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NATIONAL ANNUAL REPORT ON HIV&AIDS

July 2011 – June 2012

October 2012

RWANDA BIOMEDICAL CENTER

A Healthy People. A Wealthy Nation

HIV, AIDS, STIs and OBBI DIVISION

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The HIV annual report was developed in collaboration with various partners involved in the National Response to HIV in Rwanda.

The RBC-IHDPC-HIV&AIDS, STIs and Other Blood borne Infections Division would like to take this opportunity to thank all stakeholders who actively participated in providing the necessary information on the progress in implementing the National Strategic Plan 2009-2012 for the fiscal year July 2011 to June 2012.

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

We are very grateful for the technical support provided by different development partners to contribute to the achievements of the national HIV response during this reporting period.

Dr Sabin NSANZIMANA

Head of HIV/AIDS, STIs and Other Blood Borne Infections Division

RBC- IHDPC

EXECUTIVE SUMMARY

The 2011-2012 National Annual Report on HIV program presents the progress in implementing the strategies and activities articulated in the National Strategic Plan on HIV and AIDS 2009-2012, commonly referred to as the HIV NSP.

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

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

The increase in the number of health facilities offering VCT services contributed to the increase in the number of clients tested for HIV. Actually, there is 485 health facilities offering voluntary counseling and testing. In the last eight years, 2003-2012, the HIV&AIDS, STIs and Other Blood Borne Infections Division has registered a downward trend in HIV positivity rate in clients tested in HCT facilities from 10.8% reported positives in 2004 to 1.1% at the end of June 2012. The scale-up of health facilities offering VCT services contributed to the increase in the number of clients counseled and tested for HIV. There were **2,018,481** tests done in health facilities and mobile VCT from July 2011 to June 2012. The total number of HIV tests performed from 2003 up to June 2012 was **10,640,404**. This number includes people tested in both health facilities (VCT&PIT) and mobile VCT.

During this period, IHDPC through HIV/AIDs, STIs and OBBI division organized and coordinated mobile VCT activities for specific occasions from July 2011 to June 2012, among them the Ceremony commemorating World AIDS Day (WAD) 2011 under the theme "Youth let us join efforts in protecting ourselves and others against HIV for a brighter future".

The availability and accessibility of condom as dual protection was increased. The MoH in partnership and support of the social marketing sector initiated the rapid sales outlet creation to increase availability and accessibility of condoms. With the support of UNFPA, 700 condom vending machines have been procured to support the social marketing sector in increasing the number of condoms sales outlets especially in hotspots including bars, hotels, motels, lodges and restaurants. In partnership with the Private Sector Federation through the

Rwanda Hotel Association, UNFPA and PSI-Rwanda, 685 machines have been installed countrywide.

After the development of a male circumcision operational plan and during its initial phase of implementation, the MC program laid a foundation for scale up of male circumcision.

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

- Master trainings surgeons and post graduates in collaboration with Rwanda surgical society.
- National Training of trainers: two per 41 districts Hospitals and one medical doctor and one nurse were trained. 82 participants were trained as trainers of trainers to continue with the cascade trainings at health center level.

The provision of MC during weekends has been started in different districts hospitals (Kibagabaga, Gahini and Kabgayi) and is in process in other districts hospitals.

Regarding the procurement of MC kits, in phase one, 38,600 disposable kits were distributed to 40 district hospitals and their health centers which have completed decentralized trainings.

Even though there is good implementation in MC, the following challenges need to be mentioned: mostly the availability of MC kits and the consideration of Male Circumcision in mutuelle de santé.

By June 2012, 467 HF were offering PMTCT services, an increase of 55 from the previous year's 412 Health Facilities. This means that 94.5 % of Health facilities (Hospitals and Health centers) are offering PMTCT services. There are 445 health facilities (health center and hospitals) collecting samples (DBS) including some District Hospitals for early infant diagnosis for children born to HIV-positive mothers.

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

From July 2011 to June 2012, among 22,428 newly enrolled clients, 21361 (95%) were screened for active TB. Among those screened, 1969 patients had a positive screening. After para-clinical examinations, 675 patients were started on anti-TB treatment and were followed up with one stop TB/HIV services. Since August 2011, Isoniazid Preventive Therapy (IPT)

was introduced in three pilot sites and by the end of June, 4636 patients have begun the treatment.

By the end of June 2011, **336** health facilities were offering care and treatment services to persons living with HIV/AIDS, and by the end of June 2012, **430** health facilities were offering care and treatment services. We note that there was an increase of health facilities offering care and treatment services during these last 12 months, and the total number of patients increased as well. Since 2002, Rwanda assured large-scale access to ARVs and observed a marked increase in uptake of ARVs, an increase of over a hundred times, from 870 patients in 2002 to 107,938 patients by June 2012.

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

With Single Stream of Funding (SSF) funds from Global Fund, the SPIU through 90 implementing agencies are operating in 30 Districts, in all sectors (416) where 23.948 beneficiaries have received 3,860,000 USD as the IGA package for 2011-2012.

CHF project "Higa Ubeho" has conducted financial and market literacy trainings and provide technical assistance to 50 cooperatives and pre cooperatives during 2011-2012.During fiscal year 2011-2012, RRP+ has registered 88 new cooperatives with Global Fund support.

Identification of orphans and vulnerable children (OVC) for education support was done in October 2010 as pilot phase with a total number of 580,878 OVC in secondary, primary/nursery, and vocational training. Through the coordination of National Child Commission implementing partners provided support to OVC on different components included in the OVC minimum package with a total number of 184,149 of OVC supported as reported by partners at the end of June 2012.

RRP+ with partner institution like HAGURUKA has provided the legal assistance for person living with HIV and AIDS in some judicial cases.

Future actions to be prioritized in the next implementation period:

- Strengthen HIV prevention programs in light of the incidence rate
- Look at combination HIV prevention interventions

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

TABLE OF CONTENTS

List of Figures

List of maps

ABBREVIATIONS

ABC	Abstinence, Be faithful and Condoms

ABS	Advanced Business Strategies
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-Natal Consultations
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
BSS	Behavioral Sentinel Surveillance
C&T	Care and Treatment
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDLS	Comité de District de Lutte contre le SIDA (District AIDS Control Committee)
UTH-B	University Teaching Hospital of Butare
UTHK	University Teaching Hospital of Kigali
CHW	Community Health Worker
CPDS	Coordinated Procurement and Distribution Systems
CSO	Civil Society Organization
HCT	HIV Counseling and Testing
DH	District Hospital
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment – Short course
EDPRS	Economic Development and Poverty Reduction Strategy
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child HIV Transmission
FBO	Faith Based Organization
FHI	Family Health International
FOSA	Formation Sanitaire (Health Facility)

FP	Family Planning
FSW	Female Sex Workers
GIPA	Greater Involvement of People living with HIV and AIDS
GSLSA	Group Saving and Loan Associations
GOR	Government of Rwanda
HBC	Home Based Care
HF	Health Facilities
HIV	Human Immunodeficiency Virus
HRT	Health Resource Tracking Tool
HSSP	Health Sector Strategic Plan
ICAP	International Center for AIDS Care and Treatment Programs
IEC	Information, Education, Communication
IGA	Income Generating Activity
IHDPC	Institute of HIV/AIDS, Disease Prevention and Control
IMCI	Integrated Management of Childhood Illnesses
M&E	Monitoring and Evaluation
MARPs	Most at Risk Population
MC	Male Circumcision
MCH	Maternal Child Health
MDG	Millennium Development Goals
MIFOTRA	Ministry of Public Services and Labor
MIGEPROF	Ministry of Gender and Family Promotion
MIJESPOC	Ministry of Youth, Sport and Cultural
MINAFET	Ministry of Foreign Affairs
MINAGRI	Ministry of Agricultural

MINALOC	Ministry of Local Government, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MINICOM	Ministry of Commerce and Industry
MINIJUST	Ministry of Justice
MININFRA	Ministry of Infrastructure
MINIYOUTH	Ministry of Youth
MoH	Minister of Health
MPDD	Medical Procurement and Distribution Division
MSM	Men who have Sex with Men
NCBT	National Center for Blood Transfusion
NCC	National Commission of Children
NGO	Non-Government Organization
NISR	National Institute of Statistics of Rwanda
NRL	National Reference Laboratory
NSP	National Strategic Plan on HIV and AIDS
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PBF	Performance Based Financing
PCR	Polymerase Chain Reaction
PE	Peer Educators
PEP	Post Exposure Prophylaxis
PEPFAR	Presidential Emergency Plan For AIDS Relief
PIT	Provider Initiated Testing
PLHIV	People Living with HIV

PMTCT	Prevention of Mother to Child HIV Transmission
PWD	People With Disabilities
QC	Quantification Committee
RBC	Rwanda Biomedical Center
RCLS	Réseau des Confessions religieuses dans la Lutte contre le SIDA
RH	Reproductive Health
RHCC	Rwanda Health Communication Center
RNYC	Rwanda National Youth Council
RPOs	Rwanda Partners Organizations
RRP+	Réseau Rwandais des Personnes vivant avec le VIH
RWANARELA	Rwanda Network of Religious Leaders living with AIDS
SGBV	Sexual Gender Based Violence
SOP	Standard Operating Procedures
SPIU	Single Project Implementation Unit
SSF	Single Stream Funds
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendants
ToT	Training of Trainers
TS	Task Shifting
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund

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

1. INTRODUCTION

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

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

1.1 Purpose of Annual Report on HIV and AIDS 2011-2012

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

The National Annual HIV Report also includes a financial section describing HIV expenditures for the same time period. This financial report refers to the total HIV expenditures from recent years (since the beginning of the current NSP) and compares those past expenditures to the estimation of HIV expenditures for fiscal year 2011-2012. For GOR HIV expenditures, more details are given on the main cost categories to which it contributes.

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

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

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

- The incidence of HIV in the general population is halved by 2012
- Morbidity and mortality among people living with HIV are reduced

- People infected and affected by HIV have the same opportunities as the general population

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

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

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

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

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

2.1.1 Output 1.1.1.1. General Population is reached by comprehensive HIV prevention programs

This output seeks to ensure that all members of the Rwandan population are informed about HIV and STI prevention, and the existence of key services such as family planning, HIV testing and availability of condoms. During the reporting period of July 2011 to June 2012, all partners worked together to provide HIV prevention services to the general population according to the key strategies outlined in the NSP.

A. **Community sensitization for promotion of safe sexual behaviors, including HIV testing and promotion of condom use**

- **Extension and Improvement of HCT Services**

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

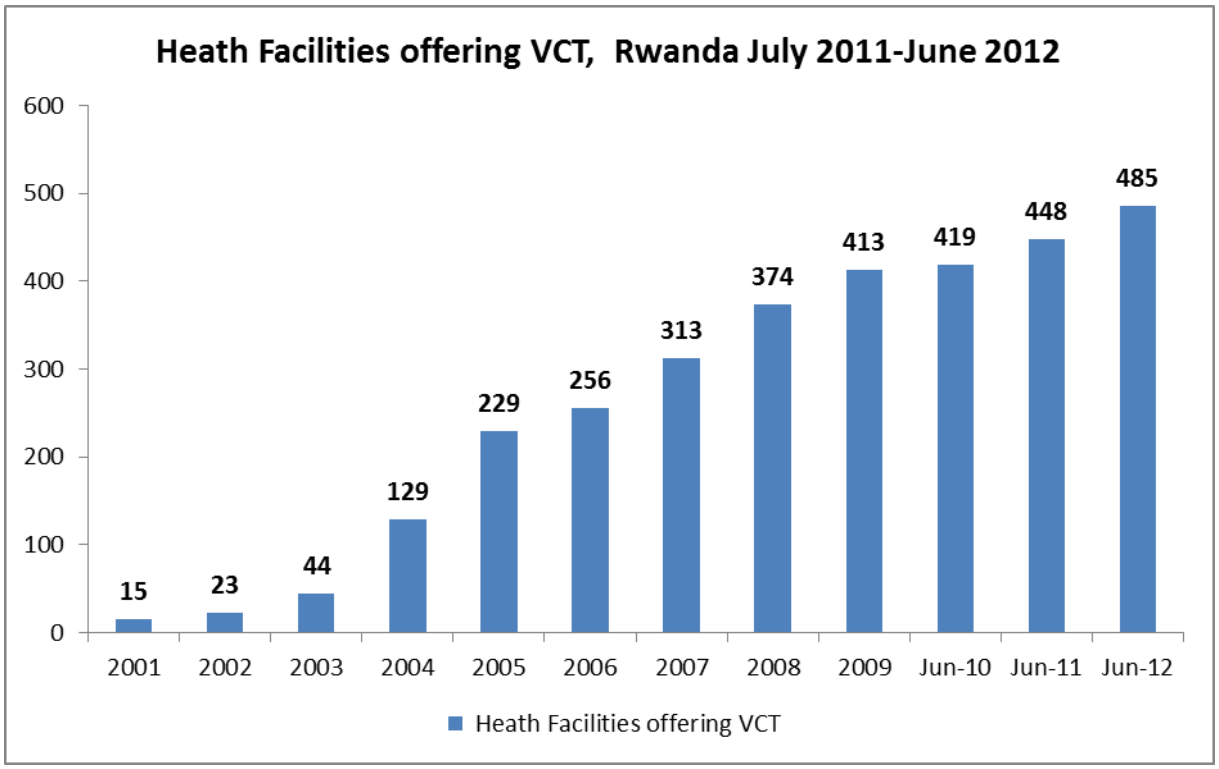
The outreach HIV counseling and testing (mobile VCT) was also carried out at the community level though the collaboration and partnership with community-based organizations, the private sector, NGOs and Faith-Based Organizations with the support of health facilities' staff trained in HIV counseling and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

Since 2003, WHO recommend the use of finger prick blood collection method in HIV testing as this one has several advantages - the test is simple and fast while still maintaining quality. It is less invasive and better tolerated by the clients. In addition, patients spend less time at facilities because of the quick test.

With the collaboration of NRL division and clinical partners, finger prick tools (trainer's manual, provider's manual and finger prick booklet) were developed and elaborated. The multiplication of tools is in process and training of trainers from districts hospitals countrywide are planned.

The scale-up of health facilities offering VCT services contributed to the increase in the number of clients counseled and tested for HIV. There were **2,908,146** tests done in health facilities and mobile VCT from July 2011 to June 2012.

