



Republic of Rwanda  
Ministry of Health

**rbc** Rwanda  
Biomedical  
Centre  
Healthy People, Wealthy Nation



# HIV, STIs and Viral Hepatitis Programs

ANNUAL REPORT  
2022-2023



## FOREWORD

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Every year, the Ministry of Health publishes an annual report detailing national progress in HIV, STI, and viral hepatitis disease control. This year's report compiles activities achievements and challenges recorded between July 2022 and June 2023.

The accomplishments outlined in this report are the result of effective partnerships and collaboration between the Government of Rwanda, development and implementation partners, Civil Society Organizations in HIV response, UN agencies, and other valuable partners who daily provide assistance and contribute to reducing the burden of the HIV, STIs, and viral Hepatitis in Rwanda.

In addition, this annual report provides an opportunity to recognize the tireless efforts of scientists and epidemiologists from various technical working groups, healthcare workers at various levels of health service delivery, and advocates and supporters of peer groups at the community level.

Despite the significant progress made to control the HIV epidemic in Rwanda in the previous 20 years, this report emphasizes the need for future investments to reduce new HIV infections among key populations and youth especially adolescent girls and young women, through the implementation of evidence-based interventions targeting groups at risk and in the most high-burden districts of Rwanda.

This report additionally highlights high-priority areas to guide the next fiscal year's HIV response implementation by the Government of Rwanda, its stakeholders, and partners to ensure Rwanda remains on track to end AIDS by 2030.

Zachee IYAKAREMYE  
Permanent Secretary

## Executive Summary

This report presents the key achievements of all actors in HIV/AIDS, STIs, and viral hepatitis response, from July, 1 2022 to June 30, 2023, as referred to as the reporting period. It covers essential areas of interventions in the fight against HIV/AIDS, STIs, and viral hepatitis, namely prevention, care and treatment, social impact mitigation, health system strengthening, financing HIV national response, and strategic information.

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

Rwanda embarked on the plan for the elimination of mother-to-child HIV transmission. From July 2022 to June 2023, 389,531 pregnant women attended their first ANC Visit. 5,558 were known to be HIV positive, whereas 365,759 were tested for HIV, both with unknown HIV status and negative HIV status. Among them 1,421 pregnant women tested positive for HIV, translating into a positivity rate of 0.4%.

Overall, 99% of pregnant women living with HIV received ART to reduce mother to child HIV transmission during the fiscal year 2022-2023.

Rwanda is implementing oral Pre-exposure prophylaxis (PrEP) among key populations and sero-discordant couples as part of the HIV prevention package. By June 2023, the number of female sex workers and men who have sex with men receiving PrEP had gradually increased from 10,078 in July 2022 to 10,789 in June 2023. In addition, during this fiscal year, 309,822 men were circumcised.

During this reporting period, people who were diagnosed with HIV were linked to HIV care and treatment services. By the end of June 2023, 218,314, representing 92.3% of all people living with HIV were retained on ART.

As Rwanda is still in the eliminating Hepatitis C virus (HCV) campaign, in the current fiscal year, 579,584 people were screened for HCV, 11,621 individuals were HCV antibody positive and 2,781 had a detectable viral load and 2236 were initiated on treatment.

Alongside, 4,216,885 people screened for sexually transmitted infections (STIs) with 5.32% screened positive and treated. Successful implementation to contain HIV, STIs and viral hepatitis and sustain the gains during this last fiscal year, is a sign of effective collaboration between the government of Rwanda, development partners, united nations (UN) agencies, implementing partners, civil society organizations and beneficiaries toward targets set by the national strategic plan.

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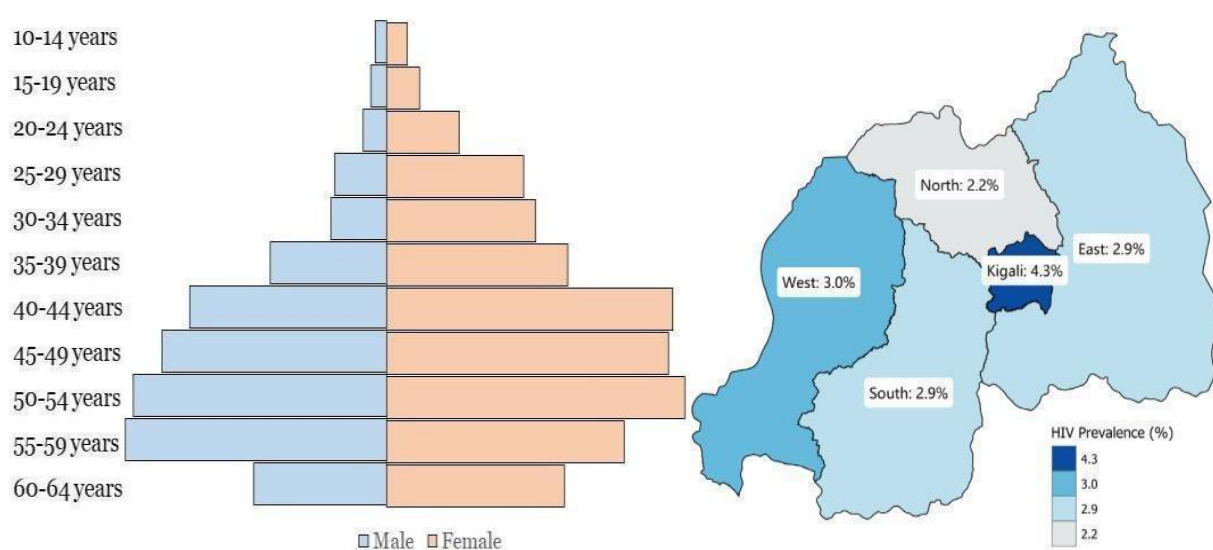


## Acronyms

<b>ARV</b>	Antiretroviral
<b>ART</b>	Antiretroviral Therapy
<b>BSS</b>	Behavioral Surveillance Survey
<b>CDC</b>	Centers for Disease Control and Prevention
<b>EIDSR</b>	Electronic integrated Diseases Surveillance and Response
<b>EID</b>	Epidemic and Infectious Disease
<b>FELTP</b>	Field Epidemiology Laboratory Training Program
<b>FY</b>	Fiscal Year
<b>GSMM</b>	General Senior Management meeting
<b>HCV</b>	Hepatitis C Virus
<b>HQ-I</b>	HEALTHQUAL-International
<b>HPV</b>	Human Papillomavirus
<b>HR</b>	Human Resources
<b>IHDPC</b>	Institute of HIV and Disease Prevention and Control
<b>IPPIS</b>	Integrated Personnel and Payroll Information System
<b>ICAP</b>	International Centre for AIDS Care and Treatment Programs
<b>EQA</b>	International External Quality Assurance
<b>MINECOFIN</b>	Ministry of Finance and Economic Planning
<b>MOH</b>	Ministry of Health
<b>NCD</b>	Non-Communicable Diseases
<b>OPD</b>	Outpatient Department
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission of HIV
<b>QA</b>	Quality Assurance
<b>QC</b>	Quality Control
<b>QI</b>	Quality Improvement
<b>RBC</b>	Rwanda Biomedical Centre
<b>SPIU</b>	Single Project Implementation Unit
<b>SSF</b>	Single Stream Funding
<b>GFATM</b>	The Global Fund to Fight AIDS, TB and Malaria
<b>TTI</b>	Transfusion Transmission Infections
<b>VPPD</b>	Vaccines Preventable Diseases Division
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization

## 1. HIV PROGRAM AT GLANCE

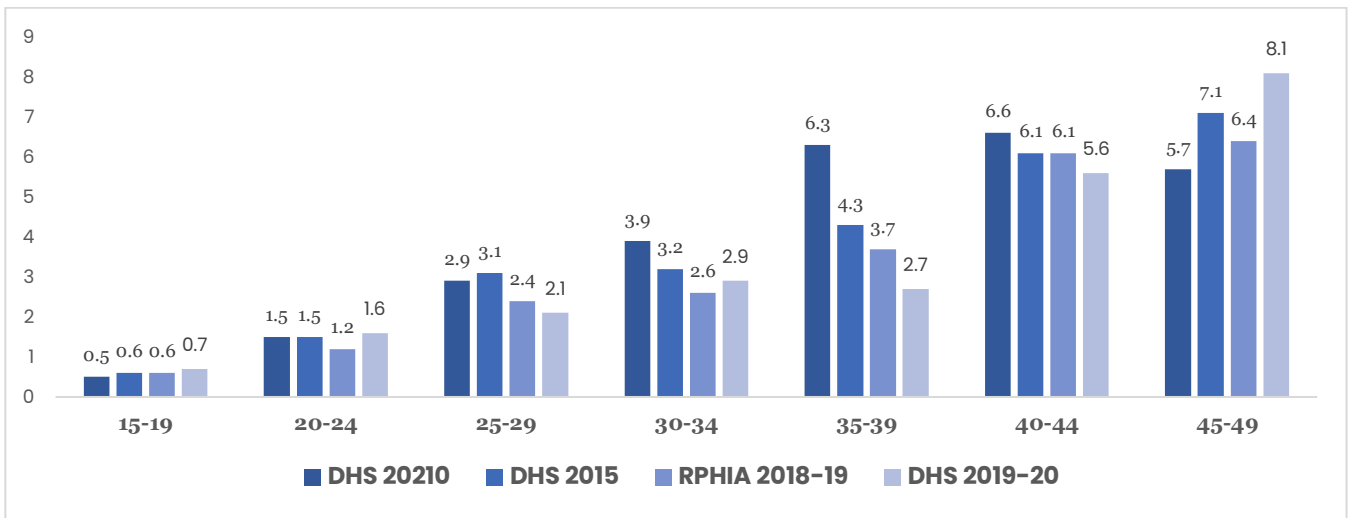
The HIV Incidence in Rwanda has decreased from 27 per 10,000 person-years in 2013-2014 to 8 per 10,000 person-years in 2018-2019. In addition, the recent Rwanda Population-based HIV Impact Assessment (RPHIA), a national household-based study conducted in 2018–19, revealed a 0.4% decline in prevalence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



**Figure 1: HIV prevalence by age category and sex** **Figure 2: HIV prevalence by province**

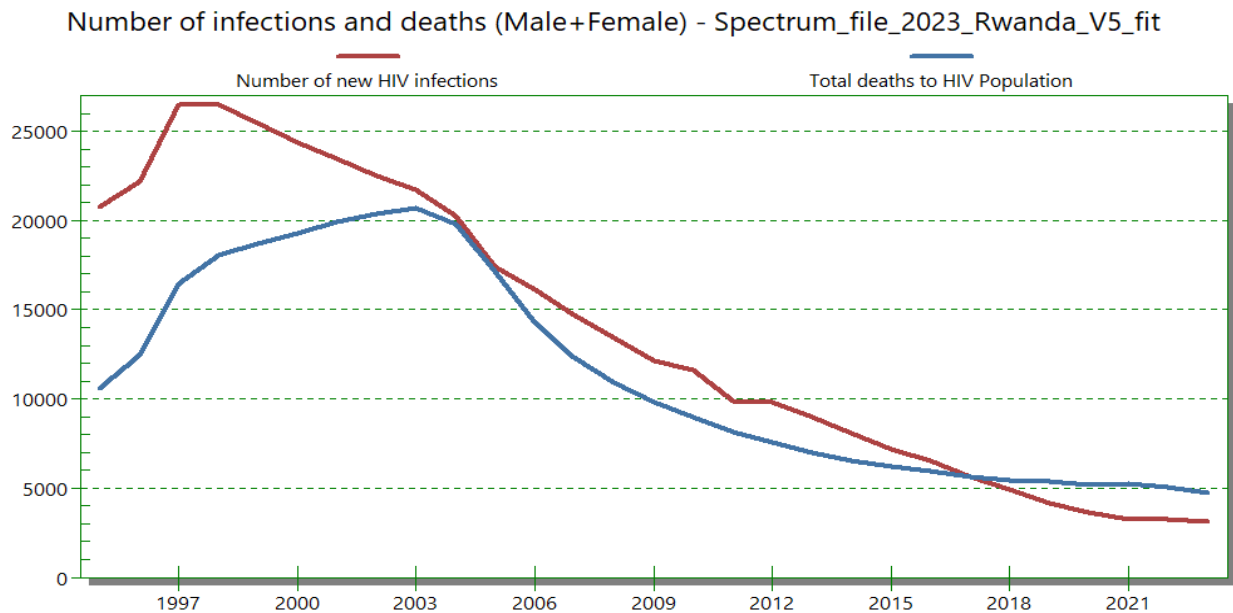
Despite the low and stable prevalence of HIV in the general population, it remains significantly higher among key populations such as female sex workers (35.5%) and men who have sex with males (6.5%). HIV prevalence among FSWs declined from 51% in 2010 to 35.5% in 2019. As an outcome of the implementation of facility-based HIV prevention programs for high-risk populations, the HIV infection rate in Kigali and the southern province has declined significantly since 2015. In contrast, HIV prevalence among FSWs in the eastern province increased from 2010 (33%) to 2019 (42%).

The HIV prevalence rate among the general population aged 15–49 years in Rwanda decreased from 3.0% in 2015 to 2.7% in 2019–2020, according to data from demographic and health surveys (RDHS). Nonetheless, the peak of HIV prevalence shifted from 40–44 years in 2015 to 45–49 years in 2019–2020. The cohort effect subsequently reflects the positive clinical outcome of ART retention and decreased mortality and comorbidities among people living with HIV.



**Figure 3: Trends in HIV prevalence by age and period**

In the last decade, HIV services have been scaled up across the country. As a result, Rwanda has been internationally recognized for its effective response to HIV epidemic control. The Global UNAIDS report 2023, released in July 2023, ranked Rwanda as one of five African countries that achieved the 95-95-95 targets, with an estimated 95% of people living with HIV aware of their status, 97.5% receiving antiretroviral therapy, and 98% achieving viral load suppression. According to these estimates, Rwanda is on a path that will end AIDS by 2030. These achievements demonstrate Rwanda's dedication to ending the HIV/AIDS epidemic and improving the quality of life for the infected and affected population.



**Figure 4: Trend of new infections and AIDS deaths from 1997 -2021 (source: EPP Spectrum 2022)**

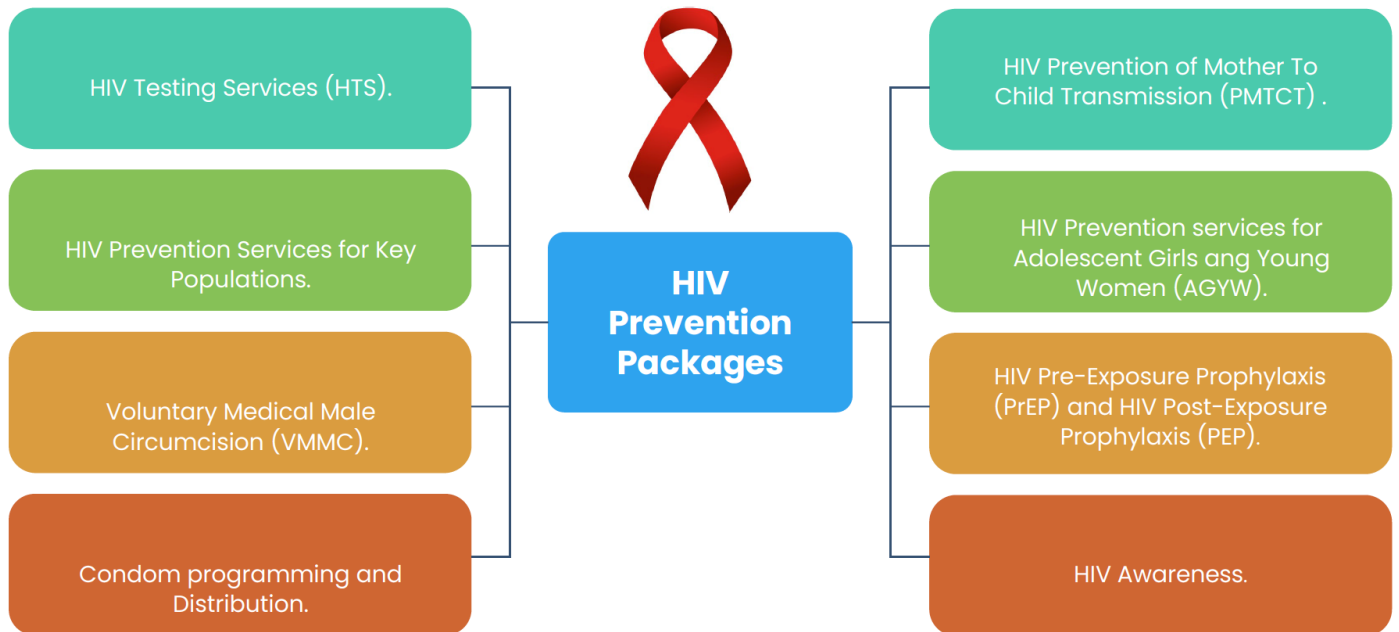
Rwanda has put efforts into biomedical interventions for HIV prevention. Male circumcision has increased from 13% in 2010 to 56% in 2020 and the mother-to-child HIV transmission rate has stabilized below 2% from facility-based prevention of mother-to-child transmission programs.

## 2. HIV PREVENTION

### 2.1. Introduction

HIV prevention remains the key pillar in the fight against HIV, reducing new HIV infections, and assuring that people living with HIV are diagnosed and initiated on treatment early.

To align with the global target to end AIDS by 2030, the Government of Rwanda, through the Ministry of Health and its implementing partners, is implementing different HIV prevention packages.



**Figure 5: HIV Prevention Packages**

### 2.2 HIV Testing Services (HTS)

The HIV/AIDS program has sought to provide universal access to sustainable and high-quality HIV prevention, care, treatment, and support services. Access to HIV care and treatment services begins with HIV testing, which occurs in health facilities and in the community through outreach targeting hotspots.

HIV testing services are integrated with other HIV services such as medical male circumcision, post-exposure prophylaxis (PEP), Pre-Exposure Prophylaxis (PrEP), prevention of mother-to-child transmission (PMTCT), and screening and management of sexually transmitted infections (STIs). HIV testing services also provide a valuable opportunity for service providers to offer health information and education, information on behavior adjustments, and raise awareness of HIV/AIDS, but they also continue to increase demand to engage even the most hard-to-reach populations.

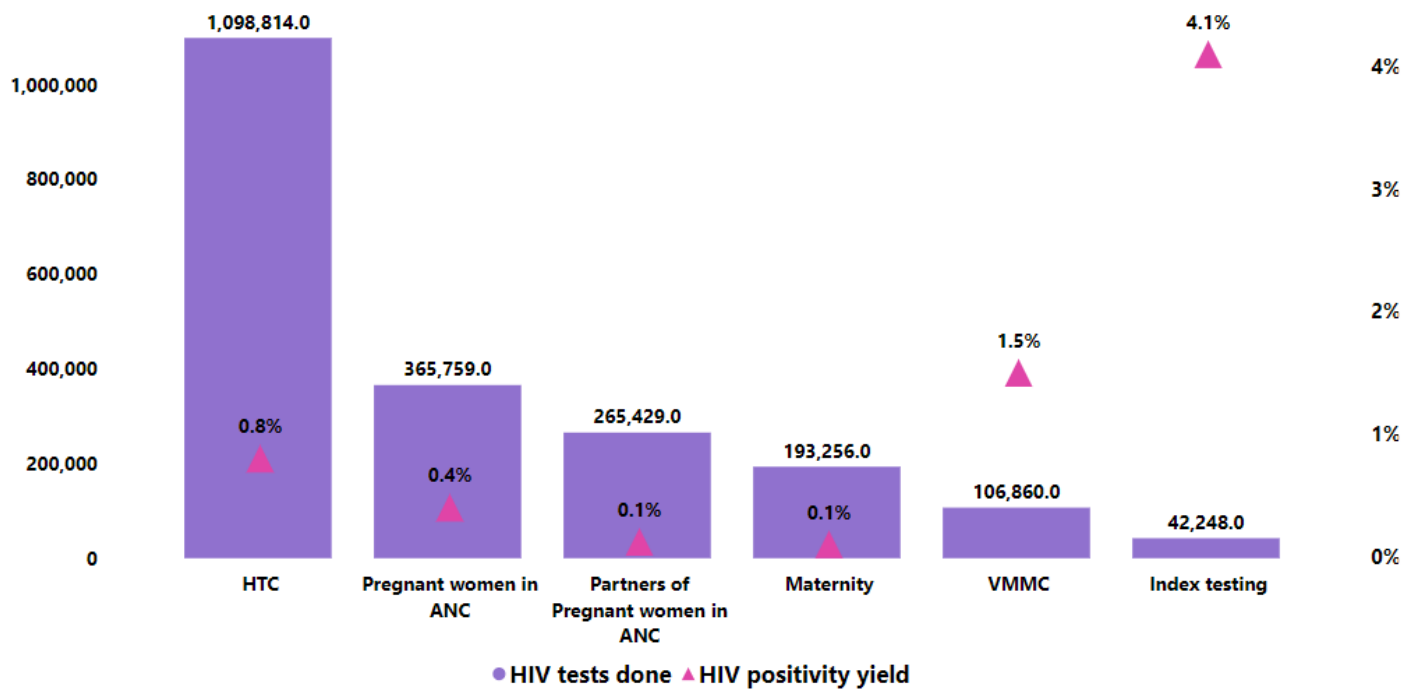


Figure 6: HIV testing and positivity yield different entry points.

From July 2022 to June 2023, health facilities performed 2,072,366 HIV tests across the country, with an overall positivity yield of 0.7%. The highest, at 4.1%, was recorded from index testing.

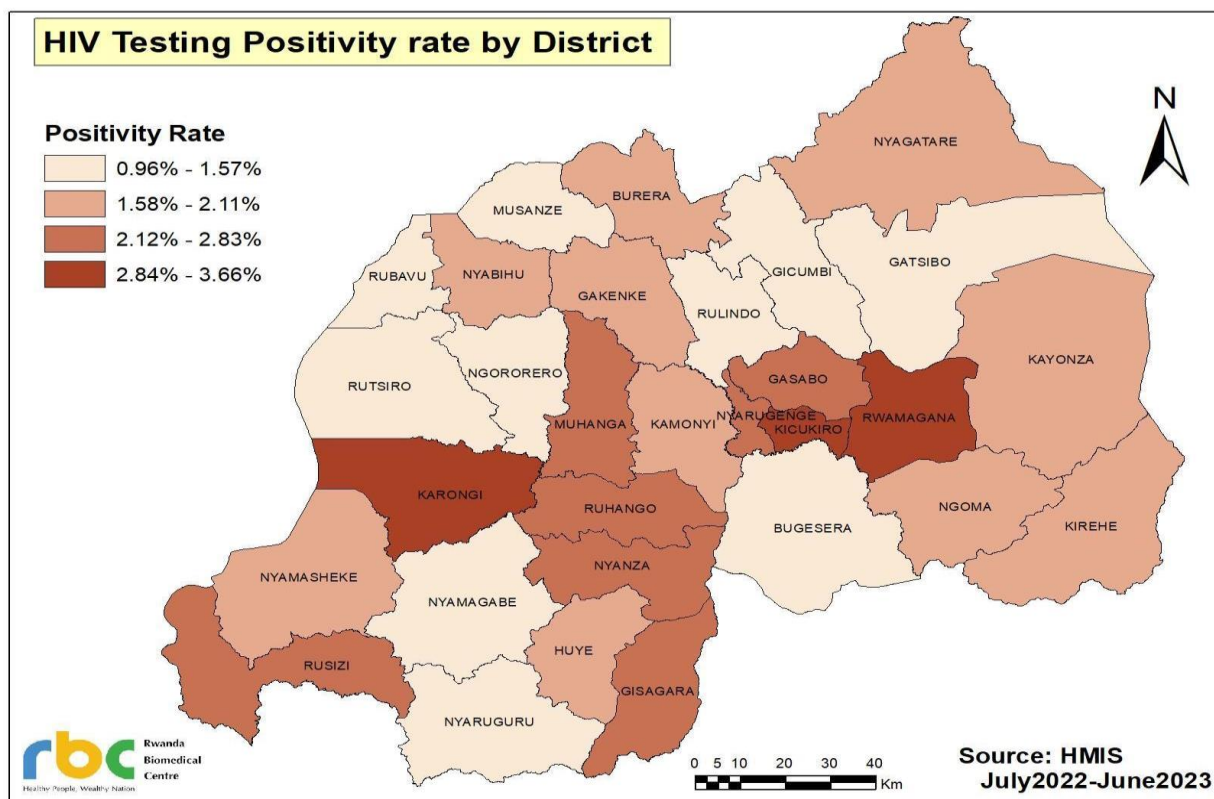


Figure 7: HIV testing yield in HTC by districts from July 2022-June 2023

In addition, the results from HIV testing demonstrated a higher yield in the City of Kigali with 2.97%. In contrast, the Northern and Western provinces reported the lowest testing yields, with percentages of 1.45% and 1.88%, respectively.

