



Republic of Rwanda
Ministry of Health



HIV, STIs and Viral Hepatitis Annual Programmatic Report

2025/2026



August 2026

Foreword

Rwanda is committed to ending AIDS as a public health threat by 2030. This past year brought major changes in global health funding, but the national response stayed on track. This was possible because of strong political support, careful implementation and active community involvement.

This report covers the fiscal year from July 2025 to June 2026. It shows how the national HIV, Sexually Transmitted Infection and Viral Hepatitis programmes performed during the year, and it sets out the priorities for the year ahead.

The results are encouraging. Adult HIV prevalence fell to 2.2% in the 2025 Rwanda Demographic and Health Survey, down from 3.0% ten years ago. New infections dropped to 2,306 and mother-to-child transmission to 0.6%. Rwanda is one of the few African countries to have reached all three UNAIDS 95 targets. Today, 96% of people living with HIV know their status, more than 98% are on treatment, and more than 98% of those on treatment have suppressed viral load.

The report is also clear about the gaps. Fewer children are diagnosed and treated than adults. Adolescents and young people have lower viral suppression than adults. Men are still tested later than women. HIV remains far more common among key populations than in the general population. Viral hepatitis and sexually transmitted infections also need more attention as we work towards triple elimination.

We thank the health workers in our 601 treatment facilities, the peer educators, the civil society organisations and the communities they serve. We also thank our development partners for their continued support. This report shows what we have achieved together, and where we still need to do more.



Prof. MUVUNYI MAMBO Claude

**Director General
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Executive Summary

This report presents the performance of Rwanda's HIV, sexually transmitted infection (STI) and viral hepatitis programmes for the fiscal year July 2025 to June 2026. It consolidates results across epidemic surveillance, prevention, care and treatment, viral hepatitis and STI services, civil society engagement, and strategic information, and sets out strategic priorities for FY 2026-2027.

Epidemic status: Rwanda continues to sustain a low-level, declining and geographically heterogeneous HIV epidemic. Adult HIV prevalence stands at 2.2% (RDHS 2025), down from 2.7% in 2020, and remains relatively higher among women (2.8%) than men (1.5%). Prevalence is almost twice as high in urban areas (3.3%) as in rural areas (1.7%), and highest in the City of Kigali (3.7%). Annual new infections declined to 2,306 and AIDS-related deaths to 2,476 in 2025. Prevalence remains substantially elevated among key populations, at 25.8% among female sex workers, with an estimate of 12.3% among people who inject drugs and 5.8% among men who have sex with men.

Progress against the 95-95-95 targets: From an estimated number of 234,164 people living with HIV in Rwanda, 96% know their status, more than 98% are on antiretroviral therapy and >98% of those on treatment are virally suppressed, placing Rwanda among the few countries in Africa to have achieved and sustained triple 95's UNAIDS targets. The paediatric cascade, however, continues to lag, with 62% of children living with HIV aware of their status.

HIV Prevention: Testing services shifted further toward targeted, higher-yield approaches: at least 1,795,856 tests were conducted in 2025-2026 with a positivity yield of 0.72%, while index testing strategies returned a yield of 3.65%, nearly three times that of any other entry point. Pre-exposure prophylaxis reached 16,571 users, of whom 81% were female sex workers, and long-acting injectable cabotegravir expanded from two to nine sites in Kigali, with 286 cumulative enrolments since its December 2024 launch. Facility - based Mother-to-child transmission fell to 0.6%, a 60% relative reduction 2020.

HIV Care and treatment: By June 2026, 234,566 people were receiving antiretroviral therapy across 601 health facilities. Against a data-quality-adjusted numerator of 230,344, national ART coverage reached 98.4%, although coverage among children aged 0-14 years remained substantially low at 58.9%, retention after 12 months of ART initiation was estimated at 93.8%, annualized loss to follow-up 1.4% and mortality 0.7%. Viral load testing coverage reached 90.1%, below the 95% national target, while 97.6% of results were suppressed below 1000 copies/mL,

with suppression consistently lower among clients under 25 years. Multi-month dispensing continued to expand, with 90.8% of clients on multi-month refills.

Integrated and person-centred services: Tuberculosis preventive treatment reached 99.1% among established ART clients but only 73.3% of newly enrolled clients. TB/HIV co-infection increased to 15.6%, partly reflecting improved case finding through increased TB LAM testing. HIV care was further integrated with mental health, psychosocial, and nutrition services, reaching 43,049 clients with supplementary feeding. Quality improvement was strengthened through training, facility-level improvement projects, and piloting of the National HIV Quality Standards Assessment Tool.

Viral hepatitis and STI: The programme sustained hepatitis B and C awareness, screening and treatment services, strengthened syndromic STI management, and expanded tele-mentorship for providers on viral hepatitis, STI management and data quality, supporting Rwanda's progress toward triple elimination of HIV, syphilis and hepatitis B.

Remaining gaps: Priority gaps concentrate in paediatric case finding and treatment coverage, viral suppression and retention among adolescents and young people, later diagnosis among men, viral load testing coverage, timely TPT initiation among new ART clients, retention on long-acting PrEP, and district-level variation in performance. Constrained external financing added pressure on service delivery across all health facilities during the reporting period.

Looking ahead: FY 2026-2027 priorities focus on sustaining epidemic control and accelerating triple elimination, strengthening targeted prevention, improving early case detection and linkage, expanding integrated service delivery, reinforcing community and civil society systems, strengthening strategic information and digital health, and improving health financing and programme sustainability.

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List of Acronyms

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AYLHIV	Adolescents and Young People Living with HIV
CAB-LA	Long-Acting Injectable Cabotegravir
CBO	Community-Based Organization
CBS	Case-Based Surveillance
CHW	Community Health Worker
CSB+	Corn Soya Blend Plus
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DQA	Data Quality Assessment
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother-to-Child Transmission
FSW	Female Sex Worker
FY	Fiscal Year
GBV	Gender-Based Violence
GF	Global Fund
GoR	Government of Rwanda
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HEI	HIV-Exposed Infant
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
IBBS	Integrated Bio-Behavioural Survey
KP	Key Population
LIS	Laboratory Information System
LTFU	Loss to Follow-Up

M&E	Monitoring and Evaluation
MMD	Multi-Month Dispensing
MoH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
MTEF	Medium-Term Expenditure Framework
NCD	Non-Communicable Disease
NSP	National Strategic Plan
PEP	Post-Exposure Prophylaxis
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNS	Partner Notification Services
PrEP	Pre-Exposure Prophylaxis
PW	Pregnant Women
PWID	People Who Inject Drugs
QI	Quality Improvement
RBC	Rwanda Biomedical Centre
RDHS	Rwanda Demographic and Health Survey
RMS	Rwanda Medical Supply
RUTF	Ready-to-Use Therapeutic Food
SNS	Social Network Strategy
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TB LAM	Tuberculosis Lipoarabinomannan Assay
TDF	Tenofovir Disoproxil Fumarate
TPT	Tuberculosis Preventive Treatment
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
VL	Viral Load
VLSMS	Viral Load Sample Management System
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

1. SECTION I: HIV EPIDEMIC OVERVIEW

Rwanda continues to sustain a generalized but low-level and declining HIV epidemic. The 2025 Rwanda Demographic and Health Survey (RDHS) estimated an HIV prevalence of 2.2% among women and men aged 15–49 years (95% CI: 1.9–2.5). HIV prevalence remains almost twice as high among women (2.8%) as among men (1.5%), while prevalence among men aged 15–59 years was estimated at 1.8%.

