



HIV SERVICE GAPS AND PEER-LED STRATEGIES FOR SUSTAINABLE INTEGRATION IN RWANDA

**A National Gap Analysis and Strategic
Framework for Community-Led
HIV Response Amid Health
System Integration and
Funding Transitions**

Rwanda has achieved significant progress in its HIV response, including high ART coverage and attainment of the 95–95–95 targets; however, persistent gaps remain in prevention, continuity of care, stigma reduction, and equitable service access—particularly among adolescents and young people living with HIV, key populations. Drawing on Community-Led Monitoring (CLM) evidence from the RRP+, this report identifies critical structural and system-level challenges and presents peer-led, community-driven strategies to sustain treatment outcomes, strengthen integration into the Community Health system, and ensure a resilient, stigma-free, and domestically sustainable HIV response in Rwanda.

By Rwanda Network of People Living
with HIV – RRP+

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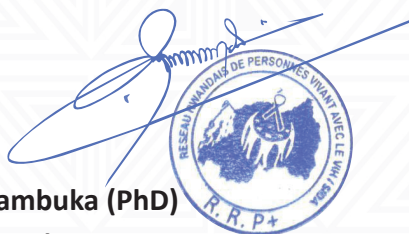


Foreword

Since its establishment in 2003, the Rwanda Network of People Living with HIV (RRP+) has been at the forefront of advocating for the rights, health, and dignity of people living with HIV across Rwanda. Over the past two decades, Rwanda has made remarkable progress in responding to the HIV epidemic, achieving high antiretroviral therapy coverage and significant reductions in HIV-related morbidity and mortality. Yet, despite these achievements, gaps remain particularly in prevention, treatment continuity, psychosocial support, and engagement of adolescents and key populations.

This report, *“HIV Service Gaps and Peer-Led Strategies for Sustainable Integration in Rwanda,”* reflects RRP+’s commitment to using evidence from community-led monitoring (CLM) and peer education to inform decision-making and strengthen the national HIV response. It highlights the critical role of People Living with HIV as peer educators and community actors in ensuring continuity of care, reducing stigma, improving adherence on ARV treatment, and enhancing access to quality HIV services even as the country transitions to an integrated health system amid funding constraints.

I am proud to present this comprehensive analysis, which consolidates data on epidemiology, service gaps, stigma, and community-led interventions. More importantly, it provides strategic recommendations that can guide policymakers, health managers, partners, and the broader community in sustaining the HIV response in Rwanda. It is our hope that these findings and recommendations will serve as a roadmap for strengthening peer-led systems, advancing domestic funding, and ensuring that all people living with HIV, particularly adolescents and young people, receive the care, support, and dignity they deserve.



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Acknowledgements

The preparation of this National Gap Analysis Report has been a collective effort, reflecting the dedication and expertise of RRP+ staff, PLHIV networks, community peer educators, and partner organizations. On behalf of the RRP+ Board, I extend our sincere appreciation to everyone who contributed to this work.

We particularly acknowledge the invaluable support of our peer educators and sector representatives, whose day-to-day engagement with People Living with HIV across Rwanda provided the critical insights and evidence captured in this report. Their unwavering commitment to community-led monitoring, adherence support, and HIV education has not only strengthened service delivery but also empowered individuals and communities to take an active role in their health and well-being.

We are grateful to our partners, including government institutions, donors, and civil society organizations, for their continued collaboration, technical guidance, and support in building a sustainable HIV response. The data, analyses, and recommendations presented here reflect a shared commitment to evidence-informed decision-making, inclusion of key populations, and the protection of human rights within the national HIV strategy.

Finally, we recognize the courage and resilience of People Living with HIV throughout Rwanda, whose voices and experiences underpin every recommendation and priority outlined in this report. It is through their lived experience, combined with the expertise of RRP+ and its partners, that we can advance a responsive, equitable, and sustainable HIV response in Rwanda.



Sylvie MUNEZA

Chairperson

Rwanda Network of People Living with HIV / AIDS (RRP+)



Acronyms and Abbreviations

Acronym	Full Form / Meaning
ART	Antiretroviral Therapy
AYPLHIV	Adolescents and Young People Living with HIV
AHD	Advanced HIV Disease
ASRH	Adolescent Sexual and Reproductive Health
BBS	Bio-Behavioral Survey
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CLM	Community-Led Monitoring
CSE	Comprehensive Sexuality Education
DHS	Demographic and Health Survey
FSW	Female Sex Worker
GF	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
LTFU	Lost to Follow-Up
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NAC	National AIDS Control Program
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NCD	Non-Communicable Disease
OI	Opportunistic Infection
PE	Peer Educator
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
RRP+	Rwanda Network of People Living with HIV
RoC	Recipients of Care
SI	Stigma Index
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VMMC	Voluntary Medical Male Circumcision
VLS	Viral Load Suppression
WHO	World Health Organization

Overview of HIV Response in Rwanda

Rwanda has made remarkable progress in its HIV response over the past two decades. National HIV prevalence in the general population has gradually declined to 2.4%, with higher burdens in Kigali City (3.2%) and the Eastern Province. HIV incidence in the general population is estimated at 0.3 per 100,000, though it remains higher in specific districts. The country has achieved the UNAIDS 95–95–95 targets ahead of schedule; however, gaps persist among key populations, adolescents, and in subnational areas.

The Rwanda Biomedical Centre (RBC) coordinates national HIV services, delivering prevention, testing, treatment, and viral suppression programs through a combination of facility-based and community-based approaches. RRP+, the national umbrella organization for People Living with HIV (PLHIV), has played a central role in peer-led interventions, community-led monitoring (CLM), psychosocial support, and advocacy since 2003. RRP+ supports 4,459 peer educators, 416 sector representatives, and collaborates with 547 health facilities across Rwanda, ensuring robust grassroots engagement and strong continuity of care for PLHIV.

Despite progress, challenges persist, including treatment interruptions, adolescent and youth school-related barriers, HIV-related stigma, limited uptake of prevention services, and “hors zone” recipients of care—PLHIV who seek services outside their catchment area. These issues are compounded by the current funding constraints and the ongoing integration of HIV services into the broader Health system.

Key Findings and Strategic Priorities

HIV Prevention Gaps

- Low uptake of family and index testing; gaps in reaching non-biological children.
- Inadequate PrEP coverage and combined prevention knowledge among key populations.
- Unequal triple elimination coverage for HIV, syphilis, and hepatitis B in maternal health. **Strategic Priority:** Strengthen peer-led HIV prevention, expand index testing, scale-up integrated maternal-child screening, and deploy digital and community-based awareness campaigns.

HIV Treatment and Continuity of Care:

- Retention at 12 months below target among adolescents and men (highest LTFU).
- Viral suppression <95% among children and under-25s.
- Hors zone recipients of care pose tracking challenges, e.g., Corunum HC (64% hors zone, 54 LTFU).

Strategic Priority: Enhance peer-led adherence support, implement home-based ART delivery, integrate CLM into national health records, and develop interoperable systems for seamless ART continuity.

HIV-Related Stigma and Discrimination:

- National stigma index dropped from 60% in 2009 to 13% in 2020; however, young people, FSWs, and MSM remain highly vulnerable.
 - School environments contribute to stigma and poor adherence among AYPLHIV.
- Strategic Priority:** Institutionalize community-led stigma reduction initiatives, train school authorities, and strengthen psychosocial support and peer-led engagement.

Community Engagement and RRP+ Expertise:

- RRP+ demonstrates a unique competitive advantage through peer-led education, CLM, and structured community participation.
- Peer educators maintain retention, adherence, and health literacy in ways that general CHWs cannot fully replicate.

Strategic Priority: Advocate for the integration of peer-led systems into the CHW structure while maintaining autonomy, strengthen community feedback loops, and build capacity for evidence-informed advocacy.

Funding and Sustainability:

- The transition to domestic funding and integration into general CHW systems presents risks of service disruption.

Strategic Priority: Ensure sustainable financing for peer-led interventions, optimize resource allocation, and leverage evidence from CLM to demonstrate impact and cost-effectiveness.

Recommendations

1. **Strengthen Peer-Led Community Systems:**

- Expand peer education for HIV prevention, adherence, and psychosocial support.
- Institutionalize community-led monitoring to track service quality, adherence, and stigma.

2. **Enhance Continuity of Care:**

- Implement home-based ART delivery and multi-month dispensing.
- Develop interoperable digital systems for tracking PLHIV across facilities, addressing hors zone challenges.

3. **Reduce Stigma and Promote Inclusive Services:**

- Conduct community and school-based stigma reduction programs.
- Provide training for health workers, teachers, and community leaders on confidentiality, equity, and PLHIV rights.

4. **Policy Advocacy and Integration:**

- Advocate for recognition of peer educators in national health policy and CHW integration strategies.
- Integrate peer-led CLM indicators into national health information systems to inform decision-making.

5. **Targeted Interventions for Key Populations and AYPLHIV:**

- Focus on adolescents, youth, FSWs, MSM, PWID, and AGYW in both prevention and treatment programs.
- Ensure school-based continuity of care and tailored psychosocial support.

