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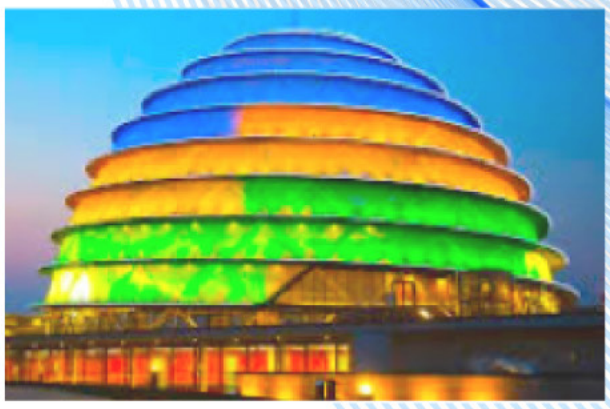
CITY OF KIGALI

HIV/AIDS STRATEGIC PLAN 2018-2023



List of Acronyms

AIDS: Acquired Immune Deficiency Syndrome
ANC: Antenatal Care
ART: Anti-retroviral Therapy
ARV: Antiretroviral
ASRH: Adolescent Sexual Reproductive Health
BCC: Behavior Change Communication
BSS: Behavioral Surveillance Survey
CHW: Community Health Workers
CoK: City of Kigali
DHS: Demographic and Health Survey
EDPRS II: Economic Development and Poverty Reduction Strategy II
EICV: Enquête Intégrale sur les Conditions de Vie
EMTCT: Elimination Mother-to-child Transmission of HIV
FSW: Female Sex Workers
HIV: Human Immunodeficiency Virus
HF: Health Facility
M&E: Monitoring and Evaluation
HMIS: Health Management Information System
HTC: HIV Testing and Counseling
HTS: HIV Testing Services
MS-excel: Microsoft excel
MSM: Men having Sex with Men
NGOs: Non-Government Organizations
NSP: National Strategic Plan
PLHIV: People Living with HIV
PMTCT: Prevention Mother to Child Transmission
RAIHIS: Rwanda AIDS Indicator and HIV Incidence Survey
RDHS: Rwanda Demographic and Health Survey
RGPC: Rwanda General Population Census
SDC: Sero-Discordant Couple
STIs: Sexually Transmitted Infections
SRH: Sexual and Reproductive Health
TWG: Technical Working Group
UNAIDS: Joint United Nations Program on AIDS
UNICEF: United Nations International Children's Emergency Fund
VMMC: Voluntary Medical Male Circumcision
WHO: world Health Organization

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FOREWORD

The City of Kigali has rapidly grown in a modern city in the last decade and it has not only become Rwanda's most important business center but also the main port of entry.

The City of Kigali which started in 1907 is one of the safest and friendliest of African capitals. It is blessed with a moderate high altitude climate that belies its tropical location, and is conveniently located within three hours' drive of the main tourist sites. The Rwandan capital provides both a comfortable and welcoming introduction to this land of a thousand hills and an ideal springboard from which to explore this magical country.

The City of Kigali continues to host a highly mobile population comprised of rural to urban migrants which has implications on the accessibility of health services. With additional factors such as poverty in the ever growing informal settlements and lingering stigma and discrimination particularly among key population and young girls, the risk of contracting HIV significantly increases.

In Rwanda, HIV prevalence has been stable since 2005 and remains at 3% among adults aged 15–49 (4% among women and 2% among men). The prevalence of HIV is higher in urban areas (6%) than rural areas (2%); HIV prevalence is 6.3% in the capital city of Kigali and 2–3% in each of the other provinces.

The global data show that 1.8 million young people living with HIV, registers 250.000 new infections among them, and AIDS related deaths are the leading cause of death among these adolescents and girls constitute 7 out 10 new HIV infection among adolescents aged 15-19 years. In addition, although improving, antiretroviral therapy (ART) coverage of children living with HIV remains unacceptably low. Only 63% of children living with HIV were on ART by 2015. In Rwanda, the young people (10-24 years) group represents 32% of the general population. Recent data from RDHS 2015 and RAIHIS study show that HIV prevalence among adolescents and youth aged 15-24 years is around 1% and HIV incidence for the same age group is 0.22 per 100 person years.

Considering the high HIV prevalence of 6.3%, Kigali City is clearly the epicenter of HIV epidemic in Rwanda and extra efforts need to be put in place to enable people living with HIV access treatment and the HIV negative population, majority of whom are adolescents and young people access HIV prevention services. The City of Kigali (CoK) has recommitted to the fight against HIV/AIDS by signing of the Fast-Track AIDS from Paris Declaration of 90-90-90 targets on ending the epidemic in cities and urban areas. A Fast-Track AIDS response means that by 2020, 90% of people living with HIV will know their HIV status, 90% of people living with HIV who know their status receive HIV treatment and 90% of people on HIV treatment have a suppressed viral load.

The present City of Kigali strategic plan outlines all identified bottlenecks and proposed solutions, the strategic actions for implementation of the HIV and SRH interventions based on results framework with targeted and costed activities. The logical framework of this strategic plan has set baselines and targets to be achieved at level of the city in general and district in particular. The development of the City of Kigali HIV & AIDS Strategic Plan 2018-2023 is a clear indication of the Government of Rwanda's commitment to addressing the challenges of HIV and AIDS in the City. This strategic plan is aligned with the recently extended Rwanda HIV and AIDS National Strategic Plan 2018-2020.

We urge all stakeholders and partners to use this strategic plan to fast-track the HIV and SRH response in all districts' areas of the City of Kigali they are supporting towards achievement of the 90-90-90 targets. In addition, the City of Kigali, under my leadership, is committed to facilitating the achievement of the goals of this strategic plan by mobilizing and allocating required resources and also engaging with public private partnerships (PPPs).

Marie Chantal Rwakazina
Mayor
City of Kigali

ACKNOWLEDGEMENTS

This City of Kigali strategic plan for HIV and SRH programmes was developed by the City of Kigali (CoK) in collaboration with Rwanda Biomedical Center (RBC) through HIV/AIDS, Sexually Transmitted Infections (STIs) and Other Blood Borne Infections (OBBI) Division. The process went through engagement with various stakeholders including the Government of Rwanda's institutions in charge of HIV and adolescents' health, the Development Partners, and Representatives of Adolescents and Youth networks. The CoK acknowledges every individual and organization that participated in these consultations and activities.

In particular, we acknowledge technical support from UNICEF, UNAIDS, UNFPA, WHO, CDC, PEPFAR, EGPAF, USAID University of Maryland, MYICT, MIGEPROF, Imbuto Foundation, and the NGOs working with the Adolescents and Youth.

Special appreciation also goes to UNICEF and UNAIDS for financial support. Additional thanks go to the core team in the coordination of all activities of this in-depth analysis, Prof. Leon Mutesa (the consultant who developed this document), Mr. Eric Remera, Mr. Dieu Donne Ruturwa, Mr. Jean Claude Ibambasi, Dr Dan Rutayisire, Dr Grace Muriisa, Dr Fabian Mwanyumba, Dr Muhayimpundu Ribakare and Dr Sabin Nsanzimana, along with other colleagues for putting together all the information to produce this document.

Being the first of its kind for the City of Kigali, this strategic plan for HIV programmes will lay the foundation for implementation of HIV and SRH interventions and for monitoring and evaluation of AYP programme in the city, and ultimately provide direction for the expansion of work with adolescents and young people.

EXECUTIVE SUMMARY

The HIV prevalence in Rwanda has been stable since 2005 and remains at 3 percent among adults age 15-49 (4% among women and 2% among men). The HIV prevalence is highest in the City of Kigali (6.3 percent) and is relatively uniform throughout the other provinces (2 percent to 3 percent). According to the latest census data, approximately 52 percent of the population is under 19 years old, majority of whom are HIV negative, given the low HIV prevalence among adolescents and youth people aged 15-24 years of 1%. However, these adolescents and young people remain at risk, particularly young girls who are five times as likely to be infected compared to boys of the same age, 2.5% vs. 0.5%. Results from the latest DHS survey show that the proportion of adolescent girls (15-19) who have begun childbearing has increased in the last 10 years and is now at 7.3 %.

Considering the high HIV prevalence of 6.3% and high seropositivity rate (2.4% vs 0.76%), Kigali City is clearly the epicenter of HIV epidemic in Rwanda. Extra efforts need to be put in place to enable people living with HIV access treatment and the HIV negative population, majority of whom are adolescents and young people access HIV prevention services.

The City of Kigali recognizes its role in coordinating the HIV and AIDS response, and is aware of the fact that successful implementation of HIV and SRH priority intervention is dependent on implementation of evidence based district specific action plans and strategic plan.

The present City of Kigali HIV Strategic Plan outlines concrete intervention/actions, which will lead to the achievement of 90-90-90 targets. It seeks to provide direction in the overall coordination and delivery of the HIV response to effectively and efficiently deliver HIV programming in the City. It focuses on cost-effective and socially inclusive interventions towards prevention, treatment and management of HIV and AIDS.

This Strategic Plan establishes strategies to address the high incidence rate of HIV infections in the City of Kigali, especially among key populations, adolescents, and pregnant women. This HIV & AIDS Strategic Plan also contains a review of HIV comprehensive data documented to help in choosing the best approaches and implications to HIV control in the City. The strategic plan considered implementing a multi-faceted approach to addressing HIV due to the unique environment of the City, including: increasing the number of drop-in centres for key populations; integrating HIV services with sexual reproductive health (SRH) and maternal, new born, child and adolescent health services to ensure mothers/women access to HIV services to ensure that adolescents remain HIV negative; and enhancing school health programs to include HIV testing and treatment and support groups, among others. The County will also enhance community health systems to ensure retention in HIV care and treatment.

To achieve the above commitments, the city of Kigali has prioritized seven-core intervention programmes, whose effective and efficient implementation is likely to result to the desired results. The prioritization is premised on both national and global evidence of the programmes efficacy. It is in these programmes that the City of Kigali will invest adequately to ensure achievement of desirable results. These programmes are:

i. HIV testing and counseling
ii. Voluntary Medical Male Circumcision
iii. PMTCT
iv. Condom use (promotion and distribution)
v. Care and treatment support
vi. Control of STIs
vii. Sexual reproductive health

This City of Kigali HIV & AIDS Strategic Plan 2018-2023 has been developed in line with the recently launched Rwanda HIV & AIDS National Strategic Plan 2018-2020.

The following are the identified priority commitments summarized in 3 logical frameworks for the City of Kigali for its HIV and AIDS response:

i. Reduced HIV incidence rates in the City of Kigali
ii. Reduced HIV related morbidity and mortality among PLHIV in the City of Kigali
iii. Reduced unwanted pregnancies in the City of Kigali

1. Logical Framework 1: Reduced HIV incidence rates in the City of Kigali

Four indicators have been defined to achieve this target within the next five years:

- Increased parcent who know their HIV status in the City of Kigali
- Increased prevalence of VMMC
- Increased consistent condom use
- Reduced HIV vertical transmission

The yielding interventions include; "the treat all HIV+, Free condom kiosks and Voluntary counselling and testing initiatives.

The most important control areas for the HIV epidemic in the city of Kigali and Rwanda in general include anti-retroviral treatment as the first one and probably the most important tool to support in fighting stigma, bring about behaviourial change, prevent mother-to-child transmission and ensure blood safety.

On the other hand, free condom kiosks placed in high risk areas in Kigali city, help control the spread of HIV. The kiosks ensure condom accessibility 24 hours daily to members of the community, individuals can pick free condoms and educational materials on safer sex practices. These will be increased accross the whole city.

Voluntary counselling and testing is also an initiative credited for great outcomes in terms of treatment, care and prevention of HIV/AIDS in Rwanda. Sites will be placed in strategic places to entice people from their busy working routine into testing.

Specific attention will be paid to addressing barriers that key populations encounter when accessing preventive health services. Health care providers will be trained on friendly services provision to key populations, in particular, adolescents, FSW and MSM. These friendly services will include HTS at health facility level and in the community through outreach, family planning and reproductive healthcare, STI screening, and treatment. The initiative from the ministry of health for creating « health posts » for better HIV access services will be emphasized in the City of Kigali during the implementation of this strategic plan 2018-2023.

2. Logical Framework 2: Reduced HIV related morbidity and mortality among PLHIV in the City of Kigali

In Rwanda, mortality and morbidity among PLHIV have reduced in recent years due to the coverage of ARV, early initiation and improvements in diagnosis and treatment of opportunistic infections such as tuberculosis, etc. Mortality has decreased by 82% in last two decades. PMTCT has almost reached universal coverage and number of new HIV infections occurring in the age group 0-14 years' account for less than 500 per year.

For better achieving this logical framework, for indicators have been identified:

- Increased linkage to HIV treatment
- Increased HIV treatment coverage and retention to care
- Increased diagnosis and treatment of HIV co-infections
- Increased viral load suppression

3. *Logical Framework 3: Reduced unwanted pregnancies in the city of Kigali*

Global initiatives such as "Adolescent ALL IN" that focuses on adolescent and young adult interventions for HIV prevention, care and treatment, and sexual reproductive health are being initiated in Rwanda and a national operational plan has been developed. "Adolescent ALL IN" is a platform aiming to drive better results for adolescents (aged 10-19 years) and young adults (aged 20-24 years) through critical changes in programs and policy. It seeks to engage adolescents and unite actors across sectors to accelerate reduction in new HIV infections as well as improving the SRH of adolescents by a strong emphasis on unwanted pregnancies.

The following indicators have been identified for this framework:

- Increased comprehensive knowledge of HIV and PMTCT in the City of Kigali
- Increased family planning uptake
- Reduced HIV-related risky sexual behaviors among adolescents

In order to enhance primary prevention of HIV among adolescents in the City of Kigali, youth sensitization will be reinforced and provided through peers. Anti-AIDS clubs, peer educator systems, youth corners, health posts and youth friendly centers (YFCs) will be working through a more effective and monitorable system. This system will target adolescents and young adults both in and out of schools. Pre-nuptial testing and counseling will be reinforced and will cover all components of primary prevention beyond its current limitation to HTS in several facilities in the City of Kigali. Vulnerable young girls and young FSW will be specifically targeted. Furthermore, emphasis will be put on young boys who represent around 36% of FSW clients as per 2015 behaviour and biological surveillance survey of FSW.

Moreover, the prevention of unwanted pregnancies among young women living with HIV and AIDS will continuously be supported to reduce unmet need for family planning. The City of Kigali will increase family planning services in health facilities including "health posts". The availability of condoms for dual protection will be ensured and will always be coupled with counseling for consistent and correct utilization.

Successful implementation of the above-prioritized core intervention programmes will also depend on the extent critical social and programme enablers are identified and adequately implemented by the City of Kigali. The social enablers that have been identified include: political commitment and advocacy, laws, legal policies, and practices, community engagement and mobilization, stigma reduction, use of mass media and local responses to change risk environment.

It is anticipated that effective implementation of these interventions, will contribute to the City of Kigali's achievement of the 90-90-90 targets.

The City of Kigali hosts a large proportion of key populations, which includes female sex workers (55%), men having sex with men and drug users. During the next five years, comprehensive services to key populations including condom distribution by increasing condom kiosks will be one of the major activities to reduce risk of infection among the general population by the City of Kigali. Special emphasize will be made to reduce HIV infection among the adolescents by implementing HIV priority interventions developed in the district HIV specific action plans.

The overall HIV coordination will be led by the City of Kigali through the Districts' action plans and in collaboration with social cluster of ministries in the Government of Rwanda, civil society organizations, NGOs and development partners.

During the period of implementation of this City of Kigali HIV strategic plan (2018 – 2023), the eight intervention components of HIV program will approximately cost about 14.3 USD. This will be subject to change due to revisions of the action plans and the new priorities.

SECTION 1: Global HIV/AIDS Overview

1.1 INTRODUCTION

There were approximately 36.3 million people worldwide living with HIV/AIDS at the end of 2017. Of these, 2.1 million were children (<15 years old)[1]. An estimated 1.8 million individuals worldwide became newly infected with HIV in 2016 – about 5,000 new infections per day. This includes 160,000 children (<15 years). Most of these children live in sub-Saharan Africa and were infected by their HIV-positive mothers during pregnancy, childbirth or breastfeeding.

The response to the HIV/AIDS epidemic has been unprecedented in its accumulation and application of re- search knowledge for policy and practice development [1]. Significant progress has been made, as marked by the achievement of Millennium Development Goal 6, with an estimated 30 million new HIV infections averted and 7.8 million AIDS-related deaths prevented since 2000 [2]. The effectiveness of treatment programmes in reducing HIV-related mortality, however, is predicated on effective implementation of policies around HIV testing, care and treatment to ensure timely treatment initiation and retention [3]. Recent systematic reviews suggest heavy attrition of people living with HIV (PLHIV) at all stages of the care continuum, resulting in persistently higher mortality in the HIV-positive popula- tion compared to those who are HIV negative [4].

Currently only 60% of people with HIV know their status. The remaining 40% (over 14 million people) still need to access HIV testing services. However, as of July 2017, 20.9 million people living with HIV were accessing antiretroviral therapy (ART) globally, up from 15.8 million in June 2015, 7.5 million in 2010, and less than one million in 2000. In addition, 1 million people died from AIDS-related illnesses in 2016, bringing the total number of people who have died from AIDS-related illnesses since the start of the epidemic to 35.0 million[2].

Recent global HIV/AIDS epidemic data show that there were approximately 36.7 million people worldwide living with HIV/AIDS at the end of 2016 [5]. The vast majority of people living with HIV are in low- and middle-income countries. Sub-Saharan Africa is the most affected region, with an estimated 25.6 million people living with HIV in 2017. About 66% of new HIV infections in 2017 occurred in sub-Saharan Africa.

Despite advances in our scientific understanding of HIV and its prevention and treatment as well as years of significant effort by the global health community and leading government and civil society organizations, too many people living with HIV or at risk for HIV still do not have access to prevention, care, and treatment, and there is still no cure. However, effective treatment with antiretroviral drugs can control the virus so that people with HIV can enjoy healthy lives and reduce the risk of transmitting the virus to others.

The HIV epidemic not only affects the health of individuals, it impacts households, communities, and the development and economic growth of nations. Many of the countries hardest hit by HIV also suffer from other infectious diseases, food insecurity, and other serious problems. Despite these challenges, there have been successes and promising signs. New global efforts have been mounted to address the epidemic, particularly in the last decade. Prevention has helped to reduce HIV prevalence rates in a small but growing number of countries and new HIV infections are believed to be on the decline.

In addition, the number of people with HIV receiving treatment in resource-poor countries has dramatically increased in the past decade.

Progress also has been made in preventing mother-to-child transmission of HIV and keeping mothers alive. In 2017, 78% of pregnant women living with HIV globally had access to antiretroviral medicines to prevent transmission of HIV to their babies; new HIV infections among children have declined by 50% since 2015.

1.2 Fast-Track cities reaching the 90-90-90 targets

Ending the AIDS epidemic by 2030 is feasible if the world's major cities act immediately and decisively to Fast-Track their AIDS responses by 2020 [6]. To make it happen, in 2014 during World AIDS Day, mayors from around the world gathered to launch the Paris Declaration on Fast-Track cities and pledging to achieve the 90-90-90 targets by 2020. The mayors declared their leadership and their cities' commitment to accelerating the scale-up of HIV prevention and treatment and achieving zero discrimination. A Fast-Track AIDS response means that by 2020, 90% of people living with HIV will know their HIV status, 90% of people living with HIV who know their status receive HIV treatment and 90% of people on HIV treatment have a suppressed viral load. The Fast-Track Targets for 2020 also call for reducing new adult HIV infections to fewer than 500.000 people worldwide and eliminating HIV-related stigma and discrimination. Combined, these targets provide a fragile, five-year window to set the world on track to ending the AIDS epidemic by 2030. Cities will only reach the Fast-Track Targets by leaving no one behind: ensuring that marginalized and stigmatized people can access sexuality education, HIV testing and prevention options such as condoms and effective HIV treatment. A Fast-Tracked AIDS approach requires cities to work with vulnerable people and populations at particular risk, including sex workers, people who inject drugs, transgender people and men who have sex with men. Cities must also be safe and free of violence, especially against young women and girls.

SECTION 2: HIV/ AIDS situation in Rwanda

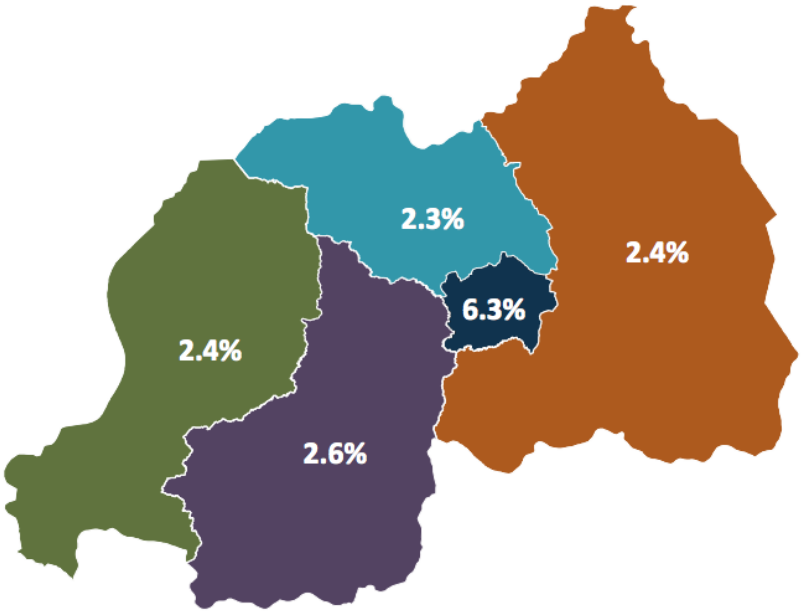
2.1 Introduction

The prevalence of HIV/AIDS is a major public health concern in Rwanda as HIV/AIDS-related mortality has substantial negative social and economic consequences on the people and the country.

The HIV prevalence in Rwanda has been stable since 2005 and remains at 3 percent among adults age 15-49 (4% among women and 2% among men). Rwanda conducted its first population based HIV incidence survey in 2013/14. Findings from this survey suggest an overall HIV incidence of 0.27 per 100 person-years. Divorcees, widows and singles were found to have a high incidence of 1.3, 0.36 and 0.35 per 100-person years respectively. HIV Incidence among youth was 0.24 per 100 person year and by geographic location the city of Kigali incidence is higher than the general population (0.40 per 100 person years) [7].

Considering the high HIV prevalence of 6.3% (Figure 1), Kigali City is clearly the epicenter of HIV epidemic in Rwanda and extra efforts need to be put in place to enable people living with HIV access treatment and the HIV negative population, majority of whom are adolescents and young people access HIV prevention services [8,9].

Figure 1: *Distribution of HIV prevalence within the 5 provinces of Rwanda*



In Rwanda, much of the information on national HIV surveillance is derived from Health Management Information System (HMIS), RDHS, Behavioral Surveillance Survey (BSS) and the antenatal care (ANC) sentinel surveillance system among others. Rwanda has made significant progress toward creating universal access to HIV and AIDs services. This was possible through the National Strategic Plan [5,7] strategic plans with a general goal for the country's response to HIV and AIDs and affirms Rwanda's commitment to a multi-sector response.

According to the latest census findings, approximately 52 percent of the population is under 19 years old, majority of whom are HIV negative, given the low HIV prevalence among adolescents and youth people aged 15-24 years of 1%. However, these adolescents and young people remain at risk, particularly young girls who are five times as likely to be infected compared to boys of the same age, 2.5% vs. 0.5%. Results from the latest DHS survey show that the proportion of adolescent girls (15-19) who have begun childbearing has increased in the last 10 years and is now at 7.3 %.

Regarding age of sexual debut, people seem to be having their first sexual intercourse at a younger age, and this is a known risk factor for HIV infection. 6.8% of girls and 13.4% of boys aged 15-19 reported they had sexual intercourse before age 15, compared to 2 percent of women and men aged 30-49 who reported having had sex before age 15. Among women whose age at sexual debut was 17 and younger, 7 to 8% were HIV positive, compared to 3 percent among women whose sexual debut was at age 20 or older[5]. Furthermore, 10% of young women and 2% of young men aged 15-19 who had sexual intercourse in the 12 months before the survey had sex with a partner who was 10 or more years older than they were. And women aged 15-17 are more likely to have had sex with someone 10 or more years older than they are, than those aged 18-19. This intergeneration sex is another risk factor for HIV infection especially among adolescent girls because of the relatively high HIV prevalence among their older partners.

In general, Rwanda's HIV prevalence rises with age. Among women, the HIV prevalence increases from 1% at age 15-19 to a pic of 8% at age 40-44 and down to 6% at age 45-49. Among men, the prevalence increases by less than 1% at age 15-19 to 4% at age 40-44 and reaches a pic of 9% at age 45-49. The prevalence differs by geographical area and age group. The HIV prevalence in urban areas is 6.2% higher than 2.2% in rural (Figure 1).

The City of Kigali (CoK) has recommitted to the fight against HIV/AIDS by signing of the Paris Declaration on ending the epidemic in cities and urban areas, a year after the global strategy was adopted (Figure 2).

Figure 2: *Kigali City Fast-Track Paris Declaration signed in 2016 by the Mayor of the City (left) and the Executive Secretary of UNAIDS (right)*

SECTION 3: HIV/ AIDS Situation in the City of Kigali

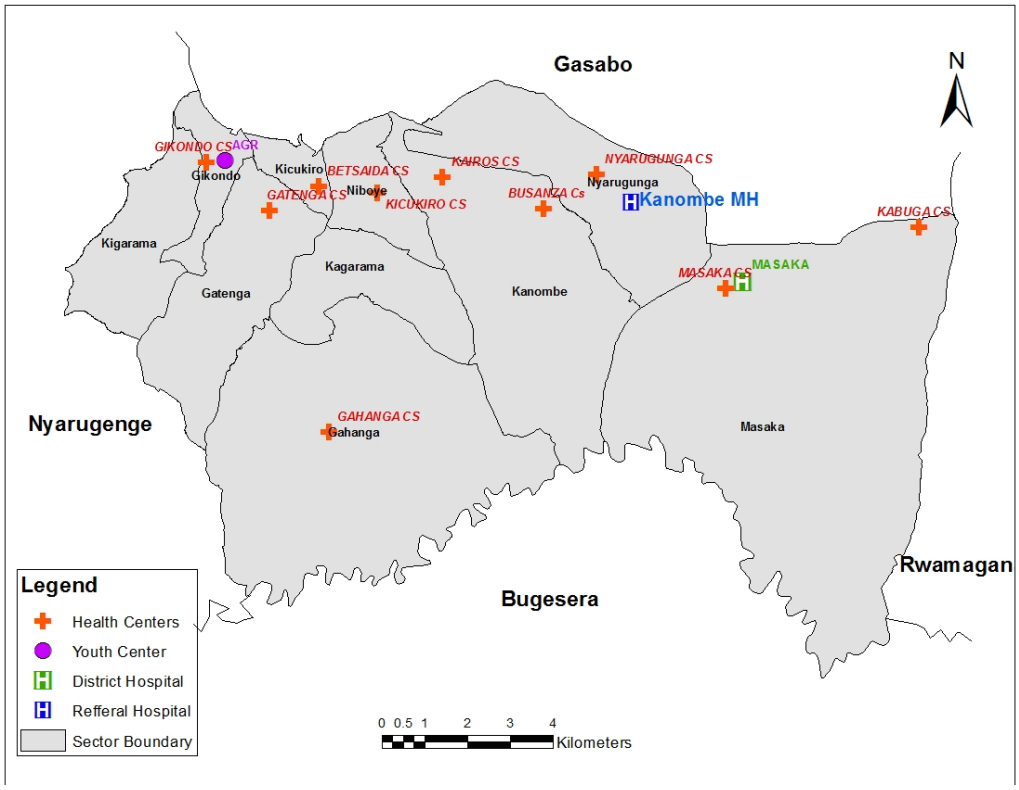
3.1 Demographic profile of the City of Kigali

The City of Kigali (CoK) is the Capital City of Rwanda; it has a surface area of 730 km2. It is composed of three Districts, namely: Gasabo, Kicukiro and Nyarugenge, 35 Sectors, 161 Cells and 1183 Villages. With a population of more than 1,2 million (2015), the CoK is the largest city of Rwanda. The city of Kigali is the most densely populated in the country than other provinces: Kicukiro (1.911), Nyarugenge (2.14), and Gasabo (1.243).