### 2.2.1 Case-based surveillance (CBS)

CBS, through active case finding, is an HIV testing approach put in place to identify people living with HIV (PLHIV) who do not know their HIV status based on index testing and recency testing strategies. Initially, during the early stages of the rollout of case-based surveillance, priority was given to enrolling newly identified HIV-positive individuals who had documented risk factors for HIV transmission. However, in recent times, established ART clients are also being enrolled in case-based surveillance. As a result, a cumulative of 91,805 individuals (index) accounting for 47% of all PLHIV above 18 years old have been enrolled in CBS by June 2023.

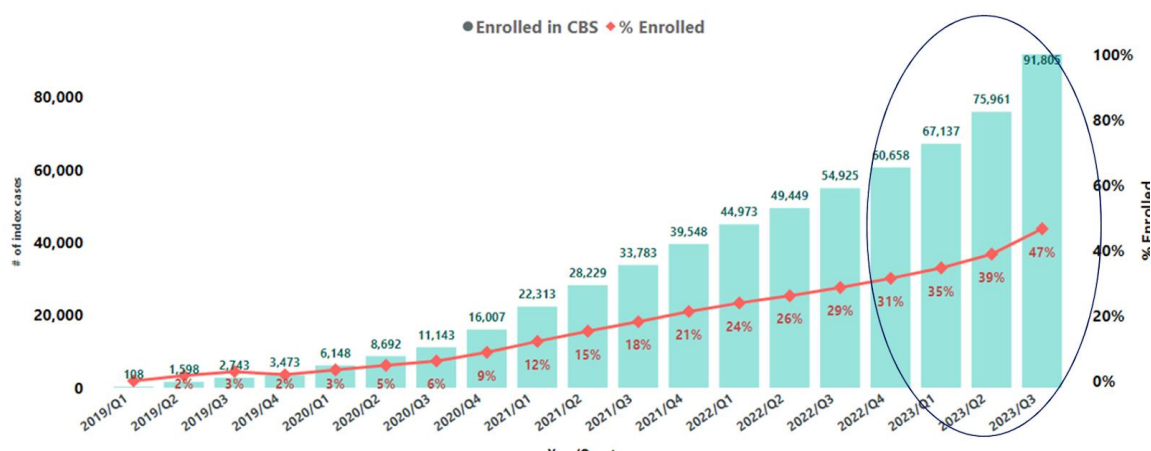
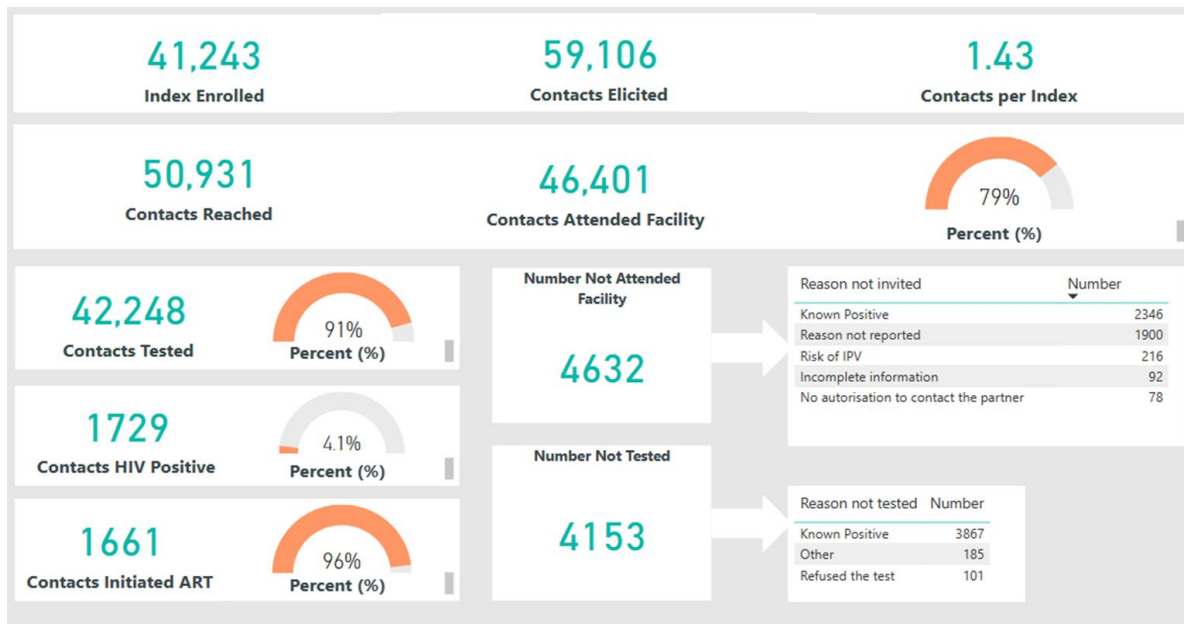


Figure 8: Figure 6: CBS Cumulative enrollment as of June 2023

#### 2.2.1.1. Index testing and partner notification services

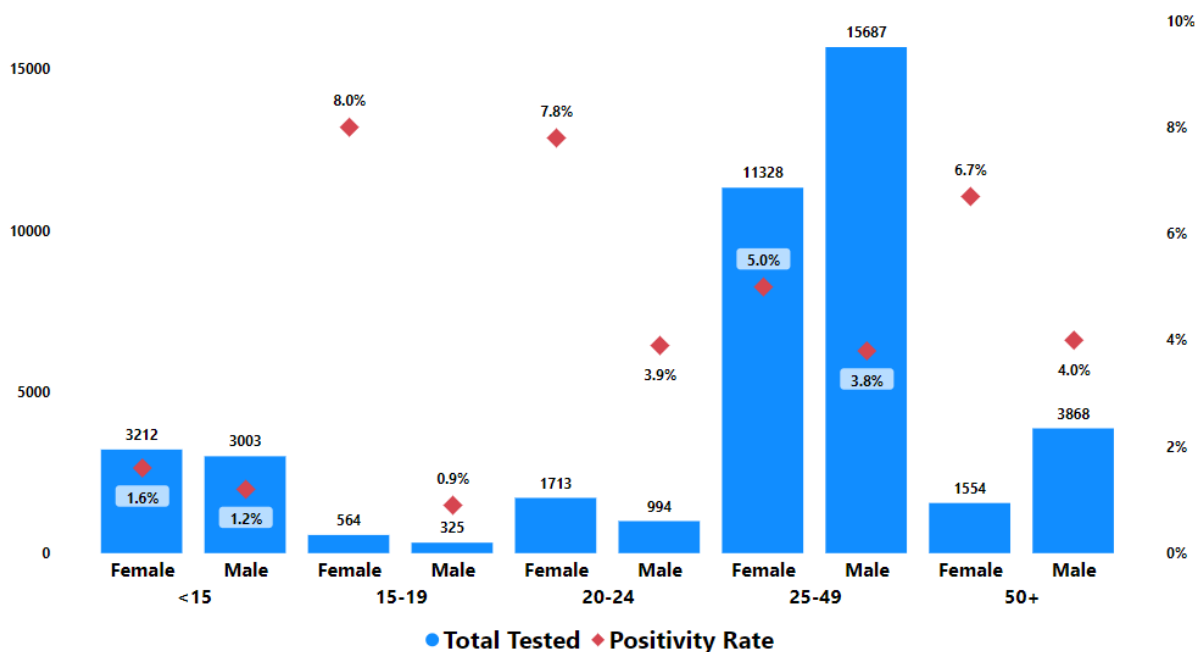
This approach focuses predominantly on identifying and locating the sexual partners, social networks, and biological children of an HIV-positive person referred to as an index client. Partner notification, on the other hand, is a voluntary program in which counselors and/or healthcare professionals inquire about the sexual relationships among clients on ART and newly diagnosed, also known as "index clients."

During partner notification and services, healthcare providers are looking for information on their sexual partners and family members. If the index clients agree to share information about their sexual relationships, they are invited to a health facility and offered a voluntary HIV test.



**Figure 9: Index testing cascade (July 2022–June 2023)**

During this reporting period, 42,248 contacts were tested and 1729 were found positive, Figure 10 shows the highest positivity rate of 8% and 7.8% among female ages 15-24 compared to their male counterparts.

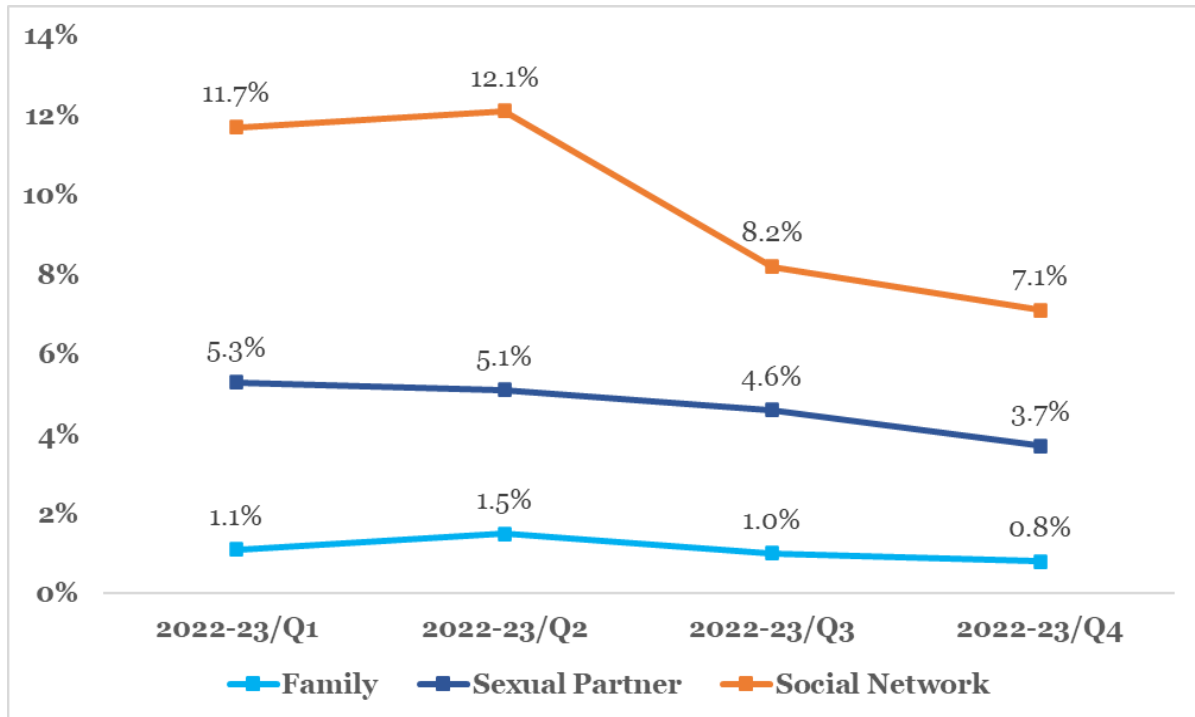


**Figure 10: Number of contacts tested by age, sex and positivity rate.**

As of June 2023, all national health facilities provided index testing and partner notification services. The positivity yield among all contact categories (family testing, sexual partners, and social networks) is 4.1% among elicited partners who were reached and tested. However, the

positivity yield varies among contact types, with the highest rate among social networks compared to sexual partners and family members (Figure 11).

The primary goal of partner notification services enabled by index testing is to increase HIV testing yield and meet UNAIDS' first target of ensuring that 95% of individuals living with HIV are aware of their HIV status by 2030.



**Figure 11: Trend in positivity rate by contact type (July 2022-June 2023)**

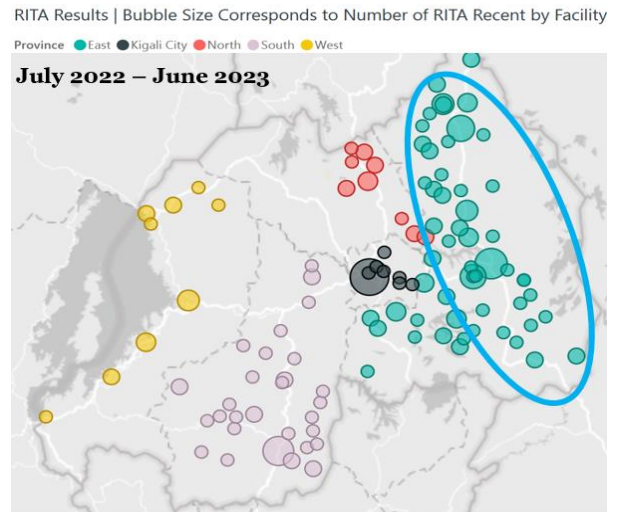
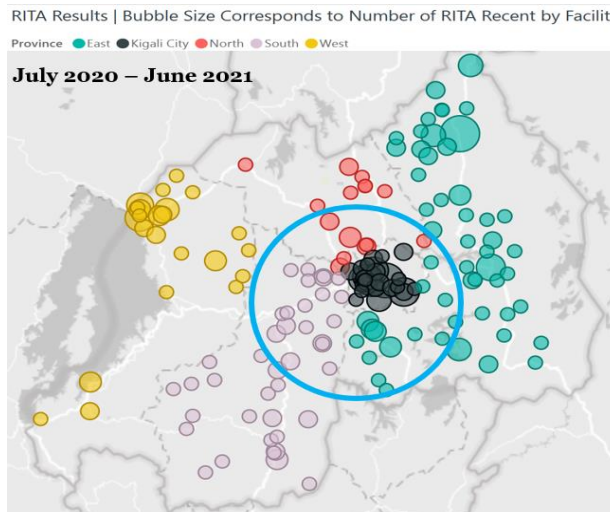
### 2.2.1.2 HIV recency testing

A rapid test conducted in the laboratory for determining whether a newly diagnosed client with HIV infection, is recent or long term, (i.e., occurred within the past twelve months or occurred more than twelve months ago, respectively).

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

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





**Figure 12: RITA Recent infections patterns by location and time**

**Recency testing approaches:**

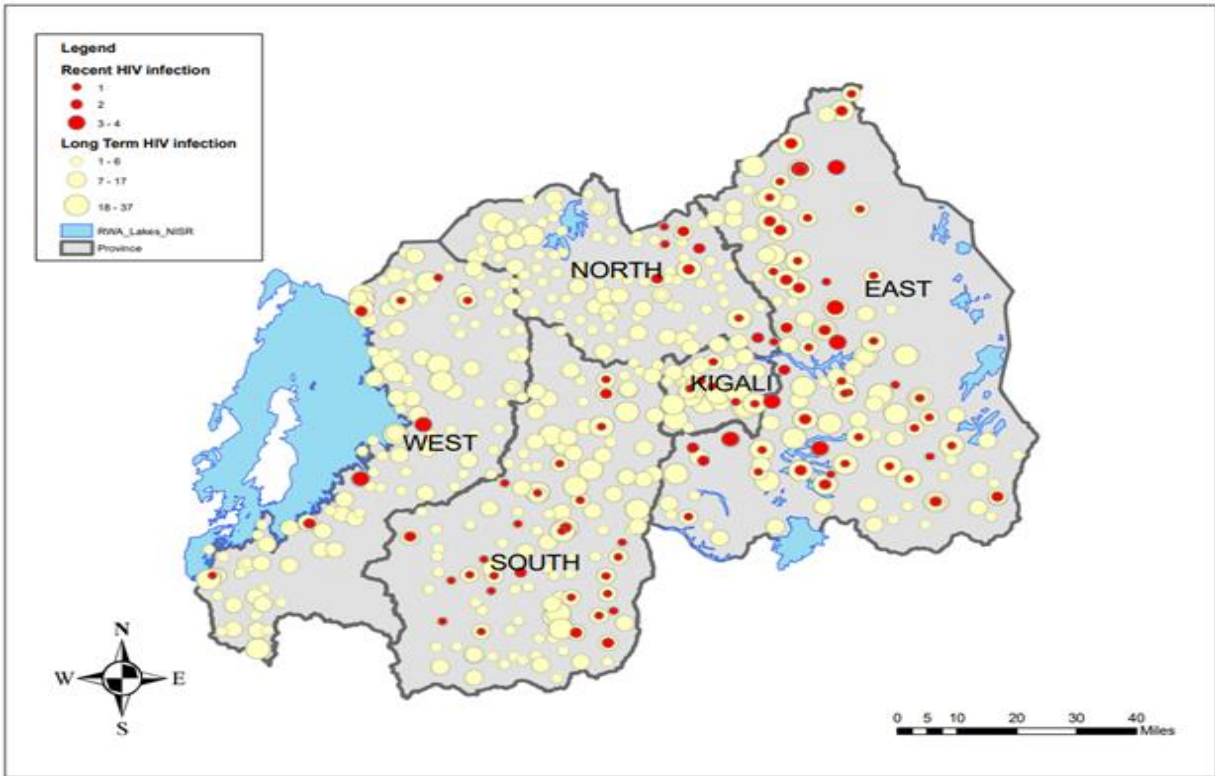
Two testing approaches in the laboratory network modes in Rwanda are currently used:

**Centralized HIV recency testing:** Performed at the National Reference Laboratory (NRL) and HIV viral load testing hubs in all provinces. As of 2021, the national program has completed HIV Recency testing scale-up in all District Hospitals countrywide.

**Point-of-care testing (POCT):** Performed at 23 different sites across the country, with the plan to increase the number of POC by focusing on sites with high numbers of recent infections. The national program has improved the quality of these services through constant quality control checks and proficient testing activities.

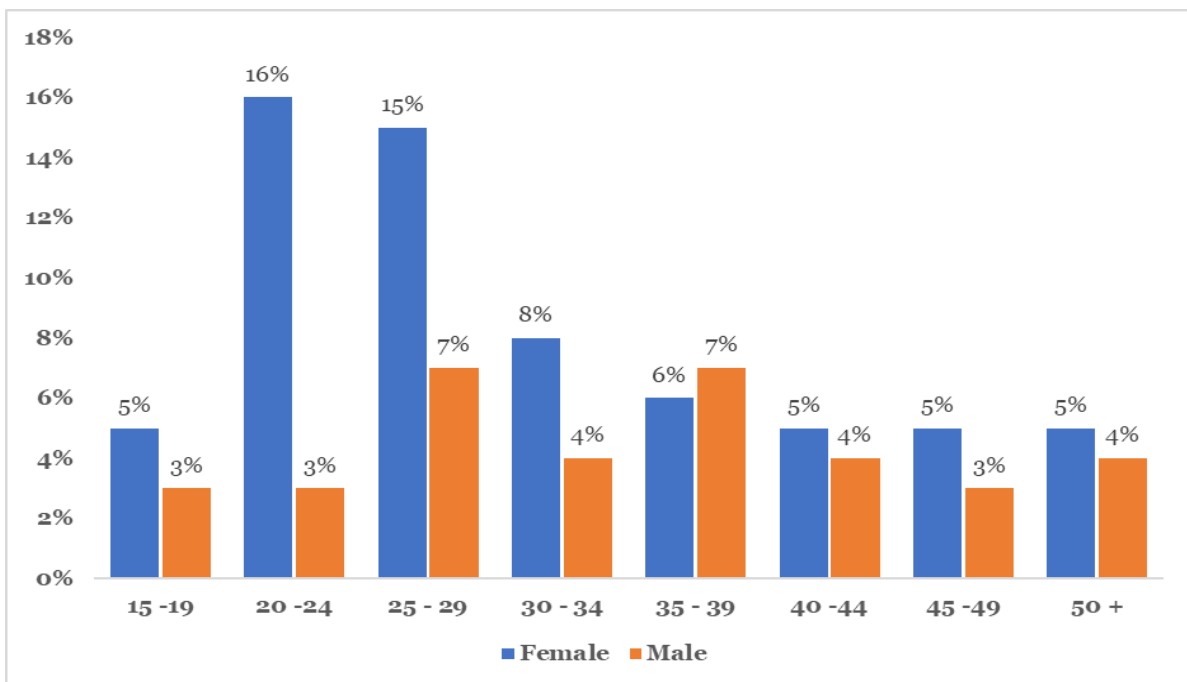
The map below shows HIV recent infections by province. The highest number of cases of recent HIV infection observed in Eastern Province has triggered program responses such as awareness campaigns in identified hotspots within that province.

Overall, 7,777 out of 11,580 newly diagnosed HIV diagnosed persons were tested through the rapid test for recent infections (RTRI). Among the 555 who were tested recently on RTRI, 293 were tested for viral load to eliminate the bias of prior exposure to ARVs. Of those tested for viral load, 204 were confirmed as recent infections, while 89 were reclassified as long-term infection, the latter representing potential people living with HIV already on ART who repeat HIV testing.



**Figure 13: Distribution of Recent and long-term infections across Rwanda, July 2022-June 2023**

HIV Recency testing is critical to the surveillance of new infections and their spatial distribution across the country. Overall, a high level of recent infections is documented among females aged between 15-30 years.



**Figure 14: Number of recent cases by age and sex (July 2022-June 2023)**

### 2.2.1.3 HIV self-testing

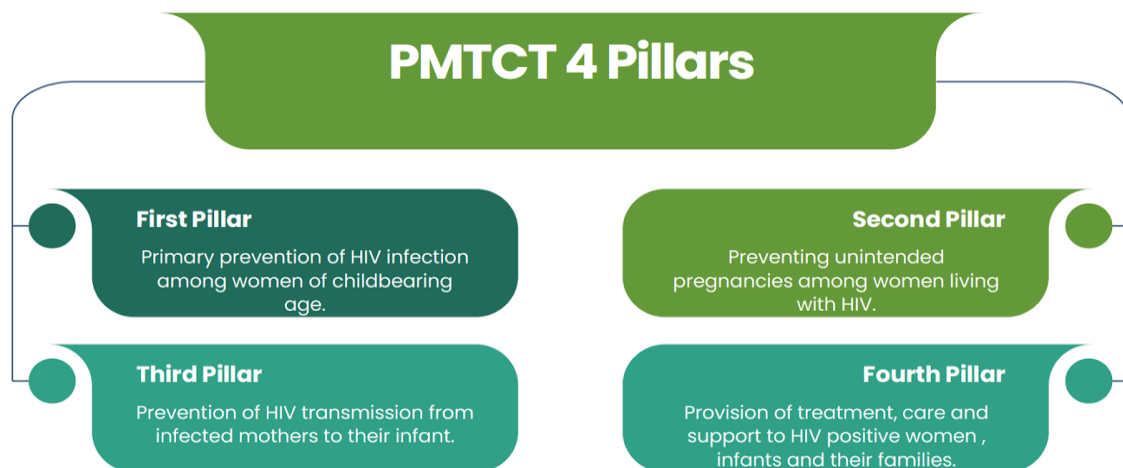
Individuals obtain their own sample, perform a test, and interpret the results, usually in a private setting, alone or with a trusted person.

Individuals with reactive test results are directed to the nearest health facility so that a skilled practitioner may validate the results, and verified positive clients are linked to HIV care and treatment programs; those with nonreactive effects are linked to HIV prevention services.

The HIV self-test kits are distributed through two main models of distribution: (i) through health facilities; integrated HIV self-testing with index testing; and partner notification services to offer HIV testing services to invited partners who are reluctant to come to the facility. During fiscal 22-23, 84,047 HIV Self-test kits were distributed within 584 health facilities across the country and 28,717 at the community level by peer educators. From July 2022 to June 2023, 112,764 HIV self-test kits were distributed across the country.

## 2.3 Prevention Mother to Child Transmission (PMTCT)

Rwanda maintained a strong commitment to eliminating HIV transmission from mother to child. On the basis of the four pillars of PMTCT, a comprehensive package of services is provided to prevent HIV transmission from mother to child.



