' resources.

Nationally and internationally, the development partners should continue to harmonise reporting requests to minimize the burden of reporting and maximize the time spent supporting beneficiaries. This includes Country Progress Report Data, Universal Access, Global Fund, PEPFAR, IHP+, MDGs, EDPRS and financial reports. In Rwanda a common monitoring and evaluation system managed by RBC/IHDPC and a Health Recourse Tracking Tool managed by the Health Financing Unit in the Ministry of Health provide the environment to streamline these processes. Development partners should fully engage with such tools for their own reporting needs.

VII. Monitoring and evaluation environment

An overview of the current monitoring and evaluation (M&E) system

As the schematic figure below is showing, Rwanda has a vast amount of different M&E systems for the Health Sector in general. These are in the process of being coordinate thought a National M&E database to allow collection of all data sources in one access tool. There are currently one M&E system for HIV data, it is divided into a clinical (facility based) and a non-clinical (community based) part. The development of this M&E system and the capacity building for its use is an integral part of the NSP 2009-2012.

Community Based M&E

The data collection and reporting is done at decentralised level by the coordinator of the CDLS. 11 indicators have been selected that the districts are reporting on quarterly. The data is coordinated centrally through CNLS net. The data is analysed at national level by M&E analysts in RBC/IHDPC. The 11 indicators that have been chosen are corresponding to the data needs for the follow up of the NSP 2009-2010.

Facility based M&E

Rwanda has a web based system called TRACnet sin 2004. It is using mainly phone and internet connections to allow health facilities to report monthly on ART, PMTCT, VC - Male Circumcision Discordant Couples modules were added in 2011. Around 400 Health Facilities are reporting into TRAC net every month. District level agencies and implementing partners can access the data for program implementation monitoring. On national level M&E analysts are compiling the data, checking the quality and providing feedback, sharing it for research, using it for reporting purposes on national and international level and for program monitoring and evaluation.

An Electronic Medical Record (EMR) for patient medical charting is under development. This will eventually cover the whole country and all health facilities. In the beginning of 2012 approximately 20 district hospitals and 120 health centers had implemented the new EMR.

Challenges faced in the implementation of a comprehensive M&E system and remedial actions planned to overcome the challenges

The national HIV M&E system used to experience problems with the paper based reporting. Data were lost or hard to interpret. This has been overcome in the new digitalised system were information is captured and sent through mobile or internet technology.

Another challenge was a shortage of Human Resources to collect and report the data. This has been remedied by training of data collectors. NSP 2009-2012 is aiming to have at least 40 data collectors with full geographic coverage.

The data that are being collected and used at national level and by research and development partners to some degree but it is not used sufficiently by the district partners to prove its usefulness to those who are being asked to report.

The M&E data is being disseminated at district level four times per year to show the result of the reporting and to stress the importance of the data collected through data quality audit visits. Health centers and Districts are not yet at a good level of effective use of data generated for planning purposes.

The need for M&E technical assistance and capacity-building

In the NCPI part B workshop the Civil Society raised an issue of capacity in their organisation to access and use the national and district M&E data. They have the intention of creating evidence-informed programs corresponding to the needs in the country but feel that they don't have the necessary level of training to interpret and use the data that is available. Therefore there is a need to increase the M&E capacity in the Civil Society Organisations working in the field of HIV and AIDS.

Rwanda is producing a lot of research in the field of HIV and AIDS. This research is sometimes done by the School of Public Health, sometimes by RBC/IHDPC, NGOs or other partner institutions. There is a need to better coordinate these research efforts and disseminate the research results in a coordinated manner to avoid duplication of studies and make sure that partners that are interested in assessing studies know where to go to find these resources. In the NSP Rwanda is planning to have a research committee and a National Agenda for Research. The Research committee is in place but the National Agenda is in planning stages.

