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NATIONAL ANNUAL REPORT ON HIV & AIDS
July 2010 - June 2011

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Through the Monitoring and Evaluation Technical Working Group, the RBC-IHDPC collected the required information and data from MOH, RBC-IHDPC/HIV&AIDS, STIs and Other Blood borne, RBC-NRL, RBC-CNTS, RBC-MPDD, CDLS, Umbrellas, EDPRS Sectors and some implementing partners.

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Last but not least, a lot of thanks go to the RBC-IHDPC M&E Team for the work well done.

Executive Summary

The 2010-2011 National Annual Report on HIV program presents the progress in implementing the strategies and activities articulated in the National Strategic Plan on HIV and AIDS 2009-2012 commonly referred to as the HIV NSP. The report presents consolidated information regarding the outputs in the second year of implementing the four year strategy. This report will serve to inform the Mid Term Review of the HIV NSP 2009-2012.

Data collection for this report was led by the Monitoring and Evaluation Team in RBC-IHDPC which has UNAIDS and MEASURE Evaluation as key technical partners. Information on achievements and challenges was gathered in line with each of the NSP outputs from both government agencies and nongovernmental partners supporting the national response to HIV and AIDS.

The NSP clearly articulates the progress towards set targets by planned strategies to achieve the implementation of the four year strategy. The country has made great progress during the reporting period and some of the key achievements are summarized under the three impact areas below.

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

- The increase in the number of health facilities offering VCT services contributed to the increase in the number of clients tested for HIV. Actually, there is 448 health facilities offering voluntary counseling and testing. In the last seven years, 2003-2011, the HIV&AIDS, STIs and Other Blood Borne Infections Division has registered a downward trend in HIV positivity rate in clients tested in HCT facilities from 10.8% reported positives in 2004 to 1.7% at the end of June 2011.
- Minimum packages of services for key populations and vulnerable groups including service provision have been developed.
- Family planning is a national priority, and FP promotion for HIV positives is one of the strategies to decrease vertical transmission of HIV. From July 2010 to June 2011, **38954** HIV positive clients received modern FP methods from health facilities.
- The availability and accessibility of condom as dual protection was increased. Blitzing activities for creation of more condoms sales outlets have been conducted in

collaboration with PSI, installation of Advanced Business Strategies (ABS) condom promotion signs has been scaled up from urban to rural areas, 700 condom vending machines have been procured and their installation is in progress. Moreover, a total number of 4,897,144 condoms were distributed during the World Aids Day 2011 campaign.

- The first phase of implementation of the Male Circumcision (MC) scale up plan was launched in two pilot sites (Nyanza and Musanze). This involved trainings of medical doctors and nurses in District hospitals and health centers, and provided MC services to 3,000 men.
- National coverage of PMTCT services was 85%, a result of increased number of Health facilities providing PMTCT services from 382 HF in 2010 to 412 in 2011. Male involvement in PMTCT increased also from 16% of male partners of pregnant women counselled and tested between July 2002 and June 2003 to 84% during the reporting period.

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

- From July 2010 to June 2011, among 33722 newly enrolled clients, 20593 (61%) were screened for active TB. Among those screened, 2492 patients had a positive screening. After para clinical examinations 809 adults and 74 children were started anti TB treatment and were followed in one stop TB/HIV services. Most successful: 97% of all TB patients registered were tested for HIV. The prevalence of HIV among those TB patients was 30% and 98% of all co infected cases received Cotrimoxazole preventive treatment.
- By the end of June 2011, 336 health facilities were offering care and treatment services with an increase in the number of patients on ARVs from 870 patients in 2002 to 96,123 patients by June 2011. Among them 98% were on First line regimen while only 2% were on second line regimen.
- New indicators on tracking and tracing lost to follow up (LTFU) clients have been incorporated in the TRAC net system. Health facilities are reporting on a monthly basis and this enables the program at both levels, central and peripheral to get updated information on LTFU.

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

- With Single Stream of Funding (SSF) funds from Global Fund, the Rwandan Network of People living with HIV (RRP+) has organized 360 members in 15 associations, and trained them in project development, management, good governance, and cooperative laws.

  CHF project "Higa Ubeho" had provided management and governance training, financial literacy training and market literacy training to 97 cooperatives representing more than 8,000 individuals, technical support in production techniques to 37 cooperatives and internal savings and lending practices training to 2000 groups representing above 40,000 individuals.
- To develop entrepreneurship among people infected and affected by HIV, 3 associations were transformed in cooperatives with RRP+ support, and CHF Higa Ubeho had provide training and ongoing technical support to assist 42 associations of PLWHA to acquire cooperative status, training on development of business plans for cooperatives and technical support to about 10,000 individuals who are involved in small income generating activities.
- From 2010 till now RRP+ with Global Fund support had spent around 27 million RWF (almost 50,000 USD) in supporting associations and cooperatives in IGAs.
- Identification of orphans and vulnerable children (OVC) for education support was done in October 2010 as pilot phase with a total number of 580,878 OVC in secondary, primary/nursery, and vocational training. Through the coordination of MIGEPROF, implementing partners provided support to OVC on different components included in the OVC minimum package with a total number of 283,391 of OVC supported as reported by partners at the end of June 2011.
- RRP+ has developed the manual on human rights with specific focus on the rights of PLWHA. This manual is intended to contribute to overall efforts to prevent the violation of their rights, by equipping PLWHA with a legal guide that meets their needs for knowledge of human rights, administrative and legal services as well as possible remedies.

Future actions to be prioritized in the next implementation period

- Strengthen HIV prevention programs in light of the incidence
- Look at combination HIV prevention interventions
- Transition from Prevention of Mother to Child Transmission (PMTCT) to Elimination of Mother to Child Transmission (EMTCT)
- Ensure that key populations are reached by minimum package of services for prevention, care and treatment.
- Continue the training of HF on MC to achieve the set targets in prevention through MC
- Conduct the Mid Term Review of the NSP 2009-2012 after two years of implementation.

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ABBREVIATIONS

ABC	Abstinence Be faithful and Condoms
ABS	Advanced Business Strategies
AIDS	Acquired immunodeficiency syndrome
ANC	Ante-natal consultations
ART	Anti-retroviral therapy
BCC	Behavior Change Communication
BSS	Behavioral Sentinel Surveillance
C&T	Care and Treatment
CAMERWA	Centrale d'Achat des Médicaments Essentiels du Rwanda (Central Agency for Procurement of essential Medicines)
CBO	Community based organization
CCM	Country coordinating mechanism
CDLS	Comité de District de Lutte contre le Sida (District AIDS Control committee)
CHUB	University Teaching Hospital of Butare
CHUK	University Teaching Hospital of Kigali
CHW	Community health worker
CNLS	Commission Nationale de Lutte contre le Sida (National AIDS Control Commission)
CPDS	Coordinated Procurement and Distribution Systems
CSO	Civil society organization
CT	Counseling and Testing

DH	District Hospital
DHS	Demographic and Health Survey
DOTS	Directly observed treatment – short course
EDPRS	Economic Development and Poverty Reduction Strategy
EER	Eglise Episcopal du Rwanda
EID	Early Infant Diagnosis
FBO	Faith based organization
FHI	Family Health International
FOSA	Formation Sanitaire (Health Facility)
FP	Family Planning
FSW	Female Sex Workers
GF/MAP PMU	Global Fund / MAP Project Management Unit
GIPA	Greater involvement of people living with HIV and AIDS
GLIA	Great Lakes Initiative against AIDS
GLSA	Group Saving and Loan Associations
GOR	Government of Rwanda
HBC	Home Based Care
HCC	Health Communication Center
HF	Health Facilities
HIV	Human Immunodeficiency Virus
HRT	Health Resource Tracking Tool
HSSP	Health Sector Strategic Plan

ICAP	International Center for AIDS Care and Treatment Programs
IEC	Information, Education, Communication
IGA	Income generating activity
IHDPC	Institute of HIV/AIDS, Disease Prevention and Control
IMCI	Integrated Management of Childhood Illnesses
M&E	Monitoring and Evaluation
MARPs	Most at Risk Population
MC	Male Circumcision
MCH	Maternal Child Health
MDG	Millennium Development Goals
MIFOTRA	Ministry of Public Services and Labor
MIGEPROF	Ministry of Gender and Family Promotion
MIJESPOC	Ministry of Youth, Sport and Cultural
MINAFET	Ministry of Foreign Affairs
MINAGRI	Ministry of Agricultural
MINALOC	Ministry of Local Government, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MINICOM	Ministry of Commerce and Industry
MINIJUST	Ministry of Justice
MININFRA	Ministry of Infrastructure

MINIYOUTH	Ministry of Youth
MoH	Minister of Health
MPDD	Medical Procurement and Distribution Division
MSM	Men who have sex with men
NCBT	National Center for Blood Transfusion
NCC	National Commission of Children
NGO	Non Government Organization
NIS	National Institute of Statistics of Rwanda
NRL	National Reference Laboratory
NSP	National Strategic Plan on HIV and AIDS
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PBF	Performance based funding
PCR	Polymerase Chain Reaction
PE	Peer Educators
PEP	Post exposure prophylaxis
PEPFAR	Presidential Emergency Plan For AIDS Relief
PIT	Provider Initiated Testing
PLHIV	People Living with HIV
PMTCT	Prevention of mother to child transmission of HIV
PWD	People With Disabilities
QC	Quantification Committee
RBC	Rwanda Biomedical Center

RCLS	Réseau des confessions religieuses dans la lutte contre le Sida (Network of Faith Based Organizations against AIDS)
RH	Reproductive Health
RHCC	Rwanda Health Communication Center
RNYC	Rwanda National Youth Council
RPOs	Rwanda Partners Organizations
RRP+	Rwanda Network of People Living with HIV
RWANARELA	Rwanda Network of Religious Leaders living with AIDS
SGBV	Sexual Gender based violence
SOP	Standard Operating Procedures
SPIU	Single Project Implementation Unit
SSF	Single Stream Funds
STI	Sexually Transmitted Infection
TBA	Traditional birth attendants
ToT	Training of Trainers
TRAC Plus	Treatment and Research AIDS Centre
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund

UPHLS	Umbrella des personnes handicapées dans la lutte contre le Sida (Umbrella of people with disabilities in the fight against AIDS)
USAID	US Agency for International Development
USD	US Dollars
USG	United States Government
VCT	Voluntary Counseling and Testing
WAD	World Aids Day
WHO	World Health Organization
YFC	Youth Friendly Center

1 Introduction

The Annual Report on HIV and AIDS 2010-2011 captures the main achievements and progress to date in the implementation of the multi-sectoral HIV response in Rwanda, as outlined in the National Strategic Plan on HIV and AIDS 2009-2012 (NSP).

The NSP serves as the guidance document for all HIV implementers in the country, indicating key national results that should be achieved through the delivery of high quality HIV services in both health facilities and community settings. Following the Three Ones framework, the NSP clearly describes the roles and responsibilities of all actors and stakeholders in the HIV response at the international, national, and decentralized levels, indicating key strategies to guide implementation.

1.1 Purpose of Annual Report on HIV and AIDS 2010-2011

The report is meant to serve as the overall reference document for the HIV response in Rwanda, providing the most comprehensive data on progress in NSP implementation and achievements against NSP results and targets and will inform the Mid Term Review of the NSP with the purpose of informing key stakeholders on the progress against outputs and strategies in order to reorient actions and interventions with the aim of maximizing the results of the plan and inform other planning processes.

For the first time, the National Annual HIV Report also includes a financial section describing HIV expenditures for the same time period. In this financial report, we will refer to the costing and gap analysis produced at the time of development of the HIV NSP 2009-2012, and will compare those projections to the actual commitments made by major funding sources of the HIV response for fiscal year 2010-2011 and to the effective HIV expenditures for the same period. For GOR HIV expenditures, more details will be given on the main cost categories to which it contributes.

1.2 Organization of Annual Report on HIV and AIDS 2010-11

This National HIV Annual Report is largely focused on the progress in implementation based on the national and programmatic indicators with a small narrative summary on the description of activities and strategies.

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

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

In the NSP, each Impact Result is further organized into outcome results, intermediate results (for the HIV Prevention Impact Result), and output results. For this report, the progress is described at a secondary level by output result under each impact result with a narrative describing the achievements of HIV actors in the country according to key strategies under each output.

The financial part of the report provides information on HIV expenditure during the reporting period with a comparison of the gap and budget projections to the expenses and actual commitment by different stakeholders. The expenditures are available by NSP categories.

At each result level, performance and success indicators have been selected as national and program level indicators with annual targets to measure progress. Impact and outcome results are higher level results obtained and measured at the population level. These changes take several years to detect through population-based surveys and other research studies, and thus are beyond the purview of this report. Nonetheless, some data are available to report against the NSP national and program-level indicators (typically divided according to the community-based and facility-based HIV response) and these data are reported in the section on NSP Indicators in ANNEXES A, B, and C.

2 PROGRESS ON THE IMPLEMENTATION OF KEY STRATEGIES BY NSP OUTPUT RESULTS

2.1 IMPACT 1: THE INCIDENCE OF HIV IN THE GENERAL POPULATION IS HALVED BY 2012

2.1.1 Output1.1.1.1. General Population are reached by comprehensive HIV prevention programs

This output seeks to ensure that all members of the Rwandan population are informed about HIV and STI prevention, and the existence of key services such as family planning, HIV testing and condoms. During the reporting period, all partners worked together to provide HIV prevention services to the general population according to the key strategies outlined in the NSP.

Community sensitization for promotion of safe sexual behaviors, including HIV testing and condom promotion

Regarding HIV testing, the outreach HIV counseling and testing (mobile VCT) was also carried out at the community level through the collaboration and partnership with community-based organizations, the private sector, NGOs and faith-based organizations with the support of health facilities' staff trained in HIV counseling and testing. Mobile VCT is mainly carried to overcome the problems related to geographical inaccessibility of VCT services and to reach key populations at higher risk and vulnerable groups. This strategy was especially used in detention centers, youth-friendly centers, and among key populations, e.g. sex workers, truck drivers, men in uniform.

Involvement of local authorities in community sensitization

To ensure the involvement of local authorities in different community sensitization activities, it was evident that the local authorities must have needed information on different risk factors that the community is facing and strategies in place to overcome them. With that purpose, a booklet targeting the local authorities with HIV, STIs, RH, and SGBV information was developed through RHCC and a workshop with local authorities will be organized next year to exchange on those information.

Involvement of Medias in community sensitization

Different media tools were used to provide information on HIV. A weekly radio program entitled « *Tega amatwi wumve ubeho* » (*Listen and live)* was produced by RBC-IHDPC (Former CNLS) and transmitted by Radio Rwanda every Saturday, from 8:30am to 9:00am. This radio show was posted on Former CNLS website (www.cnls.gov.rw); and as a result, this helped its visitors from over the World to hear different themes developed on HIV and AIDS issues.

To reach a wider audience, RBC-IHDPC (Former CNLS) provided various messages on HIV and AIDS through publications of articles on RBC-IHDPC big events like conferences and campaigns (World AIDS day campaign). A special coverage of 2010 World AIDS day was reported on 8 pages in Dispatch Magazine and different medias (radio stations, TV, printed press, websites) that had been invited to cover the event.

Extension of youth friendly HIV prevention and reproductive health services

In the reporting period, a total number of 18 Youth friendly centers were operational throughout the country: 5 in Kigali, 3 in Eastern province, 4 in western province, 3 in northern province and 1 in southern. In the same period, PSI Rwanda constructed and rehabilitated 6 youth centers with support from Global Fund and 1 additional Youth Center was constructed in Nyamasheke with support from UNICEF towards the annual target of 7 youth centers.

The following are newly established youth centers during that period:

- 3 youth centers constructed in Bugesera, Rulindo, and Rubavu districts;
- 1 youth center constructed in Nyamasheke;
- 3 youth centers rehabilitated in Kicukiro (AGR), Nyarugenge (Rafiki Club), and Rutsiro districts.

Within the process to construct and rehabilitate the newly established youth centers, PSI Rwanda in collaboration with RNYC under MIJESPOC recruited youth centers managers. Several meetings were held between MIJESPOC, Rwanda National Youth Council (RNYC) and PSI Rwanda to work out the details of transitioning staffing and subcontract to sub- recipients. Those Youth Services Manager from PSI Rwanda started working at the (RNYC) as a technical support person to youth centers. They are coordinators, Youth Centers VCT Counselors, Clerks, Peer Educators, and Security Guards.

Moreover, trainings in HIV prevention were organized for 312 CHWs, 146 Public Sector Health providers. Twelve out of 42 new youth center staff for Rulindo, Nyamasheke, Bugesera and Rubavu, have been trained in peer education and the youth center reporting system.

During the period of April 2011 to June 2011, PSI/Rwanda also trained 123 VCT counselors on how to use Male Circumcision IEC materials developed in collaboration with RBC-IHDPC and UNICEF. During the same period, Abajene-Dushishoze youth centers trained 375 new peer educators in AB and OP.

The referrals system for youth in YFC is done through the facilitation of nearest Health center in order to get youth friendly HIV counseling and testing, STIs treatment, and FP/reproductive health.

As challenges, there is a need to rehabilitate 3 YFC (in Muhanga, Nyanza and Kayonza) as well as comprehensive IEC tools for each YFC in order to improve their service and sufficient budget supporting them to implement and coordinate their daily activities. But regarding IEC tools, they are in process of development by different institutions such as RHCC, Health centers and different Partners.

By the end of May 2011, 185 anti AIDS clubs were created for secondary schools. This was done following a study that assessed the gaps of anti AIDS clubs in secondary schools. The report revealed that some secondary schools did not have anti AIDS clubs and MINEDUC embanked on training of patrons for anti AIDS clubs (Two teachers per schools with a total of 371 teachers) who were commissioned to go back to their respective schools and start up anti AIDS clubs.

Integration of HIV prevention component into schools' curricula

With support from UNESCO, MINEDUC has commissioned a study to guide effective mainstreaming of HIV and AIDS in the school curriculum. The report was validated by the TWGs and send to UNESCO for validation. Thereafter, the report will be disseminated.

MINEDUC has also developed the National Education HIV and AIDS Policy which will guide HIV and AIDS activities in the education sector. The policy is at the stage of being approved by the Cabinet.

Outreach work and provision of complete package of prevention with out-of- school youth through peer education, including provision of information on HIV and STIs, gender based violence, condom promotion, life skills, and referral for HIV testing and STI

Rwanda Health Communication Center has developed a specific training manual for out of school youth and 1970 youth out of school have been trained as peer educators in HIV, STIs, RH and GBV.

During the reporting period, a mass mobilization campaign was organized by the Ministry of Youth in 21 districts. In those 21 districts at least 200 youth out of school have been reached by this mass mobilization campaign which focused on HIV and RH questionnaires and answers.

Through PSI Rwanda, 1441 IST booklets, 4208 Abajene T-Shirts, 1267 comic books were distributed to out of school youth and community members to promote healthy sexual behavior and HIV prevention. Other promotional materials distributed to out of school youth and community members by Rwanda Partners Organizations in 21 districts are 41605 including booklets, Sinigurisha booklets, IST booklets, condom kits, Sinigurisha T-shirts (Sinigurisha is a multi-media campaign sensitizing youth and the general population about the dangers of inter-generational sex).

Between July 2010 and September 2010, 406 youth were trained in Abstinence Be faithful and Condoms (ABC) and 30 trained in VCT, 349 out-of-school peer educators trained in Condoms (C). Between October 2010 up to June 2011, PSI Rwanda organized trainings and refresher training for 867 Peer Educators from different Anti-Aids Clubs in Youth Cooperatives and Associations on Abstinence Be Faithful and Condoms (ABC).

The condom outlets targeting youth are mainly in 4 youth centers in Gasabo, Ngoma, Musanze, and Huye. However, between July 2010 and June 2011, PSI Rwanda created new and supported old retail outlets for a total of 841 outlets serving key target groups including youth.

Extension and Improvement of CT services

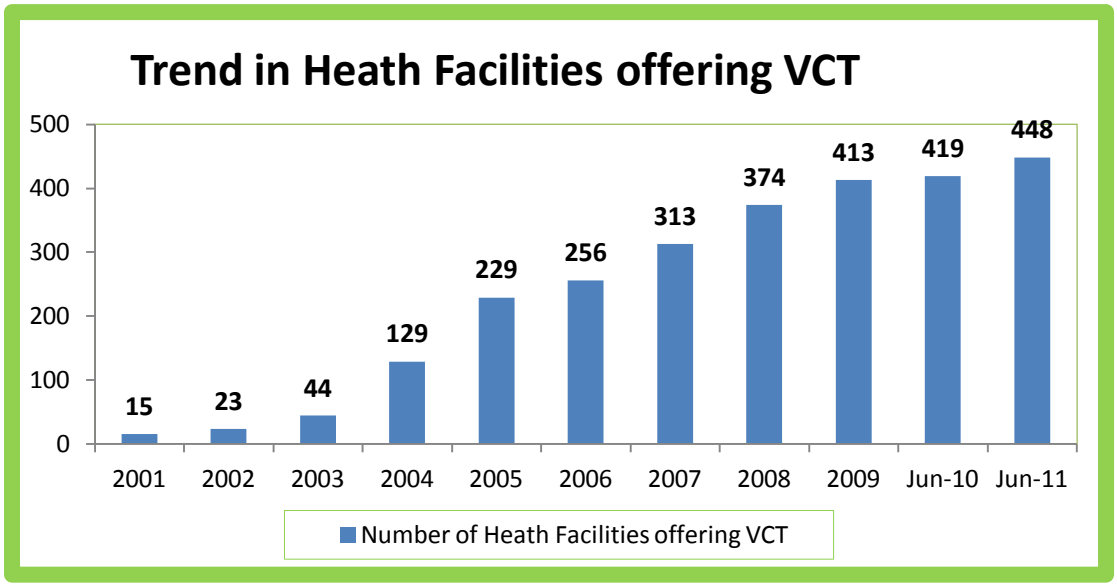
VCT is performed in health facilities as a preventive activity. Many strategies are used to ensure that this service is offered to everyone who wishes to know his/her HIV status; those who come to health facilities with signs, symptoms or health conditions that could indicate the suspicion of HIV infection are advised by care providers to do the HIV testing through PIT.

The outreach HIV counseling and testing (mobile VCT) was also carried out at the community level though the collaboration and partnership with community-based organizations, the private sector, NGOs and Faith-Based Organizations with the support of health facilities' staff trained in HIV counseling and testing. Mobile VCT is mainly carried out to overcome the problems of geographical accessibility to VCT services and to reach key populations and vulnerable groups. This strategy was especially used in youth-friendly centers and among key populations, such as sex workers and mobile populations.