*Figure 15: PMTCT Pillars*

### 2.3.1 HIV testing and continuum of care for pregnant women with HIV

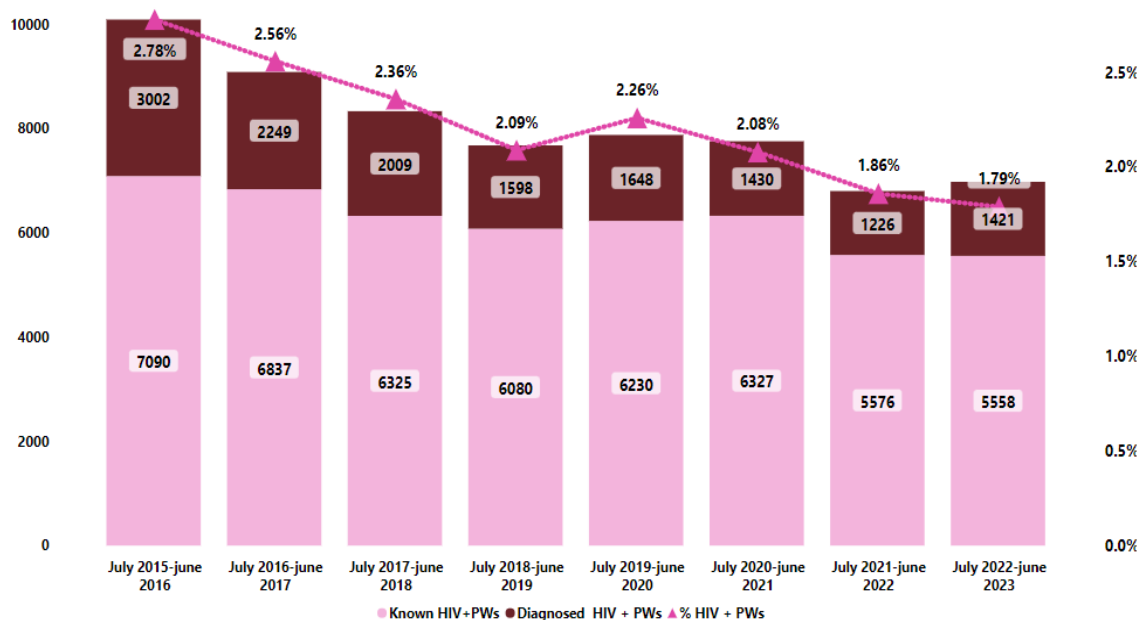
HIV testing services are systematically provided to all pregnant women and their partners with unknown HIV status or Negative HIV status at their first antenatal care visit. Thus, those tested HIV positive are linked to care and treatment to prevent mother-to-child HIV transmission.

From July 2022 to June 2023, 389,531 pregnant women attended their first ANC Visit. 5,558 were known to be HIV positive, whereas 365,759 were tested for HIV, both with unknown HIV status and negative HIV status. 1,421 pregnant women tested positive for HIV, translating into a positivity rate of 0.4%.

A total of 265,429 male partners were tested for HIV in ANC visits, yielding 0.12% of the positivity rate.

From July 2015 to June 2023, the HIV prevalence among pregnant women who attended antenatal care visits decreased from 2.78% to 1.8%, respectively. Furthermore, the proportion of newly HIV-diagnosed pregnant women in antenatal care decreased from 29.7% in 2015-16 to 20.4% in 2022-2023.

During this fiscal year, the HIV prevalence among all women tested in ANC is approximately 1.8%. All women who were not tested for HIV during ANC or those who received negative results were again tested in maternity during labor or at the time of delivery. Out of a total of 193,256 pregnant women who were tested for HIV during labor or delivery, 205 (0.1%) tested positive for HIV. Among all women who tested positive for HIV during both ANC and maternity, 99% of them received ART to prevent the transmission of HIV to their babies.



**Figure 16: Trend of HIV prevalence in ANC among Pregnant women**

### 2.3.2 Triple Elimination of mother-to-child-transmission of HIV, Syphilis and Hepatitis

As a public health priority, Rwanda has pledged to implement the triple elimination of mother to child transmission of HIV, Syphilis, and Hepatitis B. The triple e-MTCT program will promote a cohesive strategy for Improving Mothers and their children's outcomes.

Rwanda has long been implementing a double elimination of HIV and syphilis, and in the current fiscal year, 365,759 pregnant women were screened for HIV with a positivity rate of 0.4%. 289,648 pregnant women were screened for syphilis, and 2,772 (75.4%) were confirmed positive. Regarding HBV, about 57,853 pregnant women were screened, and among them, 1,364 had a detectable HBV viral load, while 476 were eligible and initiated treatment. In the context of

universal health coverage and the integration of communicable disease prevention and control services, Rwanda is in the process of moving from double elimination to triple elimination, where, in addition to HIV and syphilis screening, HBV screening is mandatory for all pregnant women as a full package at their first visit.

The triple elimination plan aims to guarantee the quality, availability, and accessibility of reproductive, maternal, and child health (MCH) services. To date, more than a third of Rwanda's health facilities have begun comprehensive screening of pregnant women for HIV, syphilis, and HBV.

Specific guidelines for triple elimination are under development, as is a functional surveillance system to comprehensively identify and track women living with or at risk of these three infections, as well as infant outcomes.

### 2.3.3 Follow-up of HIV-exposed Infants

Infants born to HIV-positive mothers are regularly followed under the Prevention of Mother-to-Child Transmission (PMTCT) program, which includes continued monitoring for up to two years after delivery. This extended monitoring is intended to closely monitor their HIV status. Infants exposed to HIV undergo planned testing at specific time periods (at 6 weeks, 9 months, 18 months, and 24 months) to guarantee a quick diagnosis and prompt beginning of antiretroviral medication (ART) for those who test positive for HIV during follow-up. This testing program is regarded as the accepted standard of care. Infants are screened using PCR at six weeks and serological assays at nine, eighteen, and twenty-four months. A rapid PCR test is used to confirm a positive serology result.

This year, we included children who were born to HIV-positive mothers and completed their two years in the current reporting period. In total, 3631 children were included in the analysis, with an overall MTCT rate of 1% at 24 months.

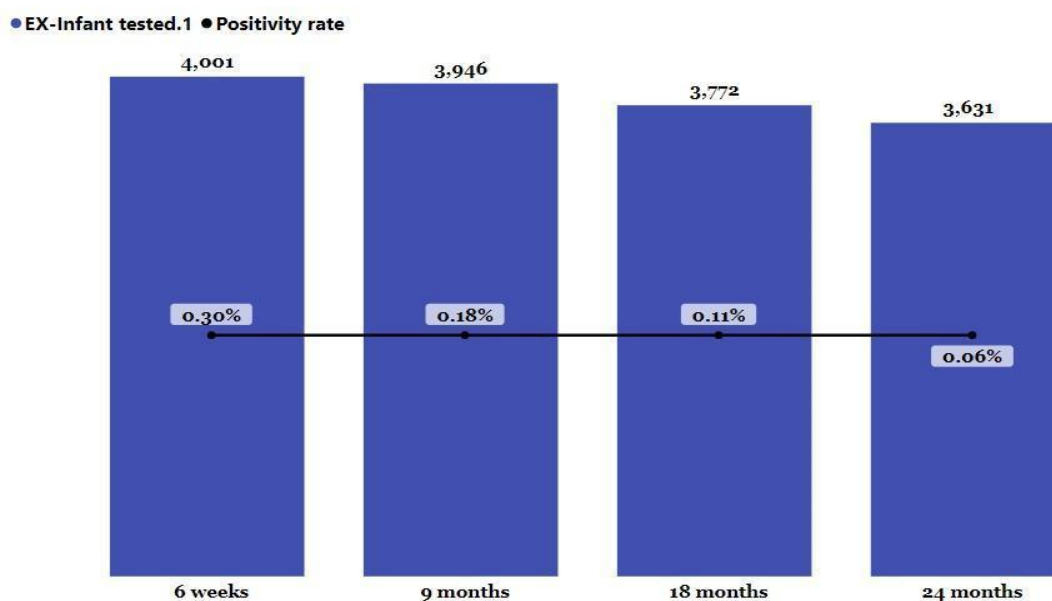
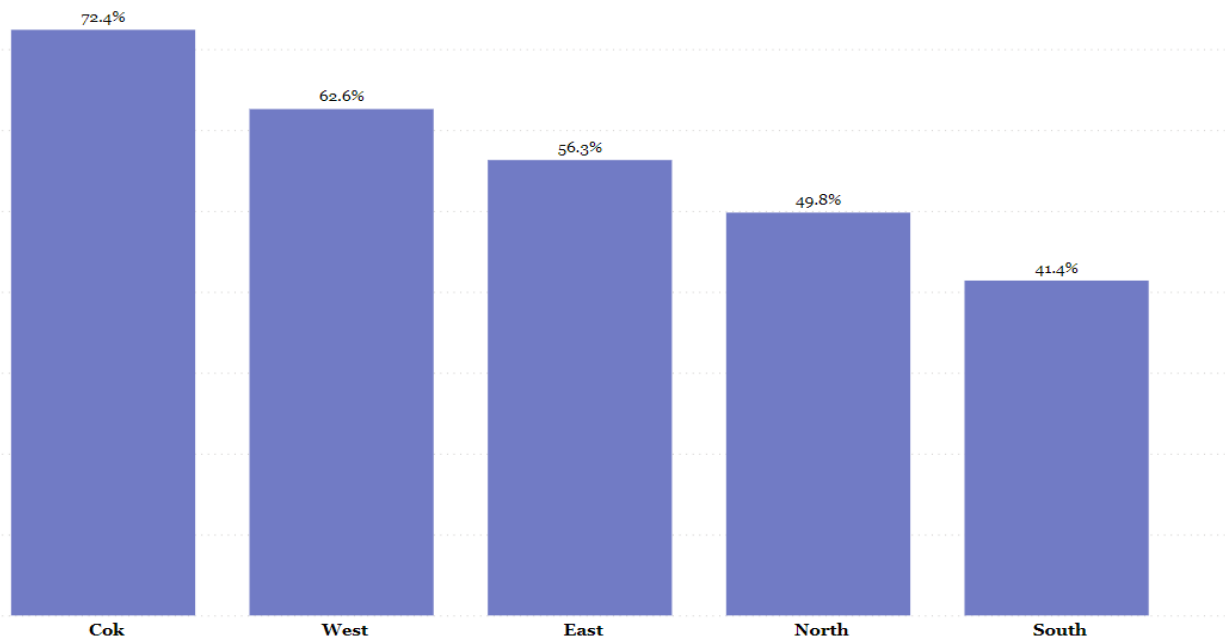


Figure 17: Trend of HIV positivity rate in Exposed infants by Age

## 2.4 Voluntary medical male circumcision (VMMC)

In countries with a high HIV prevalence and low rates of male circumcision, the World Health Organization has recommended voluntary medical male circumcision (VMMC) as a crucial component of a combination HIV prevention strategy since 2007. Three randomized clinical trials have demonstrated that male circumcision reduces HIV transmission by 60%. (WHO/UNAIDS, 2007).

In 2008, Rwanda started to implement VMMC as part of its prevention service package. The Ministry of Health, through the Rwanda Biomedical Center, in collaboration with other implementing partners, has scaled up the service throughout the country in all health facilities. As a result, DHS 2019-2020 findings showed that 56% of men aged 15-64 years are circumcised, with the highest coverage among boys and men aged between 15-24 years and in urban (75%) compared to rural (52%).



**Figure 18: Percentage of VMMC coverage by Province (DHS 2019-2020)**

Significant efforts have been committed nationwide since then in accordance with the HIV national strategy plan to raise VMMC prevalence and program sustainability. The primary activities carried out were capacity building for healthcare providers, mentorships, and campaign activities in various districts.

As a result, 309,822 males were circumcised, whereby 305,373 (98.56%) were circumcised using the surgical method and 4,449 (1.44%) were circumcised using the medical device (Morgan Clamp) in this reporting period of July 2022- June 2023.

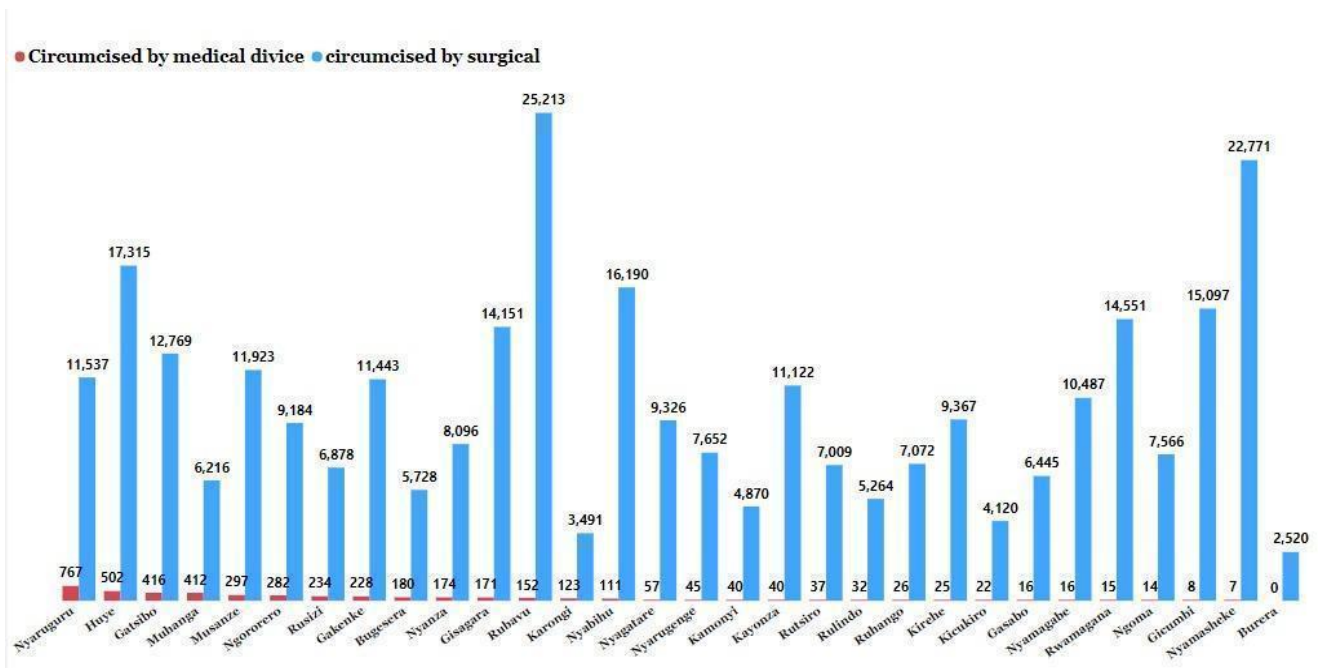


Figure 19: Total VMMC by methods and districts (HMIS 2022-2023).

Figure 20 shows the high proportion of males circumcised in the current fiscal year were aged 15-19 years, 126,220 (40.7%), followed by those below 15 years, 95,558 (30.8%), 20-24 years, 41,232 (13.3%), and 25-49 years, 40,042 (12.9%), notably showing the low coverage of VMMC among men aged 50 years and above, 6,770 (2.1%).

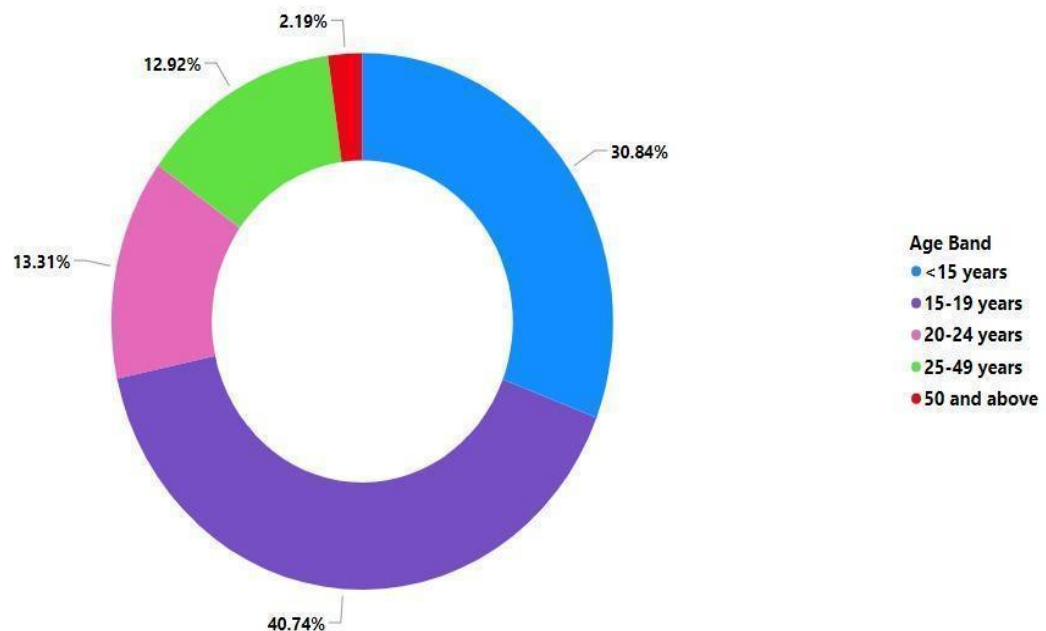


Figure 20: Number of VMMC performed by age group, July 22-June 23

Figure 20 shows the trend of circumcised men for the last 3 years by age category, with a high proportion of men aged 50 years and above circumcised compared to the following years.

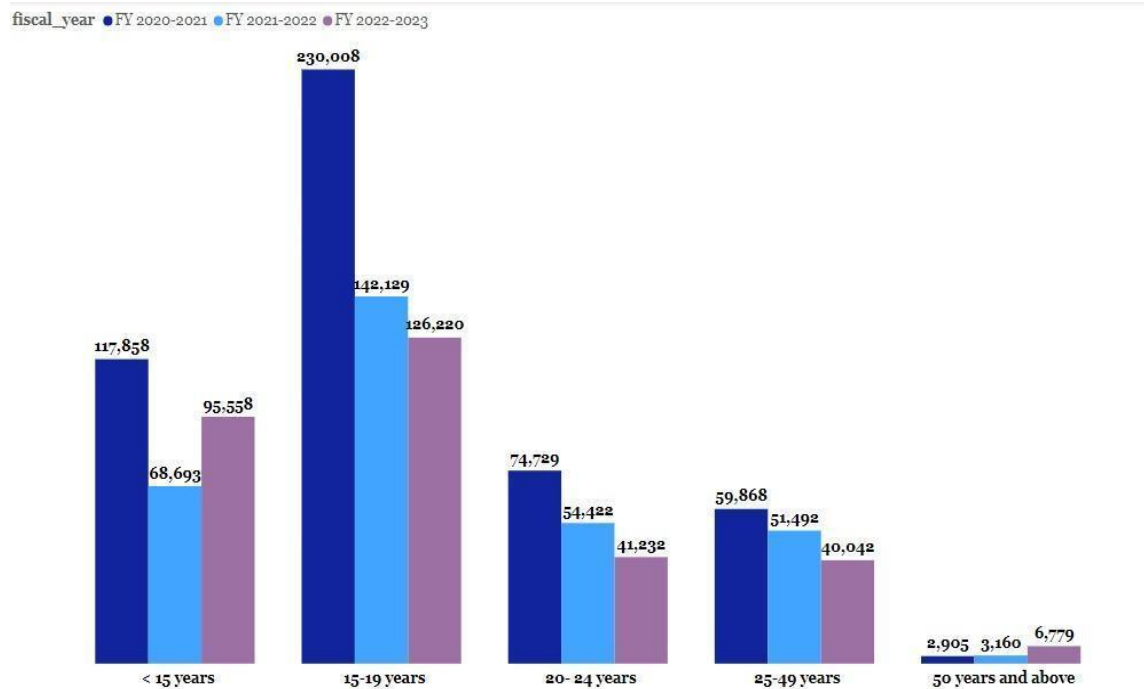


Figure 21: Tend total number of male circumcisions for the last 3 years by age category (HMIS)

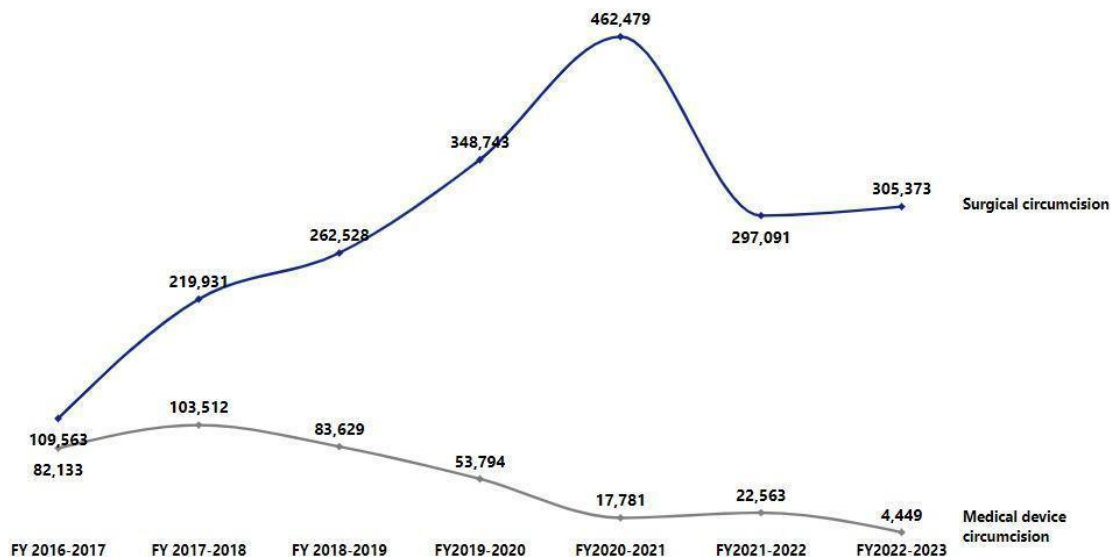


Figure 22: The trend of total number of male circumcisions over the last seven years (HMIS)

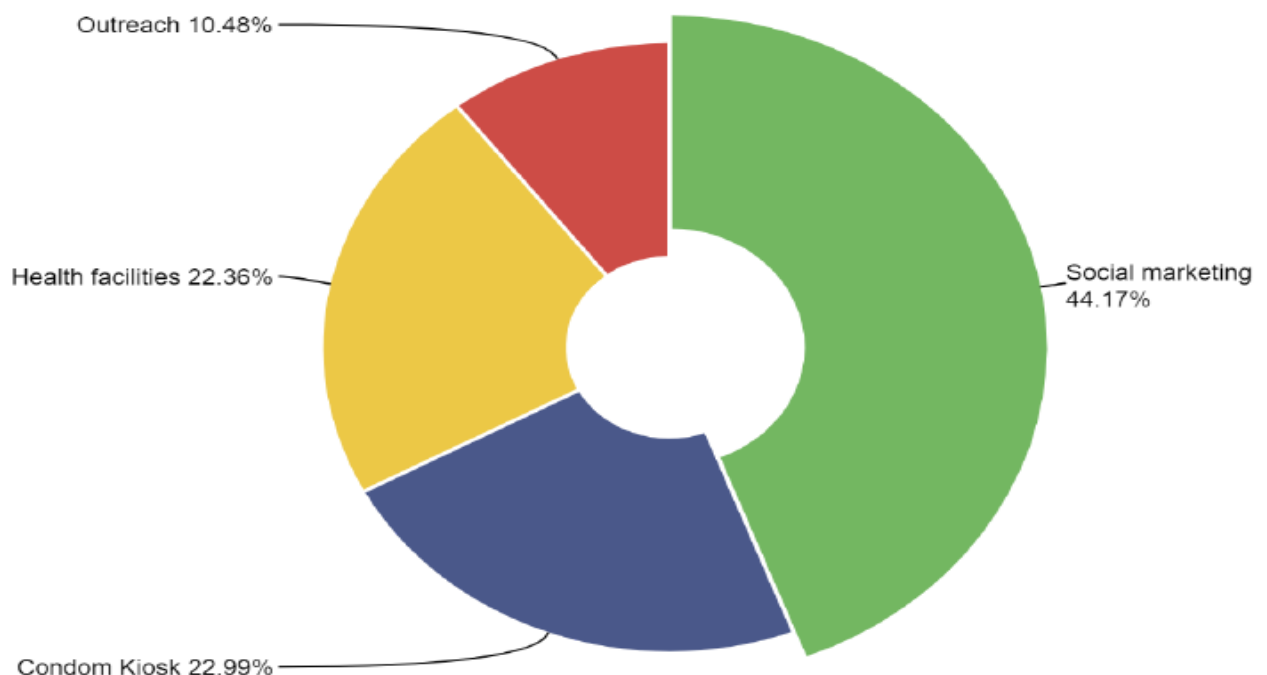
## 2.5 Condom programming and distribution



Rwanda has experienced a progressive increase in condom use over the past two decades, specifically at a rate of approximately 0.9% per year for sexual encounters among unmarried, non-cohabiting partners. The National Condom Strategy and Operational Plan (2021) is a comprehensive guide for condom programming throughout the Country. It includes leadership, coordination, and partnerships, as well as ensuring stable supply and commodity security, promoting access, demand, and utilization, and establishing effective condom programming and support systems.