3.1.1 Demographic profile of Kicukiro District

Kicukiro is one of the 3 districts of Kigali City with a surface area of 167 km^2 (64 sq mi). Its headquarters is the Kigali suburb of Kicukiro. Kicukiro is home to a thriving market, a number of NGOs and the Bralirwa Brewery. In addition, it is the headquarters for the Friends Church in Rwanda. Kicukiro district is divided into 10 sectors (*imirenge*): Gahanga, Gatenga, Gikondo, Kagarama, Kanombe, Kicukiro, Kigarama, Masaka, Niboye and Nyarugunga (Figure 2).

Figure 3: *Sectors of Kicukiro District*



The Integrated Household Living Conditions Survey (EICV3)[9] survey results showed that the total population of Kicukiro district in 2010-2011 was 318.564 (with a density of 1,900/km^2), representing 28% of the total population of the City of Kigali and 2.8% of the total population of Rwanda. Females comprised 49.8% of the population of Kicukiro district. The majority of the population is young, with 87% of the population aged less than 40 years old ; females in this group represent 86% of all females, while males represent 87% of all males.

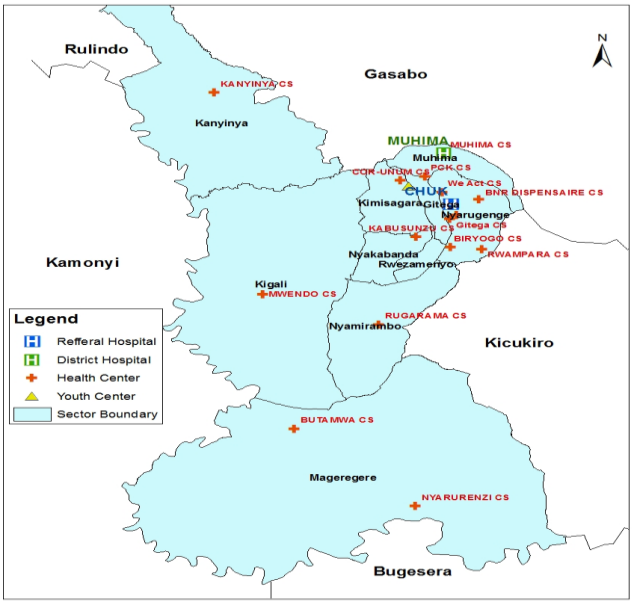
3.1.2 Demographic profile of Nyarugenge District

Nyarugenge district is the heart of the City Centre of Kigali, which contains most of the city's businesses. Nyarugenge district is divided into 10 sectors (imirenge).

Among the population of Nyarugenge district close to 282.000, 49% are aged 19 years or younger. People aged 65 years and above make up 2% of the population. About 52% of the population is constituted by female individuals and the majority is young, with about 87% still under 40 years of age. Demographic survey data[9] show that females outnumber males in Nyarugenge district with 109 females per 100 males, which is below the national average of 111 females per 100 males.

About 90% of the population in Nyarugenge district is identified as non-poor, 6.5% as poor (excluding extreme-poor) and only 3.6% as extreme-poor. Compared with other districts of Kigali City, Nyarugenge district comes second for non-poor after Kicukiro district, which has 2.8% of extremely poor, 5.5% poor and 91.7% non-poor. **Nyarugenge District** is divided into 10 sectors (imirenge): Gitega, Kanyinya, Kigali, Kimisagara, Mageragere, Muhima, Nyakabanda, Nyamirambo, Nyarugenge, and Rwezamenyo (Figure 3).

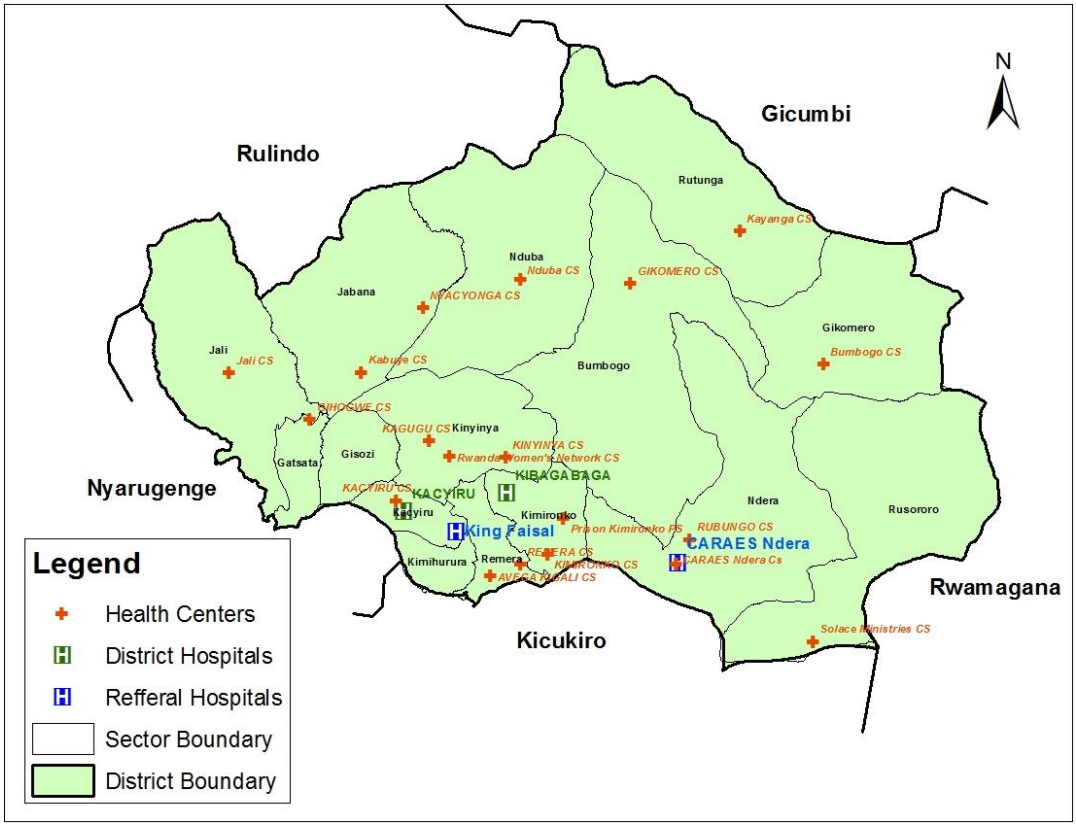
Figure 4: *Sectors of Nyarugenge District*



3.1.3 Demographic profile of Gasabo District

Gasabo is a district (akarere) in the City of Kigali. The district includes large areas of the city itself, including Kacyiru, Remera, Nyarutarama and Kimihurura sectors. The district occupies the northern half of the City of Kigali. Gasabo district is divided into 15 sectors (imirenge) (Figure 4). Gasabo population is mostly young. 57.6% of the resident population is under 25 years, reflecting the high level of fertility in the recent past. The elderly (60 years and above) represent 2.2% of the total population of the district.

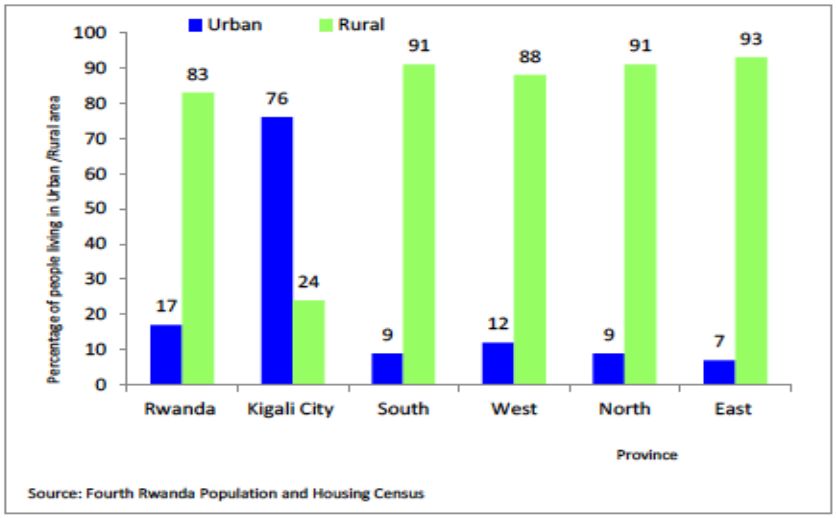
Figure 5: *Sectors of Gasabo District*



City of Kigali has rapidly grown in a modern city in the last decade and it has not only become Rwanda's most important business center but also the main port of entry.

The Rwanda General Population Census (RGPC), showed that in 2012 Kigali City had 1,132,686 inhabitants. Gasabo district is the most populated with more than 500,000 inhabitants and the least populated is Nyarugenge district, which has less than 300,000 inhabitants. The highest populations of 76% are living in the urban area, compared to other provinces that vary between 7% and 12% (Figure 5).

Figure 6: *Rwanda demographic profile*



The age distribution of the population of the city of Kigali and Rwanda in general confirm the youthfulness of population. In Kigali the mean and median age are 22.6 and 22, respectively.

3.2. HIV programme in the City of Kigali

In Rwanda, HIV prevalence is higher in urban areas than in rural areas, and women are at higher risk of HIV infection than men. Young women ages 15 to 24 are twice as likely to be infected with HIV as young men in the same age group.

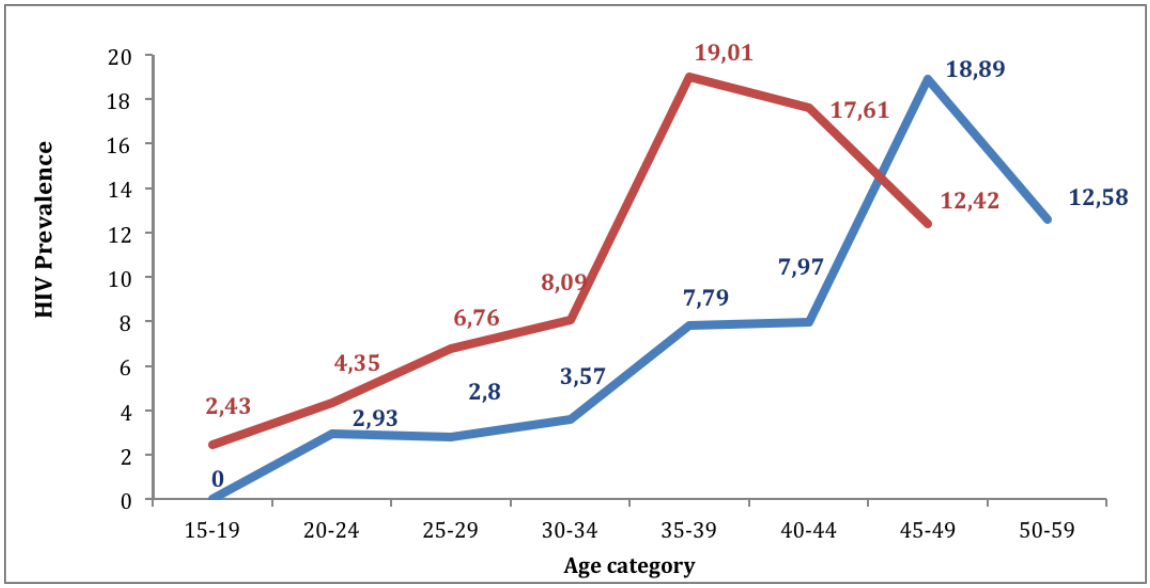
Recent data show that the HIV prevalence is highest in the City of Kigali (6.3 percent) and is relatively uniform throughout the other provinces (2 percent to 3 percent).

Considering this high HIV prevalence of 6.3%, Kigali City is clearly the epicenter of HIV epidemic in Rwanda and extra efforts need to be put in place to enable people living with HIV access treatment and the HIV negative population, majority of whom are adolescents and young people access HIV prevention services.
The City of Kigali recognizes its role in coordinating the HIV and AIDS response, and is aware of the fact that successful implementation of the HIV and SRH priority intervention is dependent on implementation of evidence based district specific action plans.

3.2.1 HIV prevalence

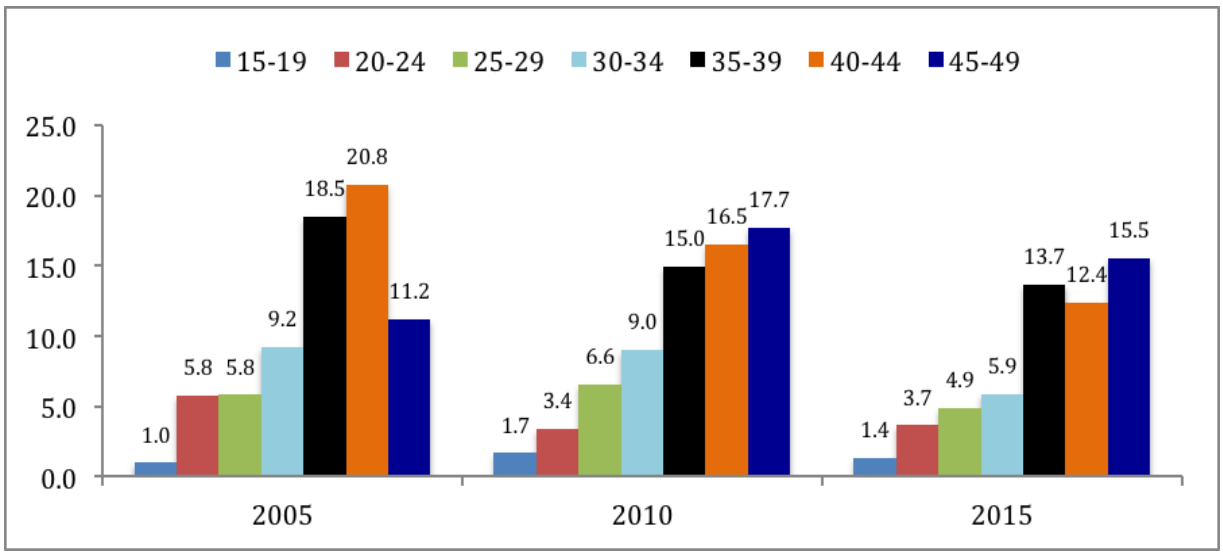
The prevalence of HIV remained stable at 3% for the last decade, the analysis of HIV prevalence data in 2010 and 2015 stratified by sex and age groups indicate that, HIV epidemic in Rwanda is aging as the highest prevalence shift overtime to the right (Figure 6). With a high prevalence among women that men, 3.6% and 2.2%, respectively. In general, HIV prevalence rises with age. Figure 5 shows the HIV prevalence trends in the City of Kigali

Figure 7: *Pattern of Rwanda's HIV prevalence as per DHS 2015*



This national figure shows that the adolescent and adults prevalence trends, which increase with age with a high prevalence rate of 7.8% and 9.3% in women, aged 40-44 and men aged 45-49, respectively.

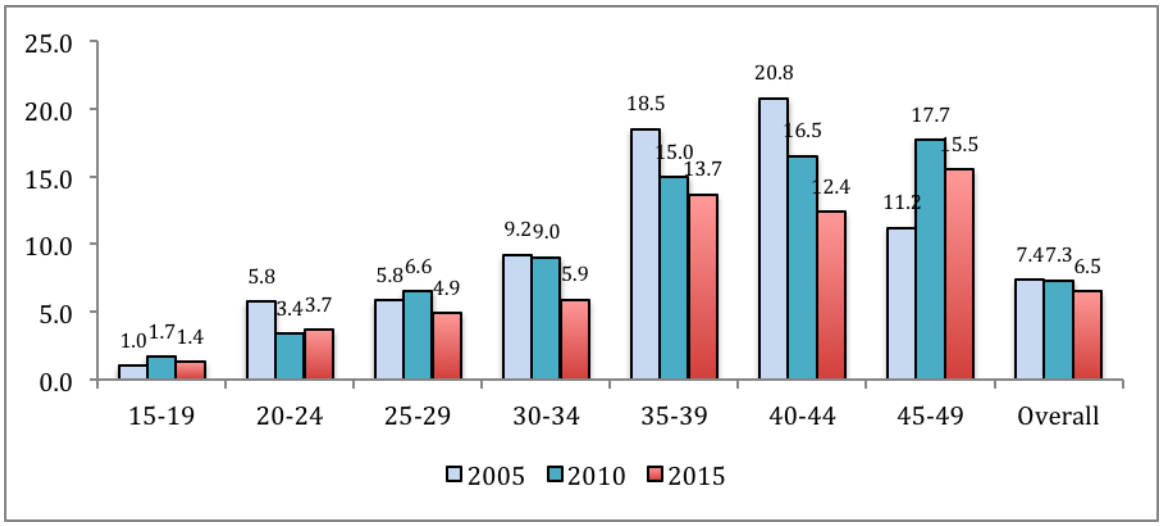
Figure 8: *HIV prevalence by sex and age group (15-49) in the City of Kigali*
(Source: DHS 2005, 2010 & 2015)



With regards to the CoK, the HIV prevalence rate similarly increases with age. However, the CoK prevalence is higher in all group ages (Figure 7).

Though the prevalence of adolescent and young adults aged 15-24 have been stable at 1% since 2005, there is a remarkable difference in the City of Kigali and the trend changed over the years (Figure 8).

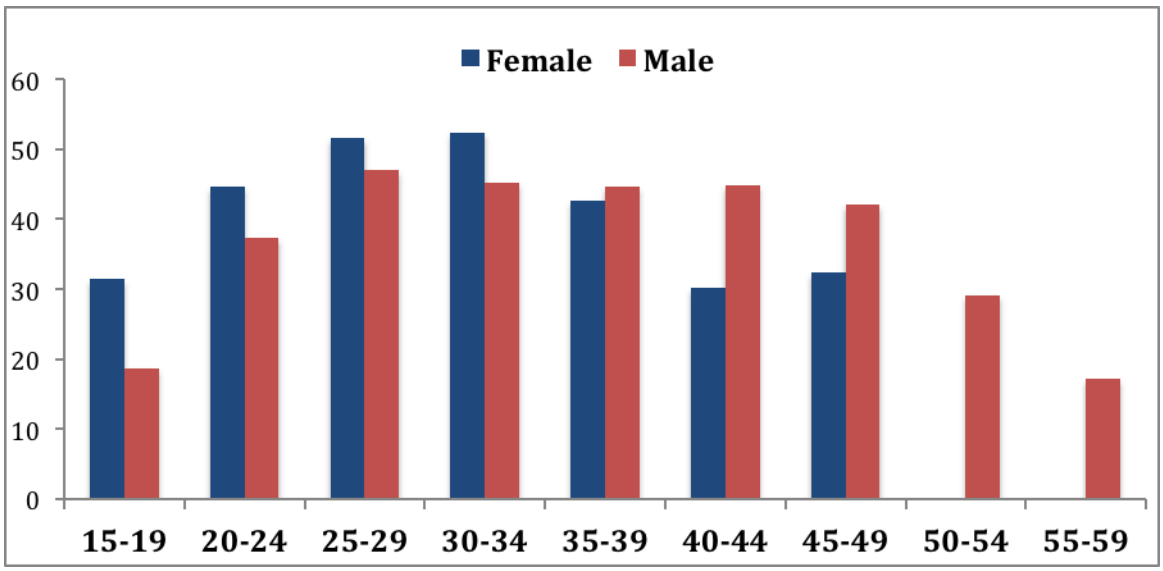
Figure 9: *Trend of HIV prevalence in the City of Kigali and districts compared to the national prevalence (Source: DHS 2005- 2010-2015)*



3.2.2 HIV Testing and Counseling

In line with the global target 90-90-90, National data show that 87% of PLHIV in Rwanda know their status. However the uptake of HIV testing and counseling (HTC) among adolescents and young adults is still low. Less than 30% of adolescents aged 15-19 tested and received results in a period of 12 months. According to DHS 2015, data show that there increase in testing uptake among females aged 15-34 (Figure 9).

Figure 10: *Percent of Male and Female tested in the last 12 months prior the survey by age category among adults in the City of Kigali,* (Source: DHS 14-2015)



Considering HIV Testing among adolescent and adults, the rate was lower among adolescent aged 15-19 in both males and females (Figure 10 & 11).

Figure 11: *Time for Testing and Gap in HIV Testing among Male, (Source: DHS 14-2015)*

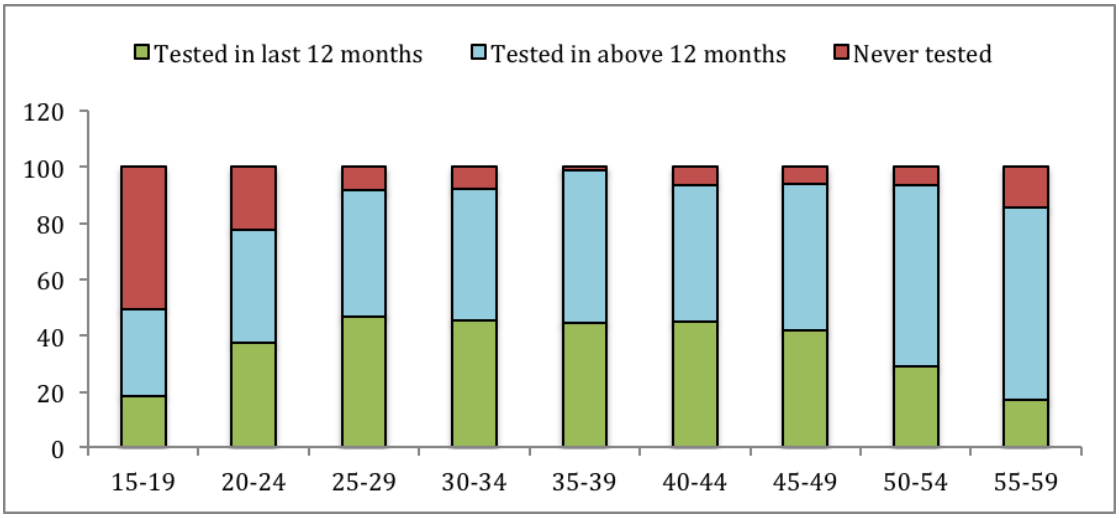
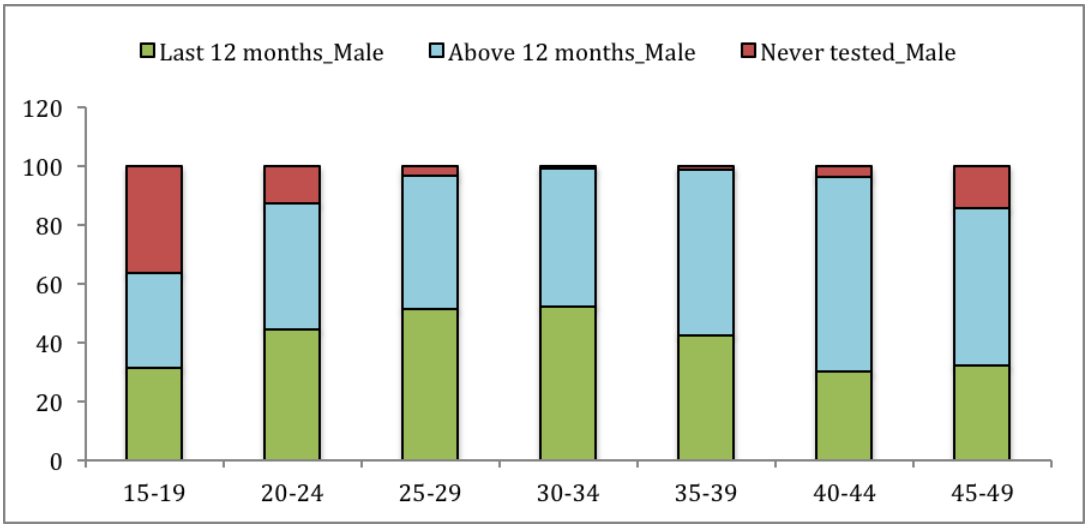
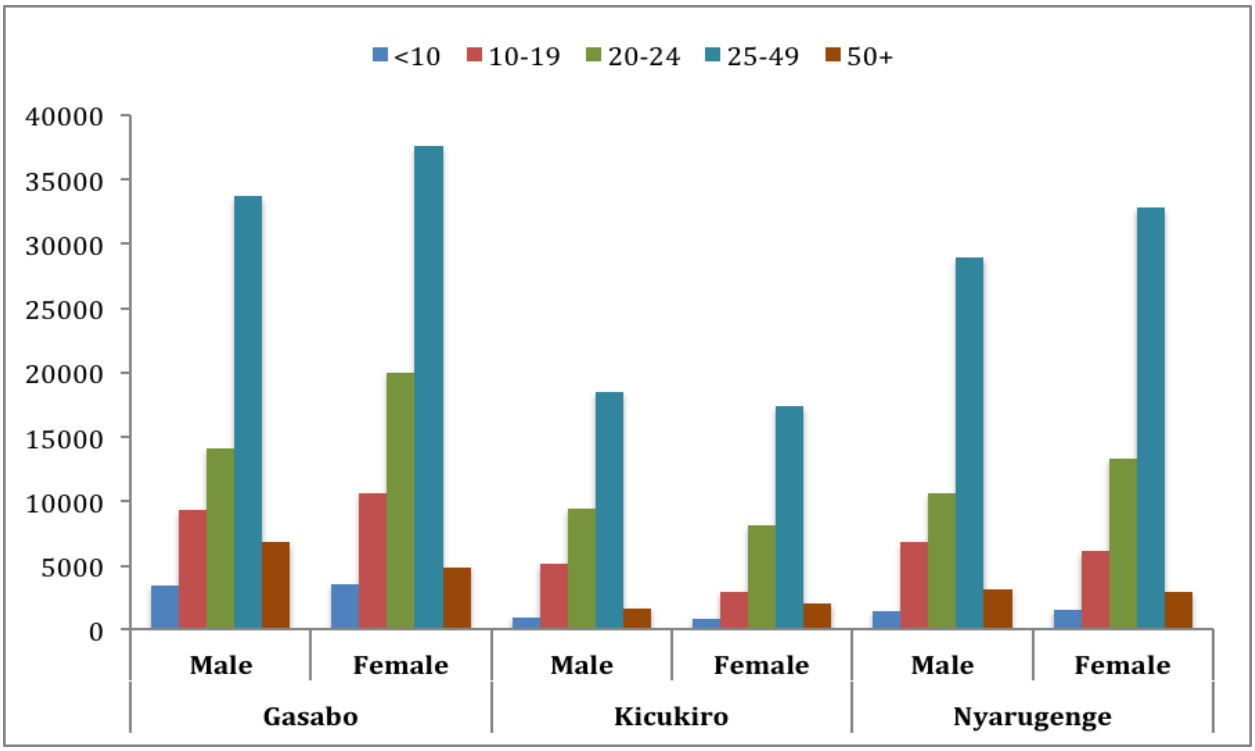


Figure 12: *Time for Testing and Gap in HIV Testing among Female (Source: DHS 14-2015)*



Overall data show that there is a low rate of HTC in age group 10-19 in all 3 districts of the CoK and has a very low HTC uptake (Figure 12).