6. **Evidence-Driven Resource Allocation:**

- Utilize RRP+ CLM data to inform funding decisions and prioritize high-burden districts and facilities.
- Strengthen collaboration with government and partners to optimize domestic funding and sustain HIV outcomes during service integration.

Rwanda has made substantial progress in HIV control; however, persistent gaps in prevention, treatment, stigma reduction, and continuity of care require focused strategic interventions. RRP+ with its extensive community-led expertise and peer educator network, is uniquely positioned to ensure sustainable HIV outcomes, especially during the integration of HIV services into the broader CHW system and amidst funding transitions. By leveraging its strengths and implementing the strategic priorities outlined, RRP+ can maintain high-quality, rights-based, and community-centered HIV services for all Rwandans.



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Background and Context

Rwanda has made significant strides in controlling the HIV epidemic over the past two decades. National HIV prevalence has gradually declined to 2.4% in the general population, with disproportionately higher burdens in Kigali City (3.2%) and the Eastern Province. HIV incidence remains low at 0.3 per 100,000 overall but is higher in specific districts and among key populations, including female sex workers (FSWs), men who have sex with men (MSM), people who inject drugs (PWID), and adolescent girls and young women (AGYW).

The country has achieved the UNAIDS 95–95–95 targets ahead of schedule. Despite this progress, critical gaps persist in prevention, testing, treatment, and community engagement, particularly among adolescents and young people living with HIV (AYPLHIV), school-going populations, and “hors zone” Recipients of Care (RoC) PLHIV who seek services outside their catchment area. Additionally, HIV-related stigma and discrimination, while reduced nationally from 60% in 2009 to 13% in 2020, continues to disproportionately affect young people and key populations, limiting access to services and retention in care.

In the context of funding transitions and the integration of HIV services into the broader Community Health Worker (CHW) system, maintaining continuity of care, psychosocial support, and peer-led engagement is critical. Rwanda’s national HIV response is coordinated by the Rwanda Biomedical Centre (RBC), while RRP+ serves as the national umbrella organization representing PLHIV, offering leadership, community-led monitoring (CLM), and peer education programs that are essential for sustaining high-quality HIV services at the community level.

Purpose of the Report

The purpose of this report is to:

1. Provide a comprehensive analysis of the current gaps in HIV prevention, treatment, and community engagement in Rwanda.
2. Highlight RRP+’s expertise in peer-led interventions and community-led monitoring as a critical component of HIV service delivery.
3. Inform strategic priorities and evidence-based recommendations to maintain continuity of care, enhance retention, reduce stigma, and support the integration of HIV services into general community health systems.

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4. Guide policymakers, health authorities, and partners on resource allocation, program design, and sustainable approaches for peer-led HIV interventions amid funding transitions.

Scope and Methodology

This report covers national and subnational analyses of HIV prevention, treatment, viral suppression, and community engagement. The methodology includes:

- **Data Review:** National HIV program reports, Demographic and Health Surveys (DHS), and UNAIDS estimates.
- **RRP+ CLM Evidence:** Quantitative and qualitative data from 504 health facilities, peer educator reports, and surveys conducted in 2025, including “hors zone” Recipients of Care (RoC) and continuity of care for AYPLHIV in schools.
- **Stakeholder Consultations:** Insights from RRP+ staff, PLHIV sector representatives, community leaders, and healthcare providers.
- **Gap Analysis:** Identification of key service, system, and structural gaps in prevention, treatment, and community engagement, with a focus on priority populations and high-burden districts.
- **Strategic Prioritization:** Mapping of interventions to strengthen peer-led approaches, continuity of care, and community participation within the broader integration of HIV services into the CHW system.

The report emphasizes actionable, evidence-based recommendations that leverage RRP+’s unique community-led expertise while addressing challenges posed by resource constraints and service integration.

RRP+ Organizational Overview and Expertise

RRP+ is the national umbrella organization of PLHIV in Rwanda, established in 2003 to provide leadership, coordination, and representation of PLHIV networks at national, district, and sector levels.

Organizational Capacity:

- 28 staff members led by the Executive Secretary (E.S.)
- Representation of key and priority populations (FSWs, pregnant and breastfeeding women, sero-discordant couples, MSM, and youth) across district and national boards

Network Coverage and Reach:

- Total **Recipients of Care (RoC): 222,604**, with 162,703 (73%) served directly through RRP+ network structures
- 4,459 Peer Educators and 416 PLHIV sector representatives
- Collaboration with 547 health facilities

Implementation Model:

- **National Level:** Central coordination and strategic leadership
- **District Level:** District representatives and 12 affiliated NGOs
- **Sector Level:** 416 PLHIV sector representatives and associated cooperatives
- **Cell Level:** Structured HIV peer education system

Through this multi-tiered structure, RRP+ ensures strong grassroots engagement, community ownership, and effective service delivery. The organization's peer-led approach, evidence-based CLM system, and rights-focused advocacy form the backbone of sustained HIV responses in Rwanda, particularly during periods of service integration and funding constraints.

National HIV Prevalence and Incidence

Rwanda has achieved substantial progress in controlling the HIV epidemic, with national prevalence declining to **2.4%** in the general population. Despite this overall decline, prevalence remains elevated among key populations, including female sex workers (FSWs), men who have sex with men (MSM), people who inject drugs (PWID), and adolescent girls and young women (AGYW).

HIV incidence in the general population is estimated at **0.3 per 100,000 populations**, reflecting the effectiveness of national prevention strategies. However, incidence remains higher in urban centers and selected districts, particularly in **Kigali City** and parts of the **Eastern Province**, where it ranges between **0.3 and 0.7 per 100,000 populations**¹.

Subnational Trends and High-Burden Districts

Subnational analyses reveal that HIV prevalence and incidence are not uniformly distributed across Rwanda:

- **Kigali City:** 3.2% prevalence; highest concentration of PLHIV across all age groups.
- **Eastern Province:** Elevated prevalence and incidence, with several districts reporting rates above the national average.
- **Other Provinces:** Western, Northern, and Southern Provinces show moderate prevalence, though high-risk populations remain vulnerable.

Key drivers of subnational disparities include population density, mobility, urban migration, and persistent gaps in prevention and treatment coverage for key populations.

HIV Cascade Performance: 95-95-95 Targets

Rwanda has achieved the **UNAIDS 95–95–95 targets** in 2024 ahead of schedule:

1. **First 95 (Diagnosis):** High levels of HIV testing coverage; however, gaps remain among key populations and children aged 0–14 years. Notably, >2,000 PLHIV in Kigali City and >3,000 in the Eastern Province are not yet on ART.
2. **Second 95 (ART Coverage):** Nationwide coverage is strong, though adolescents and young adults (15–24 years) experience the highest loss-to-follow-up (LTFU) rates.

¹ HIV, STIs, Viral Hepatitis Programs Annual Report, June 2024

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3. **Third 95 (Viral Load Suppression):** National suppression rates exceed 95%, yet children and adolescents continue to have lower viral suppression compared to adults.

RRP+ data highlight additional challenges in “**hors zone**” **Recipients of Care (RoC)**, where PLHIV choose to access ART outside their residential catchment area, impacting continuity of care, follow-up, and data tracking².

Mortality and Morbidity Patterns

Although AIDS-related mortality has declined due to widespread ART access, gaps persist:

- In 2024, an estimated **4,746 AIDS-related deaths** occurred among PLHIV, including **1,580 deaths among those on ART**.
- Morbidity patterns indicate significant co-morbidities, including tuberculosis (TB), advanced HIV disease (AHD), and non-communicable diseases (NCDs), particularly among adolescents, young adults, and those lost to follow-up.
- Viral load suppression among children (0–14 years) remains suboptimal, ranging between 64.7% in Kigali City and 73.7% in the Western Province, reflecting challenges in pediatric ART adherence and optimized regimens.

Special Focus: Adolescents and Young People Living with HIV (AYPLHIV)

Adolescents and young people (12–24 years) represent a vulnerable population with unique challenges:

- **Total AYPLHIV (12–20 years):** 3,013 (in-school and out-of-school) as per RRP+ CLM survey, October 2025.
- **Gender Distribution:** 45% male, 55% female.
- **School Dropouts:** 28% overall, with **55% among female learners**, concentrated in Kamonyi, Rubavu, Gasabo, and Kicukiro districts.
- **School Enrollment:** 2,168 learners enrolled; 669 in boarding schools (31%), 1,499 day scholars (69%).

Key Challenges Identified:

1. Inadequate privacy and confidentiality in managing ART in schools.
2. Persistent stigma and discrimination within school and peer networks.
3. Emotional stress and fear of disclosure affecting adherence.
4. Rigid school routines limiting consistent medication use.

² RRP+ CLM data, Dec. 2025.

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5. Limited psychosocial and mental health support.
 6. Knowledge gaps among students and educators on HIV.
 7. Socioeconomic barriers, including poverty and weak parental support.

RRP+ Recommendations for AYPLHIV:

- Implement national guidelines ensuring stigma-free, confidential ART access in schools.
- Train school staff on inclusive HIV support and prevention education.
- Strengthen school, health facility–, and community collaboration.
- Provide psychosocial and mental health support for affected learners.
- Engage parents/guardians in adherence support and emotional well-being.