- **Clients received and tested for HIV**

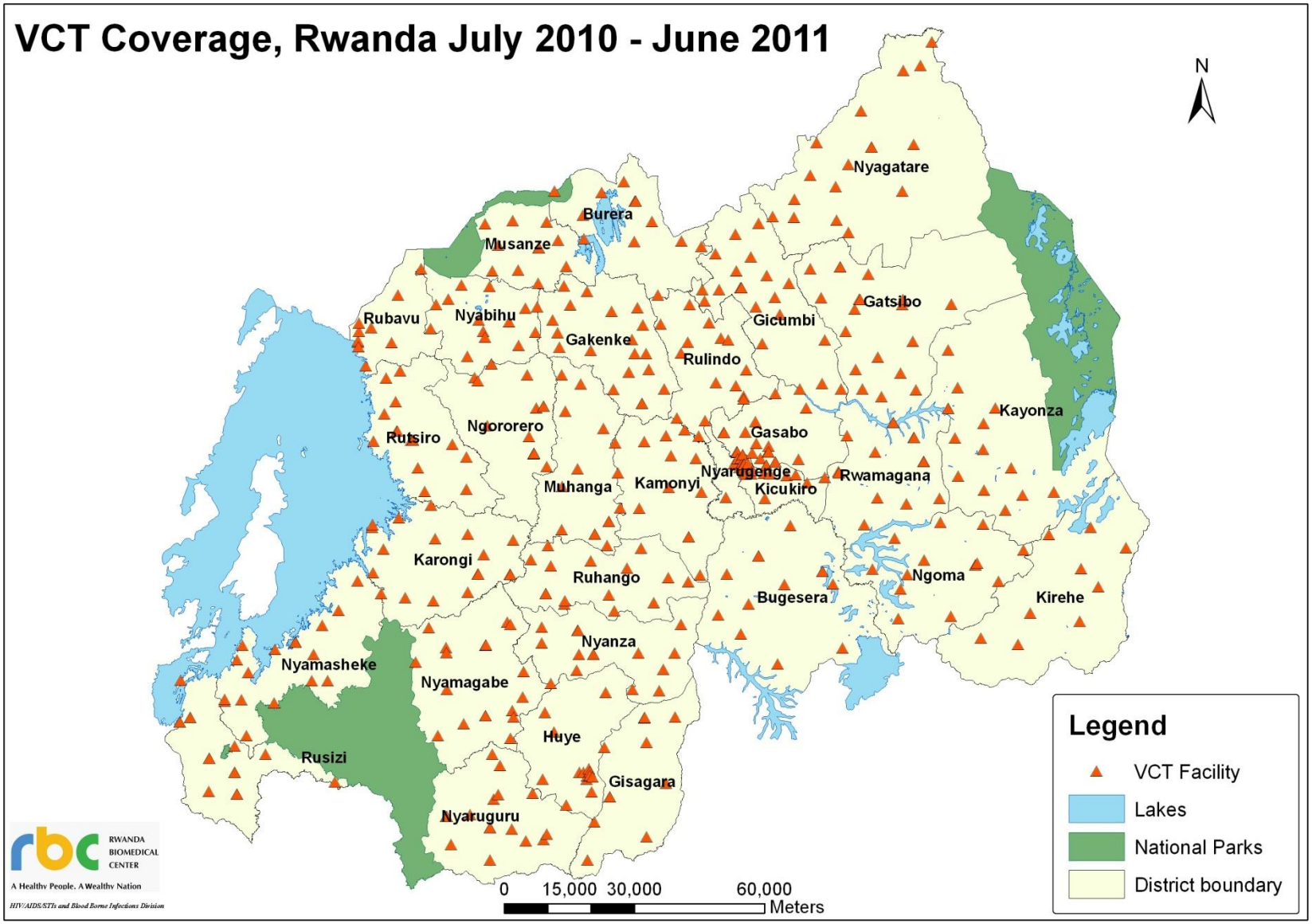
Scale up of health facilities offering VCT services contributed to increase the number of clients counseled and tested for HIV **(1,627,556 tests done)** in health facilities and mobile VCT from July 2010 to June 2011.

Figure 1: Trend in health facilities offering voluntary counseling and testing since 2001



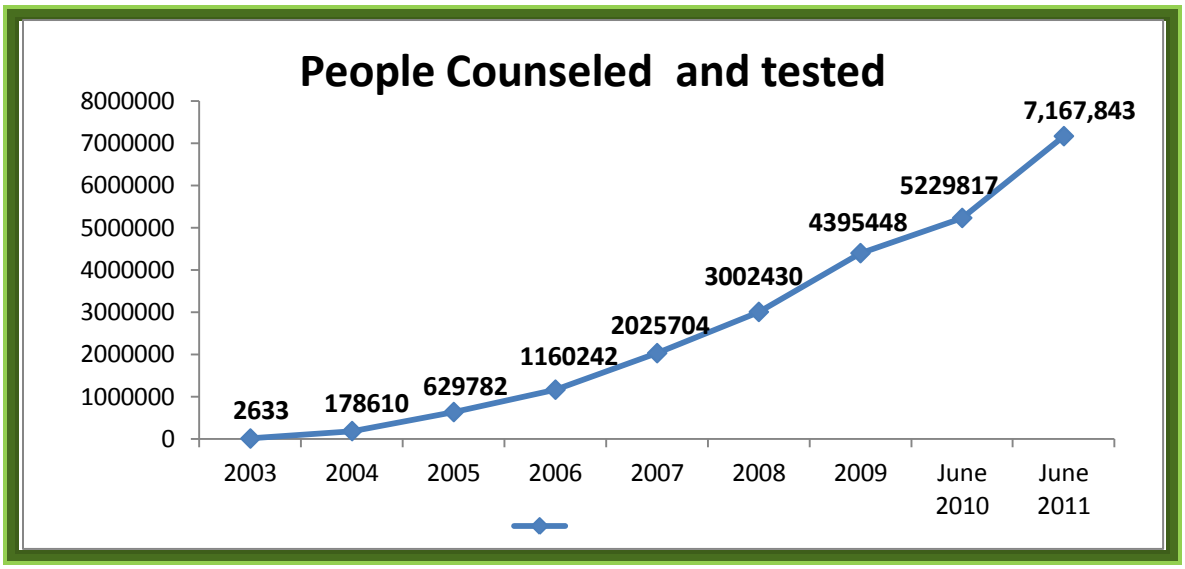
The Figure above shows a significant increase in number of health facilities offering VCT from 15 in 2001 up to 448 health facilities in 2011.

Map1: VCT Coverage



The increase of Health Facilities offering VCT services is also reflected in the mapping above with a good repartition of HF with VCT services through all the Country.

Figure 2 : Cumulative number of People tested for HIV from 2003 to June 2011



The total number of people tested for HIV since 2003 up to June 2011 was 7,167,843. This number includes people tested in both health facilities and mobile VCT.

Map 2: Repartition of people counseled and tested

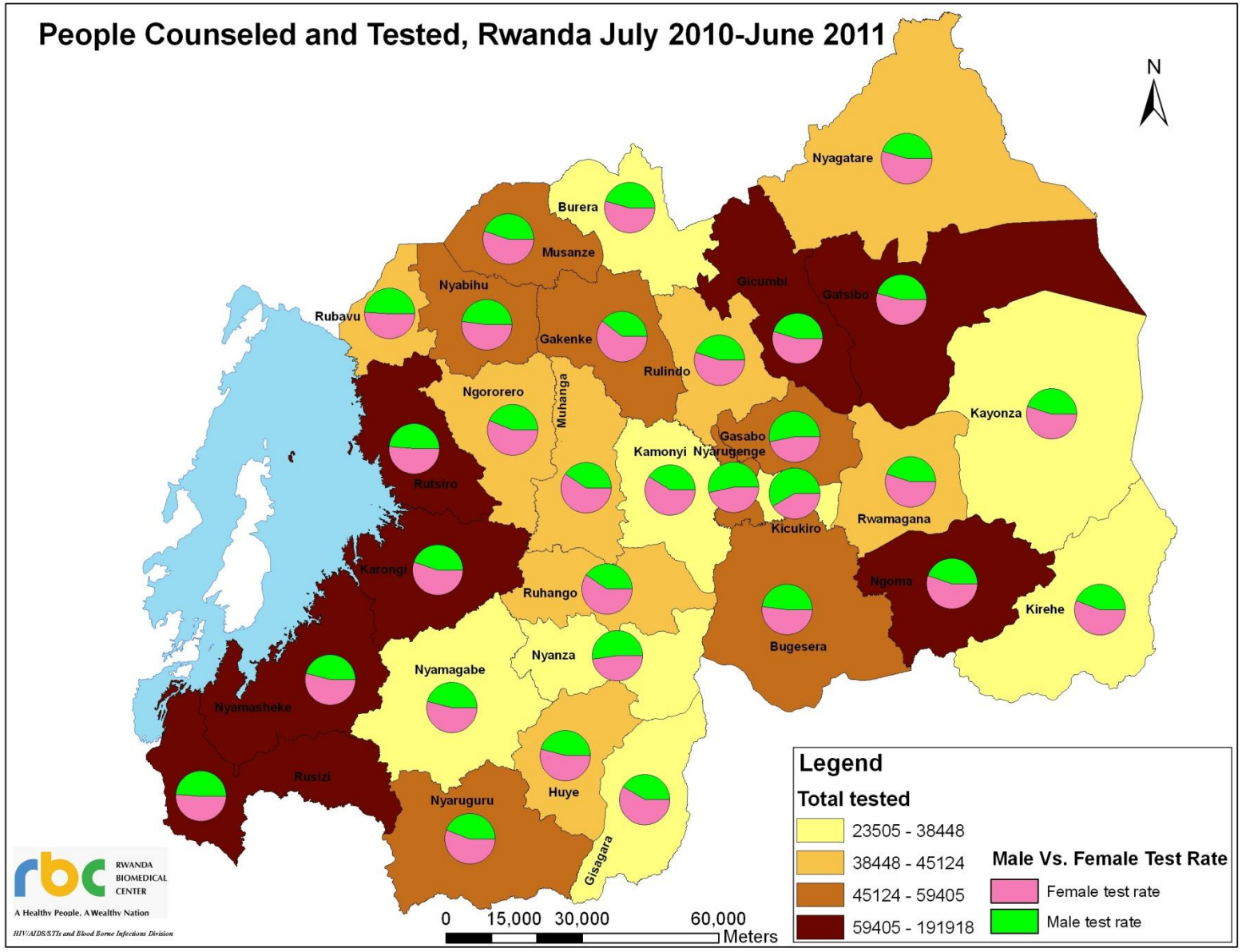
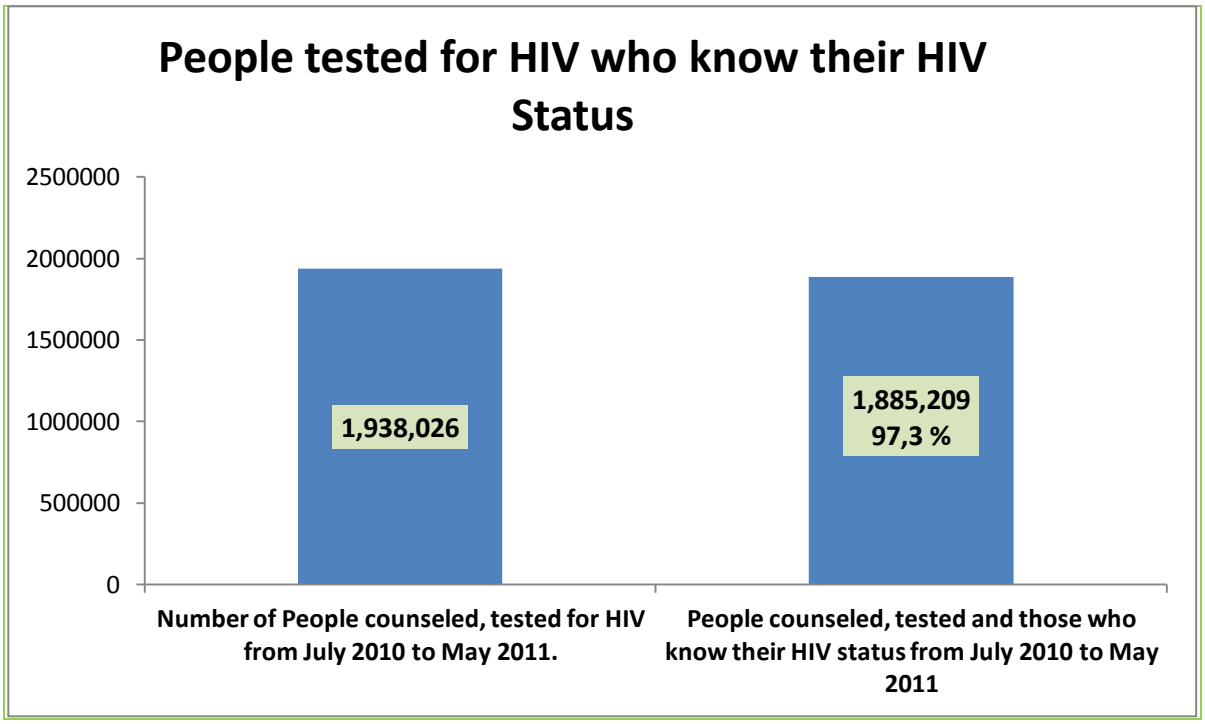
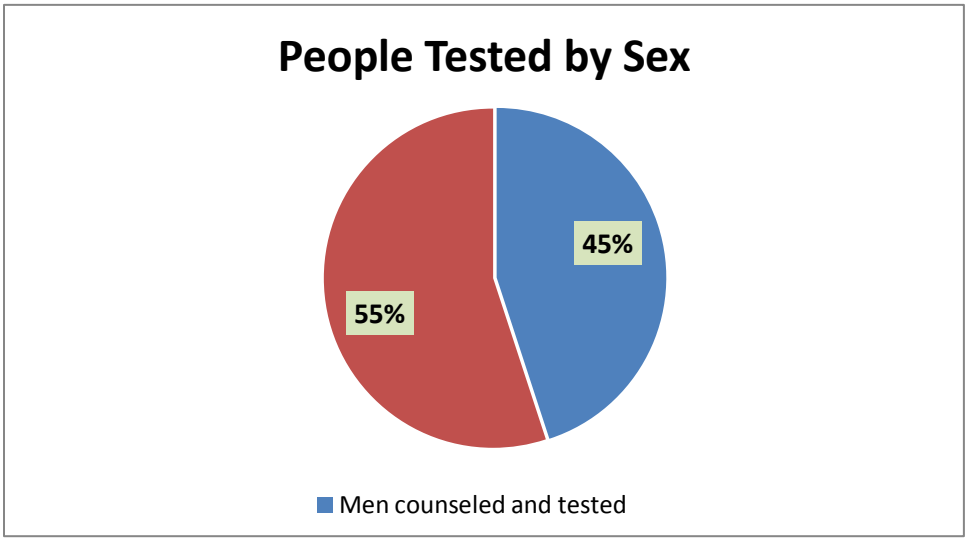


Figure 3: People tested for HIV who know their HIV Status



Among 1,938,026 people who were tested in health facilities and mobile VCT; 1,885,209 (97, 3%) know their HIV status.

Figure 4 : Distribution by sex

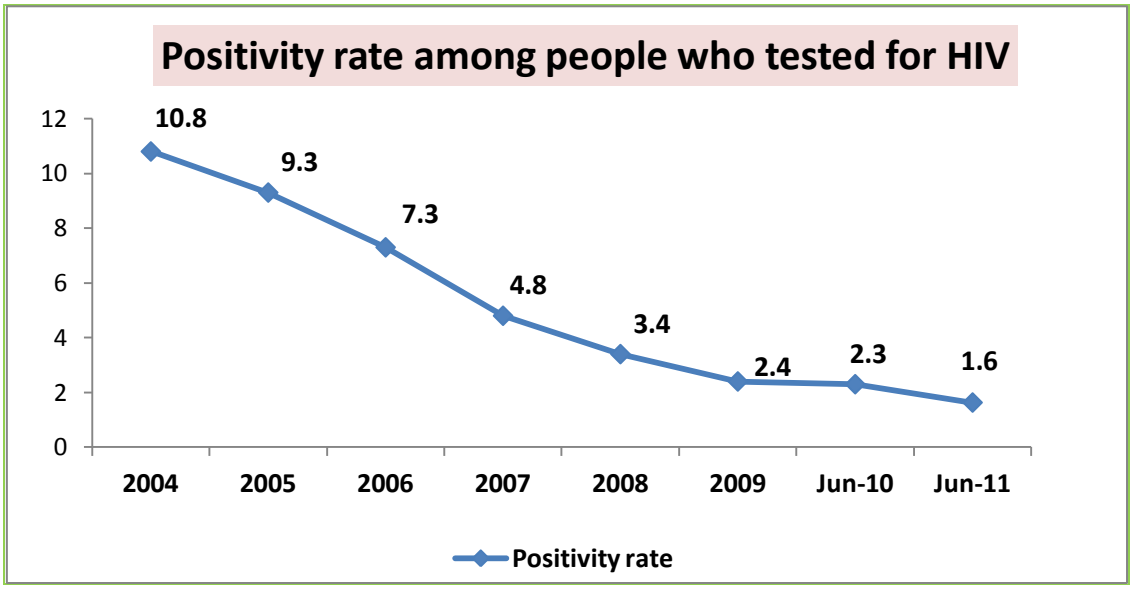


In a total of 1,938,208 people tested from July 2010 to June 2011, 55% were women and 45% were men.

HIV positivity rate among people tested

In the last seven years, the HIV/AIDS, STIs and Other Blood Borne Infections Division has registered a downward trend in HIV positivity rates across clients tested in VCT services, from 10.8% in 2004 (TRAC Report 2004) to 1.6% reported positivity rate at the end of June 2011.

Figure 5: Positivity rate among people who tested for HIV



Among 33,863 people who tested HIV positive (1.6%), 13,884 (1.5% positivity rate) were men and 19,979 (1.7% positivity rate) were women.

The highest positivity rate is in Kigali (Kicukiro: 7.9 % Nyarugenge: 5.7% and Gasabo: 5.34%) than in other provinces as showed in the map below.

Map 3: HIV Positivity rate in Rwanda

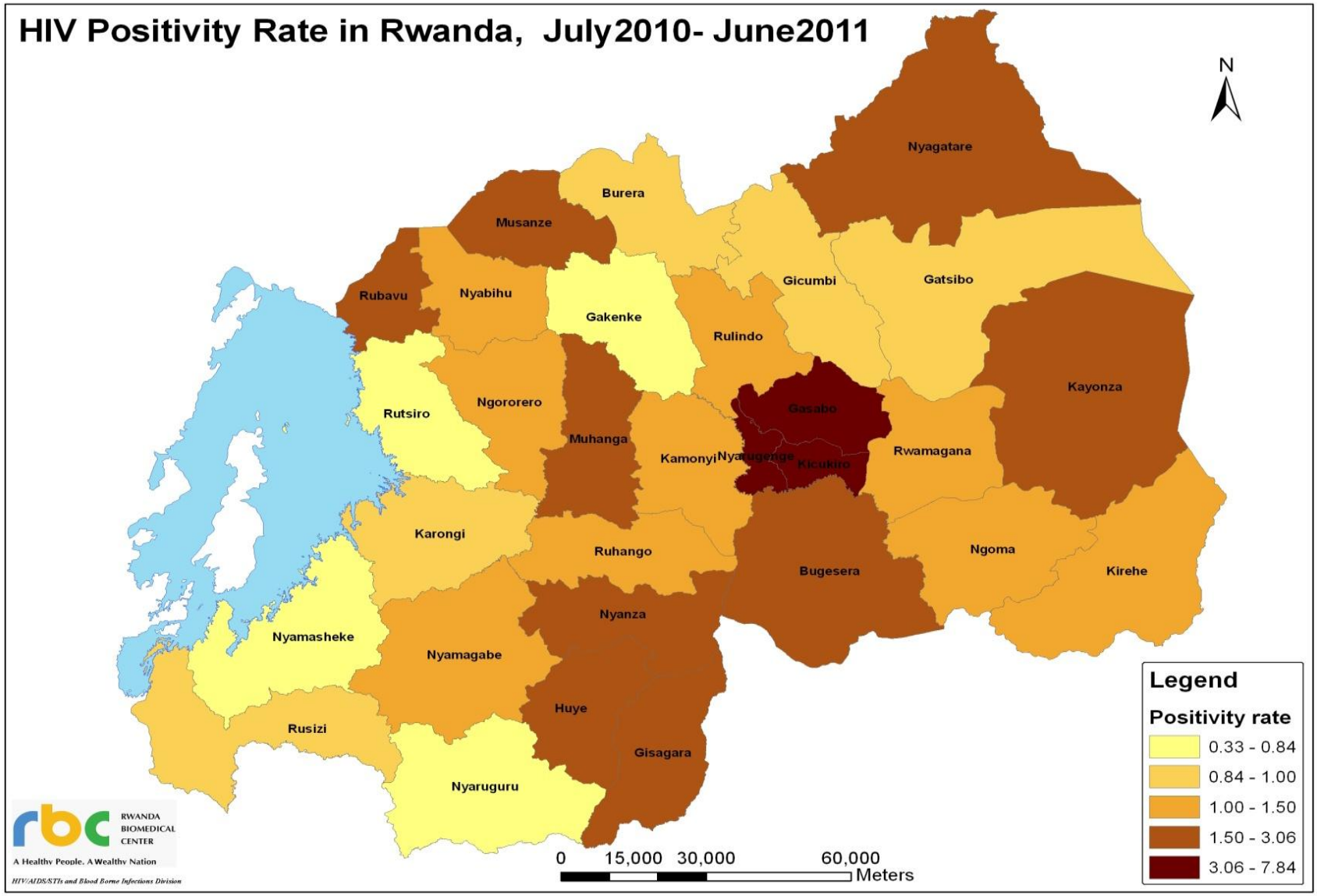
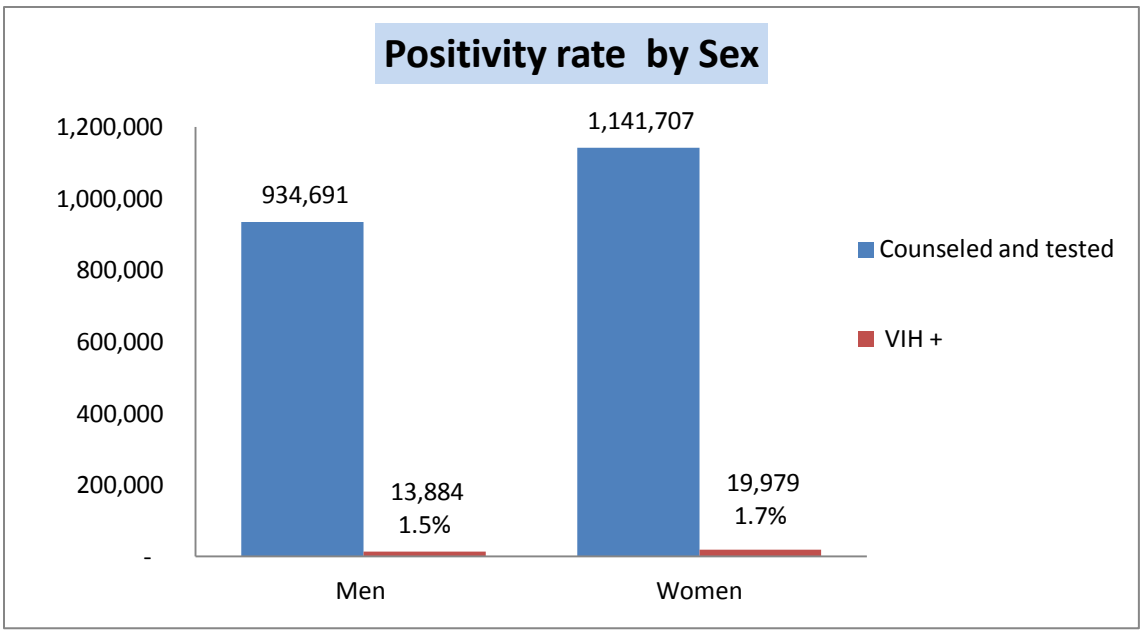