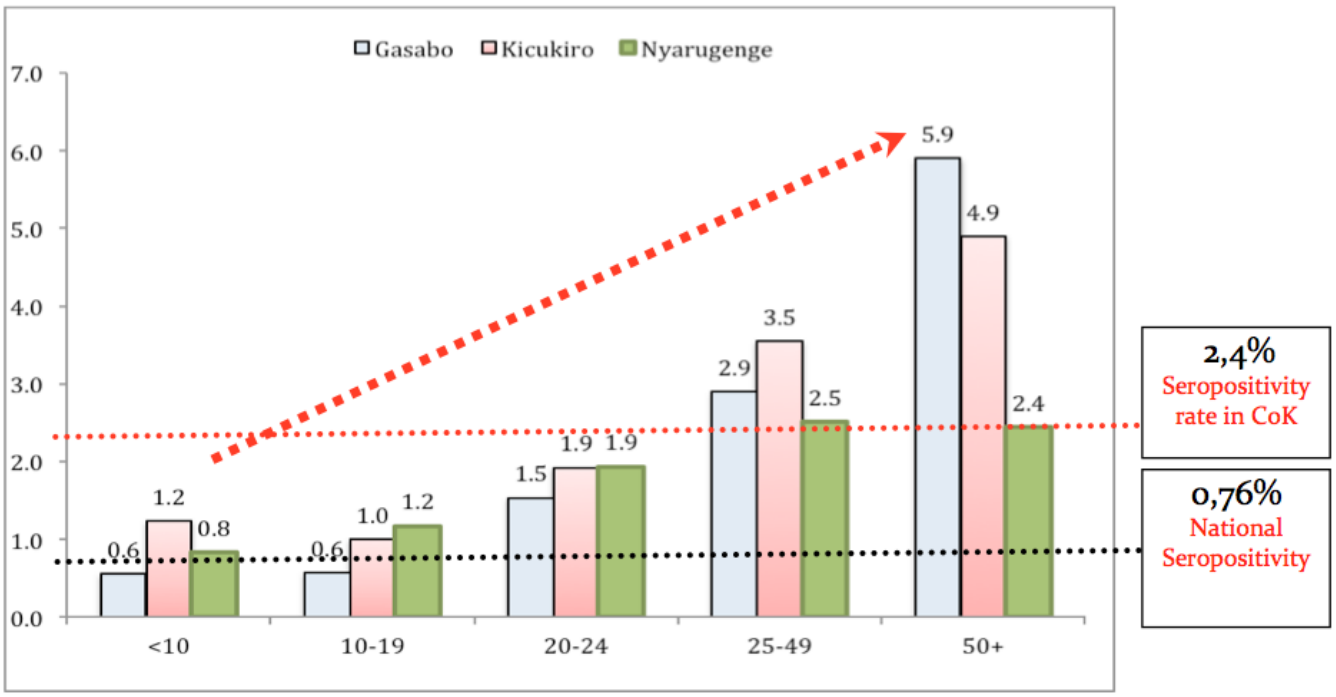
Figure 13: *Number of HIV tests conducted in Kigali by age group and district (Source: DHS 2014-2015)*



In the fiscal year of July 2016 to June 2017, a total, 2,338,944 clients received HTC across the country, among them 17,661-tested HIV positive yielding a positivity rate of 0.76%. In the city of Kigali, the high positivity rate is identified among adults aged 25 year and above in the districts of Gasabo (3.32%) and Kicukiro (3.67%). Nonetheless the positivity rate among adolescent is higher than the positivity rate in the general population. Data show a high sero-positivity rate in CoK 2.4%) compared to the national rate of 0.76% and it increases with age (Figure 13).

Having a relatively low yield among adolescents and if corroborated by evidence that less number of adolescents living with HIV are being diagnosed, may indicate a need for a more targeted approach for testing

Figure 14: *HIV sero-positivity in HIV Testing Services in the City of Kigali (Source: HMIS 2017)*

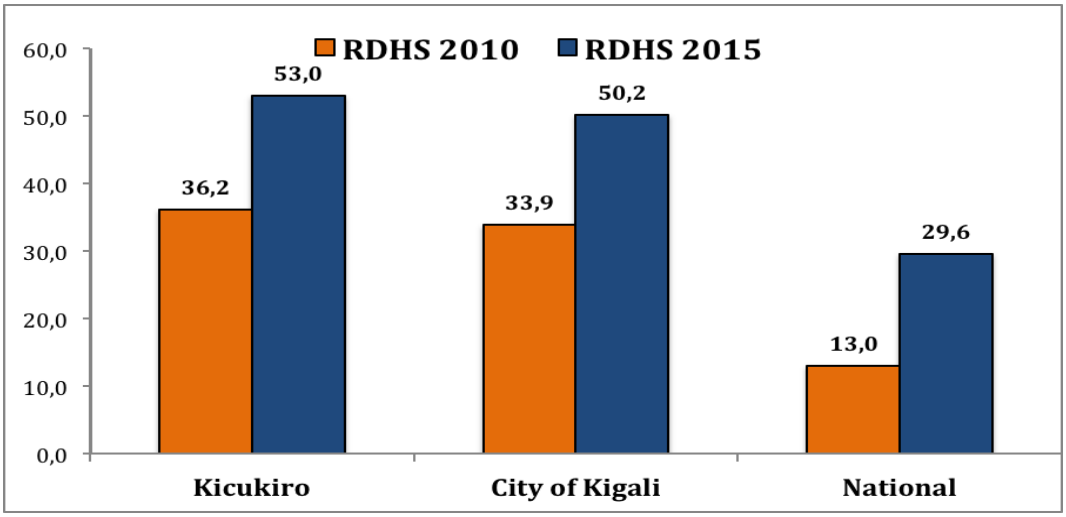


3.2.3 Voluntary Medical Male Circumcision

Voluntary Medical Male circumcision (VMMC) is one of the major interventions in HIV Prevention. The demographic and health survey showed an increase of male circumcision prevalence from 13% in 2010 to 30% in 2015.

The 2010 and 2015 demographic and health survey's data showed an increase of male circumcision prevalence from 13% in 2010 to 29.6% in 2015. For the CoK, the high VMMC prevalence was found among adolescents aged 20-24 with 33.9% and 50.2% in 2010 and 2015, respectively (Figure 14).

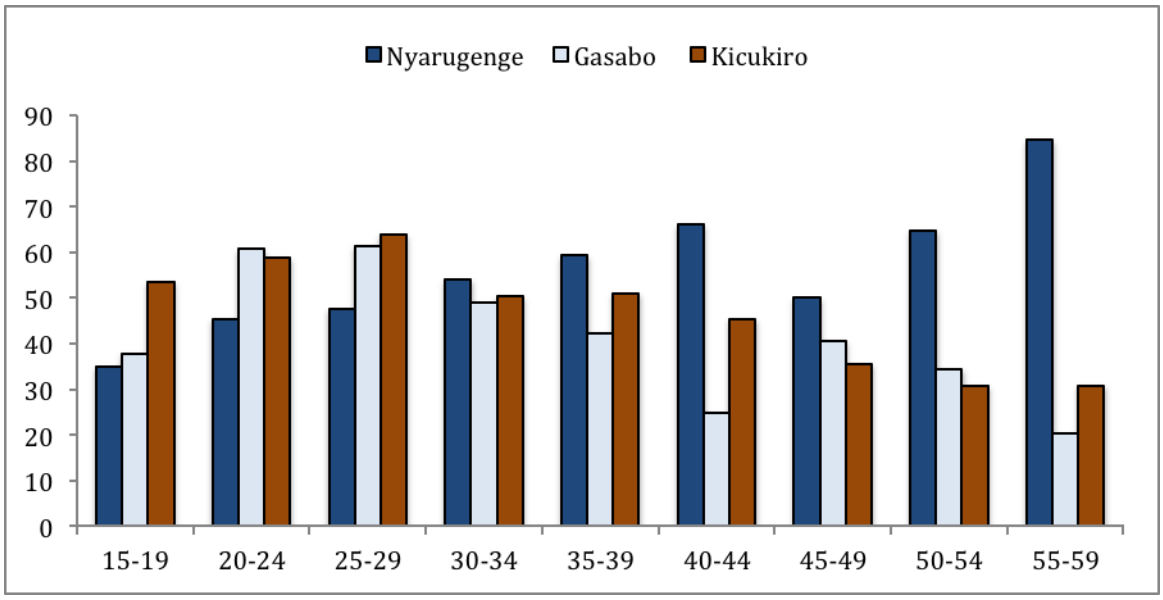
Figure 15: *Trends of Voluntary Medical Male Circumcision in the City of Kigali (Source: DHS 2014-2015)*



This below figure (Figure 15) shows a low prevalence of VMMC among adolescent aged 15-19 in Nyarugenge (34.9%) and Gasabo (37.8%) districts. The high prevalence rate of VMMC in Kicukiro in adolescents aged 15-19 (53,5%) could be due to the recent VMMC service delivery and infrastructure in this district (Center of Excellence for medical device PrePex at Rwanda Military Hospital). However, the VMMC rate is higher in Nyarugenge among

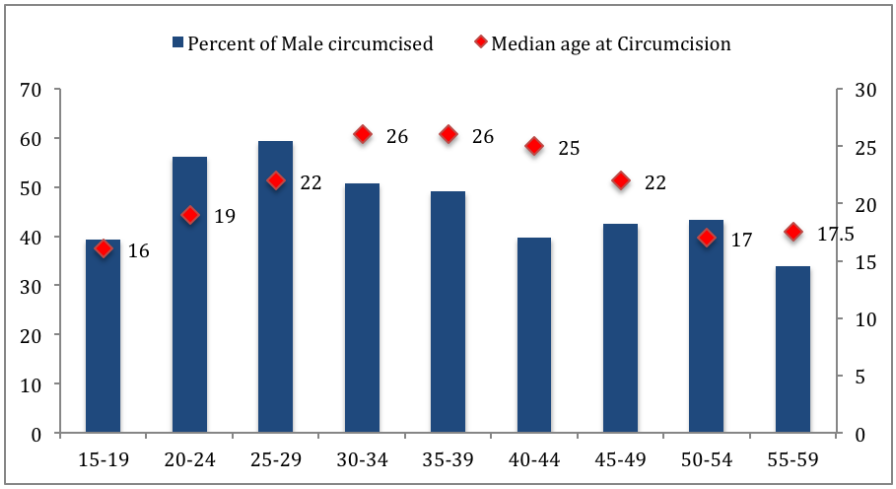
men aged 35+. This is probably due to the past muslim infrastructures which were performing VMMC procedures in this district (Mosques Khadaffi, Biryogo, etc).

Figure 16: *Voluntary Medical Male Circumcision by district and age group in the City of Kigali (Source: DHS 2014-2015)*



In addition, there was no remarkable difference between median age and age at circumcision among adolescents. This indicates the recent circumcision among adolescents (Figure 16). In contrary, adults above 35 years were circumcised at young age.

Figure 17: *Prevalence of Male Circumcision in the City of Kigali and median age of Circumcision (Source: DHS 2014-2015)*

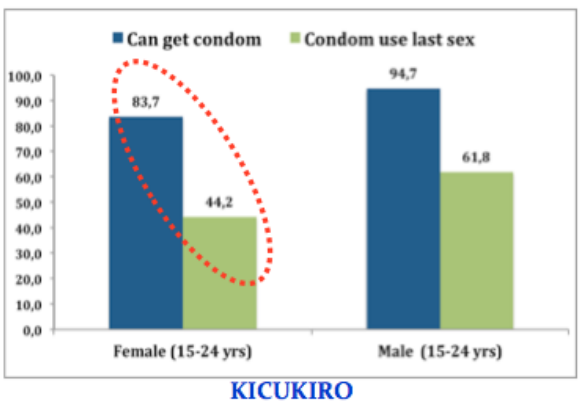


3.2.4 Condom use in the City of Kigali

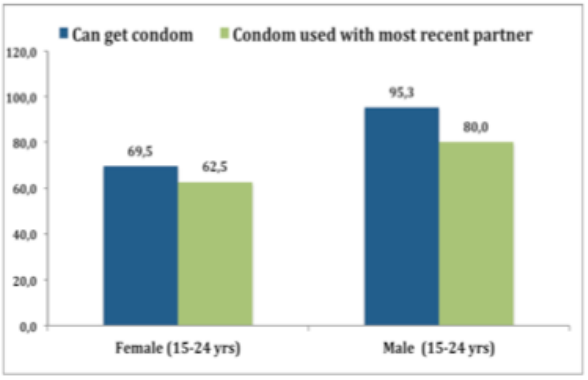
Condom use is one of the most effective strategies for combating the spread of HIV. While HIV has been contained at 3% over the past couple of years, recent data show that condom has declined, raising fears of spreading HIV infections and other sexually transmitted infections as well as increasing unplanned pregnancies.

DHS 2014-2015 and HIV program data in Rwanda show that at least 85% of adolescents know where to access a condom. However, condom is less used at premarital sex in 47% of males and 38% of females at first sex, respectively. Kicukiro district has a low coverage of condom use 44.2% and 61.8% among females and males respectively in the age group of 15-24 years (Figure 17). However, rate of condom use among adolescents in Nyarugenge district is higher among males than females; the same trends are observed in Gasabo district.

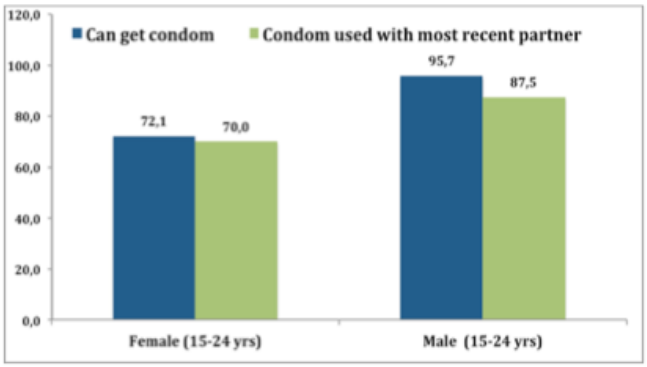
Figure 18: *Condom use among adolescents in the City of Kigali*
(Source: RAIHIS 2014)



KICUKIRO



NYARUGENGE



GASABO

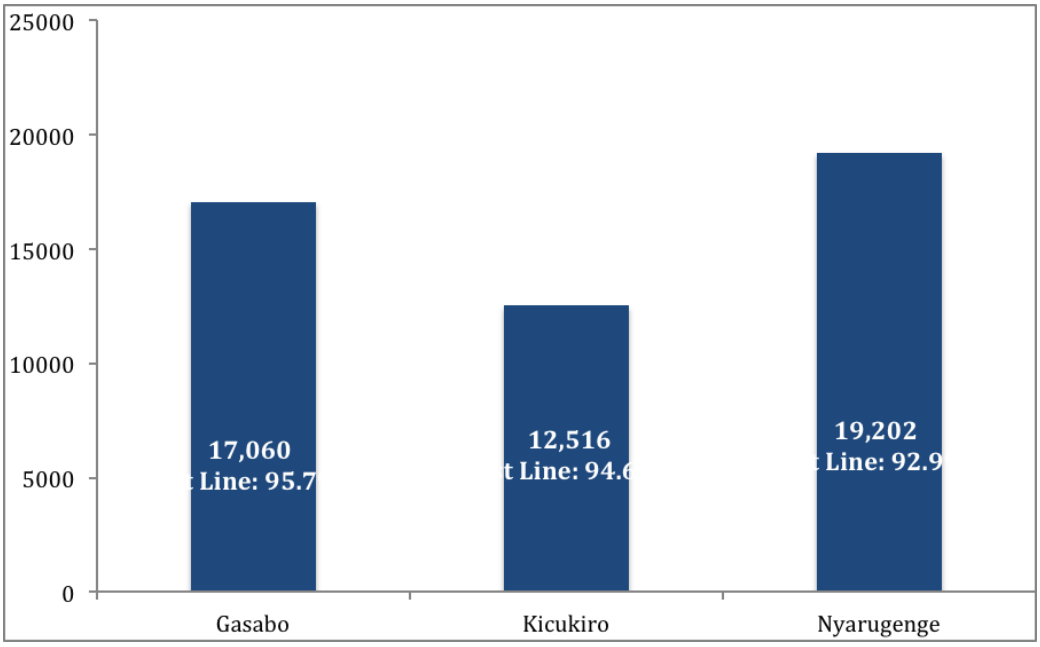
3.2.5 Care, Treatment and Support for PLHIV in the City of Kigali

Rwanda has been in the first countries to adopt the WHO Recommendation of "Treat All" since June 2016. This was another golden opportunity to increase the number of new patients on treatment and put the national HIV program in the right direction towards attainment of the 90-90-90 targets.

By June 2017, 180,927 patients, representing 81% of total people living with HIV, were initiated in ART. Of them, 9904 (5.5%) are adolescent aged between 10-19 years, 26% are located in the city of Kigali and 114,415 (62,9%) of all patients on ART are women.

The city of Kigali districts encounter many patients (adolescents and adults) on ART compared to other districts (Figure 18).

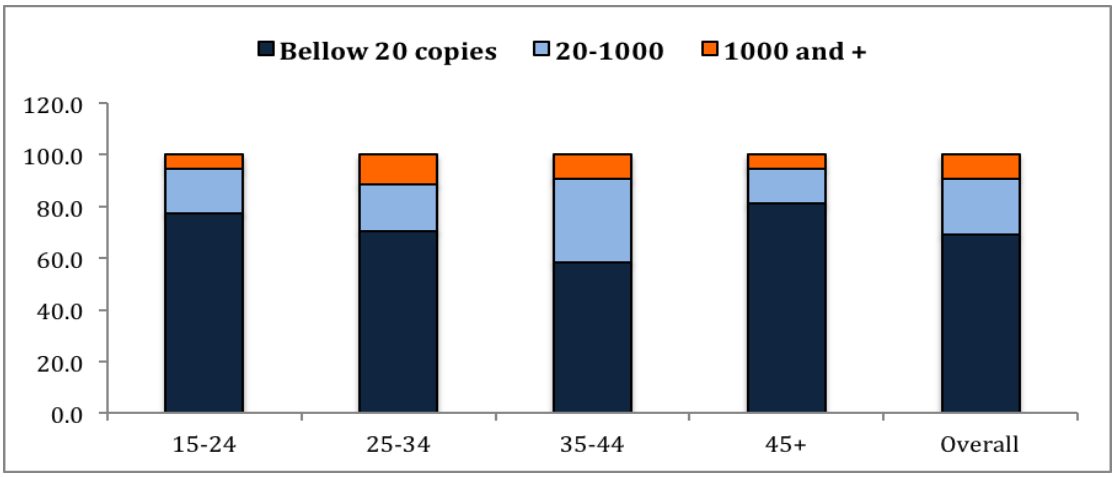
Figure 19: *Distribution of patients on ART by district (Source: HMIS March 2018)*



These data show that City of Kigali health facilities enroll many patients compared to the other districts. This burden is probably affecting follow-up and retention of PLHIV on ART. For example, while retention after 12 months on treatment has been stabilized at 92% in the last 5 years. However, data show a lower retention of patients on ART in the city of Kigali of 89.2% and 83.6% among adults and adolescent, respectively.

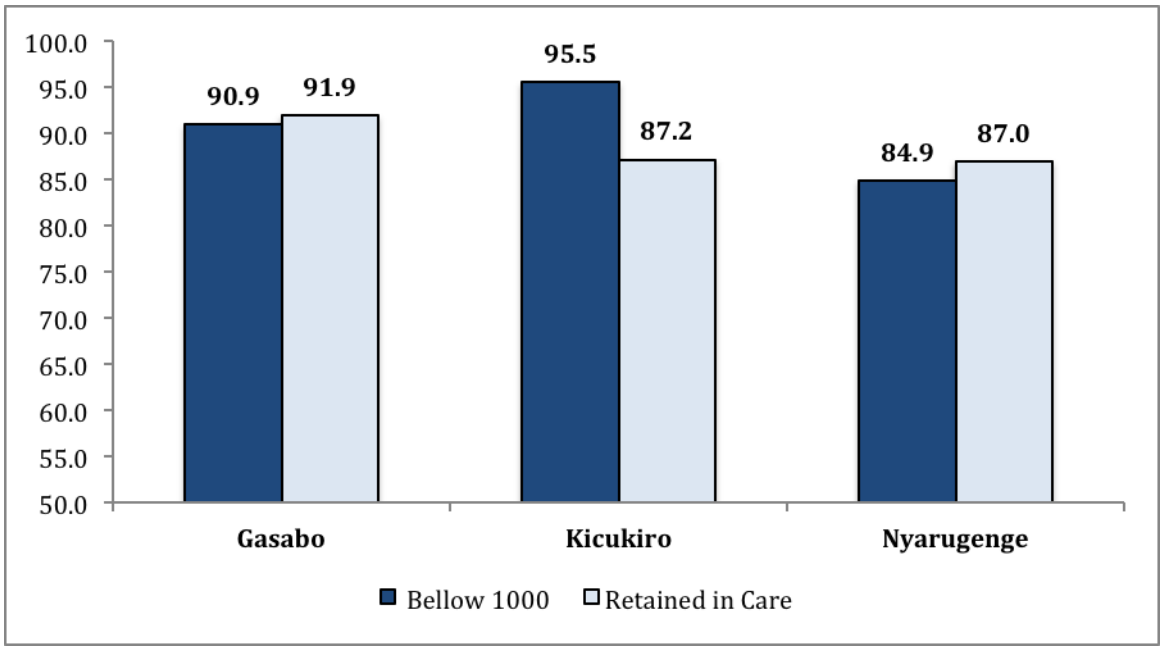
Furthermore, viral load suppression in the first 12 months of treatment was found to be lower in the CoK (69,1%) (Figure 19). The DHS 2015 data shows an average rate of 77.8% of viral load for the remaining provinces.

Figure 20: *Viral load suppression after 6 months on Treatment by age category in the City of Kigali (Source: Health Facility Record)*



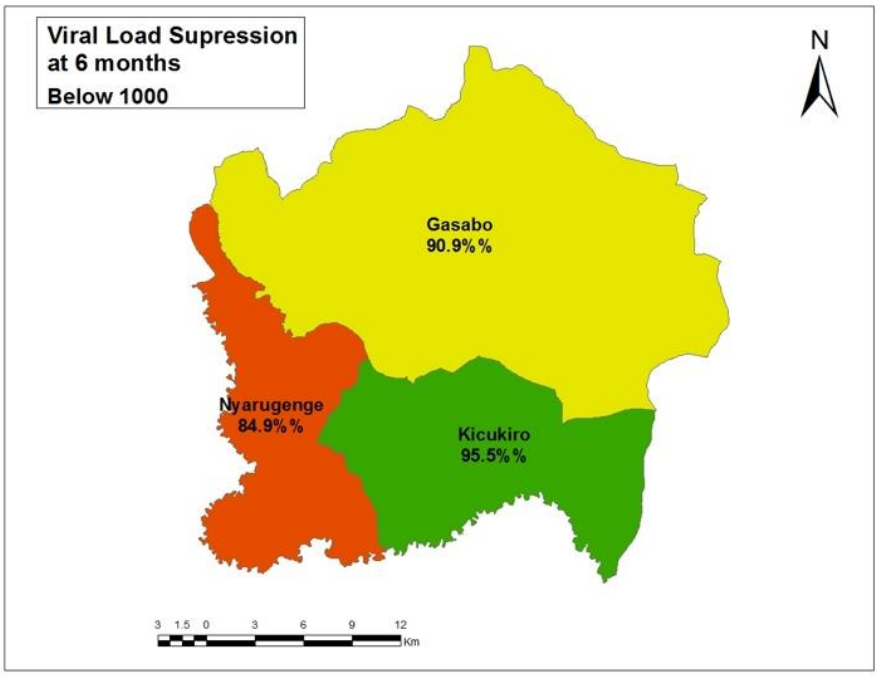
Nyarugenge district has a low proportion of viral load suppression compared to other districts of the City of Kigali (Figure 20). This could be due to the high number of PLHIV who are lost for the follow-up and also to the high number of hotspots for FSW.