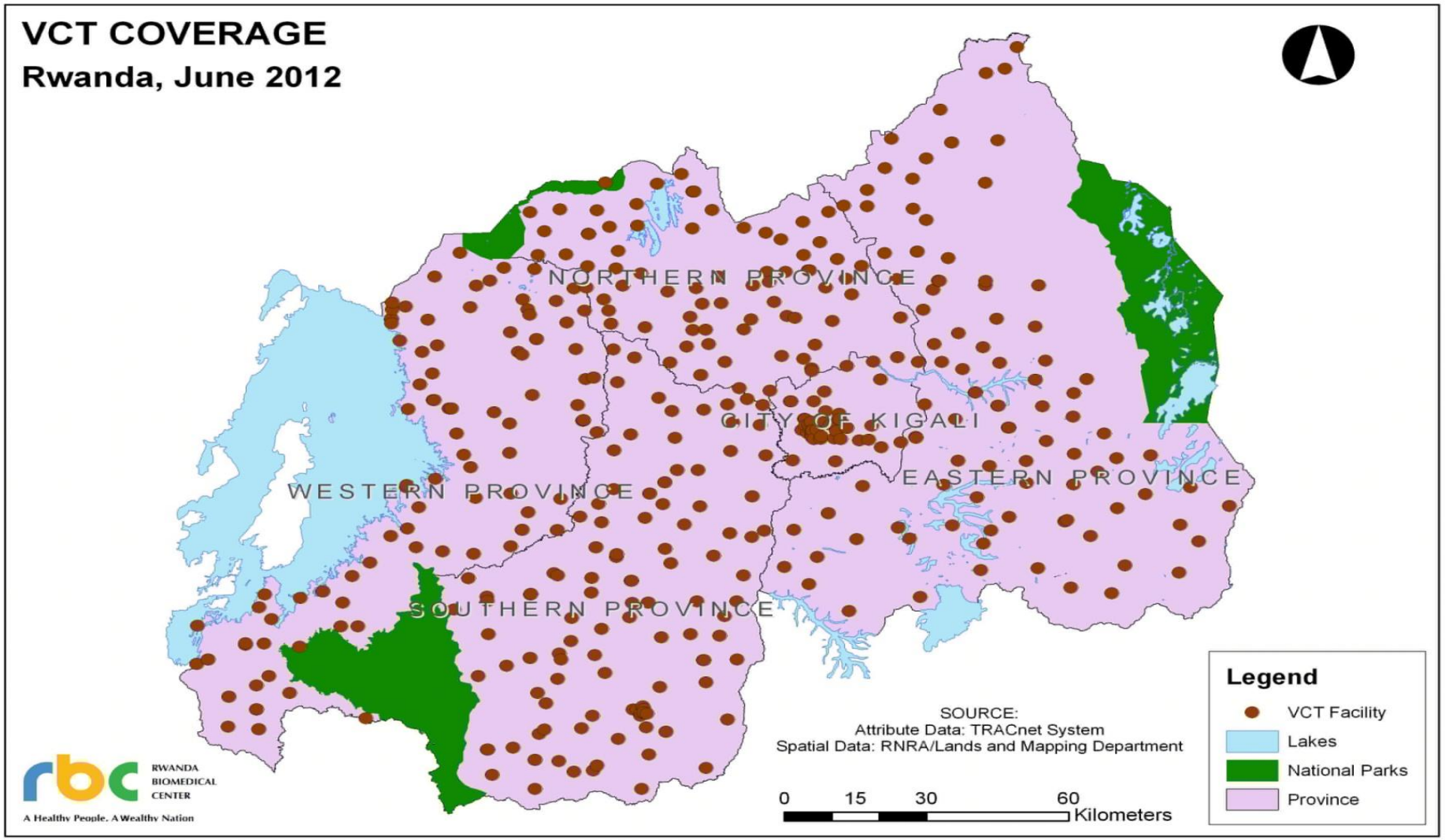
Figure 1: Trend in health facilities offering voluntary counseling and testing since 2001



Source: TRACnet, 2011-2012

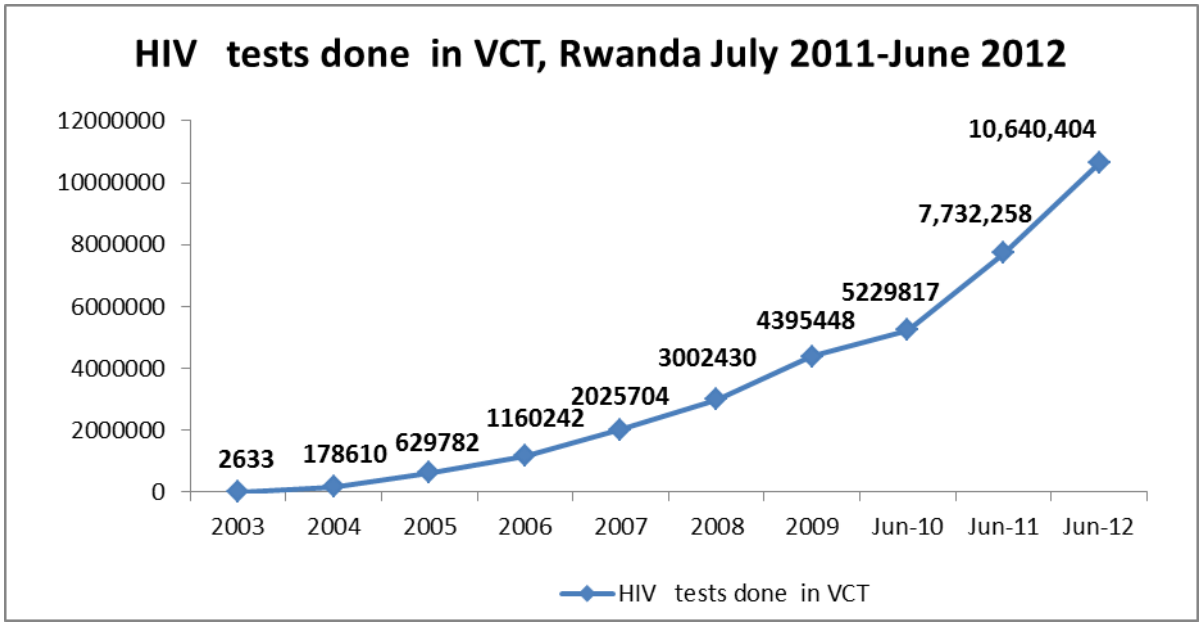
The Figure above indicates a significant increase in the number of health facilities offering VCT, from 15 in 2001 up to 485 health facilities in 2012.

Map 1: HCT Coverage, Rwanda July 2010 – June 2012



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

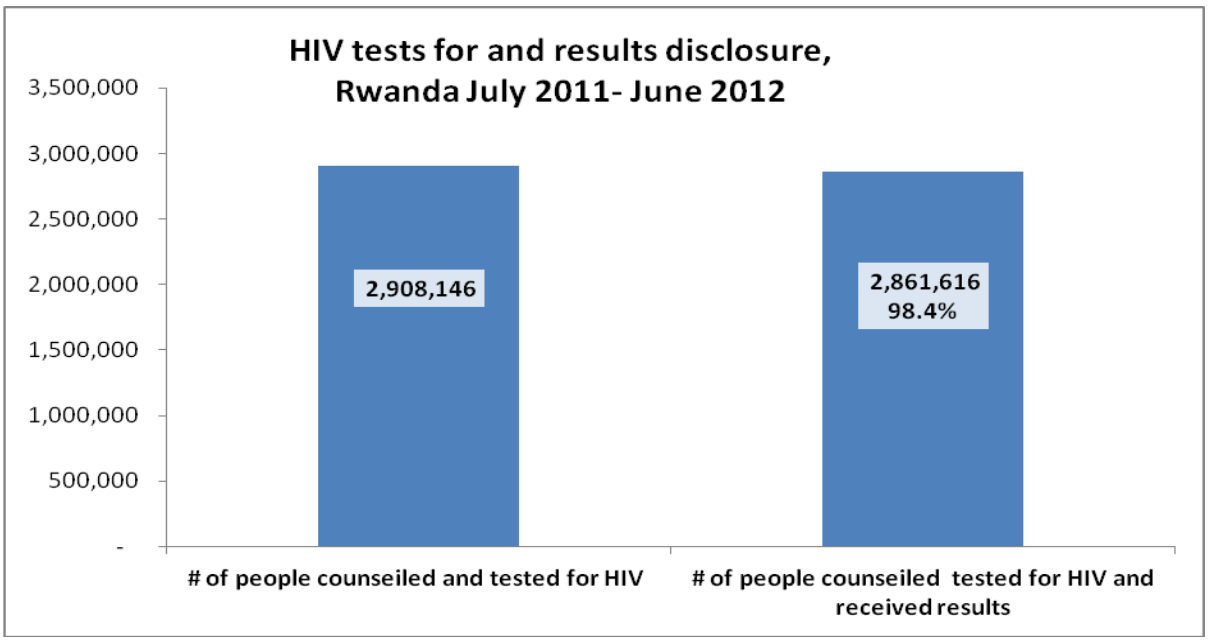
Figure 2: Cumulative number of HIV tests performed from 2003 to June 2012



Source: TRACnet, 2011-2012

The total number of HIV tests performed from 2003 up to June 2012 was 10,640,404. This number includes people tested in both health facilities (VCT&PIT) and mobile VCT.

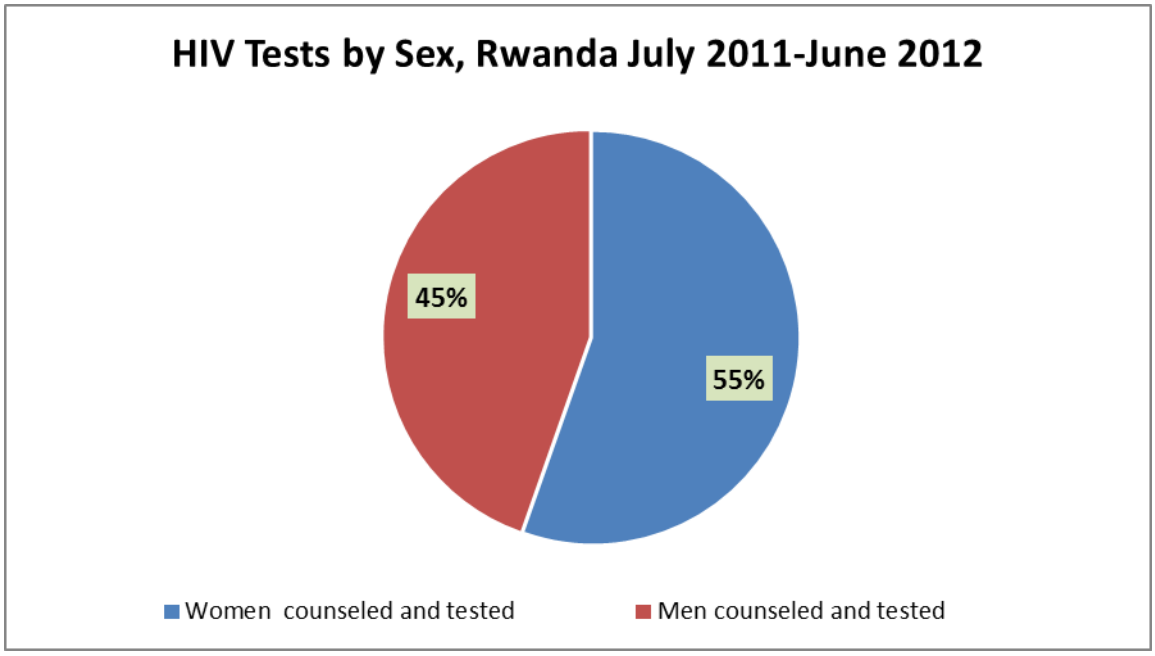
Figure 3: People tested for HIV who know their HIV Status



Source: TRACnet, 2011-2012

Among 2,908,146 people who were tested in health facilities and mobile VCT; 2,861,616 (98.4%).know their HIV status.

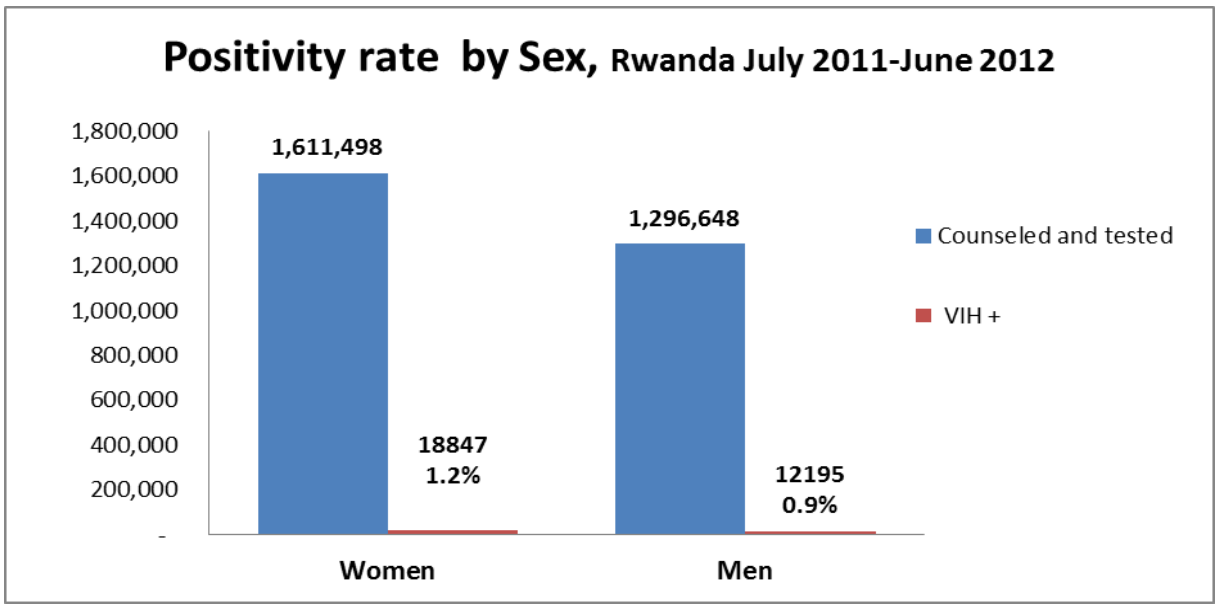
Figure 4: Distribution of People tested by sex, June 2011- July 2012



Source: TRACnet, 2011-2012

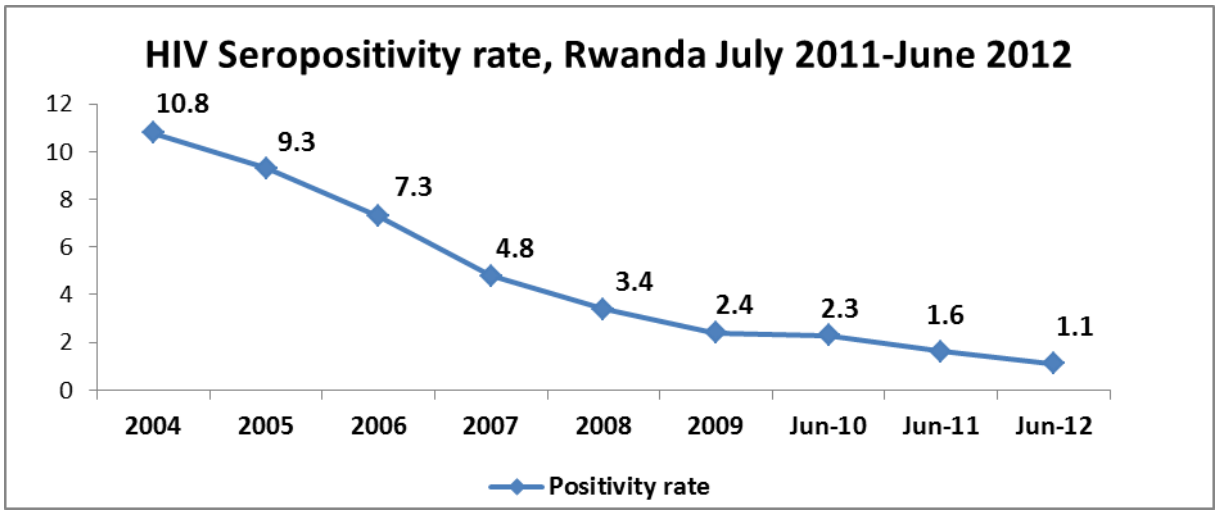
Of the total 2, 956,508 people tested from July 2011 to June 2012, 55 % were women and 45% were men.