The condom program also supports interventions directed at critically affected populations, such as sex workers, men who have sex with other men, and long-haul truck drivers. This targeted intervention involves the distribution of condoms in high-traffic areas frequented by vulnerable populations. Condom programming is one of the HIV Prevention strategies implemented at both the health facility and community levels, and condoms are one of the essential services provided to key and priority populations.

During the fiscal year 22-23, 22,191,059 condoms were distributed nationwide, a drop of 19% compared to last year, including through Health facilities, social marketing, and condom kiosks displayed in Kigali City (7), Rubavu (1), Rusizi (1), and Huye (1) Districts. In addition, peer educators distributed a significant number of condoms in the community during outreach sessions.



**Figure 23: Condom distribution**

In conclusion, 11% of condoms (2,325,288) were disseminated in the community through peer educators during outreach sessions, 5,102,544 (22%) condoms through direct condom kiosks, and 9,802,006 (44%) condoms through social marketing.

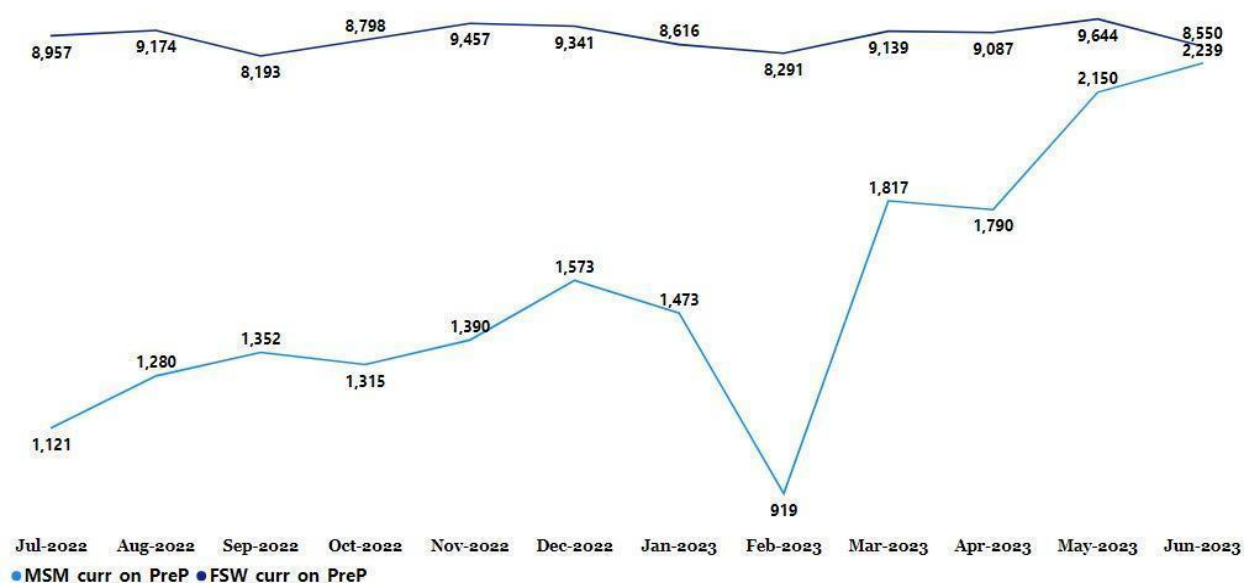
## 2.6 HIV prevention services for key populations (KPs)

Key and priority populations are thought to be major drivers of the HIV epidemic. Individual mindsets, societal movements, various sexual preferences, and gender identity all have an impact on their vulnerability. Furthermore, indulging in risky activities such as drinking and substance misuse, having unprotected sex, and bartering sex for benefits, increases their susceptibility. Poverty, stigmatization, and prejudice, as well as a lack of access to assistance, all contribute to their vulnerability.

In Rwanda, this category includes but is not limited to men who have sex with other men (MSM), female sex workers (FSW), clients of female sex workers, and adolescent girls and young women (AGYW). Health facilities receive specific training to provide services that are friendly to these groups at risk, such as HIV testing and counseling, condom distribution, and comprehensive HIV prevention messages.

### 2.7 Pre-Exposure Prophylaxis (PrEP)

Pre-Exposure Prophylaxis for HIV has been rolled out in stages, with a focus on key populations and other high-risk groups. This includes female sex workers (FSWs), men who have sex with men (MSM), HIV serodiscordant couples (SDCs), sexual partners of index clients, and adolescent girls and young women (AGYW) facing significant risk of HIV infection. By the end of June 2023, the number of female sex workers and men who have sex with men receiving PrEP had gradually increased from 10,078 in July 2022 to 10,789 in June 2023.



**Figure 24: Key Population currently enrolled on PrEP**

### 2.8. Adolescent Girls and Young Women (AGYW)

Adolescent girls and young women (AGYW) are among the most affected population and at risk of acquiring HIV. In Rwanda, AGYW are considered as the priority population, and the national HIV program designed a comprehensive package of services specific to this group. The AGYW program's goal is to prevent new HIV infections among adolescent girls and young women aged

10 to 24 in Rwanda, as well as teen pregnancies. It also aims to empower AGYW on sexual and reproductive health rights (SRHR), HIV/AIDS and STIs, prevention, family planning, and the prevention of unwanted pregnancies and mental health wellbeing. Also, through partners and implementers AGYW received formal education, life skills, and TVET support, as well as economic strengthening support to build their economic resilience. The primary goal of the HIV prevention program targeting AGYW is to comprehensively understand their most vulnerable situations and enhance their accessibility to both biomedical and non-biomedical HIV prevention services.

### 2.8.1 Enrollment and follow up of adolescent girls and young women.

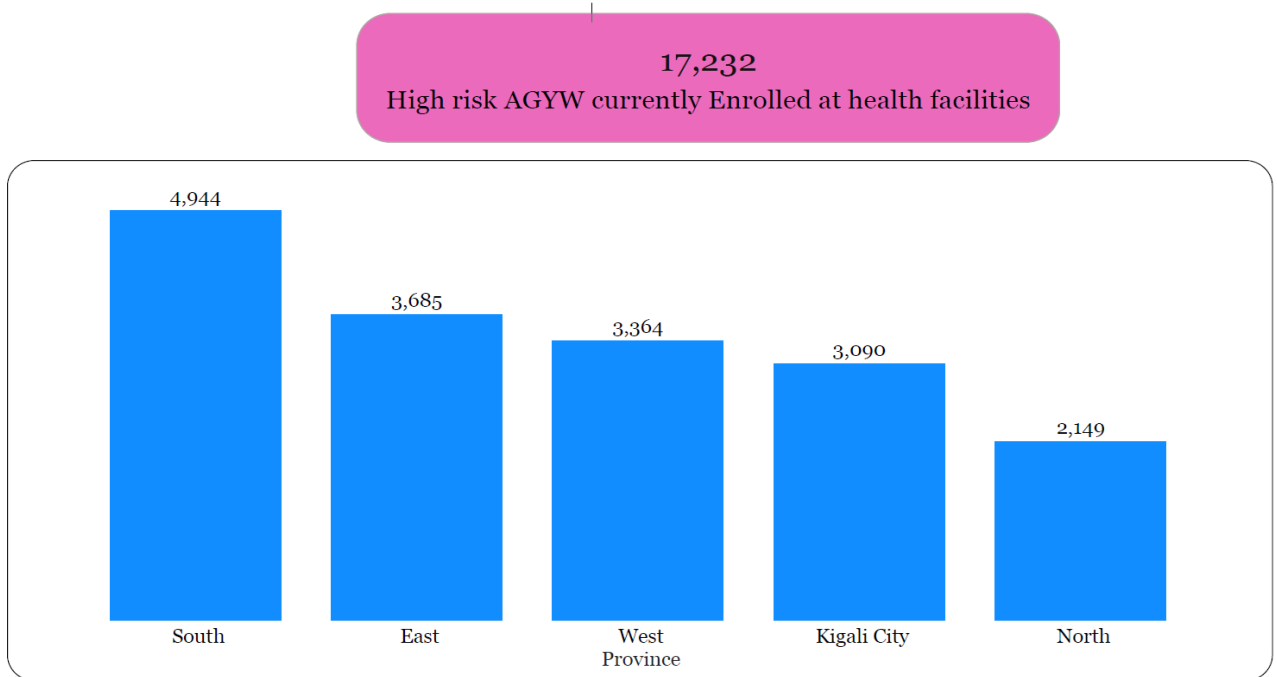
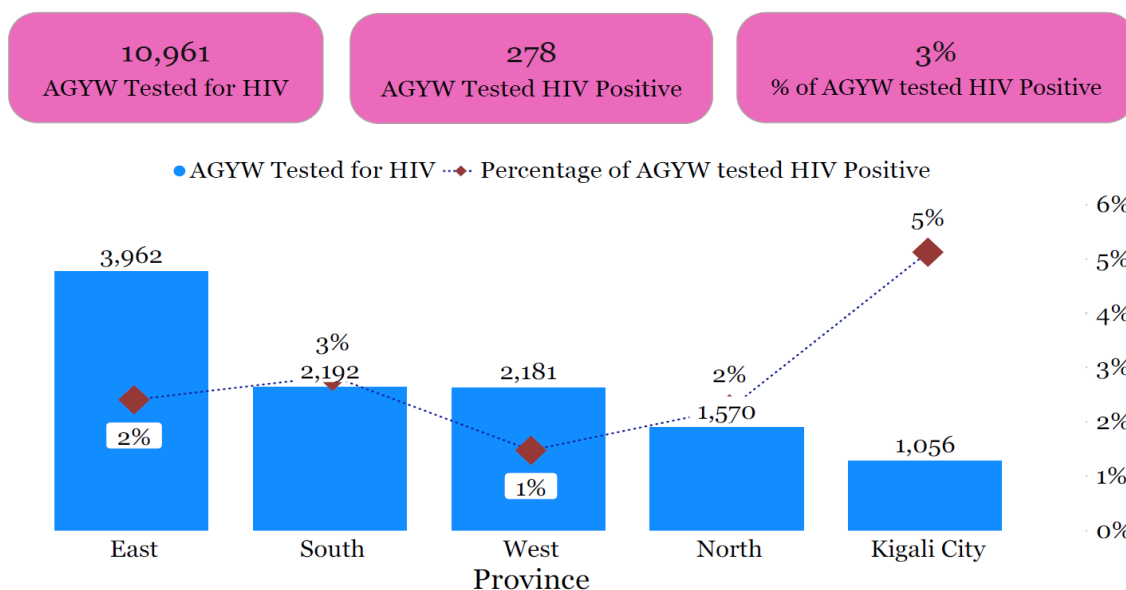


Figure 25: AGYW enrollment by Province

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

HIV positivity rate is estimated at 3% among high-risk AGYW who were linked to health facilities, with a high positivity rate in Kigali (5%) and lowest in the western province (1%).



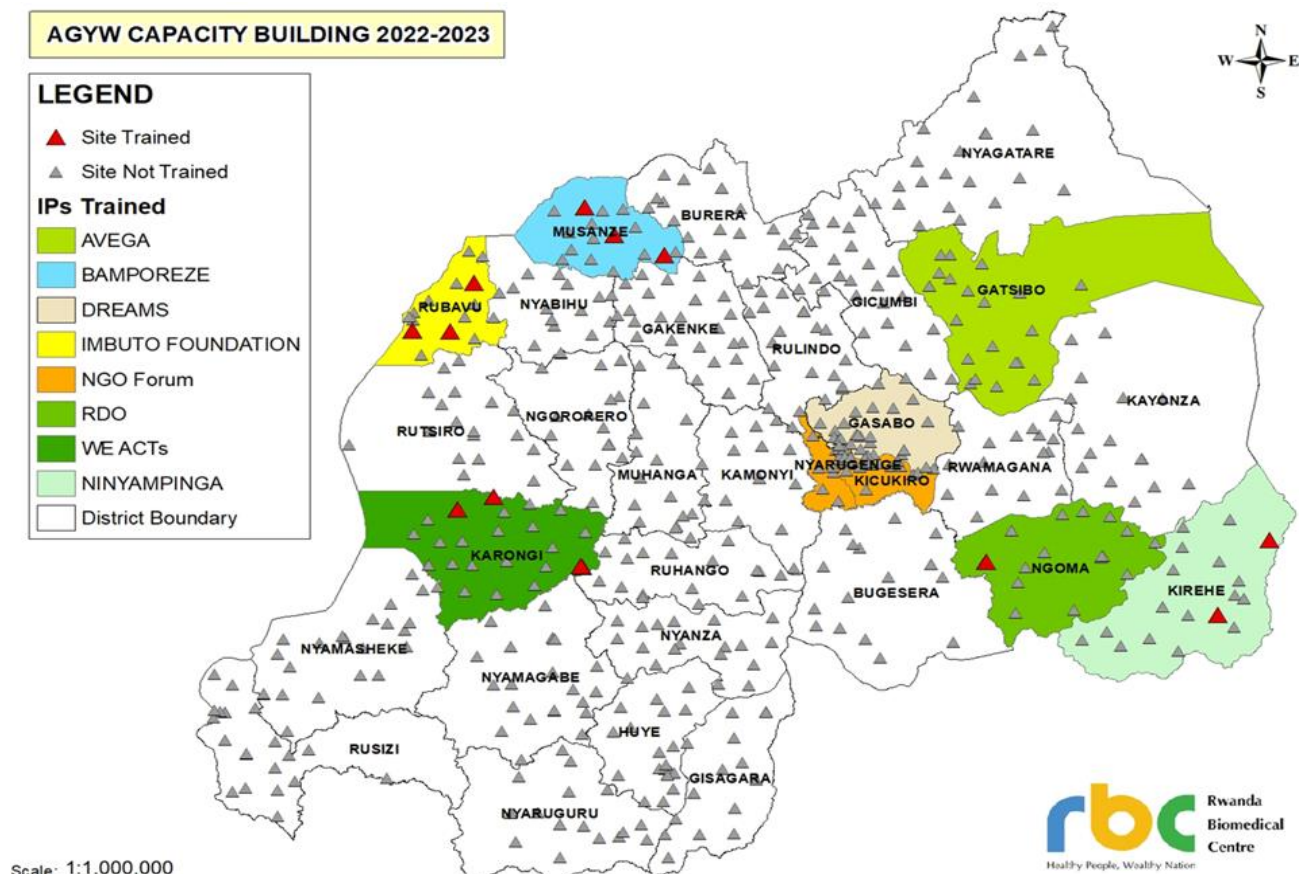
**Figure 26: Positivity yield among AGYW by province**

### 2.8.3 Sexual transmitted infections positivity yield among high-risk adolescent girls and young women

During the reporting period of July 2022-June 2023, Among the enrolled AGYW, 48% tested positive for STIs, with a peak in the Eastern Province having the highest positivity yield and Kigali City having the lowest.

### 2.8.4 Capacity building initiatives among service providers both at health facilities and in the Community

Efforts to improve healthcare facilities' capacity to provide friendly and effective services to AGYW through a minimum package of services to empower healthcare providers and key implementers with tools and conditions to deliver and addressing the determinants of health about new HIV infection, creating a welcoming, non-discriminatory, and supportive environment for AGYW, and PrEP is widely integrated into existing healthcare services. Youth peer educators have gained effective communication skills as a result of the mentorship program, allowing them to engage in meaningful discussions with AGYW, answer questions, and address concerns. An investigation into the effect of PrEP provision on HIV prevention, will be highlighted from the community-led monitoring tools developed by AGYW and healthcare providers provide feedback mechanisms.



**Figure 27: Community engagement in AGYW program and coverage**

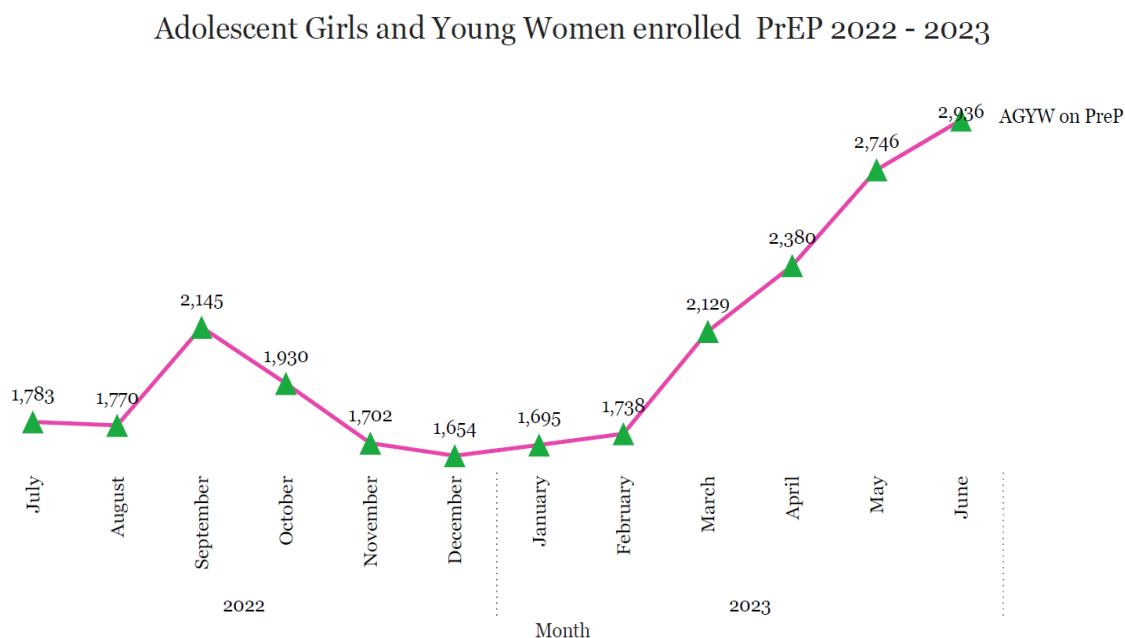
During the piloting phase of the minimum package of services to AGYW, 15 Trainer for trainee (TOT) (Health care providers, data managers, and CSO AGYW focal persons) were selected by the regions on the map (figure 27) focusing on HIV high burden districts, Comprehensive HIV prevention and SRH service delivery, streamlining the prevention strategy for the next generation, the training increased the capacity of trainers and, as a result, youth-friendly centers (safe spaces) and service providers to provide AGYW and youth-friendly services.

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

Community outreach efforts to raise awareness and reduce stigma, as well as health education campaigns aimed at AGYW emphasizing the benefits of comprehensive HIV prevention and SRH, are all underway. Collaborations with community organizations and stakeholders increased access to PrEP services. AGYW peer educators and or mentors were given information about comprehensive HIV prevention, SRH, VMMC for their male sexual partners, and PMTCT services. Measures are being scaled up to improve the quality of care in healthcare facilities and community level focusing on delivering a complete minimum package of service by establishment of confidential and comfortable consultation safe spaces for AGYW. Targeted interventions are being implemented to address specific healthcare challenges faced by AGYW, increased awareness by training a cohort of youth peer educators on HIV prevention and SRH.

## 2.8.6 Pre-exposure prophylaxis (PrEP) among AGYW and their male partners

Moreover, 330 out of 584 trained health facilities are offering PrEP, 2,936 AGYW have been enrolled and retained on PrEP for HIV Prevention by the end of June 2023.



**Figure 28: AGYW current on PrEP from July 2022- June 2023.**

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

Rwanda is dedicated to advancing initiatives for altering behavior and enhancing communication (BCC) schemes that center around modifications in personal conduct as well as shifts in behavior within the community and societal spheres. BCC strives to revamp the underlying elements that influence the embrace and perpetuation of favorable actions. BCC measures will advocate precise awareness and assessment of hazards while enhancing an individual's drive to steer clear of hazardous conduct.

Delivering BCC interventions will require a combination of strategies that target risky behaviors and the drivers of the epidemic. BCC will also demand increased access, uptake, and adherence to behavioral and biomedical interventions.

The behavior changes and communication (BCC) and information education and communication (IEC) programs aim to strengthen public awareness and comprehensive knowledge of HIV risks and vulnerabilities to increase personal risk reduction and uptake of prevention services.

### 2.9.1 HIV Awareness

Promoting awareness about HIV stands as a pivotal approach in the endeavor to limit the spread of HIV. It is imperative for both the wider public and specific target groups to possess an understanding of the existence and attainability of HIV prevention, care, and treatment services. During this fiscal year, diverse strategies were implemented to increase the awareness of HIV, sexually transmitted infections (STIs), and viral Hepatitis prevention. These initiatives

encompassed the utilization of media channels such as radio and television spot creation and broadcast newsletters, as well as leveraging the influence of social media and expansive promotional campaigns.

### 2.9.2 Mass campaigns

Preventive initiatives (i.e: campaigns) have played a significant role in greatly enhancing the accessibility of comprehensive HIV service packages for both the broader public and key populations, particularly those with limited access or utilization. These campaigns have also been instrumental in disseminating extensive information pertaining to comprehensive HIV prevention methods.

Rwanda Biomedical Center (RBC), through its division of HIV, STIs, viral hepatitis, and other viral disease control, organized and launched a national campaign mainly during the preparation of World AIDS Day 2022. In the same line, follow-up outreach campaigns were conducted at the district level targeting the community in each province with the partnership of local NGOs in response to HIV within their respective working districts.

### 2.9.3 World AIDS Day (WAD) 2022 campaign



On December 1st, 2022, Rwanda joined the world to celebrate World AIDS Day (WAD 2022) under the theme “Young Rwandans taking the lead in HIV/AIDS response”. “*Rubyiruko, tube ku isonga mu guhangana na SIDA*”.

In the presence of the high leadership from the Ministry of Health and Rwanda Biomedical Center, the US Embassy Charge d'Affaires in Rwanda, representatives of the UN family, and partners in HIV response, key achievements of the national HIV program were presented, and gaps were raised and discussed for improvement. Participants were briefed on the continuous

availability and accessibility of HIV prevention, care, and treatment services in Rwanda to the beneficiaries and the implementation of the global targets to end AIDS by 2030. Different speakers increased community awareness about their role in HIV prevention and impact mitigation and the willingness of the general population to participate in the HIV interventions conducted for them. They recommended the youth change their attitude, adopt positive behavior, and know their HIV status.

Different activities were organized and conducted one week before the launch of the campaign and continued after the launch. Integrated mentorship was one of the activities undertaken in various health facilities in Huye district. Other different awareness activities include the display of banners, stickers, and edutainment by musicians. The media houses produced news supplements about the theme, and leaders' speeches were one way of disseminating critical messages around the theme of the year.

#### **2.9.4 Youth Campaign**

HIV/AIDS awareness campaigns targeting youth were conducted from April 21 to 30 in Eastern Province (Nyagatare, Gatsibo, Kayonza, and Rwamagana districts).

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

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

#### **2.9.5 Radio and TV shows to raise awareness.**

During this last year, 2022-2023, public and private media houses were used to provide information and education on available HIV prevention services, including new strategies for HIV service delivery. During this reporting period, 868 DJ mentions, 42 TV talk shows, 71 radio live talk shows, several Radio weekly healthy programs (with a brand name), 12 Radio programs recorded, and 9,785 TV programs were produced.

### **2.10 Civil society organizations engagement**

#### **2.10.1 Background and Context**

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



This year, 7 CSOs implemented the key population activities in SFR, MRO, ASOFERWA, HDI, FVA, SFH, and FXB in 18 districts, and 10 CSOs implemented the AGYW program activities in HIV prevention and response; those CSOs are Imbuto Foundation, Bamporeze, We Actx for Hope, RDO, AVEGA, Access to Health, PACT/ACHIEVE, AEE, FXB, and DUHAMIC, under the coordination of the Rwanda NGO Forum. Supported AGYW are screened through selection eligibility criteria, putting AGYW at higher risk of acquiring HIV and having unwanted pregnancies. Furthermore, CSOs conduct outreaches, referrals, and linkages to health centers or other institutions for service provision, as well as airing radio series on community radios with messages targeting AGYW and beyond.