Adult HIV prevalence has continued to decline over the past two decades. After remaining stable at 3.0% between 2005 and 2015, prevalence declined to 2.7% in 2020 and further to 2.2% in 2025. Among women, prevalence declined from 3.5% to 2.8%, while among men it decreased from 1.7% to 1.5%. As the epidemic has matured, the burden of HIV has increasingly shifted toward older age groups, with the highest prevalence observed among women and men in their 50s. This demographic shift reflects both improved survivals resulting from effective antiretroviral therapy (ART) and the ageing of cohorts who acquired HIV in earlier years. Currently, people living with HIV (PLHIV) aged 50 years and above account for approximately 36% of all PLHIV receiving ART, highlighting the growing importance of addressing the health and care needs of an ageing population.

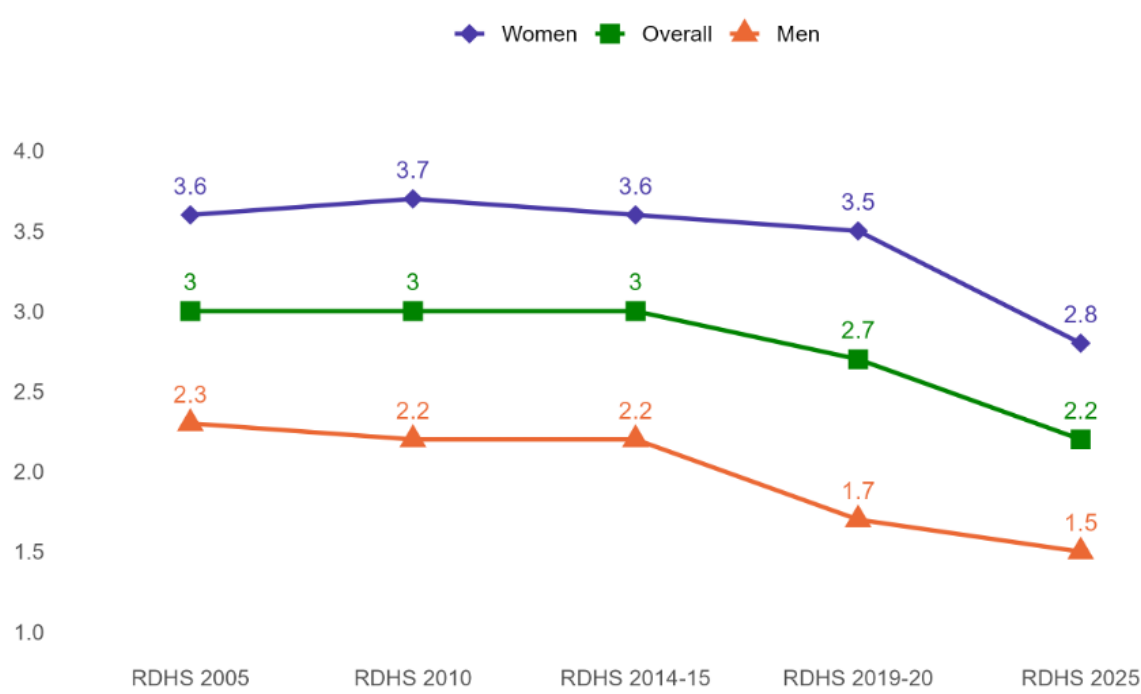


Figure 1: Trends in HIV prevalence over time (source: RDHS 2025)

HIV prevalence increases with age and differs considerably by sex. Among women, prevalence rises from 0.6% at ages 15–19 to 4.4% at ages 30–34 and 4.9% at ages 35–39, falls to 2.7% at ages 40–44, and peaks at 7.8% among those aged 45–49 years. Among men, the increase is

more gradual and sustained, reaching 3.5% at ages 45–49 years and peaking at 4.3% among those aged 50–59 years. HIV prevalence among young people aged 15–24 years remains low at 0.7% among young women and 0.9% among young men, suggesting substantially reduced HIV transmission among adolescents and young people and an epidemic increasingly concentrated among older age groups. At the same time, younger cohorts are entering adulthood with substantially lower HIV prevalence as a result of successful prevention programmes, contributing to the continued decline in overall adult HIV prevalence (15–49).

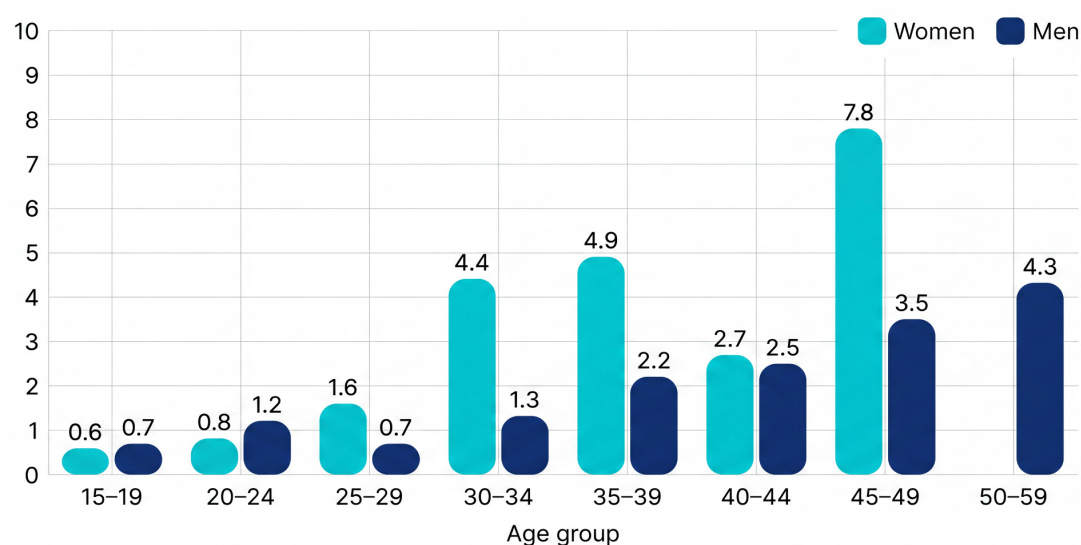


Figure 2: HIV prevalence by age and sex (source: RDHS 2025)

The HIV epidemic remains geographically heterogeneous. HIV prevalence is almost twice as high in urban areas (3.3%) compared with rural areas (1.7%), with the largest burden observed in the City of Kigali (3.7%), followed by the Southern (2.3%), Western (2.2%), and Eastern (2.0%) Provinces. The Northern Province (1.0%) continues to report the lowest prevalence.