Figure 5: Positivity Rate by Sex
During the reporting period, the HIV prevalence was 1.2% in women and 0.9% in men)



Source: TRACnet 2011-2012

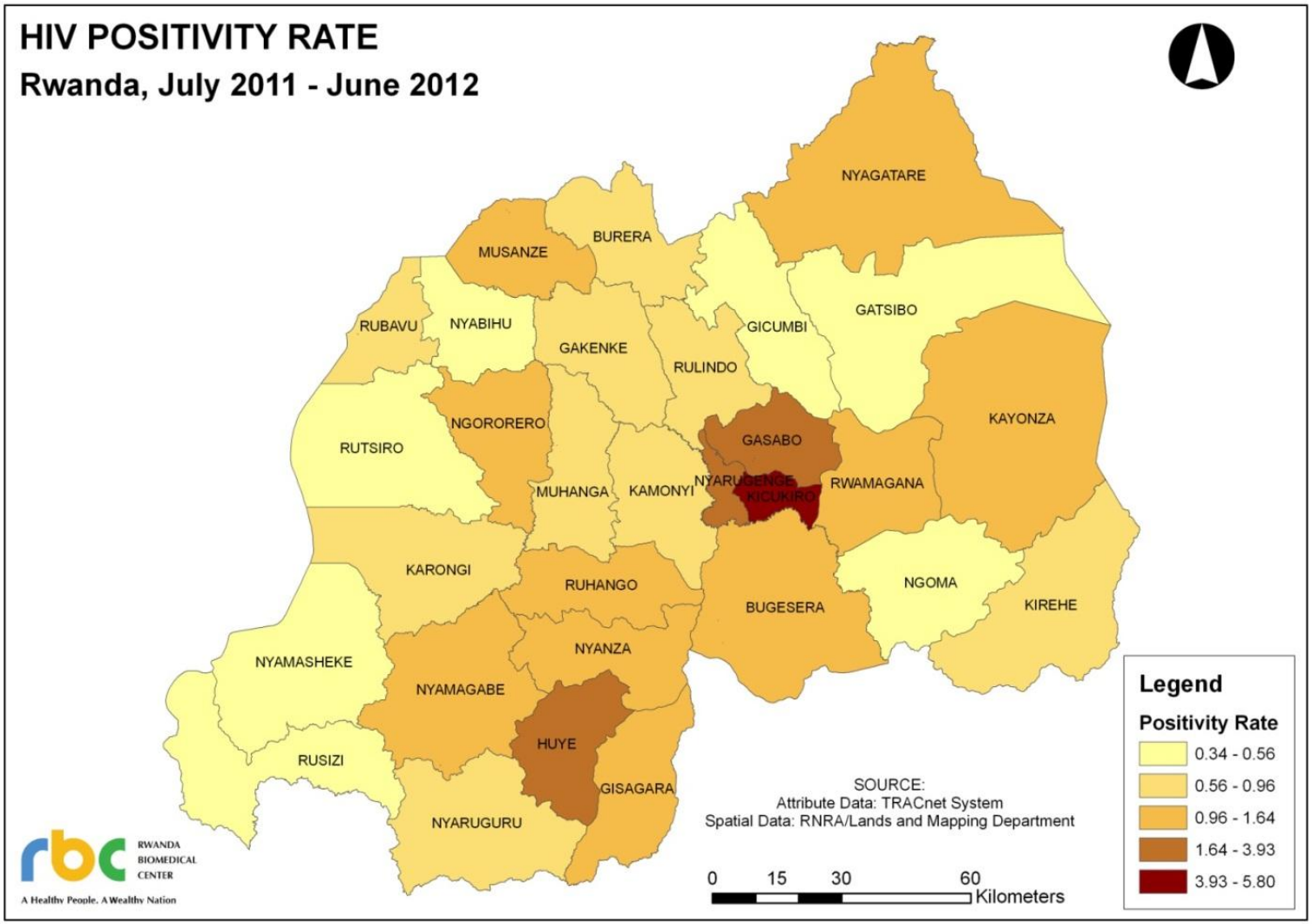
Figure 6: Seropositivity rate among people tested for HIV from 2004 to June 2012



Source: TRACnet, 2011-2012

In the last seven years, the HIV/AIDS, STIs and Other Blood Borne Infections Division has registered a downward trend in HIV positivity rates among clients tested in VCT services, from 10.8% in 2004 (TRAC Report 2004) to 1.1% reported positivity rate at the end of June 2012. The HIV positivity rate is higher in Kigali City and Huye District as indicated in the map bellow

Map 2: HIV Positivity Rate in Rwanda, June20 July 2011-



- **Mobile VCT**

During this period, IHDPC through HIV/AIDs, STIs and OBBI division organized and coordinated mobile VCT activities for specific occasions from July 2011 to June 2012, among them the Ceremony commemorating World AIDS Day (WAD) 2011 under the theme "***Youth let us join efforts in protecting ourselves and others against HIV for a brighter future"***. The launch was on 1st December 2011 at Petit Stade Remera and more than 5000 youth from Kigali city, including Itorero of Secondary schools finalists, participated in this event where they were called upon to utilize the Voluntary Counselling and testing services offered at the event.

The purpose of this VCT was to sensitize youth on Comprehensive Knowledge of HIV &AIDS and to encourage youth to know their HIV status.

During the launch of the World AIDS day campaign, 387 clients were counseled and tested. Among them only 18% (70) were female clients and 317 (82%) were male clients. The proportion of HIV positive clients was 2.06%.

- **Provision of specific counseling services for people with disabilities**

As next steps, tools are in the process of multiplication: CDs and Braille documents. After multiplication, tools will be distributed to health facilities and in specialized centers for people living with disabilities. Refresher training of trainers as well as training of providers are in process of organization.

- **World AIDS Day**

Regarding HIV/AIDS Control, the World AIDS Day (WAD) was launched in December 2011 under the theme ***"Youth let us join efforts in protecting ourselves and others against HIV for a brighter future"***. It was an opportunity for people to unite in the fight against HIV, show their support for people living with HIV and to honor people who have died from HIV/AIDS.

- **Outreach Campaigns**

The outreach campaigns were conducted all year-round (2011-2012) and a total of 11,825 people were reached, with a predominance of women (53 %). During these campaigns, 5542

of 11825 (47%) got tested for HIV&AIDS, again with a predominant attendance of women (54%).

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

In this reporting period, UNWOMEN, RRP+, Kigali Hope Association and FRLS among other networks of women living with HIV in Rwanda jointly developed terms of reference of the technical working group on gender and HIV, which was approved.

Furthermore, RBC-IHDPC key staff-members and CDLS coordinators were trained on how to integrate the needs and rights of women and girls in the planning, design, and budgeting of the HIV response.

2.1.3 Output 1.1.1.3 Sex Workers are reached by comprehensive prevention Programs

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

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

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

The national guidelines for HIV Prevention interventions among sex workers was developed and disseminated. There is a need to implement these guidelines effectively to ensure that sex workers, as key populations for HIV prevention, get optimal health and social services in line with the objectives set out in the HIV National Strategic Plan 2009-2012. We therefore look forward to receiving feedback from the users on areas that need revision and improvement.

We put in place the coordination mechanism for Female Sex Workers (FSWs).

The committee is the multidisciplinary coordinating organ for HIV and AIDS at the District level that collaborates with other steering committees within the District HIV and AIDS

Committee. It oversees the implementation of HIV prevention intervention among FSWs by different stakeholders at the District level in relation to the NSP 2009-2012 and other related policy and strategic documents including the memorandum of understanding and the approved minimum package for services to FSWs.

B. Outreach to sex workers through peer education programs

Training of sex workers, including provision of information on HIV and STIs, condom promotion, life skills and referral for HIV testing and STI diagnosis, violence, reproductive health services VCT and PMTCT, were organized during this reporting period.

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

- Increasing FSW knowledge on HIV/AIDS, STIs, HIV care and treatment, family planning, condom use and negotiation, GBV prevention, the effect of alcohol and other drug abuse/consumption and existing services in the country and locality, etc. This is done through peer education, IEC/BCC material distribution, etc.
- Improving positive behaviors, including reducing the number of sexual partners, consistent use of condoms, increasing the use of modern contraceptive methods, increasing the use of dual contraceptive methods, decreasing drug and alcohol abuse, as well as increasing health seeking behaviors such as STI screening and treatment, HIV C&T, GBV services, care and treatment for those who are HIV positive.
- Improving health services/product accessibility. This is done through active condom distribution through peer education, paying mutuelle de santé for all FSW and their children.
- Reaching FSW partners by including condoms in the minimum package for HIV prevention for sex workers. Currently no specific sex workers' targeted interventions at the country level have started, until results for the population size estimation and site assessment for sex workers are available.

C. Reduce socio-economic vulnerability of sex workers

Through FHI ROADS project, 42 Groups Savings and Loans associations (GSLA) of FSWs were formed to introduce economic strengthening activities among FSWs as part of their HIV prevention and care and support strategy and as an alternative way to gain and save money. To improve alternative income generation among FSWs, the FHI 360/ ROADS II project applied a household economic strengthening strategy framework developed to increase household resilience among vulnerable households.

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

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

In each site, FHI ROADS collaborated with District hospitals, Health facilities, CDLS and FSWs to identify which health facility will be supported to provide health services to FSWs. FHI 360/ROADS II provided the following technical assistance to health centers:

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

As results, 2,139 active FSWs have been identified and are now reached by program interventions; 223 FSWs were trained in peer education; 42 GLSA groups were formed with 1009 members; 1,581 were screened for STI; 1,457 presented with STI syndromes and received treatment; 1,199 were counseled and tested for HIV, 338 were tested HIV positive.

The following were the activities accomplished by FVA:

- **2127** female sex workers were trained in peer education, covering HIV and STIs, cooperatives and life skills, violence and rights, and referral for HIV testing and STIs at District and local level.
- 616 law enforcement authorities participated in advocacy activities to ensure the Female Sex Workers are adequately protected from violence and discrimination
- 2285 FSWs participated in discussion meetings between Female Sex Workers on themes such as health, well-being, and violence and rights (***Support group meetings per person per meeting)*** and provide transport for participants in their meeting with policy making bodies, coordination and CDLS.
- 222 representatives of Female Sex Workers were facilitated to participate in CDLS, Civil Society in meetings and National Conferences.
- 41600 male condoms were availed to FSWs and their clients.
- 5009 FSWs participated in sex workers-friendly events covering HIV and STIs, condom negotiation skills, life skills and referral for HIV testing and STIs diagnosis, violence, reproductive health services VCT and PMTCT.
- 175 FSWs were involved in defining and conducting related activities on advocacy.

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

A. Develop and disseminate IEC tools and guidelines for the inclusion of PWDs in HIV/AIDS programs

During the reporting period of July 2011-June 2012, RBC in collaboration with UPHLS developed the inclusion guide document to be used by different partners for people with disabilities (PWD).

RBC in collaboration with partners also adapted IEC tools to various types of disabilities including large print, Braille, Audio CD, video messages with sign language and image boxes which have been distributed to trainers and peer educators for use in the community awareness campaigns.

B. Disseminate training manual on HIV&AIDS, STI, FP & GBV

This training manual, adapted to people with disabilities to ensure their full inclusion, has been approved in February 2012 and printed copies are being disseminated and can be used during trainings of trainers and Peer Educators.

C. Umbrella Coordinating Bodies of HIV Response

In the year 2011-2012, RBC/IHDPC worked to achieve its objective of strengthening the structures for the fight against HIV and AIDS and among them "Umbrella organizations", by improving the coordination tools to fulfill its mission and by supporting them in various activities related to their action plans.

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

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

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

In addition, different trainings targeting mainly private and public sector HIV focal persons were conducted on HIV work place programs.
For the public institutions, different coordination activities were carried out such as the development of HIV and AIDS annual action plan 2011-2012 (MIFOTRA and Private sector, CSO sector) aligned Strategic Plan for HIV 2009-2012.

MIFOTRA and RBC-IHDPC trained HIV focal persons on M&E and transformational leadership and CSO, as well as skills on planning M&E for the CSO umbrella coordinators at the district level for RCLS and RRP+.

Civil Society Umbrella organization in collaboration with RBC and UNAIDS developed a CSO WEBSITE that resulted from the mapping exercise that that was conducted for all CSO umbrellas and will be updated on a regular basis by selected umbrella focal person.

D. Conduct capacity analysis and capacity development plan

UPHLS with the technical support of RBC/IHDPC conducted a capacity analysis and developed the capacity building plan which facilitated to UPHLS to develop organizational development plan (ODP). The creation of an ad hoc committee on organizational development, which meets regularly on a monthly basis to monitor the implementation of the ODP and advises on the way forward, was also overseen. The report on the capacity assessment also highlights some gaps and missed opportunities of the organization and a baseline survey was carried out. This led to development of a fund-raising committee to make the organization's interventions more sustainable.

There was a technical working group that met on a regular basis to give advice on the functioning of the umbrellas (PWD).

E. Train HIV/AIDS educators about people with disabilities and their needs

Equally important, this reporting period was mainly marked by a total of 130 people who were trained on disability and HIV&AIDS. Those include 10 members of the UPHLS staff at district level. Among all the trainees, 40 over 130 received their first and refresher trainings while 90 others who were first trained last year, were retrained this year.

F. Other Most at Risk Population

a. Fishermen

After mapping of fishermen done in 2010-2011, RBC-IHDPC/SIM Unit has organized the training of peer educators within cooperatives of fishermen around the country. Training of 35 peer educators at the level of fishermen cooperatives of Lake Kivu riverside districts with 7 persons per District (Rusizi, Nyamasheke, Karongi, Rutsiro and Rubavu) leading to a total of 35 peer educators, were trained. They have been trained in different themes related to HIV and AIDS, sexual transmission infections and family planning.

Another series of training for peer educators come out of Nothern, Estern and Kigali City districts. One District of Bugesera holds 30 peer educators of fishermen cooperatives, while Musanze and Gasabo District gathered 30 peer educators of Lake Burera fishermen. The last training took place in the district of Rwamagana and gathered 30 peer educators of fishermen cooperatives of Ngoma District, Kirehe, Kayonza and Rwamagana. This time, themes of training were based on HIV and AIDS, Malaria, TB and Mental health. In brief, the efficient number of peer educators up to now has reached 125 persons.

b. Motorcyclists

This group has formed a federation named "FERWACOTAMO." In the domain of response to HIV/AIDS supported by FHI-ROADS, from July 2011 to June 2012; 91 peer educators (71 in Kigali City and 20 at Rubavu District) have been trained. This includes multiple sensitizations on HIV/AIDS within their respective groups.

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

Up to now, a total number of 651 health providers are trained on couples-counseling and discordant-couple follow-up. Counselors from Kigali and eastern province HCs were previously trained. Discordant couples are also followed up in PMTCT program according to new PMTCT guidelines.

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

To increase demand for condom use and build awareness around condoms, in 2009, 2010 and 2011, RBC/IHDPC and its partners engaged all stakeholders in successive National campaigns for the promotion of condom use and to dispel myths and misconceptions around condoms. These campaigns involved key political and religious leaders including Ministers, Parliamentarians, Governors, District Mayors, popular musicians and other artists, at all central and decentralized levels and aimed at breaking the silence about condoms. Campaigns involved events organized at different levels including football matches, music festivals, radio and television shows broadcast at all national and community stations, competitions and debates in schools, sensitization sessions, organized marching, rallies and use of promotional items like billboards, radio spots, etc.

To address the issue of supply following the successive efforts in demand generation, UNFPA supported RBC/IHDPC in reviewing the condoms supply chain system for the public health sector to ensure condom access to all groups at risk in Rwanda.

These at risk groups include but are not limited to populations at higher risk of HIV, people in organized community groups such as associations, cooperatives, youth groups, youth centers, employees in Government and private institutions, NGOs, students, women without partners, and people living with HIV/AIDS and vulnerable groups of adolescents and young people in and out of school that are at risk of being HIV infected or re-infected, acquiring STIs or becoming involuntarily pregnant. The overall understanding with all key stakeholders (central, district and facility based personnel) was that for the condom distribution system to work, parallel structures should not be created but rather work should be done within the current system to enhance synergies and complement the current efforts.