Figure 6 Positivity rate by sex



Provider initiated testing (PIT)

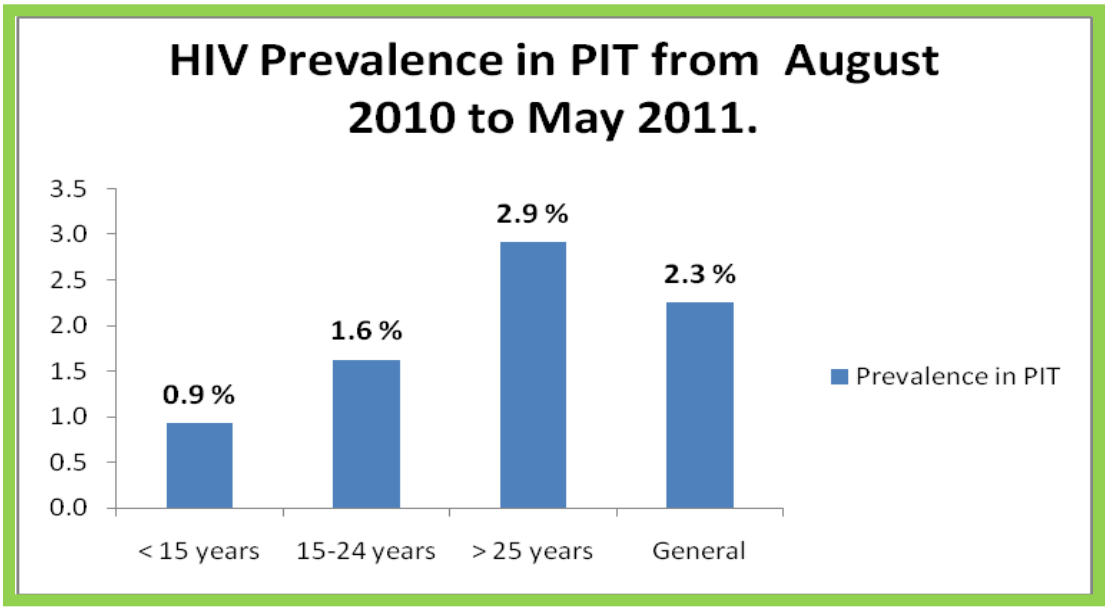
People who come to health centre with signs and symptoms which could indicate the presence of HIV infection are advised by care providers to do the HIV test (PIT).

PIT was first implemented in 2008. 448 health facilities were offering provider initiated counselling and testing by the end of June 2011, HIV testing is provided in health facility services including outpatient consultation, tuberculosis service, nutrition services and hospitalization.

Number of clients who were counseled and tested for HIV in PIT

PIT indicators were added to the TRACnet reporting system in August 2010, reporting that 481,693 clients have been counselled and tested through PIT services in August 2010-June 2011 period.

Figure 7: HIV positivity rate among people tested in PIT



Mobile VCT

IHDPC organized and coordinated mobile VCT activities in specific occasions from July 2010 to June 2011:

- At the occasion of the first graduation of youth after 1 year of professional training at IWAWA vocational and training center: 621 youth were tested for HIV, of which 1.6% tested HIV positive
- Ceremony commemorating World AIDS day 2010 in Gisenyi and also in Nyanza where 384 people were tested, 48% were female and 51.7% were male. 4% tested positive for HIV.
- In encouraging VCT in work places, in both public and private institutions where a total number of 398 people received mobile VCT.
- A mobile VCT session for street children and sex workers organized in collaboration with EER Biryogo tested 26 people, 30.7% tested positive.

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

Youth in general are reached through interventions outlined under Output 1.1.1.1 as part of activities targeting the general population. But it is recognized that youth have particular HIV risks that are unique to their age group, with young women particularly vulnerable to HIV

acquisition. As such, this output specifically outlines strategies aimed at working with women aged 15-24 years in order to better understand the risk factors that are related to their higher vulnerability to HIV and to develop appropriate responses to their specific needs.

Improve understanding of specific vulnerabilities of women aged 15-24

A qualitative participatory study to understand vulnerabilities and risk factors of HIV among women and girls aged 15-24 has been conducted in one selected district per province and Kigali City totaling five districts. The final report is expected by mid January 2012 and dissemination by end of January 2012.

A minimum package of women friendly services for women aged 15-24 was mainstreamed in other minimum packages for youth, female sex workers, people living with disabilities and mobile population. In addition, specific interventions for women aged 15-24 were identified and disseminated for wide implementation, as agreed by all stakeholders and civil society organization (CSOs) that will implement the Global fund strategy to reach women aged 15-24 have been selected.

Outreach work with women aged 15-24 to promote safe sexual behaviors on HIV and STIs, referral for HIV testing and STI diagnosis, reproductive health services, condom promotion, GBV and PMTCT

An integrated booklet that aims at harmonizing and disseminating HIV prevention messages to the community has been developed and distributed to all community leaders countrywide. The booklet contains information about HIV and STIs, violence, condom negotiation, life skills and referral for HIV testing and STI screening and treatment.

Through different sensitization sessions on HIV prevention conducted by implementing partners, a total number of 47,036 women aged 15-24 years were reached by behavioral change messages.

During the assessment of the condom supply chain, support supervision visits for condoms supply were conducted in district pharmacies, hospitals, youth centers and women's groups and technical guidance was provided on building community mechanisms for availability and accessibility to condoms by all groups of the community including women's groups.

2.1.3 Output1.1.1.3. Sex workers are reached by comprehensive prevention programs

Recent evidence clearly showed that female sex workers constitute a key driver of the HIV epidemic in Rwanda. During the reporting period, RBC-IHDPC in collaboration with UNFPA and Global Fund had coordinated different HIV prevention interventions targeting female sex workers in order to ensure that they have access to comprehensive HIV services in each district by increasing coverage of districts. To ensure good coverage and appropriate interventions, the minimum package for sex workers was developed and their size estimation was ongoing during the reporting period.

To this end, significant achievements were made to improve HIV services provided to female sex workers, notably:

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

The 2010 Female Sex Workers BSS was disseminated in December 2010. Also, data collection for the 2010 Size Estimation of Female Sex Workers was conducted in August 2010, data analysis is finalized and the report is soon to be disseminated.

Outreach to sex workers through peer education programs involving training sex workers including provision of information on HIV and STIs, condom promotion, life skills and referral for HIV testing and STI diagnosis, violence, reproductive health services VCT and PMTCT

To reach active FSWs, ROADS II facilitates the peer education activities whereby ten (10) FSW are asked to form a group. They are also asked to select one leader among them who will be trained as peer educator. It is through these groups of 10 FSWs that community HIV prevention activities are carried-out on a weekly basis. These include:

a. ***Increasing FSW knowledge*** **on HIV/AIDS, STIs, HIV care and treatment, family planning, condom use** and negotiation, GBV prevention, the effect of alcohol and other drug abuse/consumption and existing services in the country and locality, etc. this is done through peer education, IEC/BCC material distribution, etc.

b. ***Improving positive behavior change*** which includes reducing the number of sexual partners, consistent use of condoms, increasing the use of modern contraceptive methods, increasing the use of dual contraceptive method, decreasing drug and alcohol abuse, increasing the health seeking behaviours for STI screening and treatment, HIV C&T, GBV services, care and treatment for those who are HIV positive.
c. ***Improving health services/product accessibility***. This is done through active condom distribution through peer education, paying *mutuelle de santé* for all FSW and their children
d. ***Reaching CSW partners.***

Condoms were included in the minimum package for HIV prevention for sex workers and shall be provided once the minimum package is distributed. Currently no specific sex workers' targeted interventions at the country level have started, until results for the population size estimation and site assessment for sex workers are available.

Reduce socio-economic vulnerability of sex workers

Through FHI ROADS project, groups of 30 FSWs were formed to introduce the economic strengthening activities among CSW as part of their HIV prevention and care and support strategy and as an alternative way to gain money in save mode. To improve alternative income generation among CSWs, the FHI ROADS project applied household economic strengthening strategy framework developed to increase household resilience among vulnerable households.

The economic strategy framework is built on three pillars: Increase household food production through combined agriculture technologies (kitchen gardens, organic agriculture, improve household production through changes in agriculture techniques) increase household incomes through Group Saving and Loan associations (GLSA) methodology, market orientated production through value chain and market analysis.

Extension of HIV, STI and family planning services to sex workers

In each site, FHI ROADS collaborated with District hospitals, Health facilities, CDLS and CSWs to identify which health facility will be supported to provide health services to FSWs. FHI ROADS provided the following technical assistance to health centers:

a. Training of health providers in STI screening and treatment using the national guidelines,
b. Provision of adequate equipment (such as gynecologic tables, lamps, national guidelines, STI screening and treatment algorithms),
c. Provision of iPAD for electronic data management and the training of health providers and data managers in the use of iPAD.
d. Provision of adequate IEC/BCC materials.

As results, 2,139 active FSWs have been identified and are now reached by program interventions; 223 FSWs were trained in peer education; 70 GLSA groups were formed; 1,581 (74%) were screened for STI; 1,457 (92%) presented with STI syndromes and received treatment; 1,199 (82%) were counseled and tested for HIV, 338 (28%) were tested HIV positive.

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

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

Technical meetings specific to each key population group were held and every member of the subgroup of HIV Prevention on key populations was invited to attend those monthly meetings.

Equally important, this reporting period was mainly marked by the definition of minimum packages for all key populations and other vulnerable groups which include services to reduce their personal risk of HIV transmission and acquisition, improve their access to condom and post exposure prophylaxis, provide voluntary and non-stigmatizing access to health and social

services to all populations, improve the environment for interventions with marginalized groups, and increasing the participation of at-risk groups in the planning, implementation, monitoring and evaluation of HIV programs. For all key populations, defined minimum packages were developed and disseminated to key HIV prevention partners.

The following were the achievements on strategies under the output:

Operational Research to identify risk populations and routine surveillance to monitor trends in behavior, prevalence, etc. (activities and costs in M&E)

During the reporting period, different Behavior surveillance surveys (BSS) and HIVDR studies were completed:

- 2009 youth BSS disseminated in December 2010
- 2010 Female Sex Workers BSS, disseminated in December 2010
- HIV Drugs Resistance Early Warning Indicators (HIVDR EWI) Surveillance disseminated in December 2010.
- 2011 Size Estimation of Female Sex Workers soon to be disseminated.
- 2010 behaviour Surveillance Survey among Truck Drivers, data analysis finalized, the final report is waiting for dissemination.

Provision of specific counseling services for people with disabilities

To achieve that strategy, the process of recruiting a consultant to review and update the training manuals on disability and HIV/AIDS with inclusion of BCC, FP, MC & PE topics is ongoing. The same applied to the recruitment of consultants to develop the database on Disability and HIV/AIDS and the capacity analysis and capacity development plan of the Umbrella organization of people living with disability (PHLS).

To be able to provide specific counseling services for PWDs, trainings and workshops were organized for services providers and local authorities.

1. Training workshops with VCT/PMTCT service providers and district hospitals directors on specific needs of PWDs in HIV services

Trainings covering such topics as VCT, HIV&AIDS, Disability, Condom Promotion, and Gender Based Violence were conducted. With the objective of reaching PWDS with HIV services, a workshop with VCT/PMTCT service providers and district hospitals directors on specific needs of PWDs in HIV services was held in Eastern (July,2010) and Southern (August 2010) provinces in collaboration with provincial authorities. Those workshops were a success with a higher participation of 138 trained health care providers against 124 persons planned to be trained (111%).

From the workshops participants made recommendations to different stakeholders on how to improve services for PWDs but also committed themselves to improve and make some adjustments to accommodate Persons with Disabilities.

2. Advocacy workshop with the local authorities and the representatives of the national police from the eastern and southern provinces

Workshops to create awareness on the specific needs of People with Disabilities were organized on July 13th and August 20th, 2010 in Eastern and Southern Provinces respectively. During those two trainings, 156 people participated with limited representation from the national police. Mainly two topics were developed during the workshops: Disabilities, HIV/AIDS and legal framework: Worldwide and countrywide and Disabilities, HIV/AIDS and Sexual and Gender Based Violence. The trainings included group work with identification of problems and challenges that People with Disabilities face in their communities with a formulation of recommendations:

- The local authorities should understand disability instead of vulnerability;
- The local authorities should mainstream disability into their socio-development programs including the various specific needs;
- More attention to be given by the National police on abuse of People with Disabilities in prevention and investigation process.

Outreach for PWDs

To ensure the outreach of PWDs, different activities were conducted regarding development, updating, or dissemination of materials targeting PWDs.
Regarding IEC/BCC tools, by the end of August 2010, new IEC/BCC messages were approved by the National Behavior Change Committee as the organ that assesses messages and tools before the dissemination.

The following messages were approved and will be disseminated by UPHLS: *Ahorukomeye, Bwiza, Umwali Dukuze.* The following adapted messages were from TRACPlus: Antiretroviral Therapy, HIV/AIDS and Sexual Transmitted Infections, PMTCT Services, Treatment of Opportunistic Infections, VCT Services.

For the inclusion guide, the drafting team did incorporate the comments from partners and amendments from the NBC subcommittee to improve the content of the inclusion guide which is now at Former CNLS level. Still on the inclusion of PWDs, the dissemination of the training manuals on disability and HIV/AIDS and include topic on BCC, FP, and MC & PE has delayed due to the process of recruiting the consultant to revise and update the training manual.

On the activity of training HIV and AIDS educators about different needs of people with disability, on May 2011 at Muhanga District, 82 ToTs from 20 Districts have been trained about people with disabilities and their needs. ToTs from the 10 remaining Districts will be trained in the next quarter.

From May 31st to June 10th, 2011, 551 Peer Educators (PE) have been trained on HIV/AIDS generalities, factors leading to HIV infection, STIs and HIV/ AIDS, HIV Prevention methods, Condom use and VCT, PMTCT and Family Planning, Rwandan legal framework on disability and UN convention, Behavior change communication, strategies to communicate with PWDS with various types of disability as well as BCC data collection tools.

The activity of conducting disability friendly outreach campaign by Disabled People organizations and prevention BCC is still in the identification process where trained Peer educators, ToTs together with District coordinators are identifying persons with disabilities in villages to be trained in small groups; activity which will continue in August 2011. The delay

was caused by the delay in training of ToTs and PE who were supposed to play a great role in outreach campaigns.

From March 30 to April 1st, 2011, UPHLS organized the 2nd National forum on HIV&AIDS and Disability. The theme was "Exchange and sharing of the achievements and success stories in inclusion of PWDs in HIV/AIDS national response, way forward for any challenge encountered"

UPHLS have been implementing the prevention activities among Persons with disabilities but till now don't have a baseline either on HIV/AIDS prevalence among Persons with disabilities or on the attitudes and behavior of the Persons with disabilities towards HIV/AIDS national wide. This constitutes a big barrier to further planning and there is a desperate need to conduct such studies/survey to inform evidence based planning.

Outreach programs to migrant and mobile workers (truck drivers, moto taxi drivers, Fishermen) through peer education programs involving training about prevention among MSM, provision of information on HIV and STIs, referral for HIV testing, condom promotion and STI diagnosis

To determine the size and location of fishermen, a mapping exercise for fishermen was done by RBC-IHDPC/HIV Division (Former TRACPLus). For their outreach, a situation analysis on accessing HIV services was conducted in Rubavu and Rusizi Districts.
An exploratory study on HIV&AIDS risk for fishermen from Kivu Lac, Rubavu District, was also conducted. Peer education among fishermen trained on HIV prevention and condom distribution were done at Rusizi District as well as sensitization campaign for fishermen during the WAD 2010 fishermen sites districts.

During the reporting period, there was a continuous of IEC program at the 3 sites stop for truck drivers (Magerwa, Rubavu & Huye). Truck drivers from Rusumo, Gisenyi & Butare stop sites accessed to mobile VCT and referral services to the nearest health center for VCT. Still in the prevention of HIV, family days with sensitization on VCT & HIV prevention were organized for trucks drivers & their families.
With that accessibility to HIV services, many numbers of truck drivers conduct VCT at the corridor (health centre Kirehe, Gisenyi & CUSP).

For migrant population, a situation analysis on HIV related risks and GBV was conducted in Gihembe refugee camp and all packages services were provided in the 3 refugees' camps (Kiziba, Gihembe & Nyabiheke). Surrounding communities are benefiting from that by using the public health services near the camps.

Outreach for MSM through peer education programs including provision of information on HIV and STIs, referral for HIV testing and STI diagnosis

As far as MSM are concerned, RBC-IHDPC (Former CNLS) in collaboration with MEASURE Evaluation and UNAIDS conducted a qualitative study to better understand the primary determinants of HIV transmissions among MSM: "QUALITATIVE STUDY OF HIV RISK BEHAVIORS AMONG MEN WHO HAVE SEX WITH MEN (MSM) IN KIGALI, RWANDA". Preliminary results are available but final report will be disseminated after its validation.

Also during the reporting period, PSI has trained 25 MSM peer educators on HIV and STI testing.

Extension of testing, HIV and sexual health services to MSM

In February 2011, in collaboration with ICAP/ Columbia University, HIV division participated in 3 days workshop held to Rubavu District. The objective of the workshop was to elaborate tools targeting Men who have sex with men (MSMs) at Health center level. The tools were tested in HIV Counseling and testing services at 3 selected sites located in Kigali City: Kabusunzu H.C, Rugarama H.C and Carrefour Clinic.

Tools which were developed:

- Sexual behavior Screening tool
- 3 Algorithms for HC , PITC and Care and treatment services targeting MSM
- Monthly Data collection form

In April 2011, 37 health workers participated in 3 days training on sensitivity and clinical services for MSM. Participants were from different institutions (MOH, health workers from the 3

selected sites, Muhima District Hospital Supervisors and ICAP) and trainers were Medical Doctors and LGBTs members association from South Africa.

2.1.5 Output1.1.1.5. People living with HIV including sero-discordant cohabiting couples are provided with prevention services

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

Expansion of diagnosis and treatment of STI, OIs for PLHIV (activities under Result 2)

Care services include diagnosis and treatment of sexual transmitted infections as well as opportunistic infection management. These services are available in all health facilities offering ART and are integrated within the holistic management of PLWHIV.
Guidelines have been developed, disseminated and are now used by trained health care providers in all HF.

Expansion of access and utilization FP and reproductive health services by PLHA

Family planning services are integrated in almost all ART and PMTCT health facilities to help clients who are looking for ways to avoid unintended pregnancies. The offer of family planning methods is completely voluntary and HIV positive clients interested in having children are supported in this decision and enrolled in PMTCT services when pregnant.

Outreach work with sero-discordant cohabiting couples including ongoing counseling, referral for HIV testing, reproductive health services and PMTCT

During the reporting period, a total number of 514 health providers (145 Counselors, 78 Lab Technicians, 119 Data managers, 78 Health Promoters, 94 Managers) were trained. Counselors from Kigali HCs were previously trained. For the Eastern province, many sites started training before July 2010 and only 28 HC have been trained in this year. In Western province, only 18

HCs have been trained in all categories and it was completing those services which have not been finished before. The next step is to conduct decentralized training for covering all HCs located in the Western Province.

In maternity, 2480 HIV+ women and in discordant couples received prophylaxis. 1421 HIV negative women in a sero-discordant couple received single dose of triple therapy while 1059 HIV+ women initiated triple therapy for PMTCT.

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

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

GBV one stop centers were scaled up in Rubavu District and a national plan to scale up one stop centers was developed. Important awareness raising activities were done during the 16th days of activism.

2.1.7 Output1.1.1.7. Male and female condoms are available and accessible for all populations

The promotion of use of condom as dual protection, both as family planning and HIV prevention, has continued during different awareness and sensitization campaigns conducted by RBC-IHDPC and partners.

The Country has continued to strengthen the two distribution chain of condom: the Social Marketing approach which ensures availability of condoms through the commercial sector with a total market approach (shops, bars, youth centers and other sales outlets) and a Public sector approach, which ensures distribution of free condoms, with health facilities being the traditionally accepted final distribution points for condoms for purposes of both HIV prevention and Family planning. To ensure that general population and key populations have access to

condom through both chains of condom distribution, some activities for the set strategies were achieved.

Increase in social marketing of both male and female condoms

The male condoms distributed during the mass sensitization related to the 2010 World AIDS Day (WAD) campaign in villages after Umuganda of 29th January 2011, Universities, Institutions of high Learning, during launching ceremonies of World AIDS day campaigns in districts and during the closing ceremony held at Nyanza Stadium totaling 455,432 condoms (Love Condoms) with support of AHF Rwanda. The social marketing sector with the support of PSI Rwanda in line with the 2010 WAD campaign distributed 4,447,144 condoms both during the campaign events and through different approaches including the "Buy One Get One for Free" activities. During all the 2010 WAD Campaign period (December 2010- March 2011), a total of 4,897,144 condoms were distributed.

