



HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	11.4 million (mid-2010)
Estimated Population Living with HIV/AIDS**	150,000 [130,000–170,000] (end 2007)
Adult HIV Prevalence**	2.8% [2.4–3.2%] (end 2007)
HIV Prevalence in Most-at-Risk Populations***	Sex workers: 59% (Kigali) (2009)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy****	>95% (2010)

*National Institute of Statistics of Rwanda **UNAIDS ***UNGASS ****WHO/UNAIDS/UNICEF *Towards Universal Access*, 2010

The first case of HIV/AIDS in Rwanda was reported in 1983. Just three years later, with the national HIV prevalence rate at 17.8 percent among urban populations and 1.3 percent among rural populations, Rwanda was one of the African countries most affected by HIV/AIDS. The Rwandan genocide of 1994 increased the risk of HIV infection, and thousands of survivors contracted the virus as a result of systematic sexual violence and rape against women. Following the genocide, the first data collection on HIV prevalence took place in 1996 in 10 sentinel sites. At these sites, the infection rate was 27 percent among the urban population, 13 percent among the semi-urban population, and 6.9 percent among the rural

population. Moreover, an estimated 70 percent of woman survivors who were raped during the conflict were infected with the virus. The rise in the prevalence rate was especially significant since approximately 800,000 people, 20 percent of the entire population, were killed during the genocide.

Since that time, however, Rwanda has experienced a steady decline in the overall national HIV prevalence rate and has been able to collect more precise nationally representative data. The 2009 *HIV and AIDS Epidemiologic Update* estimated the median number of infected individuals (adults and children) in Rwanda at 172,673. Approximately 3 percent of the Rwandan population between the ages of 15 and 49 is HIV positive, according to the 2005 Rwanda Demographic and Health Survey (RDHS). Modeling of RDHS data further suggests more than 90 percent of new heterosexually acquired HIV infections in Rwanda occurred within couples in cohabitation (Dunkle, et al., *The Lancet*, 2008). HIV prevalence appears to be higher among those with at least a secondary school education and tends to vary by employment status; those who are employed showed a slightly higher prevalence than those unemployed.

As in many sub-Saharan African countries, the differences in HIV prevalence between men and women are striking, with higher prevalence among women ages 15 to 49 (3.6 percent) than that of men in the same age cohort (2.3 percent). The prevalence in urban areas among young woman 15 to 24 years of age (3.9 percent) is nearly four times the prevalence among young men (1.1 percent). In rural populations, prevalence among young women (1 percent) is more than three times greater than the prevalence in young men (0.3 percent). HIV prevalence varies both regionally and between urban and rural populations. Sixty percent of Rwandans live in rural areas, where the prevalence (2.2 percent) is below the national average of 2.8 percent. At 7.3 percent, prevalence in urban areas is more than three times higher than in rural populations. Kigali and West provinces have markedly higher prevalence rates than the East, North, and South provinces.

Compared with the general population, young people ages 15 to 24 years have lower HIV prevalence rates. Approximately 19,000 Rwanda children under age 14 are living with HIV. Additionally, Rwanda has seen an increase in orphans due both to the genocide of 1994 and to the death or illness of one or both parents. Conservative estimates suggest approximately 1,264,000 vulnerable children live in Rwanda, of whom 820,000 are orphans (2005 RDHS and 2002 Government of Rwanda Census). According to the Joint United Nations Program on HIV/AIDS (UNAIDS), an estimated 220,000 children have been orphaned by HIV. Care for orphans and vulnerable children (OVC) falls primarily on extended family or the community, who often lack the capacity to care for them. Many OVC also serve as heads of households caring for a chronically sick HIV-infected parent or are the sole caregivers to their siblings.