Figure 21: *Viral load suppression after 6 months on Treatment by district in the City of Kigali*
(Source: Health Facility Record)



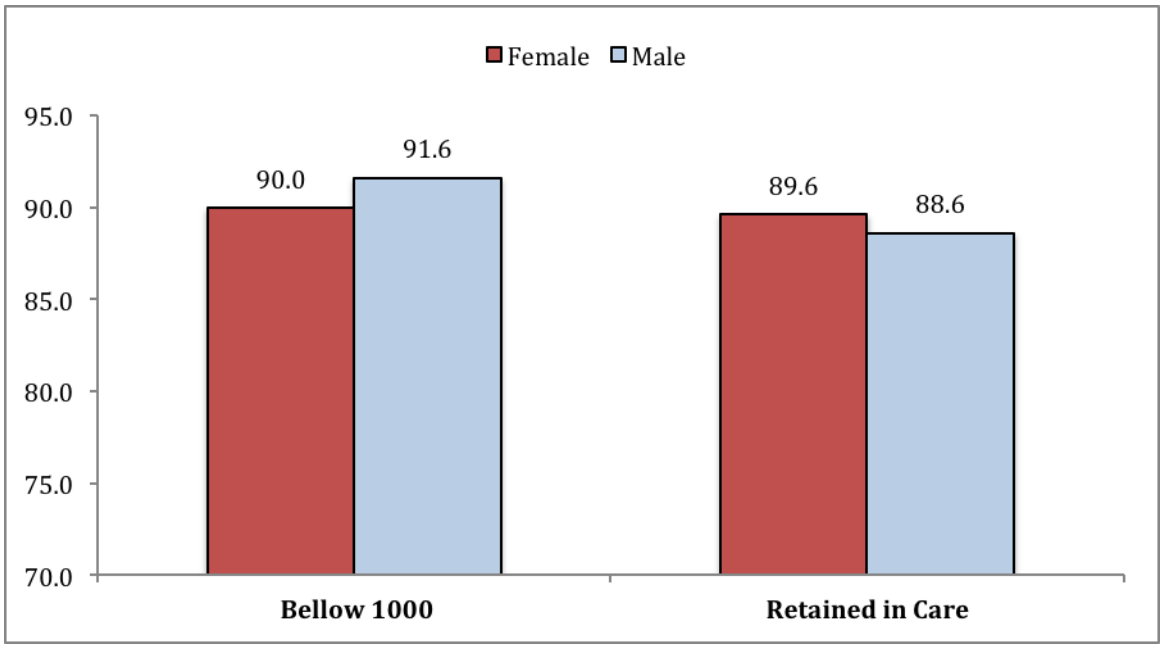
The below map (Figure 21) gives overall information on district performance for viral load suppression.

Figure 22: *District performance for viral load in the city of Kigali*
(green: best performance; yellow: mild performance; red: low performance)



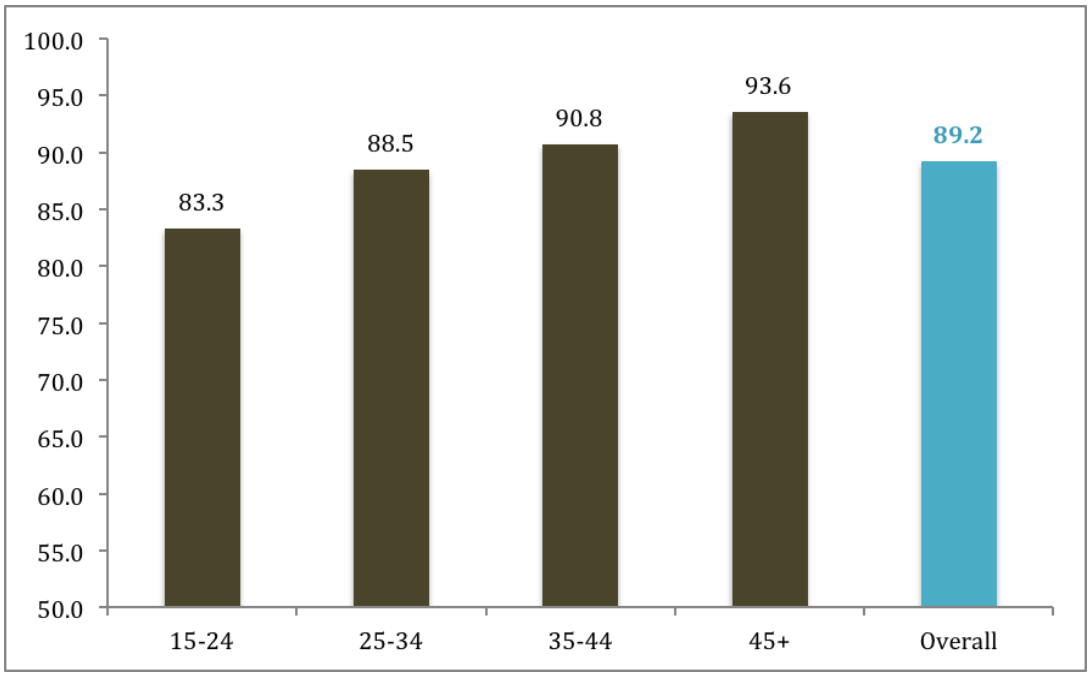
The viral load suppression is low in females compared to males in the CoK (Figure 22).

Figure 23: *Viral load suppression after 6 months on treatment by gender in the City of Kigali (Source: Health Facility Record)*



In addition, the retention in care after 12 months on ART in the CoK is low (83.3%) in the age group of 15-24 (Figure 23). These data show that the CoK has to improve HIV quality of care especially for adolescents.

Figure 24: *Retention in care after 12 months on ART in the city of Kigali*

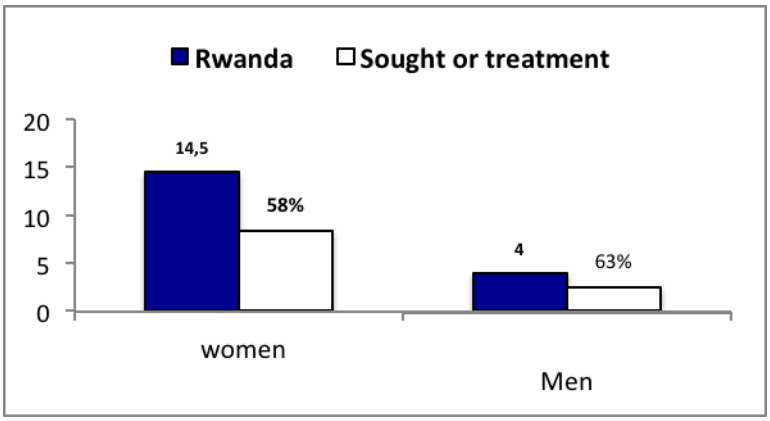


3.2.6 Control of sexually transmitted infections (STIs) in the CoK

More than 30 different bacteria, viruses and parasites are known to be transmitted through sexual contact. Eight of these pathogens are linked to the greatest incidence of sexually transmitted infections (STIs). Of these 8 infections, 4 are currently curable: syphilis, gonorrhoea, chlamydia and trichomoniasis. The other 4 are viral infections and are incurable: hepatitis B, herpes simplex virus (HSV or herpes), HIV, and human papillomavirus (HPV). Symptoms or disease due to the incurable viral infections can be reduced or modified through treatment and control.

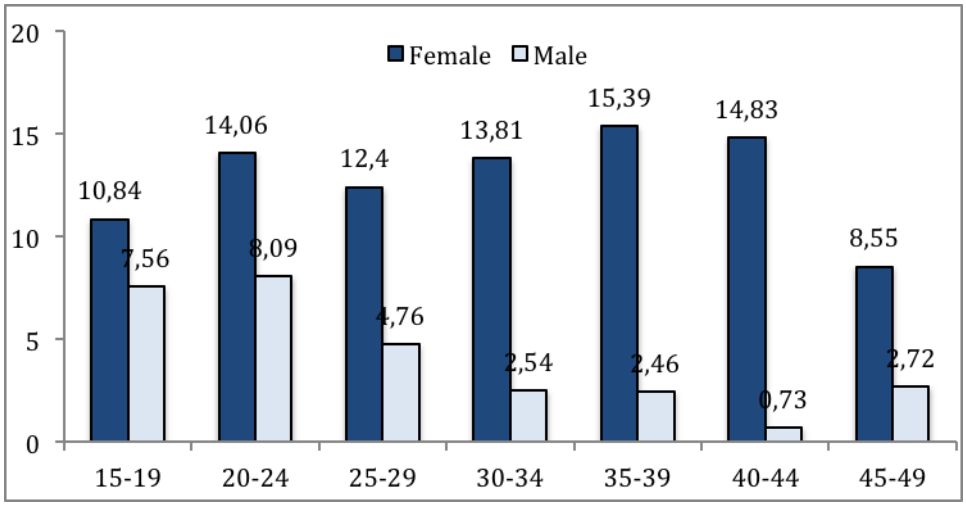
The Rwanda 2015-DHS data showed that HIV prevalence is higher among respondents with a recent history of STIs or STI symptoms than among those with no recent STIs or STI symptoms (7 percent versus 4 percent). These DHS 2015 data show that the prevalence among adults varies from 4% to 14,5% in men and women, respectively (Figure 24).

Figure 25: *Prevalence of STIs among adults*



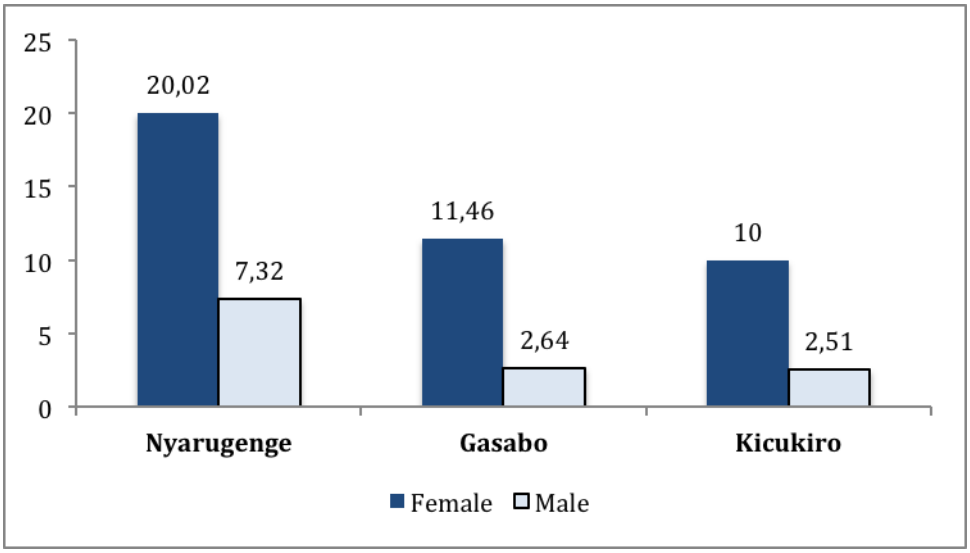
In addition, DHS-2015 shows that the City of Kigali has a high prevalence of STIs in almost all age groups

Figure 26: *Prevalence of STIs in different age groups in the City of Kigali*



Nyarugenge district shows a high prevalence of STIs (20.02% in females vs 7.32% in males) compared to Gasabo (11,46% in females *vs* 2.64% in males) and Kicukiro districts (10% in females vs 2.51% in males, respectively (Figure 26).

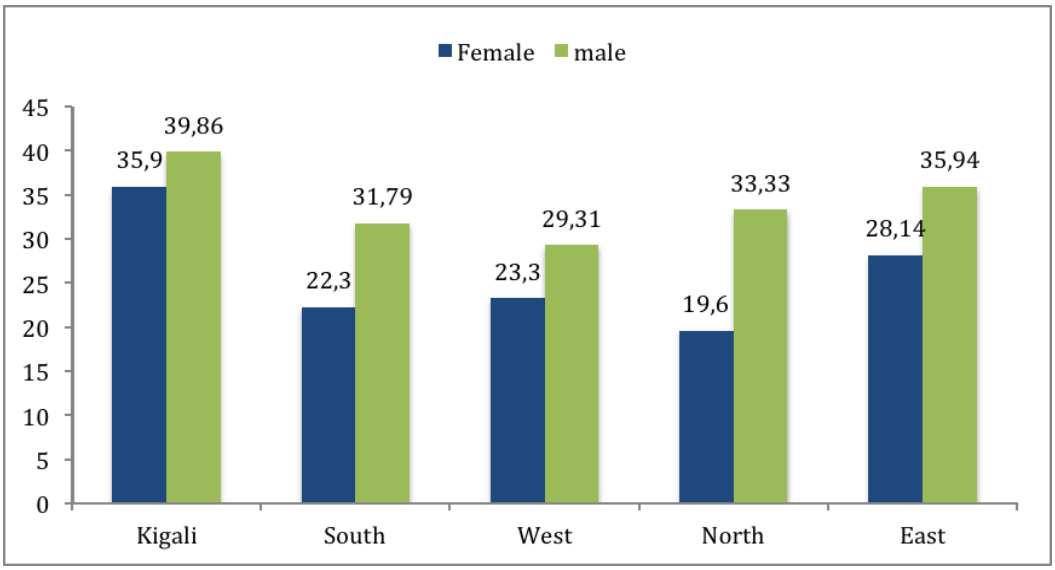
Figure 27: *Prevalence of STIs in 3 districts of the City of Kigali*



3.2.7 Adolescent Sexual Reproductive Health (ASRH)

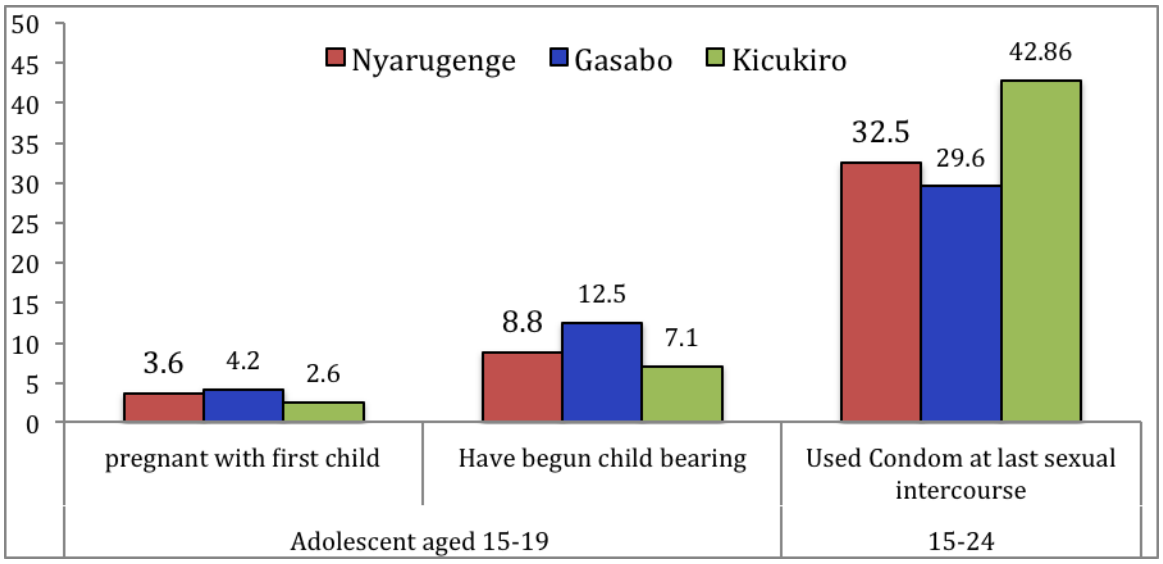
According to RDHS 2015, the median age the first sexual intercourse is at 18 and 19 years of age for female and male respectively in the city of Kigali.
More than 35% of adolescent and young adults aged 15-24 years are sexually active (Figure 27).

Figure 28: *Percent of adolescent 15-24 years who are sexually active by province (Source: DHS 2014-2015)*



Teenage pregnancy in the city of Kigali districts was higher varying from 2.6% in Kicukiro to 4,2% in Gasabo. Condom use among adolescent aged 15-24 years was also lower in Gasabo district (Figure 28).

Figure 29: *Adolescent pregnancy and condom use in the City of Kigali*
(Source: DHS 2014-2015)



3.2.8 Comprehensive knowledge on HIV and SRH

Comprehensive knowledge[3] about AIDS was assessed in RDHS 2014-15 using a combination of questions on common misconceptions about transmission of AIDS and HIV (a healthy-looking person to have the AIDS virus and whether a person can contract the AIDS virus from mosquito bites, by supernatural means, or by sharing food with a person who has AIDS) (Figures 29 & 30).

Figure 30: *Comprehensive knowledge about AIDS in the City of Kigali and 3 districts*
(Source: DHS 2014-2015)

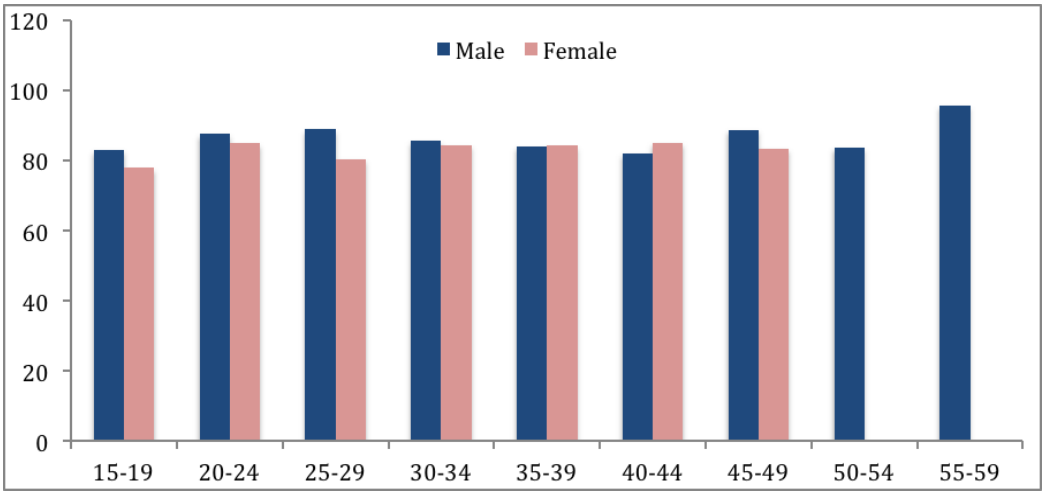
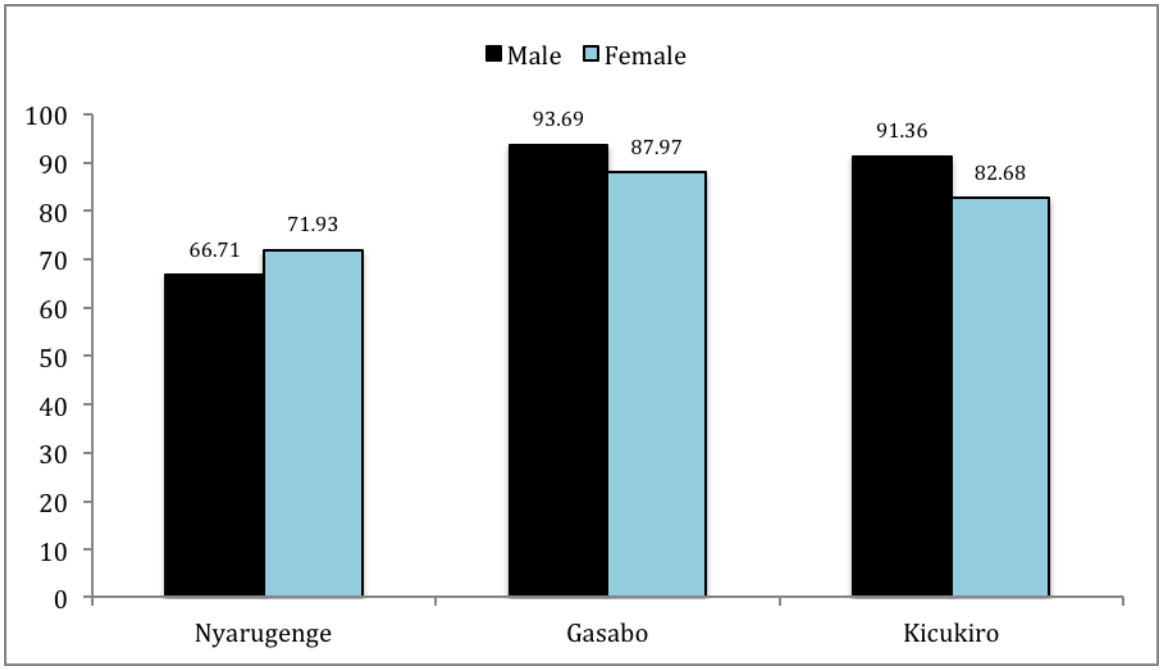


Figure 31: Comprehensive knowledge about AIDS in the City of Kigali by district
(Source: DHS 2014-2015)

[3] Comprehensive knowledge (as per DHS): Percentage of young women (15-24 years) who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can have HIV.



The prevalence of comprehensive knowledge on HIV and SRH in Nyarugenge district is below 80% when compared to other districts in both males and females age groups, respectively (Figures 31 & 32).

Figure 32: *Comprehensive knowledge about AIDS in the City of Kigali by district, Male (Source: DHS 2014-2015)*

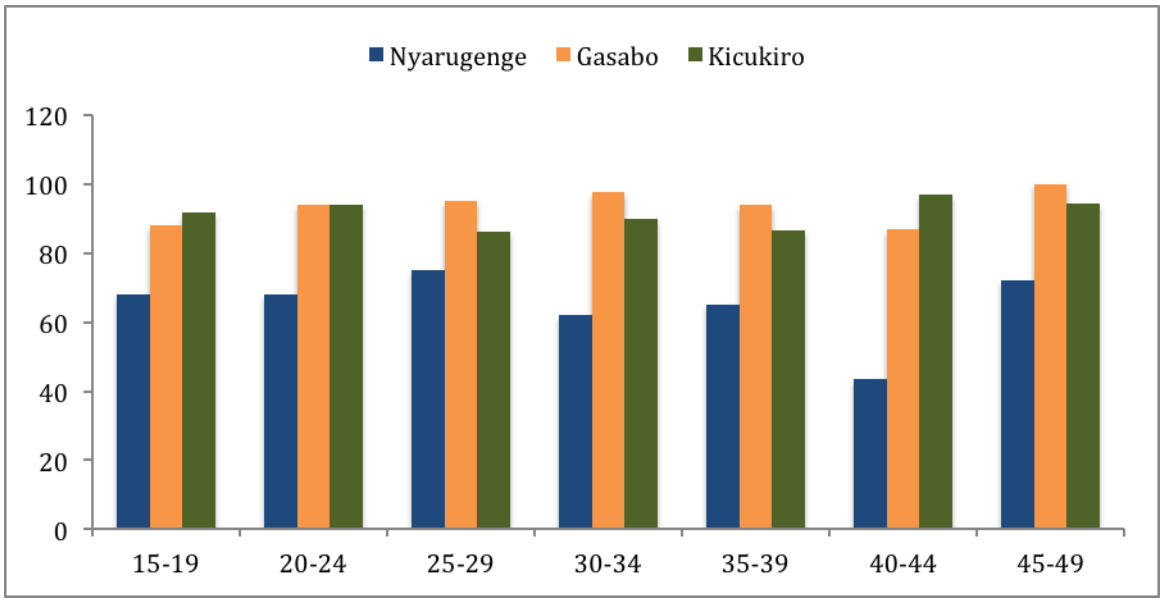
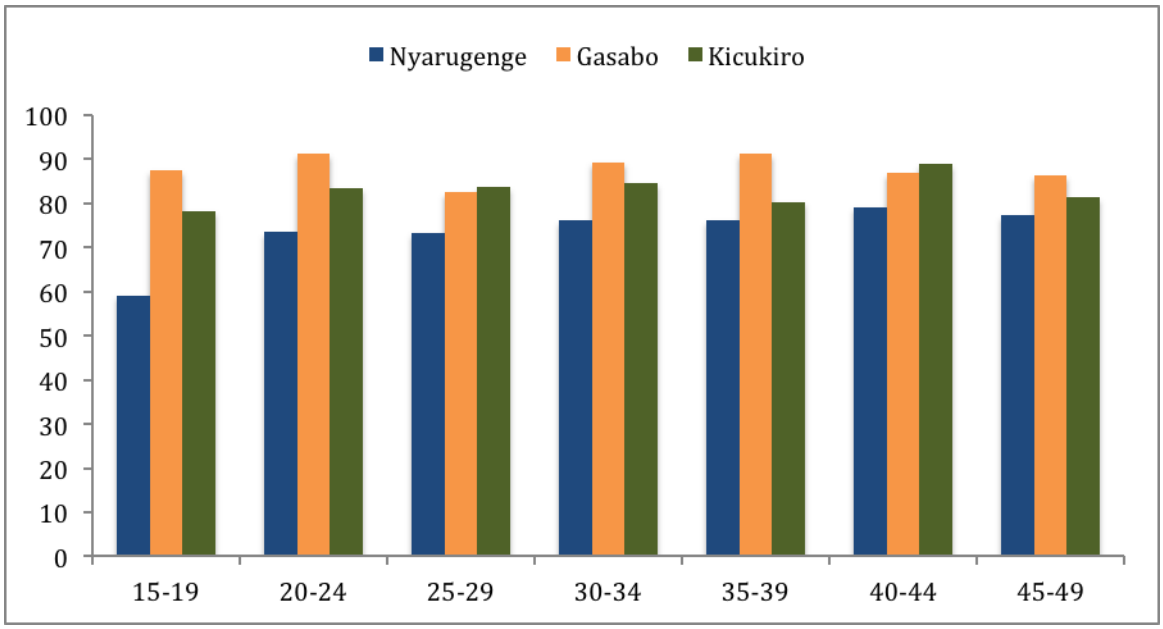


Figure 33: *Comprehensive knowledge about AIDS in the City of Kigali by district, Female (Source: DHS 2014-2015)*



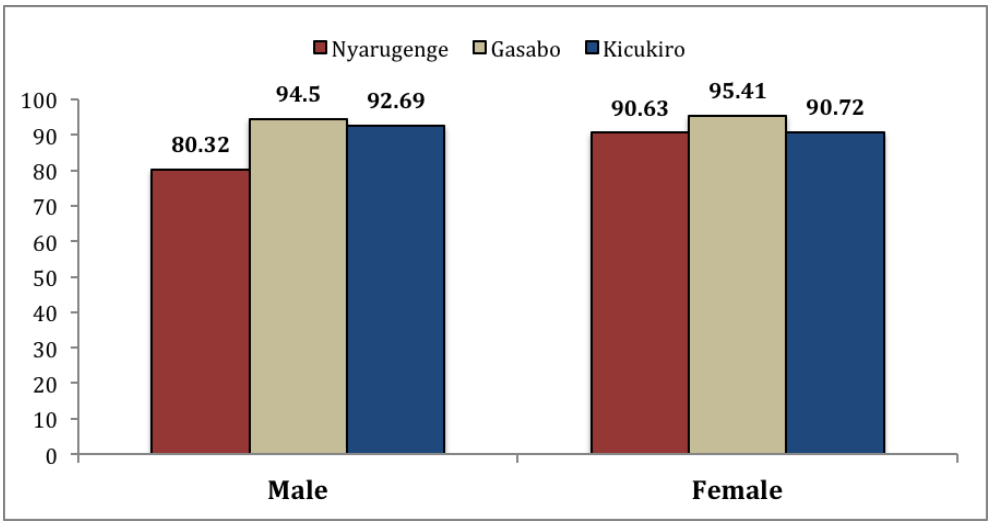
3.2.9 Comprehensive knowledge of PMTCT

Reduction of new paediatric HIV infections remains high on the national agenda for the HIV response. The Government of Rwanda has developed a number of strategies to prevent paediatric infections and ensure a better life for those children living with HIV. These include the strategic plan for elimination of mother-to-child transmission and the adoption of Option B+.

