RWANDA NETWORK OF PEOPLE LIVING WITH HIV / AIDS (RRP+)

BACK TO CARE PROJECT PROGRAMMATIC REPORT

July 2025

Through peer support, community tracing and compassionate care, we help people re-engage in HIV Treatment and rebuild their lives.

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EXECUTIVE SUMMARY

The Rwanda Network of People Living with HIV (RRP+) is a national civil society umbrella organization representing individuals infected and affected by HIV. Established in March 2003, RRP+ serves as a coordination body for community-based HIV response and champions the Greater Involvement of People Living with HIV (GIPA) in all aspects of the national HIV response.

In partnership with AIDS Healthcare Foundation (AHF), RRP+ implemented the **Back to Care Initiative** to support the re-engagement and retention of People Living with HIV (PLHIV) who had discontinued their antiretroviral therapy (ART). Through a Memorandum of Understanding, the two organizations mobilized and deployed community peer educators to identify, trace, and support individuals lost to follow-up (LTFU), facilitating their return to care and ensuring continuity of treatment through ongoing community support.

Between July 2024 and June 2025, the initiative successfully re-engaged **255 out of 275** identified LTFU clients. This was achieved through the dedicated work of **14 trained peer educators,** in collaboration with **5 champion healthcare providers** across **4 AHF-supported health facilities in Kigali,** an area with a high burden of LTFU cases. The intervention applied a people-cantered approach that included home visits, personalized follow-up, and patient navigation to overcome common barriers such as stigma, transportation challenges, and gaps in patient data.

The outcomes of the Back in Care Initiative demonstrate the value of sustained, community-led efforts in improving ART adherence and long-term health outcomes among PLHIV. Key recommendations for scaling and sustainability include:

- Strengthening digital health tools for real-time patient monitoring
- Enhancing the capacity of healthcare workers in patient retention strategies
- Advocating for policy support and institutionalization of community-led follow-up models

RRP+ extends its sincere appreciation to the **Government of Rwanda** and the **AIDS Healthcare Foundation (AHF)** for their continued financial and technical support in advancing community peer-led HIV interventions.

INTRODUCTION

Rwanda has made significant progress in its HIV response, that stabilized the HIV prevalence rate at less than 3% of the population. However, the Rwanda population HIV impact assessment (RPHIA) has shown that 2.5% of people living with HIV are not on treatment (97.5% of people tested HIV positive were receiving ART). Some of them have never initiated the treatment, while others have been on treatment but have dropped out for different reasons.

As a continuation of AHF's collaboration with the Ministry of Health, within **4 health facilities of Kigali City,** supported by AHF, **275 people** have been reported to be no longer on treatment (AHF Rwanda report, April 2023). The **4 health facilities** with a high number of lost follow-up people in the ART service (Kagugu HC (70), Remera HC (99), Kinyinya HC (47), and Kacyiru HC (59). Some have left without prior notice, others were transferred but did not reach the place where they were transferred, nor returned to where they were, and others are no longer interested in the health services offered.

All these people need a push-up to re-engage in treatment for good adherence, retention, and well-being, but also for the country to reach and go beyond the three UNAIDS targets and the global target of zero new HIV infection by 2030.

RRP+ committed, under the **BACK TO CARE PROJECT,** to use the capacities of 121 peer educators in place in the community working within the catchment area of the 4 health facilities under the support of AHF to trace those people no longer on treatment and link them with nearby health facilities. The peer educators collaborate closely with the **Champions health care providers** in the ARV service for information on the person who dropped out of treatment and those who declared to be no longer interested in psycho-social counselling and group therapy to help reconnect to the health services and support groups.

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Objectives Of the Project

Global objective: The number of new HIV infections decreases in the community.

Specific objective: : More enhanced conditions are created to ensure an effective and sustainable reintegration into care of patients who stop taking medications, relying on community health support (peer educators and peer support groups).

Measurable objectives

- The 121 peer educators are equipped with the capacity and information on the strategies to trace and link people from the community to the health facilities for re-engagement on ARV treatment.
- 275 PLHIV no-longer on treatment are re-engaged and adhere well on treatment

Expected Outcomes

- The 275 PLHIV who were no longer on treatment are re-engaged and adhering well to treatment.
- They suppressed the VL well
- The decrease in new HIV infections in the community.
- Advocacy for country-wide project extension

Activities Conducted

1.Project Introduction Meeting

Participants in the Back to Care project introduction meeting

This meeting has been organized to inform the stakeholders that there is a pilot project aiming to ensure an effective and sustainable reintegration into care of patients who stop taking medications, relying on community health support (peer educators and peer support groups). It has been attended by the representatives of all stakeholders: Ministry of Health, the Rwanda Bio-medical Centre, the WHO, UNAIDS, Concerned Health Facilities, RRP+, and the peer educators and RRP+ youth ambassadors.