In partnership with PSI Rwanda, blitzing activities for creation of more condoms sales outlets have been conducted and scale up to more rural areas is in progress. Installation of Advanced Business Strategies (ABS) condom promotion signs has been scaled up from urban to rural areas. To reinforce the social marketing initiatives for distribution of condoms through a market driven approach, 6,972,440 Prudence condoms were distributed to private sector and 2,260,422 Prudence condoms distributed free of charge to VCT Clients, Dushishoze Centers, and others distributed as promotions during BCC activities.

Between July 2010 and June 2011, 478 (236 Male and 242 Female) Rwanda Local NGOs, Community Based Organizations, Community Health Workers, and Public Health providers from 55 Health Centers were trained in correct and consistent condom use.

The community based distribution approach has been integrated in work plans of Rwanda Partners organizations (RPOs) implementing BCSM Project funded by USAID through PSI Rwanda. 50,000 condoms have been targeted to be sold by each RPO in respective district. The output of this approach shall be reported in the Annual Report 2011-2012.

In partnership with the Rwanda Health Communication Center of the Rwanda Biomedical Center, communications for promotion of responsible and safe sexual behaviors with emphasis on condom use were used as part of the condom promotion campaigns.

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

Community based distribution for the general population has been initiated at District level. Studies on size estimation for key populations are still under way and these will inform the needs for condoms for specific key population groups. In addition, 700 condom vending machines have been procured to increase accessibility of condoms at the community level. Installations for the machines are in progress.

Strengthen initiative for promotion of female condom use

An operational study on the acceptability of female condoms has not been implemented as planned due to lack of competent consultants to conduct the study among those who had applied. The tender is re-advertised and this is planned to be concluded by June 2012.

Sensitization for female condom use has been done during the 2 previous WAD campaigns with the active participation of opinion leaders including members of parliament.
FRSL+ has been supported to strengthen women's cooperatives in the prevention of HV, with emphasis on prevention with positives and promotion of condom.

Expanding distribution of condoms in the private sector

Commitment to avail condoms in hotels was signed between the Rwanda Private Sector federation, the Rwanda Hotel Associations and Hotels in 2010 and currently over 80% of Kigali based hotels avail condoms. 641,976 Plaisir condoms were also distributed and among them 353,184 were distributed free of charge and promotions and 288,792 Plaisir condoms distributed in private sector. Between July 2010 and June 2011, communication programs that provided advice on where and how to access condoms were ensured through condom product promotions that reached 32480 community members and general populations and mobile video shows that reached 39797 community members and general populations. Most product promotions are conducted around market centers and hot spots such as Bars/Restaurants, Hotels, etc.

All youth centers ideally avail condoms to the youth and Youth centers have been defined as key entry point for availing condoms to youth and therefore included in the revised supply chain system for condoms in the Public sector. With the support of the Umbrella of the Public Sector in the Ministry of Public Service, condoms have been availed to Public sector institutions.

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

Different channels of communication including Radio, TV, mass campaigns through sensitization events organized at central and decentralized levels, advocacy campaigns with support of top political figures like Government Ministers, Members of Parliament, Governors of respective Provinces and Mayor were conducted.

RBC/IHDPC commissioned the review of the national condoms supply chain system to improve accessibility and availability of condoms to all through community based HIV/AIDS groups and all other HIV/AIDS partners at the decentralized levels. Consequently, Standard Operational Procedures for all identified HIV/AIDS community based groups and partners at all levels of the supply chain in the public sector have been developed. There are plans to disseminate the results of this supply chain review at the district level in 2012. 2012-2013 Condom needs have also been determined based on the proposed supply system and the identified gaps for use of the proposed supply chain system.

Supply and distribution mechanisms were reinforced between traditional final distribution points (Health centers and local HIV/AIDS community based groups (cooperatives, associations, peer group etc.) and Community health Workers). Civil society was also supported to initiate sustainable distribution mechanisms amongst their respective target communities in 4 Districts. Activities for reinforcing mechanisms of distribution of condoms through HIV/AIDS work place program are still being reinforced.

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

Advocacy for integration of circumcision in minimum package of health centres

After the development of a male circumcision operational plan and during its initial phase of implementation, the MC program laid a foundation for scale up of male circumcision. The phase one implementation in two pilot sites of Nyanza and Musanze involved trainings of medical doctors and nurses in District hospitals and health centers, and provided MC services to 3,000 men.

According to the MC operational plan, there is a cascade of trainings which included:

- Master trainings of 31surgeons and post graduates in collaboration with Rwanda surgical society. National Training of trainers: two per 41 districts Hospitals and one medical doctor and one nurse were trained. 82 participants were trained as trainers of trainers to continue with the cascade trainings at health center level.
- Decentralized trainings are ongoing with DH training affiliated Health Centers: 8 Districts Hospitals and 97 Health centers have completed Decentralized trainings.

To integrate circumcision into the minimum package of health centres, strengthening the capacity of Community Leaders, Community Health Workers and Civil Society to Support Male Circumcision and HIV Prevention in Musanze and Nyanza Districts (80 participants) was realized. Provision of MC during weekends has been started in 3 DH (Kibagabaga, Gahini and Kabgayi) and will be continued in other DHs.

Regarding the procurement of MC kits, in phase one, 38,600 disposable kits were distributed to 40 district hospitals and their health centers which have completed decentralized trainings and procurement for phase 2 (Reusable kits and autoclaves) which is underway.

A joint monitoring visit to phase one pilot sites has been carried out to assess the challenges and strategize on the way forward.

In collaboration with TRACnet team, male circumcision indicators have been elaborated, validated, and incorporated in the monthly data collection at district hospital sites and in PBF.

Even though there is good implementation in MC, the following challenges need to be mentioned as well as their status:

- Regarding the MC communication plan/Strategy, the document is in MIFOTRA and will be probably available in January 2012.
- For MC Registers, they are available and distribution is planned before the end of January and will include private clinics (entails trainings to be done at provincial level.
- On the payment of intervention, according to SPIU a proposal to remunerate MC under PBF was rejected.
- To overcome the delays in request for training funds is ongoing and many hospitals have received the funds and trainings are ongoing.
- Funds for weekend scale up were not yet received at the time of writing and the scale up at Kibagabaga DH was delayed due to administrative issues, the funds requested from the One UN to increase weekend scale up were still to be disbursed by mid 2011.

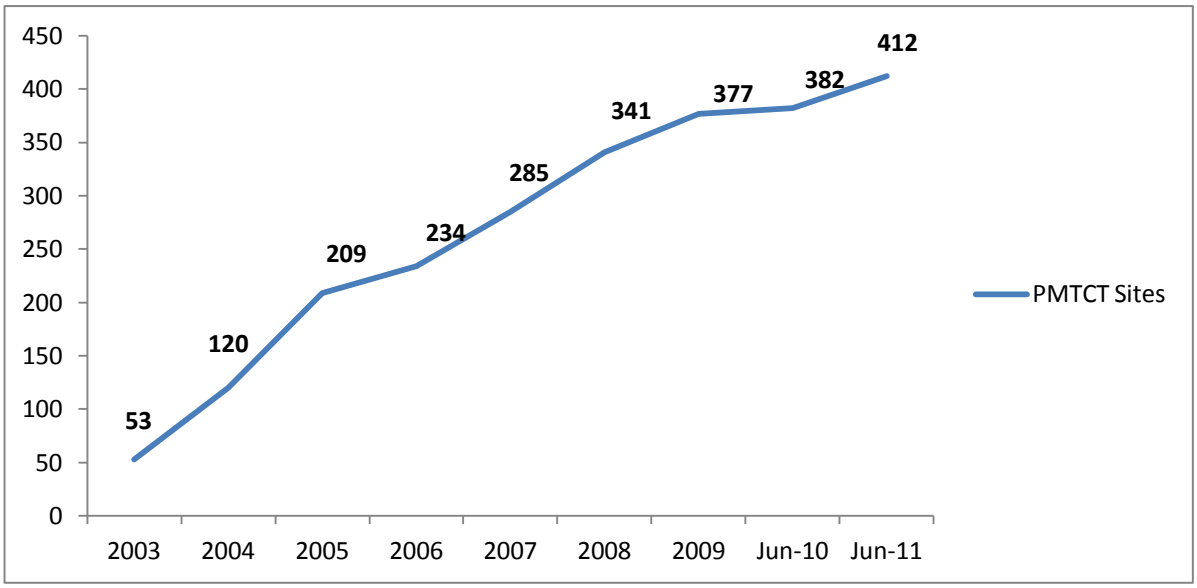
2.1.9 Output 1.2.1.1. Increased availability and accessibility of PMTCT services

Expansion of integrated PMTCT services in all health facilities and ensure national coverage

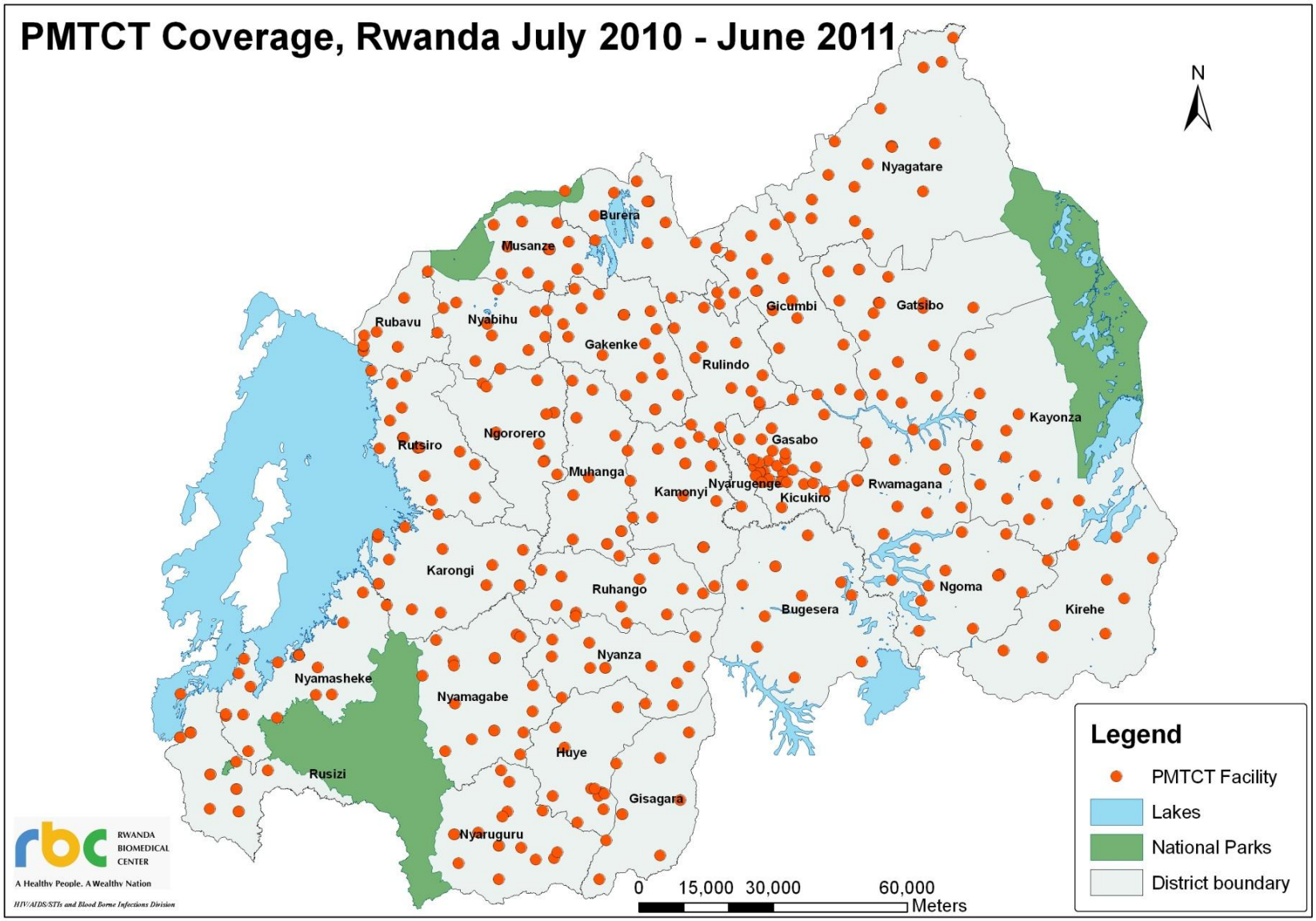
PMTCT activities are integrated at the Health Facilities (HF) level into Maternal and Child health (MCH) services. Activities done in various services of PMTCT program between July 2010 and June 2011 included: scaling up Health Facilities offering PMTCT services, increasing the number of pregnant women receiving PMTCT services, providing ARV prophylaxis to pregnant women in need, ensuring adequate maternity and infant follow-up, following discordant couples and availing Family Planning services.

By June 2011, 412 HF were offering PMTCT services, an increase of 30 from the previous year's 382 Health Facilities. This means that 85 % of Health facilities (Hospitals and Health centers) are offering PMTCT services. There are 417 health facilities (health center and hospitals) collecting samples (DBS) including some District Hospitals for early infant diagnosis for children born to HIV-positive mothers. These samples are sent to the Rwanda National Reference Laboratory (NRL) where they are analyzed using PCR.

Figure 8: Health facilities offering PMTCT services (from 2003 –June 2011)



Map 4: PMTCT Coverage by District



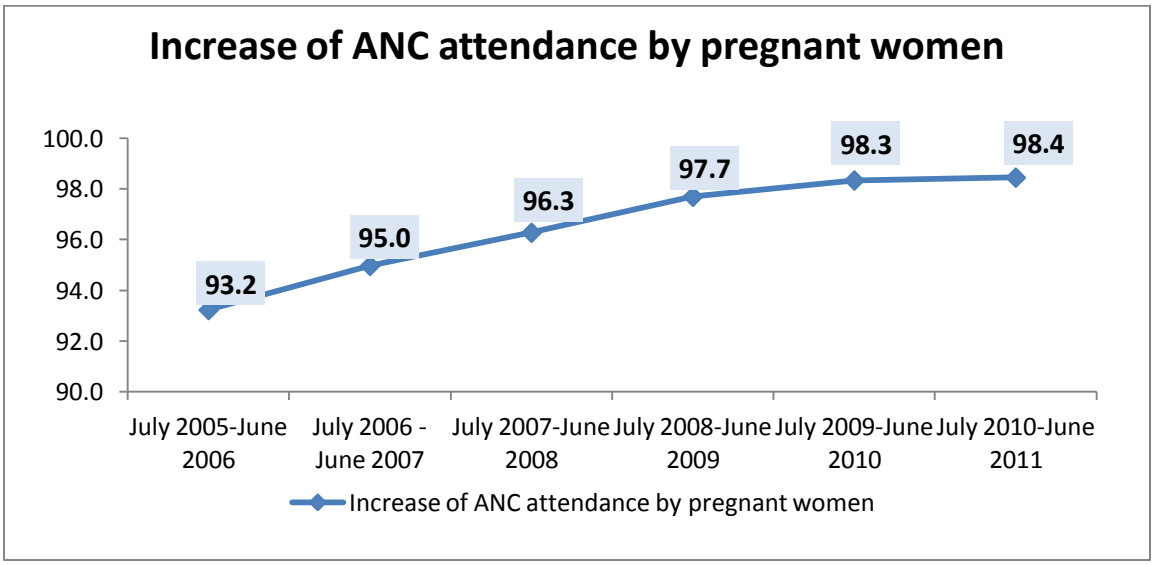
Strengthening integration of PMTCT services in existing health facilities

PMTCT services are integrated in existing MCH services in Health facilities: HIV testing is offered during ANC and in maternity to pregnant women who don't know their status, and those who are HIV + are offered prophylaxis as well as their babies and they are also enrolled for follow up. During immunization visits, HIV exposed infant are identified and sent for PCR and other appropriate follow up.

Increase ANC attendance by pregnant women

The attendance of pregnant women in ANC has increased from 93.2% in July 2005 up to 98.4% in June 2011.

Figure 9: Increase of ANC attendance by pregnant women



Increase male uptake and family approach for PMTCT

Following the Government's initiative to encourage male partners of pregnant women attending ANC visits to be counselled and tested for HIV, an increased proportion of male partners have been counselled and tested over the years. 16% male partners of pregnant women were counselled and tested between July 2002 and June 2003 and this increased fivefold to 84% during the July 2010 to June 2011 period.

Figure 10: Proportion of male partners counseled and tested for HIV in PMTCT

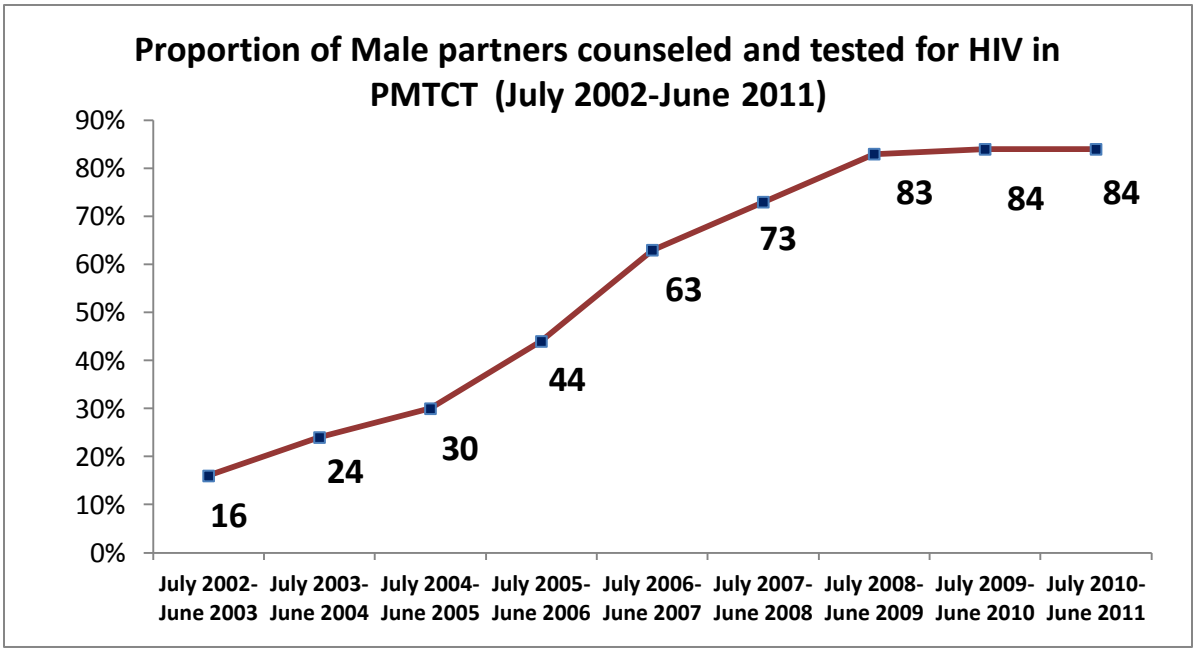


Figure 10 shows the trend of the HIV male partners testing in PMTCT program since 2002.

But the cartography below shows a need for more sensitization interventions towards men for their involvement in couples counseling and testing and PMTCT in general. Those districts are Gicumbi, Rulindo, Gatsibo in Nothern Province, Karongi in Ouestern province, Nyanza and Gisagara in Southern Province, Bugesera in Eastern and finally Kicukiro in Kigali City.