Consequently:

- A distribution system that assumes the full supply chain system and that ensures enough stock of condoms at national level to absorb the anticipated increased condom consumption has also been designed. The condom supply system describes the distribution, the movement of condoms and reporting channels for proper accountability.
- A standard operational procedures manual for the revised supply chain system was also developed to adequately guide all stakeholders involved in the storage, distribution and reporting of condoms at central and decentralized levels.

The MoH in partnership and support of the social marketing sector initiated the rapid sales outlet creation to increase availability and accessibility of condoms.

With the support of UNFPA, 700 condom vending machines have been procured to support the social marketing sector in increasing the number of condoms sales outlets especially in hotspots including bars, hotels, motels, lodges and restaurants. In partnership with the Private Sector Federation through the Rwanda Hotel Association, UNFPA and PSI-Rwanda, 685 machines have been installed countrywide.

Results:

- The 2010 RDHS reported that 85.6% and 90.7% of young women and men respectively aged 15-24 knew a source for condoms, increased from the previously reported from 37%

and 73% in women and men respectively. Results from the recent 2010 BSS show that condom use at last sexual intercourse among both the youth aged 15-24 and CSWs has increased at 43% and 83% respectively as compared to previous 2000 and 2006 surveys. While 80% of female sex workers used condoms at last sex with a client, the proportion for consistent condom use with a paying sexual partner in the month preceding the survey rose from 28% in 2006 to 33% in 2010.

- Though faced with the challenge of accounting for condoms distributed in the private commercial sector, Rwanda is on course to achieve its target of distributing 26 million condoms annually by the end of 2012. Distribution reports from both the public and social marketing sectors show a substantial increase in annual condoms distribution i.e. over 24 million condoms from 15 million in 2009.

- Condom use/promotion has been integrated in all HIV prevention minimum packages for populations at higher risk of HIV infection except for prisoners.

- The standard operations procedures manual for the condoms supply chain system is under dissemination to all stakeholders at both the central and decentralized levels and different small organized community groups including associations, cooperatives, Anti AIDS Clubs in schools, youth centers, NGOs, peer groups etc involved in HIV prevention are ready to distribute condoms to members especially since potential users in these groups often easily interact for other purposes, creating a bigger window for accessing condoms.

- Condom vending machines complement initiatives for rapid sales outlets creations like blitzing. This could also contribute to reducing the burden of purchasing and distributing free condoms by the Government and its partners especially UNFPA and USAID.

- Following demand by HIV prevention programs among MSM in Rwanda, RBC/MPD with the support of ICAP procured personal lubricants applied to the condom at the time of intercourse, usually used by MSM and commercial sex workers to improve lubrication, moistening and comfort during intercourse.

Challenges:

- About 40% of health facilities which were established by the Catholic Church do not contribute to the promotion of the use of modern contraceptives including condoms.
- Vandalism of condom vending machines.
- Difficulty of estimating needs for personal lubricants.
- Low distributions and awareness about female condoms.

Opportunities:

- MoH has promoted the creation of secondary health posts that complement Catholic based health facilities in the promotion of family planning services including the use of modern contraceptives, including condoms.
- Condom vending machines are a source of income to outlet owners.
- RBC/IHDPC has started the exercise for the Population size estimation of MSM which could inform the estimates and needs for personal lubricants in Rwanda.
- A study for utilization and acceptability of female condoms is in progress. This will help in understanding the need for female condoms.
- Plans to widely distribute female condoms through condom vending machines are underway to increase awareness and availability.

Strategic direction:

To ensure improved responsibility towards safe sex and increased sustainability of these programs, partners need to focus more on raising HIV risk perception. This will weigh down the burden of purchasing and distributing free condoms by the Government and its partners especially UNFPA and USAID.

Other than other reproductive health commodities, all stakeholders in the supply chain system for condoms for the public health sector need to contribute to the dissemination of the guidelines for access to and reporting of condoms.

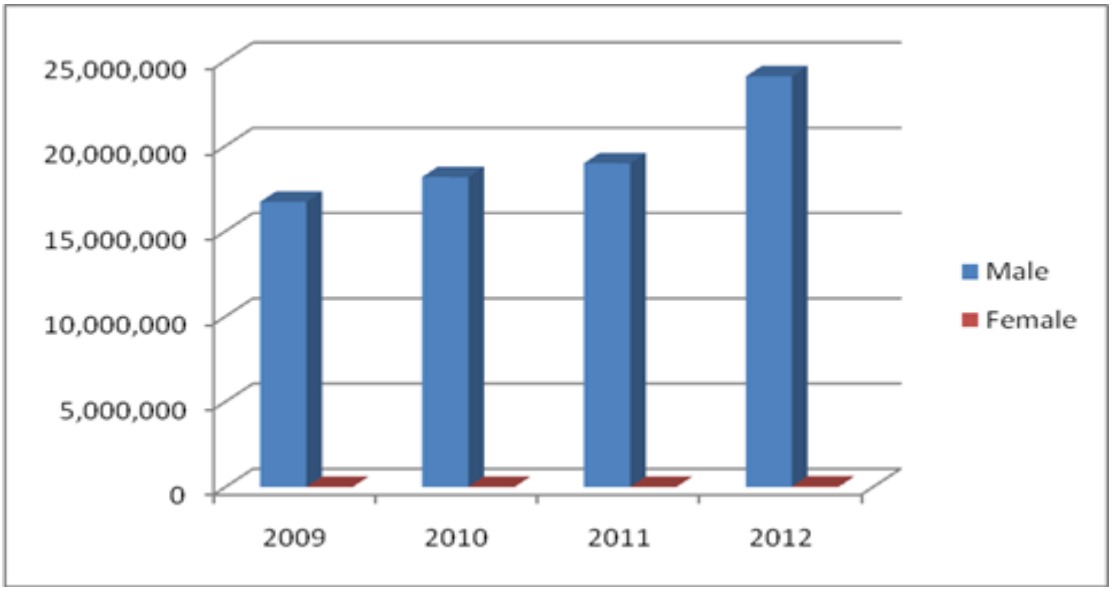
Consistent follow up is needed to ensure that the established supply chain system is functional;

- Open to new stakeholders,
- The new stakeholders are given appropriate orientation to the system, and

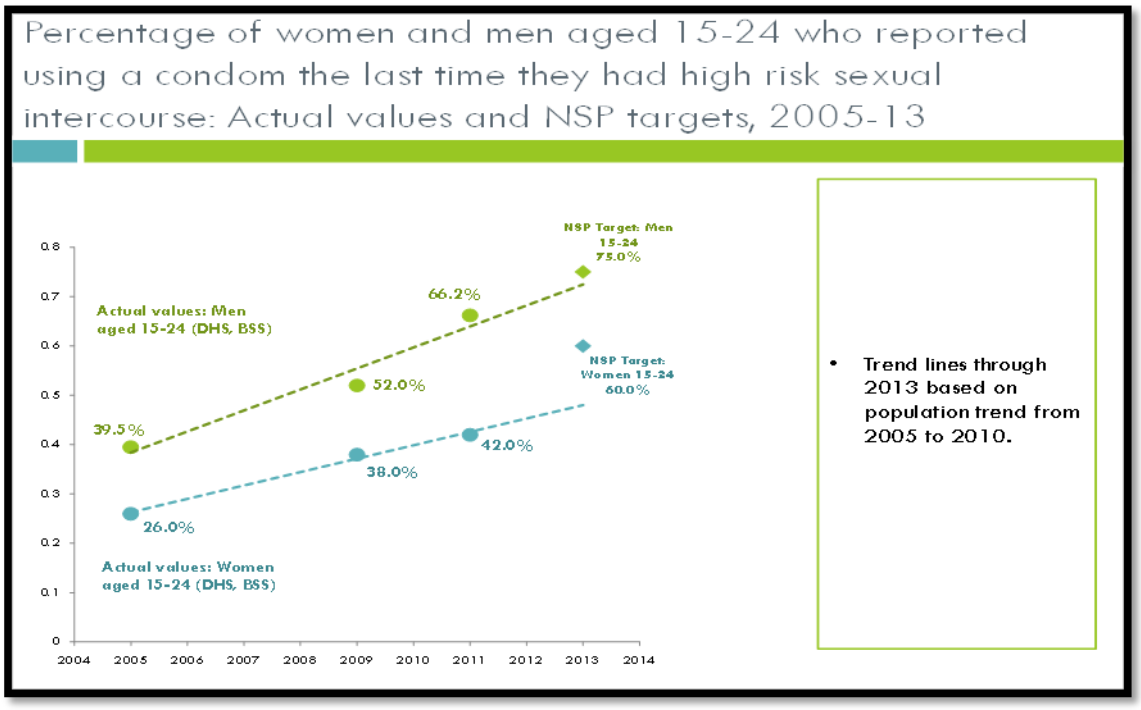
- The system is owned by all stakeholders from the central, decentralized, to community levels.

There is need to develop a comprehensive communication plan for both outlet owners where condom vending machines were placed and the general public to increase ownership and reduce vandalism of the machines.

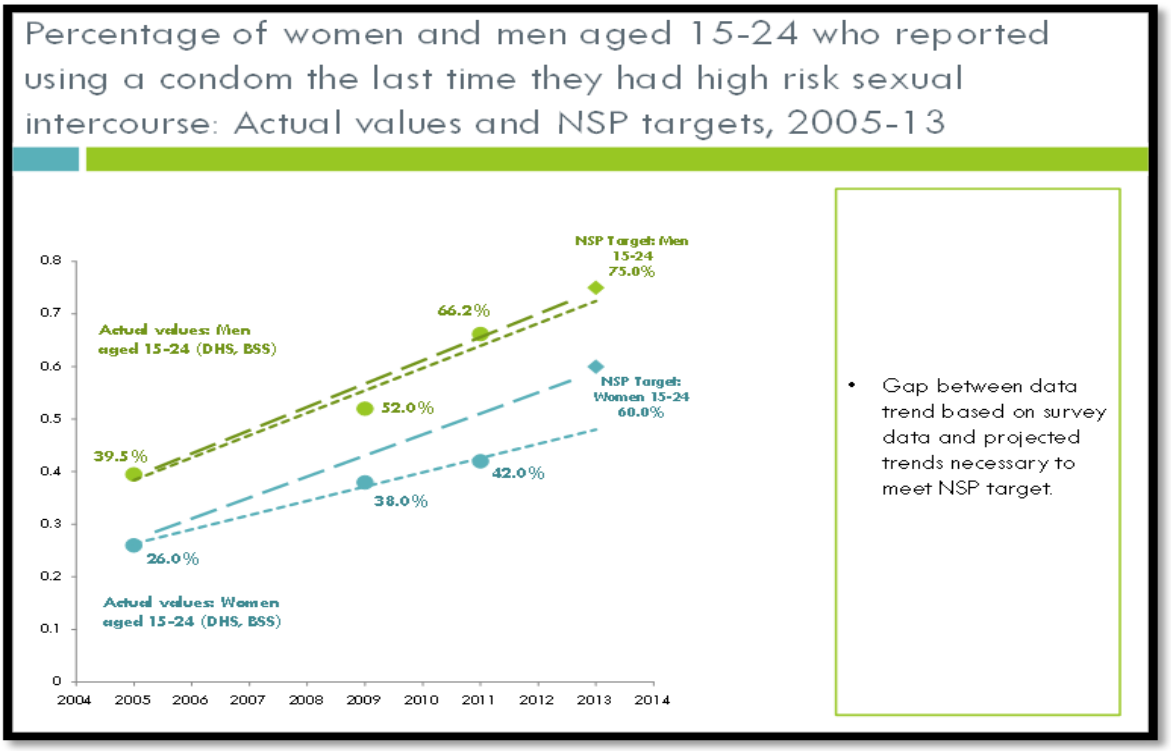
Figure 7: Trends analysis for condoms distributions



Source: RBC/MPDD and PSI-Rwanda distributions data



Source: MTR NSP 2012



Source: MTR NSP 2012

Trends for condoms distribution and use at high risk sexual intercourse among the 15-24 age group demonstrate that there is a remarkable increase in condom usage. However, the data also suggests that the NSP target will be met for young men but not likely for young women. It is therefore recommended to intensify condom education and negotiation skills among young women.

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

A. Advocacy for Integration of Circumcision in Minimum Package of Health Centers

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

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

- Master trainings surgeons and post graduates in collaboration with Rwanda surgical society.
- National Training of trainers: two per 41 districts Hospitals and one medical doctor and one nurse were trained. 82 participants were trained as trainers of trainers to continue with the cascade trainings at health center level.

The provision of MC during weekends has been started in different districts hospitals (Kibagabaga, Gahini and Kabgayi) and is in process in other districts hospitals.
Regarding the procurement of MC kits, in phase one, 38,600 disposable kits were distributed to 40 district hospitals and their health centers which have completed decentralized trainings. The procurement for phase 2 (Reusable and sterilisable in autoclaves) is in process.
In collaboration with TRACnet team, male circumcision indicators have been elaborated, validated, and incorporated in the monthly data collection at district hospital sites and in PBF. Health facilities are reporting on MC indicators since May2012.

Even though there is good implementation in MC, the following challenges need to be mentioned: mostly the availability of MC kits and the consideration of Male Circumcision in *mutuelle de santé.*

2.1.8 Output 1.2.1.1. Increased availability and accessibility of PMTCT services

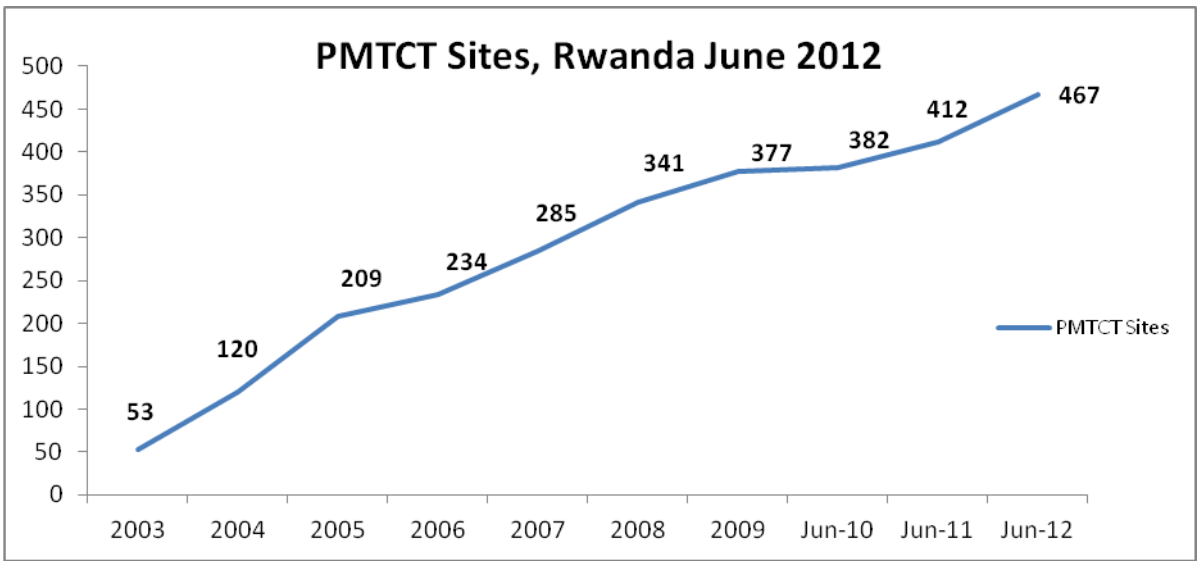
Expansion of integrated PMTCT services in all health facilities and ensure national coverage

PMTCT activities are integrated at the Health Facilities (HF) level into Maternal and Child health (MCH) services. Activities done in various services of PMTCT program between July 2011 and June 2012 included: scaling up Health Facilities offering PMTCT services, increasing the number of pregnant women receiving PMTCT services, providing ARV prophylaxis to pregnant women in need, ensuring adequate maternity and infant follow-up, following discordant couples and availing Family Planning services.