Mother-to-Child Transmission and Triple Elimination

Rwanda has made significant progress in preventing mother-to-child transmission (PMTCT) of HIV, with national mother-to-child transmission (MTCT) rates during breastfeeding at **1.7%**, below the UNAIDS threshold of 2%. However, gaps remain in achieving **triple elimination** (HIV, syphilis, and hepatitis B) in maternal and child health³:

Key Gaps:

- Unequal testing coverage: 99.5% for HIV, 93.2% for syphilis, 86.7% for hepatitis B.
- Retention of mother–infant pairs is suboptimal in high-risk populations, including adolescent girls, young women, and female sex workers (FSWs).
- Low awareness and literacy among pregnant and breastfeeding mothers about triple elimination interventions.

Proposed Strategies:

- Strengthen routine HIV retesting and early case-finding among breastfeeding mothers.
- Integrate HIV, syphilis, and hepatitis B screening using three-in-one testing.
- Reinforce peer education programs to improve retention in PMTCT programs, particularly for adolescent and high-risk mothers.
- Use SMS reminders, CHW alerts, or EMR prompts to improve follow-up adherence.

Priority by 2030:

- Implement risk screening tools at each maternal-child visit to identify mothers needing frequent retesting and tailored support.
- Achieve full triple elimination coverage across all high-burden districts.

HIV Testing and Index Case-Finding

Maintaining the first 95 target diagnosis of PLHIV is challenged by gaps in family and index testing, particularly among children and high-risk populations.

³ HIV, STIs, Viral Hepatitis Programs Annual Report, June 2024; RRP+ CLM data, Dec. 2025.



Key Gaps:

- Low family testing uptake and inadequate testing of non-biological children in households.
- Limited linkage of HIV-negative contacts to prevention services.
- Low awareness of combined prevention methods (PrEP, condoms, HIV testing) among youth and key populations.

Proposed Strategies:

- Optimize pediatric case-finding, including non-biological household members.
- Scale up **Social Network Strategy (SNS)** and index testing for high-risk contacts.
- Strengthen peer education systems to improve knowledge on combined prevention.
- Deploy multi-channel, peer-led digital advocacy and community-interactive messaging to expand awareness and service uptake.

Priority by 2030:

- Ensure systematic early diagnosis of PLHIV, especially among children and adolescents.
- Integrate risk assessment tools for all HIV-negative contacts to guide follow-up and prevention.

Data Source: DHS 2025; RRP+ CLM data, Dec. 2025.

Voluntary Medical Male Circumcision (VMMC)

VMMC coverage among sexually active men remains below national targets (>70%), particularly in older age groups and in low-prevalence districts⁴.

Key Gaps:

- Low circumcision rates among men aged 40–59 years.
- Geographic disparities, notably in Southern, Northern, and Eastern Provinces.



Proposed Strategies:

- Implement tailored outreach and service models targeting older men, STI clinic attendees, male ANC companions, and HIV-negative contacts of index cases.
- Integrate VMMC into broader HIV prevention and male health services.

Priority by 2030:

- Achieve >70% VMMC coverage among sexually active men, focusing on high-risk and older populations.

PrEP and Prevention Services for Key Populations

Despite high HIV risk among key populations, PrEP and prevention services remain underutilized.

Key Gaps:

- Low PrEP uptake among FSWs, MSM, PWID, and AGYW.
- Limited access to integrated HIV and viral hepatitis prevention services in hard-to-reach areas.
- High stigma and discrimination inhibiting service utilization.

Proposed Strategies:

- Expand availability of PrEP, including long-acting formulations, and integrate into community-based delivery models.
- Enhance peer-led awareness campaigns to improve knowledge and demand for prevention services.
- Strengthen provider capacity to deliver stigma-free and inclusive services.

Priority by 2030:

- Achieve equitable PrEP coverage among all high-risk populations.
- Ensure community-led interventions reduce stigma and promote uptake of combined prevention services.

3.5 Community Knowledge and Awareness Gaps

Comprehensive HIV and sexual and reproductive health (SRH) knowledge remains limited, particularly among youth and key populations⁵.

Key Gaps:

- HIV knowledge among young people aged 15–24 has declined slightly (women: 59% → 57%; men: 57% → 53%).
- Misconceptions about transmission, moral judgment, and lack of digital literacy reduce engagement with health messages.
- Weak integration of peer-led education into school and community settings.

Proposed Strategies:

- Implement targeted, peer-led education campaigns to improve HIV, SRH, and prevention literacy.
- Institutionalize community-led monitoring (CLM) to capture gaps in knowledge and service delivery.
- Integrate HIV and SRH education into schools, youth centers, and digital platforms, ensuring inclusion of AGYW, PWDs, and other vulnerable populations.

Priority by 2030:

- Achieve comprehensive HIV and SRH knowledge among all youth and high-risk populations.
- Strengthen rights-based, peer-led community engagement as a core strategy for sustainable HIV prevention.

ART Coverage and Retention

Rwanda has achieved high ART coverage nationally, contributing to declines in HIV-related morbidity and mortality. However, retention remains below targets for specific populations:

Key Gaps:

- Retention at 12 months: **94%**, below the NSP target of >95%.
- Highest loss-to-follow-up (LTFU) among **adolescents and young adults (15–24 years)**.
- Men aged 25–49 also demonstrate elevated LTFU rates.
- Geographic disparities exist, with lower retention in Kigali City (93%), East (94.3%), North (93.7%), and South (93.9%) compared to the West (95.5%)⁶.

Proposed Strategies:

- Develop a **national client continuity framework** enabling seamless ART access across facilities through interoperable digital systems and unique patient identifiers.
- Introduce long-acting injectable ART (cabotegravir + rilpivirine) for eligible clients to enhance adherence.
- Implement targeted interventions for adolescents and young adults, including youth-friendly services and psychosocial support.

Priority by 2030:

- Ensure uninterrupted, lifelong ART continuity for all PLHIV.
- Reduce disparities in retention across age, sex, and geographic location.

Viral Load Suppression and Pediatric Case-Finding

While viral load suppression (VLS) rates are >97% nationally, children and adolescents continue to experience suboptimal outcomes⁷:

⁶ Data Source: RHMIS 2024; RRP+ CLM data, Dec. 2025.

⁷ Naomi estimates Dec. 2024; RRP+ CLM data, Dec. 2025.



Key Gaps:

- ART coverage among children 0–14 years: **75%** (target $\geq 95\%$).
- VLS among children varies by province: Kigali City (64.7%), Southern (69.8%), Western (73.7%), Northern (67.4%), Eastern (70.8%).
- Overall positivity yield is low: 0.3% nationally, with higher community-based detection (0.53%) than facility-based (0.15%).

Proposed Strategies:

- Intensify **index testing** and optimize pediatric case-finding, including non-biological household members.
- Strengthen linkage to treatment immediately upon diagnosis.
- Scale up peer-led education and digital outreach targeting caregivers and households.

Priority by 2030:

- Achieve $\geq 95\%$ ART coverage and viral suppression among children and adolescents.
- Reduce pediatric HIV-related morbidity and mortality.

Advanced HIV Disease and Opportunistic Infections

Advanced HIV disease (AHD) and opportunistic infections (OIs) remain critical contributors to HIV-related morbidity and mortality:

Key Gaps:

- Limited TB and OI diagnostic capacity at primary care level.
- Inadequate implementation of the AHD care package (CD4 testing, TB-LAM, CrAg screening, prophylaxis).
- Persistent morbidity among PLHIV with AHD despite ART initiation.

Proposed Strategies:

- Expand AHD package implementation at all ART initiation sites.
- Decentralize molecular TB diagnostics and integrate digital chest radiography at primary care facilities.
- Implement routine resistance surveillance and targeted genotyping for high-risk ART failure cases.