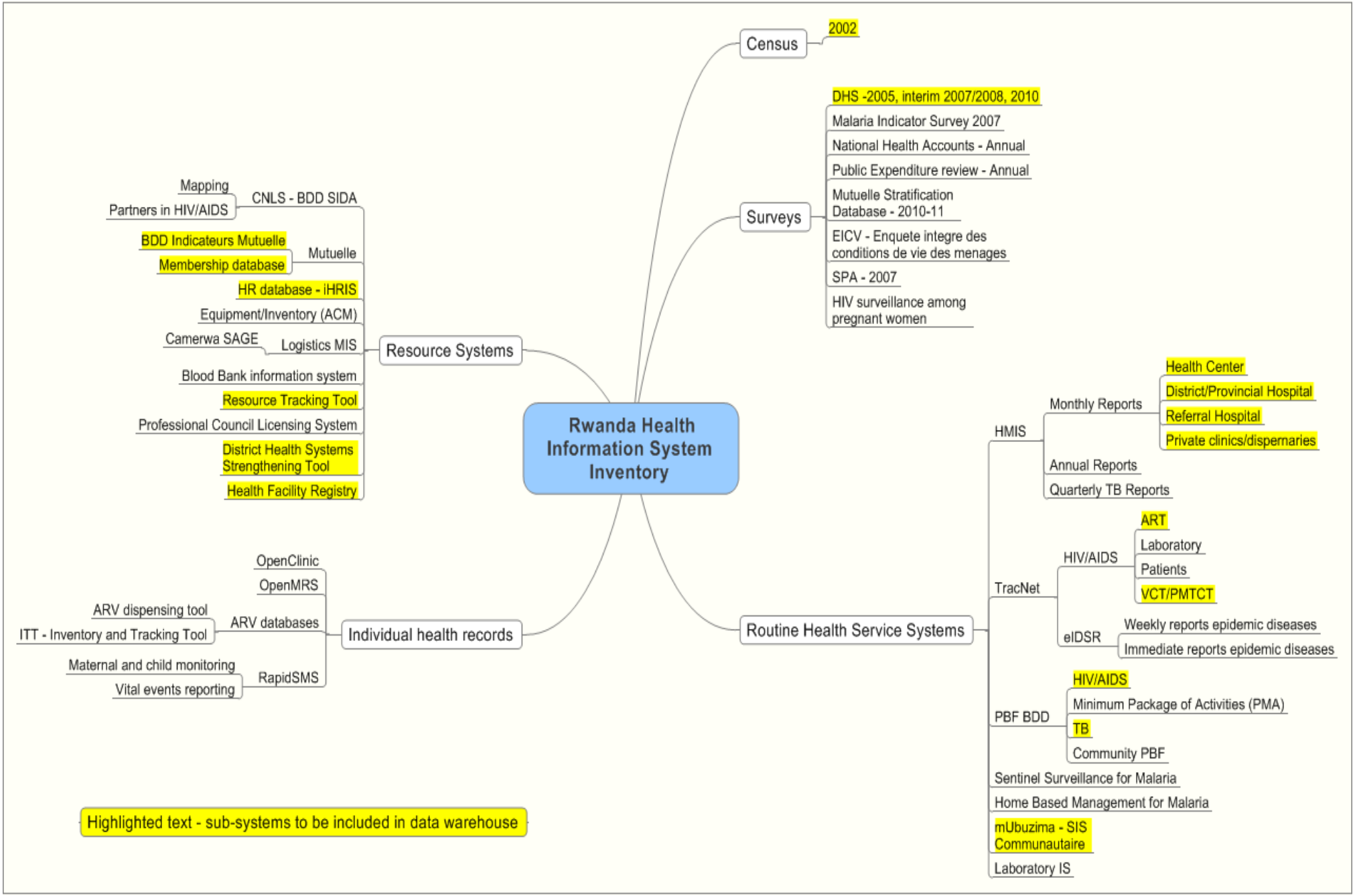


Figure 7.1 Key Ministry of Health Data Sources (Rwanda Ministry of Health, 2012)

	Information Obtained

Data sources	Financing	Quality Assurance	Service Delivery & Access	Medicines	Infrastructure & Equipment	Human Resources	Leadership & Governance	Strategic Information for health (epidemiology and demographics)
HMIS/SISCOM	■		■	■				■
DHSST	■	■	■		■	■	■	■
District Hospital Baseline survey	■	■	■		■		■	■
HRIS						■		
Resource Tracking database	■							
DHS			■					■
Census								■
Mutuelle system	■							
National budget law	■							
SmartGov	■							
PBF quality assessment		■	■					

Table 7.1 Selected data sources and information obtained through these (Rwanda Ministry of Health, 2012)

VIII. ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

ANNEX 2: National Commitments and Policy Instrument (NCPI) Part A

ANNEX 3: National Commitments and Policy Instrument (NCPI) Part B

END