By June 2012, 467 HF were offering PMTCT services, an increase of 55 from the previous year's 412 Health Facilities. This means that 94.5 % of Health facilities (Hospitals and Health centers) are offering PMTCT services. There are 445 health facilities (health center and

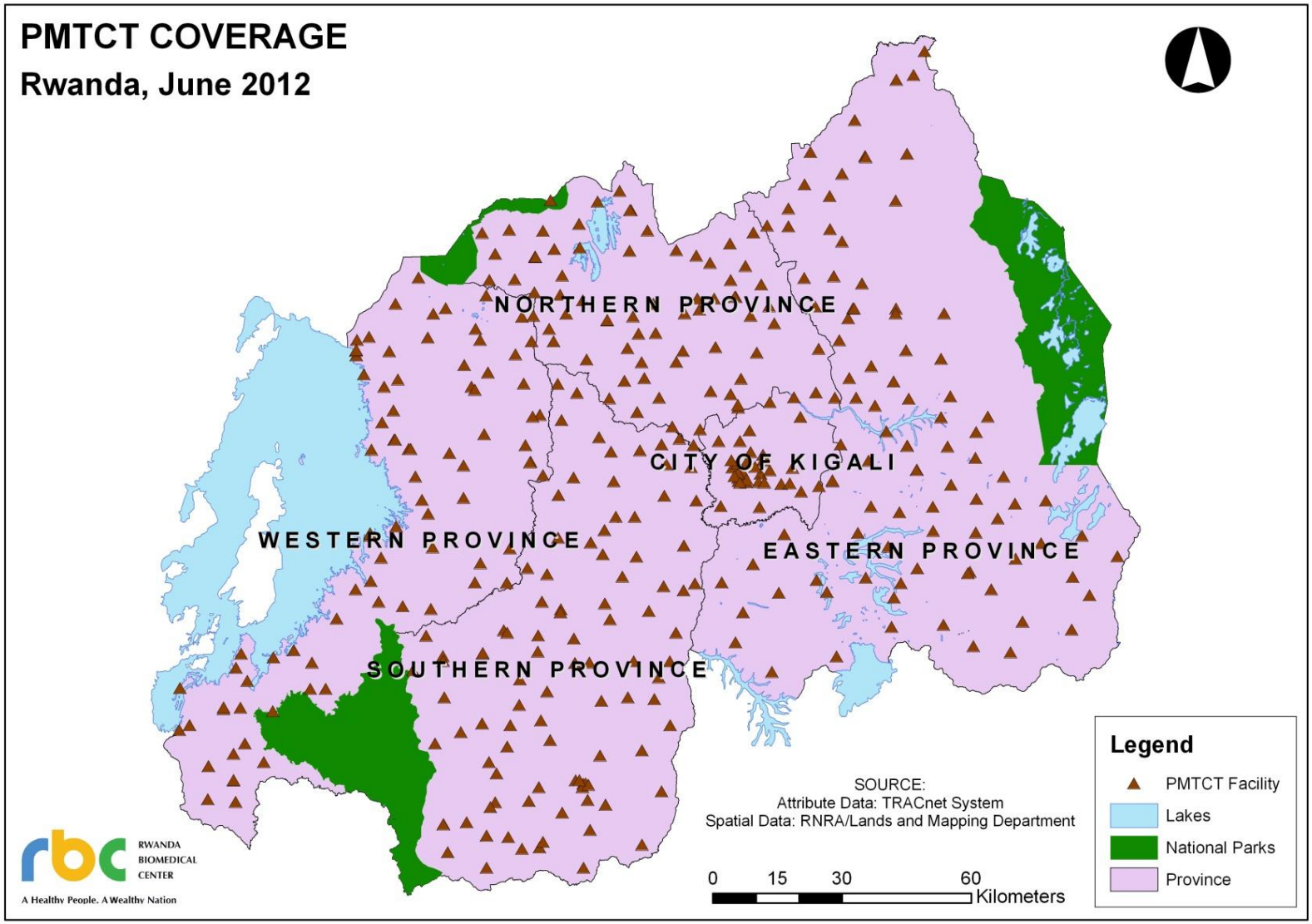
hospitals) collecting samples (DBS) including some District Hospitals for early infant diagnosis for children born to HIV-positive mothers. These samples are sent to the Rwanda National Reference Laboratory (NRL) where they are analyzed using PCR.

Figure 8: Health facilities offering PMTCT services (from 2003 –June 2012



Source: TRACnet, 2011-2012

Map 3: PMTCT Coverage, Rwanda July 2011- June 2012



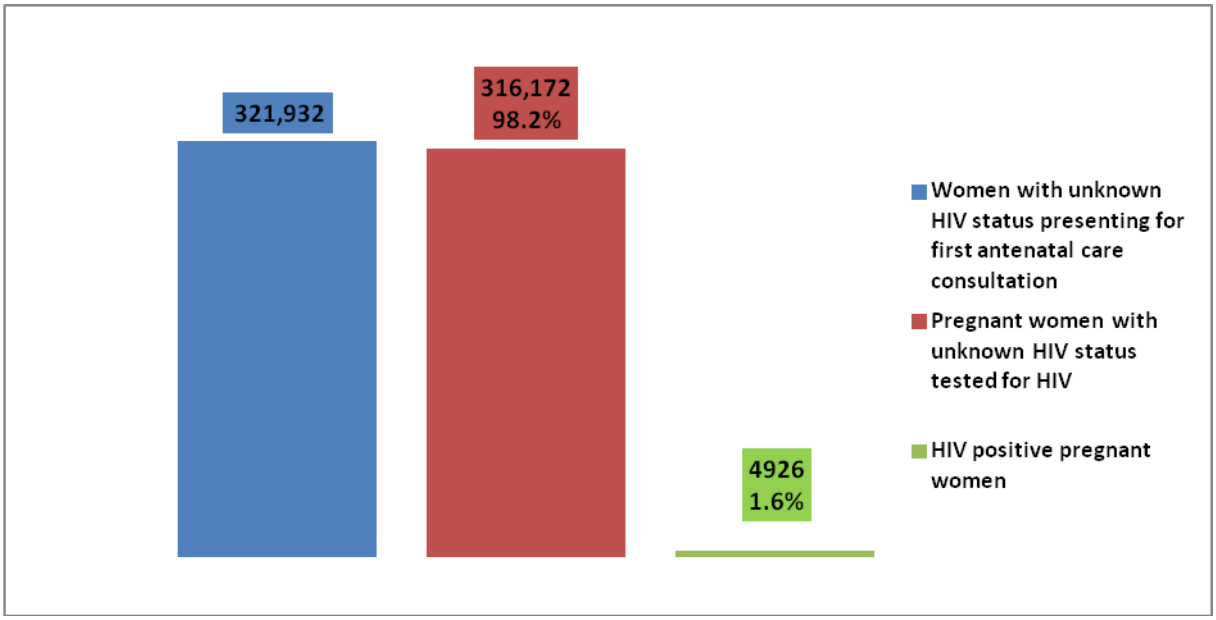
Strengthening integration of PMTCT services in existing health facilities

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

ANC attendance by pregnant women

The attendance of pregnant women in ANC from July 2011-June 2012 was 98,2 %

Figure 9: ANC attendance by pregnant women

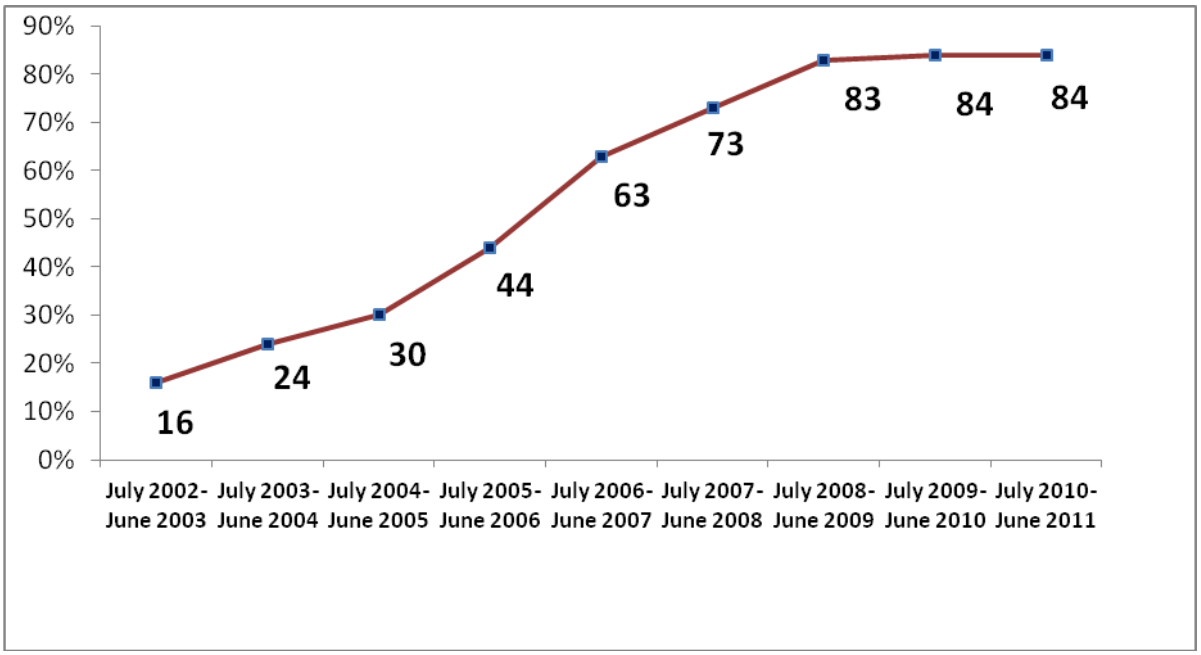


Source: TR ACnet, 2011-2012

Male uptake and family approach for PMTCT

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

Figure 10: Proportion of male partners counseled and tested for HIV in PMTCT, Rwanda, July 2002-June 2012



Source: TRACnet, 2011-2012

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

Map 4: Male uptake in ANC, Rwanda July 2011-June 2012

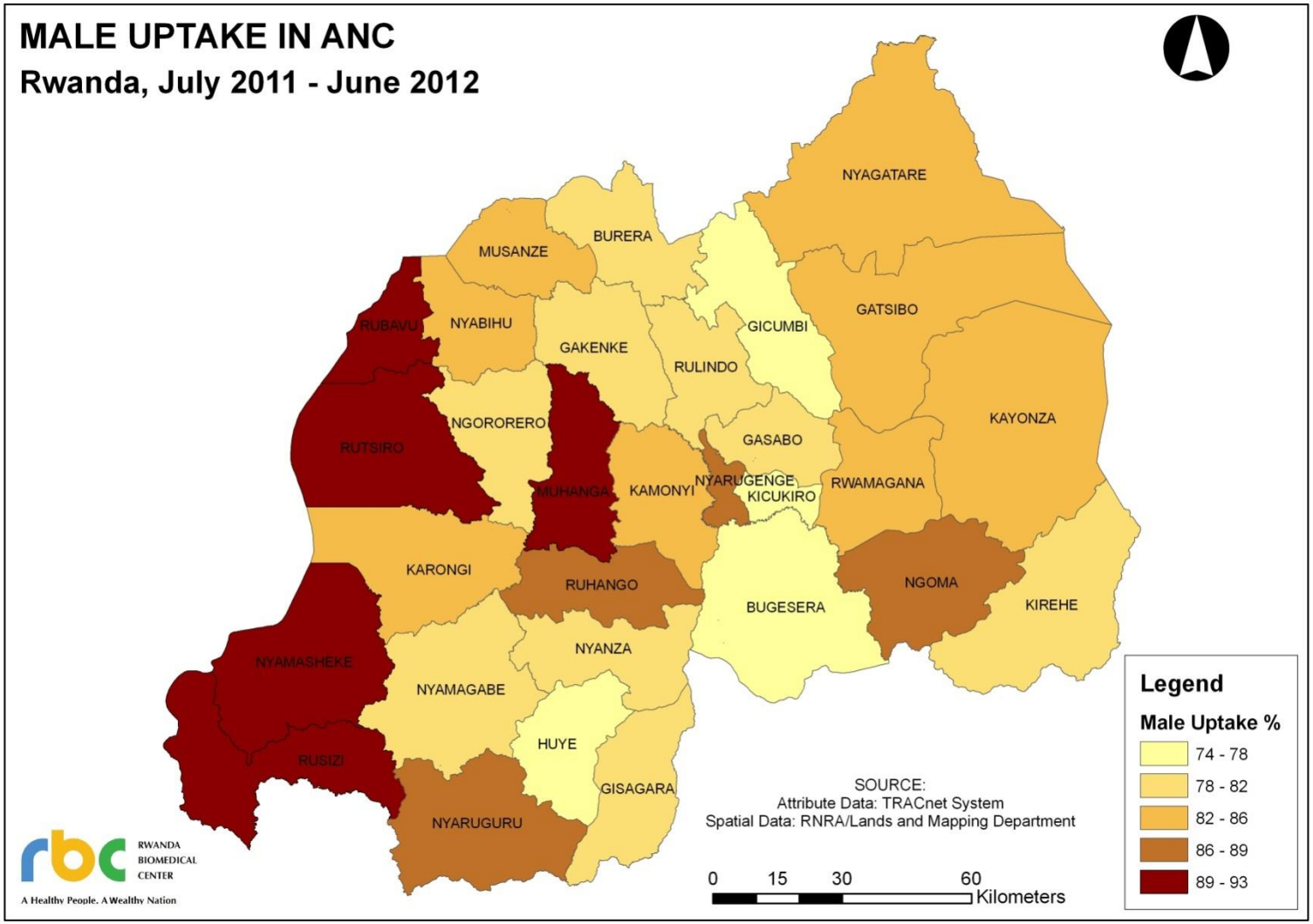
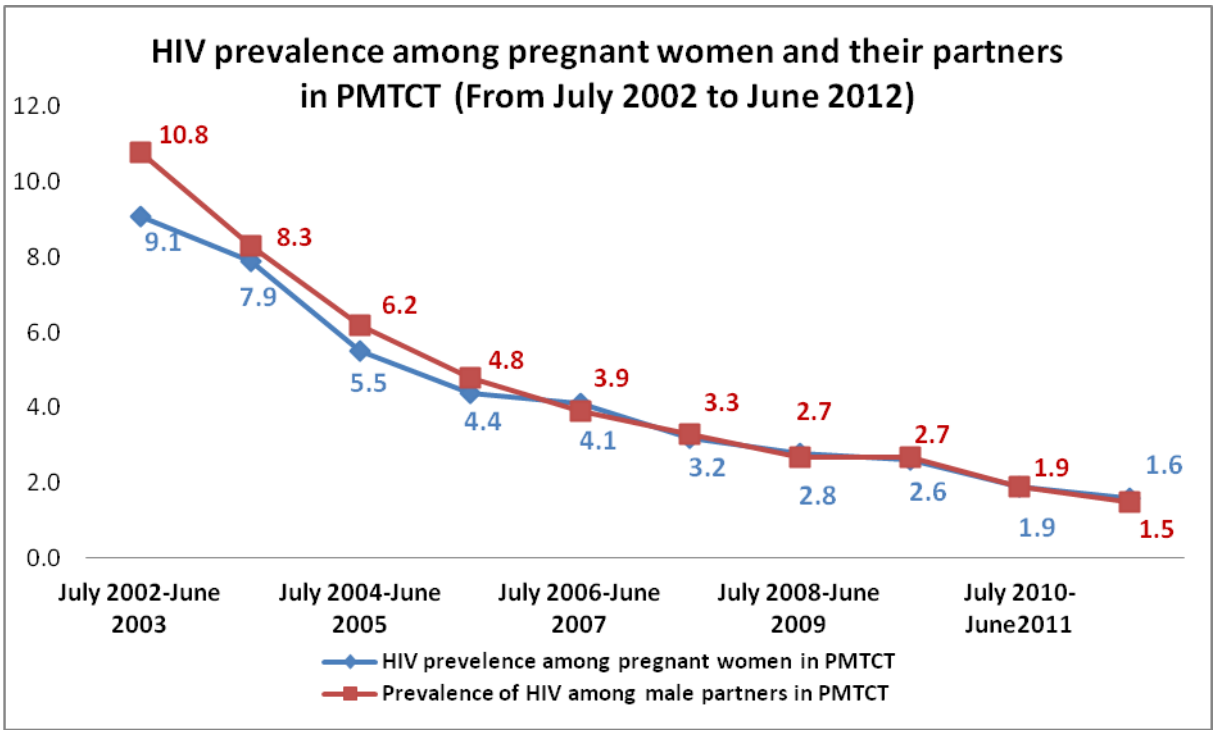


Figure 11: HIV positivity rate among pregnant women and their male partners in PMTCT (July 2002 to 2012)



Source: TRACnet, 2011-2012

The Figure 11 indicates HIV positivity rates between pregnant women attending ANC and their male partners between July 2002 and June 2012.