Map 5: Repartition of male uptake in ANC by district

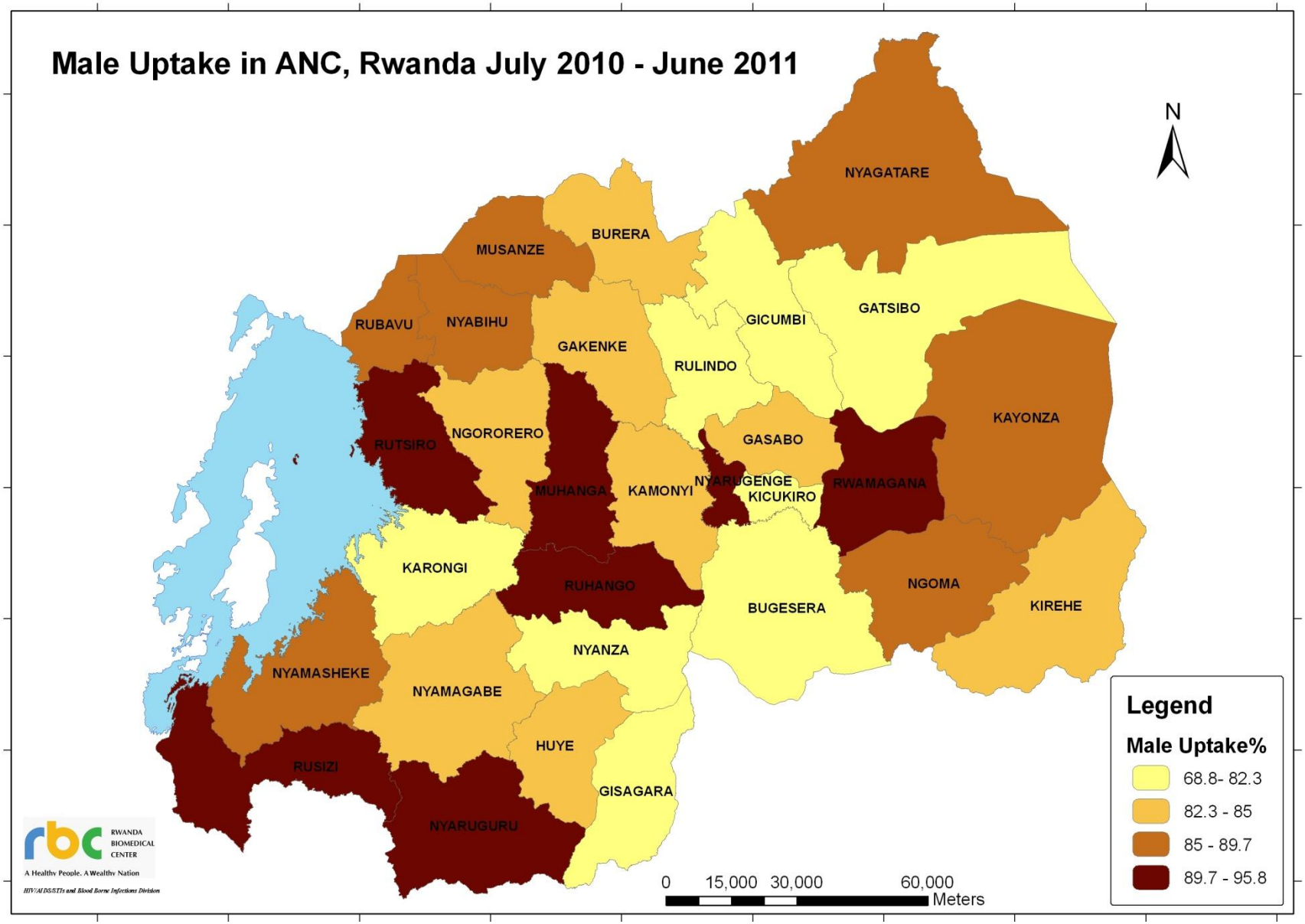
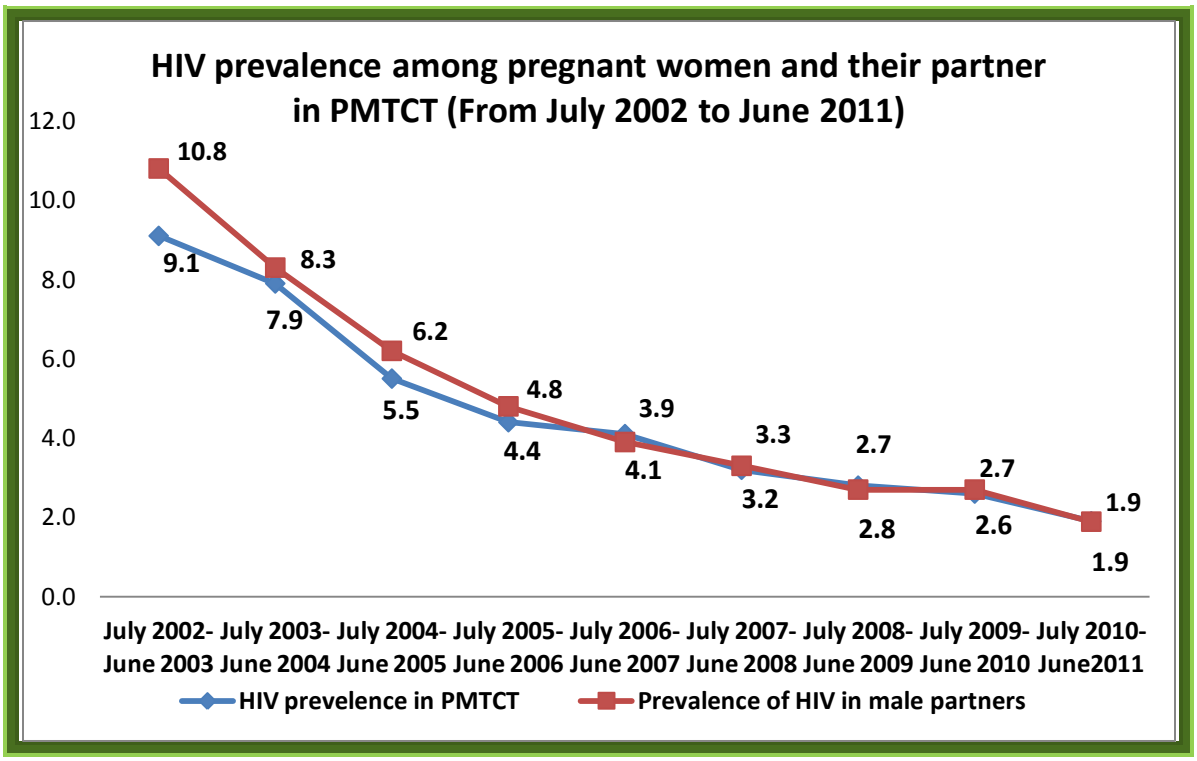


Figure 11: HIV positivity rate among pregnant women and their male partners in PMTCT (July 2002 to 2011)



The Figure 11 shows HIV positivity rates between pregnant women attending ANC and their male partners between July 2002 and June 2011.

Increase delivery by pregnant women at health facilities

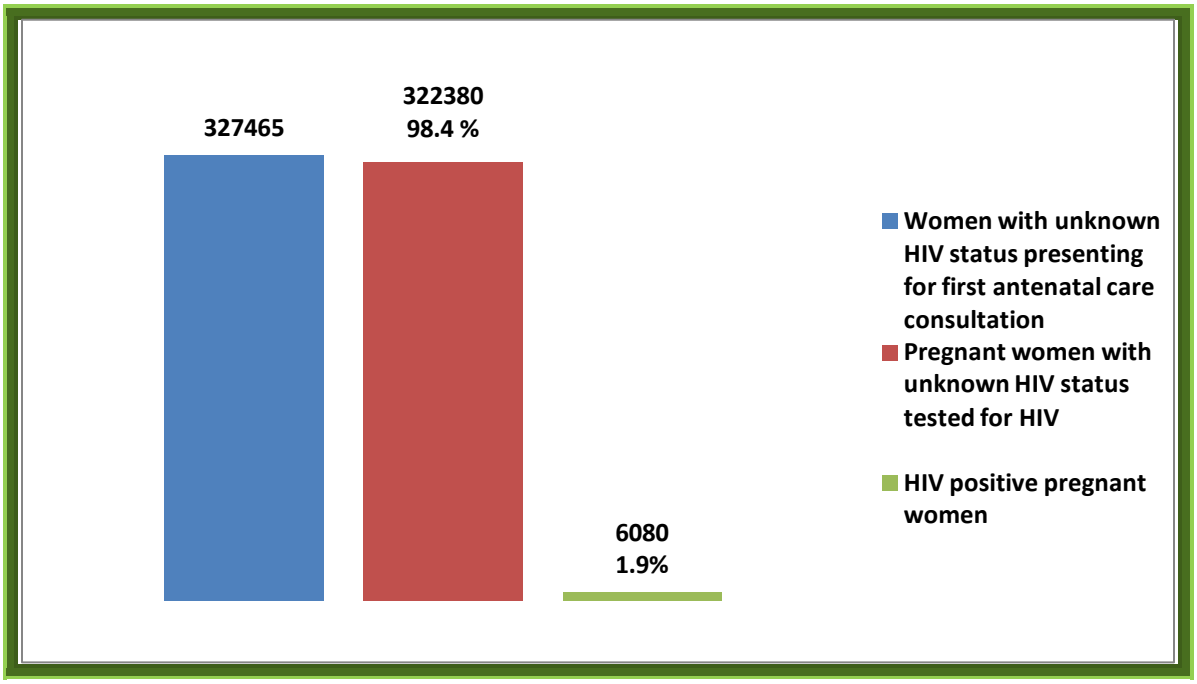
From July 2010- June 2011 a total of 323,919 deliveries were expected in the HF offering the PMTCT services. Out of 7400 HIV + pregnant women expected to deliver in HF, 6422 (86.6%) actually delivered in HF and 351(4.7%) delivered at home but notified at HF.

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

All pregnant women are routinely tested and counseled for HIV during pregnancy (at least at first ANC)

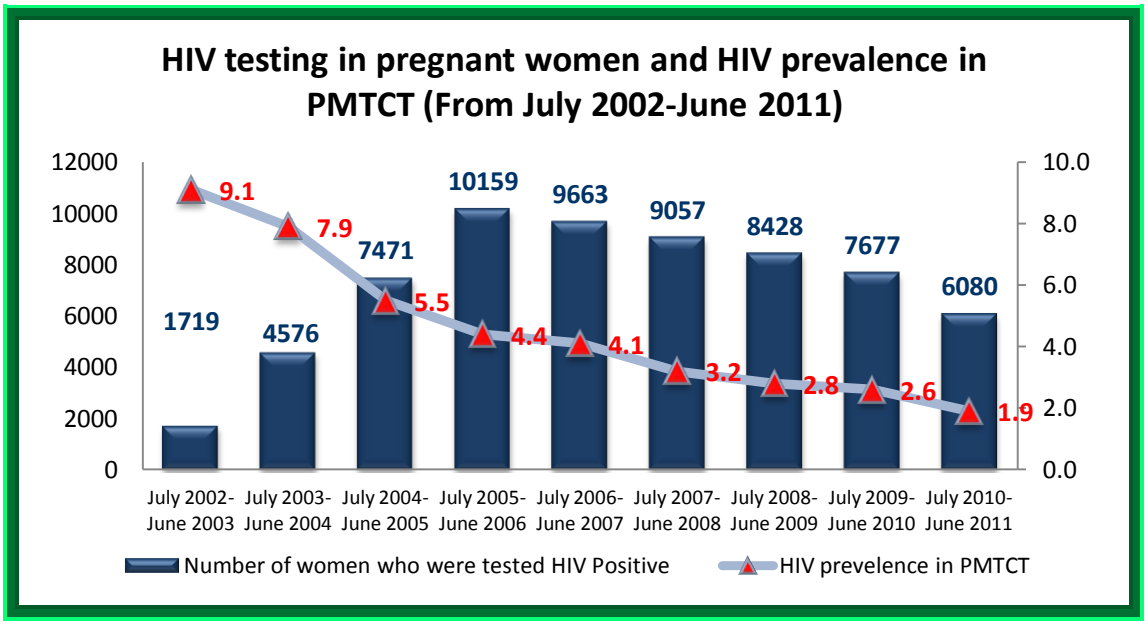
The number of pregnant women with unknown HIV status attending ANC from July 2010 to June 2011 was 327,465. Among them, 322,380 (98.4%) were counseled and tested for HIV and received their results; 6080 (1.9%) tested HIV positive (Figure 12).

Figure 12: HIV testing in pregnant women and HIV prevalence in PMTCT.



The Figure below shows the number of pregnant women who tested HIV positive in PMTCT and HIV prevalence over the last 8 years. The HIV positivity rate for pregnant women tested at ANC reduced from 9.1% in 2003 to 1.9% in June 2011.

Figure 13 : HIV testing in pregnant women and HIV prevalence in PMTCT (From July 2002-June 2011)



Increase percentage of HIV+ pregnant women receiving ART as prophylaxis in PMTCT setting

A more effective regimen of ARVs used in PMTCT was introduced in 2005. In accordance with the November 2009 WHO recommendations for PMTCT, a new PMTCT protocol was approved by the Ministry of Health in June 2010. Rwanda chose HAART (Tenofovir based/regimen) for all HIV positive pregnant women from 14 weeks of gestation up to the end of breastfeeding (weaning). The implementation of this new protocol started in November 2010.

5960 (98%) HIV infected pregnant women attending the national PMTCT program received ARV prophylaxis/treatment according to the current protocol used in Rwanda; of these, 2212 (37 %) received triple therapy treatment (eligible to ARV treatment with CD4< 500 or WHO stage 3 or 4), 2873 (48%) received triple therapy for MTCT prophylaxis, and 875 (15 %) received dual therapy for prophylaxis (AZT from 28 weeks of gestation as per old protocol).

Increased case-finding so that HIV+ pregnant women who initiated PMTCT are followed up to completion

In order to improve the follow up of women in PMTCT, the health care providers at health facilities record the appointments for follow up, and for women who are missing their appointments, home visits are organize to trace them.

Reinforce linkages between health facilities and community

At community level (Umudugudu), community health workers have among their responsibility the follow up of pregnant women by sensitizing and mobilizing them to attend the anti natal consultation and also to deliver at health facility.
A booklet to integrate follow up of HIV exposed infant at community level was developed for community health workers.

Reinforcement of nutritional support for pregnant and lactating women - and babies

Nutritional support is given to pregnant and lactating women who present signs of moderate malnutrition. For HIV Exposed infant, the nutrition support is given to all children regardless of nutrition status. However this program is still limited in 40% of health facilities.

Reinforcement of OI and STI screening, prophylaxis, treatment and referrals for HIV+ pregnant women

The screening, prophylaxis and treatment of OIs and STIs are included in the routine package offered to HIV+ pregnant women during follow up.

Improvement of OI prophylaxis and treatment for HIV exposed infants

Cotrimoxazole to prevent an important number of OIs is given to all HIV exposed infants since their 6th week of life. The screening of OIs is done during the whole period of follow up of HIV exposed infants and the treatment is offered to the infant diagnosed from IOs.

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

Ensure access to PEP for all health care workers and other cases in need

In order to prevent new HIV infections from exposure to HIV infected blood and other body fluids, PEP services have been expanded to all ART and PMTCT health facilities where exposed health care providers and other cases with non occupational exposure, are receiving prophylactic ARVs free of charge. From July 2010 to June 2011, out of 3375 people who reported at health facilities nationwide as being exposed to HIV (all forms), 2596 (77%) received ART as prophylaxis.

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

Ensure blood safety in all health facilities (e.g.: Screening for HIV all blood donated for transfusion)

The RBC-National Blood Transfusion Centre regularly collected blood from non remunerated volunteer donors. This blood is tested for HIV, Hepatitis B and C and Syphilis. The Former CNTS is supplying the districts and referral hospitals for blood transfusion. No blood transfusion is done in Health Centres.

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

Raising awareness of general population on blood exposure risks and about PEP availability

More than 10 radio broadcasts were produced by CNTS and diffused on different radio channels during the reporting period. In June 2011, World Blood Donor Day was celebrated in the country. During the week before the World Blood Donor Day, adverts were produced and posted in different places, and an opening day was organized in all Former CNTS institutions and all regional centers for blood transfusion.

To increase awareness of population on blood exposure risks, printed materials (leaflets, brochures) in Kinyarwanda regarding blood safety transfusion were produced and disseminated. Also the distribution of social promotion materials with messages related to blood transfusion was done.

During the reporting period, a toll free line (1011) was established where people can call for free to get all needed information regarding blood safety. CNTS has also a website which is weekly updated with messages and events related to safe blood transfusion.

Ensure access to PEP for all exposed people outside of health facility settings

HIV exposed people outside of health facility related work, such as rape or unprotected sex, have equal access to PEP as health care workers. The service of PEP is open 24 hours a day and clients are receiving all related services freely including follow up visits. In this reporting period, among 2596 clients who received ARV in PEP, 2140 (82.5%) were exposed outside the health facility.

IMPACT 2: MORBIDITY AND MORTALITY AMONG PEOPLE LIVING WITH HIV ARE SIGNIFICANTLY REDUCED

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

OI Service availability in each health facility and FOSA capacity building to administer OI treatment

All 336 ART health facilities are offering OI management including prevention**,** screening, diagnosis, and treatment. In addition, 76 stand alone PMTCT services are offering opportunistic infection management.

The capacity of health care providers to administer OI treatment is being built through training of trainers and providers and the trainings are integrated and cover all aspects of HIV/AIDS. From July 2010 to June 2011, a lot of trainings of providers have been organized, focusing on task shifting. This has increased the number of nurses capable of prescribing ART as well as OI treatment.

Support to five referral laboratories

During the reporting period, July 2010-June 2011, infrastructure upgrades and purchase of equipment for PCR were completed in CHUB Butare. Training and Supervision activities on bacteriology were done quarterly as continuous activities. In the same period, Global fund supported the recruiting and maintaining of positions of 26 staff.

But there is still a need to implement histopathology techniques in all laboratories, currently done only in CHUK, CHUB and King Faisal Hospital labs.

Support National Reference Laboratory

The need assessment of equipment and infrastructure for labs was conducted between December 2010 and February 2011 to inventory damaged equipment and need for new ones. The needs assessment report is available and the next steps are to standardize lab network equipment.

Infrastructure and equipment for PCR were completed in CHUB Butare during the reporting period and training and Supervision on bacteriology are quarterly done. Training of lab technicians in bacteriology is done quarterly with an average of 15 lab technicians by session. 2 lab technicians were recruited and trained on PCR to support CHUB molecular biology lab and 2 Technical Assistants were recruited with Global Fund support.

As already mentioned for histopathology, there is a need to implement cytology and mycology technique which is currently done only in CHUK, CHUB, and King Faisal Hospital labs.

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

FOSA capacity building to treat TB

TB control activities are integrated in the national health system: microscopic diagnosis of TB (Ziehl-Neelsen and since 2009 also fluorescence microscopy) has been decentralized to 194 sites (39 district hospitals and 4 reference hospitals, 9 prisons and 142 health centres). These sites, called CDTs (centres of TB diagnostic and treatment), together with the other health centers have integrated TB treatment activities. For those health facilities that do not have diagnostic facilities, a referral system for smears is set up.

Integration of TB and HIV activities is being scaled up and follows the model "one-stop TB/HIV services'.

Increase case finding and diagnosis of TB in people living with HIV

The national guideline recommends systematic TB screening for all new patients enrolled into care and treatment programs and every three months for those in follow up. This strategy increases the detection of TB among PLHIV as it is main opportunistic infection and the greatest cause of HIV infected people globally. The diagnosis for those screened positive has to follow the national algorithm. Once TB disease is confirmed, the patient must be followed up in one stop service as part of integration of those two diseases.

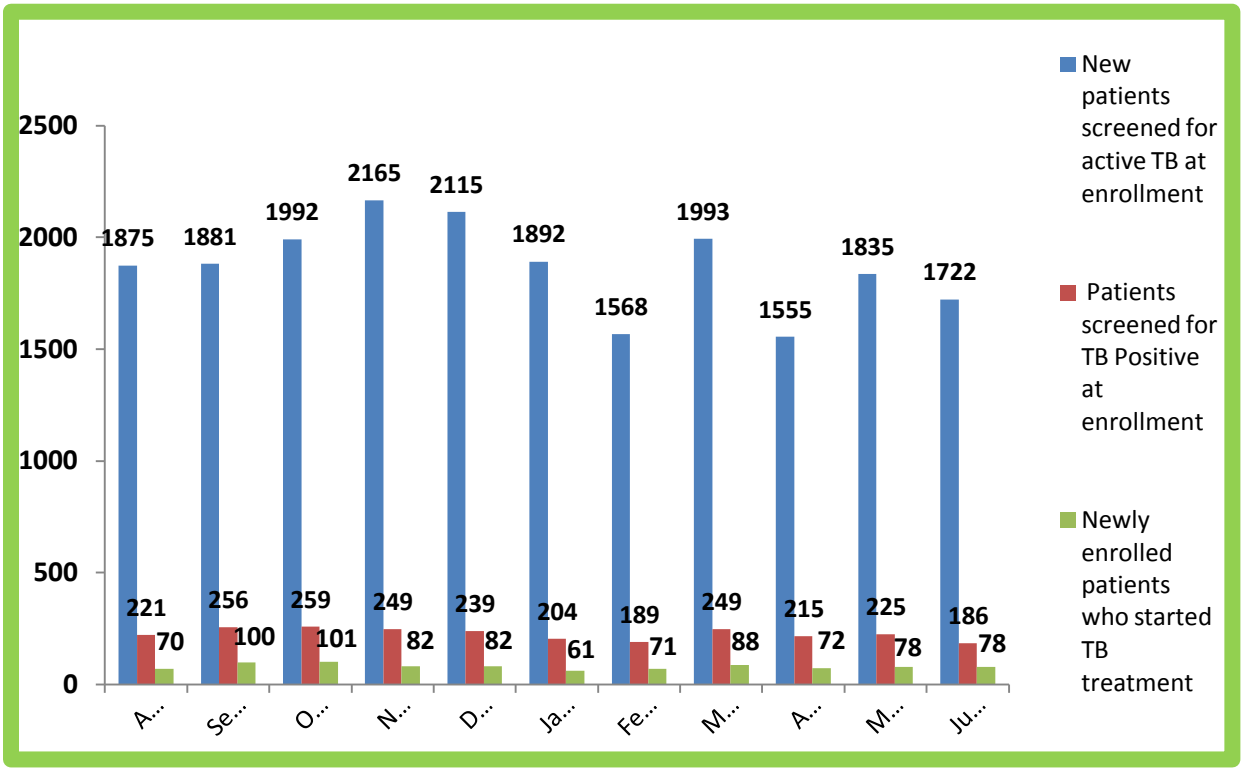
From July 2010 to June 2011, among 31199 newly enrolled clients, 20961 patients (67%) were screened for active TB. Among those screened for TB, 2475 (2,475/20,961=12%) patients had a positive screening test.

After para clinical examinations 796 adults and 84 children started anti TB treatment and were followed in one stop TB/HIV services.

The component of improving TB-HIV integration and management is one of the most successful: 97% of all TB patients and TB suspects 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.

The proportion of TB/HIV patients on antiretroviral therapy (ART) by the end of TB treatment was 68% (1458/2160) for the cohort of patients (all forms) registered from July 2009 to June 2010.

Figure 14: Tuberculosis screening among newly enrolled HIV+ patients (July 10-june11)



This Figure shows patients screened for active TB at enrolment

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

Increase service coverage to FOSAs including VCT and PIT

Regarding VCT, the increase of the number of health facilities offering HCT services contributed to the increase of the number of clients tested for HIV. Since 2001, there is a significant increase in number of health facilities offering VCT, actually there are 448 health facilities offering voluntary counseling and testing.

By the end of June 2011, the same number of HF offering VCT services was also offering provider initiated counselling and testing. Services are provided in all services on consultation with tuberculosis services, malnutrition, hospitalization etc.

Public Private Partnerships for expanding HIV testing

- In total 83244 male condoms from CAMERWA were available for use in the public institutions.
- Organization and holding of 30 one-day sessions of training in general knowledge on Sexual Transmission Infections (STI), HIV,/AIDS and VCT for Employees of 30 Administrative Districts.