Priority by 2030:

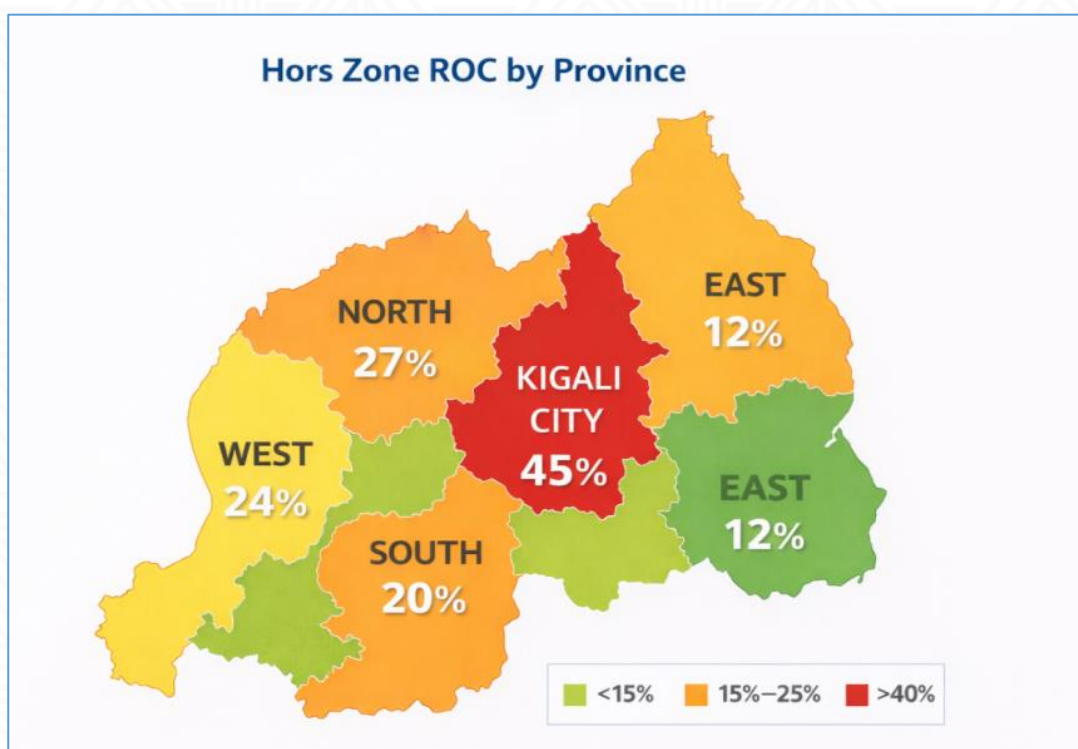
- Universal early identification and standardized management of AHD.
- Reduce opportunistic infection-related morbidity and mortality.

Continuity of Care Challenges and “Hors Zone” Recipients of Care

A significant proportion of PLHIV seek care outside their residential catchment area (“hors zone”), which poses challenges for continuity of care ⁸.

Key Gaps:

- 26% of PLHIV nationally receive ART at facilities outside their residential sector.
- High proportions in Kigali City: 45% hors zone ROC; Eastern: 12%; North: 27%; South: 20%; West: 24%.



Map showing hors zone recipients of care by provinces

- Contributing factors include:

⁸ RRP+ CLM data, Dec. 2025.

- Accessibility barriers (distance, terrain, transport costs)
- Fear of stigma or disclosure
- Confidentiality concerns at local facilities
- Perceived higher quality of care at distant facilities



Proposed Strategies:

- Strengthen **community-based ART delivery** and home-based support by peer educators.
- Improve interoperability of health information systems to track clients across facilities.
- Conduct community literacy campaigns emphasizing the importance of accessing nearest health facilities while ensuring privacy and quality care.
- Integrate HIV CLM indicators into national community medical records to monitor and respond to hors zone utilization.

Priority by 2030:

- Reduce hors zone utilization while maintaining uninterrupted ART access and adherence.
- Leverage peer educators' unique role in supporting PLHIV engagement across decentralized services.

Case Study: Corunum Health Center

Corunum Health Center (Nyarugenge District, Kigali City) provides an illustrative example of hors zone dynamics and continuity-of-care challenges⁹:

- ROC on ART: **3,571**
- Hors zone ROC: **2,300 (64%)**
- Partner: **CDC**
- Number of LTFU: **54**

Analysis:

- A large proportion of PLHIV at Corunum HC choose care outside their residential catchment, highlighting the importance of confidentiality, perceived quality, and flexible service provision.
- Tracking LTFU is complicated, as many patients move between facilities, and standard facility records may not capture silent transfers.
- Peer educator engagement, home-based ART support, and community-led monitoring are essential strategies to maintain continuity of care for these patients.

⁹ RRP+ CLM data, Dec. 2025.



Picture of CLM Data collectors, December 2025

National Trends and Key Populations at Risk

HIV-related stigma and discrimination in Rwanda have significantly decreased over the past decade. According to the **Stigma Index (SI, 2020)**, overall stigma among PLHIV declined from **60% in 2009 to 13% in 2020**. Despite these gains, specific populations remain disproportionately affected¹⁰:

- **Key Populations at Higher Risk:** Female Sex Workers (FSWs), Men who have Sex with Men (MSM), People who Inject Drugs (PWID), Adolescents and Young People (AYPLHIV), and Serodiscordant Couples.
- **Drivers of Stigma:** Misconceptions about HIV transmission, moral judgment, and fear of disclosure persist in both urban and rural communities.
- **Implications:** Stigma leads to delayed testing, avoidance of nearby health facilities, non-disclosure to partners, and poor adherence to ART.

Proposed Strategies:

- Institutionalize **community-led stigma reduction programs** targeting high-risk populations.
- Strengthen training of healthcare providers to ensure **non-discriminatory, confidential, and inclusive services**.
- Promote peer-led advocacy to normalize HIV care and treatment in communities.

School-Based Stigma and Challenges for AYPLHIV

RRP+ conducted a national survey in October 2025 across 504 health facilities, highlighting the experiences of **Adolescents and Young People Living with HIV (AYPLHIV, 12–20 years)** in schools¹¹:

Key Findings:

- **Total AYPLHIV surveyed:** 3,013 (45% male, 55% female)
- **School Enrollment:** 2,168 learners (31% boarding, 69% day scholars)
- **School Dropouts:** 28% overall; 55% among female learners
- **Most affected districts:** Kamonyi, Rubavu, Gasabo, Kicukiro

¹⁰ Rwanda Stigma Index Survey, 2020; RRP+ CLM data, Dec. 2025.

¹¹ RRP+ CLM data, Oct. 2025.



Identified Challenges:

1. Inadequate privacy and confidentiality for treatment routines (e.g., public medication checks).
2. Persistent stigma and discrimination within school settings.
3. Fear of disclosure leading to emotional stress and isolation.
4. Poor ART adherence due to rigid school schedules.
5. Limited psychosocial and mental health support.
6. Inadequate HIV knowledge among teachers and students.
7. Socioeconomic barriers, including poverty and weak parental support.

Recommendations:

- Develop **national guidelines** to ensure stigma-free and supportive learning environments for AYPLHIV.
- Train school staff on **HIV prevention, treatment, and inclusive education practices**.
- Establish confidential systems for medication management and counseling within schools.
- Strengthen collaboration between schools, health facilities, and communities.
- Provide psychosocial and mental health support, with parental/guardian engagement for adherence and emotional support.

Community Engagement Gaps and Opportunities

Despite progress, gaps remain in sustaining meaningful community engagement:

Key Gaps:

- Fragmented **data systems** limiting evidence-informed interventions.
- Weak institutionalization of community-led monitoring (CLM) for HIV and SRHR services.
- Limited integration of **peer support systems** into broader health governance and CHW structures.
- Persistent **digital literacy gaps** constraining multi-channel community engagement.

Opportunities:

- Strengthen **community consultation and feedback mechanisms** to ensure program design reflects PLHIV and key population priorities.
- Enhance **peer educator and PLHIV sector representative capacity** for advocacy, stigma reduction, and program monitoring.
- Integrate **digital platforms and multi-channel approaches** for community education and reporting.

5.4 Strategies for Stigma Reduction

To reduce HIV-related stigma and strengthen community engagement, RRP+ proposes the following strategic interventions¹²:

1. **Peer-Led Advocacy and Education:**
 - Engage PLHIV and key populations in awareness campaigns to normalize HIV testing and treatment.
 - Use social media, community forums, and edutainment to disseminate inclusive messages.
2. **Institutionalization of CLM Systems:**
 - Integrate HIV CLM into national community health and medical records.
 - Monitor stigma indicators and feedback mechanisms to inform service delivery improvements.
3. **Capacity Building for Health Providers:**
 - Train CHWs and facility staff on **confidentiality, rights-based care, and stigma-free service delivery**.
4. **School-Based Interventions:**
 - Implement policies and systems that ensure **confidential medication access, counseling, and anti-discrimination protocols** in schools.
5. **Policy and Legal Advocacy:**
 - Support **evidence-informed legal reforms** to protect PLHIV and key populations from discrimination.
 - Advocate for inclusion of community priorities in national HIV and SRHR governance structures.

¹² SI, 2020; RRP+ CLM data, Dec. 2025; RRP+ School Survey, Oct. 2025.

Priority by 2030:

- Achieve **equitable access** to stigma-free HIV services for PLHIV and key populations.
- Ensure **sustainable community engagement** through institutionalized CLM, peer support, and integrated school-based interventions.

Overview of RRP+ CLM System

RRP+ operates a robust **Community-Led Monitoring (CLM) system**, which systematically collects and analyzes data from the grassroots level to inform HIV programming and policy. The **system** is a secure, digital platform designed to **collect, manage, and analyze community-level HIV service data** in Rwanda. It empowers PLHIV networks and peer educators to systematically monitor service delivery, identify gaps, and inform evidence-based advocacy for improved HIV responses. The platform strengthens **continuity of care, service quality, and community-led accountability**, particularly for adolescents, youth, and key populations.



Photos of data monitors during the training on CLM

Established as part of RRP+’s mandate to represent People Living with HIV (PLHIV) in Rwanda, the system enables:

- **Evidence-informed advocacy:** Providing actionable insights to national and district-level health authorities.
- **Service quality monitoring:** Tracking HIV service delivery across 547 health facilities, including ART coverage, viral load suppression, and retention.
- **Community empowerment:** Equipping peer educators and PLHIV sector representatives with tools to monitor services, report gaps, and advocate for improvements.
- **Integration potential:** The CLM platform can be linked with national community medical records to reinforce peer-led monitoring in the context of broader health system integration.