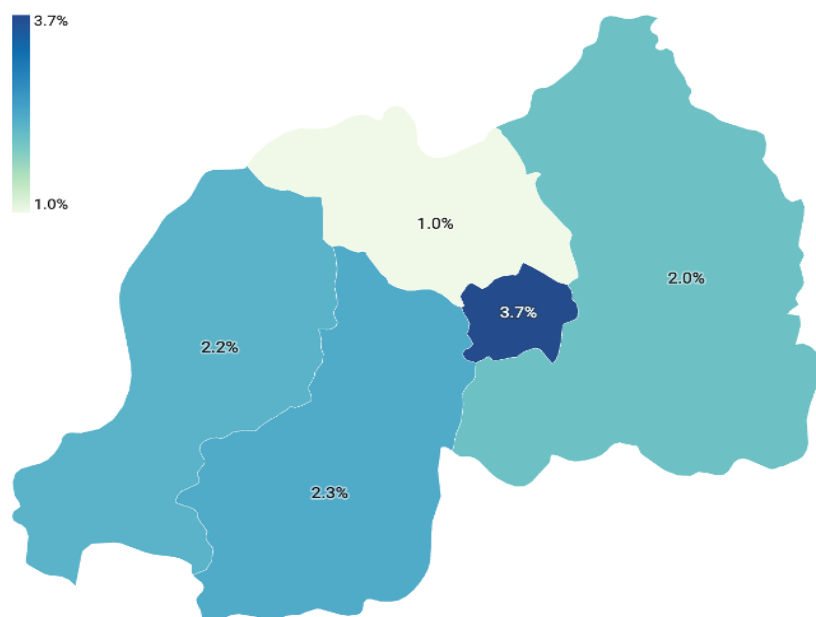


Figure 3: HIV prevalence among people aged 15-45 by Province (source: RDHS 2025)

District-level analysis further highlights the geographic heterogeneity of the HIV epidemic across Rwanda. The highest HIV prevalence is observed in Nyarugenge District, followed by Kicukiro and Gasabo districts, all located within the City of Kigali, where urbanization, population density, and high population mobility may contribute to increased HIV transmission. Outside Kigali, relatively high prevalence is reported in Rwamagana, Bugesera, and Kayonza districts in the Eastern Province. In contrast, the lowest HIV prevalence is observed in Gisagara, Burera, Nyaruguru, and Huye districts (all below 2%), which are predominantly rural districts with lower levels of urbanization and population mobility.

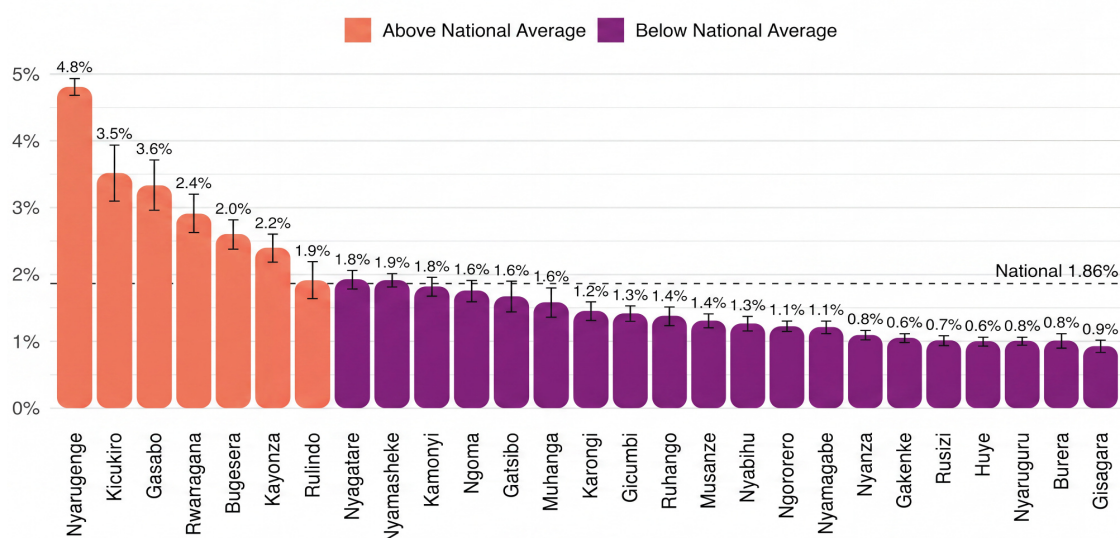


Figure 4: HIV prevalence among people aged 15-45 by District (source: Naomie Estimates 2025)

Despite the declining epidemic in the general population, HIV prevalence remains substantially higher among key populations. HIV prevalence is estimated at 25.8% among female sex workers (FSWs), 12.3% among people who inject drugs (PWID), and 5.8% among men who have sex with men (MSM), representing approximately twelve, six and three times the national adult prevalence, respectively. Trends differ across populations: HIV prevalence among FSWs has steadily declined from 51% in 2010 to 25.8% in 2025, reflecting sustained prevention and treatment efforts, whereas prevalence among MSM has increased from 4.0% in 2015 to 5.8% in 2024, highlighting the need for intensified, targeted interventions.