Increase delivery by pregnant women at health facilities

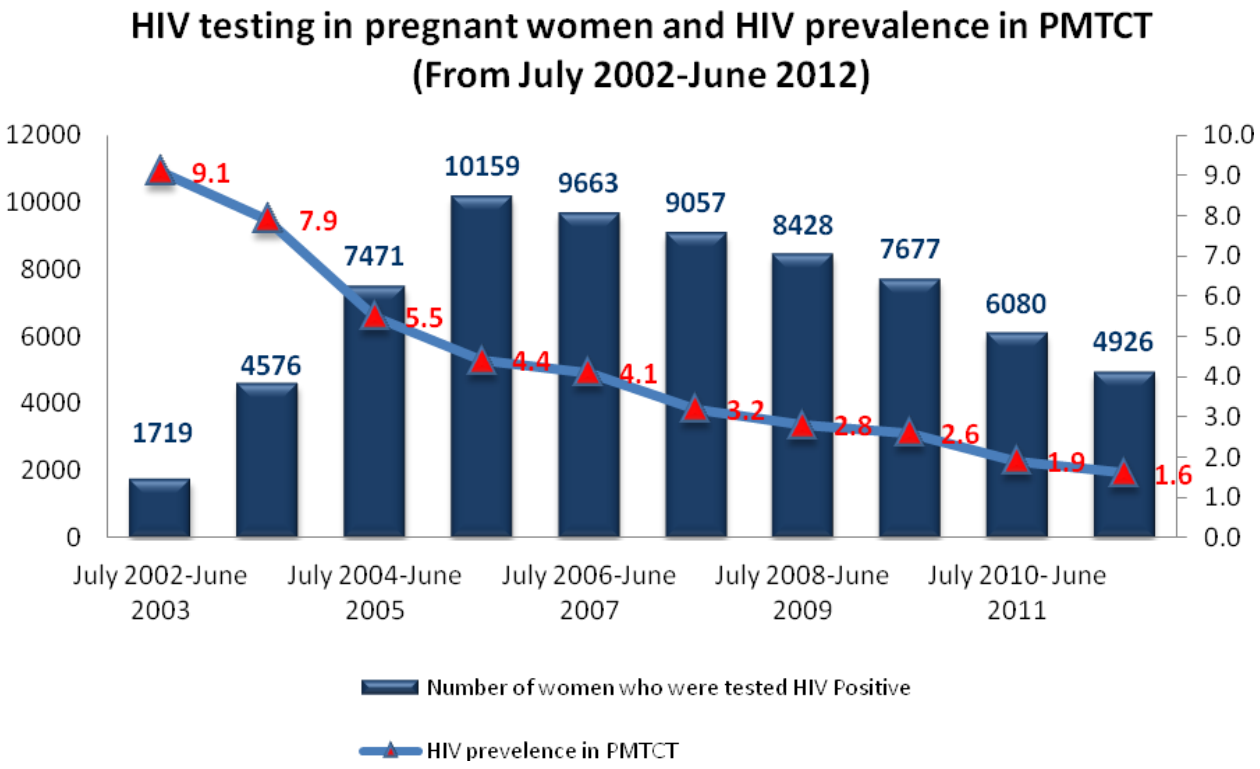
From July 2011- June 2012 a total 368,338 deliveries were expected in the HF offering the PMTCT services. Out of 7303 HIV + pregnant women expected to deliver in HF, 7020 actually delivered in HF and 371 delivered at home but notified at HF.

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

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

The number of pregnant women with unknown HIV status attending ANC from July 2011 to June 2012 was 321,932. Among them, 316,172(98, 2%) were counseled and tested for HIV and received their results; 4926 (1.6%) tested HIV positive (Figure 12).

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



Source: **TRACnet, 2011-2012**

The Figure above indicates the number of pregnant women who tested HIV positive in PMTCT and HIV prevalence over the last 8 years. The HIV positivity rate for pregnant women tested at ANC reduced from 9.1% in 2003 to 1.6% in June 2012.

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

A more effective regimen of ARVs used in PMTCT was introduced in 2005. In accordance with the November 2009 WHO recommendations for PMTCT, a new PMTCT protocol was approved by the Ministry of Health in June 2010. Rwanda chose HAART (Tenofovir based/regimen) for all HIV positive pregnant women from 14 weeks of gestation up to the end of breast-feeding (weaning). The implementation of this new protocol started in November 2010. The update of the above mentioned protocol was done in 2011 where all HIV positive pregnant women receive ART treatment for life.

All HIV infected pregnant women attending the national PMTCT program received ARV treatment according to the current protocol used in Rwanda.

Increased case-finding so that HIV+ pregnant women who initiated PMTCT are followed-up at regular basis

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

Reinforce linkages between health facilities and community

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

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

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

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

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

Improvement of OI prophylaxis and treatment for HIV exposed infants

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

Implementation of strategies for EMTCT

Rwanda joined other countries in EMTCT (Elimination of Mother to Child HIV Transmission) plan. Elaboration of based district plans regarding EMTCT was done in separate sessions. In every session, HIV supervisors and ME officers from districts hospitals

presented their own plans, after discussion received comments from their colleagues from other districts hospitals. As next steps, all plans will be reviewed by HIV division/PMTCT team and sent back to district hospital for the implementation.

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

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

A- FOSA capacity building to treat TB and Reduce the burden of tuberculosis in people living with HIV

A.1. Increase case finding and diagnosis of TB in people living with HIV

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

From July 2011 to June 2012, among 22,428 newly enrolled clients in ART clinics countrywide, 21,361 patients (95%) were screened for active tuberculosis. Among those screened for TB, 1,969 (9%) patients had a positive screening based on a standardized 5-question checklist.

After para-clinical examinations, 675 patients were confirmed to have active tuberculosis and started anti TB treatment in one stop TB/HIV services (Data from TRAC net system).

In the same line of improving the quality of intensified TB case finding and its reporting, we conducted evaluation meetings with care providers and district hospital M&E team from ART clinics nationwide. The meetings took place at district hospital levels and lasted for one day: In total, 393 health facilities were represented (40 DHs and 353 HCs) out of 416 health facilities planned (94%)

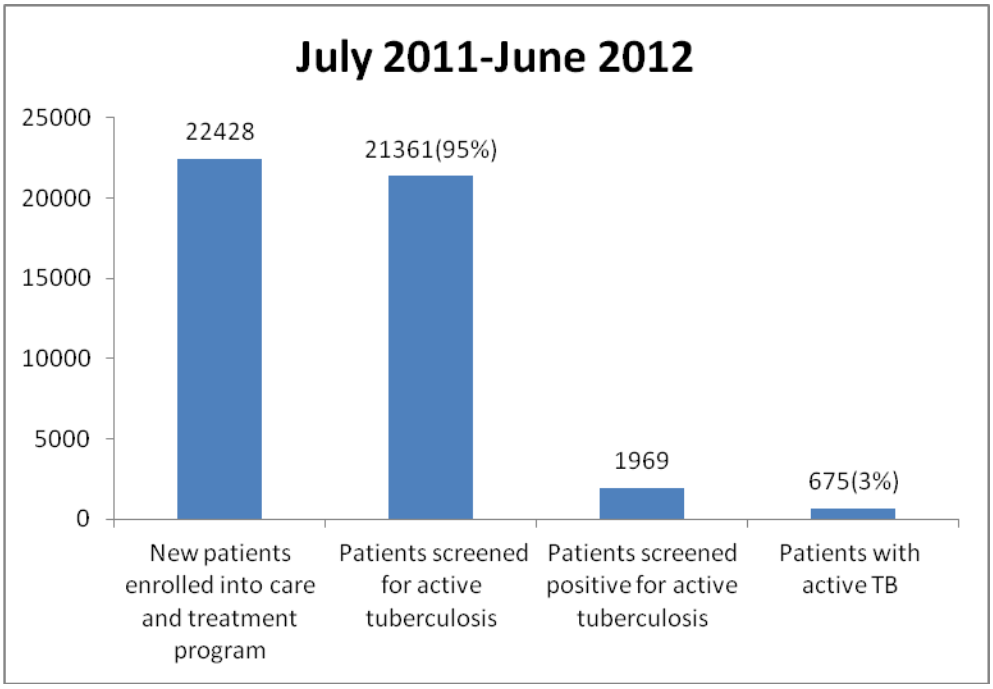
Out of 608 participants expected, 558 (92%) health care workers including DH supervision team, administration and ART clinic nurses attended the meetings

A.2. Provide Isoniazid Preventive Treatment to PLHIV

Providing Isoniazid as preventive therapy to people living with HIV is one of the major three strategies to reduce the burden of TB in PLHIV. Isoniazid is given to PLHIV after a negative TB screening or after ruling out active tuberculosis.

In the same line, since August 2011, IPT was initiated in three pilot sites namely Kabgayi district hospital, Kimironko and Kivumu health centers. As per June 2012, in those 3 pilot sites; 4636 HIV positive patients have initiated treatment on isoniazid. The implementation in those sites is continuing and the scale up in other ART sites is to be taken soon based on experience from pilot sites.

Figure 13: Tuberculosis screening among newly enrolled HIV+ patients (July 2011-June 2012)



Source: TRAC net, 2011-2012

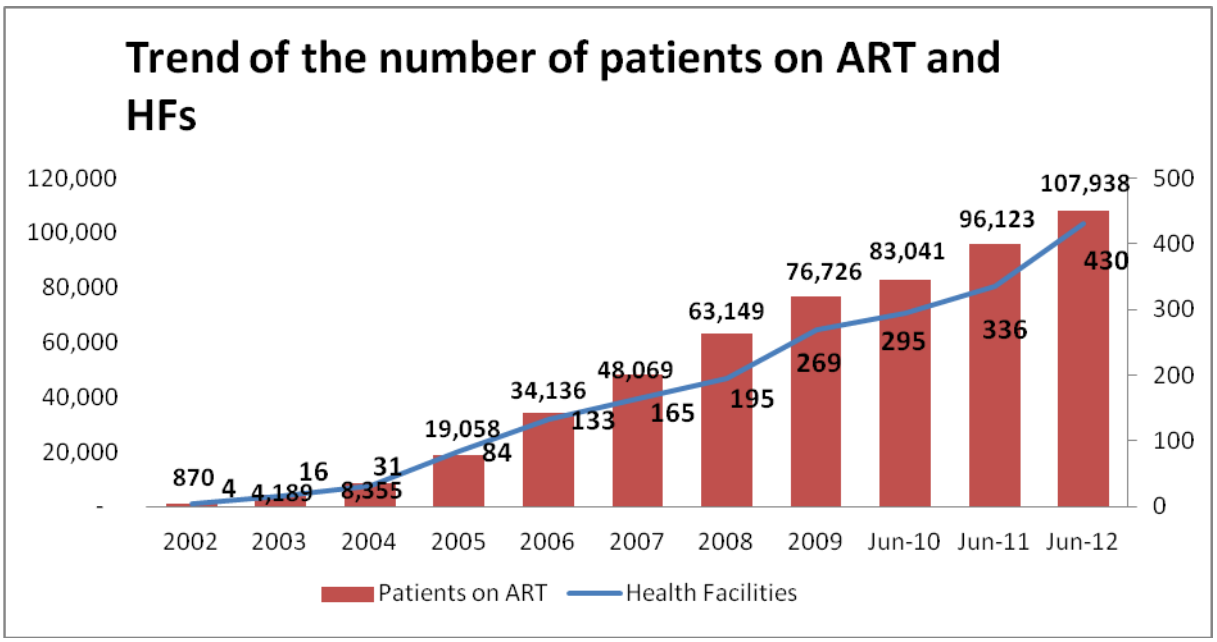
This Figure indicates the number of patients newly enrolled into HIV care and treatment program, screened for active TB, screened positive and those diagnosed with active tuberculosis.

2.2.2 Output 2.2.1.3. Coverage of facilities offering ART is increased

A- Increase the availability and coverage of ART at health facility level

By the end of June 2011, 336 health facilities were offering care and treatment services to persons living with HIV/AIDS, and by the end of June 2012, 430 health facilities were offering care and treatment services. We note that there was an increase of health facilities offering care and treatment services during these last 12 months and in the same way, the total number of patients increased. Since 2002, Rwanda assured large-scale access to ARVs and observed a marked increase in uptake of ARVs almost hundred times to-date from 870 patients in 2002 to 107,938 patients by June 2012.