They agreed to unify the efforts to help the patients who dropped out of ART medication TO re-integrate and to retain on treatment and rebuild their lives.

2.Training of the peer educators on the strategies of tracking and tracing the LFU

Dr Gilbert from AHF Rwanda is training the peer educators

The RRP+ executive Secretary explains to the
the Peer educators why we should re-engage the LFU

Tracking lost patients represents a difficult task for the peer educators: those who dropped out of care are usually patients harder to reach who face psychologic, economic and social challenge. The current peer educators' user manual booklet does not provide sufficient guidance to handle such situations and answer the following questions:

- What is the definition of a "lost follow up" patient?
- What could be the causes of lost follow-up?
- How could the peer educator do to track and reconnect those patients into health care?
- How could the peer educator ensure retention of those patients into care?

The objectives of this training were to:

- Create and ensure an effective and sustainable reintegration into care of patients who stop taking medications, relying on community health support (peer educators and peer support groups).
- Equip Peer educators with capacity and information on the strategies to trace and link people from the community to the health facilities for re-engagement on ARV treatment.

During the training, out of the 121 participants expected 114 attended. The facilitators used participative methods: presentations, discussions, group works for a better understanding. English and Kinyarwanda were used

Among the challenges encountered generally in the community the trained peer educators mentioned that there are:

- Patients who have discontinued ARV treatment face stigma and discrimination from the community (they fear their status to be disclosed in the community)
- Limited resources, such as transportation can hinder the ability of peer educators to effectively trace and link patients back to health facilities. (the patients in Kigali do not stay in the same place. They are not permanent resident)
- Patients who have stopped taking their medications may have lost trust in the healthcare system and providers
- Patients often face social and economic barriers, such as poverty and unstable living conditions in urban areas

Peer educators who participated were better equipped with the necessary knowledge and strategies to trace and link individuals with the health care Providers but also ensured that there is a close collaboration with the Champions HCP for information and counselling support where it is necessary.

3. Supervision of the peer educators in the community and at the Health facility level

RRP+ field officers and the peer educators at Kacyiru HC assessing the reports

With the aim of ensuring the effectiveness of this initiative aiming to increase the retention on treatment among PLHIV, RRP+ organized the supervision of the PEs in the community and at the Health Facility level to evaluate their activities. This activity was conducted by the RRP+ staff in collaboration with ARV service.

During the supervisions, more enhancive conditions are created to ensure an effective and sustainable reintegration into care of patients who stop taking medications, relying on community health support (peer educators and peer support groups); the peer educators are evaluated on the number of people re-engaged on treatment by their efforts and interventions in the community and the tool to be used by the peer educators and check on the list of people re-engaged is availed.

The peer educators mentioned the challenges they encountered: The transportation costs discourage PLHIV from returning to care, and unstable living conditions may take priority over treatment adherence. Wrong information about the contact and names of the Lost to follow Ups due to fear of stigma and discrimination.

4. Mid-term coordination meeting with stakeholders

Stakeholders discussing the strategies for increasing re-engaged people

The meeting aimed to evaluate the project after 6 months, discuss the results and the challenges encountered in the community and set recommendations to boost the activities for the performance of the project. It gathered, RRP+. AHF Rwanda, the 4 health facilities representatives and 4 representatives of the peer educators.

They discussed on the achievement of the projects within the 9 pasted months: 114 PEs trained, 51 peoples who were LFU up-to-date been re-engaged on treatment by 14 PEs and 4 HCP; and the challenges faced by the community peer educators have been documented.

Some challenges have been mentioned and recommendations set to boost the project results within the 3 remaining months:

CHALLENGES	RECOMMENDATIONS
Wrong contact information (Names and phone)	The HCP, at the time of enrolment and every visit, should update patient information, including nicknames
Many people (among LFU) out of Kigali	The PEs should share with RRP+ through the RRP+ toll free line (1245) the information on the LFU out of Kigali for follow up by the PEs of the place.
LFU are among the ROC who do not want to be followed by the PEs (many are the newly enrolled patients who provide wrong personal information)	The HCP should follow up themselves these patients
ROC of Kigali do not have permanent address: they move and do not stay in one place	The PEs should share with RRP+ through the toll free the information on the LFU out of Kigali for follow up by the PEs of the place
Some called LFU in one place are in other HF because of some advantages like: MUSA, nutritional support, and other advantages provided there.	RBC will help with 'ONE-ID SYSTEM)
On-site testing issues: The PEs are sent to trace the people tested who have not honoured their appointment to the HF for further test and counselling while the person doesn't want that his/her status to be known by anyone	The HCP should follow up themselves these patients and increase counselling time

Apart from the recommendations to boost the project results, some discussion on the ART service have been done and the participants conclude that:

- The HCP should revise the way the on-site testing is done in order to limit the risks of stigma and discrimination towards the new HIV positive patients
- They also increase the counselling by including individual counselling before and after testing
- Follow up themselves the patients newly engaged in treatment without relying on community health workers

The meeting ended with a commitment of everyone to work together in order to track and trace more as possible of LFU for achieving the country's goal of ZERO New infections by 2030.