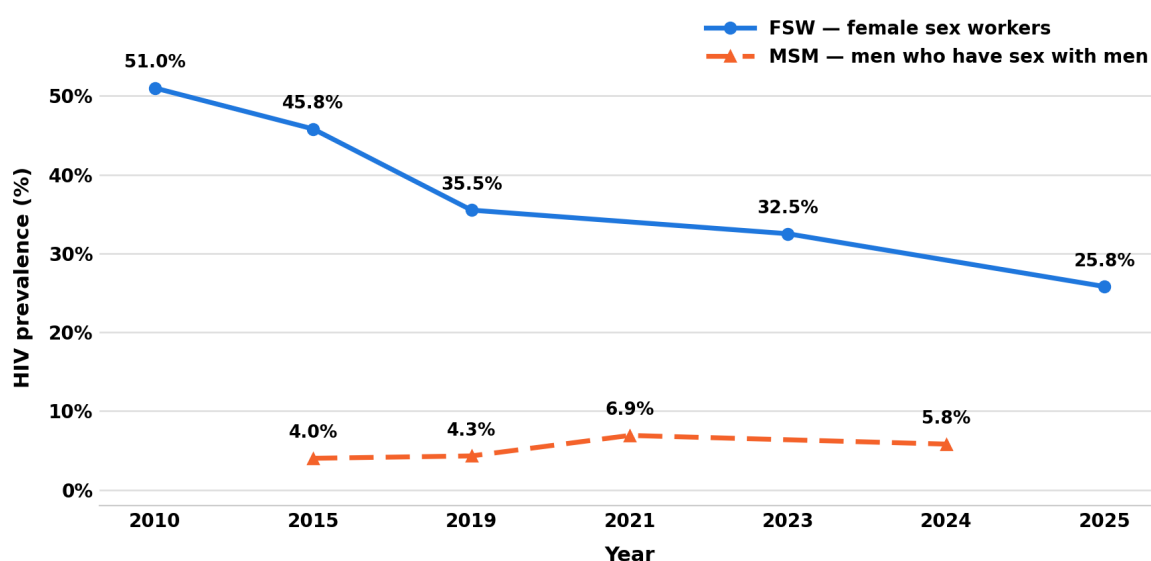


Figure 5: Trends in HIV prevalence among FSWs and MSM (source: IBBS)

The HIV epidemic continues to contract as both new infections and AIDS-related deaths decline. Annual new HIV infections decreased from approximately 12,000 in 2010 to 3,200 in 2020 and 2,306 in 2025, corresponding to an incidence rate of 0.16 per 1,000 population. During the same period, AIDS-related deaths declined from approximately 7,721 in 2010 to 2,476 in 2025. Of the estimated new infections in 2025, approximately 1,900 occurred among adults aged 15 years and above, with women accounting for the majority of new adult infections.

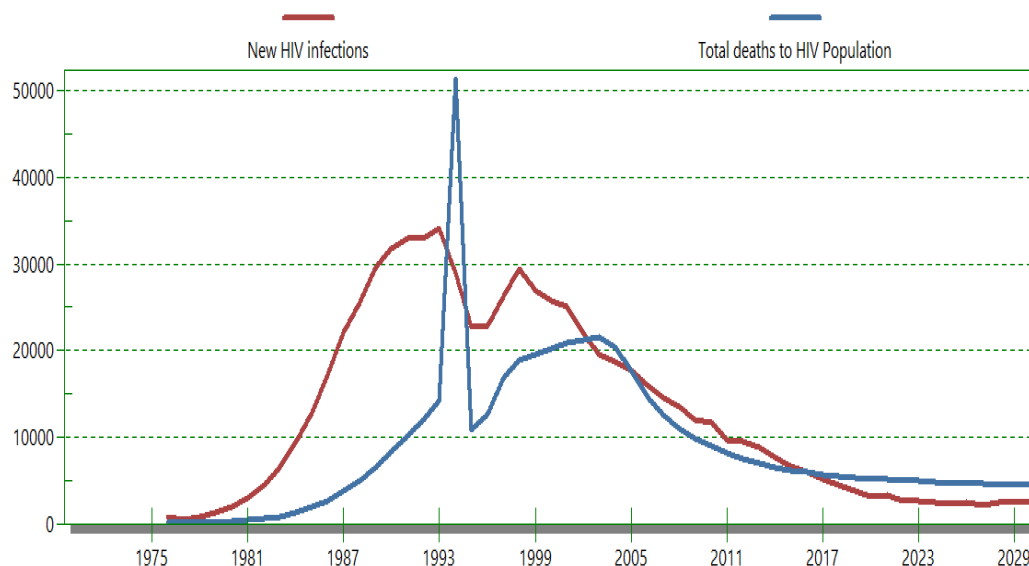


Figure 6: Trend of new infections and AIDS deaths from 1997-2025 (source: Spectrum 2025)

Rwanda has sustained remarkable progress toward achieving the UNAIDS 95-95-95 targets. In 2025, approximately 234,164 people are living with HIV, of whom 96% know their HIV status, 98% are receiving ART, and 98% of those on treatment are virally suppressed, making Rwanda one of the few African countries to achieve the UNAIDS 95-95-95 targets.

Despite these achievements, important gaps remain. The paediatric HIV cascade continues to lag behind that of adults, with only 62% of children living with HIV aware of their status, >98% receiving ART, and 94% achieving viral suppression. Men also remain less likely to know their HIV status than women. In addition, viral load testing coverage (90%) indicates that further improvements are needed to ensure optimal treatment monitoring. These remaining gaps particularly paediatric case finding, male HIV diagnosis, and viral load monitoring represent key priorities for the national HIV response.

2. SECTION II: HIV PREVENTION

2.1. Introduction

Rwanda's national HIV prevention program aims to reduce 10% of new HIV infections by 2030 through a comprehensive, integrated, and evidence-based approach. A central component of this effort is HIV testing within the case-based surveillance system, including index testing, which supports the early identification of HIV cases and ensures timely linkage to care and treatment services.

The program also strengthens prevention of mother-to-child transmission services to protect mothers and infants, sustains Voluntary Medical Male Circumcision as an important biomedical prevention intervention, and provides targeted prevention services for key and priority populations. In addition, broad condom programming improves access, availability, and consistent use, ensuring that HIV prevention efforts remain inclusive, practical, and responsive to the needs of the wider population.

2.2. Objective and Goal

The HIV prevention program defines its goal and outcomes to support a comprehensive and effective national response to the HIV epidemic. These priorities are aligned with the HIV National Strategic Plan and focus on reducing new infections, expanding access to prevention services, and protecting mothers, infants, and populations at increased risk.

2.2.1. Goal

- To reduce new HIV infections by 10% by 2030.

2.2.2. Outcomes

- Reduced transmission of new HIV infections through sexual intercourse.
- Improved access to integrated reproductive health and HIV prevention services for populations most at risk.
- Increased access to and use of services aimed at eliminating mother-to-child transmission of HIV, syphilis, and hepatitis.

Table 1: Contribution of HIV prevention programme areas to the national response

Program Area	Contribution to HIV Prevention
HIV Testing and Case-Based Surveillance	Supports early diagnosis, strengthens monitoring, and enables timely linkage to care.
Index Testing	Helps identify individuals who may have been exposed to HIV and connects them to testing and services.
PMTCT Services	Protects mothers and infants by reducing the risk of transmission during pregnancy, delivery, and breastfeeding.
Voluntary Medical Male Circumcision	Provides a proven biomedical prevention intervention as part of a combination of HIV prevention.
Key and Priority Population Services	Ensures that populations at increased risk can access appropriate, inclusive, and integrated prevention services.
Condom Programming	Improves access to condoms and promotes consistent and correct use across the population.

2.3. HIV Testing Services

Rwanda provides nationwide HIV Testing Services (HTS) to promote early diagnosis, timely initiation of ART, and strong linkage to care. HTS is integrated with major prevention and treatment services, including voluntary medical male circumcision (VMMC), post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), and prevention of mother-to-child transmission (PMTCT).