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

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

### **2.10.2 Activities and achievements by indicators**

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

In total, during this reporting period, 60460 FSWs were identified and 78.1% were referred to HFs for different HIV services, whereas 13818 MSM were identified and 49.7% were referred to HFs.

For the benefit of key populations, condoms, lubricants, self-test kits, and IEC materials were distributed. Targeted awareness was raised through radio and TV talk shows.

### **2.10.3 Key achievements**

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

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

#### **2.10.4 Partnerships and Collaboration**

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

### **3. HIV CARE AND TREATMENT**

#### **3.1 Introduction**

HIV care and treatment services are crucial in ensuring the wellness of people living with HIV (PLHIV). Rwanda is among five countries in Africa that are on their way to achieving the ambitious 95-95-95 UNAIDS target, signifying remarkable progress in controlling the HIV epidemic and ending AIDS. During 2022-2023, care and treatment interventions focused on key activities that included clinical mentorship and continuous quality improvement. The primary objective was to strengthen people-centered differentiated service delivery (DSD) and scale up optimized treatment for children living with HIV, which is pediatric dolutegravir (pDTG).

Additionally, efforts are being made to integrate services for non-communicable diseases (NCDs), mental health, opportunistic infection prevention and treatment, including TB, by providing TB preventive Therapy (TPT) services and family planning within HIV-differentiated services to ensure comprehensive care. In line with controlling the HIV epidemic, other prioritized activities included psychosocial care and support for PLHIV and improvement of the supply chain for laboratory and medical commodities. These dedicated efforts aimed to enhance the quality of life for PLHIV in Rwanda and prevent HIV transmission by optimizing treatment outcomes, serving as a beacon of progress for the region and beyond.

#### **3.2. Case-Based Surveillance**

HIV case-based surveillance involves a longitudinal follow-up of HIV-positive clients to closely monitor both their clinical outcomes and the risk of HIV transmission. This comprehensive surveillance approach comprises two primary arms: active case finding and routine longitudinal follow-up of clients in care and treatment.

The process of HIV case-based surveillance (CBS) begins with the enrollment of HIV-positive clients into care and treatment. This entails documenting all the programmatic packages provided to them, including Index testing, recency testing, and monitoring both biological and clinical outcomes. By diligently tracking the progress of these clients, the surveillance system ensures a thorough understanding of their health status and helps identify any potential risks related to HIV transmission.

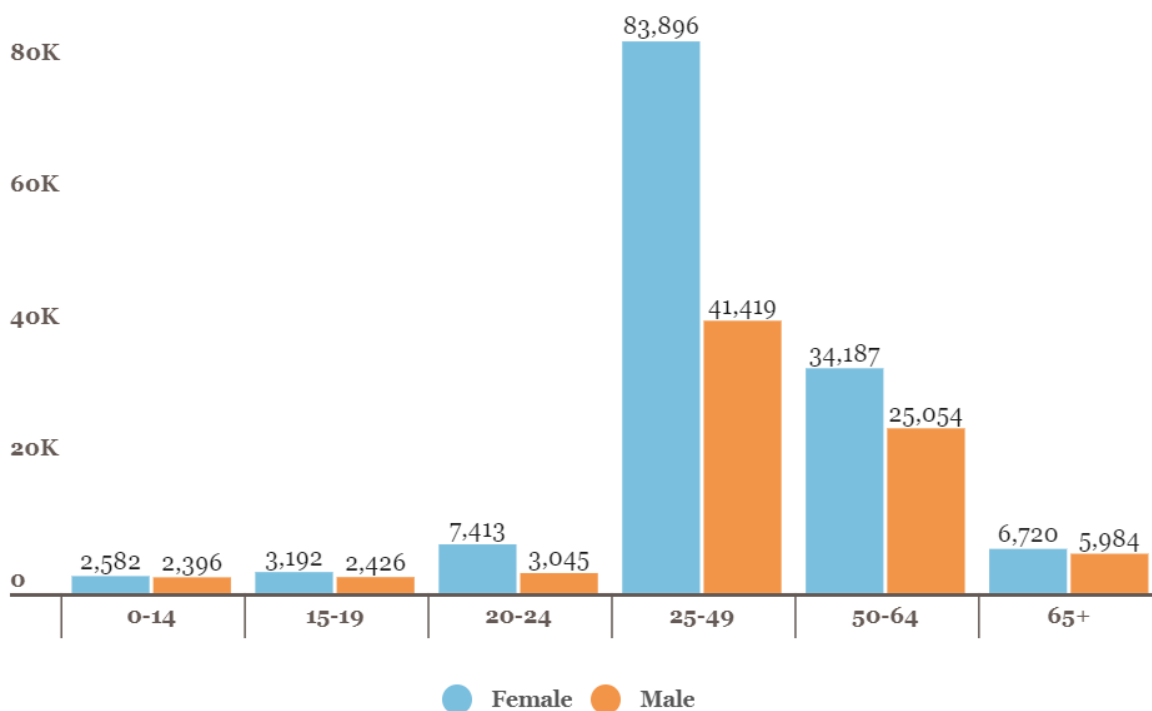
The program has improved its strategies to track new positives by expanding the eligibility criteria to include all PLHIV 18 years of age and older. As a result, from July 2022 to June 2023, a total of 41,243 index clients were enrolled in HIV CBS. This enrollment contributed to an overall total of 91,805 index clients in CBS, which accounts for approximately 47% of all PLHIV aged 18 years and above (Figure 9).

#### **3.3. ART coverage**

The effectiveness of antiretroviral therapy (ART) in reducing mortality among individuals living with HIV has been well-documented, and endeavors are being undertaken to enhance its affordability in low- and middle-income nations. Through the implementation of the "Treat all" policy, all individuals who test positive for HIV are promptly linked to care and initiated on ART. Ideally, this initiation occurs on the same day, whenever feasible, irrespective of their CD4 count.

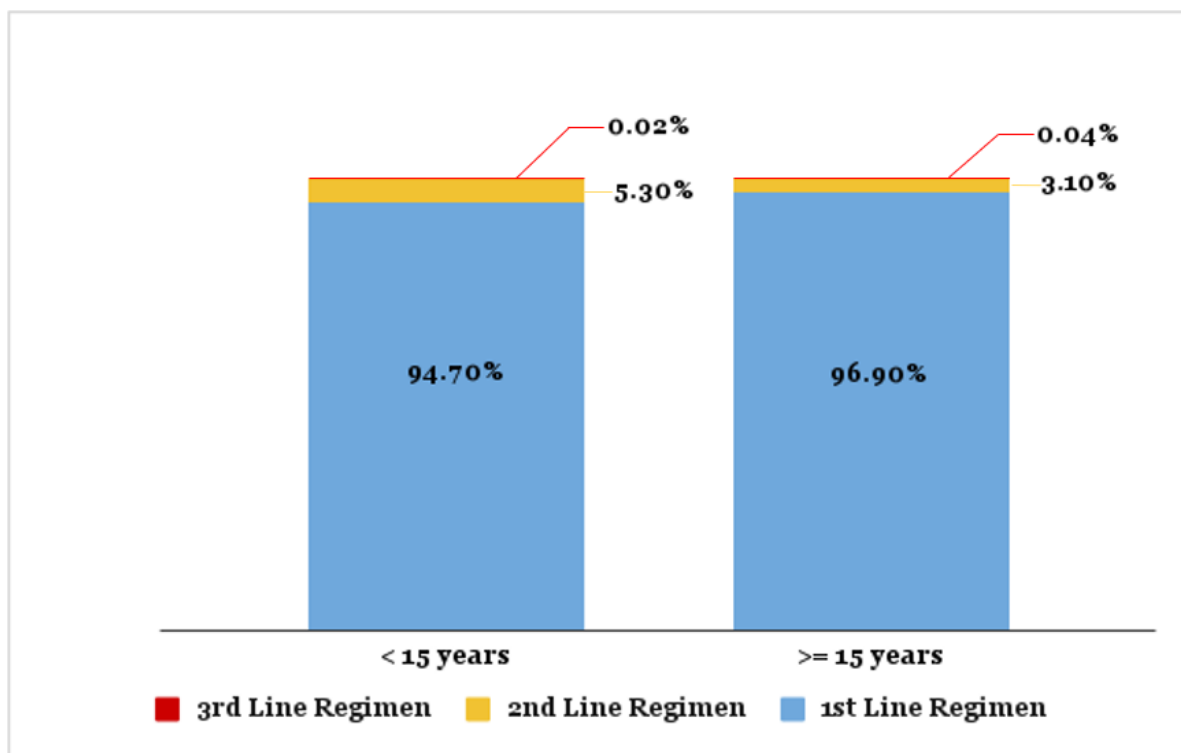
ART coverage for PLHIV in Rwanda stands at 92.3% using the UNAIDS 2023 EPP spectrum, showcasing the nation's commitment to ensuring broad access to life-saving treatment.

By the end of June 2023, a total of 218,314 clients were enrolled on ART and care. Females constitute the majority representation at 63.5%, whereas males account for 36.5%. Furthermore, females are the most represented among all age groups of PLHIV who are on ART (Figure 29).



**Figure 29: ART distribution by age category and sex as of June 2023**

Among all children and adolescents living with HIV (CLHIV) aged less than 15 years on ART, 94.70% are on the 1st line regimen, 5.30% on the 2nd line regimen, and a few of 0.02% on the 3rd line regimen. Among recipients of care aged 15 years and older, 96.90% are on the 1st line regimen, 3.10% on the 2nd line regimen, and 0.04% on the 3rd line regimen(Figure 30).



**Figure 30: ART Coverage by lines and age**

### 3.3.1. Linkage and retention in care and treatment

The treat-all strategy introduced early linkage to care and treatment, which significantly reduced HIV/AIDS-related morbidity and mortality. This proactive approach effectively limits further HIV transmission and optimizes the health benefits of treatment while preventing secondary spread. To enhance the connection and initiation of newly diagnosed positive clients into ART, Rwanda's HIV care and treatment program has bolstered its strategies to foster better communication between testing entry points and ART services. This is achieved through practices like intensified counseling upon enrollment, same-day enrollment, ART initiation, and the introduction of facilitating tools like ART linkage registers.

Retention in care is a spectrum of continuum care packages, from the diagnosis of HIV infection to lifelong services. By the end of June 2023, a total of 584 health facilities, including public hospitals, health centers, and private facilities, would be equipped to offer comprehensive antiretroviral treatment, thereby facilitating optimal retention in care.

The figure below shows the retention rates among women and men after one year of ART initiation, with lower retention rates recorded among males within the 15-19 years and 20-24 years age groups. The overall retention rate was at 94.5%, with 96% and 93% among females and male respectively.

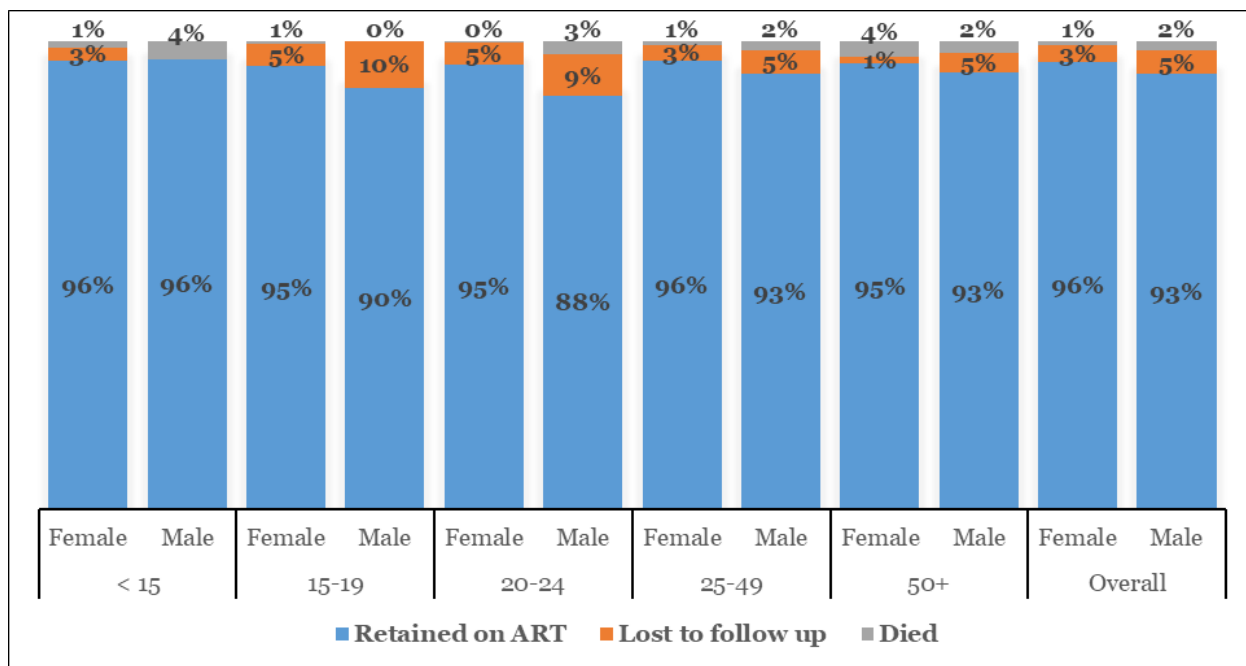
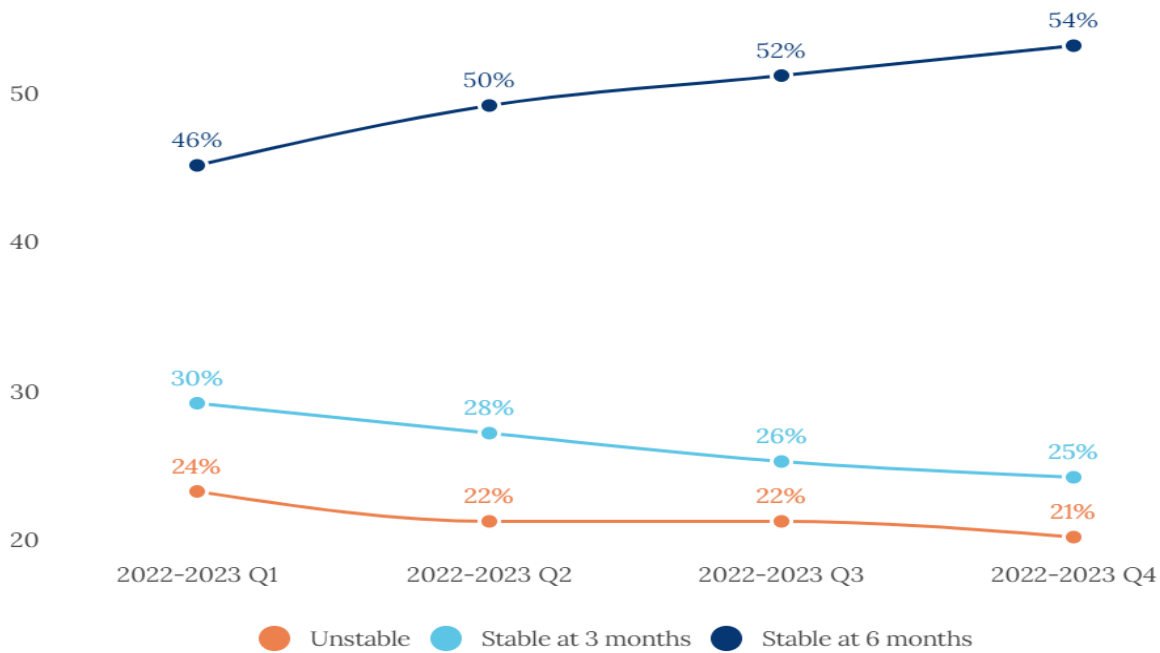


Figure 31: Retention after one year of ART initiation

### 3.3.2. Differentiated service delivery (DSD)

Following the “Treat All” strategy in Rwanda since 2016, the number of clients eligible for ART has gradually increased, resulting in potentially overwhelming visits to health facilities and affecting the quality of services delivered to PLHIV. In response to this challenge, Rwanda, along with several other nations, has incorporated differentiated service delivery (DSD) into its national HIV management guidelines. This approach aims to provide HIV-related services that are tailored to individuals' specific needs and circumstances.

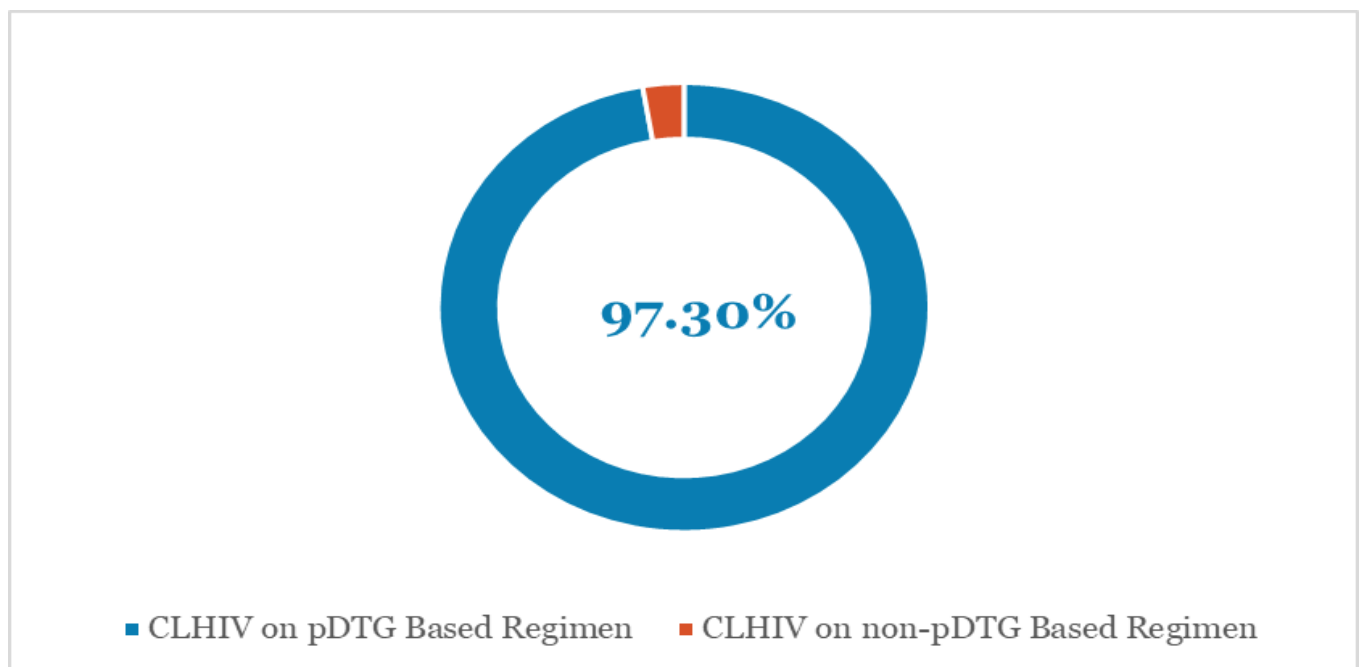
Rwanda has adopted multi-month dispensing (MMD), starting with the 3-MMP initiative in 2017 and extending to 6-MMD in July 2020. This has been scaled up countrywide as a response to clients centered services to avoid unnecessary visits and reduce the burden on health facilities. From July 2022 to June 2023, the proportion of recipients of care (RoC) established on ART on 6-MMD has increased from 43% to 54.3%, contributing to 79% of RoC receiving less-intensive services (Figure 34).



**Figure 32: Trends in the scale-up of DSD model categories from July 2022 to June 2023**

### 3.3.3. Pediatric DTG coverage

The introduction of a DTG dispersible tablet has been a significant advance in optimal treatment for CLHIV. Based on data reported from studies among adults, DTG’s efficacy has been proven to be superior to both PIs and NNRTIs. Studies have also shown that the introduction of DTG directly addresses pre-treatment drug resistance among CLHIV as well as acquired drug resistance after failed NNRTI- or PI-based regimens. Currently in Rwanda, the national HIV program has adopted pDTG 10mg at a full scale across all health facilities providing HIV services. It is the preferred regimen for all CLHIV that fall in the eligibility criteria according to our national HIV guideline. An active data collection conducted in 478 health facilities showed that among 1195 CLHIV who weighed under 20kg, 1163 were on pDTG 10 mg-based regimen giving a total coverage of 97.3%.



**Figure 33: Pediatric DTG coverage as of February 2024**

### 3.3.4. Viral load testing and monitoring

Routine VL testing (RVLT) is a critical component of successful HIV treatment, and when used correctly, it has the potential to optimize the effectiveness of ART. Viral load is one of the eligibility criteria for DSD. In order for a client to be categorized as established on ART (stable), they must have a suppressed viral load (<200 copies/ml in the context of Rwanda), which renders them eligible for less-intensive services. Allowing focused, more-intensive services to RoC with unsuppressed VL and a risk of HIV disease progression.

The program set high targets to maximize treatment outcomes through a number of interventions focused on improving adherence among age groups that had previously had poor treatment outcomes. As of July 2023, 79% of RoC are in less-intensive models (receiving 3 to 6 multi-month ART and bi-annual clinical visits), showcasing a significant achievement of VLS among PLHIV across the board. Between July 2022 and June 2023, most viral load tests (95%) had successful suppression below 200 copies/ml, with 82% having undetectable levels (<20 copies/ml), and those under 1000 copies/ml achieving a 97% success rate. However, it is important to note that there is a persistent gap, particularly among PLHIV under the age of 25, for whom the VLS rate falls below 90%.