5.Payment of performance-based incentives to peer educators and recipients of care who returned to care

At the end of the project, all the 14 peer educators and 5 champions health care providers who participated in bringing back to care the LFU have been paid their transportation fees based on their performance: the number of people reached and brought back on treatment.

More on that, the 255 people who were back to care have been paid the transportation fees to support their effort to continue treatment.

6. Closing workshop with stakeholders

This workshop gathers the project's different stakeholders to evaluate the different activities and outputs and come up with recommendations that will help to advocate for its scale across the country.

Out of 17 invited participants, 11 attended.

The stakeholders are informed about the project output. They provided the recommendations to enhance better conditions for adherence and retention on treatment and the scale-up of the best practices across the country.

PROJECT ACHIEVEMENTS & CHALLENGES

PROJECT ACHIEVEMENTS

- 114 Peer educators out of 121 have been trained in the strategies of tracking and tracing the lost to follow up, and 14 among them helped to bring back to care 255 LFU
- 5 HCP champions within the 4 health facilities collaborate closely with the peer educators in the community tracing of the LFU
- 93% of the tacked LFU (255 out of 275 have been found and brought back into care (66 at Kacyiru, 44 at Kagugu, 83 at Kinyinya, 62 at Remera)

CHALLENGES

- The tracked LFU are not in peer education (they do not want their status to be known by someone else than the HCP
- The Contact and place of residence in the client file are generally wrong because of stigma and fear
- Few participants compared to the Pes-trained participated (14/114) collaborated with the champions HCP in tracing of LFU. Others lost interest due to the fruitless efforts in tracing the LFU.
- 5 LFU have been found out of Kigali and refused to collaborate
- 7 LFU from Kacyiru HC relocated themselves to Remera HC
- 12 LFU have transferred themselves to other HF without prior notice to their service providers

BEST PRACTICE

1.COMMUNITY LED RE-ENGAGEMENT THROUGH PEER EDUCATORS

Description:

Trained peer educators, who are also members of the community, served as key agents in tracing and re-engaging who had discontinued ART. Their lived experience with HIV and deep connection to the community enabled meaningful and empathetic outreach.

Why it Works:

- Leverages trust and shared lived experience
- Expands reach into hard-to-access households and informal settlements
- Promotes voluntary disclosure and reduces stigma

Impact:

Through this approach, peer educators and health care providers successfully supported the re-engagement of 255 lost to follow up across Kigali

2. STRONG COLLABORATION BETWEEN COMMUNITY AND HEALTH FACILITIES

Description:

The initiative established strong working relationships between peer educators, health facility-based Champions, and RRP+ staff. This ensured a smooth continuum of care from tracing in the community to reintegration into clinical services.

Why it Works:

- Strengthens referral and linkage system
- Increases accountability for follow-up and retention
- Provides a safety of psychosocial support and adherence counselling

Impact:

Facility based support enabled effective reintegration of LTFU, improving treatment adherence through ongoing psychosocial services and routine follow-up.

3. USE OF STANDARDIZED TRACKING TOOLS AND STRUCTURED SUPERVISION

Description:

Peer educators utilized uniform data collection tools to document tracing outcomes. RRP+ staff conducted regular supervisory visits to assess the quality of services and provide mentorship

Why it Works:

- Enables evidence-based decision-making and planning
- Ensures consistency, quality, and transparency in service delivery
- Allows for real-time identification of challenges

Impact:

Supervision improved coordination across four health facilities (Kinyinya, Kagugu,Kacyiru and Remera), ensuring that progress was tracked, and maintained throughout the re-engagement process.

RECOMMENDATIONS

- HCP to collaborate with the community PEs to trace the LFU without delay
- As it has been found that the LFU are mostly newly enrolled in service, HCP should ask to the recipients of care more than 1 alternative contact (phone) in case his/her own does not respond and try to be a close-friend to newly enrolled ones for the better follow up.
- MOH and RBC to urge the system (one ID system) that will help to trace people moving from one HF to another.
- RRP+ to Continue fight the stigma and discrimination that hinder the disclosure of status among the ART service recipients of Care
- RRP+ should continue to mitigate HIV impact among the PLHV and reverse their economic and financial situation that might hinder the proper adherence and retention to treatment.
- RRP+ should advocate to extend the project to the urban health facilities with great number of LFU.

CONCLUSION

The initiative established strong working relationships between peer educators, health facility-based Champions, and RRP+ staff. This ensured a smooth continuum of care from tracing in the community to reintegration into clinical services. It would not be possible without the technical and financial support from the Government of Rwanda and the AIDS Healthcare Foundation (AHF). Our deep gratitude goes to them.

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