Most-at-risk populations (MARPs) in Rwanda include serodiscordant couples, female sex workers (FSWs) and their clients, prisoners, and men who have sex with men (MSM). A June 2009 “modes of transmission” model suggested MARPs may account for one-quarter to one-half of new infections. An estimated 7.6 percent of stable heterosexual couples in Kigali are serodiscordant. Preliminary results from a recent behavioral surveillance survey showed the HIV prevalence rate among sex workers in Kigali was 59 percent. Key factors that seem to drive the epidemic are marginalization of MARPs, punitive penal codes affecting MARPs, stigma and discrimination, gender inequity, multiple concurrent partners, nonprotective social norms and/or networks, violence against women and girls, lack of comprehensive health services for people living with HIV, low condom use by some groups, and low male circumcision.

According to the 2010 United Nations General Assembly Special Session (UNGASS) report, condom use among FSWs rose from 81.8 percent in 2000 to 86.6 percent in 2006, when only 36.2 percent had comprehensive knowledge of HIV. A preliminary study conducted in

2008 and 2009 of approximately 100 MSM indicated only one-third of the men used a condom consistently with male sexual partners. According to this data, 34 out of 98 men who have sex with male or female partners stated they did not use condoms. This study did not provide an HIV prevalence rate among MSM because of the small sample size. However, the study notes MSM in Kigali have a higher risk of HIV infection, and in 2008, approximately 15 percent of new infections were among MSM.

As in many countries in sub-Saharan Africa, tuberculosis (TB) poses significant health problems in Rwanda. Although Rwanda is not one of the world’s 22 high-TB burden countries, the World Health Organization (WHO) reports Rwanda’s TB incidence rate in 2008 was 390 cases per 100,000 population. Approximately 34 percent of adult TB cases are HIV positive. TB-HIV co-infection complicates the care and treatment of both diseases.

National Response

Rwanda’s national HIV response has made significant progress toward the goal of universal access to HIV/AIDS services. Rwanda’s HIV/AIDS activities are coordinated by the National AIDS Control Commission (CNLS), and include support from the Ministries of Health, Defense, Education, Finance and Economic Planning, Gender and Family Promotion, Justice, Local Government, and Youth. Civil society partners include local and international nongovernmental organizations, faith-based organizations, associations of people living with HIV/AIDS (PLWHA), and HIV/AIDS umbrella organizations. CNLS also has a committee in each of Rwanda’s 30 administrative districts that coordinates its activities at a decentralized level.

Building upon the National Strategic Plan for 2005–2009, the National HIV/AIDS Strategic Plan (NSP) for 2009–2012 aims to reduce the incidence of HIV in Rwanda by half, reduce HIV morbidity and mortality, and ensure people infected with and affected by HIV have the same opportunities as the general population. The NSP supports the overarching goals of Rwanda’s Vision 2020, Economic Development and Poverty Reduction Strategy (EDPRS) 2008–2012 and Health Sector Strategic Plan (HSSP II) 2009–2012. The EDPRS provides a medium-term framework for achieving the long-term development goals of Vision 2020 and incorporates a number of cross-cutting issues, including gender, HIV/AIDS, the environment, social inclusion, and youth. HSSP II is a strategic framework for attaining the Government’s vision of continually improving the health status of the population, thereby helping to reduce poverty. All of these national strategies include specific targets to achieve key health outcomes, including the Millennium Development Goals.

Under HSSP II, the Government has made significant improvements in the health sector and has achieved one of the highest coverage rates of antiretroviral therapy (ART) in Africa. According to the *Towards Universal Access* report, more than 95 percent of those eligible are receiving ART. The Government has also emphasized couples counseling and testing. Nationally, partner testing has increased from 13 percent in 2003 to 84 percent in September 2009, with approximately 2.64 percent of partners testing positive. Services for preventing mother-to-child transmission of HIV (PMTCT) have also been scaled up significantly in recent years. The number of health facilities for PMTCT has increased from 11 in 2001 to 372 in 2009, providing access to a greater number of women. Nearly all pregnant women in antenatal care and PMTCT settings (98 percent) are tested for HIV and receive their results. By the end of 2007, 60 percent of HIV-infected pregnant women in Rwanda were receiving antiretroviral drugs to prevent

transmission to their newborns. As a result, mother-to-child transmission rates have decreased dramatically, from 30.5 percent in 2001 to 8.9 percent in 2007.