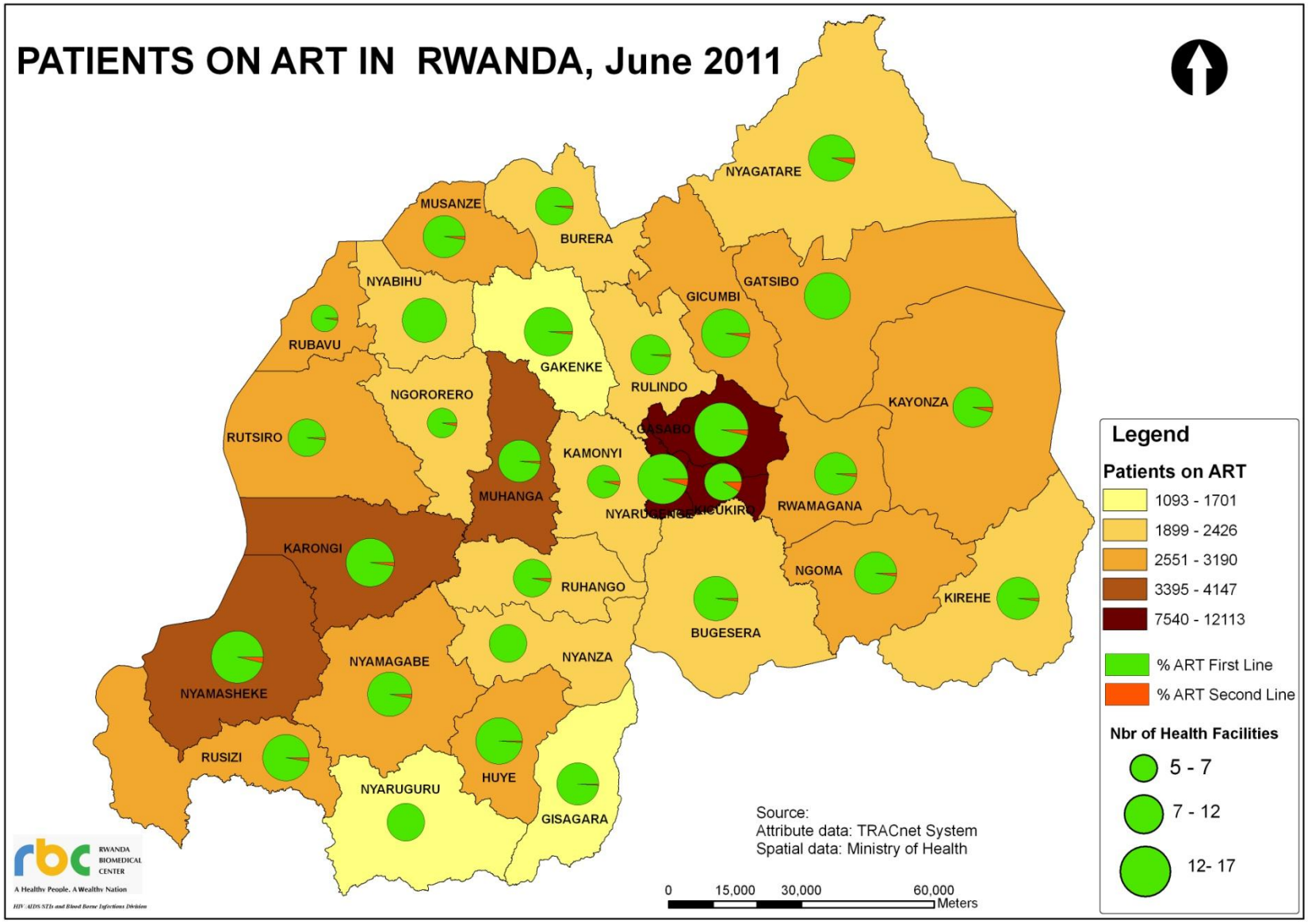
2.1.16 Output 2.2.1.3. Coverage of facilities offering ART is increased

Increase the availability and coverage of ART at health facility level

By the end of July 2010, **295** health facilities were offering care and treatment services to persons living with HIV/AIDS, and by the end of June 2011, 336 health facilities were offering care and treatment services. We note that there was an increase of health facilities offering care and treatment services during these last 12 months and in the same way patients increased. Since 2002, Rwanda assured large-scale access to ARVs and observed a marked increase in uptake of ARVs almost hundred times to-date from 870 patients in 2002 to 96123 patients by June 2011.

The map bellow shows that the high number of patients on ART and the high proportion of patients on second line are located in Kigali city.

Map6: Patients on ART in Rwanda, June 2011

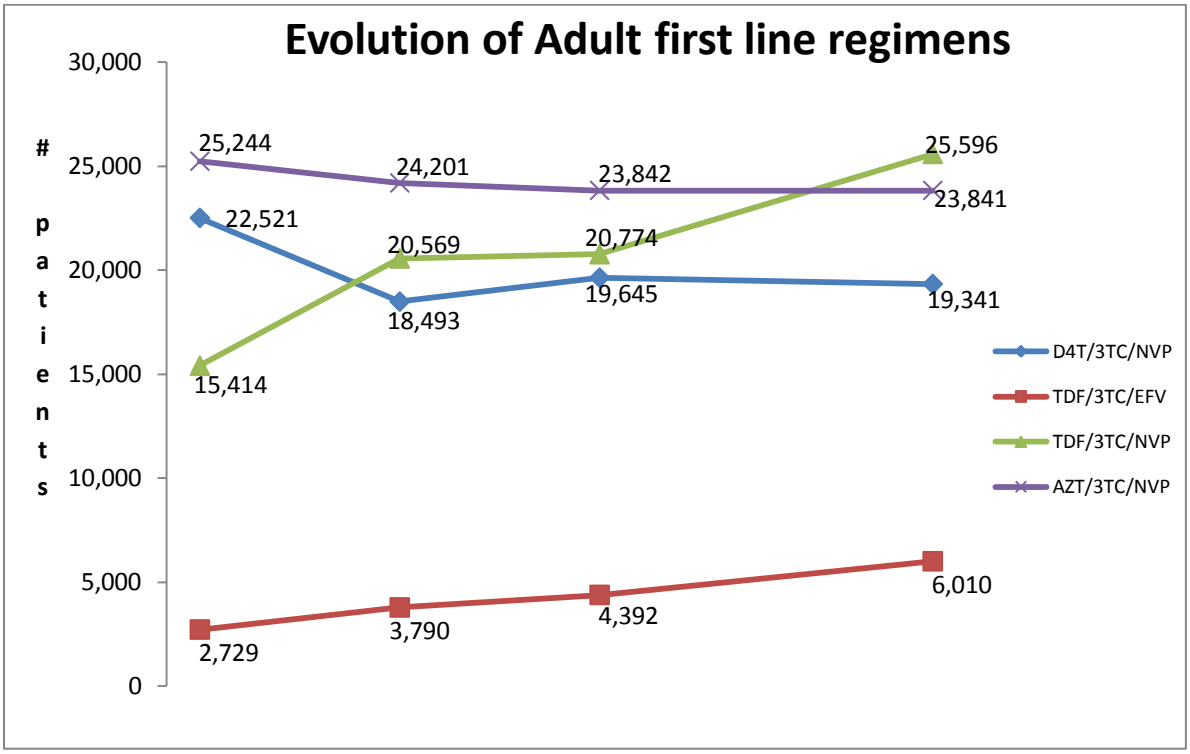


Strengthen the supply and distribution of drugs and commodities

The availability of HIV/AIDS commodities is a key prerequisite to ensuring the continual HIV/AIDS program scale up and disease control. The forecast and quantification of commodities needs are conducted every year, the stock status at both national and site levels are monitored on monthly basis through CPDS (Coordinated Procurement and Distribution System) mechanism. Monthly quantification committee (QC) meetings were scheduled and a number of recommendations were made to maintain the stock in desired quantities, to minimize losses and expiries, as well as to avoid stock outs. The trainings of trainers and supervisions at district level are main support to the health professionals including pharmacists and nurses; this is in line of capacity building in order to sustain the rational management and rational use of HIV related commodities.

In this year, the stock of HIV related commodities was closely monitored in collaboration with the Medical Procurement and Distribution Division (MPDD) and other Implementing Partners through the CPDS mechanism. The stock levels were in general in the range of predefined maximum and minimum levels except some ARV not used as expected especially the pediatric formulations and some reagents for clinical follow up of PLWH. The ARV consumption trend was generally in line with the programmatic scale up and the number of patients however the consumption of some regimens increased while others decreased. This trend is explained by the introduction of TDF/ABC based regimen moving from the D4T or AZT based regimens in the new care and treatment guidelines . According to the recorded consumptions figures at MPDD, the patients on AZT and D4T based regimens decreased by 5.6% and 14.1% respectively while the number patients on TDF continue to increase as shown in the below figure.

Figure 15: Evolution of Adult first line



Implementation of task shifting

Training was organized in December 2010 and aimed to develop capacity of nurses providing HIV services within ICAP-supported sites on the prescription of ARVs and monitoring of HIV positive patients or exposed to HIV. These sites were selected because some nurses who were previously trained on Task Shifting had changed their sites. During these two weeks of training, 48 Nurses from Kibuye, Kirinda, Murunda, Gisenyi, Kabaya, Shyira and Mugonero district hospitals were trained on Task Shifting and will be mentored from January 2011 before validation.

A special mentorship intended to strengthen task shifting process. After initiating task shifting training countrywide (from February 2010), RBC and its partners has been organizing mentorship training at national level to improve quality in HIV, TB and STIs areas. This activity started from 13th September 2010 and will continue with the next year to cover all districts.

2.1.17 Output 2.2.1.4. Quality standards for ART are maintained

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

There are systems in place at the level of health facility of tracking and tracing people who miss their appointments namely electronic data bases like IQ Chart and appointment registries. Quality improvements projects are being carried out in many health facilities to sort out the problem of lost to follow up. Many mentorships done in health facilities are putting much emphasis on lost to follow up issues and on top of that, home visits are done to look for those who missed their appointments**.**

New indicators on tracking and tracing lost to follow up clients have been incorporated in TRAC net system and health facilities are reporting on them at monthly basis and this enables the program at both levels, central and peripheral to get updated information on LTFU**.** To develop strategies using evidence, a study on lost to follow up between testing entry point and care & treatment is under development and results will help to focalize efforts where needed.

PLHIV receive adherence support at FOSAS and in community

Adherence has been always a concerning area for comprehensive care and treatment of people living with HIV/AIDS. In this area, emphasis has been put on adherence through integrated mentorships where health care providers have been initiated to systematic adherence assessment using both objective and subjective methods. A study has been done to evaluate adherence among orphans and non orphans adolescents in Kigali city. Results showed lower adherence among double orphans (both parents lost).

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

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

Mental Health and HIV Integration is a new strategy initiated for better prevention of HIV care and treatment of patients with both HIV and mental problems:

Three main areas have been focused on:

- Development of training module and tools: In addition to training module developed two mental health screening tools have been adapted, tested and used. These are SAMISS for general mental health problems screening and PHQ9 for screening of depression.
- Mentorship to initiate integration of HIV and Mental health services: In addition to the integration initiated in Ndera Neuropsychiatric referral hospital, this integration has been done in 9 district hospitals; Muhima, Muhororo, Gisenyi, Murunda, Kibuye,, Shyira, Kabaya, Mugonero and Kirinda.
- Training of health care providers: Two trainings of health care providers have been done for 43 health care providers from mental health and HIV services where integration has been initiated.

For psychosocial care and support, four main areas in psychosocial care and support have been focused on:

a. **Providing guidance and needed tools:** This has been done by production of needed tools to health facilities and technical support through technical meetings with Implementing Partners and District Hospitals.
b. **Increase capacity and skills of health care providers through clinical mentorship and trainings:** Psychosocial care and support has been a key integrated component in mentorships done in health facilities. Main addressed challenges are related to management of complicated psychosocial cases and adherence issues. A decentralized training has been done for 34 health care providers in Northern Province where gaps have been identified during mentorship sessions.
c. **Improvement of quality of care of specific groups (mainly children and adolescents)**: This area is a critical one and the RBC/IHDPC-HIV Division has put effort in extension of psychosocial services. These support groups (disclosure and support groups) are currently functional in 182 health facilities in the country.
d. **Stress management sessions for health care providers**: Caring for Health care providers has been identified as a key strategy to improve not only the care of HIV positive patients but also health care providers. Two sessions gathering 29 staff at central level have been done. Two other short sessions have been supported for Kacyiru Police Hospital staff and Gikondo Health center.

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

Nutrition and HIV/AIDS are strongly interdependent. Malnutrition is a common complication of HIV infection and likely to play significant and independent role in its progression, morbidity and mortality. The program of nutrition has a mission to integrate and reinforce nutritional care and support within HIV and AIDS services in particularly PMTCT, Care and treatment services in health facilities through elaboration of guidelines and protocols, norms curriculum and capacity building of health workers.

Nutrition support for PLHIV on treatment is integrated within all ART services and done according to national recommendations. Different activities are done in the domain such as: nutritional counseling to all, home visits for needs assessment and nutritional support when eligible criteria are met.

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

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

Capacity building for infected and affected people with HIV

In supporting associations of PLHIV, associations for vulnerable people as a model of SSF programs were created in Rusizi District. RRP+ has organized 360 members in 15 associations, and trained them in project elaboration, management, good governance, and cooperative laws. Each association had been represented by 5 persons.

CHF Higa Ubeho has provided management and governance training, financial literacy training and market literacy training to 97 cooperatives representing above 8,000 individuals. Those cooperatives benefited also of learning exchange field visits between cooperatives to share experiences and best practices. CHF Higa Ubeho had also provided technical support in production techniques to 37 cooperatives and internal savings and lending practices training to 2000 groups representing above 40,000 individuals.

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

Development of entrepreneurship among people infected and affected by HIV

To develop entrepreneurship among people infected and affected by HIV, 3 associations in Bugarama sector which are supported by RRP+ from 2009 have been transformed into cooperatives.

CHF Higa Ubeho project has provided training and ongoing technical support to assist 42 associations of PLWHA to acquire cooperative status, training on development of business plans - 6 for cooperatives and technical support to about 10,000 individuals who are involved in small income generating activities.

Create links between the industries and people infected and affected by HIV to access markets

CHF Higa Ubeho has supported 24 cooperatives to participate in national and international trade fairs. The organization also facilitated recruitment of 46 field officers for 9 RPOs in order to provide services such as market research, negotiation with industry, and business plan development for cooperatives to link them to industry.

The project provided also capacity building to 46 staff from 9 RPOs in cooperative management, financial literacy, market literacy, entrepreneurship skills, farmer field schools and business planning among others.

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

Improve food production for PLHA

Through trainings, RRP+ supported associations in IGAs such as livestock (pigs, cows), agriculture activities (rice, maize and cassava). From 2010 till now RRP+, with Global Fund support, has spent around 27 million Rwfs in supporting associations in IGAs such as livestock (pigs, cows). For the associations with cows, they are breeding 2 cows, for the pigs each association has 11 pigs with necessary needs for those activities.

RRP+ has spent around 50 million since 2009 on improving food production for PLHA. In collaboration with the local authorities, the associations supported with the sector agronomist select

the best seeds according to the region and fertilizers in needs. Some associations that started since 2009 were supported for their own fields in Bugarama sector.

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

Improve management and coordination transparency of OVC programme

The identification of OVC for education support was done in October 2010 as pilot phase with a total number of 580,878 OVC in secondary, primary/nursery, and vocational training. This was to prepare the general OVC identification for all services. The consultant to design the OVC database was recruited and the database has been finalized including data collection and analysis tools. MIGEPROF/NCC is organizing the general identification to start in January 2012 to get data that will be put in the database.

At District level, a staff in charge of OVC was recruited and coordination meetings are organized on quarterly basis and quarterly reports from Districts sent to MIGEPROF. Partners meetings are also organized by MIGEPROF on semi-annual basis with a regular follow up organized quarterly.

Provision of package of support to OVC

Through the coordination of MIGEPROF, implementing partners provided support to OVC on different components included in the minimum package (secondary school fees, primary education, Housing support, nutrition, protection, health, psychosocial support) with a total number of 283,391 OVC reported by partners at the end of June 2011.

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

Ensure the accessibility of legal aid services to infected and affected by HIV

For the awareness of PLHIV and OVC on their rights, RRP+ has elaborated the manual on human rights with specific objectives of PLWHA's rights awareness.

The development of this manual is intended to contribute to overall efforts to prevent the violation of PLHA rights, by equipping a legal guide that meets their needs on knowledge of human rights, administrative and legal services available in relation to PLWHA as well as possible remedies.

Besides this general goal, this manual also aims to:

- Send a message on the rights of PLHIV
- Help participants and the general population, analyzing the legal issues related to HIV/AIDS
- Analyze deeply and thoroughly national laws relating to the rights of PLWHA;
- Analyze deeply and thoroughly international conventions relating to the rights of PLWHA;
- Enable participants and the general population to meet the provisions that protect the rights of those infected and affected by HIV / AIDS;
- Analyze other policy putted in place by the Rwandan government and the international community to fight against the frequent violations of rights of PLWHA such as stigma and discrimination;
- Show the gaps and areas of shadows that exist in our laws and possible solutions;
- To identify cases of frequent violations of the rights of PLWHA and their legal solutions.
- Inform the participants and the public, the ways and means at their disposal in case of violations of the rights of PLWHA.

Regarding continuing legal education for lawyers on rights of PLHA and OVC, this manual will be used in the training of trainers for each district in the person of Deputy Mayor for Social Affairs, The petition charged at the sector level, lawyers in the districts, The responsible for the legal support service (MAJ), basic courts representatives.

These representatives are the main entrance for the legal support institutions fighting the stigma and discrimination in the community addressed to the PLWHA. The sessions of trainings have been conducted in the Southern province and will continue in other districts.

3 COORDINATION OF THE NATIONAL HIV RESPONSE

RBC/IHDPC (Former CNLS) Overall coordinating body of the national HIV response

Under RBC/IHDPC, the HIV/AIDS and Other Diseases Planning and M&E Evaluation Division are responsible for planning, coordination, monitoring, and evaluation of activities to fight against HIV and AIDS countrywide.

Activities for the fiscal year 2010 – 2011 are mainly concerned with the following major activities:

- Integration of the National Strategic Plan 2009-2012 priorities in the action plans of partners both at the national and decentralized levels;
- Strengthening the TA of CDLS and Umbrellas M&E staff through an annual capacity building program;
- Development of new monitoring and evaluation indicators and tools to collect and report on the National Strategic Plan for HIV and AIDS 2009-2012;
- Three months sensitization campaigns on the World AIDS Day and commemoration of this event through community work; Organization of sensitization campaign on cross-generational sex and sensitization campaigns on HIV prevention means including male circumcision;
- Organization of national and international conferences namely: the Fifth International Conference of Exchange and Research, the Fifth National Conference on Pediatric Care of Children infected and affected by HIV and AIDS and follow up of their recommendations;
- Supervision field visits on HIV and AIDS activities at the decentralized level;
- Participation in and support to activities of different partners involved in the fight against HIV and AIDS.

RBC/IHDPC HIV/AIDS and STIs Division (Former TRAC+): Coordinating body of HIV clinical prevention and treatment

The HIV/AIDS and STIs Division RBC/IHDPC has a mission to implement national surveillance of HIV/AIDS and STIs and to provide technical assistance to public and private sectors in prevention through VCT, PMTCT, PIT, MC, care & treatment of People Living with HIV and AIDS (PLWHA) in Rwanda. It is responsible for national planning, policy development, training of trainers and curriculum development for clinical programs. The Division provides assistance and technical guidance in the organization and effective management of programs against HIV /AIDS and STIs. It

is also responsible for formative supervisions, monitoring, evaluation and coordination of performance of the health sector as a whole to reduce transmission of HIV and AIDS. In carrying out these activities, HAS Unit uses high quality information technology and innovative approaches in planning, treatment, technical support and research.

The following are the main program interventions under the division:

- HIV prevention that gives an overview of programs in VCT, PMTCT, PIT, MC, PwP;
- Clinical management of people living with HIV and AIDS, that gives an overall view on the care and treatment of PLWHA.
- Epidemiology that gives the epidemic status.

RBC-LNR Coordinating body of all laboratory activities linked with HIV

The National Reference Laboratory (NRL) was established in July 2003 with the main roles to provide training and technical support to laboratory personnel in the national lab, establish quality assurance for laboratory network in the country, perform specialized tests for the diagnosis, prevention and surveillance of various infectious diseases, participate in the epidemiological surveillance; carrying out research and develop a national medical laboratory system, in line with the national decentralized health system.

To achieve the above mission, NRL is mandated with the following responsibilities:

- ***Prevention, control and surveillance of diseases*** by providing expertise and serves as a centre for detection, identification and analysis of biological agents in human diseaseswith an accurate analytical results for assessment, monitoring and surveillance of infectious, communicable and chronic diseases. LNR provide also specialized tests for low-incidence, high risk diseases like rabies.
- ***Provision of laboratory reference and specialized testing*** as a referral laboratory services to all health care providers in the country, and also a center where specialized testing services are provided.
- ***Integrated data management*** as a focal point for generation, processing/ analysis and dissemination of scientific/ laboratory related information in support of public health programs.

- ***Policy development and regulation*** by providing scientific and managerial leadership in developing public health laboratory policy, develops and enforces standards for all medical laboratories in the national network. NRL oversees the licensing, certifying and accreditation of medical laboratories in both public and private.
- ***Public health and related research*** – Research and Development (R&D) in biomedical and public health issues, is one of the core tasks of the NRL. Evaluation and implementation of new technologies and analytical methods, before adoption.
- ***Education and Training***: To improve the quality of healthcare services, the NRL participates in pre-service training of biotechnologists, curriculum development and review of courses offered at KHI. Provision of biotechnologists with scientific and technical skills during industrial orientation; Organizing short term training courses and workshops for laboratory personnel in both public and private laboratories.
- ***Quality Assurance and quality control*** is a core function of the NRL. NRL develops sufficient capacity to manage the task of having all laboratories involved in QA.

RBC-CNTS coordinating body of all blood transfusion services in the country

The former National Centre for Blood Transfusion (NCBT) is currently under RBC/MPPD Division (Medical Production, Procurement and Distribution Division) and has the mission to provide blood and blood products of quality for transfusion to all patients in need.

To achieve its mission, the NCBT has elaborated the following objectives: promotion of the voluntary non-remunerated blood donation, organization of blood collection in sufficient quantity, ensure the screening of 100% of the units of collected blood for transfusion transmittable infections (TTIs) and the distribution of blood to 100% of the patients in need.

The RBC/MPPD/NCBT has five operating blood centers at Kigali, Huye, Musanze, Rwamagana and Karongi. RCBT Rubavu construction is completed and needs to be staffed and equipped to be operational like other regional Centers for an equitable distribution on the national territory; thus each province will be equipped with a regional center of blood transfusion in accordance to the national policy of decentralization of health services. NCBT Kigali, is the most important, which collects, transforms and distributes fully of all blood collected in the country. The activities of screening for Infectious diseases are also carried out at the NCBT Kigali.

After the staff hiring in February 2011, the NCBT staff moved from 80 to 139 staff. Actually, the NCBT staff is composed of 139 personnel. 72 are females and 67 are males.

CDLS Coordinating body for each district (30) HIV response

Districts AIDS Control committees were able to coordinate and monitor HIV activities with SSF/HIV funds transferred to Districts. Those funds were transferred quarterly and Technical Assistants of CDLS submitted reports on the use of those funds.