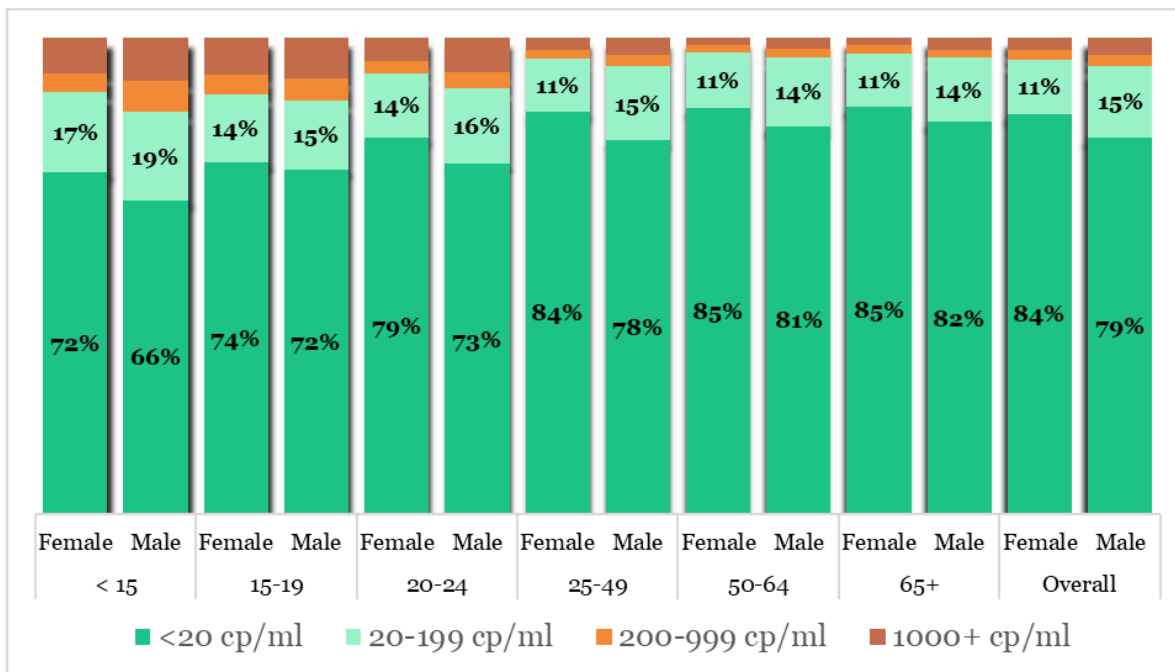
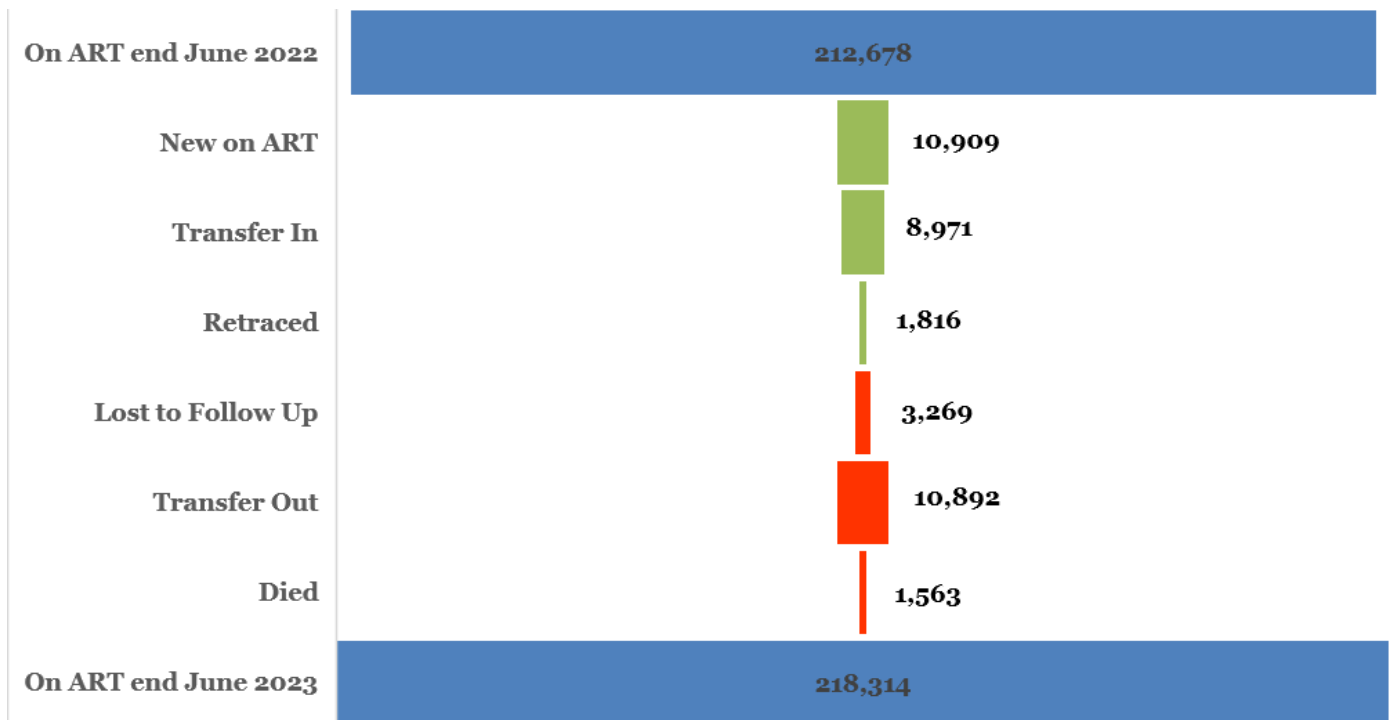


Figure 34: Viral load suppression among clients on ART by sex and age

### 3.3.5. Movements among recipients of care on ART

From July 2022 to June 2023, there was a 2.7% rise in the total number of PLHIV enrolled in care and treatment, from 212,678 in June 2022 to 218,314 in June 2023. This growth can be attributed to the overall net increase resulting from various factors, including new clients initiating ART, previously lost-to-follow-up cases returning to care, and transfers into healthcare facilities. During this period, a total of 10,909 individuals were initiated on ART, 3,269 individuals were lost to follow-up and 1816 were traced back, while 1,563 individuals on ART died due to different causes.



**Figure 35: Movements among recipients of care on ART from July 2022 to June 2023**

### 3.4. Integration of other services in HIV differentiated ART models

#### 3.4.1. Mental health

Hospitals and health facilities in their catchment areas have taken up the integration of mental health services into their HIV services for optimum delivery of services. Integrating mental health services into HIV care is crucial to providing comprehensive and holistic support for individuals living with HIV. The intersection of HIV and mental health is significant, as PLHIV often experience a range of psychological, emotional, and social challenges that can impact their overall well-being and quality of life.

In collaboration with the Mental Health Division, we conducted training for social workers and mental health professionals from all 47 hospitals on the psychosocial and Mental health of PLHIV. During this training, an overview of HIV in Rwanda, mental health challenges within PLHIV, and resolutions to these challenges were discussed.

#### 3.4.2. TB-HIV co-infection

Tuberculosis preventive therapy among PLHIV was re-initiated in 2019. In July 2020, TPT was scaled up scale-up across the country for all eligible clients. Currently, all 30 districts have been trained and provided with the necessary skills and commodities to integrate TPT into HIV service delivery in a one-stop shop model. As of June 2023, 88.7% (193,724) of PLHIV have been initiated on TPT, with significantly high completion rates of 95%.



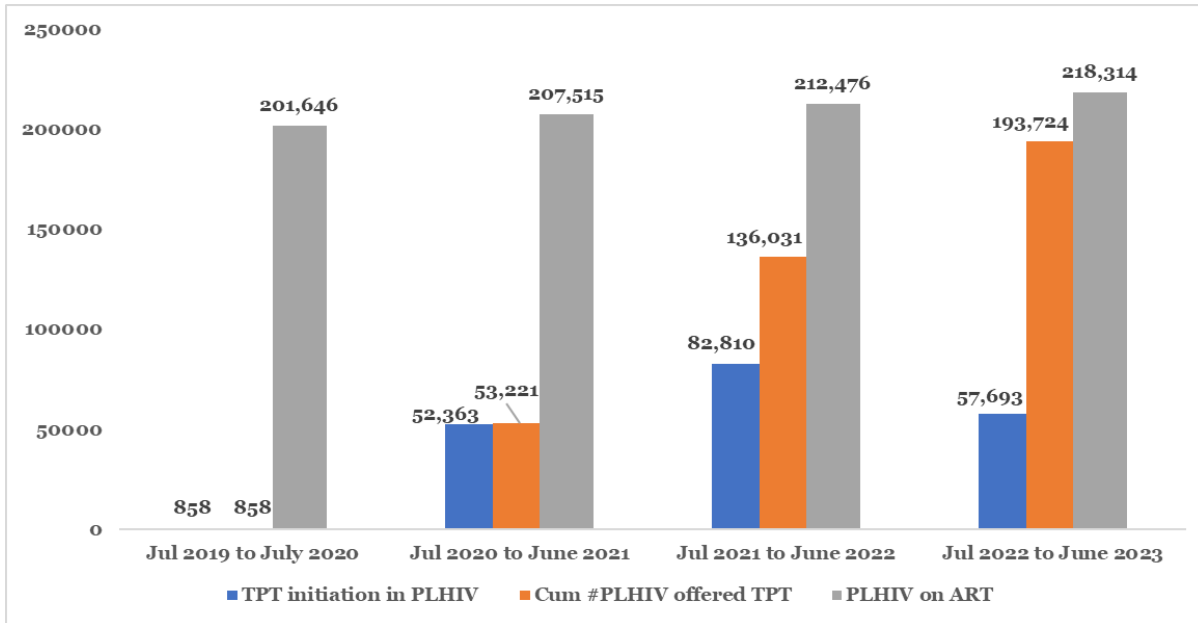


Figure 36: The trend of TPT coverage among PLHIV from as of June 2023

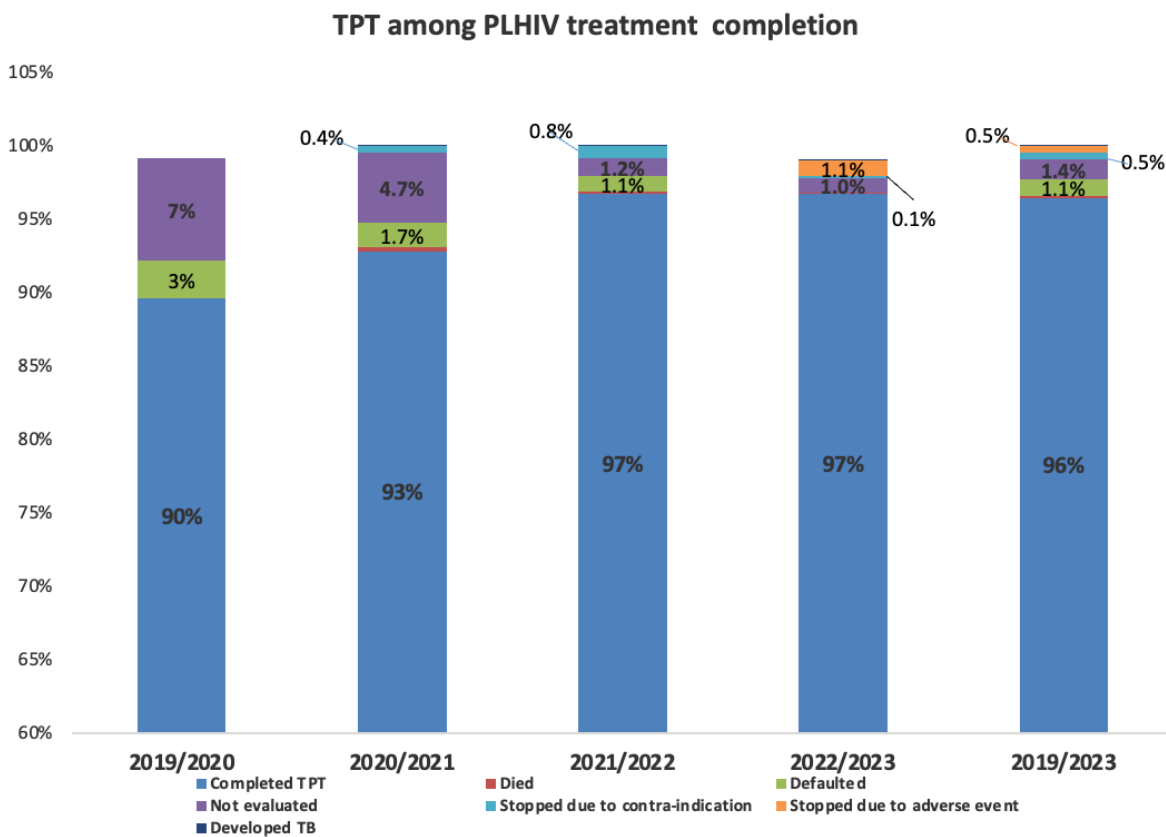


Figure 37: TPT outcomes among PLHIV, July 2019-June 2023

### 3.4.3. Family planning

The GoR embraces family planning as a central component of development, in the 4th health sector strategic plan (2018-24) it reflects on increasing demand for adolescent SRH services, including FP, by increasing access to services for all PLHIV, including adolescents and youths.

FP unmet need has persistently remained at 14% since 2015, however, the most recent DHS survey shows a significant increase in the mean contraception rate (mCPR) at 58% as of 2022 and is in line to reach the 60%

targets set for the end of 2023. Emphasis has been put on ensuring a sufficient supply of multiple and nuanced-proven modern methods to support the integration of FP in less-intensive differentiated ART models. One such activity done in this fiscal year 2022-2023 is the capacity building of service providers to purposely link PLHIV to FP services and seize missed opportunities in linkage to SRH services.

#### **3.4.4. NCDs**

Access to antiretroviral therapy has extended PLHIV's life expectancy. Programme data shows that 33% of Rwandan PLHIV taking ART are 50 or older and 57.4% are 25–49. HIV infection and genetics increase the risk of NCDs like diabetes, hypertension, cardiovascular disease, and cervical cancer in HIV-positive older adults. Thus, NCDs are a major cause of death and illness in this group. A core committee was formed by the HIV programme to address the growing NCD burden among PLHIV. Since 2022, several interventions have been implemented based on successful regional initiatives and Rwanda's NCD division and healthcare professional bodies. A consultative meeting sought consensus on NCD/HIV integration and developed simple algorithms to identify patients with a double burden of disease. After obtaining test kits, the HIV programme has added annual glyceamic control for PLHIV on DTG-based regimens to its guidelines. The HIV and NCD divisions will work together to strengthen HIV healthcare providers' abilities and ensure the HIV clinics have enough diagnostic and management capabilities to screen and manage NCDs.

### **3.5. Psychosocial care support among PLHIV**

Rwanda's HIV/AIDS status has stabilised. An upgraded and well-coordinated national response plan that emphasises HIV prevention, treatment, care, and social support for recipient of care has attained stability. Rwanda's comprehensive HIV treatment method emphasizes psychosocial support and adherence counselling to help PLHIV cope with a lifetime disease. The gap in HIV-positive children, adolescents, and young adults required us to train peer educators to use the CATs project model to support them psychosocially. Peer educators from health facilities in the city of Kigali were trained.

### **3.6. Nutrition support**

Nutritional support is crucial for PLHIV patients to prevent deficits, maintain weight, and prevent AIDS-related illnesses. During this fiscal year, 116 nutritionists from hospitals and health centers were trained through experience sharing on nutrition assessment, education, counseling, support, follow-up, and referral. Two thousand nine hundred PLHIV from 46 hospitals and health centers in their catchment area benefited from ready-to-use therapeutic food (RUTF).

### **3.7. Community engagement and CSOs**

Civil society organizations play a crucial role in HIV/AIDS response, bridging clinical services and impacted populations. RRP+, AHF, UPHLS, Dream Village Organisation, PACT, AEE, FXB, DUHAMIC, CARITAS, YWCA, RICH, and PROFEMME implemented HIV response community activities in 2022/2023, improving ART retention and linkage to care. Community mobilization targeted orphans, vulnerable children, people with disability (PWDs), and discordant couples, using evidence-based training manuals. CSOs provided psychosocial assistance, counseling, nutrition and health insurance to PLHIV and their families in need.

### **3.8. HIV-related commodities supply chain management**

Supply chain management is crucial for health systems and programs to maintain high-quality services. This includes integrating quantification exercises to calculate HIV/AIDS, Tuberculosis, Malaria, and MCCH needs, creating a report for 2023-2029, and regularly checking new and current commodities. Regular stock

status reviews, continuous monitoring of novel and phased-out compounds, and supply chain mentorship at Rwanda Medical Supply Ltd. branches and health facilities are essential for ensuring adequate service delivery.

### **3.9. Mentorship and continuous quality improvement**

HIV/AIDS healthcare requires continuous education, guidance, and clinical mentorship to improve quality. The quality of care for PLHIV and the general community determines HIV response success. In addition to health care provider training, experience-sharing workshops, coordination meetings, clinical mentorships, and supportive supervision monitoring improved HIV care and treatment for PLHIV. Psychosocial and mental healthcare mentorship was provided at 23 hospitals and health facilities nationwide. These clinical mentorships enabled clinical mentors and health care providers to improve adherence counseling and support for PLHIV, conduct support groups for children and adolescents, and screen and manage mental disorders according to their needs. Care and support options are needed to provide effective healthcare. Nutrition mentorship was provided at 47 hospitals and health centers in their catchment region to improve knowledge, practice, and attitude towards nutrition service delivery.

Quality improvement (QI) projects underpin HIV care and treatment services to control HIV. In FY 22–23, twenty nurses and mentors from 12 health facilities received training on QI principles and HIV service delivery improvements. Fourty health facilities with QI projects received mentorship to empower their QI committees and track success. QI initiatives improved clients' DSD categories and VL monitoring assessments. A QI dashboard helps with data analysis and project tracking.

## 4. VIRAL HEPATITIS AND SEXUALLY TRANSMITTED INFECTIONS

### 4.1 Introduction

WHO statistics show that 296 million people worldwide are chronically infected with HBV, with between 20% and 30% developing advanced complications. In Rwanda, the proportion of detectable viral load of HBV and HCV infection was 0.35% and 0.39% in 2021-2022, respectively. Rwanda has made progress in program growth and community awareness since the elimination plan's launch in 2018. Preventing other sexually transmitted infections (STIs) is crucial to mitigate health consequences, including chronic disease, fertility problems, cancer, and death. Rwanda has invested in a monitoring and evaluation system to improve health sector staff, infrastructure, community awareness, and continuous guidance on prevention, treatment, and follow-up of STI cases.

### 4.2. Trainings and mentorship on HBV, HCV and STIs management

Healthcare workers need continuous training and mentorship to provide equitable and quality healthcare services. In the current fiscal year, a number of staff and managers from various health centers and hospitals have been trained in the management of viral hepatitis and STIs. The following table shows the staff and managers trained on national viral hepatitis and STI guidelines, monitoring and evaluation, and hepatitis tools to improve the quality of comprehensive service delivery through continuous capacity building of healthcare providers. The training also improved the management of viral hepatitis and STI data using an electronic data recording system and enhanced the skills and motivation of healthcare workers by providing them with effective technical support.

*Table 1: People trained on viral hepatitis and STIs, 2022-2023*

Trained healthcare providers	Total number
Hospital Directors	46
Directors of health at the district	30
Nurses in different hospitals	92
Medical doctors	92
Data managers in different hospitals	92
Heads of health centers	1130
Data managers at health centers	1130
<b>Total</b>	<b>2612</b>

### 4.3. Management of viral hepatitis B

#### 4.3.1. Hepatitis B awareness, testing, and treatment

Public awareness of diseases is key for their control and elimination. In the current fiscal year, the population was continuously informed about viral hepatitis and STIs through radio and TV broadcasts and live chats to answer questions from the public, resulting in increased demand for health services and behavior change, as well as demand for screening, as shown in the following figure: a total of 475,625 people were screened for HBV, 7,639 of them (1.6%) tested positive for hepatitis B surface antigen (HBsAg), 1,711 (0.36%) had detectable viral load and 1,123 were eligible and initiated on HBV treatment.

### 4.3.1.1. Hepatitis B annual cascade of care 2022-2023

HBV CASCADE OF CARE: 2022 - 2023

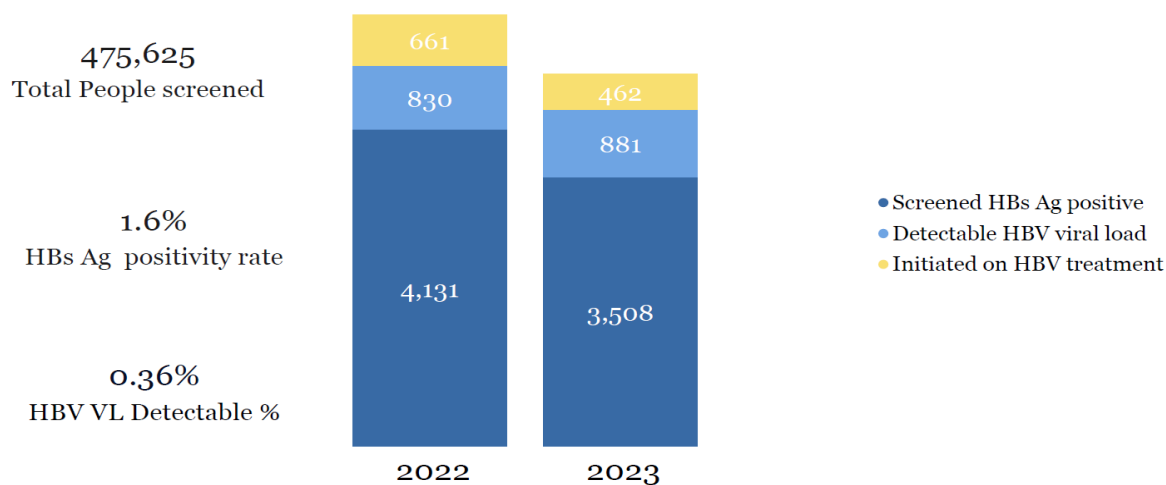


Figure 38: Hepatitis B cascade of care from July 2022 to June 2023

### 4.3.1.2. Hepatitis B cumulative cascade of care, 2015-2023

With regard to the program's achievements in terms of HBV management, it is worth noting that almost five million people have been screened since screening services began in 2015, 138,512 have tested positive for HBsAg and 8,258 have been put on HBV treatment to date.

HBV CUMULATIVE CASCADE OF CARE: 2015 - 2023  
TOTAL SCREENED: 4,604,468

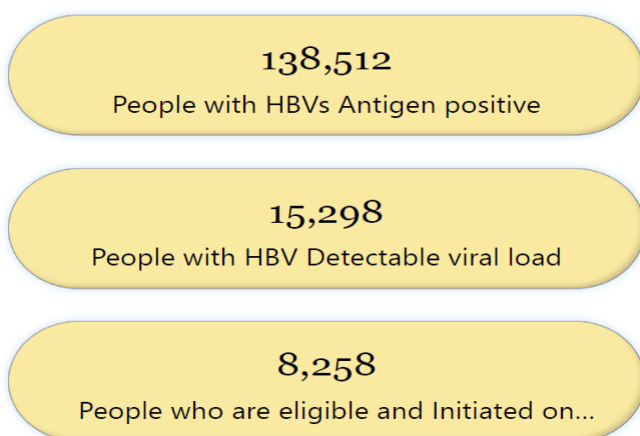
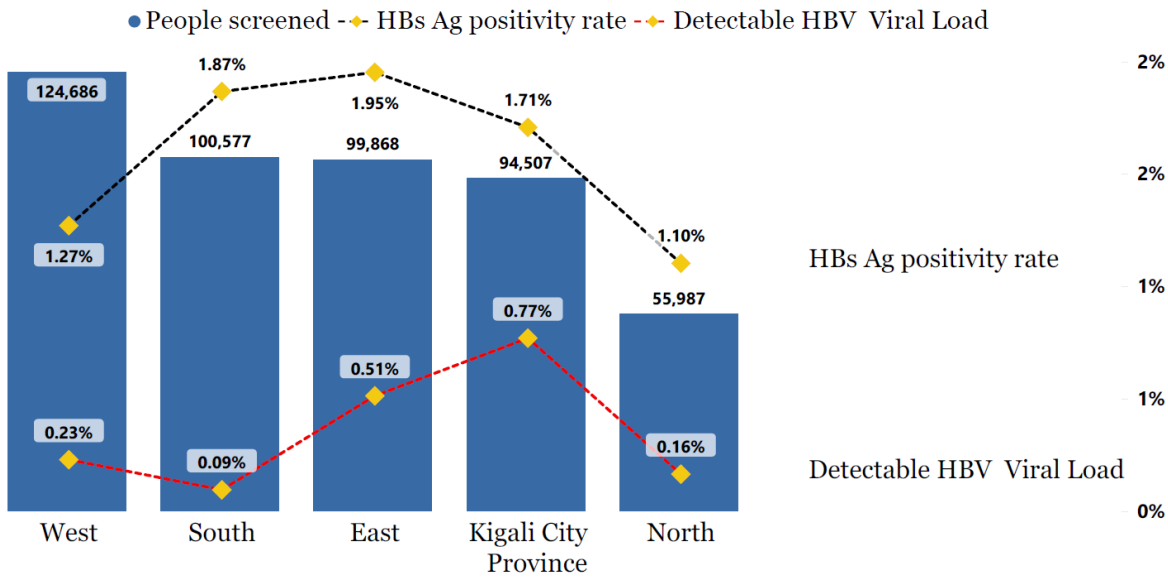


Figure 39: Hepatitis B cumulative cascade of care from FY 2014/2015 to FY 2022/2023

### 4.3.1.3 Hepatitis B infection by Province

In the context of hepatitis B infection distribution across the country, aiming at targeting interventions and improving disease management, the analysis of hepatitis B cascade of care by Province, showed that the Western Province screened the highest number of people (124,686), while the Northern Province screened less (55,987). The highest proportion of positivity was observed in the Eastern Province (1.95%) and the Southern Province (1.87%) respectively.