In last four years, the Mother To Child Transmission (MTCT) rate has been kept below 2% in Rwanda. A cohort of infants born from October to December 2015 was followed up for 18 month and the MTCT rate was calculated. In the city of Kigali, the MTCT was estimated at 1.57 %. This MTCT rate was not statistically different to the national estimate of 1.5%.

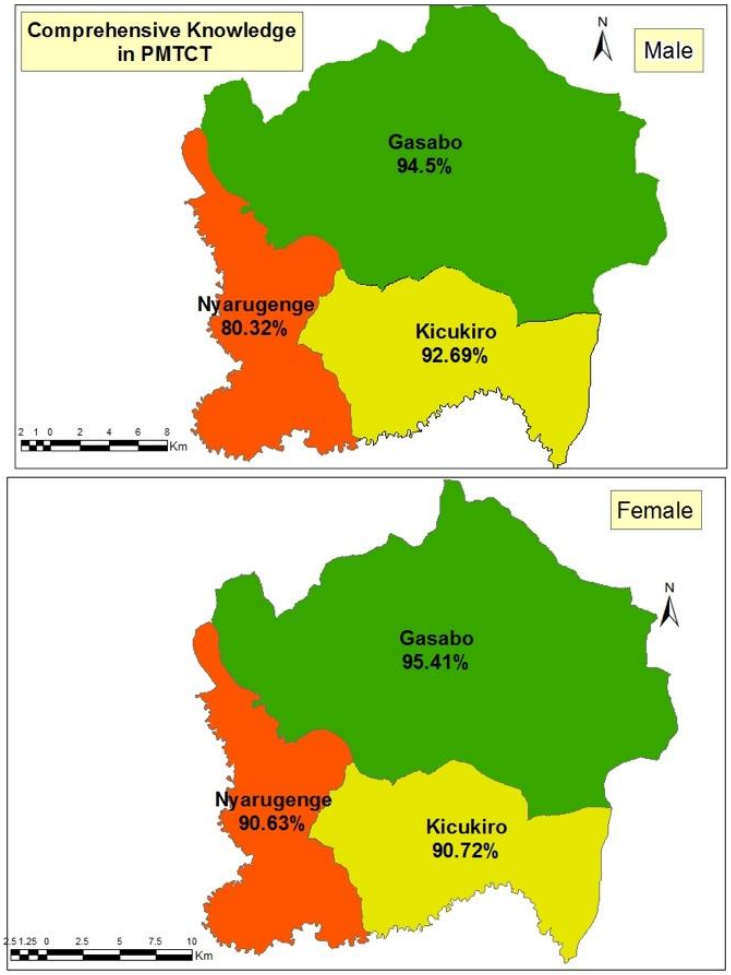
In DHS 2014-15 the knowledge on mother to child was composed of two variables (HIV can be transmitted from mother to child by breastfeeding and that the risk of mother-to-child transmission (MTCT) of HIV can be reduced by the mother taking special drugs during pregnancy). Comprehensive knowledge about PMTCT was less reported in Nyarugenge District in both males and females (Figure 33).

Figure 34: *Proportion of comprehensive knowledge of PMTC in 3 districts of the City of Kigali (Source: DHS 2014-2015)*



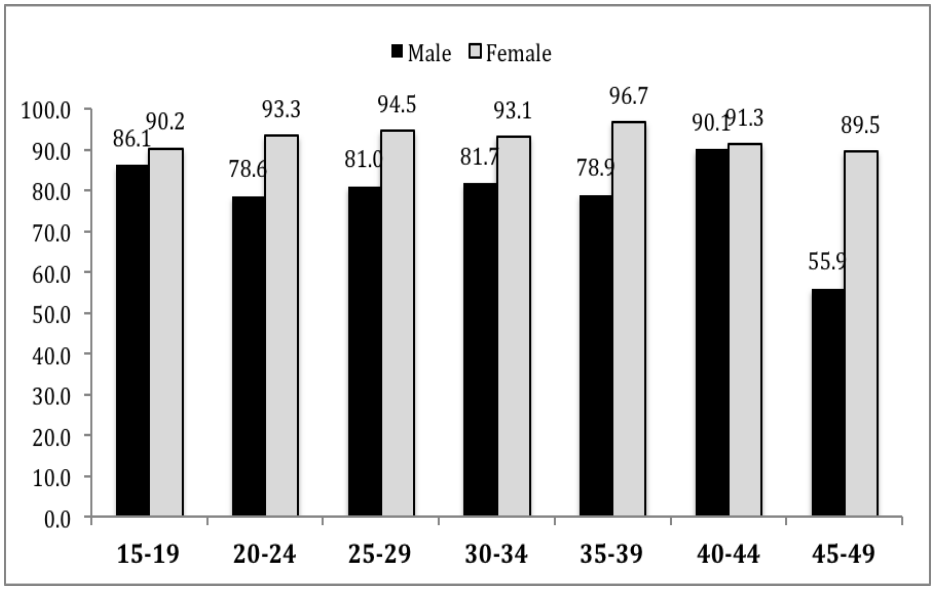
The below map (Figure 34) gives overall information on district performance regarding comprehensive knowledge on PMTCT in 3 districts of the City of Kigali.

Figure 35: *District performance for comprehensive knowledge on PMTCT in the City of Kigali (Green: best performance; yellow: mild performance; red: low performance)*



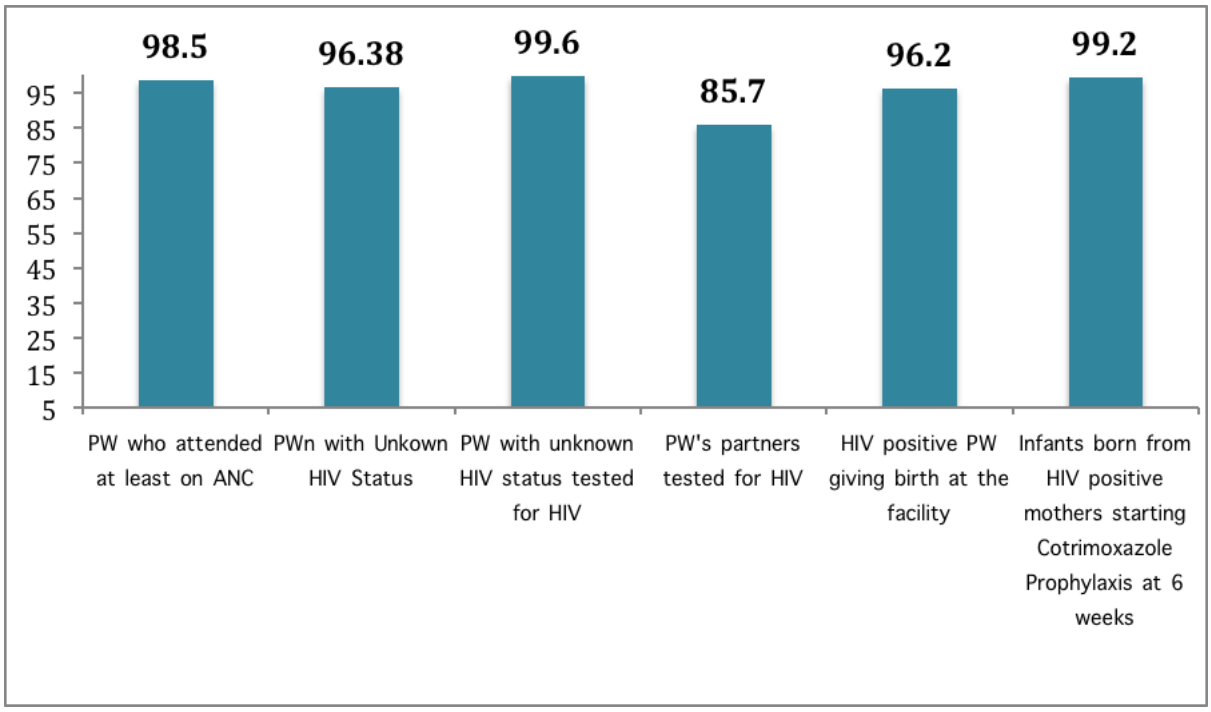
In general, females show a high rate of comprehensive knowledge about PMTCT in all age groups in the CoK (Figure 35).

Figure 36: *Comprehensive knowledge about PMTCT by age groups and sex in the City of Kigali*



In the City of Kigali, 98.5% pregnant women attend at least one antenatal care. Among them, 3.6% are known HIV +. 99.6% of pregnant women who do not know their status are tested for HIV and have received results, while 85.7 % of their male partners were also tested. (Figure 36)

Figure 37: *PMTCT Cascade in the City of Kigali* (Source: HMIS July 2016- June 2017)

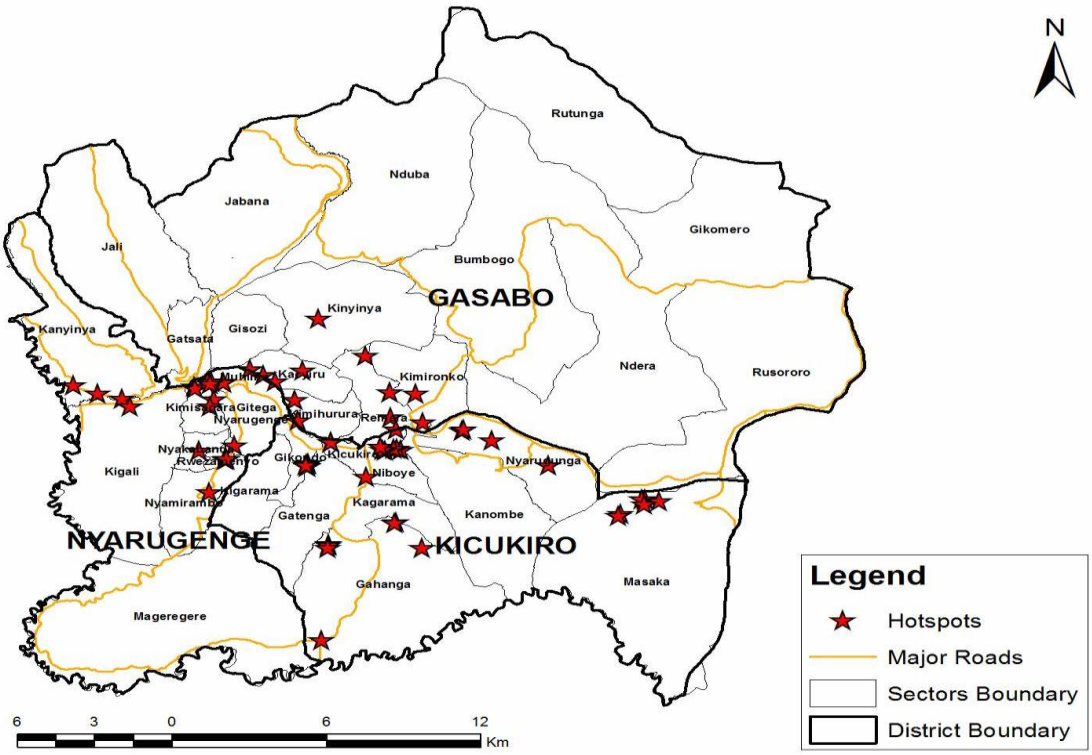


*PW: Pregnant Women

3.2.10 Key population

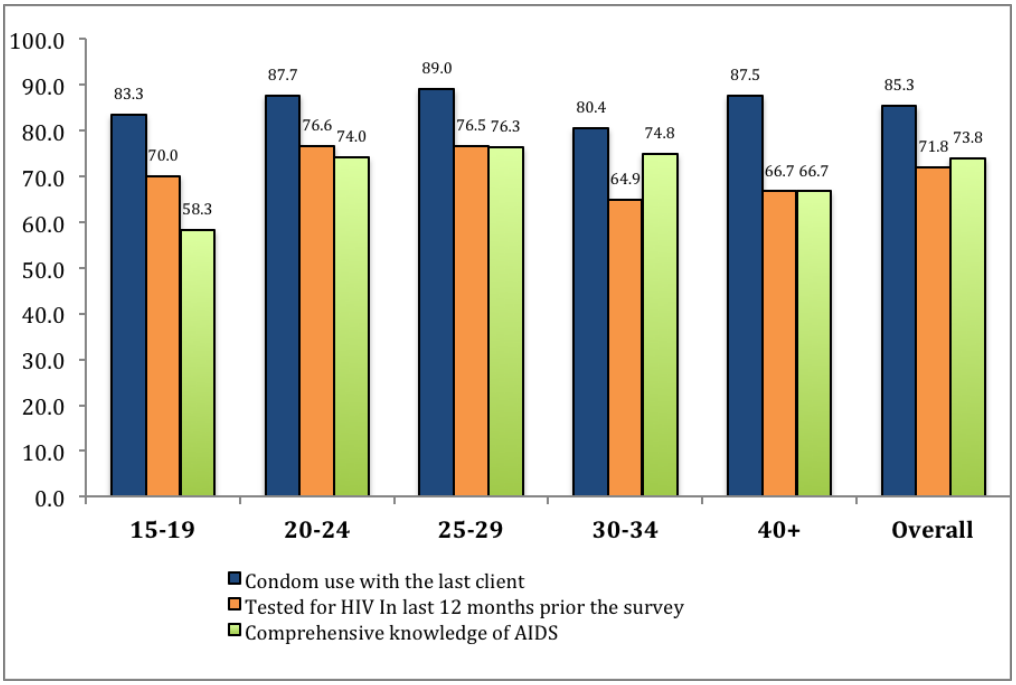
The mode of transmission identified key population as female sex workers (FSW), Men who have sex with men (MSM) and sero-discordant couples (SDC). The Integrated behavior and Biological survey among FSWs conducted in 2015, showed a high HIV prevalence of 45.8%. Although HIV prevalence has slightly decreased from 51% in 2010, Kigali city prevalence among female sex workers remained the highest in the country and unchanged at 55% [4] (Figure 37).

Figure 38: *Hotspots FSW in the City of Kigali (Source: RBC-HIV Division)*



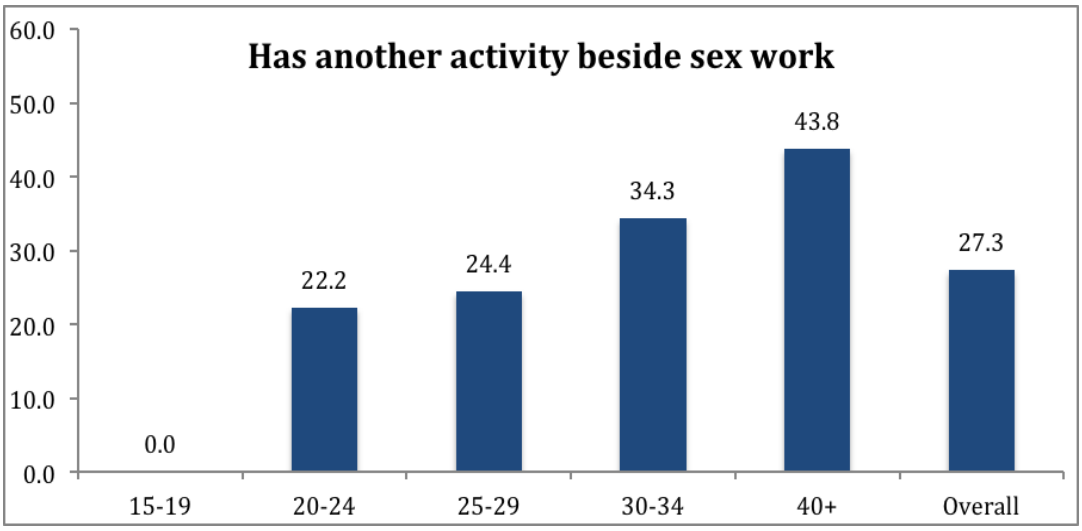
It is estimated that 31.7% of adults FSW in Kigali are young women (15-24 years). The figure bellow shows the coverage of condom use with the last client, recent HIV Testing, comprehensive knowledge of AIDS and involvement on other activities beside sex work (Figure 38).

Figure 39: *Condom use, HIV Testing and Comprehensive knowledge about Aids among Female Sex workers in the City of Kigali (Source: BSS-FSW 2015)*



The majority of FSW who reported to have another activity than sex work were above 30 years (Figure 39).

Figure 40: *Percent of female sex workers who self reported having another source of income beside sex work in the city of Kigali (BSS-FSW: 2015)*



Rwanda also conducted the first behavioral surveillance survey among MSM. It was a respondent driven sample of 492 males. Results show that the HIV prevalence among MSM in Rwanda is 4%[4].

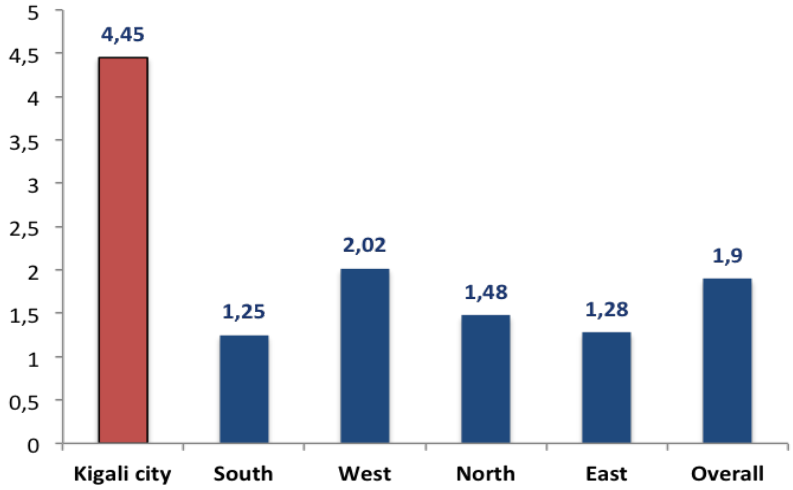
Comprehensive services to key population, including condom distribution (Figure 40), are delivered both at health facility and community levels. Condom is one of the essential services delivered to KPs. By June 2017, 500,701 condoms were distributed through the four condom kiosks displayed in the hotspots of Kigali (Migina, Corridor, Nyamirambo-Matimba and Gikondo-Magerwa).

Figure 41: *Launching of condom kiosk in the City of Kigali (Source: RBC-HIV Division)*

The DHS-2015 data show a high prevalence in the City of Kigali (4.45%) for men who pay for sex comparing to other districts (Figure 41).

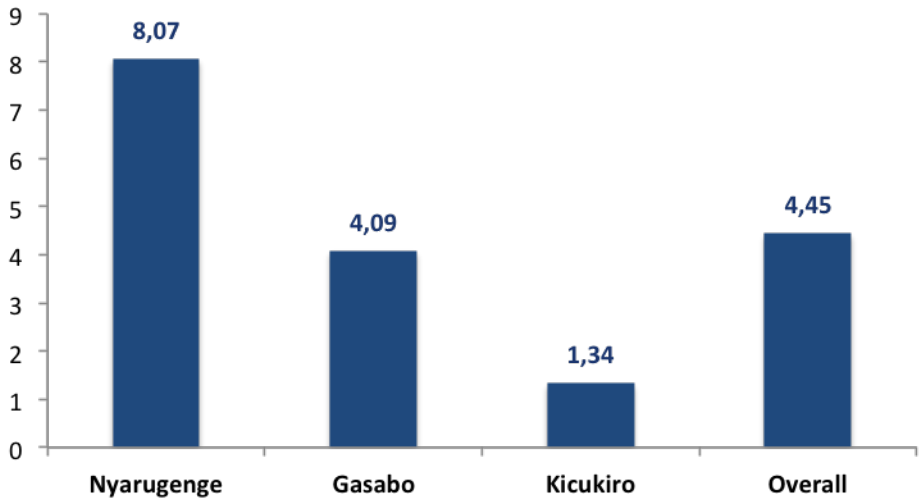
[4]2015 Integrated Behavior and Biological Surveillance survey among Men having Sex with Men

Figure 42: *Proportion of men who paid for sex in the last 12 months prior the survey in all districts (Source: DHS-2015)*



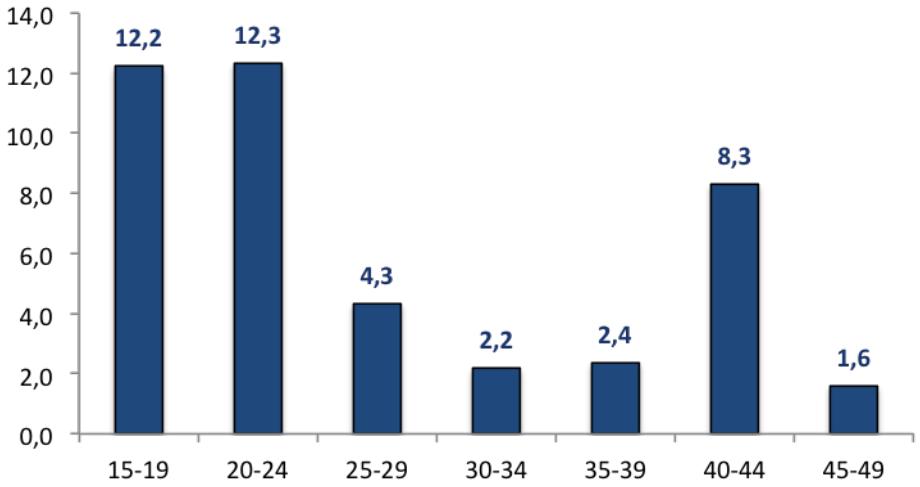
In Nyarugenge district, the proportion of men who pay for sex is high than in other districts of the CoK (Figure 42).

Figure 43: *Proportion of men who paid for sex in the last 12 months prior the survey in 3 districts of the City of Kigali (Source: DHS-2015)*



There is a remarkable high proportion of men who pay for sex in age groups between 15-24 (Figure 43). This could be due to the fact that most adolescents' males are independent and always seek to test for their experience for sex activity. Additionally, the proportion rates could biased in adults' males' age groups (25-45) who are married and are not supposed to self-report paying for sex.

Figure 44: *Proportion of men who paid for sex in the last 12 months prior the survey in all age groups in the City of Kigali (Source: DHS-2015)*



The City of Kigali has a high proportion (4,45%) of men who pay for sex comparing to other provinces (Figure 44) and Nyarugenge district has a record number (Figure 45).

Figure 45: *Proportion of men who paid for sex in the last 12 months per provinces (Source: DHS-2015)*

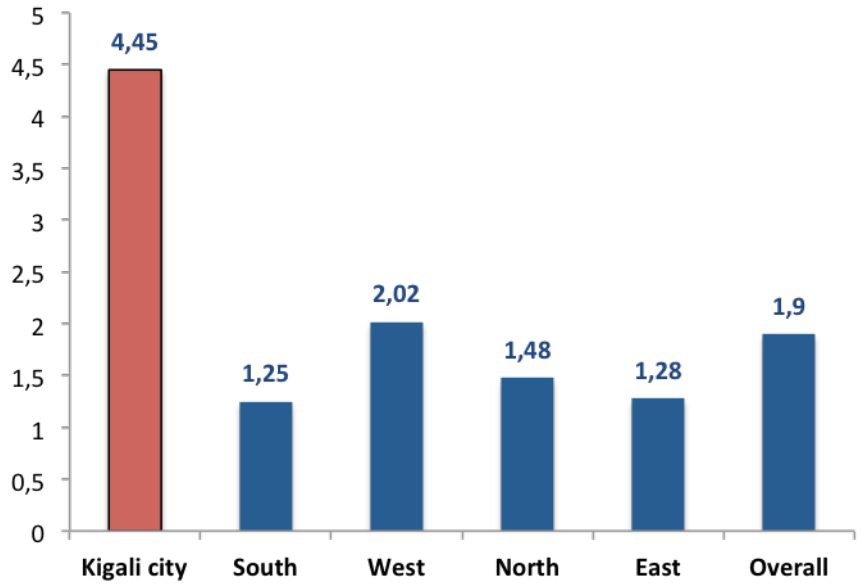
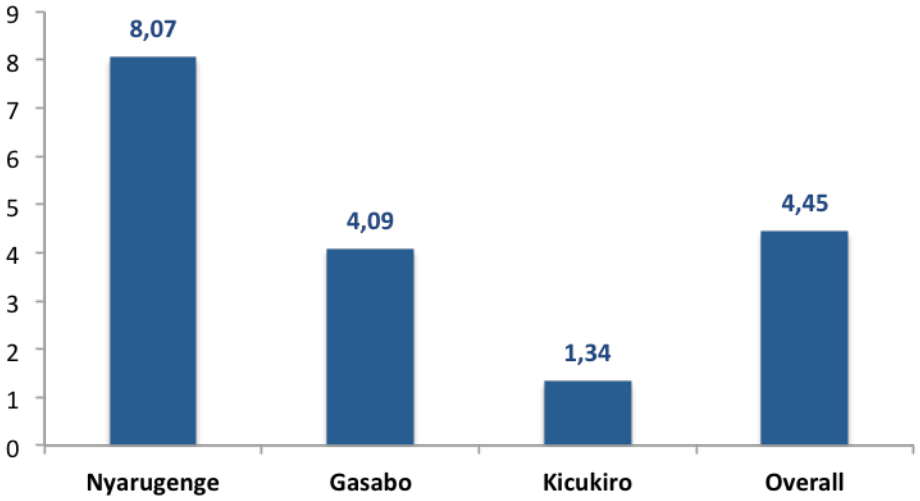


Figure 46: *Proportion of men who paid for sex in the last 12 months per district of the City of Kigali (Source: DHS-2015)*



SECTION 4. The City of Kigali Monitoring and Evaluation Framework for HIV program

4.1 Introduction

The M&E Plan examines the status of monitoring and evaluation in the national response; presents the results framework of all the core programme areas and other strategic interventions; the results corresponding indicators; the needed data sources; the data collection, management and reporting; the institutional and management arrangements; and the costed implementation plan.

The overall goal of the City of Kigali M&E plan is to support the generation and use of strategic information in decision making and optimal resource allocation for AIDS response.
The specific objectives are :

i. To increase capacity and strengthen systems for leadership, organization, planning, partnerships, coordination of HIV monitoring, evaluation and management
ii. To increase human resource, logistical and strategic capacity and systems for monitoring and evaluation
iii. To enhance systems and capacity for routine HIV programme data collection, management, support supervision and data quality assurance
iv. To increase capacity and systems for routine logistics and supplies monitoring and quality assurance
v. To strengthen capacity and systems for routine HIV financial monitoring, budget and expenditure analysis
vi. To strengthen capacity and systems to generate strategic HIV information through biological and behavioural surveillance, surveys and research and
vii. To strengthen capacity and systems for HIV Information dissemination, utilization, learning & Comprehensive Knowledge Management

At the level of CoK the HIV response priorities are aligned to the current National Strategy for Transformation Priorities, the National Health Policy and the National HIV Strategic Plan (2018-2023).
The following are the identified priority commitments summarized in 3 logical frameworks for the CoK for its HIV and AIDS response (Diagrams 1, 2 & 3):

1. Reduced HIV incidence rates in the City of Kigali
2. Reduced HIV related morbidity and mortality among PLHIV in the City of Kigali
3. Reduced unwanted pregnancies in the City of Kigali

It is anticipated that effective implementation of these objectives, will contribute to the City of Kigali's achievement of the 90-90-90 targets.
During the next 5 years 2018-2023, the City of Kigali is expected to implement this strategic plan through the leadership of the 3 districts.