Testing is delivered through strategic entry points such as provider-initiated testing and counselling (PITC), voluntary counselling and testing (VCT), antenatal care (ANC), labour and delivery services, and other facility and community-based platforms. Priority approaches include index testing, family testing, and the Social Network Strategy (SNS) within Case-Based Surveillance (CBS). Together, these interventions strengthen early case detection, continuity of care, and Rwanda's progress toward sustained epidemic control.

The figure below presents trends in HIV testing volume, positivity rates, and testing efficiency across five years. Testing volume declined steadily, from 2,286,931 in 2021-2022 to 1,795,856 in 2025-2026, a pattern consistent with a broader transition toward more targeted testing approaches rather than large-scale general screening. Notably, positivity yield increased in the final year to 0.71% (12,839), coinciding with the lowest testing volume observed, which may indicate that testing resources are being directed more effectively toward higher-risk populations, thereby enhancing case-finding efficiency despite the overall reduction in tests conducted.

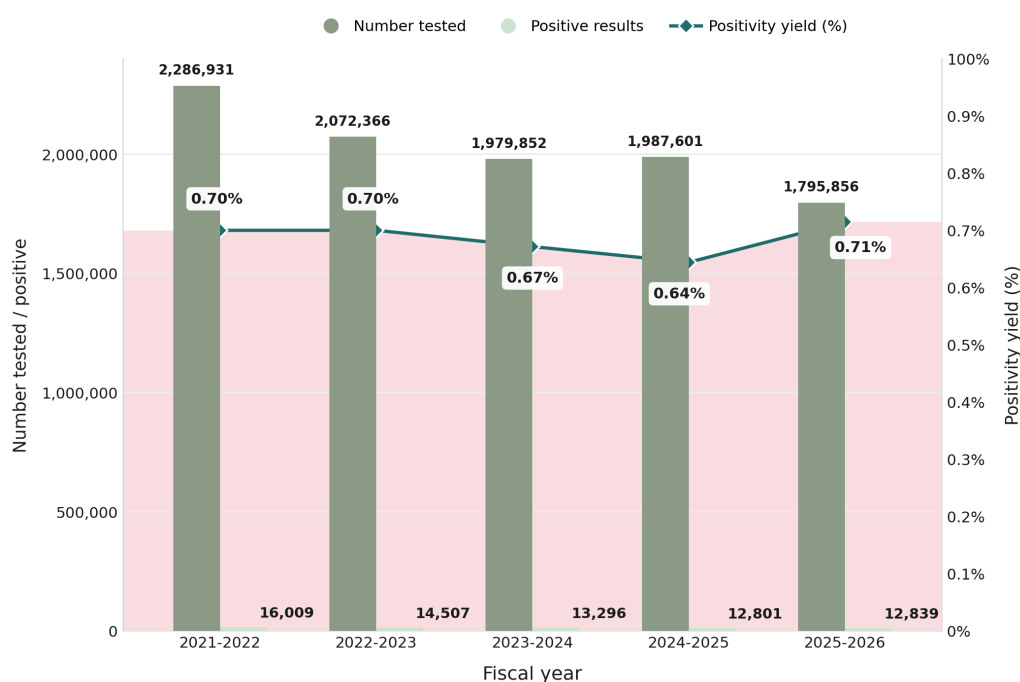


Figure 7: Trend of Total HIV Test done and Positivity yield for the last 5 years (HMIS)

The chart below illustrates considerable variation in HIV positivity yield across testing entry points. Facility-based entry points, including HTC (1.0%), ANC (0.33%), Maternity (0.08%), partners of pregnant women attending ANC (0.22%), and VMMC (0.52%), demonstrate low positivity yields. Index Testing, by contrast, breaks this pattern entirely, returning a yield of 3.65%, nearly three times higher than any other entry point.

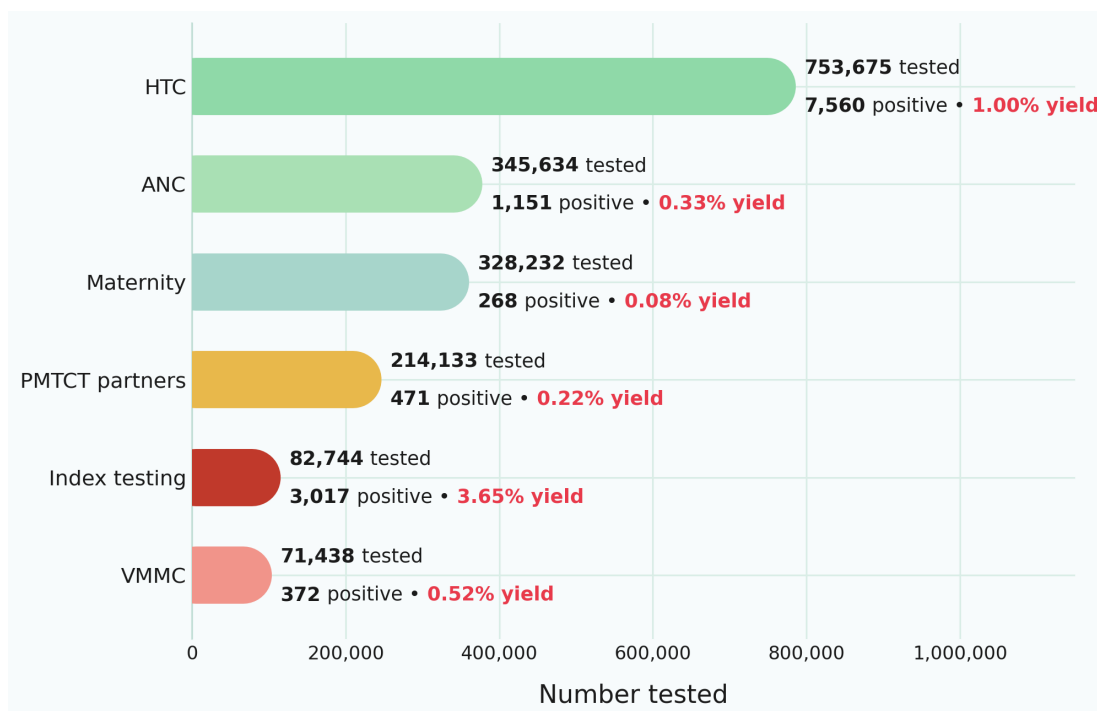


Figure 8: HIV testing and positivity yield different entry points

The maps illustrate HIV testing positivity rates at both provincial and district levels for the period July 2025–June 2026 (Figures 9 and 10). Positivity rates are lowest in the Northern and Western provinces (0.39%–0.48%), moderate across Southern and Eastern districts (0.60%–0.80%), and highest in Kigali Province (1.09%). Notably, three districts diverge sharply from their provincial averages Kicukiro (1.18%) and Bugesera (1.14%) within Kigali and Eastern Province respectively, alongside Nyabihu (1.04%) in the Western Province. These localized hotspots indicate priority areas for testing and targeted prevention interventions.