RBC-CNLS is committed to robustly fulfilling its mandate of strengthening different structures, coordinating and monitoring activities to fight against HIV and AIDS at different levels; it is in this context that RBC-CNLS in collaboration with MEASURE Evaluation and UNAIDS organized different trainings aimed to build the capacity of CDLS Technical Assistants (CDLS/TAs) in data collection, management, analysis and use, and also to give them a good knowledge of HIV National M&E Tools. This included defining program-level indicators adapted from the National Strategic Plan (NSP) and the Monitoring and Evaluation (M&E) Plan, developing district-level data collection methodologies and tools, and reporting on aggregate data by entering them into the RBC-CNLS Database and through District-level reports.

From March to May 2011 RBC-CNLS jointly with its partners organized supportive supervision visits in 15 Districts of the country in order to improve HIV/AIDS coordination activities at the decentralized level. The overall objective of those supportive supervision field visits in districts was to build capacities of CDLS and exchange with partners on best practices and difficulties in implementing HIV activities at Decentralized level for a better response to HIV/AIDS in districts.

Umbrellas Coordinating bodies of HIV response for different constituencies of civil society, private and public sector (10)

In the year 2010-2011, RBC-CNLS worked to achieve its objective of strengthening the structures for the fight against HIV and AIDS and among them the "Umbrella organizations", by improving the coordination tools to fulfill its mission and by supporting them in various activities related to their action plans.

RBC-CNLS organized several meetings with the umbrellas so as to share the best practices in the fight against AIDS. RBC-CNLS offered technical and financial support to both public and private sectors and ensured that all strategic plans of the umbrella organizations, operational plans, and action plans are aligned to the National HIV and AIDS Strategic plan.

Different coordination meetings with all umbrellas were held on a quarterly basis to evaluate the progress of umbrellas in accomplishing their mandate, challenges faced and solutions for those challenges.

For the capacity building of Umbrellas as the coordination structures of community activities in the fight against HIV and AIDS, RBC-CNLS has continuously supported them to build an improved and solid structure to help them better coordinating HIV activities at their level through different trainings with focus on management of their umbrellas and familiarizing them with monitoring and evaluation tools.

Sectors Coordinating agents of HIV priority activities in different economic sectors (12)

The private sector with the support of RBC-CNLS was able to develop minimum package for HIV work place programs. This will be a guideline to all the private enterprises in developing HIV and AIDS programs. Mapping exercise for all private sector enterprises, HIV services offered by companies to their employees and validation workshop were conducted.
In addition, different trainings targeting mainly private and public sector HIV focal persons were conducted on work place HIV and AIDS programs.

For the public institutions, different coordination activities were carried out such as the nomination of HIV Focal Point (FP) in each Ministry and attached institutions were done in public institutions. The development of HIV and AIDS annual action plan 2010-2011 (MIFOTRA, MINEDUC, MININFRA, MIGEPROF, MINAGRI, MINALOC, MINIJUST, MINICOM) and Development of "The Public Sector Strategic Plan for HIV and AIDS 2011-2013" were achieved.
MIFOTRA and RBC-IHDPC (Former CNLS) had signed a Financing Agreement.

Also M&E quarterly visits were carried out by the USPLS staff in public institutions as well as **c**oordination of training on the STI/HIV/AIDS and HIV voluntary testing in 30 Districts.

During this reporting period, 6 EDPRS sectors were selected to implement the HIV response as a cross cutting issue in Agriculture, Justice, Youth, Education, Social Protection and Infrastructure as leading sectors. All sectors have an operational plan aligned to the NSP on HIV&AIDS 2009-2012 and received SSF/HIV funds with the objective of facilitating the implementation of operational plan of each sector.

4 NATIONAL MONITORING AND EVALUATION PLAN ON HIV AND AIDS

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

To reinforce the Districts Coordination and M&E activities, new functional equipments were purchased with SSF/HIV funds. For all the 30 CDLS to be well coordinated and monitored by the central level, a decentralization officer was recruited to support CDLS Coordinators in their duties.

Umbrellas organizations were strengthened in their structure with recruitment of new M&E staffs for each Umbrella with the support of SSF/HIV money. Moreover, for some Umbrellas Districts coordinators were also recruited to reinforce their coordination and M&E activities done at District level. That increased also the coverage of several districts by Umbrellas.

To ensure HIV mainstreaming, Also EDPRS sectors were reinforced with appointment of focal points in charge of M&E of HIV activities.

Regarding Umbrellas, one M&E Manager was recruited by RRP+ with MEASURE support.

4.1.2 Component 2: Human capacity for HIV M&E

Regarding capacity building for HIV M&E, different trainings were organized by RBC-IHDPC for CDLS Coordinators, Umbrellas and EDPRS Sectors M&E staff on the data management and system as well as on the HIV M&E system.

Different staffs have also participated in international and regional seminars on HIV. Short courses specific to M&E of HIV activities were done by RBC-IHDPC staff.

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

In order to assess progress in implementing HIV activities, several Planning and M&E TWG meetings were conducted.

Specifically, the PM&E team had met to agree on different steps to start the NSP 2009-2012 mid Term review planned to start by next year.

RRP+ conducted a meeting with coordinators and presidents of RRP+ associations during the reporting period. But the annual coordination meeting for all RRP+ stakeholders was planned but not conducted, lack of funds.

4.1.4 Component 7: Routine HIV program monitoring

The national guidelines for planning, data collection, management and reporting including monitoring and DQA by RRP+ and training for RRP+ Association leaders on it was done. RBC units are also conducting regular supervision visits and mentorship activities to the decentralized service providers.

4.1.5 Component 8: Surveys and surveillance

During the reporting period, the National Statistic institute of Rwanda was conducting the Demographic and Health Survey 2010 and its results did inform the report. The results of the survey will be disseminated next year.

After BSS for sex workers and youth, the HIV Division was conducting a BSS for truck drivers. Data analysis and production of the final reports for these different surveys were performed for the sex workers and youth studies. The truck drivers' survey will be completed next year.
Other important activities in terms of surveillance include HIV drug resistance surveillance, for which several studies are being planned and regular sero surveillance activities, particularly on pregnant women.

5. ANNUAL FINANCIAL REPORT ON HIV EXPENDITURES 2010-2011

Rwanda reports annually on the programmatic performance of the HIV response through monitoring of the national indicators and programmatic indicators included in the National HIV M&E plan. For the first time, we also include in this report a financial section describing HIV expenditures for the same time period. In this financial report, we will refer to the costing and gap analysis produced at the time of development of the HIV NSP 2009-2012, and we will compare those projections to the actual commitments made by major funding sources of the HIV response for fiscal year 2010-2011 and to effective HIV expenditures for the same period. For GOR HIV expenditures, we will give more details on the main cost categories to which it contributes.

METHODOLOGY

To obtain this information, the Health Resource Tracking Tool (HRT) was used, an online database which attempts to track all financial flows in the health sector from funding source to implementer. The system requires MOH and RBC institutions as well as international donors and NGOs to enter detailed budget information about the activities they plan to carry out for the current fiscal year as well as expenditure information for the last fiscal year. For the present exercise, Round 2 of data collection ended in September 2011, and achieved a 96% response rate. The HRT classification tree requires that data reporters specify the purpose of their activity, and how much they spend to achieve this purpose. All activities with an HIV purpose code were summed to calculate HIV expenditures.

It must be pointed out that this tool did not exist at the time of development of HIV NSP costing and gap analysis. The costing was carried out according to the NSP Result Based Framework, according to the three impacts related respectively to prevention, care and treatment, and impact mitigation and to the two cross-cutting areas (Coordination and M&E)**.** The cost of each activity was estimated using a standardized framework involving two sets of assumptions: Unit Cost Variables and Quantitative Assumptions. Estimates of total available resources for the gap analysis were derived from two sources: the budgets for currently active Global Fund proposals and the 2009/2010 Health Sector Joint Annual Work Plans. The fact that different tools were used in the NSP and in the current report explains some discrepancies in the numbers obtained.

Sources of funding

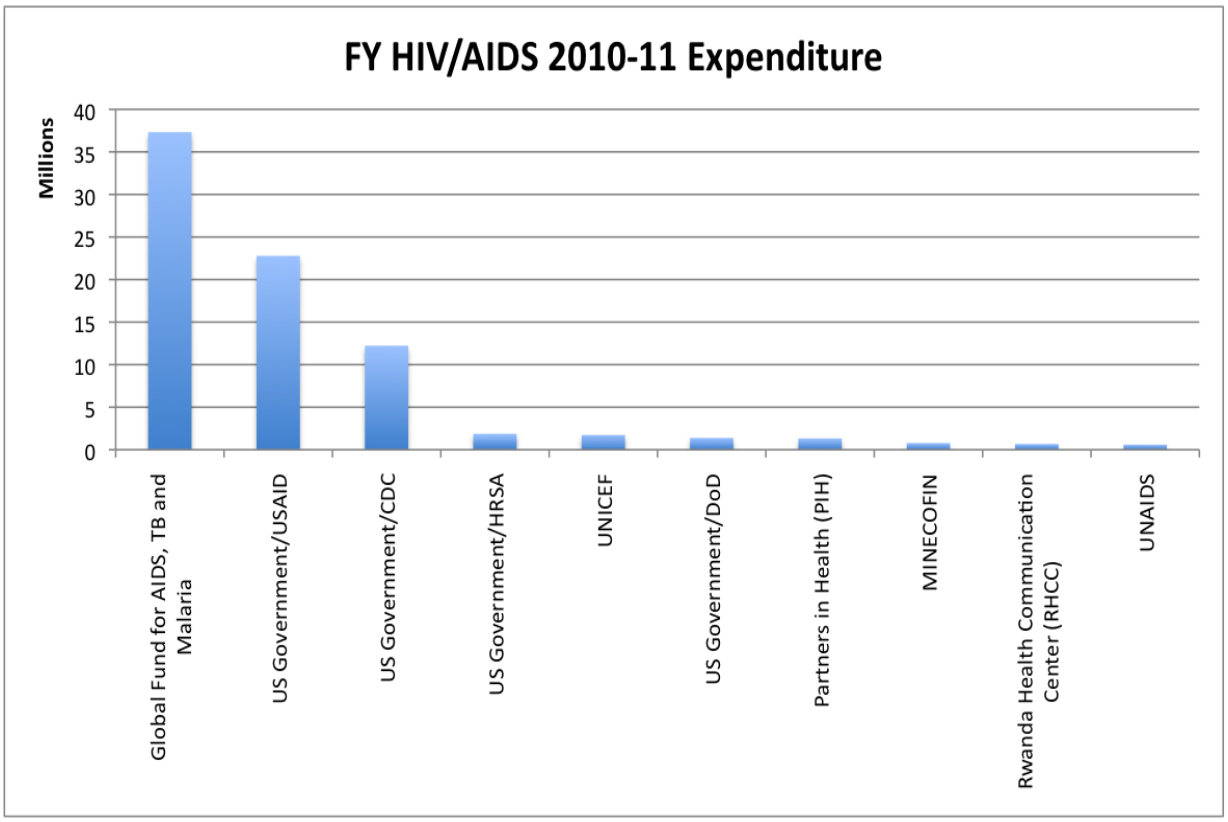
The following table gives the HIV budget 2010-2011 from the different funding sources as they are provided in the Health Resource Tracking Tool and the amount actually spent by each donor for the same time period and comparing these numbers to the original estimates from the HIV NSP gap analysis.

	Amount estimated in the NSP Gap Analysis for year 2010-2011	Commitment in USD (Budget from HRT)	Share as % of commitments	Amount Spent in USD	Share as % of expenditures
Global Fund	32.8 M$ (+98M$ of NSA)	121,639,186	54%	55,834,424	36%
USG PEPFAR	67.6 M$	82,182,577	37%	82,995,106	53%
One UN	4.3M$	4,880,025	2%	2,752,995	2%
GOR	15.3M$	15,300,000	7%	14,338,500	9%
Total	218 M$	224,001,788	100%	155,921,025	100%

Of course, the contribution of the Global Fund has increased markedly after the NSP development because of the NSA grant that was accepted by GF in 2010. The low level of disbursement of the Global Fund for the reporting period is due to the late arrival of those additional funds (contract signed between GOR and Global Fund in November 2010 and first funds available in January 2011). Only 6 months remained for disbursement, and much less for many new sub recipients that were selected later.

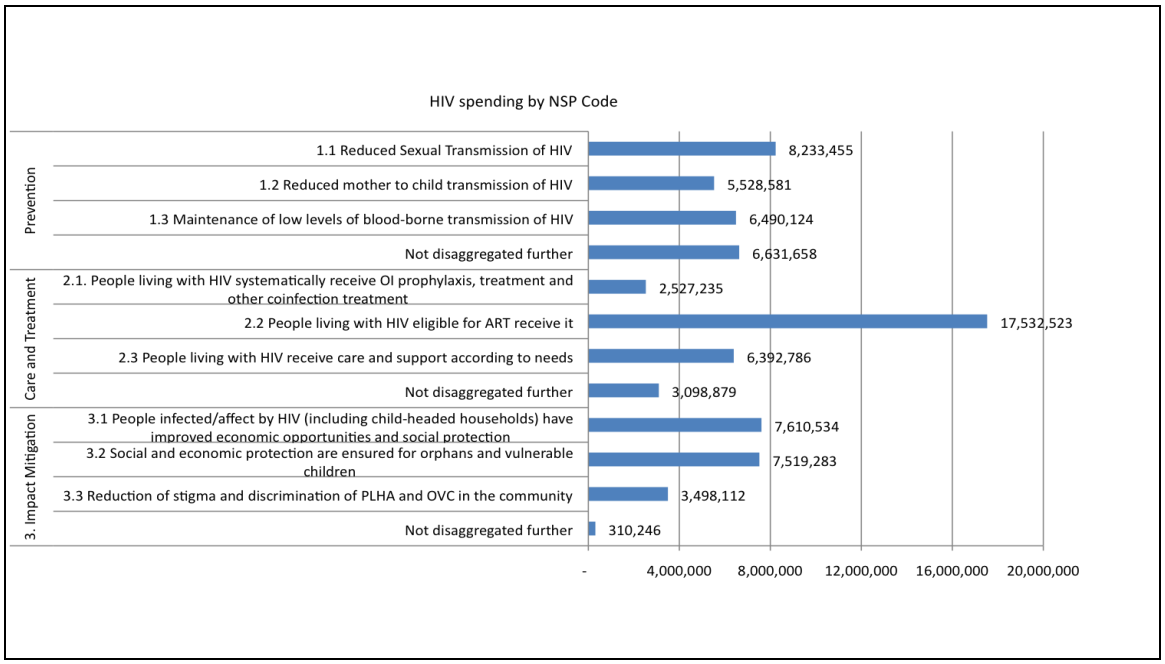
For the PEPFAR commitment, the same rationale used at the time of the NSP gap analysis was applied to the total budget announced for the reporting period. This means that funds allocated to overheads, technical assistance not related to HIV and general health system strengthening that are included in the overall commitment from USG but are not identified as HIV expenditures are subtracted from the commitment for HIV. The total commitment for PEPFAR program for the period was of USD 149M and the commitment identified for HIV is USD 82.2M. This estimation is quite realistic, as the total PEPFAR expenditures are very close to the estimated commitment.

The following graph illustrates the relative weight of different donors. It must be noted that these numbers represent institutional health spending. They do not reflect private health spending in Rwanda either from employers or households through out-of-pocket spending. These data will be available in the near future with DHS 2010 results and National AIDS Spending Assessment (NASA). According to data from the Resource Tracking Tool, institutional health spending on HIV/AIDS in the fiscal year 2010-2011 was USD 85,753,203 out of USD 419,636,013 or 21% of all institutional health spending expenditures. This percentage will be used to estimate the total GOR contribution to HIV expenditures.



Funds used by NSP objectives

The following graph presents the expenditures according to the main results of the HIV NSP. The numbers are those generated by the HRT (USD 85,753,203) and do not include all HIV expenditures (USD 155,921,025), as some budget categories are not identified as HIV expenditures but rather as general health expenditures. Many health expenditures are classified in cross-cutting categories such as human resources, infrastructures and are not allocated to disease-specific expenditures. To have a better estimate of the total expenditures affected to a specific disease such as HIV/AIDS, part of these general health expenditures is attributed to HIV expenditures proportionately to the weight of HIV services within the health care system.



The total HIV expenditures are categorized according to the three impact results, but also the two cross-cutting components (M&E and coordination) of the HIV NSP. The weight of each of these categories is presented in the following table.

NSP Objective	**Total amount spent according to HRT**	**% of total HIV expenditures**
1. Prevention	26, 883, 818	31,35%
2. Care and Treatment	29, 551, 424	34,46%
3. Impact Mitigation	18, 938, 175	22,08%
4. M&E	6, 082, 688	7.09%
5. Coordination	4, 297, 099	5.01%
Total	85,753,203	100%

For a more detailed description of allocation of funds to each NSP objective, expenditures for the three impact results of the NSP have been further analyzed according to the outcome results within each impact.

NSP Code	**Amount $**	**Percentage**	**NSP Code**	**Amount $**	**Percentage**
1. Prevention	26 883 818	35,67%	1.1 Reduced Sexual Transmission of HIV	8 233 455	10,92%
			1.2 Reduced mother to child transmission of HIV	5 528 581	7,33%
			1.3 Maintenance of low levels of blood-borne transmission of HIV	6 490 124	8,61%
			Not disaggregated further	6 631 658	8,80%
2. Care and Treatment	29 551 424	39,21%	2.1. People living with HIV systematically receive OI prophylaxis, treatment and other coinfection treatment	2 527 235	3,35%
			2.2 People living with HIV eligible for ART receive it	17 532 523	23,26%
			2.3 People living with HIV receive care and support according to needs	6 392 786	8,48%
			Not disaggregated further	3 098 879	4,11%
3. Impact Mitigation	18 938 175	25,13%	3.1 People infected/affect by HIV (including child-headed households) have improved economic opportunities and social protection	7 610 534	10,10%
			3.2 Social and economic protection are ensured for orphans and vulnerable children	7 519 283	9,98%
			3.3 Reduction of stigma and discrimination of PLHA and OVC in the community	3 498 112	4,64%
			Not disaggregated further	310 246	0,41%
Total	75 373 417	100,00%		75,373,417	100,00%

Analysis of the National counterpart

The amount contributed by GOR to HIV expenditures was estimated for the gap analysis of the HIV NSP on the assumption that HIV represented approximately 20% of health expenditures taken from the Joint Annual Work Plan 2009-2010. This led to an estimation of 14 million USD for fiscal year 2009-2010, and a projection of 15.3 million USD for year 2010-2011. The table below shows the basis on which GOR contribution to HJV spending was calculated at that time.

Sum of 2009/2010 (USD) for HIV	
Cost category	**Total**
Behavio(u)r Change Communication	80 743
Budget Support	350 775
CHW support	390 214
Drugs, Commodities & Consumables	1 699 170
Infrastructure	67 724
Mutuelle financial support	221
Other	238 548
PBF financial support	1 526 234
Running costs - fuel, electricity, communication, office supplies	43 302
Salaries	9 559 092
Vehicles	106 150
Grand Total	**14 062 172**

For estimation of expenditures by GOR for HIV activities in 2010-2011, we combined funding for HIV specific central institutions (ex-CNLS, ex-TRAC+ and CNTS) and for peripheral health facilities (District hospitals and health centers). On the basis of the HRT data, it was estimated that about 21% of all health expenditures were related to HIV and AIDS. This percentage was then applied to the main budget lines in the MOH expenditures to estimate the contribution of GOR to HIV expenditures.

As the following table shows, the total estimate comes to 14.3 million USD, which is slightly less than the 15.3M USD that had been projected at the time of development of the NSP. As was pointed out earlier, this amount does not reflect private health spending in Rwanda either from employers or households through out-of-pocket spending as these data are not captured in the HRT. Two important documents estimating private and out of pocket HIV expenditures will be published in the coming months (DHS 2010 results, awaiting official validation and

National AIDS Spending Assessment (NASA) that will be conducted soon as part of the Country progress report).

	TOTAL	HIV	%
Salaries	$ 30 000 000	$ 6 300 000	21%
Drugs		$ -	
Mutuelle (govt)	$ 5 500 000	$ 1 155 000	21%
Mutuelle (population)	$ 45 000 000	$ -	0%
Infrastructure	$ 350 000	$ 73 500	21%
Quality services	$ 1 800 000	$ 378 000	21%
Community health	$ 1 800 000	$ 378 000	21%
PBF (general)	$ 9 400 000	$ 1 974 000	21%
PBF (HIV specific)	$ 2 300 000	$ 2 300 000	100%
Sub total	**$ 96 150 000**		
Central level	$ 1 780 000	$ 1 780 000	100%
		$ 14 338 500	

Conclusion

This first attempt at presenting HIV expenditures as part of the Annual HIV Report is still limited and some data are not yet available. However, the newly introduced Health Resource Tracking Tool is showing its potential to inform and orient decisions for the health sector in general and in particular for implementation of the National HIV response.

This report shows that financial resources for HIV have continued to increase in 2010-2011, with high level of funding from the main international donors and a continuing increase of HIV expenditures from the GOR. The level of disbursement from the different funding sources is quite low (total HIV expenditures represent only 53% of commitments), but this situation is due to unusual circumstances related to late availability of funds and corrective steps are being taken to improve efficiency in financial disbursements.

Allocation of funds has been in keeping with the NSP costing and equitably allocated to the different programmatic areas.

The National counterpart has continued to increase and is consistent with the GOR commitment to contribute as much as possible to improvement of the health of the Rwandan population, and specifically to the National HIV response.