4. *Logical Framework 1: Reduced HIV incidence rates in the City of Kigali*

Four indicators have been defined to achieve this target within the next five years :

- Increased parcent who know their HIV status in the City of Kigali
- Increased prevalence of VMMC
- Increased consistent condom use
- Reduced HIV vertical transmission

The yielding interventions include; "the treat all HIV+, Free condom kiosks and Voluntary counselling and testing initiatives.

The most important control areas for the HIV epidemic in the city of Kigali and Rwanda in general include anti-retroviral treatment as the first one and probably the most important tool to support in fighting stigma, bring about behaviourial change, prevent mother-to-child transmission and ensure blood safety.

On the other hand, free condom kiosks placed in high risk areas in Kigali city, help control the spread of HIV. The kiosks ensure condom accessibility 24 hours daily to members of the community, individuals can pick free condoms and educational materials on safer sex practices. These will be increased accross the whole city.

Voluntary counselling and testing is also an initiative credited for great outcomes in terms of treatment, care and prevention of HIV/AIDS in Rwanda. Sites will be placed in strategic places to entice people from their busy working routine into testing.
Specific attention will be paid to addressing barriers that key populations encounter when accessing preventive health services. Health care providers will be trained on friendly services provision to key populations, in particular, adolescents, FSW and MSM. These friendly services will include HTS at health facility level and in the community through outreach, family planning and reproductive healthcare, STI screening, and treatment. The initiative from the ministry of health for creating « health posts » for better HIV access services will be emphasized in the City of Kigali during the implementation of this strategic plan 2018-2023.

5. Logical Framework 2: Reduced HIV related morbidity and mortality among PLHIV in the City of Kigali

In Rwanda, mortality and morbidity among PLHIV have reduced in recent years due to the coverage of ARV, early initiation and improvements in diagnosis and treatment of opportunistic infections such as tuberculosis, etc. Mortality has decreased by 82% in last two decades. PMTCT has almost reached universal coverage and number of new HIV infections occurring in the age group 0-14 years' account for less than 500 per year.
For better achieving this logical framework, for indicators have been identified:

- Increased linkage to HIV treatment
- Increased HIV treatment coverage and retention to care
- Increased diagnosis and treatment of HIV co-infections
- Increased viral load suppression

6. Logical Framework 3: Reduced unwanted pregnancies in the city of Kigali

Global initiatives such as "Adolescent ALL IN" that focuses on adolescent and young adult interventions for HIV prevention, care and treatment, and sexual reproductive health are being initiated in Rwanda and a national operational plan has been developed. "Adolescent ALL IN" is a platform aiming to drive better results for adolescents (aged 10-19 years) and young adults (aged 20-24 years) through critical changes in programs and policy. It seeks to engage adolescents and unite actors across sectors to accelerate reduction in new HIV infections as well as improving the SRH of adolescents by a strong emphasis on unwanted pregnancies.

The following indicators have been identified for this framework:

- Increased comprehensive knowledge of HIV and PMTCT in the City of Kigali
- Increased family planning uptake
- Reduced HIV-related risky sexual behaviors among adolescents

In order to enhance primary prevention of HIV among adolescents in the City of Kigali, youth sensitization will be reinforced and provided through peers. Anti-AIDS clubs, peer educator systems, youth corners, health posts and youth friendly centers (YFCs) will be working through a more effective and monitorable system. This system will target adolescents and young adults both in and out of schools. Pre-nuptial testing and counseling will be reinforced and will cover all components of primary prevention beyond its current limitation to HTS in several facilities in the City of Kigali. Vulnerable young girls and young FSW will be specifically targeted. Furthermore,

emphasis will be put on young boys who represent around 36% of FSW clients as per 2015 behaviour and biological surveillance survey of FSW.

Moreover, the prevention of unwanted pregnancies among young women living with HIV and AIDS will continuously be supported to reduce unmet need for family planning. The City of Kigali will increase family planning services in health facilities including “health posts”. The availability of condoms for dual protection will be ensured and will always be coupled with counseling for consistent and correct utilization.

Diagram 1 *Logical framework Prevention*

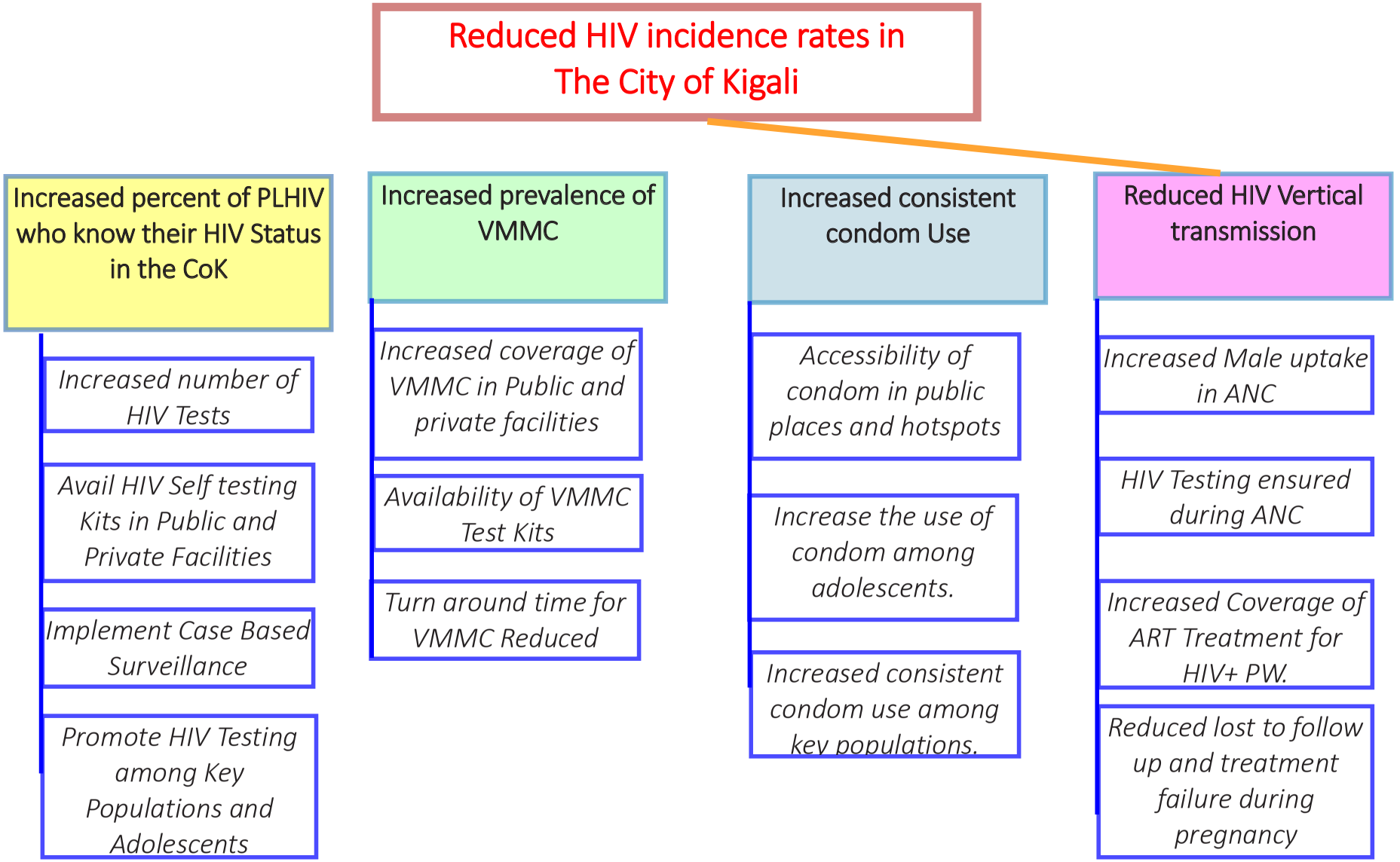


Diagram 2. *Logical framework Care and Treatment*

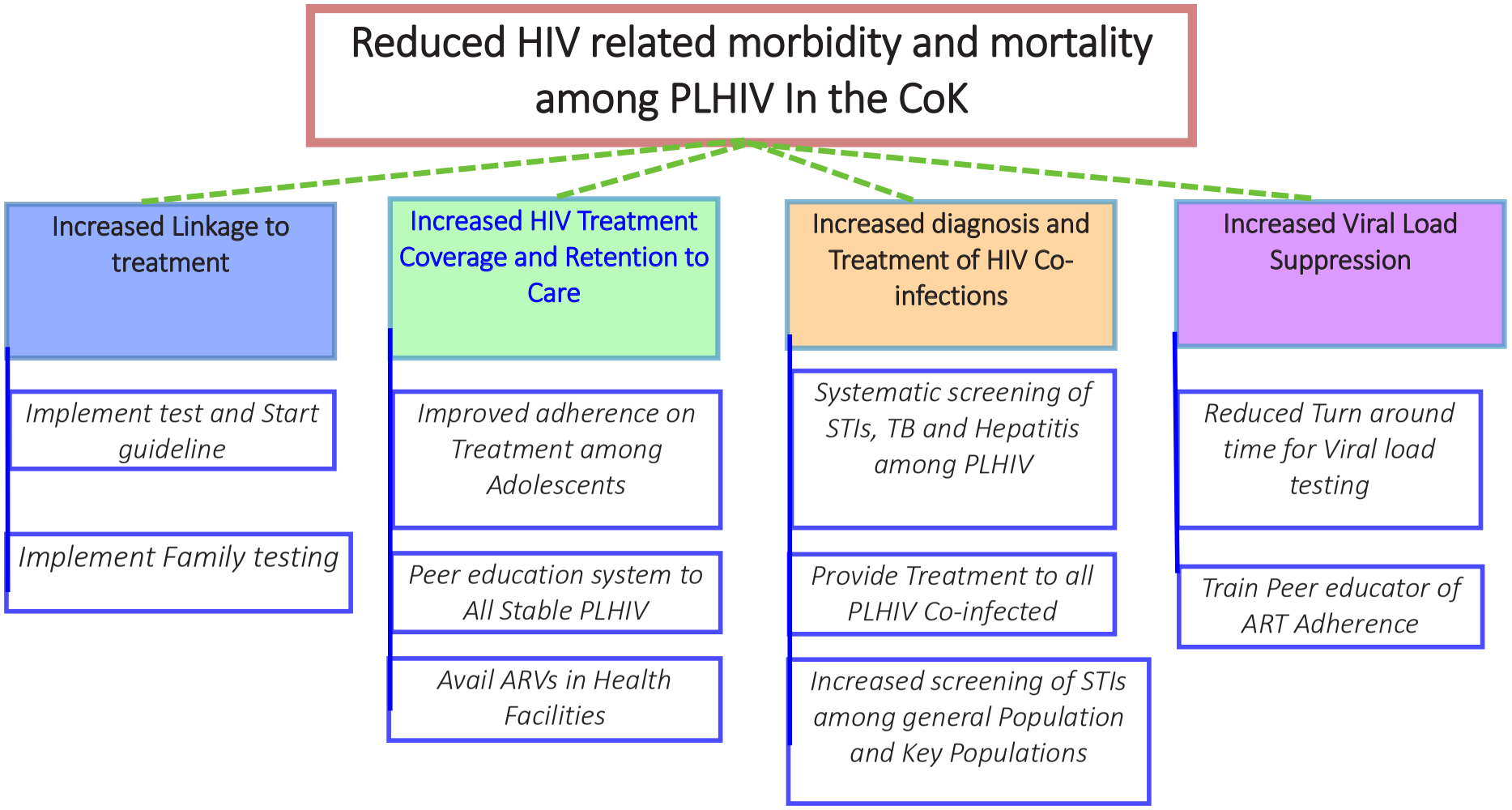


Diagram 3. *Logical framework Sexual and reproductive health*

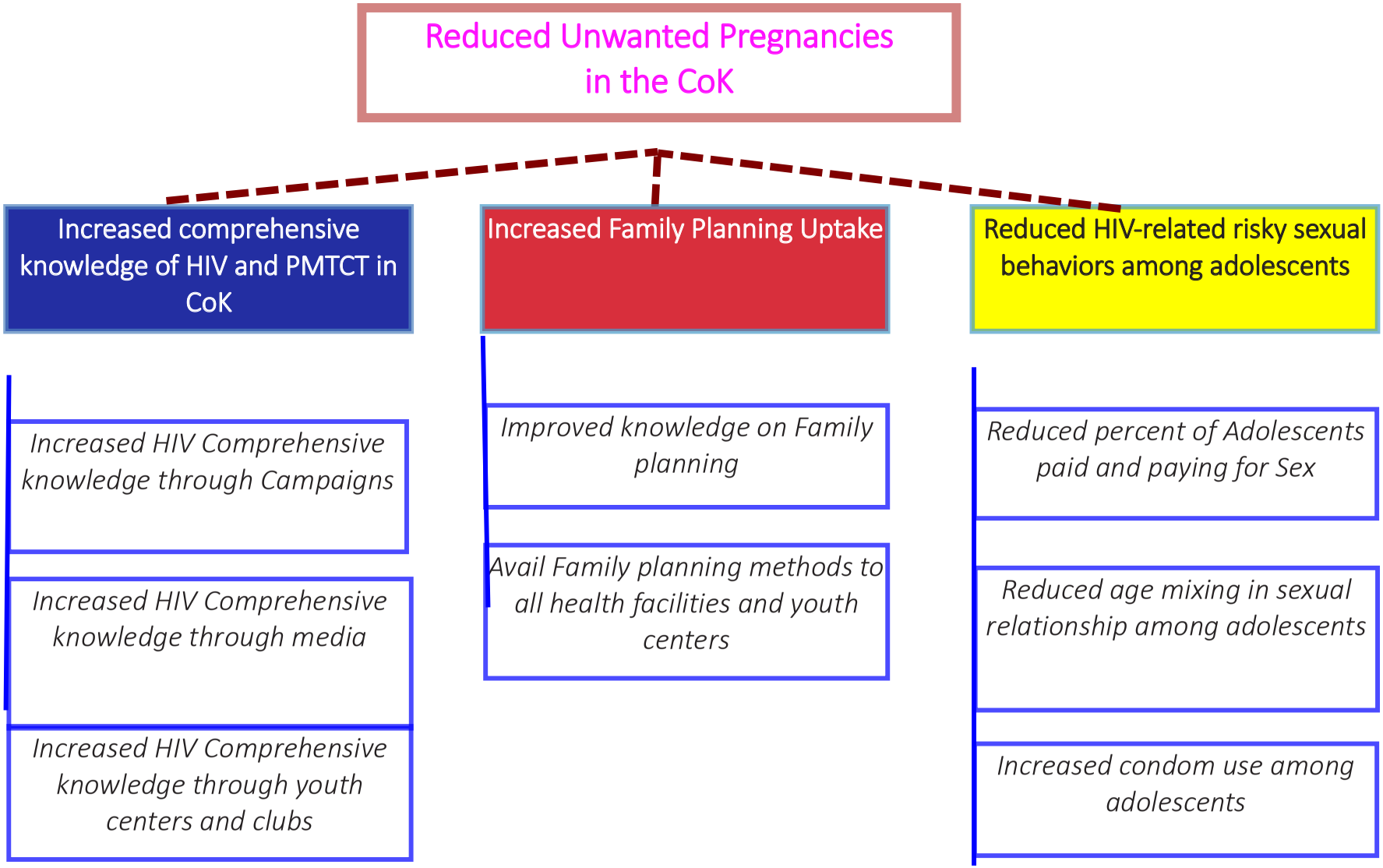


Table 4: *Summary of logical frameworks*

Intervention	Outputs	Outcomes	Impact
Intervention 1. HIV Testing	○ Increased number of HIV Tests ○ Avail HIV Testing guidelines and algorithm in Testing services ○ Increase the accessibility of HIV Testing Kits in Public and private facilities ○ Improve testing strategies by availing HIV Self testing in Public and Private facilities ○ Facilitate the implementation of new testing strategies and innovations: Recency testing , … ○ Promote HIV Testing among Key Populations (MSM and FSW) ○ Design HIV Testing messages for Adolescents and youth	Increased percent of PLHIV (Adolescent and adults) who know their HIV Status in the City of Kigali Improved capacity at health capability to implement and support national HIV programs Increased number of PLHIV linked, initiated and retained in treatment	Reduced HIV incidence rates in the City of Kigali Reduced HIV related morbidity and mortality among PLHIV In the city of Kigali
Intervention 2. VMMC	○ Increased accessibility of VMMC in Public and private health facilities ○ Improved availability of VMMC Kits and devices ○ Turn around time for Male circumcision is reduced	Increased prevalence of VMMC	
Intervention 3. PMTCT	○ Increased attendance at Antenatal Care ○ HIV Testing ensured during ANC ○ Improved Male Uptake for Male partners ○ Coverage of ART Treatment for HIV Positive pregnant women is increased. ○ Increased comprehensive knowledge of HIV and PMTCT ○ Reduced lost to follow up and	Increased facility assisted deliveries Increased HIV coverage among Pregnant women who are HIV Infected Increased consistent condom use	Reduced HIV Prevalence Reduced HIV Vertical transmission

	treatment failure during pregnancy.		
Intervention 4. Condom Use	○ Accessibility of condom at public places and hotspots ○ Increase the use of condom among adolescents		
Intervention 5. Care and Treatment	○ Increased linkage to treatment ○ Improved adherence on Treatment among Adolescents	Viral load suppression increased among PLHIV	Reduced Prevalence of STIs
Intervention 6. Control of STIs	○ Increased screening of STIs among general Population and Key Populations	Reduced STIs and Co-Infections cases	
Intervention 7. Sexual Reproductive Health	○ Reduced HIV-related risky sexual behaviors among at risk populations		

4.2 The City of Kigali HIV Strategic Plan Core Programmes, Critical Enablers and Development Synergies

To achieve the above commitments, the city of Kigali has prioritized seven-core intervention programmes, whose effective and efficient implementation is likely to result to the desired results. The prioritization is premised on both national and global evidence of the programmes efficacy. It is in these programmes that the City of Kigali will invest adequately to ensure achievement of desirable results. These programmes are:

viii. HIV testing and counseling
ix. Voluntary Medical Male Circumcision
x. PMTCT
xi. Condom use (promotion and distribution)
xii. Care and treatment support
xiii. Control of STIs
xiv. Sexual reproductive health

Successful implementation of the above-prioritised core intervention programmes will also depend on the extent critical social and programme enablers are identified and adequately implemented by the City of Kigali. The social enablers that have been identified include: political commitment and advocacy, laws, legal policies, and practices, community engagement and mobilization, stigma reduction, use of mass media and local responses to change risk environment.

The programme enabler's range from community centred design and delivery, programme communication (to galvanise support for behaviour change programmes), procurement and supply chain management, gender equality and gender- based violence interventions, research and innovation in addition to engaging local policy decision makers (Table 2).

Development Synergies between social protection, systems (health and community) strengthening, care and support of orphan and vulnerable children will be strengthened via collaboration with development partners and agencies such USAID in its DREAM program. The City of Kigali HIV strategic plan will support interventions promoting a paradigm shift from social welfare to social development through multi-sectorial coordination with joint work plans and budgets.

Table 5: *The City of Kigali HIV Strategic Plan Core Programmes, Critical Enablers and Development Synergies*

Core programmes/interventions	Enabling environment interventions
1. HIV testing and counseling 2. Voluntary Medical Male Circumcision 3. PMTCT 4. Condom use (promotion and distribution) 5. Care and treatment support 6. Control of STIs 7. Sexual reproductive health	8. Laws, legal policies and practices 9. Stigma Reduction and Discrimination 10. Human Rights, Gender Equality and Gender-Base violence 11. Coordination and Management 12. Resource Mobilization and Management 13. Strategic Information Management
Cross-cutting programmes/interventions	**Development sectors (for synergies/interventions)**
14. Social and Behaviour Change Communication (SBCC) 15. HIV Prevention among Key Populations at High Risk of HIV Infection	16. Ministry of health and Rwanda Biomedical Center 17. Ministry of Gender and Family Promotion 18. Ministry of youth 19. UNAIDS, UNICEF, WHO, UNFPA 20. City of Kigali (health and social affairs) 21. Nyarugenge, Kicukiro and Gasabo districts 22. Muhima, Kibagabaga and Masaka district hospitals 23. JhPiego, PEPFAR, CDC, USAID, Imbuto Foundation, Health Development Initiative (HDI), Projet San Francisco, AIDS Health Care Foundation (AHF), PLHIV Association

As is the City of Kigali development framework, the HIV and AIDS M&E framework guarantees focus on: multi-sectorial response, multi-thematic interventions, and participation by both public and non-public sectors and all programmes and service delivery levels; the national, the decentralized and community levels with support of policy makers.

SECTION 5. Core Impact Indicators and Results Frameworks

This section is the main axis of the M&E Plan since it presents the performance framework of the City of Kigali HIV response guided by the recently revised NSP 2018-2023. The performance framework presents the overall impact, outcome and output results contributed to by all the interventions by core programmes, critical enablers and development synergies; the matching indicators, data sources, baseline and set target values over the remaining CoK SP duration (2018 – 2023).

5.1 Overall Impact Indicators

The key results or impact of implementing the CoK SP HIV interventions is to reduce the new HIV infections and to keep those on treatment alive and improving quality of life towards 90-90-90 targets (Table 3).

5.2 Performance Indicators, Targets

Performance indicators are arranged in the following order:

1. Overall impact indicators
2. Core programme indicators/interventions: HIV testing and counseling, Voluntary Medical Male Circumcision, PMTCT, Condom use (promotion and distribution), Care and treatment support, Control of STIs, Sexual reproductive health
3. Cross-cutting programme indicators: Social and Behaviour Change Communication (SBCC), HIV testing and Counseling (HTC), HIV Prevention among Key Populations at High Risk of HIV Infection.
4. Critical enabler indicators – laws, legal policies and practices; stigma reduction & discrimination; Human rights, Gender Equality and Gender-Based Violence; coordination & management; Resource mobilization; strategic information management development sectors synergies.

Details can be found in Table 4.

Table 6: *Impact indicators*

Indicator	Type	Source	Disaggregation	Baseline Value	2019	2020	2021	2022	2023
HIV prevalence among adult 15-49	Impact	DHS 2015	Male	4.40%	na	3.5%	na	na	na
			Female	8%	na	7.0%	na	na	na
			15-24 yrs	2.6%	na	2.0%	na	na	na
HIV Incidence in the City of Kigali	Impact	RAIHIS 2013-14		0.4 per 100 Pyrs	0.25 per 100 pyrs		na	na	na
Percentage of exposed infants who are HIV-free by 24 months	Impact	RBF		98.40%	98.5%	98.5%	98.5%	98.5%	98.5%
Percentage of sex workers who are living with HIV	Impact	IBBS- FSW: 2015	15-49 yrs	55.50%	50%	na	na	45%	na
			15-24 yrs	41.08%	36.0%	na	na	30.0%	na
Percentage of men who have sex with men who are living with HIV	Impact	IBBS-MSM: 2015		4.3	4.0%	na	na	4.0%	na
Prevalence of STIs among adults 15-49	Impact	DHS 2015	Male	4	na	3.5%	na	3.0%	na
			Female	13.2	na	10.0%	na	na	na
Percentage of people living with HIV and on ART who suppressed Viral load (< 1000 copies /ml in the first 6 months of initiation)	Impact	RBF	15-49 yrs	90.1	91.0%	91.5%	92.0%	92.5%	93.0%
			15-24 yrs	90.94	91.0%	91.5%	92.0%	92.5%	93.0%
Teenage Pregnancies (Adolescent who have started childbearing)	Impact	DHS 2015		7.30%	na	5.0%	na	na	na

Table 7: *Performance indicators and targets*

Indicators	Type	Source	Disaggregation	Baseline Value	2019	2020	2021	2022	2023
Percent of PLHIV who know their status	Outcome	HMIS, DHS and Spectrum	ALL	91%	92.0%	93.0%	93.5%	94.0%	95.0%
Prevalence of VMMC	Outcome	DHS 2015	15-49 yrs	50.2	na	60.0%	na	na	na
			15-24 yrs	49.3	na	65.0%	na	na	na
Percent of Pregnant women who delivered at health facility	Outcome	DHS 2015	15-49 yrs	94.2	na	96.0%	na	na	na
Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	Outcome	RBF	15-49 yrs	89.2	90.0%	91.5%	92.0%	92.5%	93.0%
			15-24 yrs	90.7	90.0%	91.5%	92.0%	92.5%	93.0%
Percentage of sex workers reporting the use of a condom with their most recent client	Outcome	IBBS- FSW: 2015	15-49 yrs	85.2	na	88.0%	na	na	na
Percentage of women attending antenatal care	Outcome	DHS 2015		98.5	na	99.0%	na	na	na
Percent of eligible adults and children currently receiving antiretroviral therapy	Outcome	HMIS, Spectrum		97.0	97.0%	97.0%	97.5%	97.5%	98.0%
Percentage of Male and Female tested in the last 12 months prior the survey	Outcome	DHS 2015		38.20%	na	45.0%	na	na	na
HIV Sero-positivity in the City of Kigali	Outcome	HMIS	15-49 yrs	2.40%	2.4%	2.4%	2.1%	2.0%	2.0%
			15-24 yrs	1.40%	1.4%	1.4%	1.2%	1.2%	1.2%
Comprehensive knowledge about AIDS	Outcome	DHS 2015	Female	81.80%	na	85.0%	na	na	na
			Male	85.10%	na	88.0%	na	na	na
Knowledge of prevention of mother-to-child transmission of HIV	Outcome	DHS 2015	Female	92.90%	na	95.0%	na	na	na
			Male	90.20%	na	93.0%	na	na	na
Mean/ Median age at first sexual Intercourse among Sexually active adolescents	Outcome	DHS 2015		17/17	na	1.0%	na	na	na

Percent of Adolescent Male who ever paid for sex	Outcome	DHS 2015		17.10%	na	15.0%	na	na	na
Percent of Adolescent Male who paid for sex in the last 12 months	Outcome	DHS 2015		11.84%	na	7.0%	na	na	na
Number of male adolescents who received VMMC in the last 12 months	Output	HMIS	15-49 yrs	38,392	40,000	40,000	40,000	40,000	40,000
			15-24 yrs	17,379	20,000	20,000	20,000	20,000	20,000
Number of PLHIV on ART	Output	HMIS		48,824	60,000	60,000	60,000	60,000	60,000
Male Uptake	Output	HMIS		85.00%	85.50%	86.00%	86.00%	86.50%	87.00%

5.3 HIV and AIDS Stakeholders and Service Providers Mapping

The CoK mapping of HIV and AIDS services/interventions and Service providers will be conducted every two years. This will build an inventory and database at CoK, Districts (Kicukiro, Nyarugenge, and Gasabo), sectors and umbrella agencies and will greatly aid the, equitable planning, development, coordination and monitoring of the HIV response. This will minimize duplications, overcrowding of areas and inequitable programme interventions.