Through the current NSP and the EDPRS 2008–2012, the Government aims for at least 10 percent of OVC under age 17 to have access to a minimum package of at least three basic services, including medical, social, and school-related services, by 2012. According to the 2005 RDHS, only 0.2 percent of under-17 OVC were able to access these services.

Rwanda is a pioneer among African countries in the development of e-health enterprise architecture, which supports the response to HIV/AIDS. In collaboration with both development and private sector partners, multiple systems have been developed using Web-enabled and/or open systems platforms, including performance-based financing, community health information systems, disease surveillance, and electronic medical records. The overall coordination and goals for these systems is included in the national E-Health Strategic Plan for 2009–2014.

The Government has also increased national budget allocations for HIV programming. According to the 2007 interim RDHS report, budget allocations for health care between 2002 and 2007 have increased by 304 percent. Public funds are directed to support health infrastructure, human resources for health, education, and basic health care for OVC and public institutions engaged in planning and coordinating the response to the HIV epidemic.

Rwanda's primary multilateral, bilateral, and other partners for HIV programs are the U.S. Government (USG) through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR); the Global Fund to Fight AIDS, Tuberculosis and Malaria; WHO, UNAIDS, and other United Nations agencies, including the United Nations Children's Fund (UNICEF), Population Fund, Development Program, High Commission for Refugees, and Development Fund for Women; the Great Lakes Initiative on HIV/AIDS; the private sector; the Belgium Technical Cooperation; European Union; German Society for Technical Cooperation; Netherlands Embassy; Lux-Development; Swedish International Development Cooperation Agency; U.K. Department for International Development; and the Clinton Foundation.

The Global Fund has disbursed a total of \$385.2 million in funds since 2004 to support HIV programs in Rwanda. In 2009, the Global Fund approved a ninth-round \$213.8 million grant to provide full funding for programs organized under the NSP. The USG provides nearly 30 percent of the Global Fund's total contributions.

USAID Support

Through the U.S. Agency for International Development (USAID), Rwanda received \$79.8 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in Rwanda are implemented as part of PEPFAR. Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

In collaboration with the Rwandan Government, key strategic priorities for USAID/PEPFAR in Rwanda include HIV/AIDS prevention, counseling and testing, care and treatment, and health systems strengthening activities. Prevention activities are focused on PMTCT, sexual transmission, biomedical prevention, and integrated counseling and testing services. The PMTCT program focuses on providing follow-up for mothers and their infants and early infant diagnosis and improving the PMTCT referral system. Other strategic priorities include access to basic health care and support services, TB-HIV services, and care and support services for OVC.

The PEPFAR program has been, and will continue to be, integrated into the overall health program in Rwanda, supporting wraparound activities with other areas of the development program. This approach provides needed basic health services in conjunction with HIV/AIDS services, broadening the reach of the program and the impact of PEPFAR funding. Improved health information systems are used for supervision and monitoring and evaluation of program activities. A performance-based financing payment system is used to provide incentives and promote quality across all health services. In addition, 60,000 community health workers have been trained to provide comprehensive health services at decentralized levels. USG investments to improve care, treatment, and prevention services are also contributing to the improvement of general health services.

Direct PEPFAR support accomplished much in Rwanda in 2009. Achievements included:

- Care and support services, including TB-HIV co-infection support, for 89,500 PLWHA
- ART for 46,300 individuals and antiretroviral prophylaxis for 5,000 HIV-positive pregnant women to prevent mother-to-child transmission
- PMTCT services, including counseling and testing, for 132,800 pregnant women and counseling and testing for 861,700 other people
- Support for 75,000 OVC
- Activities to promote correct and consistent condom use that reached 925,800 individuals
- Nearly 70 million condoms provided cumulatively since 2004

Important Links and Contacts

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USAID's HIV/AIDS Web site for East Africa: <http://www.eastafrica.usaid.gov/en/program.10aspx>.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids.

October 2010