Technical Architecture

- **Platform:** Built on **REDCap (Research Electronic Data Capture)**.
- **Hosting:** Locally hosted by **AOS Rwanda**, ensuring data security, compliance with national standards, and integration readiness with Rwanda’s health information systems.
- **Accessibility:** Accessible via desktop and mobile devices, allowing **real-time entry and reporting from both health facilities and community settings**.
- **User Roles:**
 - **Peer Educators:** Input community-level data and monitor service use.
 - **Sector Representatives:** Aggregate sector-level data for district-level analysis.
 - **District & National Coordinators:** Review trends, generate reports, and guide programmatic decisions.

Data Hosted in the System

The RRP+ CLM system hosts and tracks the following categories of information to ensure the right to health for PLHIV including the availability, accessibility, acceptability and affordability of quality HIV services:

1. **Service Users / Recipients of Care (RoC)** – ART clients, including adults, children, and key populations.
2. **Facility Managers** – Data on facility-level performance, capacity, and service delivery quality.
3. **Key Populations** – Female sex workers (FSWs), men who have sex with men (MSM), people who inject drugs (PWID), and other priority populations.
4. **Adolescents and Young People (AYPLHIV)** – Including those in and out of school, capturing adherence, retention, and school-related challenges.

- 
5. **Observation Tools** – Structured tools for community-led monitoring of service quality and facility responsiveness.
 6. **Community Call Center “1245”** – Logs inquiries, referrals, psychosocial support, and information requests from PLHIV and the community.
 7. **Continuity of Care for Learners Living with HIV in Schools** – Captures medication adherence, privacy and confidentiality issues, stigma, and support mechanisms in school settings.
 8. **Hors Zone Recipients of Care** – Tracks PLHIV accessing services outside their home catchment area, including reasons for facility choice and follow-up outcomes.

Core Functionalities

- **Real-Time Monitoring:** Enables tracking of ART adherence, loss-to-follow-up (LTFU), and viral suppression outcomes.
- **Continuity of Care Management:** Highlights service gaps, especially for hors zone clients and school-going AYPLHIV.
- **Evidence-Based Reporting:** Generates dashboards, heatmaps, and analytical reports for sector-, district-, and national-level decision-making.
- **Community-Led Accountability:** Facilitates peer-led documentation of service gaps, stigma, and barriers to care, supporting advocacy with health authorities.
- **Integration Potential:** Aligns with Rwanda’s Health Management Information System (RH MIS) for future inclusion of CLM indicators in national community health records.

Impact

- Provides **granular insights on service gaps** and continuity challenges for key populations and adolescents.
- Demonstrates the **unique role of peer educators** in maintaining engagement and adherence, especially in the context of hors zone service utilization.
- Supports **data-driven advocacy, policy adjustments, and resource allocation**, ensuring sustainability of HIV services during periods of funding transitions.

Future Opportunities

- Embed CLM indicators into **national CHW digital platforms** to ensure sustainable monitoring.
- Expand AI-driven analytics for **predictive identification of treatment gaps** and high-risk populations.
- Scale to reach all remote, high-burden, and marginalized communities, reinforcing RRP+’s **peer-led, evidence-based HIV response**.

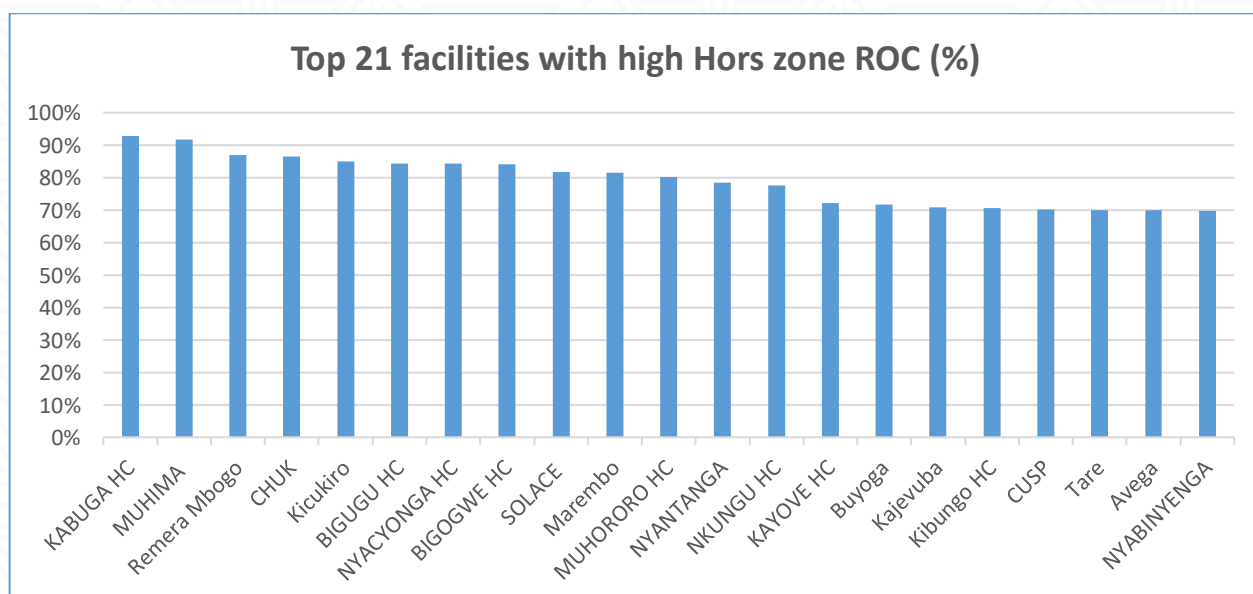
Findings on Hors Zone Recipients of Care

The CLM system identified the total of **56,052 “hors zone” recipients of care (ROC)**, representing an average of **26% of the total PLHIV on ART** in Rwanda. Hors zone patients are those who access HIV services outside their official geographic catchment areas¹³.

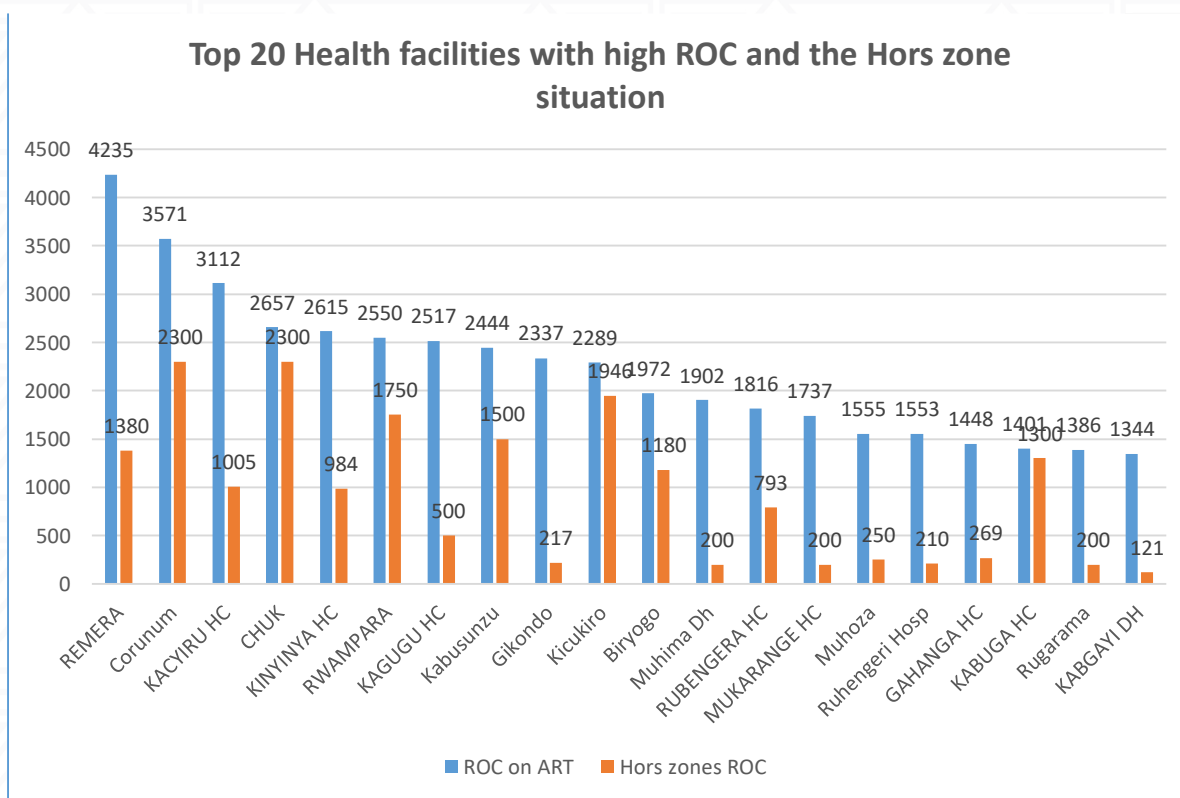
Province	# HEALTH FACILITY	# ROC on ART	Hors zones ROC	Hors Zone ROC (%)
City of Kigali	41	54,036	24,155	45%
EAST	127	50,425	6,128	12%
NORTH	108	24,041	6,377	27%
SOUTH	138	43,175	8,839	20%
WEST	133	44,411	10,553	24%
Total	547	216,088	56,052	26%

Key Highlights:

- **High concentration in Kigali City:** 24,155 hors zone ROC (45% of city’s PLHIV).
- **Top 20 facilities:** Facilities such as **Nyabinyenga HC in Nyanza district** and **Kabuga HC in Gasabo district**, have 70–93% of their ROC classified as hors zone.