Mapping information will support the production of service maps against geographical areas to produce an atlas and maps on different services in HIV and AIDS across the city. These maps will be useful for monitoring of service distribution and an analysis of possible relationship with observed levels of different outcome and impact indicators.

In addition to the stakeholder mapping, hotspots data on HIV by district will be generated to guide localized and underserved areas.

Development partners who include United Nations Agencies, Bilateral and Multilateral agencies, international NGOs shall be expected to support the implementation of the M&E plan through funding and technical assistance (Annex 1).

SECTION 6. Coordination of HIV Programmes in the CoK

6.1 Overall CoK Coordination of the HIV Strategic Plan

A coordinated response to HIV/AIDS remains one of the 'grand challenges' facing policy makers today [45].

Effective coordination facilitates the pooling of efforts of many actors for greater synergy. Coordination of the national HIV/AIDS response is critical in combating the epidemic. It is, therefore, important to achieve efficient HIV/AIDS coordination in all districts.

A major goal of HIV/AIDS coordination structures is to promote multisectoral decision making, specifically to involve non-health government departments and non-governmental actors.

The CoK, as the "One Coordinating Authority", shall support the planning, monitoring and evaluation the NSP. The CoK shall be expected to support the strengthening and sustenance of coordination arrangements in all 3 districts and with all the different categories of stakeholders in the national response at all programme levels (MoH, RBC, etc), on or not on project support or funding.

The CoK shall also be responsible for leading and supporting the mobilization of the strategic, human, logistical and material resources for the implementation of the Monitoring and Evaluation Plan at all programme levels.

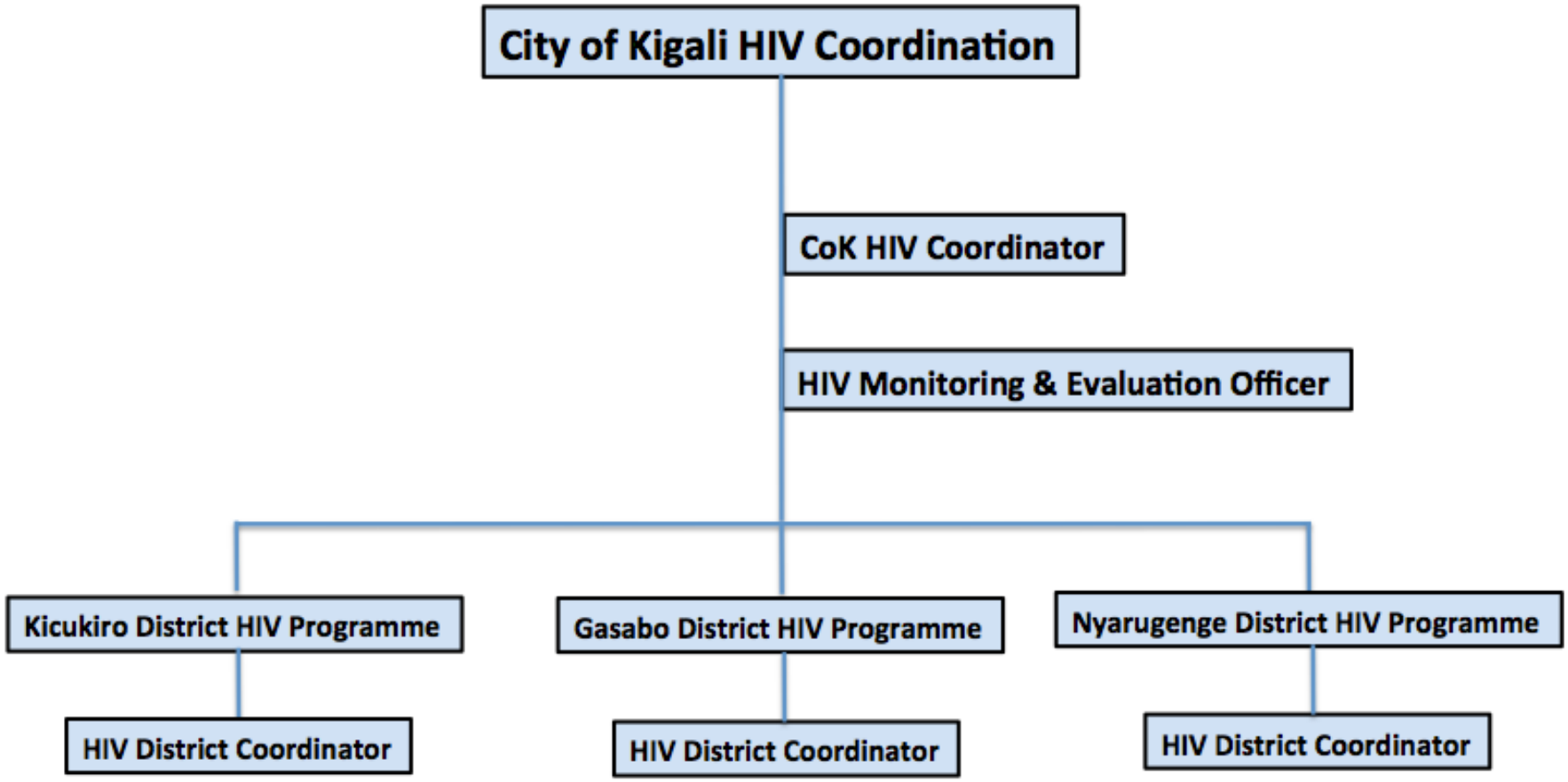
The CoK HIV and AIDS Multisectoral M&E Technical Working Group (M&E TWG) working in collaboration with the various sectoral and thematic TWGs, shall provide the overall technical oversight and strategic direction to the roll out and implementation of this HIV strategic plan.

This document is a policy guideline for strengthening HIV/AIDS coordination at the City of Kigali and district levels. The guideline emphasizes strong, unified leadership at the various decentralized levels. Through this coordination mechanism, stakeholders at district and lower levels will be better linked and have their activities harmonized. The mechanism will also facilitate closer linkages between the district and the national level.

Outcomes from the key-informant interviews of policy makers showed that leadership invested by key members of coordination bodies and commitment of high-level government leaders from the City of Kigali are important factors in controlling HIV/AIDS epidemics in the city and country in general (*Annex 3*).

For effective coordination of HIV programmes, the following structure should be proposed for the CoK.

Figure 47: *Proposed City of Kigali HIV Coordination Structure*



SECTION 7. Activity Costing for the City of Kigali HIV Programme

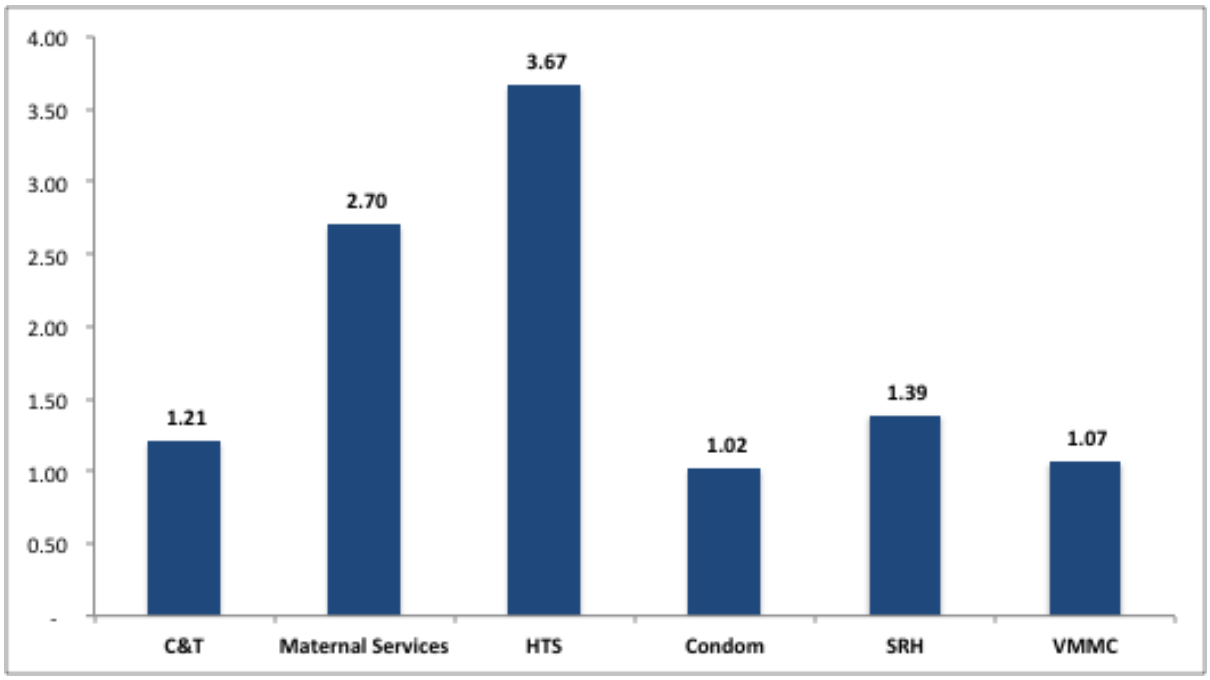
7.1 Activities' Cost of Implementing CoK HIV Strategic Plan

During the period of implementation of the CoK HIV strategic plan (2018 – 2023), the eight intervention components of HIV program will approximately cost about 14.3 USD. The costs are broken down by component in **Annex 2** and displayed below.

Table 8: *Summary of the cost by intervention and per year (in 1.000.000 USD): Total 14.3*

	Year 1	Year 2	Year 3	Year 4	Year 5
C&T	0.29	0.23	0.23	0.23	0.23
Maternal Services	0.57	0.54	0.54	0.52	0.52
HTS	0.75	0.74	0.74	0.74	0.69
Condom	0.23	0.20	0.20	0.19	0.20
SRH	0.28	0.27	0.25	0.34	0.24
VMMC	0.19	0.19	0.26	0.28	0.14
Total	**2.31**	**2.17**	**2.22**	**2.30**	**2.03**

Figure 48: *Summary of the cost by intervention (in 1.000.000 USD)*



The estimated cost shows that HTS intervention will need more funds than other interventions (Table 47) and the funds' trends over next five years will almost be constant (Table 48 & 49).

Figure 49: *Trends of years (in 1.000.000 USD)*

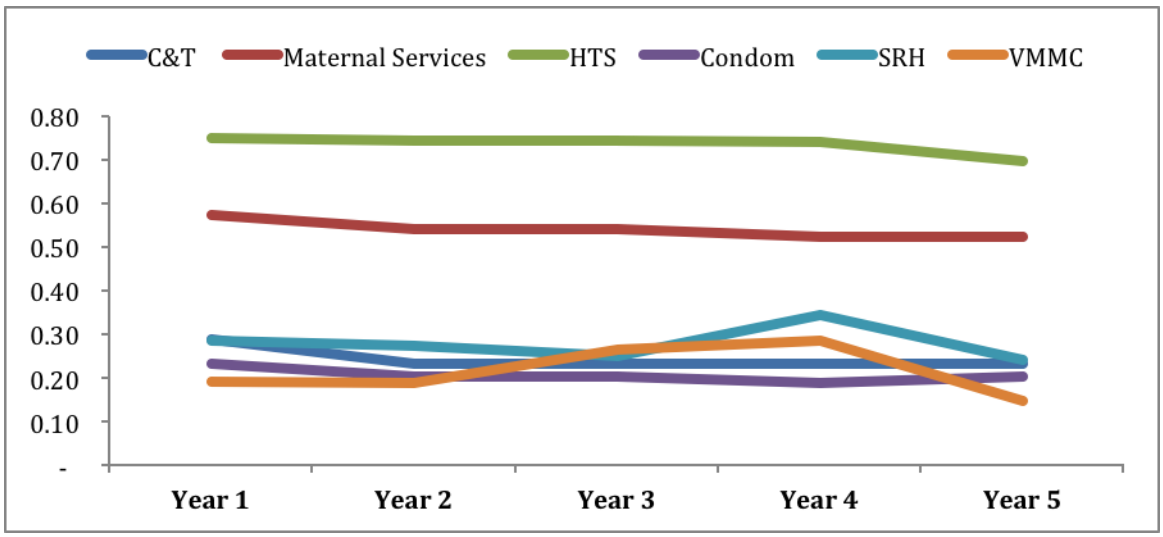
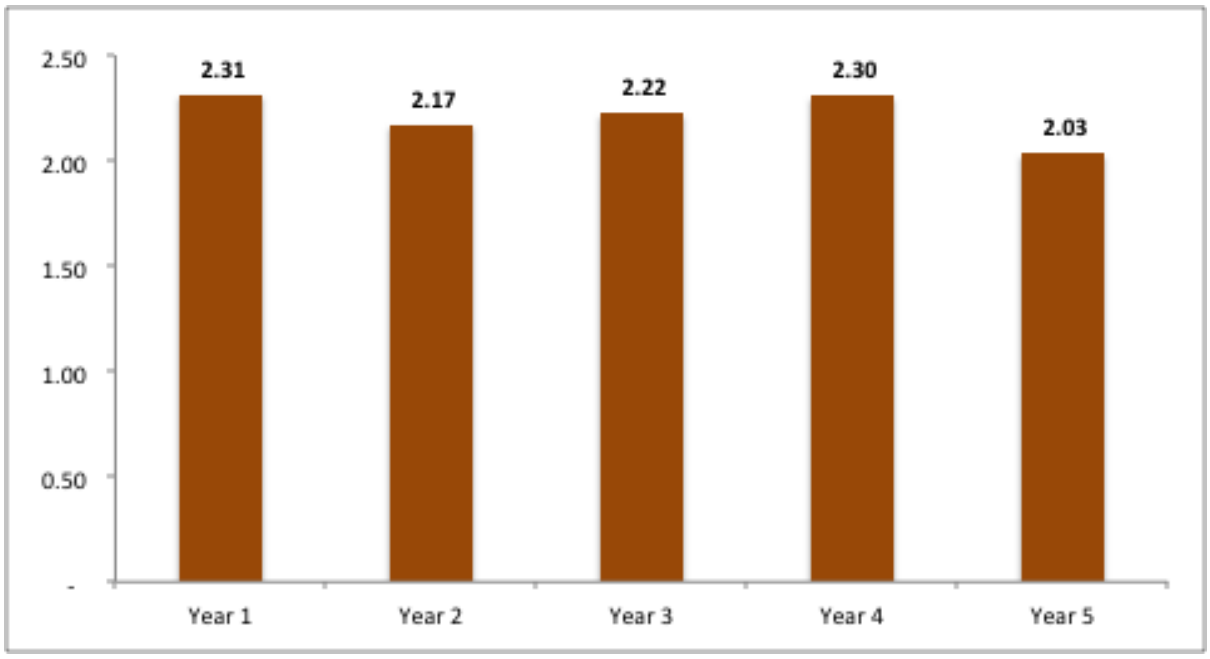


Figure 50: *Trends of years and by intervention (in 1.000.000 USD)*



SECTION 8. Conclusion

This strategic plan shows trends of HIV and SRH data from the City of Kigali. Building upon on these baseline data, it will be possible to define targets and generic indicators to better implementing HIV Strategic Plan for the City of Kigali in order to achieve 90/90/90 goals of HIV treatment for all.

The City of Kigali hosts a large proportion of key populations, which includes female sex workers (55%), men having sex with men and drug users. During the next five years, comprehensive services to key populations including condom distribution by increasing condom kiosks will be one of the major activities to reduce risk of infection among the general population by the City of Kigali.

The “Treat all HIV positive” strategy shows how much the Government of Rwanda is committed to improve lives of its population, especially those who live with HIV-AIDS. Its implementation has not only increased the number of people on treatment but also improved health status of PLHIV.

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Annex 1: Mapping of Key stakeholders in the city of Kigali

Area	Type	Partner-Stakeholders	Coverage-District- Sector		
			Kicukiro	Gasabo	Nyarugenge
Clinical Prevention	Implementing Partner	AIDS HEALTH CARE FOUNDATION	Kacyiru, kimironko, kinyinya, jabana	GAHANGA, GATENGA, MASAKA	RRP+, HDI, Kigali Youth Center, PSF
Clinical Prevention	Implementing Partner	PROJET SAN FRANCISCO	District	District	SFH, AHF, Imbuto Foundation
Community - Peer Education	Umbrella	RRP+	District	District	RRP+
Community Prevention	CSO	AEE	na	District	HDI
Community Prevention	CSO	AGR	na	District	Kigali Youth Center
Community Prevention	CSO	AHC	na	District	PSF
Community Prevention	CSO	Alliance for Health	GIKOMERO		AHF
Community prevention	CSO	Handicap International	All Sectors	??	
Community Prevention	CSO	HEALTH DEVELOPMENT & PERFORMANCE: HDP	GIKOMERO	??	
Community Prevention	CSO	KIGALI HOPE	na	District	
Community Prevention	CSO	RDO	na	District	
Community Prevention	CSO	UWEZO	na	District	
Community Prevention	CSO	VCO	na	District	
Community Prevention	CSO	YWCA	na	District	
Community Prevention	Implementing Partner	Global communities	Gikomero, Ndera ,Nduba		Kigali Hope Association
Community Prevention	Umbrella	UPLHS	na	District	
Condom distribution	CSO	SFH	District	District	
Key Population	CSO	Assoferwa	Gatsata	Gikondo, Kicukiro, Gatenga,	

				Kigarama	
Key Population	CSO	HEALTH DEVELOPMENT INITIATIVE-RWANDA:HDI	District	District	
Key Population	CSO	IMRO (Ihorere Munyarwanda)	Remera, Kimironko, kacyiru	Nyarugunga, Kanombe, Kigarama, Niboye,Gikondo	
VMMC	Implementing Partner	jpeigo	kimironko/ kibagabaga		JHPIEGO IMRO
Women Empowerment	CSO	AVEGA Gahozo	Remera		
Women Empowerment	CSO	RWANDA WOMEN'S NET WORK	KINYINYA		
Young Girls	CSO	IMBUTO FOUNDATION	district	??	
Youth Center	Youth Center	Centre des Jeunes Kabuga(CJK)	Rusororo		

Annex 2: Costing Summary

Intervention	Activity	Total Year 1	Total Year 2	Total Year 3	Total Year 4	Total Year 5	Total
Care and Treatment	Organize awareness campaigns through school health clubs to address stigma	13,825,000	13,825,000	13,825,000	13,825,000	13,825,000	69,125,000
Care and Treatment	Train in boarding schools teachers and dormitory wardens on the follow up of adolescents living with HIV	3,690,324	1,845,162	1,845,162	1,845,162	1,845,162	11,070,972
Care and Treatment	Train peer educators on DSDM	100,537,200	100,537,200	100,537,200	100,537,200	100,537,200	502,686,000
Care and Treatment	Organize psychosocial events between HIV positive adolescents from different health facilities	92,056,500	92,056,500	92,056,500	92,056,500	92,056,500	460,282,500
Care and Treatment	Produce counseling booklets adopted to adolescents “Ibanga ryanje” (produce age - appropriate counseling bookelts)	11,250,000	-	-	-	-	11,250,000
Care and Treatment	Conduct quarterly coordination meetings for HIV stakeholders at district and CoK level	6,262,368	6,262,368	6,262,368	6,262,368	6,262,368	31,311,840
Care and Treatment	Train district's health team, M&E and HCP on data analysis to inform quality improvement	2,516,130	2,516,130	2,516,130	2,516,130	2,516,130	12,580,650
Care and Treatment	Develop videos that promote ART treatment ON all the 7 interventions	35,000,000	-	-	-	-	35,000,000
Care and Treatment	Procure portable medication boxes for school going children	9,000,000	-	-	-	-	9,000,000
Care and Treatment	Refresher Training of nurses on counseling	12,567,150	12,567,150	12,567,150	12,567,150	12,567,150	62,835,750
Condom Use	Organize concerts targeting youth in schools (universities, secondaries)	40,000,000	40,000,000	40,000,000	40,000,000	40,000,000	200,000,000
Condom Use	Awareness campaign targeting youth associations/out of schools and cooperatives	140,000,000	140,000,000	140,000,000	140,000,000	140,000,000	700,000,000

Condom Use	Organize talk show on Radio on Condom use	56,000,000	56,000,000	56,000,000	56,000,000	56,000,000	280,000,000
Condom Use	Organize talk show on TV on Condom use	48,000,000	48,000,000	48,000,000	48,000,000	48,000,000	240,000,000
Condom Use	Ensure the monthly distribution of condoms for all HFs	1,728,000	1,728,000	1,728,000	1,728,000	1,728,000	8,640,000
Condom Use	Increase accessibility and visibility of condoms in hotels, bars and lodges./ Organization of meeting with private sector	4,802,200	4,802,200	4,802,200	4,802,200	4,802,200	24,011,000
Condom Use	Ensure the availability of condoms in all hotels, bars and lodges	216,000,000	216,000,000	216,000,000	216,000,000	216,000,000	1,080,000,000
Condom Use	Organization of advocacy meeting with churches representatives and faith based organizations on their role in prevention of sexual transmitted infections, with emphasis on condom use	67,230,800	33,615,400	33,615,400	16,807,700	16,807,700	168,077,000
HTS	Provide Facilitation to 300 youth clubs PE.	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	22,500,000
HTS	Organize entertainment activities for youth (and adolescent) to provide message on HIV Testing (Conduct 12 Campaigns)	90,000,000	90,000,000	90,000,000	90,000,000	90,000,000	450,000,000
HTS	Conduct refresher training of 300 HCP on youth friendly services	7,203,300	7,203,300	7,203,300	7,203,300	7,203,300	36,016,500
HTS	Organize targeted mobile VCT for youth groups, Key pop in their hotspots such as Moonlight testing targeting hotspots/ 50 campaigns (selecting Friday to Sunday)	300,000,000	300,000,000	300,000,000	300,000,000	300,000,000	1,500,000,000
HTS	Designing, Developing and disseminating IEC tools,(Billboards,User aid,fliers,posters,brochures…) / Organize workshop to review and design IEC messages	12,005,500	6,002,750	6,002,750	6,002,750	6,002,750	36,016,500
HTS	Designing, Developing and disseminating IEC tools, (Billboards,User aid, fliers, posters, brochures…)/ Hiring consultant to design and	25,000,000	25,000,000	25,000,000	25,000,000	25,000,000	125,000,000

	print IEC materials and hiring 14 locations for billboards						
HTS	Designing, Developing and disseminating IEC tools,(Billboards, User aid, fliers, posters, brochures…)/Developing two documentary films, quarterly Vox pop, to be aired at Radio, TV, Peer education,	17,600,000	17,600,000	17,600,000	17,600,000	17,600,000	88,000,000
HTS	Designing, Developing and disseminating IEC tools,(Billboards, User aid, fliers, posters, brochures…)/Organizing ten dissemination events	8,000,000	8,000,000	8,000,000	4,000,000	8,000,000	36,000,000
HTS	Train health care providers on HIV testing algorithm both private and public (Training of 1000 HCP)	24,011,000	24,011,000	24,011,000	24,011,000	-	96,044,000
HTS	Training of 1000 HCP on n new, HIV case finding strategies: Index partner testing, Family testing, routine screening among high risk individuals (People with presumptive TB, STIs symptoms, AGYW, KP, PWD, Multiple sexual partners) and couple testing	24,011,000	24,011,000	24,011,000	24,011,000	-	96,044,000
HTS	Monitoring the HIV test kits availability at all the health facilities	216,000,000	216,000,000	216,000,000	216,000,000	216,000,000	1,080,000,000
HTS	Facilitate 1000 HCP to strengthen community and health facility referral system for VCT and care &treatment.	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000	100,000,000
Maternal Services	Organize a meeting with All Executive secretaries and Social affaires emphasizing importance of FP for young people	9,002,154	9,002,154	9,002,154	9,002,154	9,002,154	45,010,770
Maternal Services	Sensitization on FP services through radio spots and television spots	106,077,760	106,077,760	106,077,760	106,077,760	106,077,760	530,388,800

Maternal Services	Train HCP to provide age appropriate services according SHRH policy and guidelines.	6,290,325	6,290,325	6,290,325	6,290,325	6,290,325	31,451,625
Maternal Services	Training of teachers to enforce comprehensive reproductive health education in schools	3,690,324	3,690,324	3,690,324	3,690,324	3,690,324	18,451,620
Maternal Services	Develop videos on breast feeding best practices	250,000	-	-	-	-	250,000
Maternal Services	Develop training materials on life skills for SRH and HIV prevention	2,430,000	-	-	-	-	2,430,000
Maternal Services	Train ART providers on current FP guidelines	12,580,650	12,580,650	12,580,650	-	12,580,650	50,322,600
Maternal Services	Training targeting church leaders, leaders of blue collar job coops eg moto, taxi,caperters from every cell	45,010,770	45,010,770	45,010,770	45,010,770	45,010,770	225,053,850
Maternal Services	Develop IEC materials to be distributed to CHWs with emphasis on ANC targeting women of child bearing age	724,500	-	-	-	-	724,500
Maternal Services	Organize training of HCP on best practices on breast feeding	7,548,390	7,548,390	7,548,390	7,548,390	7,548,390	37,741,950
Maternal Services	Organize monthly meeting at cell level conducted by ART HCP for youth on FP and HIV	3,240,000	3,240,000	3,240,000	3,240,000	3,240,000	16,200,000
Maternal Services	Print posters with FP messages emphasizing availability of services and location to be pinned on public places e.g bus stops, schools, bars etc	27,400,000	-	-	-	-	27,400,000
Maternal Services	To train midwives on HIV counseling and new PMTCT guidelines	6,290,325	6,290,325	6,290,325	6,290,325	6,290,325	31,451,625
SRH	Organize and provide ToT for teachers on SRH	54,000,000	-	-	54,000,000	-	108,000,000
SRH	Organize and provide training for health clubs leaders on SRH for youth in schools by teachers	-	13,500,000	-	13,500,000	-	27,000,000

SRH	Monitoring and evaluation of implementation of SRH information in secondary schools	-	-	-	-	-	-
SRH	Prepare and provide training on SRH for youth committees	4,560,000	-	-	4,560,000	-	9,120,000
SRH	Organize and provide training for health clubs leaders and other peer educators on SRH for out of schools youth by youth committees	-	1,140,000	-	1,140,000	-	2,280,000
SRH	Scale up of the "girl's room" in schools well equipped	52,950,000	52,950,000	52,950,000	52,950,000	52,950,000	264,750,000
SRH	Implement Mentorship Model in schools, youth safe spaces, youth centers, sector level and HFs: Training of mentors on SRH	-	16,807,700	8,403,850	-	-	25,211,550
SRH	Facilitate Mentors to deliver SRH coaching to youth	28,000,000	28,000,000	28,000,000	28,000,000	28,000,000	140,000,000
SRH	Operationalize youth corners at public HFs (equip them with all the necessary materials)	8,800,000	-	-	-	-	8,800,000
SRH	Provide refresher courses on SRH for youth centers and public HFs staff	1,440,660	-	-	1,440,660	-	2,881,320
SRH	Train youth on life skills	50,000,000	50,000,000	50,000,000	50,000,000	50,000,000	250,000,000
SRH	Conduct entertainment activities for youth and adolescent to provide message on SRH	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	10,000,000
SRH	Provide training on parent-adolescent communication/dialogues on SRH to Community health workers	27,780,727	-	-	27,780,727	-	55,561,454
SRH	Organize bi-annual SRH specific campaigns targeting adults	54,000,000	108,000,000	108,000,000	108,000,000	108,000,000	486,000,000
VMMC	Conduct 1 mass campaign on VMMC by semester in each district of CoK	42,765,896	21,382,948	21,382,948	42,765,896	21,382,948	149,680,636
VMMC	Conduct IEC/BCC on EIMC into the at MCH Services.	49,840,000	49,840,000	49,840,000	49,840,000	49,840,000	249,200,000

VMMC	Select and Train Community Health workers in VMMC and EIMC as peer educator.	-	42,810,000	-	-	-	42,810,000
VMMC	Train health-care providers on VMMC methods	-	-	117,900,000	117,900,000	-	235,800,000
VMMC	Sensitization of parents/caretakers on the benefits of circumcision through community gatherings	46,200,000	46,200,000	46,200,000	46,200,000	46,200,000	231,000,000
VMMC	Produce updated MC counseling package	24,920,000	-	-	-	-	24,920,000
VMMC	Mentorship and Coordination including private health clinics and faith based health facilities by MoH	26,400,000	26,400,000	26,400,000	26,400,000	26,400,000	132,000,000
						TOTAL	14,300,000.00

Annex 3: Key informant interview report for policy makers on HIV programmes in the city of Kigali

Key Informant Interview Report for Policy Makers
On HIV Programmes in the City of Kigali :
« *HIV Strategic Plan for the City of Kigali* »

June 2018

Prepared by :
Prof. Leon Mutesa

List of abbreviation

AGYW : adolescent girls and young women

AHF: AIDS Health Care Foundation

ANSP+: Association de Soutien aux PVVIH+

ARV: Anti-retroviral

CDC: Centers for Disease Control and Prevention

CoK: City of Kigali

DREAM project (Determined Resilient Empowered AIDS-free Mentored Safe

FP: Family planning

GBV : Gender Based Violence

HDI: Health Development Initiative

HTC: HIV testing and counseling

IPPF: international Planned Parenthood Federation

MCCH: Maternal Child and Community health

NGO: Non- governmental organization

PEPFAR: The U.S. President's Emergency Plan for AIDS Relief

PHC: Primary Health Care

PIH: Partners In Health

PLWH: People living with HIV/AIDS

PMTCT: Prevention of mother-to-child transmission (of HIV)

PSF: Projet San Francisco

PWD: People with Disabilities

RRP+: Rwanda Network of People living with HIV/AIDS

SRH: Sexual and Reproductive Health

STI: Sexually Transmitted Infection

UNAIDS: United Nations programme on HIV/AIDS

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

USAID: United States Agency for International Development

WHO: World Health Organization

Table of Contents

1. Introduction

The HIV prevalence in Rwanda has been stable since 2005 and remains at 3 percent among adults age 15-49 (4% among women and 2% among men). Rwanda conducted its first population based HIV incidence survey in 2013/14.