2.4. Case-based surveillance

Rwanda's Case-Based Surveillance is a data driven system that identifies, links, and continuously monitors PLHIV aged 18 and above throughout their care journey. It targets individuals unaware of their status, newly diagnosed high-risk cases, HIV-exposed infants found through family testing, and index clients on ART needing ongoing follow-up.

2.4.1. Active Case-Finding Strategies

Active case finding under Rwanda's CBS proactively targets undiagnosed HIV cases, focusing on high-risk groups and contacts of known PLHIV through index and recency testing. This enables early detection, timely linkage to care, and tailored interventions. Once identified, cases are documented with demographic and clinical data to guide treatment initiation and monitor adherence and viral suppression. Beyond individual care, CBS generates real-time data on transmission patterns and high-burden populations, informing resource allocation and prevention strategies to reduce new infections and improve outcomes nationwide.

2.4.1.1. Index testing and partner notification services

Index testing and partner notification are core to Rwanda's HIV control strategy, facilitating early detection and rapid linkage to care among partners, children, and sexual contacts of people living with HIV. As a result, Rwanda has made strong progress toward its diagnosis goals, with the vast majority of PLHIV already diagnosed well ahead of the 2030 timeline.

The figure... below presents Rwanda's index testing cascade. Overall, 16,309 index clients were enrolled, resulting in the elicitation of 27,479 contacts, equivalent to an average of 1.68 contacts per index client. Of these contacts, 92% (25,347) were successfully reached, and 89% (24,564) subsequently presented at a health facility. Testing was completed for 87% (23,966) of elicited contacts, identifying 835 HIV-positive cases, corresponding to a positivity rate of 3.5%. Of these, 97% (809) were promptly initiated on antiretroviral therapy (ART), reflecting robust linkage to care and treatment services.

Regarding the 1,156 contacts never invited, most were already known to be HIV-positive (539), with fewer cases linked to unreported reasons (485) or intimate partner violence concerns (88). Similarly, of the 598 contacts who attended but were not tested, the majority were already known positive (524), while refusal and other reasons accounted for the rest.

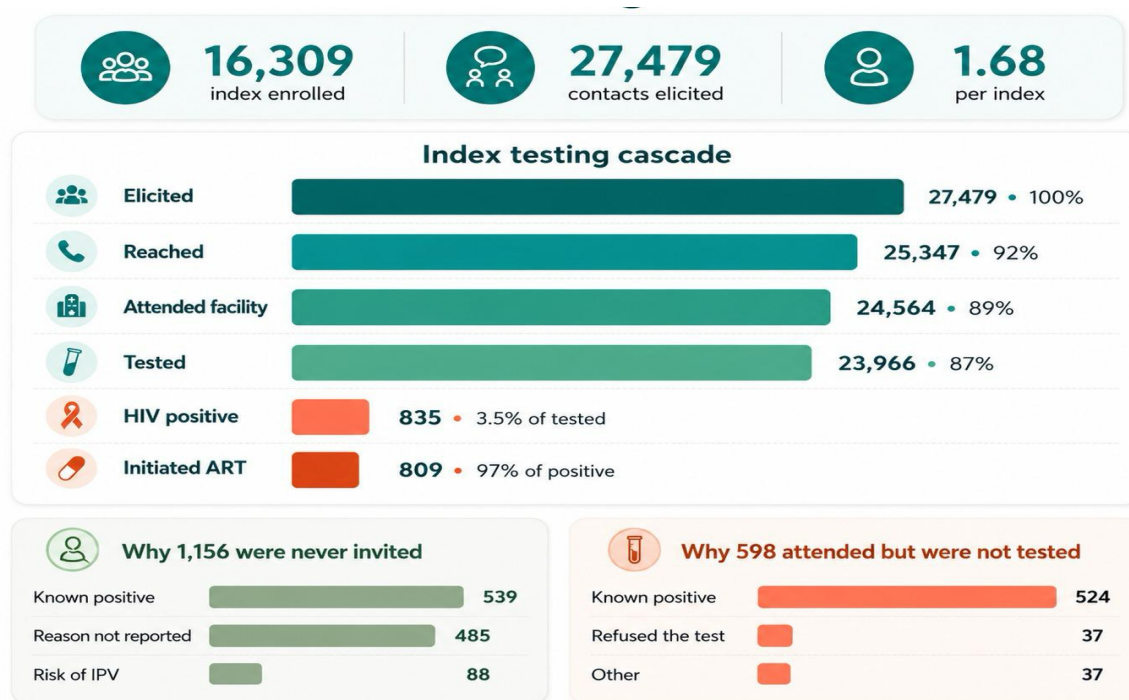


Figure 11: Index testing cascade (July 2025-June 2026)

The image below shows that index client enrolment was concentrated in the 25–49 age group, with 2,695 females and 1,595 males by far the largest share. The 50+ group followed (792 females, 890 males), notably the only band where male enrolment surpassed females. Married clients represented the largest share by marital status (33%), ahead of single (25%) and cohabiting (24%) individuals, while divorced/separated (11%) and widowed (7%) clients made up smaller proportions.

Voluntary Counselling and Testing served as the leading entry point, accounting for 4,044 enrolments, ahead of Provider-Initiated Testing and Counselling (901), Labor and Delivery (685), and Transfer In (511). Within provider-initiated services, antiretroviral therapy accounted for most enrolments (79.6%), with inpatient (18.2%) and tuberculosis (2.1%) services contributing smaller shares.