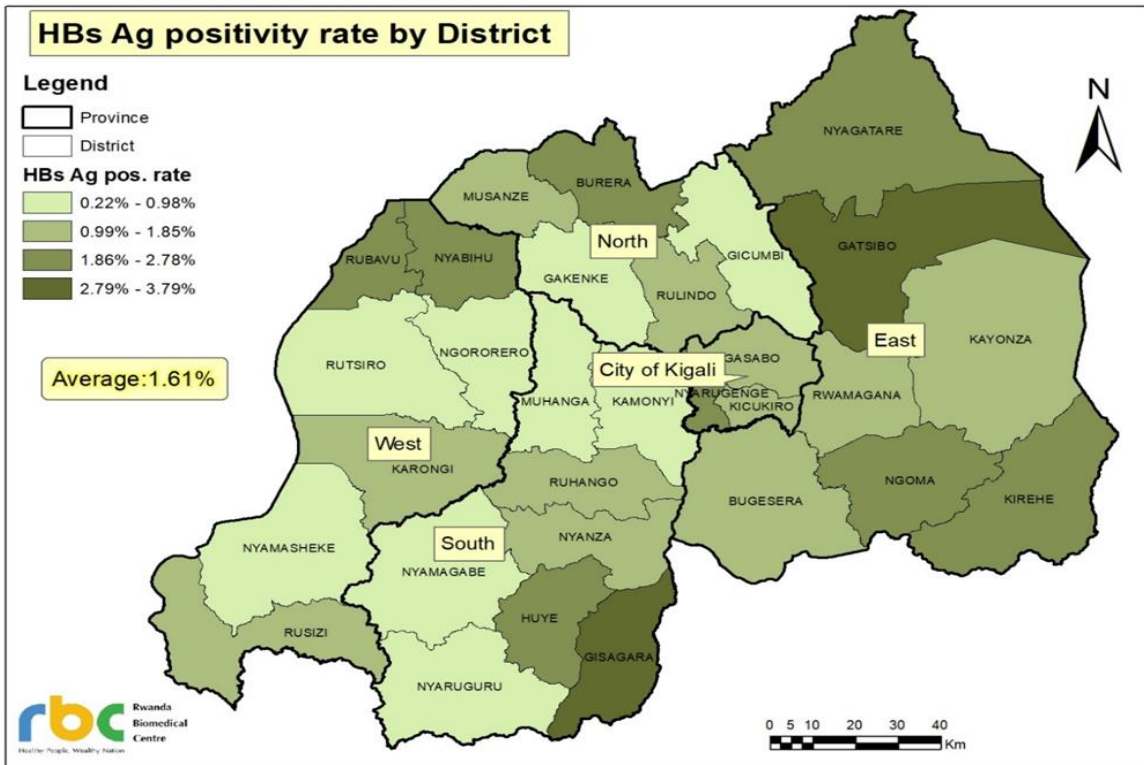
## HEPATITIS B INFECTION BY PROVINCE



**Figure 40: HBV cascade of care by Province, July 2022 - June 2023**

### 4.3.1.4 Hepatitis B infection by District

The map below shows that Gatsibo, in the Eastern Province, and Gisagara, in the Southern Province, have the highest positivity rates, between 2.79% and 3.79%, and that almost all the districts with high positivity rates are located on the borders, suggesting cross-border transmission.



**Figure 41: HBsAg positivity rate by District, July 2022 - June 2023**

#### 4.3.1.5. HBV infection in pregnant women

Rwanda's national HBV guidelines suggest that all pregnant women should be routinely screened for HBsAg at first contact, third trimester and delivery, and followed up to determine whether they are infected and can benefit from treatment but also to prevent the transmission from mother to child. The results show that a total of 57,853 women were tested for HBV in the 2022-2023 fiscal year, of whom 1,364 (2%) had a detectable viral load and have been put on treatment in line with eligibility criteria. The Western Province was the first to screen more women (14,524), while the Southern Province screened fewer pregnant women (7,013). These differences could be explained, among other reasons, by prenatal consultation coverage and fertility rates, which probably vary from one Province to another.

HEPATITIS B INFECTION AMONG PREGNANT WOMEN BY PROVINCE

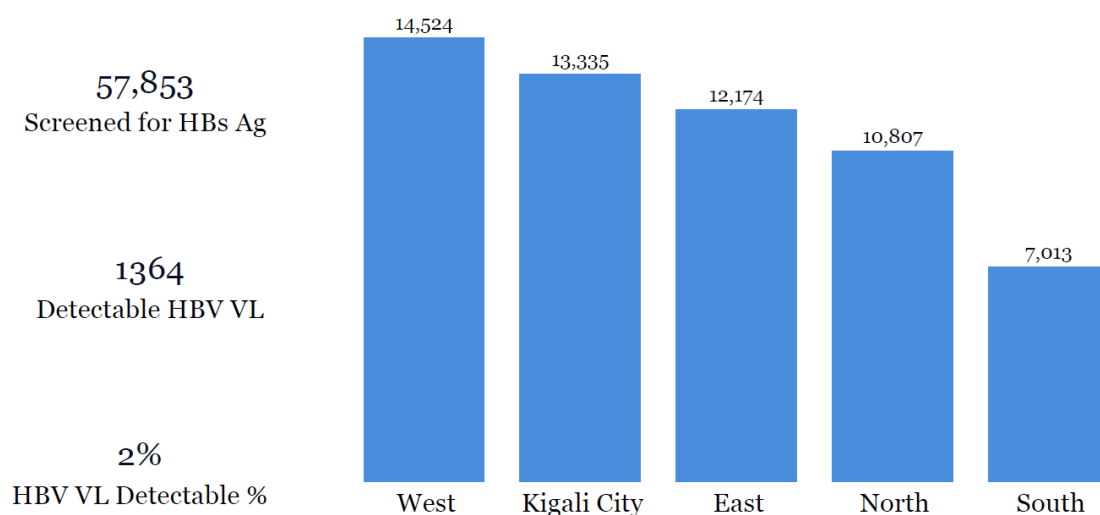


Figure 42: HBV infection among pregnant women, July 2022 - June 2023

#### 4.3.2 Hepatitis B vaccination

Infant immunization against HBV has been in place since 2002 in Rwanda, and the national coverage reached 99% in 2020 (Rwanda DHS, 2019-2020). Subsequently, more than 7,000,000 individuals benefited from this service. From July 2022 to June 2023, a number of 351,181 children have been vaccinated against HBV as part of the pentavalent vaccine, 312 children born to HBV infected mothers have received HBV vaccine within 24 hours of birth and 18,531 adults were vaccinated against HBV.

### 4.4 Management of viral hepatitis C(HCV)

#### 4.4.1. Hepatitis C awareness, diagnosis, and treatment.

##### 4.4.1.1. Hepatitis C annual cascade of care, 2022-2023

In the current fiscal year, 579,584 people were screened for HCV, 11,621 people were HCV antibody positive and 2,781 had a detectable viral load.

### HCV CASCADE OF CARE: 2022 - 2023

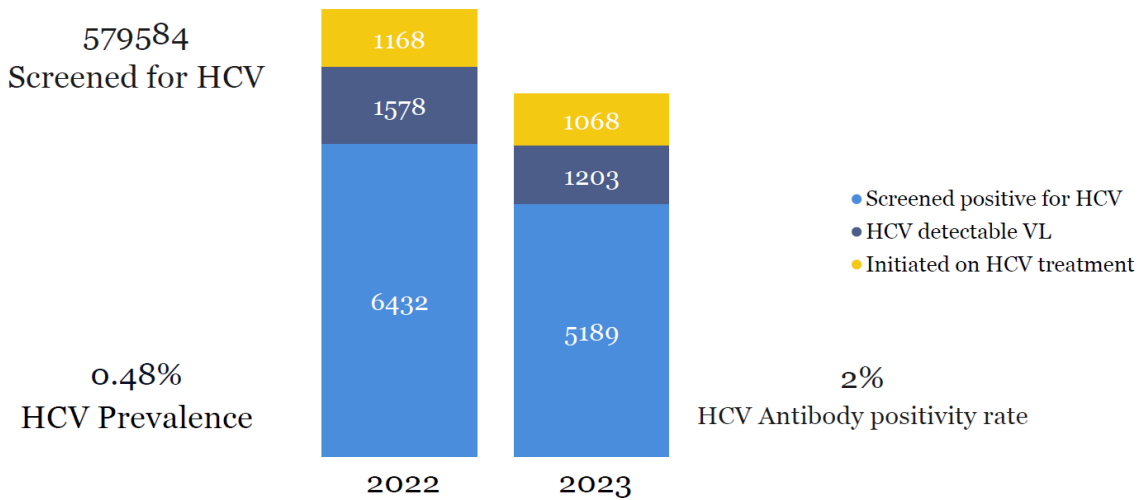


Figure 43: HCV cascade of care, July 2021 – June 2022

#### 4.4.1.2. Hepatitis C cumulative cascade of care, 2015-2023

Since the beginning of the HCV management in 2015, almost eight million people have been tested for HCV in Rwanda. Of the 157,276 people with positive HCV antibodies, 63,404 (40.3%) had a detectable viral load and were eligible for treatment.

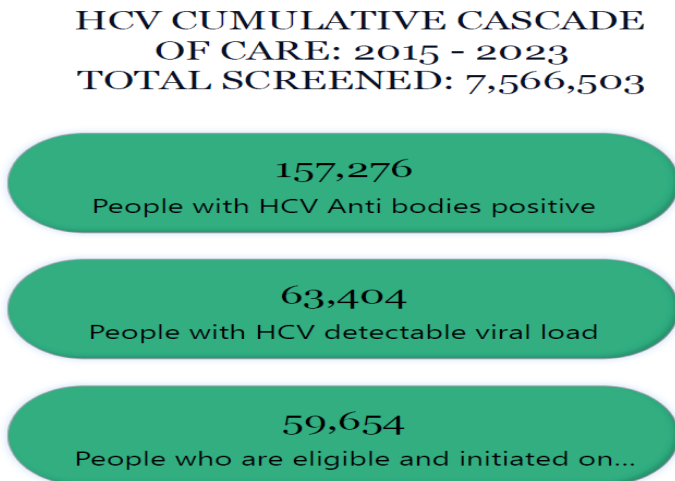


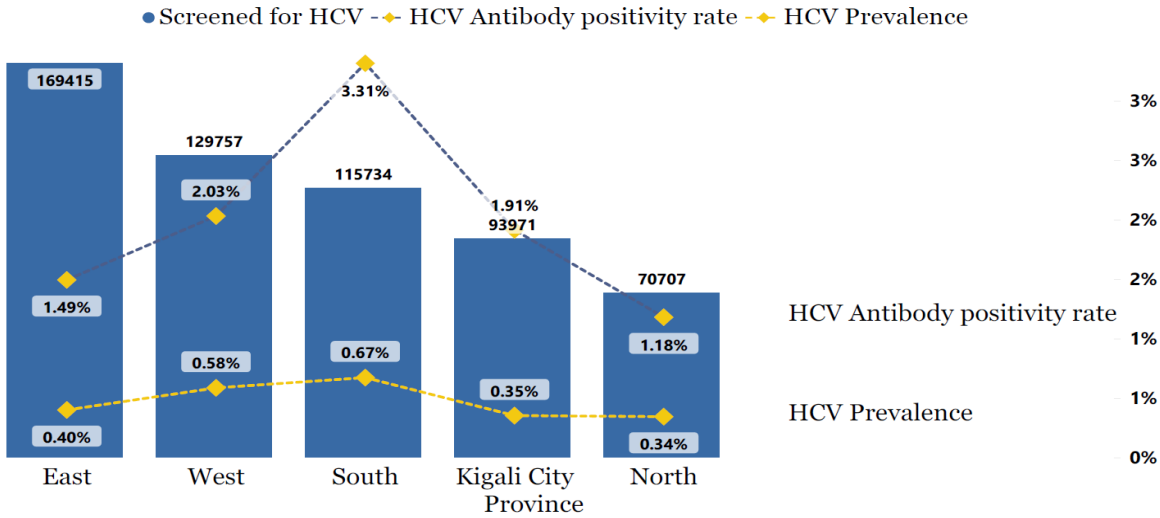
Figure 44: Hepatitis C cumulative cascade of care from FY 2014/2015 to FY 2022/2023

#### 4.4.1.4 Hepatitis C positivity rates by Province

Analysis by Province shows that the Eastern province tested the highest number of people, (169,415), while the Northern Province tested fewer (70,707), and the Southern Province recorded the highest proportion of HCV-detected viral load (0.67%).



## HEPATITIS C INFECTION BY PROVINCE



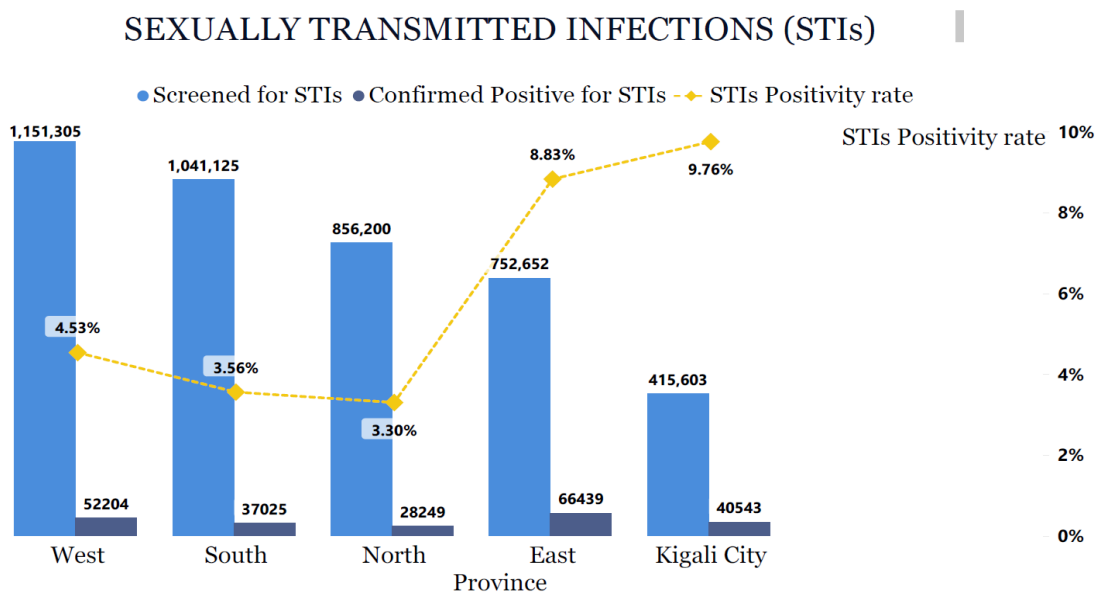
**Figure 46: HCV positivity rate by Province**

### 4.5 Management of sexually transmitted infections

#### 4.5.1. STIs awareness, testing and treatment.

STI management is a cornerstone in the fight against HIV and HBV, as they share similar modes of transmission. Rwanda has adopted systematic screening of all people visiting health facilities in order to increase the unmet need for STI-related services, mainly due to cultural barriers and stigma. Five syndromes have been adopted from WHO for oral screening, physical examination, treatment, and reporting. From July 2022 to June 2023, over four million people have been screened for STIs, of whom 224,460 (5.3%) had one or more STI signs and/or symptoms. The Western province recorded the highest number of screened people (1,151,305) and the lowest number was recorded by the City of Kigali, 415,603, the latter having the highest positivity rate (9.7%), which is not surprising given that HBV and HIV are also widespread in this capital city.

#### 4.5.1.1. STIs screening and positivity rates by Province

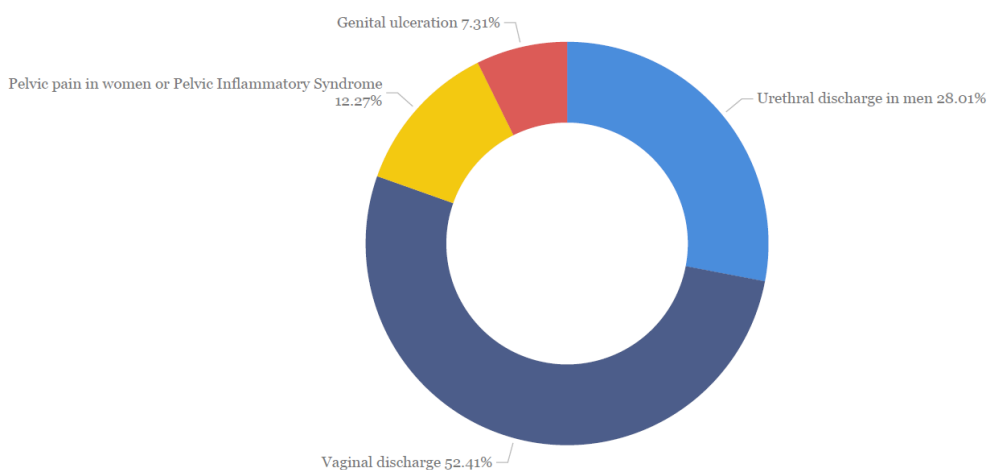


**Figure 47: STIs screening and positivity rates by Province**

#### 4.5.1.2. STIs syndromic management

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

#### SEXUALLY TRANSMITTED INFECTIONS BY SYNDROME, JULY 2022- JUNE 2023

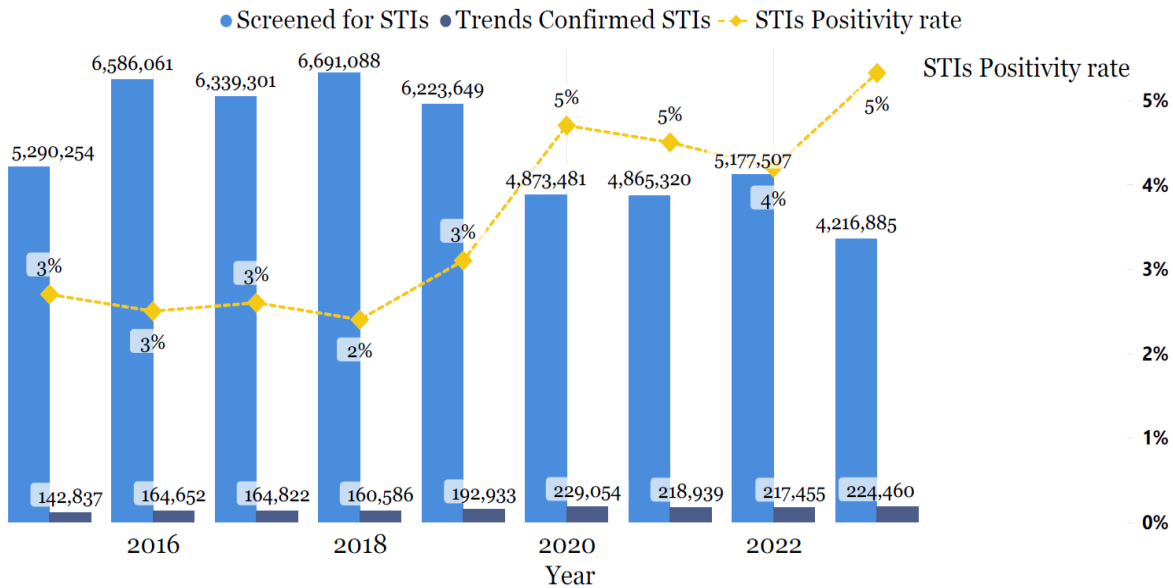


**Figure 48: STI cases by syndrome, July 2022-June 2023**

#### 4.5.1.3 Historical STIs screening, confirmation, and treatment activity

The following figure shows a fluctuation in STI screening since 2015, where the proportion of confirmed cases increased from 2020, rising in the current fiscal year to 5.3% from 2.7% in 2015. There could be various reasons for this increase, which need to be explored thoroughly.

## SEXUALLY TRANSMITTED INFECTIONS (STIs)

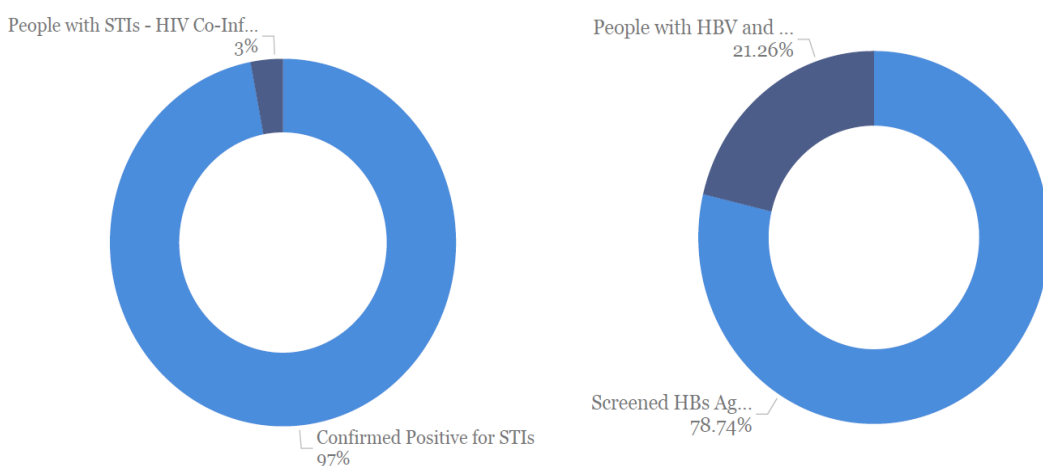


**Figure 49: Individuals diagnosed and treated for STIs from FY 2014/2015 to FY 2022/2023**

### 4.6 HBV, HCV, STIs and HIV coinfection

Of those confirmed with STIs, 3% were co-infected with HIV, raising the possibility that increased condom use among HIV-positive individuals could help reduce the spread of HIV and STIs in general. As for HBV, 21.2% of HBsAg-positive people were infected with HIV.

### HBV, SEXUALLY TRANSMITTED INFECTIONS (STIs) AND HIV CO-INFECTION



**Figure 50: Figure 48: Coinfection STIs & HIV and HBV & HIV**

### 4.7 Monitoring and evaluation(M&E)

Management Information System (HMIS) and District Health Information Software 2 (DHIS2) Health Management Information System (HMIS) and District Health Information Software 2 (DHIS2), are used and updated to reflect the new guidelines on viral hepatitis and STIs. Meetings were regularly organized with medical doctors, nurses, data managers and laboratory technicians to verify the quality of data and to inform

the system update.

## **5. STRATEGIC INFORMATION**

### **5.1 Introduction**

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

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

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

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

### **5.2. Health information systems**

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

### **5.3 Monitoring and evaluation systems**

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

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

### **5.4 HIV Data monitoring and reporting**

The routine monitoring of facility-based HIV services is well established through a series of published



### **5.5 HIV data flow**

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

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

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

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

### **5.6 Supportive supervision and data auditing**

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

### **5.7 Coordination of HIV Partners in Response**

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

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

### **5.8 Surveys and research**

#### **5.8.1. Integrated biological, behavioral, survey and surveillance among female sex workers in Rwanda 2022 (IBBSS 2022):**

The main aim of the study was to evaluate the risk of HIV infection, sexually transmitted diseases, viral hepatitis B and C, and risky behavior among female sex workers (FSWs) in Rwanda in 2022 for improved program planning. The preliminary findings revealed that the estimated HIV prevalence among FSWs was 35.2%. A comprehensive report is currently under development by the relevant institution.

### **5.8.2 Pharmacovigilance for Dolutegravir, 2021 – Ongoing surveillance study:**

The study aims to monitor and manage the safety profile of DTG-based regimens, specifically TDF/3TC/DTG and ABC/3TC+DTG, considering their short-term and long-term effects on individuals receiving antiretroviral treatment. This research is being carried out in 10 healthcare facilities located across all provinces and Kigali city.

### **5.8.3 Non-communicable diseases study among people living with HIV (PLHIV) in Rwanda: Tackling the double burden (ongoing survey).**

The objective of this study is to determine the prevalence of major Non-Communicable Diseases (NCDs) including Diabetes mellitus, Hypertension, Cervical Cancer, Kaposi's sarcoma, and chronic respiratory diseases like Asthma among people living with HIV. The study will also explore risk factors and estimate the NCD-related mortality among PLHIV in Rwanda. It is being conducted in two arms, the first arm is a cross-sectional study design, it will consist of the screening of above mentioned NCDs in 120 selected health facilities countrywide, and the second arm was a retrospective analysis of data of died PLHIV from January 2020 to December 2022, the data collection activities have already finished and data of 4467 died PLHIV were collected with only 551 PLHIV has a recorded cause of death in CRVS system.

### **5.8.4 Cyclical acquired HIV-drug resistance (CADRE) study among PLHIV (Ongoing survey)**

The main objective of this study is to assess and monitor Drug resistance among PLHIV on DTG based regimen and to maximize the long-term effectiveness of 1st-line ART and ensure the sustainability of ART programs, to optimize patient outcomes and minimize further transmission of resistance. The study is being conducted in all health facilities countrywide and it includes all PLHIV with detectable viral load (VL) >1000 copies/ml, who have been on DTG-based ART regimen for  $\geq 6$  months.

### **5.8.5 Hepatitis C 2nd line treatment study**

The main objective of this study is to describe the population of enrolled clients on second line therapy in Rwanda, i.e., demographic characteristics and clinical data. Document safety, including side effects, adverse events (AEs), treatment discontinuations, and loss to follow-up. Document cure rates upon completion of second line therapy using SVR12. Propose possible interventions to prevent and/manage AEs associated with using SOF- VEL-RBV for HCV second line treatment in Rwanda. Main results: A total of 231 patients were recruited: 149 (64.5%) were women, 166 (71.9%) were over 60 years of age, 21 (9.2%) were living with HIV, 16 (6.9%) were cirrhotic (as defined by APRI). Using an intention-to-treat analysis, 174 participants were cured (75.3%); using a per-protocol analysis, 80.6% were cured. The most frequently reported side effects were fatigue (26, 11.3%), headache (19, 8.2%) and nausea (20, 8.7%). The most frequently reported laboratory abnormality was anemia (24, 10.4%). 10 (4.3%) discontinued treatment because of anemia or other side effects.