¹³ RRP+ CLM reports, Dec. 2025.



- **Drivers of hors zone utilization:**

- Accessibility barriers (distance, terrain, transport costs)
- Fear of stigma and desire for confidentiality
- Perceived quality of care and previous negative experiences at local facilities
- Limited clinic operating hours or multi-month ART dispensing

Factors Driving “Hors Zone” Utilization



Case Study – Corunum HC, Nyarugenge district: Hors zones ROC and Lost to Follow up (LTF)

- Total ROC on ART: 3,571
- Hors zone ROC: 2,300 (64%)
- Lost to follow-up: 54 patients
- Partners: CDC-supported

Consequences:

- Difficulty tracking loss-to-follow-up
- Disrupted continuity of care
- Increased logistical challenges for adherence support and home visits
- Highlighting the importance of peer educators in maintaining engagement outside the patient's catchment area

Continuity of Care for AYPLHIV

RRP+ conducted a **national survey (October 2025)** across 504 health facilities to assess continuity of care for **Adolescents and Young People Living with HIV (AYPLHIV, 12–20 years)**¹⁴:

¹⁴ RRP+ CLM data, Oct. 2025.

Key Findings:

- Total AYPLHIV: 3,013 (45% male, 55% female)
- School enrollment: 2,168 learners (31% boarding, 69% day scholars)
- School dropouts: 28% overall, 55% among female learners
- Highest affected districts: Gasabo, Kamonyi, Rubavu, Kicukiro

Challenges in school and community settings:

- Inadequate privacy and confidentiality for ART adherence
- Persistent stigma and discrimination
- Fear of disclosure leading to stress and isolation
- Poor adherence due to rigid school schedules
- Limited psychosocial and mental health support
- Socioeconomic barriers impacting engagement

RRP+ Interventions:

- Peer-led ART adherence support and home-based delivery
- Confidential medication management and counseling systems in schools
- Psychosocial support and parental/guardian engagement
- Strengthening school–health facility–community linkages

Impact:

- Peer educators and PLHIV sector representatives have successfully maintained engagement and adherence for AYPLHIV, mitigating school-related and community-level disruptions.

Lessons Learned from Peer-Led Interventions

RRP+ CLM data provides critical insights on the **unique value of peer-led interventions** in Rwanda:

1. **Enhanced Continuity of Care:** Peer educators ensure ART adherence and follow-up, especially for hors zone patients and AYPLHIV.
2. **Stigma Mitigation:** Peer-led support provides safe spaces for disclosure, psychosocial support, and community acceptance.
3. **Evidence-Based Advocacy:** CLM data enables RRP+ to inform national policies, integration strategies, and resource allocation.

-
4. **Community Ownership:** Engaging PLHIV in monitoring and advocacy strengthens accountability and responsiveness in service delivery.
 5. **Integration Potential:** Peer-led systems can complement Community Health Workers (CHWs) in the context of funding constraints and service integration, ensuring specialized PLHIV expertise is not lost.

Strategic Implication:

- Peer educators remain a **critical bridge** between health systems and communities, particularly under funding reductions and during integration of HIV services into broader CHW structures.

Treatment Disruptions and Loss to Follow-Up

Gaps in service delivery, accessibility, and continuity of care have resulted in **treatment disruptions** and **loss-to-follow-up (LTFU)** among PLHIV in Rwanda. Key contributors include:

- **Hors zone utilization:** Patients accessing ART outside their catchment area, such as at **Corunum HC in Nyarugenge** (64% hors zone ROC, 54 LTFU patients, CDC-supported), challenge the tracking of patient adherence and continuity of care. Patients may miss follow-up visits, interrupt treatment, or delay reporting adverse effects due to distance, confidentiality concerns, or stigma¹⁵.
- **School-based barriers for AYPLHIV:** RRP+ CLM findings show 28% school dropouts in the last two years (55% among female learners), inadequate privacy, rigid school routines, and fear of disclosure all contribute to missed doses and inconsistent clinic attendance¹⁶.
- **Suboptimal integration:** The lack of seamless integration between HIV services and broader community health structures limits coordinated follow-up for patients navigating multiple service points.

Implication: LTFU increases the risk of disease progression, drug resistance, and treatment failure, undermining national targets for ART retention.

Impact on Viral Suppression and HIV Outcomes

Disruptions in treatment and suboptimal adherence directly affect viral suppression rates:

- Adolescents and young adults (15–24 years) and children (0–14 years) show **lower viral load suppression (VLS <95%)**, increasing vulnerability to opportunistic infections and transmission.
- Hors zone patients may experience **delays in lab monitoring and ART regimen adjustments**, reducing the likelihood of achieving durable viral suppression.
- Inconsistent ART adherence contributes to **persistent viremia** and may require **complex second-line therapies**, raising costs for the health system.

¹⁵ RRP+ CLM data, December 2025

¹⁶ Data Sources: RRP+ CLM Data, Dec. 2025; RRP+ Survey on AYPLHIV, Oct. 2025; SI, 2020; National HIV Annual Report, June 2024.

Implication: Maintaining high VLS is critical to meet UNAIDS 95-95-95 targets and reduce HIV morbidity and mortality.

Social and Psychosocial Consequences

The gaps in HIV service delivery exacerbate **stigma, discrimination, and psychosocial stress**:

- **Stigma & discrimination:** Although national stigma prevalence decreased from 60% in 2009 to 13% in 2020, key populations (FSWs, MSM, AGYW, and youth) remain disproportionately affected. Fear of disclosure drives hors zone utilization, isolation, and reluctance to access local services.
- **Psychosocial stress for AYPLHIV:** School environments with inadequate privacy, public checking of medication, and peer judgment contribute to anxiety, depression, and low self-esteem.
- **Impact on families and communities:** PLHIV may experience strained social support, limiting adherence and participation in community-led initiatives.

Implication: Psychosocial distress and stigma reduce health-seeking behavior, adherence, and engagement in HIV prevention and care services.

Health System Implications

The combined impact of the gaps has significant consequences for the health system:

- **Resource inefficiency:** High hors zone utilization requires additional tracking, staff time, and coordination across facilities, increasing operational costs.
- **Data fragmentation:** Tracking LTFU and adherence becomes more complex when patients bypass their nearest facilities, complicating health information systems and planning.
- **Service integration challenges:** Integration of HIV services into CHWs' broader responsibilities may dilute specialized support for PLHIV, risking reduced quality of care.
- **Equity concerns:** Geographic, financial, and social barriers disproportionately affect rural populations, adolescents, and key populations, potentially reversing gains in national HIV outcomes.

Implication: Strengthening community-led monitoring, peer education, and psychosocial support is critical to maintain continuity, quality, and equity in HIV service delivery.

RRP+'s strategic priorities focus on maintaining and enhancing PLHIV engagement, continuity of care, and evidence-based community-led interventions, especially during periods of funding constraints and the integration of HIV services into the broader Community Health Worker (CHW) system.

Strengthening Community Peer Education

Peer educators remain a **critical bridge** between PLHIV, key populations, and health services. RRP+ will:

- Conduct **readiness assessments and awareness campaigns** among PLHIV support groups and high-risk populations to prepare for HIV integration into the general health system.
- Provide **continuous training for peer educators**, emphasizing HIV prevention, treatment literacy, and adherence support.
- Promote **community literacy** on integrated health services, ensuring that PLHIV understand their rights and available services.
- Initiate **community-based ARV pick-up and home delivery**, leveraging peer networks to maintain adherence and reduce LTFU.
- Document and communicate the **competitive advantage of HIV peer educators**, highlighting their lived experience and specialized knowledge compared to general CHWs.

Ensuring Continuity of Care and Psychosocial Support

To minimize treatment disruptions and optimize outcomes, RRP+ will:

- Implement **peer-led adherence support programs** for AYPLHIV and hors zone recipients of care.
- Strengthen **school–health facility–community linkages**, including confidential medication management and counseling for in-school learners.
- Provide **psychosocial support** for PLHIV experiencing stigma, discrimination, or fear of disclosure.
- Expand **community-based monitoring of ART adherence**, integrating with national health information systems for real-time tracking.