The HIV prevalence is highest in the City of Kigali (6.3 percent) and is relatively uniform throughout the other provinces (2 percent to 3 percent). According to the latest census data, approximately 52 percent of the population is under 19 years old, majority of whom are HIV negative, given the low HIV prevalence among adolescents and youth people aged 15-24 years of 1%. However, these adolescents and young people remain at risk, particularly young girls who are five times as likely to be infected compared to boys of the same age, 2.5% vs. 0.5%[1,2]. Results from the latest DHS survey show that the proportion of adolescent girls (15-19) who have begun childbearing has increased in the last 10 years and is now at 7.3 %.

Ending the AIDS epidemic by 2030 is feasible if the world's major cities act immediately and decisively to Fast-Track their AIDS responses by 2020[3]. To make it happen, in 2014 during World AIDS Day, mayors from around the world gathered to launch the Paris Declaration on Fast-Track Cities and pledging to achieve the 90-90-90 targets by 2020. A Fast-Track AIDS response means that by 2020, 90% of people living with HIV will know their HIV status, 90% of people living with HIV who know their status receive HIV treatment and 90% of people on HIV treatment have a suppressed viral load.

The City of Kigali (CoK) has recommitted to the fight against HIV/AIDS by signing of the Paris Declaration on ending the epidemic in cities and urban areas (Figure 1).

The City of Kigali recognizes its role in coordinating the HIV and AIDS response, and is aware of the fact that successful implementation of the HIV

1 RDHS, Rwanda Demographic and Health Survey, 2015

2 RAIHIS, Rwanda Aids Indicators and HIV Incidence Survey, 2013-2014

and SRH priority intervention is dependent on implementation of evidence based district specific action plans.

Figure 1 : Former Mayor of the CoK (L) and Michel Sidibe (R) Executive Secretary for UNAIDS after signing the Paris Declaration in 2016

This report presents a summary of HIV priorities interventions and challenges in the City of Kigali (CoK), as identified policy-makers, and other local experts and development partners ("key informants"). These findings are a critical supplement for the CoK for better implementation of the HIV Strategic Plan.

Building an effective HIV programme in the CoK is essential to providing comprehensive care and services to people with HIV or AIDS. This includes coordinating functions across multiple systems within the 3 districts (Kicukiro, Gasabo and Nyarugenge) of the city.

2. Methods

Key informant interviews were conducted with different policymakers and key stakeholders. Respondents included representatives from the Ministry of Health, Ministry of Gender and Family Promotion, Ministry of Youth, Rwanda Biomedical Centre (HIV Division, MCCH Division), City of Kigali, Districts of the City of Kigali (Kicukiro, Gasabo, Nyarugenge), District Hospitals from the City of Kigali (Muhima, Kibagabaga, Masaka), National Civil Society Organizations (Network of PWD, ANSP+, RRP+), Imbuto Foundation, One UN (UNICEF, UNAIDS, WHO, UNFPA), non-governmental organizations (NGOs) (AHF, HDI, PIH, PSF, RICH) and other development partners (JhPiego, PEPFAR, CDC, USAID). Twenty-nine key informants were interviewed (18 males, 11 females), including policy-makers working in the health policy and SRH/HIV field (see Table 1).

Table 1 Background characteristics of key informants

	N (29)
Sector:	
Government institutions	8
Civil Society Organizations	5
NGOs	6
One UN Agencies	5
Development Partners	5
Sex:	
Males	18
Females	11

A qualitative approach was chosen to provide an in- depth understanding of specific contexts considered essential to developing an innovative model for integrating SRH and HIV services.

Individuals at a local, national and international level who had knowledge and experience of integrating SRH and HIV services in South Africa were selected purposively to ensure that appropriate informants would provide rich study data.

A semi-structured interview guide explored current SRH and HIV policy and service availability and integration issues

Interviews were face-to-face or telephonic, audio-recorded and transcribed.

3. Key informants Interview Outcomes

Coordination and Integration

Policymakers stated that the Strategic Plan HIV programmes would serve to prevent new HIV infections among key populations, including female sex workers, men who have sex with men, prisoners, and drivers who travel long distances. This would drastically contribute to the decrease of HIV prevalence from the CoK, which is higher (6,3%) than in other Rwandan provinces.

The benefits from the implementation of the HIV Strategic Plan in the CoK would increase the adherence to programme by PLWH especially key population and adolescents thus reducing the prevalence.

While informants were drawn from government institutions, civil societies, NGOs, and development partners, data are presented here according to the level of HIV specific intervention in the CoK: the policy level (primarily but also factors influencing coordination and the service-delivery up to the community district level).

« Much has the programme focus nationally, we are doing very well and Kigali is not left behind for that kind of initiatives like 90-90-90 but a lot needs to be focused on because one they have more people to put on treatment due to the high prevalence and also if we are to end the epidemic we need to focus on reducing new infections in those settings… » ~Key informant, Senior HIV specialist One UN.

HIV CARE AND TREATMENT

Emphasis by donors in support of medical management of HIV through ART may result in over- sight of implementation of interventions supporting patient coordination or retention in care, which strengthen the comprehensive care package necessary for PLWH to be maintained in the long-term care system in the City of Kigali.

"…Unfortunately, I have a lot of doubts… going back to the history of ARVs, adherence among adolescent girls is very poor, even though these are individuals who are already HIV positive and they know that their survival depends on taking ARVs. Now, for a person who's not even HIV positive to start taking the medicine brings in a lot of uncertainties…" ~Key informant, Senior HIV specialist NGO.

Opinions were also divided over the role and influence of HIV/AIDS NGOs, which are often set up by representatives of most-at-risk populations and people living with HIV/AIDS. NGO representatives were proud of their achievements and described themselves as active and motivated leaders and equal players on the HIV/AIDS policy arena. They were also seen by others as proactive and vocal, energetic and quick to mobilize, and have been described by some as 'engines' or 'leaders' of change due to their advocacy efforts. Together with international agencies, NGOs have contributed to the development and implementation of some key policies on harm reduction, based on a human rights approach. One representative of a donor agency said:

"*We have a very strong NGO sector that works in the area of HIV/ AIDS. By and large, today they are the drivers of change*." ~Key informant, NGO Representative.

In the CoK, the adherence to treatment meets some challenges due to the high number of patients' enrolment with loss of follow up. Some development partners developed strategies to increase linkage to treatment especially for key population.

"*…In the CoK we established HIV case findings in all hotspots. Our primary interventions focus on clinical and prevention, with emphasize to linkage to treatment especially for key population. We support Ministry of Health and Rwanda Biomedical Centre to implement those programmes through cooperative agreements (CoAg)"* ~Key informant, Senior HIV Specialist CDC.

Retention and follow up of PLWH especially key population in the CoK has been raised as a problem as they keep moving from one place to another.

"…Strategies for improving retention, of course one is infrastructure. If you improve infrastructure you improve clients flow, minimize waiting time, avoid stock-outs of essential drugs. I think all those we need to do … then tracking those clients who didn't get lost to follow-up…" ~Key informant, Senior Policy Maker, NGO

« …there is a high migration of female sex workers which negatively impacts on the follow up in the health facilities in the CoK… » ~Key informant, Senior HIV Specialist PSF.

There is a need for strengthening the coordination and monitoring and evaluation for follow up of PLWH in the CoK.

Informants felt that HIV providers often focus on clinical management of HIV illness, partly due to the complexity of HIV disease management and burden of care, and they struggle to meet the multiple and chronic health needs of clients, including conditions directly related to HIV:

"if they are on ART they will be treated as [an] HIV positive person, they will not be treated as a woman" (~Key informant, Senior Civil Servant, Ministry of Health*) and providers were reported to feel that "we are over- loaded, we can't be asking people about […] contraception"* ~Key informant, NGO Representative

<u>COMPREHENSIVE KNOWLEDGE FOR SRH-HIV PROGRAMMES IN THE CoK</u>

Many informants highlighted the lack of national policy guidance on integrated care as an impediment to integration.

The recent prioritization of funding for HIV was seen to have contributed to verticalization of health care programming and there was consensus that SRH services across the CoK had been sidelined:

"…[FP] services are really struggling […] there's been such a push to […] get these

HIV and AIDS services up, and a lot of the dynamic people I know at district level have gone over into HIV services…". Senior Civil Servant, District.

« *There is therefore a growing imperative to develop and implement innovative policies and service-delivery modalities that enable SRH and HIV programmes to be addressed in a genuinely integrated fashion.* »

~Key informant, Senior Civil Servant, MIGEPROF

"…Development of policy and guidelines for "provider-initiated SRH" in HIV services could support more comprehensive, more integrated care for PLWH"

~Key informant, Senior SRH Program Manager

Providers in HIV services were also seen to lack the relevant technical skills and confidence required to deliver SRH services:

Providers just are not aware of what contraception should be used…providers have said to us, "we don't ask what contraception you are on, or whether you need it" because they don't know what the right answer is. (Academic)

The need to promote contraceptive services as an integral component of national HIV care and treatment programs was highlighted by all informants, and access to other SRH services for PLWHA was also considered poor, including counselling on reproductive choices, positive prevention counselling, cervical cancer screening, abortion and assisted conception services:

"…Nobody's addressing the reproductive health of a patient at the ARV clinic. I would like them to stand up and talk about it yes, if anybody would like to have a child or would like to do this, or if you fallen pregnant by mistake, this what you can do, this is the procedure…" ~Key informant, Senior Country AIDS Advisor One UN

Through PEPFAR funding mechanisms, USAID has embarked with preventing HIV in adolescent girls and young women (AGYW) using DREAM project (Determined Resilient Empowered AIDS-free Mentored Safe).

« DREAMS program has a comprehensive package of services, including the positive parenting for parents who have adolescents 10-14 and 15-17. We implement it through the Families Matter Program - an evidence based curriculum used across more than 20 countries.» ~Key informant, Senior HIV Specialist USAID.

Other NGOs like Global Community addresse issues related to community based HIV prevention, GBV and teenage pregnancy in the CoK. Their focus also targets education, linkage to treatment, fertility and clinical prevention in the adolescents.

« We are also going to implement SASA program used to challenge the community regarding the Community Norms Change. It is a tool/program used to address violence, GBV » ~Key informant, Senior HIV Specialist USAID.

"Unfortunately, there is no manual document on the ground…" ~Key informant, Senior HIV Specialist Global Community NGO.

Apart from DREAMS, some other programs support to fill the gaps by providing nutrition and food security in the community. Some specific programs have been developed and those include *Gikuriro, Isuku Iwacu, Hinga weze, Twiyubake, etc.* most of them supporting the CoK. The Orphans and Vulnerable children (OVC) and the Early Childhooh Development (ECHD) focus on the young people for HIV prevention by providing education technical and financial supports.

In addition, government institutions, like MIGEPROF, have supporting programmes for young people and women. Among these programmes we find the National Council for Women; Out-of-School forum for adolescents; Isange One Stop Centers for anti-GBV where they provide psychological support, HIV prophylaxic post-exposure; and the National Commission for Children.

"With all these proegrammes, there is a need for the CoK to coordinate HIV services with the City. Our institution would assist in this coordination" ~Key informant, Senior Decision Maker, MIGEPROF.

CHALLENGES RELATED TO HTC

Staffing shortages and high client load were the most commonly discussed service-related factors influencing coordination. Many services were considered to be operating at "their bare minimum", resulting in long queues and waiting times:

"...The bottom line is that you don't have enough health workers. Then, if you want to add services and you want to integrate them and link them, you need more people..." (Academic) ~Key informant, Senior civil servant District Hospital.

It was felt unrealistic to expect providers to explore multiple health needs within a typical consultation time- frame (six to seven minutes). Staff burnout, sickness, absenteeism, attrition, administrative duties, frequent rotation and training were also mentioned as contributing factors.

Negative attitudes of providers towards integration were also highlighted, with some purportedly "completely opposed to integrating or even [...] referring patients for some services"(NGO). Several informants, primarily from NGO or academic sectors, felt that the failure to counsel PLWHA on fertility choices stemmed partly from negative attitudes towards pregnancy in HIV-positive women. Provider inhibitions in counseling on sexual matters were mentioned, and several informants pro- posed values clarification workshops to address judgmental attitudes.

Resistance to change among providers and service managers was raised as an additional barrier to integration, either stemming from fear of increased workloads and responsibilities, or due to territorialism at the service level. Informants talked of more specialized providers, such as HCT counselors, *"trying to hold on to their jobs"(NGO)*.

Lack of attention to the SRH needs of PLWHA was also linked to a wider failure of providers to "look beyond the disease" and treat patients holistically.

Needs to increase HTC services were discussed and recommended, this should be emphasized on by the CoK:

"...Why can't the CoK use the Car Free Day to provide free HTC services like we do for NCDs?..." Private HIV Organization

"...During the recent Cycling Tour in the CoK, we received several people testing for HIV and we provided immunization in the line of planning for VMMC. This was very successful. The CoK should take an opportunity to provide HIV services during all events happening in the city where many people come to assist..." ~Key informant, Senior Country AIDS Advisor, NGO

New approaches to training were also recommended, including integrated training courses for SRH and HIV, decentralized training at district level in the CoK, appropriate pre-service training, and post-training mentorship. Suggested approaches to facilitate integrated care included screening and use of history-taking tools to support identification of multiple health and social needs.

Some key informants discussed how more efficient efforts should be directed toward HIV prevention, including the following:

- Alternative ways to get people tested for HIV besides use of incentives
- Better condom distribution at bars and clubs
- Better coordination about where agencies conduct outreach HIV testing A key informant noted that she doesn't know how much prevention is offered, especially when she and her colleagues see the same number of people being infected with HIV year after year.

  "We could end HIV as an epidemic with enough resources in prevention." Senior HIV Prevention Manager, District Hospital

SEXUALLY TRANSMITTED INFECTIONS

Integrating HIV and STI services into reproductive health programs can help expand SRH service delivery to key populations who may avoid HIV and STI

clinics due to stigma and discrimination. Moreover, service integration has been shown to reduce HIV infection significantly (IPPF/UNFPA/Young Positives and the Global Coalition on Women and AIDS, 2017).

Barriers to STI service uptake and treatment for key population and others reported during key informant interviews lack of knowledge in almost all age groups in the CoK.

VOLUNTARY MEDICAL MALE CIRCUMCISION

Since 2007 when WHO and UNAIDS have recommended voluntary medical male circumcision (VMMC) as an additional important strategy for HIV prevention, particularly in settings with high HIV prevalence and low levels of male circumcision, where the public health benefits will be maximized, Rwanda has made great achievements by introducing non-surgical procedures.

« The current non-surgical circumcision used in the CoK and other Rwandan settings involves the use of a plastic device called PrePex, comprising two rings and an elastic band, that cuts off blood supply to the foreskin, which loses sensation and shrivels, similar to the process of removing the umbilical cord of a newborn child. The PrePex has to be worn for a week, after which it is removed and the dead foreskin is cut off. » ~Key informant, Senior HIV Prevention Specialist, Development Partner.

Today the VMMC programmes run well in the CoK. One of the development partners has targeted 17 priority districts with the country with all Kigali districts being included. However, all concerned male age groups are not necessarily accessing the service. This is the case especially for old men in the CoK.

"One of the concerns we meet is to reach the old men for the program. Most of these people they work during the day and they do not have time to come to the health facilities…" ~Key informant, Senior HIV Prevention Specialist, Development Partner

New strategies are being implemented to improve access to the VMMC delivery services. The VMMC providers have extended the extra-working hours during the evening and the weekends. Since then they have seen increase in access.

CHALLENGES RELATED TO COORDINATION AND MANAGEMENT OF HIV IN THE CoK

Many informants thus emphasized the need for improved coordination and collaboration between different levels, tiers and authorities of the public health sector to bridge the separate "silos" of SRH and HIV programming, as well as the need for joint responsibility and accountability of outcomes.

Verticalized programming across national, provincial and local health directorates was also seen to have contributed to care fragmentation across different tiers of the service hierarchy, resulting in certain services being available only within the health facilities in the CoK (e.g. FP), and others only at hospitals (e.g. cervical cancer treatment). For some services, such as STI treatment, it was unclear where they belonged, resulting in patients being cross-referred multiple times. Some interventions, including HTC, may also need to be repeated on multiple occasions in different sites due to differing district program requirements. A picture thus emerged of clients, in particular HIV treatment clients being routinely sent *"from one service point to another"* Senior Civil Servant, MINISANTE

Strengthening supervision and management at all levels was also emphasized as a critical need. One participant stressed *"...if my head of department doesn't think it's important, nobody's going to look at it..." Senior Civil Servant, District*. Informants proposed strategies to improve management, including: revising monitoring and evaluation systems, using indicators to measure integration activities, conducting advocacy with managers to promote their buy- in, revising job descriptions to include a broader scope of healthcare, offering financial incentives for providers to improve and broaden skills, and using performance evaluation and accreditation processes which include the delivery of HIV integrated care in the CoK.

Lastly, some informants felt that infrastructural changes within facilities were needed, to accommodate a broadened package of care, particularly in smaller facilities. For example, one informant questioned whether there were sufficient youth friendly services to routinely provide HIV and SRH services to adolescents.

LOOKING AHEAD: STRATEGIES AND MODELS FOR THE COK HIV STRATEGIC PLAN

Despite the challenges, there was consensus from all respondents on the need to move forward and develop more integrated systems of care at local, provincial and national levels.

Many informants advocated for the establishment of "one-stop shops" with a comprehensive range of HIV services accessible within one facility. Their views varied, though, on how a precise model of integration would work within such a facility.

Several thought that having one provider offer a range of SRH and HIV services would be ideal (*"full integration" or "provider- level integration"*), overcoming problematic referral processes and reducing the need for clients to queue multiple times.

But it was acknowledged that having one provider do everything may not be realistic or achievable, in particular within HIV care:

"...If they are really overwhelmed with testing, and dishing out drugs, then I think it's utterly naïve to think that same overworked set of staff can be nudged into talking about childcare and family planning..." ~Key informant, Senior SRH Programmes manager, NGO.

Several informants felt the need to maintain sub-specialist providers, and proposed a team-based approach to comprehensive care, particularly in larger facilities. The concept of "partial" or "facility-level integration" was proposed, implying internal referral to access SRH services within the same facility.

CONDOM USE

4. Summary of findings and implications

Our findings demonstrated coverage gaps in HIV and SRH programmes in the CoK.

There was consensus among our informants regardless of sector, private or level of government from which they were drawn, on the need for emphasizing on implementation of new HIV & SRH intervention strategies with clear coordination in the CoK.

Despite the long-standing global recognition of the need for the integration of basic health and SRH services with HIV services, our data provide a perspective on inter-related systems factors at policy and service-delivery inhibiting the delivery of a comprehensive package within the city.

Separate policies, guidelines, ministerial directorates, under-funding of HIV & SRH, program district, weak management systems, lack of monitoring and evaluation systems, and ineffective coordination were considered critical barriers to address issues of HIV programmes with the CoK.

While some solutions were proposed, the complexity of managing HIV in this high prevalence city compared to other provinces of the country, will need a better coordination of the programme with a clear monitoring and evaluation strategy. Main focuses will need to be the key population and adolescents.

Policy directives mandating the delivery of health care in an integrated fashion are needed to normalize integration as a requirement, rather than an optional extra. Support, guidance and training to facilitate the integration of services are necessary to enable providers and managers to understand the need for and provide integrated SRH care, including its potential to prevent onward HIV transmission by addressing unmet FP needs and teenage pregnancy.

The enthusiasm for the implementing the CoK HIV specific programme among policy-makers and program managers was undisputed and although informants' opinions diverged on the best model to achieve integrated care, there was agreement that concerted action is needed.

Maximizing opportunities to provide HIV services during the events organized by the CoK such Car Free Day could achieve a degree of access to HIV service without placing a huge additional burden on the health system. Development of policy and guidelines for “provider-initiated SRH” in HIV services could support more comprehensive, more integrated care for PLWH. Actions should also be considered to address HIV more comprehensively in SRH settings and put in place youth corners.

5. Appendix 1: Interview Guide

Developing City of Kigali HIV Strategic Plan

INTERVIEW GUIDE FOR POLICY MAKERS

MINISTRY/RBC/ORGANISATIONS WORKING WITH HIV PROGRAMMES IN THE CITY OF KIGALI

Institution: .....

Date of interview: .....

1. Could you comment on the HIV situation in City of Kigali?

2. What do you consider to be the main issues related to HIV in City of Kigali?

3. What can be done to more effectively respond to the HIV epidemic in the City of Kigali? Probing on: planning, quality/quantity of services, coordination, monitoring, resources at all levels: City of Kigali, district and sector levels?

4. In view of limited resources and diminishing/unpredictable external funding, what strategies would you consider to be key in mobilising domestic resources and partnerships especially in an urban setting like City of Kigali?

5. In terms of access and use of services, how can more people be reached with HIV testing and treatment, treatment and interventions to reduce socio-economic impact and vulnerability to HIV?

6. Can you provide an overview of HIV programmes in Rwanda. The preceding sentence could be replaced by 1 and 2 above

7. What has been the contribution by your organization/institution/Ministry/RBC contribution maintain

8. Do you knowt that the City of Kigali has strategic plan for HIV control ? maintain

9. What progress has been made in the area of HIV response in the City of Kigali in the following aspects: (i) HIV testing to identify those who infected with HIV; (ii) ensuring that all people who are infected with HIV receive treatment; -(iii) ensuring that all those on treatment continue taking their medications as recommended in order to stay health and to minimize onward transmission of HIV to others. After the response, the interviewer could use the opportunity to briefly explain the 90-90-90 concept, if needed

10. What were the main success of the of HIV response in the City of Kigali? maintain a. What would you describe as the achievements and best practices in your Implementation/leadership of HIV & SRH program In the City of Kigali

b. What facilitated the success of the HIV response in the city of Kigali ?

11. What were the main challenges? maintain a. Did your organisation/Ministry/RBC experience any challenges in implementing the HIV

response in the city of Kigali?

b. If so, what challenges did your organisation/Ministry/RBC experience?

c. What were the major gaps in the delivery of HIV programs in the city of Kigali?

d. How do you work with the city of Kigali leadership in regard to the implementing the fast track ?

12. Would you comment on the quality of services offered in terms of maintain and see how to merge with 5 above

a. Prevention programmes

b. Treatment care and support programmes

c. Impact mitigation programmes

13. Would you comment on how you the fast track is put in place ? Do you know about the "Fast-Track" agenda for fighting HIV in Kigali City? How has it been implemented?

14. Comment on issues of equity and human rights with regards to the implementation of programs for : (i) *MSM, (ii) FSW, (iii) PLHIVs*

15. Were you (or your institution) a member of the TWG (Prevention, Treatment, Care and Support, Impact Mitigation, M&E and Strategic Information)? If yes, which TWG/s were you part of?

a. What have been the major contributions by the TWGs towards programming around the 90-90-90 in the city of Kigali?

b. What have been the major challenges of TWGs toward the achieving 90-90-90 in the city of Kigali? Not relevant because TWGs do not implement

16. What should be done differently to achieve 90-90-90 in the city of Kigali?

17. For the next strategic plan of the city of Kigali,

a. b. c.

What should the main strategies to strengthen the response to HIV?Probe around: planning, coordination, M&E, service delivery, demand and qualityHow will these strategies be funded? Who will be the main funding source

How can test and treat program be monitored and evaluated What challenges do you foresee with implementation of the strategic plan of the city of Kigali? How will these challenges be addressed? maintain

18. Are there any further comments you would like to make?

Thank you for your participation, your contribution to this very important exercise is greatly appreciated.