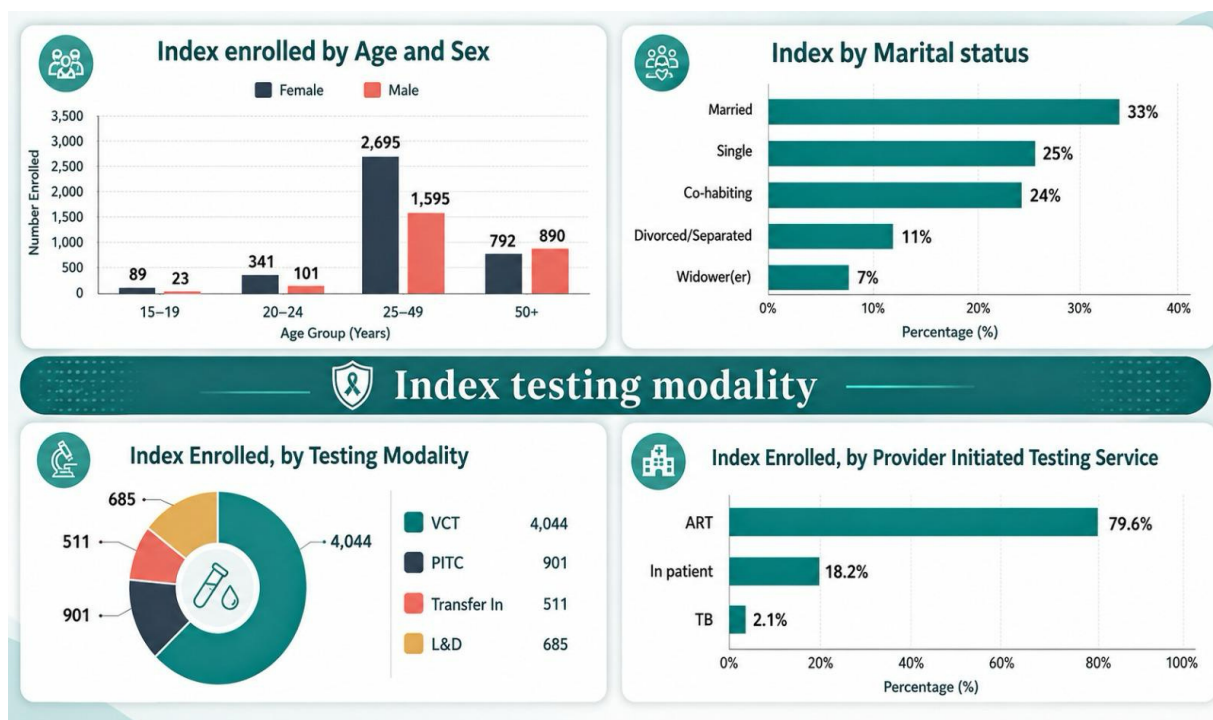


Figure 12: Characteristics of index clients enrolled in CBS (July 2025-June 2026)

The graph below illustrates that contacts elicited through index testing were concentrated among adults aged 30-49, with males in the 40-49 age group recording the highest number of contacts (4,557), closely followed by males aged 30-39 (4,410). Female contacts peaked slightly earlier, in the 30-39 age group (3,608), before declining in older age brackets. Notably, male contacts consistently exceeded female contacts from age 30 onward.

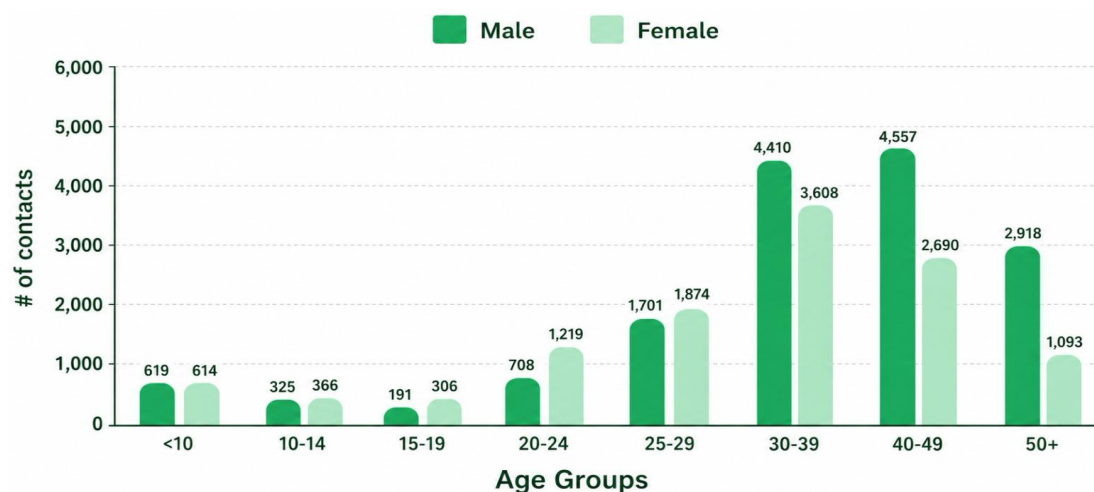


Figure 13: Number of contacts tested by age, sex and positivity rate.

The chart below tracks monthly trends in Index Testing contacts and HIV positivity yield across the fiscal year (2025-2026). Contacts tested fluctuated throughout the year, rising from 2,156 in July 2025 to a peak of 2,724 in November 2025, then declining steadily through the second half of the year to a low of 1,173 in June 2026. HIV positivity yield followed a broadly downward trend over the same period, starting at 4.8% in July and August 2025 before gradually declining. Yield held between 3% and 3.8% from September 2025 through February 2026, dropped further to 2.5-3% in March and April 2026, briefly rose to 4% in May 2026, then fell sharply to 1.17% in June 2026, the lowest point of the fiscal year.

This pattern points to a need to strengthen contact elicitation practices, particularly around ensuring comprehensive and consistent tracing of sexual partners and social networks, and to consider re-targeting index testing toward high-risk populations (e.g., contacts of newly diagnosed index clients, or networks not yet exhaustively traced).