Advocacy, Policy Engagement, and Integration into CHW System

RRP+ will actively engage with policymakers and health authorities to:

- **Advocate for formal integration of peer-led HIV services** into the national CHW structure while maintaining the specialized role of peer educators.
- Ensure that **CLM system indicators** and community-led data are incorporated into national and district-level health planning.
- Conduct **assessments of PLHIV perceptions** regarding integration to inform policy and program design.
- Promote **policy reforms** that safeguard PLHIV engagement, quality care, and community participation during funding reductions.

Capacity Building and Sustainability

To enhance long-term impact, RRP+ will:

- Provide **continuous professional development** for peer educators and PLHIV sector representatives.
- Strengthen **organizational systems** for data collection, reporting, and evidence-based advocacy.
- Promote **resource mobilization and domestic funding strategies** to ensure the sustainability of community-led interventions.
- Build **resilience in peer networks** to adapt to funding fluctuations while maintaining service quality and reach.

Community Engagement, Stigma Reduction, and Communication

RRP+ will reinforce **rights-based approaches** and community mobilization by:

- Scaling **community-led stigma reduction programs**, targeting PLHIV, key populations (FSWs, MSM, PWID), and AYPLHIV.
- Establishing **integrated feedback and CLM mechanisms** to continuously monitor community priorities and service quality.
- Implementing **multi-channel communication campaigns**, including digital platforms, edutainment, and peer-led advocacy, to increase HIV literacy and service uptake.
- Fostering **inclusive participation** of PLHIV in decision-making structures at national and subnational levels.

Strategic Outcome

Through these priorities, RRP+ aims to **maintain high-quality HIV services, ensure PLHIV engagement, and strengthen community-led oversight**, while adapting to funding constraints and the integration of HIV services into the broader CHW system.

RRP+'s recommendations focus on sustaining the HIV response, ensuring continuity of care, and strengthening community-led systems amid integration of HIV services into the broader CHW structure. Recommendations are categorized by time horizon for practical implementation.

Short-Term Priorities (Next 12 Months)

1. Strengthen Peer Education Networks

- Conduct readiness assessments and awareness campaigns with PLHIV support groups and high-risk populations.
- Reaffirm the unique role of HIV peer educators, emphasizing their expertise, lived experience, and trust within communities.
- Initiate community-based ARV delivery and adherence support programs to reduce LTFU.

2. Enhance Continuity of Care for AYPLHIV and Hors Zone Patients

- Implement confidential and supportive school–health facility–community linkages for medication adherence and psychosocial support.
- Track hors zone recipients of care with real-time monitoring to reduce treatment interruptions.

3. Community Literacy and Engagement

- Conduct campaigns to promote use of nearest health facilities while addressing stigma and confidentiality concerns.
- Roll out multi-channel peer-led communication campaigns targeting key populations, adolescents, and youth.

4. Rapid Integration Planning

- Engage stakeholders to define roles and responsibilities of peer educators within the CHW system.
- Advocate for inclusion of RRP+ CLM indicators into national community health monitoring frameworks.

Medium-Term Priorities (1–3 Years)

1. Institutionalize Community-Led Monitoring (CLM)

- Scale up CLM to cover all health facilities, including systematic tracking of ART adherence, viral suppression, and service quality.
- Integrate CLM findings into national and district-level decision-making.

2. Capacity Building and Workforce Development

- Train peer educators, PLHIV representatives, and CHWs on integrated service delivery, stigma reduction, and digital health tools.
- Strengthen RRP+ systems for data management, evidence-based advocacy, and quality improvement.



3. Policy and Advocacy

- Promote policy reforms to formalize peer-led roles in CHW structures while safeguarding PLHIV engagement.
- Advocate for sustainable domestic financing mechanisms to maintain core HIV services during funding cuts.

4. Strengthen AYPLHIV Support Systems

- Implement confidential medication management and mental health support in schools.
- Develop peer mentoring and youth-focused support groups for improved retention and viral suppression.

Long-Term Priorities (3–10 Years)

1. Sustainable Integration of HIV Services

- Ensure seamless integration of peer-led HIV interventions into the broader community health framework.
- Institutionalize CLM, peer support, and psychosocial care as standard components of the national HIV program.

2. Equity and Reach Expansion

- Address gaps in service delivery for rural areas, key populations, and high-burden districts such as Kigali City and Eastern Province.
- Optimize use of data-driven approaches to identify underserved populations and target interventions effectively.

3. Innovation and Evidence-Based Programs

- Expand digital health solutions, edutainment, and multi-channel communication platforms for HIV awareness and adherence support.
- Strengthen research and monitoring to continuously refine interventions, improve outcomes, and inform national strategies.

4. Sustainability and Resource Mobilization

- Develop diversified domestic funding streams to ensure long-term support for community-led HIV services.
- Build organizational resilience to adapt to funding fluctuations while maintaining high-quality care and community engagement.

Strategic Outcome:

Implementing these recommendations will ensure **sustained HIV prevention, treatment, and care**, maintain **high PLHIV engagement**, and **strengthen the integration of peer support within Rwanda's community health system**, while mitigating risks from funding reductions.

Key Takeaways

- Rwanda has made significant progress in HIV prevention and treatment, achieving near or above 95–95–95 targets nationally; however, gaps remain at subnational levels and among key populations, adolescents, and youth.
- RRP+’s community-led monitoring and peer-led interventions provide critical evidence and capacity to sustain continuity of care, reduce loss-to-follow-up, and address stigma, especially among hors zone recipients of care.
- Integration of HIV services into the broader Community Health Worker (CHW) system presents both opportunities and challenges, requiring strategic planning, advocacy, and capacity building to maintain quality and engagement.
- Persistent challenges include stigma and discrimination, adolescent adherence issues, gaps in key population coverage, and sustainability risks due to funding cuts.

Future Directions

- Institutionalize **peer-led services and community-led monitoring** within national health systems to safeguard continuity of care.
- Strengthen **policy advocacy and domestic financing strategies** to sustain HIV interventions in a funding-constrained environment.
- Expand **youth-focused and school-based support systems**, including psychosocial care and confidential medication management.
- Leverage **digital innovations, edutainment, and multi-channel communication** to maintain awareness, reduce stigma, and support adherence.
- Ensure **data-driven and equity-focused approaches** to address high-burden districts and underserved populations, maintaining Rwanda’s leadership in HIV outcomes in the region.



Rwanda
Biomedical
Centre

Kigali on, 06/09/2024
Ref: No. /RBC/HDPC/HIV/2024
24

HIV AIDs, STIs, VH &OVDC Division

To Whom It May Concern,

Subject: Recommendation for the Rwanda Network of People Living with HIV/AIDS (RRP+)

On behalf of the Rwanda Biomedical Center (RBC)/HIV AIDs, STIs, VH &OVDC Division , I am pleased to recommend the Rwanda Network of People Living with HIV/AIDS (RRP+) for the **implementation of Community-Led Monitoring (CLM) in Rwanda**. RRP+ has demonstrated strong leadership and commitment to improving the quality and accessibility of HIV-related services for communities, including People Living with HIV (PLHIV) and key populations.

Their collaboration with government bodies, civil society organizations, and international partners has been pivotal in driving community-driven health responses. We fully support RRP+ in leading this initiative, which will significantly contribute to advancing Rwanda's HIV response through community engagement and data-driven advocacy.

Sincerely,

Dr Gallican NSHOGIZA RWIBASIRA
Division Manager

HIV, STIs, VIRAL HEPATITIS AND OTHER
VIRAL DISEASES CONTROL DIVISION
RWANDA BIOMEDICAL CENTRE



Ref No: 00050/UCO/2025

July 25th, 2025, Kigali, Rwanda

TO WHOM IT MAY CONCERN

This letter serves as a formal endorsement of the Rwanda Network of People Living with HIV/AIDS (RRP+), recognizing its exceptional and sustained contributions to Rwanda's national HIV response over the past two decades. As the leading civil society umbrella of People Living with HIV (PLHIV) in Rwanda, RRP+ has consistently demonstrated visionary leadership, deep community engagement, and innovative approaches across the continuum of HIV prevention, care, treatment, and impact mitigation.

RRP+ has distinguished itself through the following key contributions:

Civil Society Coordination: RRP+ has effectively contributed to the coordination of Civil Society Organizations (CSOs) representing PLHIV, key, and vulnerable populations. Their leadership in convening inclusive community dialogues, particularly for PLHIV, has significantly contributed to national priorities.

Institutional Strengthening: By nurturing a vast network of associations, cooperatives, and grassroots organizations of PLHIV, RRP+ has fostered local ownership and strengthened the collective capacity of communities to respond to the HIV epidemic.

Community Empowerment: RRP+ has elevated the voices of recipients of care, empowering them through peer-led support systems, storytelling, and anti-stigma initiatives that combat HIV-related stigma and self-stigma.

Capacity Building: The organization has trained thousands of community peer supporters of PLHIV—including youth, women, and sex workers—who play a crucial role in facilitating access to treatment, promoting ART adherence, and linking clients to services.

Community-Led Monitoring (CLM): RRP+ has co-led community efforts in CLM implementation, ensuring the active participation of communities in the monitoring of health services and the promotion of accountability and quality improvement in HIV care.

HIV Stigma Index Implementation: Through its technical and grassroots expertise, RRP+ has helped lead the implementation of the HIV Stigma Index for PLHIV in Rwanda, contributing to national strategies for stigma reduction.