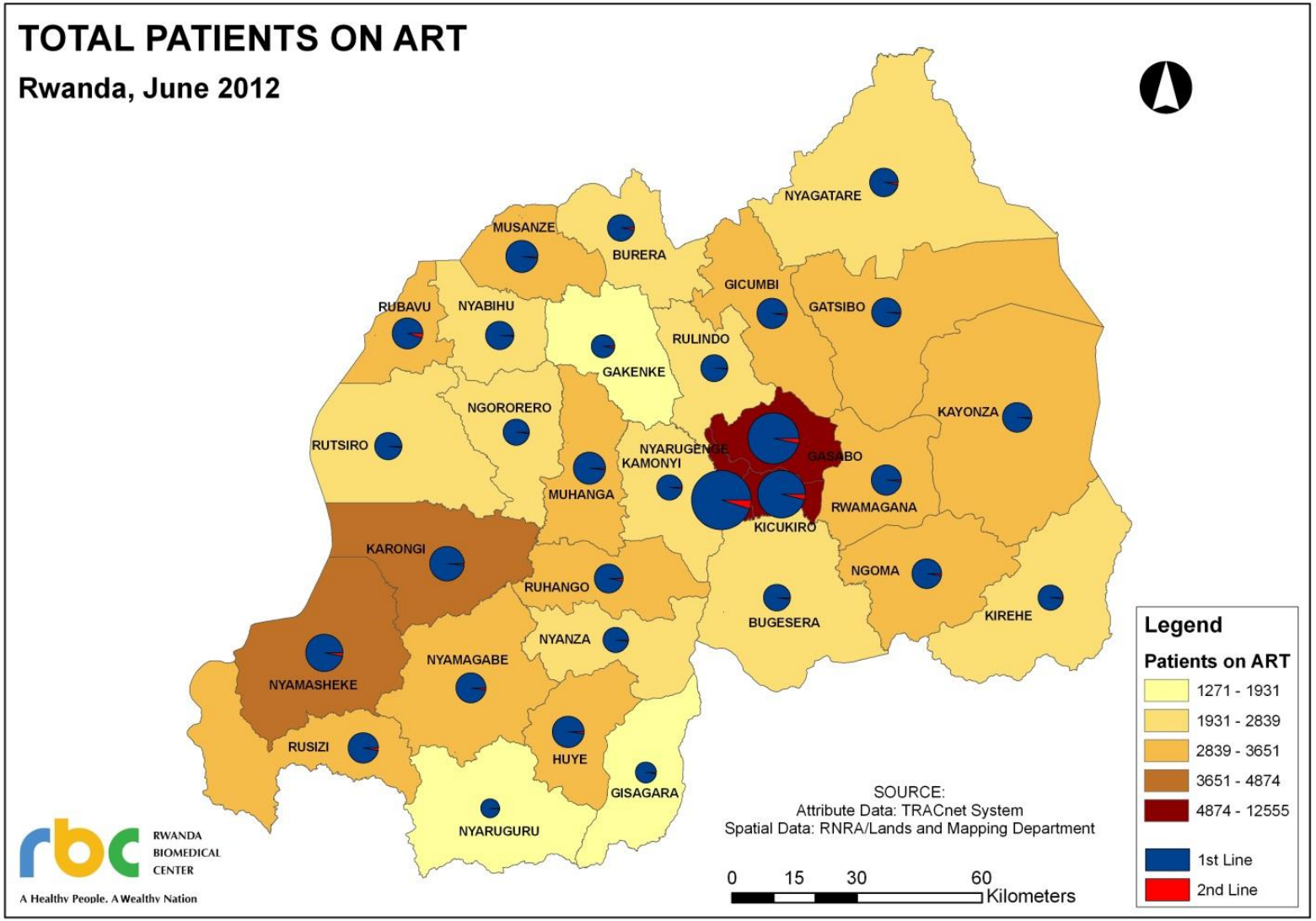
Figure 14: Trend of the number of patients on ART and HFs



Source: TRAC net, 2011-2012

The map below indicates that the high number of patients on ART and the high proportion of patients on second line are located in Kigali city

Map 5: Patients on ART, Rwanda -June 2012



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

During this year, the stock of HIV related commodities was closely monitored in collaboration with the Medical Procurement and Distribution Division (MPDD) and other Implementing Partners through the CPDS mechanism. The stock levels were generally within the range of predefined maximum and minimum levels, except some ARVs not used as expected especially the pediatric formulations and some reagents for clinical follow up of PLWH. The ARV consumption trend was generally in line with the programmatic scale up and the number of patients. However, the consumption of some regimens increased while others decreased.

B- Training of Trainers in HIV Services

With Rwanda's continued focus on capacity building for clinicians around the country, the skill of training facilitation for the nation's infectious disease leaders becomes increasingly important.

In that context, RBC/HIV Division in collaboration with Partners in Health conducted two sessions of training of trainers.

The training aimed at enhancing the training skills of those shaping and implementing HIV prevention, care and treatment in Rwanda so as to ensure that they are effective disseminators of the most up-to-date information; to cultivate a cadre of trainers who are able to share their own training skills with others, thereby building training capacity nationwide; to cultivate a cadre of curriculum and training designers to strategically envision and create training initiatives and learning materials for nation-wide trainings in HIV and other infectious

diseases. During the reporting period of July 2011 to June 2012, the following trainings were conducted

B.1. Training of Trainers in HIV Services

From 3rd to 17th June 2012, the first two sessions of Initial TOT were organized at two different sites (Rubavu and Musanze) a total of 39 participants (15 MD, 17 Nurses and 7 Psychosocial) from RBC, IHI, EGPAF and 10 District Hospitals were trained as Initial Trainers.

B.2. Decentralized Training of Providers on HIV National Guidelines 2011

With the increasing number of people living with HIV in Rwanda, the expansion of antiretroviral treatment to reach all patients who meet the eligibility criteria is one of the priorities of the Ministry of Health. There is evidence that starting eligible HIV-infected patients on ART alleviates their suffering and reduces the devastating impact of the pandemic.

Within its mission of developing and/or revision of HIV and STI guidelines and building capacity of healthcare providers in Rwanda, RBC/IHDPC/HIV Division organized trainings of providers with regard to the new recommendations on national HIV guidelines.

The objective of this training was to offer healthcare providers at different levels, knowledge and skills in HIV and STIs management according to the new national guidelines 2011.

From February to April 2012, seventeen sessions of trainings were organized and a total of 536 participants (38 Medical Doctors and 496 Nurses and 2 Social Assistants) from all over the country have been trained on the new HIV National Guidelines.
At least, one healthcare provider per each PMTCT and /ART offering facility in Rwanda was trained.

B.3. Training of Providers on HIV Drug Resistance Management

In Rwanda, the monitoring of patients on HAART is still challenging and treatment failure very difficult to detect and manage in most countries.

Viral load measurement (VL) is widely used for monitoring ART response and to determine the optimal time for switching to a second-line regimen. The role of HIV drug resistant (DR)

testing in the decision to switch ART regimens remains less clear. In fact, VL measurement can assess adherence and document ART success by demonstrating suppression of HIV replication, and diagnose treatment failure early. Early recognition of treatment failure allows switching regimens at a time when few thymidine analogue mutations (TAMs) have accumulated, thus improving the likelihood that nucleoside or nucleotide reverse transcriptase inhibitor (NRTIs) will maintain their activity in any second-line regimen.

Today, the Rwanda National Referral Laboratory has capacity to perform viral load and drug resistance testing. However, healthcare professionals who should be asking for these lab tests do not know the clear indications of these tests nor how to interpret results and how to use them to make clinical decisions (switching from first line to second line or even from second line to third line).

In this respect, RBC through HIV Division and National referral laboratory organized a training aimed at providing clinicians at district level with skills in early detection and better management of patients with clinical, immunological and virological failures.

Considering the scope and relevance of issues to be discussed during the training, participants were selected from medical doctors working in HIV services and Nurses trained on Task Shifting.

Each district hospital was required to avail one qualified medical doctor and one nurse to attend the training. From 5th to 23rd December 2011 a total of 85 providers (33 MDs and 52 Nurses) from 45 hospitals were trained on HIV Drug resistance and treatment failure.

2.2.3 Output 2.2.1.4. Quality standards for ART are maintained

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

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

New indicators on tracking and tracing lost to follow up clients have been incorporated in TRAC net system and health facilities are reporting on them on a monthly basis and this enables the program at both levels, central and peripheral to get updated information on LTFU. To develop strategies using evidence, a study on lost to follow up between testing

entry point and care & treatment is ongoing and results will help to focalize efforts where needed.

B- PLHIV receive adherence support at FOSAS and in community

Adherence has been always a concerning area for comprehensive care and treatment of people living with HIV/AIDS. In this area, emphasis has been put on adherence through integrated mentorships where health care providers have been initiated to systematic adherence assessment using both objective and subjective methods. A study has been done to evaluate adherence among orphans and no orphan adolescents in Kigali city. Results indicated lower adherence among double orphans (both parents lost).

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

A. PLHIV receive adherence support at FOSAS and in community

Adherence has been always a concerning area for comprehensive care and treatment of people living with HIV/AIDS. In this area, emphasis has been put on adherence through integrated mentorships where health care providers have been initiated to systematic adherence assessment using both objective and subjective methods.

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

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

In addition to the developed training module, M&E tools have been developed for this intervention . In collaboration with involved health care providers, indicators and reporting tools have developed.

- The screening of mental disorders has been enhanced in health facilities where the integration has been initiated. Ongoing mentorship has been done in health facilities where the integration process has been initiated.
- To ensure the scale up of mental health /HIV integration, 2 training sessions have been prepared for 30 district hospitals.

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

a. **Increase capacity and skills of health care providers through clinical mentorship and trainings:** .Decentralized trainings have been done for 74 health care providers in Northern and Southern Provinces where gaps have been identified during mentorship sessions. Again, integrated mentorship with psychosocial and adherence monitoring was done.

b. **Improvement of quality of care of specific groups (mainly children and adolescents)**: This area is a critical one and the RBC/IHDPC-HIV Division has put significant effort in extension of psychosocial services. These support groups (disclosure and support groups) are currently functional in 182 health facilities in the country and ongoing integrated mentorship has been done.

Integrate community support including palliative for people living with HIV

The community support is an important component of care and support of PLWA. The main achievement is the developed integrated community training module and plan for trainings at different levels. The content module combines HIV/AIDS, NCDs, Mental Health, oral health and SGVB.

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

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

Nutrition support for PLHIV on treatment is integrated within all ART services and done according to national recommendations. Different activities are done in the domain such as:

Nutrition support for PLHIV on treatment is integrated within all ART services and done according to national recommendations. Different activities are done in the domain such as:

- Trainings on Nutritional Care and support for PLHIV: 174 Health care providers are trained

- Revision of national nutritional Guideline
- Dissemination of nutritional tools (nutritional register)
- Coordinate nutrition /HIV activities of partners

2.2.6 Output 2.3.1.2. Adolescents Living with HIV receive Friendly HIV services

Caring for adolescents living with HIV is an emerging global issue. The number of adolescents living with HIV is increasing due to perinatally infected children accessing effective ART and growing up into adolescence and adulthood while a significant number of adolescents acquire HIV infection horizontally including engaging in risky sexual behavior. In spite of this reality, most service delivery programs are not yet tailored to the special needs of this age group especially in resource constrained settings.

Adolescent care is an opportunity: To achieve MDG 6 targets: Halt and begin to reverse, by 2015, the spread of HIV/AIDS by reducing HIV prevalence among population aged 15-24 years and to increase the proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS.

During last year, RBC- HIV Division has started the documentation of Adolescent friendly services in HF by development of policy, training of HCP, mentorship

The expected result is the improvement of the scope and quality of services and wellbeing and empowerment of adolescents living with HIV.

Strategic activities to achieve this include the following: site level assessment of needs and available services, staff training in adolescent HIV care, health and development, review and development of tools, empowerment for greater participation of adolescents and their primary care givers through peer education and support and establishing linkages with local communities for sustainable provision of non-medical basic needs.

2.3 IMPACT 3: PEOPLE INFECTED AND AFFECTED BY HIV HAVE THE SAME OPPORTUNITIES AS THE GENERAL POPULATION

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

With Single Stream of Funding (SSF) funds from Global Fund, the SPIU through 90 implementing agencies are operating in 30 Districts, in all sectors (416) where 23.948 beneficiaries have received 3,860,000 USD as the IGA package for 2011-2012.

CHF project "Higa Ubeho" has conducted financial and market literacy trainings and provide technical assistance to 50 cooperatives and pre cooperatives during 2011-2012, exchange visits have been organized for 50 cooperatives and 8 modal cooperatives in order to exchange knowledge, 2107 youth beneficiaries have received youth ISLGs services related on training and kits, 2185 adults ISLGs and implement activities related to adult ISLGs for 43700 Abahizi, 2194 ISLGs have been linked to MFI's and SACCO institutions in order to open accounts and be able to access on loan, 800 TVETs students have been served with school fees and other services related on internship. For the fiscal year 2011-2012, the planned budget in USD was 3,078,584 USD and the used budget was 3,077,414 USD.

- To develop entrepreneurship among people infected and affected by HIV, 3 associations were transformed into cooperatives with RRP+ support, and CHF Higa Ubeho had provide training and ongoing technical support to assist 42 associations of PLWHA to acquire cooperative status, training on development of business plans for cooperatives and technical support to about 10,000 individuals who are involved in small income generating activities.

- During fiscal year 2011-2012, RRP+ has registered 88 new cooperatives with Global Fund support.

- Identification of orphans and vulnerable children (OVC) for education support was done in October 2010 as pilot phase with a total number of 580,878 OVC in secondary, primary/nursery, and vocational training. Through the coordination of National Child Commission implementing partners provided support to OVC on different components included in the OVC minimum package with a total number of 184,149 of OVC supported as reported by partners at the end of June 2012. CHF Higa Ubeho has conducted 13 child friendly School activities.

- RRP+ with partner institution like HAGURUKA has provided the legal assistance for for person living with HIV and AIDS in some judicial cases.

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

Improve food production for PLHA

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

RRP+ has spent around 50 million RwF since 2009 on improving food production for PLHA. In collaboration with the local authorities, the associations supported with the sector agronomist select the best seeds according to the region and fertilizers in needs. Some associations that have operated since 2009 were supported for their own fields in Bugarama sector.

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

Improve management and coordination transparency of OVC programme

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

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

Provision of package of support to OVC

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

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

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

For the awareness of PLHIV and OVC on their rights, RRP+ has developed the manual on human rights with specific objectives of PLWHA's rights awareness.
The development of this manual is intended to contribute to overall efforts to prevent the violation of PLHA rights, by equipping a legal guide that meets their needs on knowledge of human rights, administrative and legal services available in relation to PLWHA as well as possible remedies.

Besides this general goal, this manual also aims to:

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

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

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

3. COORDINATION OF THE NATIONAL HIV RESPONSE -RBC/IHDPC

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

Activities for the fiscal year 2011– 2012 are mainly concerned with the following major activities:

- Integration of the National Strategic Plan 2009-2012 priorities in the action plans of partners both at the national and decentralized levels;
- Strengthening the TA of CDLS and Umbrellas M&E staff through an annual capacity building program;
- Development of new monitoring and evaluation indicators and tools to collect and report on the National Strategic Plan for HIV and AIDS 2009-2012;
- Three months sensitization campaigns on the World AIDS Day and commemoration of this event through community work; Organization of sensitization campaign on cross-generational sex and sensitization campaigns on HIV prevention means including male circumcision;
- Organization of national and international conferences namely: the Fifth International Conference of Exchange and Research, the Fifth National Conference on Pediatric Care of Children infected and affected by HIV and AIDS and follow up of their recommendations;
- Supervision field visits on HIV and AIDS activities at the decentralized level;
- Participation in and support to activities of different partners involved in the fight against HIV and AIDS.
- Support data quality audit team to collect community data from districts;
- In collaboration with human resource unit at RBC, we have evaluated performances and sign performance contracts with all 30 CDLS Coordinators;
- In collaboration with Finance unit at RBC, we have also transferred all funds, at the decentralized level, which were anticipated for coordination and operation of districts. Within that process of collaboration, we have collected financial reports come from districts justified the use of funds sent by RBC at decentralized level.

4. PERFORMANCE BASED FINANCING TO STRENGTHEN THE HEALTH SYSTEM

The PBF implementation is done by the PBF Desk Unit of the Health Financing Unit and the Community Desk Unit of the Ministry of Health. During the first phase of the SSF-HIV project, the following activities were conducted:

A. By the CAAC (PBF Desk Unit)

A.1. For PBF actors' capacity building:

- A Data Analyst was recruited to regularly analyze HIV data related to PBF;
- A workshop on dissemination of PBF HIV data analysis results and review of PBF evaluation tools was organized;

A.2. For monitoring and Evaluation of PBF activities:

- Quarterly analysis of reports from PBF District Steering Committees ;
- All District Hospitals were assessed once per semester by peer evaluators and central level evaluators ;
- All Health centers were evaluated monthly for quantity indicators and quarterly for quality indicators;
- PBF District Steering Committees were evaluated quarterly according to their terms of references ;

B. By the Community Desk Unit

The overall of objective of the Community PBF is to increase access to and the use of key health services especially those linked to maternal and child health. Currently, there exists 444 CHW's cooperatives and 100% of them are engaged in one of the economic activities below. Some of them are operating more than 1 economic activity so as to maximize profits.