### **5.8.6 HIV seroconversion rate among pregnant and breastfeeding mothers and related vertical transmission rate in Rwanda. Arm 2. (Ongoing survey).**

The main focus of this study is to estimate the seroconversion rate among lactating mothers and to measure the vertical transmission rate from the newly infected mothers. It is being conducted in 28 pilot health centers and it will be expanded in 175 selected health facilities countrywide. The study is still in the process of data collection.

### **5.8.7 Population size estimation among FSW in Rwanda, 2022**

FSWs are disproportionately affected by the HIV/AIDS epidemic. Establishing accurate population size estimates (PSE) is important for prioritizing target populations and planning HIV prevention and treatment services. In 2022, Rwanda Biomedical Center through HIV, STIs, Viral Hepatitis and OVD division conducted



the population size stigmatization among FSW countrywide. The specific objectives were to estimate the population size of FSW in Rwanda, use PSE estimates findings to inform local programmatic decision-making, and report on international monitoring indicators. The study targeted self-reported female sex workers aged 15 years and above presented at the FSWs hotspots during the data collection period. The mapping of FSW hotspots was conducted from March to May 2022 which was used to determine the sample size of FSWs to be tagged using object distribution in three consecutive weeks. After constituting the sampling frame of FSWs hotspots, the selected hotspots were visited by a research team and key informant/guide who helped in object distribution to FSWs meet on the hotspots (capture) during data collection. In total, 186 hotspots were selected for the survey with 62 hotspots for each capture.

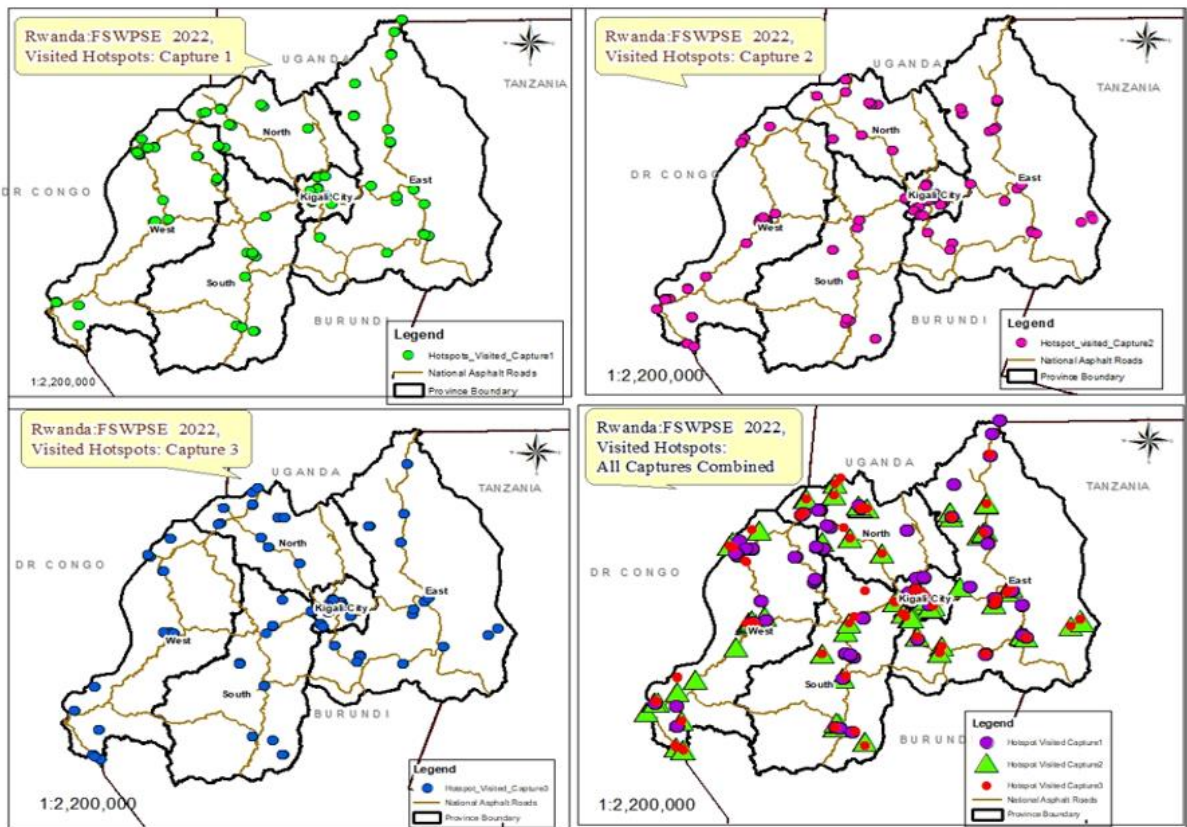


Figure 52: Hotspot for FSWs

### 5.9 E-Learning and Innovation

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

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

#### 5.9.1 Tele mentorship program

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

**Covered topics (mentorship sessions)**

<b>S/N</b>	<b>Session Name</b>
1	Clinical Mentorship in HIV Services
2	PMTCT Services Delivery in Southern Province
3	HIV CBS Services in Southern Province
4	IRIS in People Living with HIV (PLHIV)
5	Ebola Preparedness
6	Index Testing and PNS Reporting Indicators
7	Molecular laboratory Design
8	VMAC adverse events monitoring and reporting
9	VMAC adverse events monitoring and reporting
10	Pre-Exposure Prophylaxis
11	TB/HIV co-infection: TPT implementation Status
12	TB/HIV co-infection: TPT implementation Status
13	Orientation of Clinical Mentors (MDs & Nurses) on eLearning Enrollment and Usage

14	Site Improvement Through Monitoring System
15	Management of hepatitis C and B
16	TB/HIV Deaths Audit findings & Demo on TB Case Surveillance
17	TB/HIV Deaths Audit findings & Demo on TB Case Surveillance
18	TRACE Evaluation Data dissemination
19	TB/HIV Deaths Audit findings & Demo on TB Case Surveillance
20	CBS/Recency programs implementation and Data quality reports
21	TB/HIV Diagnosis among children under 15 Years
22	Monitoring QI Projets
23	TB/HIV Diagnosis among children under 15 Years
24	TB/HIV Diagnosis among children under 15 Years
25	Laboratory PTCQI data collection and reporting
26	PMTCT - Key Indicators definition & Data Quality Checks
27	Orientation of Heads of new 13 HFs (Spokes)
28	HIV Complex Cases: HIV and Hypertension
29	HIV Complex Cases: HIV & HEPATITIS COINFECTION

### **5.9.2 Priorities for the next year**

The following are the priorities for the future:

- Mobilization of the Health sector to consume the content available on the platform.
- Monitoring of the eLearning uptake
- Upgrade and update of the platform to facilitate friendly utilization.
- Scale up the tele mentorship Program to health center level.
- Develop an elearning and tele mentorship sustainability plan.

## **6. ANNEX**

### **6.1. FINANCING HIV RESPONSE: Fiscal year 2022-2023**

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### 6.1. 1. Introduction

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

- Government resources, which includes revenues generated from taxes and non-taxes, loans, grants, donations – reported as Government contribution/ budget allocation and part is allocated as earmarked transfers.
- Development partner contributions through sector budget and project support. On the budget, the donor funds are indicated in the development budget. These include the Global Fund for HIV & AIDS, TB and Malaria, PEPFAR and contributions from One UN.
- Health insurance pooled funds (Mutuelle de Santé or Community based health insurance) from household expenditures. This is not captured in this report.
- Health related household expenditures are not yet captured in this report.
- Private funds are also not captured in this report.
- Income generated from health facilities services are not captured in this report.

The data collection for the contribution of these sources is conducted on an annual basis. Therefore, the report is focused on funding sources where data were available as at the time of reporting as explained above.

### Public and External Sources of funding for HIV/AIDS National Strategic Plan

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The Ministry of Health and the Rwanda Biomedical Centre in collaboration with its partners worked on the financial data reported in HIV/AIDS annual report 2021-2022.

To facilitate the collection of financial information for this year's report, a separate data collection process was adopted using SMART FMIS (Integrated Financial Management Information System) for Global Fund grants and Government contribution; and directly from the in-country office for PEPFAR and UN agencies (One UN) contribution.

### HIV/AIDS Expenditures in Rwanda FY 2022/2023 by Sources of Financing

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The Global Fund for AIDS, TB and Malaria (GFATM) contributed the budget of USD 72,305,520 for the FY 2022/2023; whereas the United States Government (USG contribution for the FY 2022/2023, is USD 67,884,250. The Government of Rwanda contributed the budget of USD 24,839,743 and lastly the UN with USD 708,213. Hence, the total contributions to the National Strategic Plan for the FY 2022/2023 were USD 165,737,726.

*Table 2: Global fund contribution to National Strategic Plan for the FY 2022/2023*

Source of funding for NSP/HIV	Approved Budget FY 2022-2023 in USD	Expenditures FY 2022-2023 in USD	Variance in USD	B.E rate
Global Fund for AIDS, TB and Malaria	72,305,520	51,723,894	20,581,626	72%

USG PEPFAR**	67,884,250	67,884,250	-	100%
One UN	708,213	708,213		100%
GoR	24,839,743	21,479,042	3,360,702	86%
<b>Grand Total</b>	<b>165,737,726</b>	<b>141,795,399</b>	<b>23,942,327</b>	<b>86%</b>

\*The total Global Fund contribution of USD 72,305,520 includes USD 29,318,378 related to C19RM activities.

\*\* PEPFAR information adjusted to align with GoR reporting period

Regarding expenditures, the Global Fund for AIDS, TB and Malaria (GFATM) spent USD 51,723,894, the United States Government spent USD 67,884,250; whereas the GoR spent USD 21,479,042. Lastly, the UN spent USD 708,213 for FY 2022/2023, the overall total expenditure for HIV NSP was USD 141,516,577 which represents 86% of the budget.

### **Government contribution to HIV/AIDS National Strategic Plan FY 2022/2023**

The GoR funds are allocated to different health programs during the annual planning and budgeting process, which entails sectoral consultations to discuss prioritization and budget allocation between the Ministry/ RBC and decentralized levels based on HSSP III implementation and different disease program strategic plans serve as guiding documents. The planning phase also uses the disease burden and services utilization data from HMIS to inform an effective resource allocation. The expenditure was then extracted and analysed based on the disease burden.

**Table 3: GoR contribution to NSP per MTEF chapter, FY 2022/2023**

<b>MTEF Chapter</b>	<b>Approved Budget for FY 2022-2023 in USD</b>	<b>Revised Budget for FY 2022-2023 in USD</b>	<b>Committed Amount FY 2022-2023 in USD</b>	<b>Budget Balance end June 2023 in USD</b>	<b>Performance rate in %</b>
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21 Compensation of employees	13,577,915	13,541,349	11,904,509	1,636,841	88%
22 Use of goods and services	1,828,892	1,891,904	1,927,731	35,827	102%
25 Subsidies	725,278	734,394	672,918	61,476	92%
26 Grants	1,069,649	1,174,703	1,103,552	71,151	94%
27 Social assistance	2,187,031	2,138,215	2,125,910	12,304	99%
28 Other expenditures	2,916,762	2,902,911	1,819,409	1,083,502	63%
33 Inventory	16,398	16,398	16,398	-	100%
34 Fixed tangible non-financial Assets	2,351,780	2,439,869	1,908,615	531,255	78%
<b>Total</b>	<b>24,673,705</b>	<b>24,839,743</b>	<b>21,479,042</b>	<b>3,360,702</b>	<b>86%</b>

From the above table, the initial budget for the financial year 2022/2023 was USD 24,673,705 which was revised to USD 24,839,743. Out of the revised budget of USD 24,839,743, a total of USD 21,479,042 had been effectively spent by different budget entities with 86% of budget execution rate.

The medium-term expenditure framework (MTEF) chapter with the highest budget execution rate was Use of goods and services WITH 102% followed by Inventory with 100%, then social assistance with 99%, the Grants with 94%, the Subsidies with 92%, the Compensation of employees with 88%, the Fixed tangible non-financial Assets with 78%. The last MTEF chapter with the lowest budget execution rate is the other expenditures with 63%.

*Table 4: GoR contribution to NSP per budget agencies, FY 2022/2023*

As reflected in the table below, the revised budget is USD 24,839,743 whereas the expenditure is USD 21,479,042. The type of budget agencies with the highest budget ceiling is Districts hospitals with USD 9,8 Millions, RBC with USD 5,4 million and Ministry of Health with USD 4,7 million.

*Table 4: GoR contribution to NSP per budget agencies, FY 2022/2023*

Budget Agency	Approved Budget for FY 2022-2023 in USD	Revised Budget for FY 2022-2023 in USD	Committed Amount FY 2022-2023 in USD	Budget Balance end June 2023 in USD	Performance rate in %
CHUB	1,037,486	1,026,610	833,909	192,701	81%
CHUK	1,116,091	1,116,091	1,116,091	-	100%

Districts	9,872,039	9,836,966	8,163,951	1,673,016	83%
HNN	411,177	411,177	411,177	-	100%
HRHS	852,170	852,170	710,849	141,321	83%
MOH	4,675,856	4,712,159	4,612,965	99,194	98%
RBC	5,414,590	5,422,903	4,299,771	1,123,133	79%
RMH	1,005,214	1,172,583	1,049,081	123,502	89%
RWANDA FDA	289,083	289,083	281,248	7,835	97%
<b>TOTAL</b>	<b>24,673,705</b>	<b>24,839,743</b>	<b>21,479,042</b>	<b>3,360,702</b>	<b>86%</b>

### The Global Fund contribution

For the Global Fund contribution, the total approved budget C19RM inclusive is USD 72,305,520 for the financial year 2022-2023. During this financial year, the expenditure was USD 51,723,894. Hence, the total budget execution rate for the FY 2022/2023 was 72%. This total variance of USD 20,581,626 representing 28% will be used during the coming fiscal year 2023-2024 before end June 2024.

Table 5: GF budget execution per budget entities, FY 2022/2023

Budget Agency	Approved Budget for FY 2022-2023 in USD	Budget execution FY 2022-2023 in USD	Variance in USD	Performance rate in %
CHUB	36,845	36,950	-105	100%
CHUK	71,035	71,239	-204	100%
MINIYOUTH	300,726	279,753	20,973	93%
MOH	2,469,671	2,551,828	-82,157	103%
NCDA	381,785	351,668	30,117	92%
RBC	68,977,097	48,363,899	20,613,198	70%
RCS	34,184	34,282	-98	100%
RMH	34,177	34,275	-98	100%
<b>TOTAL</b>	<b>72,305,520</b>	<b>51,723,894</b>	<b>20,581,626</b>	<b>72%</b>

From the above table, out of the approved budget of USD 72,305,520, a total of USD 51,723,894 has been effectively spent by different budget entities and this represents 72% of budget execution rate. The type of budget entity with the highest budget ceiling is RBC with USD 68,9 million, MOH with 2,4 million, etc.

Table 6: GF Grant expenditure per cost category, FY 2022/2023

GF Cost Category	Approved budget in USD	Budget execution in USD	Variance	Rate
1.0 Human Resources (HR)	9,071,569	9,546,443	- 474,874	105%
10.0 Communication Material and Publications (CMP)	279,869	736,199	- 456,330	263%



11.0 Indirect and Overhead Costs	1,052,352	2,651,970	-	1,599,617	252%
12.0 Living support to client/target population (LSCTP)	683,459	600,080		83,379	88%
13.0 Payment for results	323,755	414,359	-	90,604	128%
2.0 Travel related costs (TRC)	2,994,232	5,176,440	-	2,182,207	173%
3.0 External Professional services (EPS)	892,655			892,655	0%
4.0 Health Products - Pharmaceutical Products (HPPP)	11,431,238	4,716,087		6,715,151	41%
5.0 Health Products - Non-Pharmaceuticals (HPNP)	11,266,130	9,503,073		1,763,057	84%
6.0 Health Products - Equipment (HPE)	2,741,484			2,741,484	0%
7.0 Procurement and Supply-Chain Management costs (PSM)	2,036,396	2,026,201		10,195	99%
9.0 Non-health equipment (NHP)	214,002	628,501	-	414,499	294%
<b>Total</b>	<b>42,987,142</b>	<b>35,999,353</b>		<b>6,987,789</b>	<b>84%</b>

For the normal grant budget, out of the approved budget of USD 42,987,142, USD 35,999,353 has been effectively spent which represents 84% for the Fiscal Year starting 01 July 2022 to June 2023. The variance of USD 6,987,789 representing 16% stands for commitments which will be implemented in coming Fiscal year 2023-2024.

The table above indicates that the cost category with the highest ceiling budget is for acquisition of Health Products/Pharmaceutical followed by Health products/Non pharmaceuticals.

For C19RM grant budget, out of the approved budget of USD 29,318,378, USD 15,724,541 has been effectively spent which represents 54% of budget execution. The remaining balance, which is 46%, will be spent in coming FY 2023-2024.

*Table 7: C19 RM expenditures for Fiscal Year 2022/2023*

<b>GF Cost Category</b>	<b>Approved budget in USD</b>	<b>Budget execution in USD</b>	<b>Variance in USD</b>	<b>Rate in %</b>
1.0 Human Resources (HR)	241,824.42		241,824.42	0%
2.0 Travel related costs (TRC)	2,383,980.18		2,383,980.18	0%
3.0 External Professional services (EPS)	26,567.99		26,567.99	0%

5.0 Health Products - Non-Pharmaceuticals (HPNP)	14,281,868.72	8,239,203.23	6,042,665.50	58%
6.0 Health Products - Equipment (HPE)	7,367,128.14	6,096,138.08	1,270,990.07	83%
7.0 Procurement and Supply-Chain Management costs (PSM)	1,330,819.33	278,821.51	1,051,997.82	21%
8.0 Infrastructure (INF)	695,527.47	1,105,495.91	(409,968.44)	159%
9.0 non-health equipment (NHP)	2,354,861.62		2,354,861.62	0%
10.0 Communication Material and Publications (CMP)	32,261.13		32,261.13	0%
11.0 Indirect and Overhead Costs	106,271.94	4,882.75	101,389.20	5%
13.0 Payment for results	497,267.29		497,267.29	0%
<b>Total</b>	<b>29,318,378</b>	<b>15,724,541</b>	<b>13,593,837</b>	<b>54%</b>

### The USG/PEPFAR contribution

From 1st July 2022 to 30th June 2023, the US Government invested approximately USD 67,884,250 to the National HIV response in Rwanda and this budget was spent 100%. PEPFAR fiscal calendar does not align with the Government of Rwanda calendar year. Therefore, the data provided is adjusted to align with the report. PEPFAR data includes quarter 4 of COP21 and quarters 1, 2, and 3 of COP22. Expenditure data is not available at the time of reporting, but programs are projected to spend down their funding by the close of the PEPFAR fiscal year.

PEPFAR provides support to multiple facets of the HIV program in Rwanda (figure 53). The majority of PEPFAR funding supports the care and treatment program. Program management includes funding for HRH as well as in country PEPFAR and implementing partner staffing.

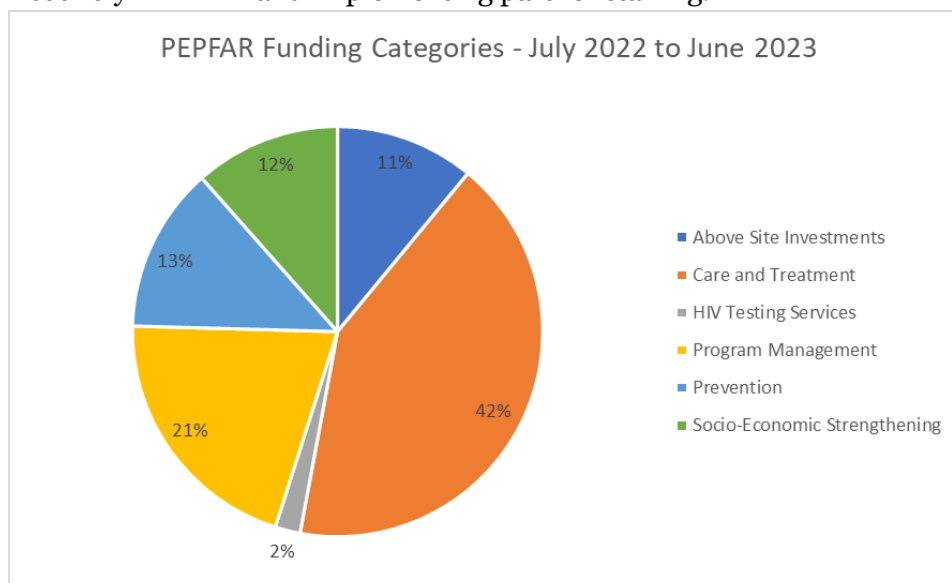


Figure 53: PEPFAR funding categories – July 2022 to June 2023

## ONE UN Contribution

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The One UN developed several flagship programs to fund HIV activities implemented from July 2022 to June 2023. The total budget for the flagships is USD 708,213. This was used as a planned funding level for ONE UN.

## 7. KEY PERFORMANCE INDICATORS

Table 8: Key performance indicators

Indicators	Data Source	Results July 2022-June, 2023
1. HIV Prevalence (15 -64)	RPHIA, 2018 -19	3%
2. HIV Incidence	RPHIA, 2018 -19	0.008 PYRS
3. HIV Prevalence among female sex workers	IBBSS, 2023	35.2% (preliminary results)
5. HIV prevalence among Men having sex with Men	IBBSS, 2021	6.5%
7. Number HIV tests conducted	HMIS (22-23)	2,072,366
8. HIV sero-positivity rate (Overall)	HMIS (22-23)	0.7%
a. VCT/PIT	HMIS (22-23)	1,098,814 (0.8%)
b. ANC Women	HMIS (22-23)	365,759 (0.4%)

<i>c. ANC-among male partners</i>	HMIS (22-23)	265,429 (0.1%)
<i>d. VMMC</i>	HMIS (22-23)	106,860 (1.5%)
<i>e. Maternity</i>	HMIS (22-23)	193,256 (0.1%)
<i>f. Index testing</i>	HMIS (22-23)	42,248 (4.1%)
9. Percent of HIV infected pregnant women in PMTCT	HMIS (22-23)	1.8%
10. Pregnant women who received ART to reduce mother to child transmission	HMIS (22-23)	99%
11. Percent of infants born to HIV+ mothers, who are not infected for 24 months. (MTCT)	Cohort data (health facility registries)	99%
12. Number of medical male circumcision performed according to national standards.	HMIS (22-23)	309,822
13. Surgical circumcision	HMIS (22-23)	305,373 (98.5%)
14. Medical Device circumcision	HMIS (22-23)	4,449 (1.5%)
15. Prevalence of male circumcision (Proportion of males circumcised among male population)	RDHS 2019-2020	56%
16. Number of female sex workers followed at health facility	HMIS (22-23)	31,336
17. Total key population and AGYW on Prep	HMIS (22-23)	13,725
18. Number of HIV negative female sex workers on PrEP	HMIS (22-23)	8,902
19. Number of HIV negative male who sex with male on prep	HMIS (22-23)	2,239
20. Percent of adults and children retained on treatment. 12 months after ART initiation	Cohort data (Health facility registries)	94.69%
21. Percent of adults and children currently receiving ARVs (ART coverage)	HMIS (22-23) & EPP spectrum, 2023	218,314 (95%)
22. Percent of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml)	VLSMS, 2022-2023	97%
23. Number of new clients initiating ART	HMIS (22-23)	10,909
24. Number of condoms distributed	HMIS (22-23)	22,191,059
25. Number of People screened for HCV	HMIS (22-23)	579,584
26. Number of people with HCV RNA positive	HMIS (22-23)	11,621
27. Number of people-initiated HCV treatment	HMIS (22-23)	2,217
28. Number of people vaccinated against HBV	HMIS (22-23)	18,531
29. Number of People screened for HBV	HMIS (22-23)	475,625
30. Number of people screened for HBV positive	HMIS (22-23)	7,639

31. Number of people screened for STIs	HMIS (22-23)	4,598,376
32. Number of people confirmed with at least one STI.	HMIS (22-23)	242,133(5,2%)

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