Advocacy for Replenishment of the Global Fund: RRP+ in collaboration with other partners and stakeholders has been a committed advocate at the national, regional, and global levels, actively engaging in campaigns to support the successful replenishment of the Global Fund, which informed Rwanda's Global Fund funding requests for the 2021–2023 and 2024–2027 grant cycles.

Policy and Strategy Engagement: The organization has actively contributed to shaping and reviewing Rwanda's national HIV Strategic Plan, ensuring the meaningful inclusion of PLHIV communities' perspectives in policy frameworks.

Program Implementation: RRP+ continues to lead impactful, community-driven HIV programs targeting PLHIV including key and vulnerable populations affected by HIV, with a focus on mobilization, health education, and integrated service delivery.

Advocacy: RRP+ has demonstrated excellence in mobilizing technical and financial resources to support HIV related activities, education, and stigma reduction programs, including through partnerships with national and international actors.

Uniting the world against AIDS



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Rights-Based Advocacy: RRP+ is a strong voice for the rights and inclusion of PLHIV and vulnerable groups, actively influencing policies and interventions at both local and national levels.

UNAIDS Rwanda recognizes and commends RRP+ for its exemplary leadership as a key stakeholder in the HIV response in Rwanda and its deep-rooted community legitimacy, and unwavering commitment to a rights-based and people-centered HIV response. We are proud to partner with RRP+ and remain committed to our continued collaboration in advancing equity, dignity, and access to services for all.

Yours Sincerely

Hind Hassan
Country Director
UNAIDS – Rwanda

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Hind Hassan Abdalgali
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25-07-25



Uniting the world against **AIDS**

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TO WHO IT MAY CONCERN

This letter serves as formal recognition of the Rwanda Network of People Living with HIV/AIDS (RRP+) for their significant contributions to HIV response efforts in Rwanda over the past two decades. The RRP+ has played a pivotal role in engaging various communities affected by HIV in prevention, care, treatment, and impact mitigation activities. Here are the key points highlighted:

1. **Coordination and Collaboration:** RRP+ has effectively coordinated civil society organizations (CSOs) and collaborated with representatives of People Living with HIV (PLHIV) and key and vulnerable populations to prioritize community interventions, influencing funding requests to the Global Fund.
2. **Establishment of Organizations:** RRP+ has established associations, cooperatives, and NGOs to intervene effectively in HIV response, focusing on engaging PLHIV and affected individuals.
3. **Empowerment and Peer Support:** The organization empowers HIV-affected individuals through community-based organizations, peer support, and capacity-building initiatives to combat stigma and promote treatment adherence.
4. **Community-led Monitoring:** RRP+ engages in community-led monitoring efforts and participates in HIV Stigma Index Surveys to address stigma effectively.
5. **Advocacy:** The organization advocates for successful replenishments of the Global Fund and contributes to the development and review of the HIV National Strategic Plan.
6. **Implementation and Service Provision:** RRP+ monitors and coordinates the implementation of HIV projects targeting key populations, mobilizing resources for advocacy, education, and service provision.
7. **Stigma Reduction:** Collaboration with CSOs and community-based organizations to combat stigma and discrimination against PLHIV and key populations is a significant focus.
8. **Rights Advocacy:** RRP+ advocates for the rights and needs of PLHIV and key populations at both decentralized and national levels.
9. **Research Participation:** The organization actively participates in research initiatives aimed at engaging communities in HIV responses, including surveys and studies focusing on HIV-related issues RPHIA, Behavioral and Biological Surveillance Survey Among, Female Sex Workers (IBBSS), HIV-related Stigma Index Survey, and Health, Determinants for Major Non-communicable Diseases among PLHIV (NCOHIRWASTUDY).

We reaffirm our commitment to collaboration with RRP+ and Health Promotion to advance the HIV/AIDS Agenda in Rwanda.



Dr Albert TUYISHIME
Head of HIV/AIDS, Diseases Prevention and Control Department.
RWANDA BIOMEDICAL CENTRE, RBC



Kigali 27th February 2024

TO WHOM IT MAY CONCERN

Subject: Recommendation Letter

I am writing to formally confirm the active participation of the Rwanda Network of People Living with HIV/AIDS (RRP+) in the Country Coordinating Mechanisms in Rwanda (CCM-Rwanda) and its role as a Sub-Recipient of the Global Fund. RRP+ has been instrumental in implementing crucial interventions aimed at supporting People Living with HIV (PLHIV) and key and priority populations.

RRP+ has made significant contributions in the following areas:

- Coordinating Civil Society Organizations (CSOs) and collaborating with representatives of PLHIV, Key and Vulnerable Populations (FSWs, MSM, AGYW, PWUD/PWID) to identify priority interventions for communities. This input has informed the Global Fund funding requests for Grant Cycles 2021-2023 and 2024-2027.
- RRP+ has been engaging in coordinating CSOs in advocating for successful replenishments of the Global Fund at Country, Regional, and Global levels.
- Coordinating CSOs working with PLHIV, Key, and Vulnerable populations to contribute to the development and review of the HIV National Strategic Plan.
- Monitoring and coordinating the effective implementation of HIV projects targeting FSWs, MSM, and AGYW delivered by CSOs and their peer educators, including community mobilization, education, empowerment, and service provision.
- Facilitating collaboration among CSOs to mobilize resources supporting interventions for Key and Vulnerable populations, focusing on advocacy, education, stigma reduction, discrimination reduction, and service provision at the community level.
- Collaborating with CSOs and community-based organizations to combat stigma and discrimination against PLHIV, FSWs, MSM, AGYW, PWUD/PWID.
- Advocating for the rights and needs of PLHIV and key and priority populations (FSWs, MSM, AGYW, PWUD/PWID) at both decentralized and national levels.
- Collaborating with Umbrella with PLWD organizations.
- Collaborating with Umbrella Religious organizations.

CCM-Rwanda reaffirms its commitment to continuing collaboration with RRP+ and Health Promotion to advance the AIDS Agenda among PLHIV and Vulnerable populations in Rwanda.

Sincerely,

CYIZA BUSHYAMA
Permanent Secretary



CCM Rwanda Secretariat, MoH building, 3rd Floor, www.ccm.rw, info@ccm.rw, 0788626228



**UMBRELLA OF ORGANIZATIONS OF PERSONS WITH DISABILITIES IN THE FIGHT
AGAINST HIV/AIDS AND FOR HEALTH PROMOTION (UPHLS)**

TO WHOM IT MAY CONCERN

This certifies that RRP+ (Rwanda Network of People Living with HIV) has successfully conducted a four days training session from December 13 – 16, 2023 on Community-Led Monitoring (CLM), and evidence-based advocacy in Muhanga District.

The training empowered 28 representatives from 13 Organizations of People with Disabilities members of Umbrella of Organizations of Persons with Disabilities in the fight against HIV&AIDS and for Health Promotion (UPHLS). This initiative led to significant outcomes, including the development of an inclusive CLM to be used by all categories of persons with disabilities.

This confirms RRP+'s dedication to advancing social inclusion of People with Disabilities and collaboration within HIV programs, ensuring active involvement and representation of vulnerable populations in addressing HIV-related challenges.

KARANGWA Francois Xavier

UPHLS Executive Director



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Date: February 26, 2024

CERTIFICATE FOR IMPLEMENTATION OF SOCIAL INCLUSION INTERVENTION

TO WHOM IT MAY CONCERN:

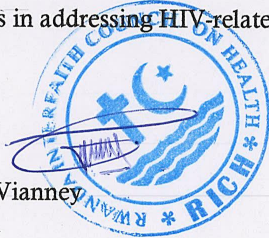
This certifies that the Rwanda Network of People Living with HIV (RRP+) successfully conducted a focused training session to promote social inclusion within HIV programs, targeting constituencies and other vulnerable population groups from Faith-Based Organizations; Held from November 22nd to 24th, 2023, the training empowered 32 representatives from Faith-Based Organizations (FBOs), members of the Rwanda Interfaith Council on Health (RICH), covering essential topics such as HIV-related stigma and discrimination, Community-Led Monitoring (CLM), and evidence-based advocacy.

This initiative led to significant outcomes, including the development of a tailored CLM tool for faith-based communities and the establishment of an alliance to support findings from the Stigma Index Survey, fostering unified action against stigma and discrimination.

Participants included religious leaders living with or personally affected by HIV and AIDS coming from members of Rwanda Interfaith Council on Health namely the Catholic Church, Protestant Council of Rwanda, Anglican Church of Rwanda, Rwanda Muslim Community, Evangelical Alliance of Rwanda, Sel et Lumiere and Fédération des Eglises Protestantes Reformées.

This certificate reaffirms RRP+'s dedication to advancing social inclusion and collaboration within HIV programs, ensuring active involvement and representation of vulnerable populations and Faith-Based Communities in addressing HIV-related challenges.

Done in Kigali,



Gatete Jean Marie Vianney

Executive Secretary

Rwanda Interfaith Council on Health (RICH)

Vision: A Healthy Nation in which Religious Denominations are United for Health and Peace

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