6 ANNEX A: HIV PREVENTION INDICATORS

6.1 NATIONAL INDICATORS

Number	Indicator	Baseline	*Value (June 2010)*	Actual value (July 2010-June 2011)	Target by 2012
1.	HIV Prevalence in the population aged 15-24	1% (RDHS 2005)		***RDHS 2010*** ***0.8% women 15-19*** ***0.3% men 15-19*** ***2.4%women 20-24*** ***0.5%men 20-24*** ***0.96% for population aged 15-24***	0.5%
1.1a	Percentage of most-at-risk populations (female sex workers, truck drivers, men who have sex with men, prisoners) who are HIV-infected	FSW: baseline 2009 Truck drivers: baseline 2009 MSM: baseline by 2010 Prisoners: baseline by 2010	*BSS 2010:* Truckers: No data MSM: no data Prisoners: no data	***FSW: 51%*** ***BSS FSW 2010***	Prevalence remains stable at baseline levels (reduction in incidence and AIDS-related mortality)
1.1b	Percent of discordant couples that remain discordant after enrolment to couples' counseling and testing at 12, 24, 36 months	Baseline by 2009	No data	***97.4% of 227 discordant couples enrolled in June 2010 were still discordant in June 2011***	90% at 36 months
1.1.1a	Percentage of women and men aged 15-49 who reported using a condom	*RDHS 2005:* 26% women 15-24 20% women 15-49	*BSS 2009:* 38% women 15-24	***RDHS 2010:*** ***29% women 15-24*** ***58% men 15-24***	60% in women 15-24 and 15-49

	the last time they had high risk sexual intercourse	40% in men 15-24 41% in men 15-49	52% in men 15-24		75% in men 15-24 and 15-49
1.1.1b	Percentage of young women and men aged 15-24, and 18-24, who have had sexual intercourse before the age of 15, and 18, respectively	*RDHS 2005:* **Before age of 15:** 4% women 15-24 13% in men 15-24 **Before age of 18:** 18% women 18-24 27% men 18-24	*BSS 2010:* **Before age 15:** 6% women 15-24 13% men 15-24 **Before age of 18:** 27% women 18-24 43% men 18-24	***RDHS 2010:*** ***Before age of 15:*** ***4% women 15-24*** ***11% men 15-24*** ***Before age of 18:*** ***17% women 18-24*** ***27% men 18-24***	**Before age 15:** No target **Before age 18:** 12% women 18-24 18% men 18-24
1.1.1c	Percentage of population aged 15-49 who had more than one sexual partner in the past 12 months	*RDHS 2005:* 0.6% women 15-49 5.1% in men 15-49	No data	***RDHS 2010:*** ***0.6% women*** ***3.9% men***	Stabilize at <5%
1.1.1d	Percentage of sero-discordant cohabiting couples reporting consistent and correct condom use during reporting period	Baseline by 2009	No data	***No data***	50% increase from baseline

1.1.1e	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Baseline by 2009	*MSM Exploratory Study (N=99)* 50% last sex with boyfriend; 51% last casual male partner	***No data (BSS for MSM not yet done)***	50% increase from baseline
1.1.1f	Percentage of female sex workers reporting condom use during last sex with a paying client	*BSS 2006:* 86.6%	*BSS 2010:* 64% with a paying client 80%	***BSS 2010: 64% with paying client 80% with a client to be considered in this case***	93%
1.1.1g	Percentage of other most-at risk populations reporting condom use during last sexual intercourse with non-married non-cohabitating partner	*BSS 2006:* 82% in Truck drivers	No data	***76% BSS for Truck Drivers***	90% (Truck drivers)
1.1.1.1a	Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	*DHS 2005:* 51% women 15-24 54% women 15-49 54% men 15-24; 58% men 15-49	*BSS 2009:* 12% women 15-24 14% men 15-24	***RDHS 2010: 55.5% women 15-49 51.6% men 15-49***	70% in men and women aged 15-24 and 15-49

1.1.1.1b	Number of couples who have received couples HIV counseling and testing and who know their results in the last 12 months	*TRAC Plus 2008:* 101,139 couples tested	*TRAC Plus 2010:* 10,514 couples (The data reported in 2009-2010 are only for VCT)	***377,270 (104,854 in VCT and 272,416 in PMTCT) HIV/AIDS&STI Division report***	200,000 couples tested per year by 2012
1.1.1.3a	Percentage of sex workers reached with HIV prevention programs	*Baseline by 2009 (Triangulation)*	*No data*	***National HIV Database: 66.1% 6722/10571(denominator: FSW size estimation)***	60%
1.1.1.3b	Percentage of sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	*BSS 2006: 36.2%*	*BSS 2010: 22%*	***22% BSS 2010***	70%
1.1.1.4a	Percentage of other most at risk populations reached with HIV prevention programs (disaggregated by population)	*Baseline by 2009 (Triangulation)*	*No data*	***CNLS Net 7,206 in PWD 4,625 in Prisoners 9,227 in transporters 1,960 in sero-discordant couples Only number are available. No baseline yet determined to have the percentage***	60% in other most at risk populations

1.1.1.4b	Percentage of other most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by population)	*BSS 2006: Truck Drivers: 39.1%* *Other baselines to be obtained*	*No data*	***BSS 2010 for truck drivers: 32%*** ***BSS for other MARPs to be conducted next year***	70% in other most at risk populations
1.1.1.5	Percentage of those testing positive for HIV receiving complete prevention package	*TRAC Plus 2008: 5%*	*No data*	***No data***	80%
1.1.1.6a	Percentage of health facilities with post-exposure prophylaxis (PEP) available	*SPA 2007: 28%*	*TRAC Plus: 65%* *(308 / 471)*	***HIV/AIDS&STI Division report*** ***68%*** ***336/494HF)***	100%
1.1.1.6b	Percentage of women presenting at health facilities reporting rape who receive PEP according to national guidelines	*Baseline by 2009*	*TRAC Plus:* *Overall: 83%* *Occupational: 94%* *Rape/Sexual assault victims: 76%* *Other: 86%*	***TRACNet*** ***87.2% without rape cases [834/956]*** ***HIV/AIDS&STI Division report*** ***Occupational :84.7%*** ***Others non occupational : 88.8 %***	100%

1.1.1.7a	Total number of condoms available for distribution nation-wide during the last 12 months	*Rwanda RHC 2009: Approximately 15,000,000 condoms*	*No data*	***41,663,414*** ***Data source:*** ***PSI and RBC-MPDD***	26,000,000 condoms
1.1.1.7b	Percentage of young women and men aged 15-24 who report they could get condoms on their own	*DHS 2005:* *37% in women 15-24* *73% in men 15-24*	*No data*	***RDHS 2010:*** ***85.6% women 15-24*** ***90.7% men15-24***	60% in women 80% in men
1.1.2a	Prevalence of male circumcision among adolescent and adult men (disaggregated by age [10-19, 20+])	*Intermediate DHS 2007/8: 15% in males 15-59*	*BSS 2009: 16% in men aged 15-24*	***RDHS 2010:*** ***13% men aged 15-59*** ***Disaggregation*** ***10% men aged 15-19*** ***18% men aged 30-34*** ***13% men aged 35-39*** ***6% men aged 55-59***	50% in men 10-19; 30% in men 20+
1.1.2b	Proportion of males born in the last 12 months circumcised at a health facility	*Not available*	*No data*	***No data***	50% of newborn males in 2012
1.1.2.1	Percentage of health facilities with staff who can perform male circumcision	*SPA 2007: 21% of health facilities*	*No data*	***HIV Division*** ***70.2%*** ***347/494***	80%
1.1.3	Percentage of people reporting symptoms suggestive of STIs and seeking treatment from	*DHS 2005:* *12% in women; 14% in men*	*No data*	***RDHS 2010:*** ***54% women and 35% men seeking for clinical services***	60% in men and women

	clinical services (disaggregated by sex)				
1.1.3.2	Percentage of health centers and hospitals offering STI treatment that have capacity to test for syphilis	*SPA 2007: 40%*	*No data*	***87.6%*** ***(433/494 Health facilities)*** ***MoH/HMIS***	100%
1.2	Percentage of HIV+ children born to known HIV+ mothers [at 6 weeks, 5 months, 9 months and 18 months]	*TRAC Plus 2008:* *3.2 % at 6 weeks* *2.8% at 5 months* *7.2% at 18 months*	*TRAC Plus:* *2.6% at 6 weeks* *No data at 5 months* *2.4% at 18 months*	***3.4% at 6 weeks*** ***2.1% at 18 months*** ***HIV/AIDS&STI Division Report***	2% at 18 months
1.2.1	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	*TRAC Plus 2008: 56%*	*TRAC Plus: 74%*	***85%*** ***(8838/10380)*** ***TRACNet and Epi Spectrum 2010***	90%
1.2.1.1	Number and percentage of health facilities that provide all four items from minimum PMTCT package	*SPA 2007: 35% of all health facilities (68% among all health facilities offering any PMTCT services)*	*80%*	***85.6 %*** ***412 /481HF*** ***HIV/AIDS&STI Division report***	60% (90% of all health facilities offering any PMTCT services)

1.2.2	Percentage of women of reproductive age attending HIV care and treatment services with unmet need for family planning	**TRAC plus and FHI 2009: 18%[1]**	*No data*	**No data**	**<10%**
1.2.2.1	Percentage of health facilities offering integrated family planning services as part of ART (With the numerator of FP HF and denominator of PMTCT HF)	*Baseline by 2009*	*TRAC Plus: 92% (371/404)*	***97.5%*** ***402/412*** ***FP sites/PMTCT sites***	80%
1.3	Percentage of donated blood units screened for HIV in a quality assured manner	*100%*	*100%*	***100%*** ***RBC-NBTC Report***	100%
1.3.1.1a	Percentage of people in the general population reporting that last injection was given with a syringe and needle taken from a new, unopened package	*DHS 2005:* *94.7% in women* *89.4% in men*	*No data*	***RDHS 2010:*** ***99 % of the general population***	100%

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

1.3.1.1b	Percentage of health facilities with safe final disposal methods for sharps and infectious waste	*SPA 2007:* *92% for sharps waste* *88% for infectious waste*	*TRAC Plus:* *20%*	***No data***	100%

6.2 COMMUNITY-BASED PROGRAM INDICATORS (RBC-IHDPC/ HIV &AIDS Division)

Number	Indicator	*Baseline*	*Value (June 2010)*	Actual value (July 2010-June 2011)	Target
D1	Number of people in the targeted population reached through community outreach with at least one HIV information, education, or behavior change communication message	*No baseline*	1,195,900 people aged 15-49	***2,108, 008 people aged between 15-24***	
D2	Number of youth reached with HIV information, education, communication or behavior change communication through HIV youth clubs (club anti-SIDA)	*No baseline*	210,029 out-of-school youth aged 15-29 178,510 in-school youth aged 15-29	***576,025 youth:*** ***155,614 in school*** ***420,411 out of school***	
D3	Number of Most-at-risk populations reached by HIV prevention interventions	*No baseline*	3,035 Female commercial sex workers 15,788 people with disabilities	***76, 776 MARPs*** ***6,722 Female Sex workers*** ***7,206 people with disabilities***	Percentage increase on baseline figures

			4,643 people in uniform 114,245 PLWHA 67 prisoners 4,766 refugees 18,436 transporters 12,254 people in Sero-discordant couples	***4,625 prisoners*** ***9,227 transporters*** ***1,960 people in Sero-discordant couples*** ***47,036 women aged between 15-24***	
D4	Number of district level implementers with the minimum capacity to deliver quality HIV prevention services to MARPs	*No baseline*		***164 partners with minimum capacity to deliver services to MARPs***	100%
D5	Percentage of health facilities that offer referral services for victims of sexual or gender-based violence (Id revised to include staff trained for GBV instead of referral services)	*No baseline*	*63%* *(247/395)*	***72%*** ***Health facilities have staffs trained for victims of sexual or gender-based violence.***	100%
D6	Number of condom points of sale in the district	*No baseline*		***7,760 of condom points of sale in the districts***	50 per administrative sector

7 ANNEX 2: HIV CARE AND TREATMENT INDICATORS

7.1 NATIONAL INDICATORS

Number	Indicator	*Baseline*	*Value by June 2010*	**Actual value (July 2010-June 2011)**	Target by 2012
2.	Percentage of adults and children with HIV known to be on treatment 12, 24, and 36 months after initiating anti-retroviral therapy			***92.7% at 12 months IQ CHART Data***	
2.1	Percentage of people enrolled in HIV care and treatment who receive cotrimoxazole prophylaxis in the last 12 months	*Baseline by 2009*	*No data*	***93% (141,993/152,786 HIV/AIDS&STI Division report***	85% in adults and children
2.1.1.1	Percentage of hospitals and health centers offering full package of HIV services (VCT, PMTCT, ART)	*TRAC plus 2008: 43%*	*TRAC Plus: 70%*	***75% 336/448 HIV/AIDS&STI Division report***	100%
2.1.1.3	Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings (at the end of the reporting period)	*TRAC Plus 2008: 59% during 6 month reporting period*	*TRAC Plus: 67% (1,916/2,865)*	***67% 20961/31199 TRACNet***	80%
2.2	Percentage of adults and children eligible for ART receiving it (disaggregated by treatment initiation eligibility	*77% in adults [CD4 <200]*	*TRAC Plus: 83% in adults (75,930/91,400) [CD4 <350]*	***TRAC Net: Overall : 91.4 % Adults: 98% [88526/90460]***	CD4 <200: 90% in adults CD4 <350: 70% in adults

	criteria [CD4 <200, CD4 <350])	*80% in children [CD4 <200]*	*53% in children (7,111/13,500) [CD4 <350]*	***Using spectrum, Medium bound 50% Children: 51.6% (7597/14730) Using Spectrum 2010, Medium Bound 50%***	90% in children
2.2.1.1a	Percentage of women and men aged 15-49 ever had sex who received an HIV test in the last 12 months and who know their results	*DHS 2005 (last 12 months): 11.6% in women 15-59 ; 11% in men 15-49 BSS 2006 (ever tested): 12.6% in girls 15-24; 11.3% in boys 15-24*	*BSS 2009: 50% in youth aged 15-24*	***RDHS 2010 38.6% in women 37.7% in men***	35% (last 12 months)
2.2.1.1b	Percentage of pregnant women who were tested for HIV and know their results	*75% (estimation based on model)*	*TRAC Plus: 69% (287,888/414,799)*	***73.3% (322,378/439,454) HIV/AIDS&STI Division report***	90%
2.2.1.1c	Percentage of partners of pregnant women in ANC who were tested for HIV in the last 12 months and who know their results	*TRAC Plus 2008: 78%*	*TRAC Plus: 84%*	***83% (272,416/327,463) HIV/AIDS&STI Division report***	90%
2.2.1.1d	Percentage of health facilities offering Provider-Initiated testing (PIT)	*Not available*	*No data*	***90.6% 448/494*** (Denominator include HS:437,DH: 41, Prisons:16) ***HIV/STI Division***	90%

				Report	
2.2.1.2	Percentage of children of HIV+ mothers who received an HIV test at 18 months	*TRAC plus 2008: 75%*	*TRAC Plus: 84%*	***89% 5699/6392 HIV/AIDS & STI Division report***	90%
2.2.1.4	Percentage of viral load suppression after 12 months of treatment	*Baseline by 2010*	*No data*	***88% HIV Drug Resistance Monitoring***	70%
2.3	Percentage of adults who received follow-up adherence assessment and counseling as part of psychosocial support package	*Baseline by 2010*	*No data*	*No data*	90%
2.3.1.1	Number of PLHIV who received at least one home visit and/or palliative care service in last 12 months	*Baseline by 2009*	*No data*	***No data***	22,000
2.3.1.2	Number of people living with HIV benefiting from nutritional support in the last 12 months	*Baseline by 2009*	*No data*	***65022 TRACnet Data***	42,000

7.2 COMMUNITY-BASED PROGRAM INDICATORS (RBC-IHDPC/ HIV &AIDS Division)

Number	**Indicator**	***Baseline***	***Value (June 2010)***	**Actual value (July 2010-June 2011)**	**Target**
D7	Percentage of ART sites with an affiliated community-based organization supporting PLWHA	*No baseline*	*12%*	***67% 225 affiliated Sites/ 336 sites of ARVs.***	100%

D8	Number of PLWHA visited by community health volunteers	*No baseline*	*5,045 at Health Centers;* *1,717 at district hospitals*	***3,739 PLWHA visited by HF and community health volunteers.*** ***4,162 PLWHA visited by implementing partners***	

7.3 FACILITY-BASED PROGRAM INDICATORS (RBC-IHDPC/ HIV &AIDS Division)

Number	**Indicator**	***Baseline***	***Value by June 2010***	**Actual value (July 2010-June 2011)**
F1	Total number of new patients enrolled in the care and treatment program	*No baseline*		***33722***
F2	Cumulative total number of patients enrolled in the care and treatment program	*No baseline*	141384 by August 2010	***152,786 by June 2011***
F3	Number of HIV-positive patients who receive prophylactic cotrimoxazole	*No baseline*	*No data*	***141,993***
F4	Number of new HIV-positive patients to whom TB screening was done in the past 12 month	*No baseline*		***20961***
F5	Number of new HIV-positive patients to whom TB screening was positive in the past month	*No baseline*	*248*	***2492***

F6	Number of HIV-positive patients assisted by the care and treatment services who have started TB treatment (including TB sufferers newly enrolled)	*No baseline*	*10 PLWHA under 15 years;* *74 PLWHA aged 15+*	***883***
F7	Number of new patients who started ART during the last 12 months	*No baseline*	18,795	***17,947***
F8	Cumulative total number of patients who are currently under ART	*No baseline*	*83,041*	***96,123***
F9	Percentage of HIV-positive patients under first line regimen	*No baseline*	*98%*	***98%***
F10	Percentage of HIV-positive patients under second line regimen	*No baseline*	*2%*	***2%***
F11	Number of patients to whom CD4 count was done in the last 6 months	*No baseline*	*No data*	***No data***
F12	Number of STI cases treated in or during the reporting period	*No baseline*	*2,534*	***5803***
F13	Number of cases of opportunistic infections treated, excluding TB, in last month	*No baseline*	*2,341*	***3166***
F14	Number of HIV-positive clients (aged 15 years or above) to whom cervix cancer was detected	*No baseline*	*No data*	***Data not yet available***
F15	Number of HIV-positive children with severe malnutrition at the level of care and	*No baseline*	*201*	***258 under 5 years***

	treatment services			
F16	Number of HIV-positive children (under 5 years) who have received nutritional or treatment supplements	*No baseline*	*149*	***207 Only under 5years***
F17	Number of HIV-positive patients with malnutrition who have received treatment or nutritional supplements	*No baseline*	*962 patients under 15 years;* *3,934 patients aged 15+*	***1163 patients under 15 years;*** ***4427 patients aged 15+***

8 ANNEX 3: HIV IMPACT MITIGATION INDICATORS

8.1 NATIONAL INDICATORS

Number	Indicator	*Baseline*	*Value by June 2010*	Actual value(July 2011-June 2011)	Target by 2012
3.1	Percentage of PLHA who have gone at least one day without food	*Rwanda Stigma Index 2008: 59% (58% females, 62% males)*	*No data*	***No data*** ***Source of data: Stigma index survey to be conducted next year by RRP+***	<20%
3.1.1.1	Percentage of PLHA who have no formal education	*Rwanda Stigma Index 2008: 16.8% (19% females, 12% males)*	*No data*	***No data*** ***Source of data: Stigma index survey to be conducted next year by RRP+***	<5%
3.1.1.2	Percentage of PLHA who are unemployed or not working at all	*Rwanda Stigma Index 2008: 20.4% (21% females, 20% males)*	*No data*	***No data*** ***Source of data: Stigma index survey to be conducted next year by RRP+***	<10%
3.1.1.3	Percentage of cooperative members applying for credit who accessed credit mechanism per year	*Baseline by 2009*	*No data*	***RRP+ Coordinators reports*** ***45,08%***	70%
3.2	Percentage of OVC aged 0-17 whose households received free basic external support in caring for the child	*DHS 2005: 12.6% at least one type of support; 0.2% all types of support*	*No data*	***283,391 OVC*** ***% to be calculated after determination of the baseline in 2012*** ***NCC Report***	30% at least one type of support 10% all types of support
3.2.1.1a	Percentage of OVC who meet national criteria for vulnerability that are in district registers	*Baseline by 2009*	*No data*	***No data*** ***Database for OVC identification finalized, identification to start next year.***	100%
3.2.1.1b	Current school attendance	*DHS 2005: Lost both*	*No data*	***RHDS 2010:***	>90% in boys and

	among orphans and non-orphans aged 10-14	*parents: 70.1% in boys; 78.8% in girls* *Non-OVC: 88.1% in boys, 90.1% in girls*		***Both parents deceased: 87.7%*** ***Both parents alive and living with at least one parent: 96.1%*** ***Disaggregation:*** ***Both parents deceased: 91,2% in boys, 83,8%in girls*** ***Both parents alive and living with at least one parent: 96.2% in boys, 96% in girls***	girls
3.3	Percentage of PLHA who report fear of being physically harassed and/or threatened	*Rwanda Stigma Index 2008: 36% (32% female, 37% male)*	*No data*	***No data*** ***Source of data Stigma index survey to be conducted next year by RRP+***	<15%
3.3.1.1a	Laws are protective of the rights of persons infected/affected by HIV	*Baseline by 2009*	*No data*	***No data***	Yes
3.3.1.1b	System for officially documenting cases of stigma and discrimination exist	*No*	*No data*	***No system available***	Yes
3.3.1.2	Number of PLHIV receiving legal aid when needing it	*Baseline by 2009*	*CNLS: 409*	***846*** ***RRP+ Districts reports***	[process only]
3.3.1.3	Percentage of population expressing accepting attitudes in relation to people living with HIV	*RDHS 2005: 46.1% in women 15-49; 51.0% in men 15-59*	*No data*	***RDHS 2010:*** ***64,5% in men15-59*** ***53% in women 15-49***	90% in men and women
3.3.1.4	Percentage of people living with HIV and AIDS who	*Rwanda Stigma Index 2008: 50%*	*No data*	***No data***	90%

	confronted, challenged or educated someone who was stigmatizing and/or discriminating them				

8.2 COMMUNITY-BASED PROGRAM INDICATORS (RBC-IHDPC/ HIV &AIDS Division)

Number	Indicator	*Baseline*	*Value (June 2010)*	Actual value by June 2012	Target
D9	Number of PLWHA who received secondary support services	*No baseline*	*1,866 received support for income-generating activities* *1,301 received capacity-building trainings;* *4,851 received support to purchase health insurance (mutuelle de santé)* *1,684 received support for food security initiatives*	***112,101 PLWHA received secondary support services as follow as:*** ***31,319 / capacity-building trainings;*** ***35,155 support for income-generating activities*** ***594 legal services*** ***9,701 for food security initiatives*** ***35,224 with support to purchase health insurance (mutuelle de santé).***	
D10	Number of associations and cooperatives of PLWHA per district	*No baseline*	*853 associations* *271 cooperatives*	***Associations: 701*** ***Cooperatives: 601***	
D11	Number of OVC receiving services as part of the National Minimum Package of	*No baseline*	*2,756 received health services* *2,616 received nutritional support*	***36,674 received health services*** ***16,593 received nutritional support***	

services	*6,103 received educational support*	***79,631 received educational support***
	1,001 received support for shelter	***3089 received support for shelter***
	1,127 received support for legal and social protection	***9,911 received support for legal and social protection***
	1,840 received psychosocial support	***36,331 received psychosocial support***
	2,388 received support for their families/caregivers	***30,612 received support for their families/caregivers on socio-economic***