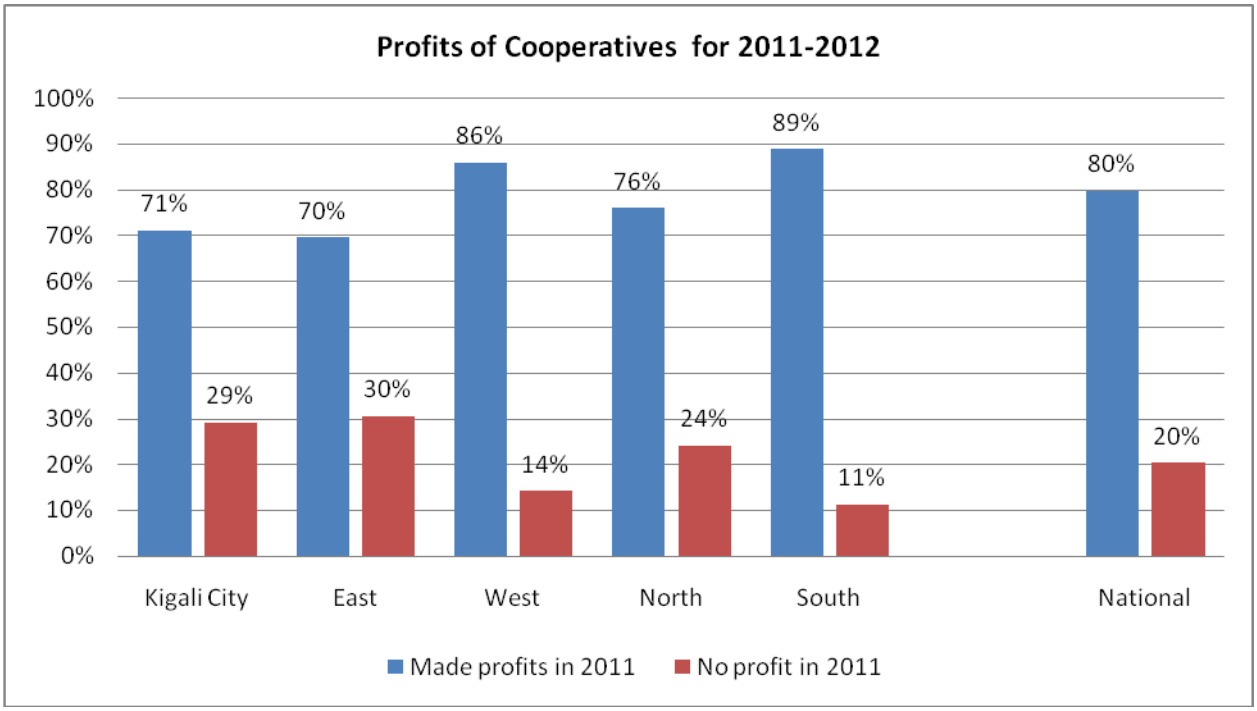
Community Health Workers' Cooperatives: activities achieved are:

- TOT's on cooperative financial management and business planning: over 2,236 participants from 172 cooperatives were trained;

- Follow up made to speed up distribution of PBF funds due to delays observed in the transfer process, and also to ensure that PBF funds are utilized for their planned activities
- CHW's cooperatives have ventured into various income generating projects that are majorly farming, and these include:

- Cattle, Pig, Goat, Rabbit, Sheep rearing.
- Crop farming: maize, beans, mushroom, fruit, cassava and wheat farming.
- Off-farm activities such as transport (motor cycles and commuter cars), rental properties where some cooperatives own commercial and residential houses for rent.
- Sale of building materials such as bricks and tiles.

The figure below shows the profitability of CHW's cooperatives for the year 2011-2012.



PBF sustainability

a. Clinical PBF

During the first phase of the SSF, the current national clinical PBF program was financed by the Government (68% and 57% of the total funding), in addition to external aid from the Global Fund (20% and 34% of the total funding) and the US agencies (12% and 10% of the total of funding).

The CAAC reports that the GOR contribution to the national PBF in Rwanda for the fiscal year 2011-2012 was circa $ US 0.8 per capita. It should be noted though that these are only the costs directly related to PBF.

As shown by the tables above, the PBF scheme has so far been good, it is embedded in the national health policy, second, political support is strong; third, the government purchases, financed from the ordinary budget, a basic package of health indicators nationwide; fourth, various donors are purchasing performance indicators specific to HIV/AIDS, reproductive health and malaria, using the same administrative model. The Government, as an expression of commitment, has increased considerably the budget allocated to purchasing indicators especially for TOP UP of 4 Referral Hospitals (CHUK, CHUB, Rwanda Military Hospital, and Psychosocial Consultation for Outpatients); TOP UP of Specialized Hospitals (NDERA Neuropsychiatric Hospital, SAMU and the Kacyiru Police Hospital), PBF payments made for the minimum package of activities "MPA" for Health Centres, the Complementary Package Activities "CPA" for the District Hospitals and fees for the District Steering committees.

b. Community PBF

Key elements on Sustainability of the PBF scheme at the community level:

a) Skills provided by The NGOs which were recruited to provide technical support to cooperatives in terms of market research, business planning and financial management among others; in addition, MOH is also yet to recruit a local company that will be exclusively responsible for day to day financial and operational issues of the cooperatives;

b) Improving the legal environment: in partnership with the national regulatory authority known as Rwanda Cooperative Agency (RCA), the Ministry of Health ensures that CHW's cooperatives adhere to the national cooperatives policy;

c) Government contribution: Ongoing government support in terms of training and refresher trainings, study visits, field supervisions, financial and operational audits and business advice from the Rwanda Development Board;

d) Establishing the cooperative unions and federations for advocacy and better bargaining power on the market

e) Furthermore, the introduction of a web based financial reporting tool will also enable MOH to make follow up on financial operations.

5. ANNUAL FINANCIAL REPORT ON HIV EXPENDITURES 2011-2012

At the time of production of this report, the primary source of data for HIV expenditures, the Health Resource Tracker, does not yet provide the information for year 2011-2012, as the implementers are presently entering their data into the HRT. It will take a minimum of one additional month before we are able to give estimates of total HIV expenditures for this period using the HRT and produce a reliable report similar to the one included in last year's HIV Annual report (2010-2011). For the purpose of this report, we are using available data from the main funding sources for the national HIV response: the GOR annual budget execution report to estimate the National counterpart, and USG and Global Fund reports for the estimation of external funding for the HIV response.

The table in *annex 4* summarizes the results of the main exercises conducted since the beginning of the HIV NSP (2009-2012) to estimate total annual HIV expenditures in Rwanda. There is quite a bit of fluctuation in these estimates, mainly because the sources of data are different from one year to the next, but also because of variations in the amount of funds available from different donors.

For the national counterpart, which is limited in this table to the GOR contribution, the drop between 2010 and 2011 can be attributed to the different methodologies used for the two years.

The 2009-10 estimate, which was presented in the recent Country progress report (March 2012), is based on the National Health Accounts (NHA) exercise that was conducted to document the year 2009-10 Total Health Expenditures, including an analysis for HIV sub-accounts.

The following year's estimate (2011-2012), although based on the same data source (Health Resource Tracker), was not conducted with the same methodological rigor (NHA has not been conducted for that year), and the reliability of data used has not been verified systematically. Correction was applied to the obtained data, using the estimated percentage of general health expenditures that could be applied to HIV for certain budget lines where expenditures are not identified per disease program (e.g. salaries of health care workers, GOR contribution to the Mutuelles de Santé program – Community-based health insurance scheme –, Community health program and PBF).

For year 2011-2012, since we do not have yet the data from the HRT for this year, we have estimated the GOR contribution using the same percentage (21%) and applying it to the same budget lines as for the previous year. The detailed methodology to generate this estimate of the national counterpart for this year is presented in the following section. The increase in GOR contribution between fiscal year 2010-2011 and 2011-2012 reflects the increase in the GOR total health budget between these two years.

For the main external donors (Global Fund and USG), the changes in the estimated contributions for years 2010-11 and 2011-12 reflect the current trends in their respective funding.

For Global Fund, the major increase is due to the catching up on expenditures in the implementation of the consolidated HIV SSF (Single Stream of Funding) program, which started in the 2010-2011 with delays in disbursements causing a lower than expected level of expenditures. Now that most SSF sub-recipients are operational and familiar with financial management requirements from Global Fund, the level of expenditures has increased and reached its "cruising speed ", with reasonable perspective of reaching expected levels of budget execution for the full first phase of the SSF program (ending in June 2013).

For USG, the decrease in estimated expenditures between 2010-11 and 2011-12 reflects the drop in overall funding allocated by PEPFAR between COP 10 and COP 11 (about 10 million USD difference in total budget). Since we do not yet have a financial report from USG about effective expenditures during COP 11 (which was just completed in September 2012), we are basing this estimate on the same ratio between total budget and effective expenditures as for the previous year.

Methodology for estimation of the National Counterpart

To estimate the GOR contribution to the total HIV expenditures, we have used the same methodology as last year. For each of the budget lines where the health expenditures are not earmarked for different disease programs, but where we know that a significant proportion of these expenses are allocated to HIV activities, we have applied the 21% obtained from the 2009-2010 HRT as the part of the total health expenses that are related to HIV activities. The table in *annex 4* summarizes the exercise done last year, and the similar exercise to estimate this year's contribution from GOR for HIV expenditures.

This exercise, in spite of its somewhat arbitrary approximation, has the advantage to give a realistic picture of the main budget lines from the GOR budget execution report that have a direct impact on the implementation of HIV activities. With this methodology, the GOR contribution to the overall national HIV response has increased from 14.3 million USD in 2010-2011 to 16.3 million USD in 2011-2012. This still represents only a small part of the total HIV expenditures (probably less than 10%), but it clearly shows the continuing commitment of the Rwandan government to increase its investment in the health sector, and specifically in the HIV response.

Conclusions

In conclusion, the main observations that can be drawn from the financial estimations presented in this chapter are the following:

- In spite of the fluctuations explained above, mainly due to different methodologies used but also in part due to changing level of funding from different sources, we can observe a marked increase in the total yearly HIV expenditures in the last three years, mostly driven by the large increase in funding from Global Fund through the HIV SSF.
- The financial contribution from GOR is also increasing steadily, driven by the overall increase in the government budget and specifically in the MOH budget.
- The decrease in funding from USG is expected to continue and possibly deepen in the coming years. With the expected similar decrease in GF funding after 2012, Rwanda has to prepare itself for a drastic change in the overall availability of financial resources to support the HIV response in the short term (after the current year).

6. CONCLUSION

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

Data indicates that financial resources for HIV have continued to increase in 2011-2012 (*Annex 3*) with high level of funding from the main international donors and a continuing increase of HIV expenditures from the GOR. The level of disbursement from the different funding sources is quite low (total HIV expenditures represent only 53% of commitments), but this situation is due to unusual circumstances related to late availability of funds and corrective steps are being taken to improve efficiency in financial disbursements.

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

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

ANNEXES

Annex 1: Financial contributions to the Clinical Performances Based Financing Scheme

Clinical PBF					
Sources of funds	**Indicators**	**Total contributions for 2010-2011**		**Total contributions for 2011-2012**	
		Rwf	**%**	**Rwf**	**%**
	CPA (DH, SH, RH, SAMU)	5 834 293 163		5 879 083 688	
	MPA	1 930 589 655		1 735 586 560	
OB	CP (Steering committees)	136 882 110	68	108 563 805	57
Subtotal Ordinary Budget		**7 901 764 928**		**7 723 234 053**	
	HIV	1 836 852 422		3 321 876 140	
GF	TB	436 789 860	20	1 289 038 751	34
Subtotal GF Budget		**2 273 642 282**		**4 610 914 891**	
IH	HIV	158 136 495		143 640 143	
FHI	HIV	268 835 107		275 605 396	
CDC/COAG	CPA and HIV	675 215 336		675 853 679	
EGPAF	HIV	246 244 193	12	233 584 325	10
Subtotal US Gov Agencies		**1 348 431 131**		**1 328 683 543**	
GIZ		**68 033 995**	1	0	0
Total PBF Clinical Budget		**11 591 872 336**		**13 662 832 487**	
Total Population		**9 820 863**	**100%**	**10 091 009**	**100%**
GF contribution to PBF in US$/c/y		0,4		0,8	
GoR contribution to PBF in US$/c/y		1		1	

Sources : CAAC Annual reports 2010-2011 and 2011-2012

N.B: During the second year of the SSF, GTZ was no longer a grant provider of the PBF fund.

Annex 2: Financial contributions to the Community Performances Based Financing Scheme

Community PBF					
GF	SSF HIV	4 074 143 945	88	8 353 236 796	92
	SSF TB	661 196 500		1 862 815 277	
Subtotal GF Budget		4 735 340 445		10 216 052 073	
GOR	GOR/World Bank	669 149 999	12	745 299 280	7
UN Agencies	WHO	0	0	132 045 977	1
	UNICEF	0		30 130 800	
Subtotal UN Agencies Budget		0		162 176 777	
Total Community PBF Budget		5 404 490 444		11 123 528 130	
Total Population		9 820 863		10 091 009	
GF contribution to PBF in US$/c/y		0,8		1,7	
GoR contribution to PBF in US$/c/y		0,12		0,12	

Sources: CHD Annual reports 2010-2011 and 2011-2012

Annex 3: Yearly estimates of Total HIV expenditures by main funding sources

Source	2008-09 (NSP Gap analysis)	2009-10 (NHA/CPR)	2010-11 (HRT/HIV Annual .Report)	2011-12 (Current estimates)
GOR	14,100,000 (11%)	16,635,507 (11%)	14,338,500 (9%)	16,299,699 (8%)
Global Fund	43,100,000 (35%)	63,649,284 (41%)	55,834,424 (36%)	120,000,000 (57%)
USG	67,600,000 (54%)	74,192,997 (48%)	82,995,106 (54%)	75,000,000 (35%)
TOTAL	**124,800,000**	**154,477,788**	**153,168,030**	**211,299,699**

Annex 4: GOR HIV activities expenditures estimation in 2010-2011and 2011-2012

	Year 2010- 2011		Year 2010- 2011	
	Total Health Exp.	HIV Exp	Total Health Exp.	HIV Exp.
Salaries	$ 30 000 000	$ 6 300 000	$ 28,317,356	$ 5,946,645
Drugs				
Mutuelle (govt)	$ 5 500 000	$ 1 155 000	$ 7,928,431	$ 1,664,171
Mutuelle (population)	$ 45 000 000	$ -		
Infrastructure	$ 350 000	$ 73 500	$ 10,669,536	$ 2,240,603
Quality services	$ 1 800 000	$ 378 000		
Community health	$ 1 800 000	$ 378 000	$ 2,101,238	$ 441,260
PBF (general)	$ 9 400 000	$ 1 974 000	$ 12,610,906	$ 2,648,290
PBF (HIV specific)	$ 2 300 000	$ 2 300 000		$ 2,500,000
Sub total	**$ 96 150 000**			
Central level	$ 1 780 000	$ 1 780 000		$ 858,730
	$ 97 930 000	**$ 14 338 500**	**$ 61,627,467**	**$ 16,299,699**