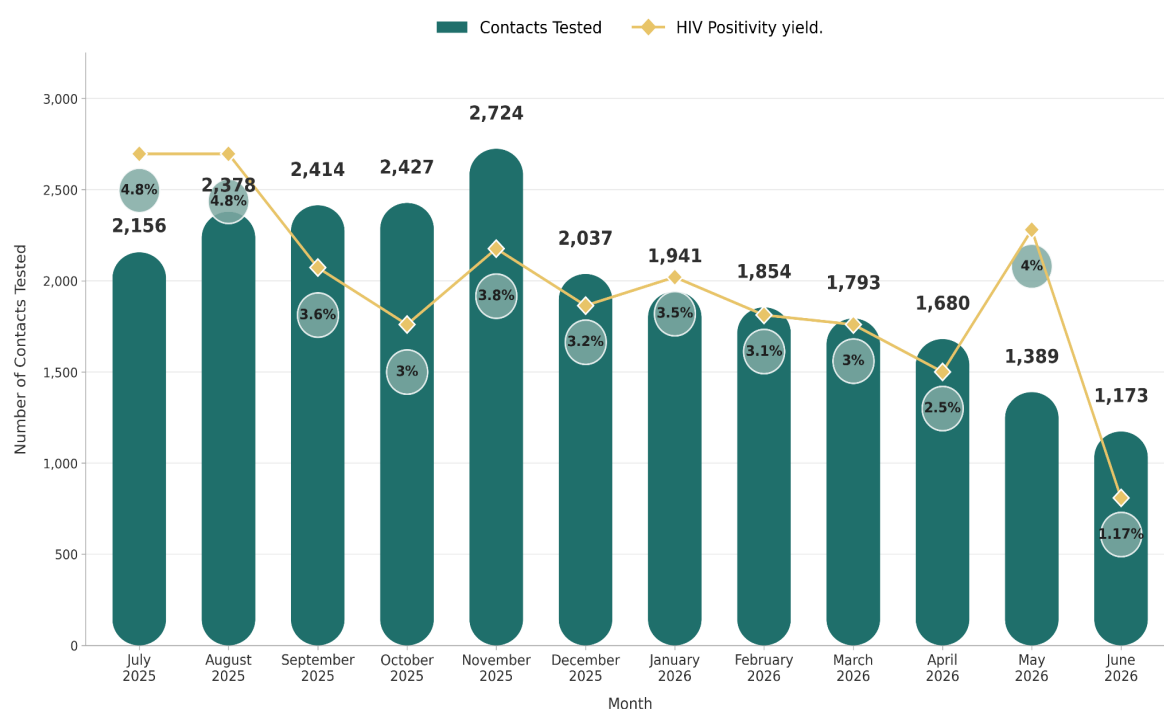


Figure 14: Trend in number and positivity rate among contact tested (July 2025-June 2026)

The graph below shows that while the number of male sexual partners tested increased with age, peaking at 4,433 in the 40-49 group, female testing volume peaked earlier, in the 30-39 group (3,439). Positivity rates followed the opposite pattern: they were highest among younger females, particularly ages 15-19 (8.1%) and 50+ (6.2%), and generally declined with age for males, from 3.8% (30-39) to 2.1% (50+). Across nearly all age groups, female positivity rates exceeded male rates despite lower testing numbers, highlighting a higher burden of HIV among female partners relative to the volume tested.

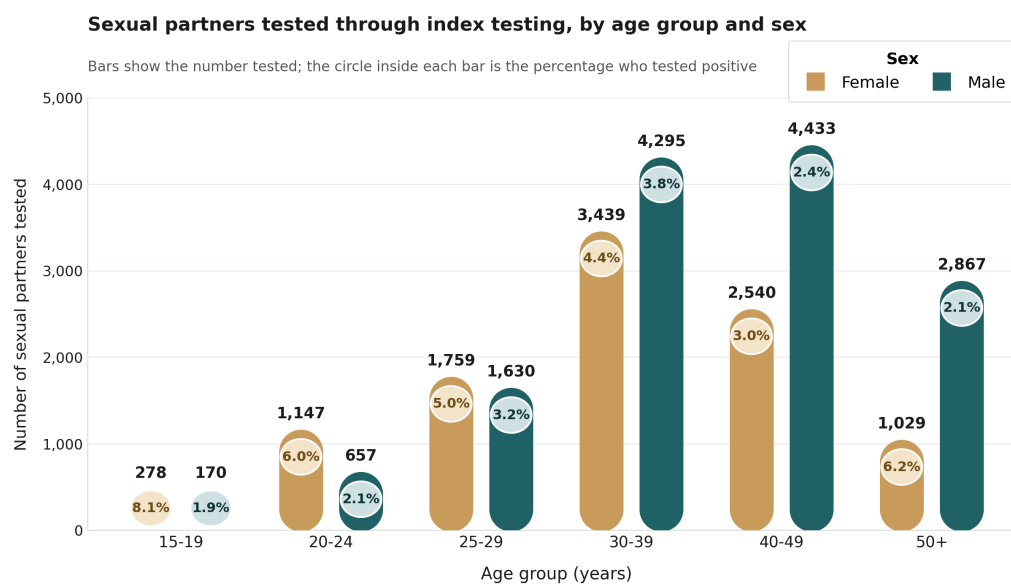


Figure 15: Tests done and positivity rate in PNS (July 2025-June 2026)

The graph below shows that female testing volume through the Social Network Strategy consistently exceeded male testing across all age groups, peaking at 169 in the 30-39 group. Positivity rates were also notably higher among females, reaching as high as 7.4% (15-19) and 6.9% (30-39), while male positivity remained low and was 0.0% in three age groups (15-19, 20-24, and 50+). Overall, both testing volume and positivity were substantially higher among females, indicating this strategy is reaching and identifying more cases among female contacts than male contacts.

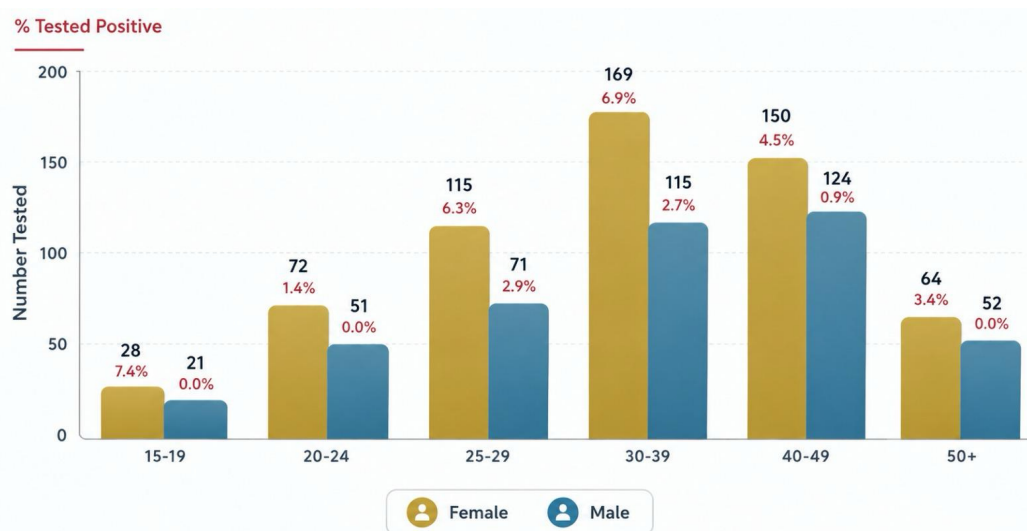


Figure 16: Tests done and positivity rate in SNS (July 2025-June 2026)

2.5. Prevention of Mother-to-Child Transmission (PMTCT)

Rwanda has demonstrated a strong and sustained commitment to eliminating mother-to-child transmission (MTCT) of HIV for the last 2 decades. Over time, the programme has contributed to the prevention of many paediatric HIV infections, improved maternal health outcomes, and expanded access to services across health facilities, including private clinics. MTCT rates have remained below 2% for the past decade, resulted from high-impact interventions such as lifelong ART, decentralized service delivery, close follow-up of mothers and infants, rigorous viral load monitoring, retention strategies, and continuous capacity-building for health providers. These efforts help ensure high-quality, people-centred care for women, infants, children, and families.

The PMTCT programme is guided by four complementary pillars that address prevention, reproductive health, treatment, and family support. These pillars remain central to Rwanda's goal of eliminating mother-to-child transmission of HIV.

2.5.1. The four pillars (or prongs) of the Prevention of Mother-to-Child Transmission

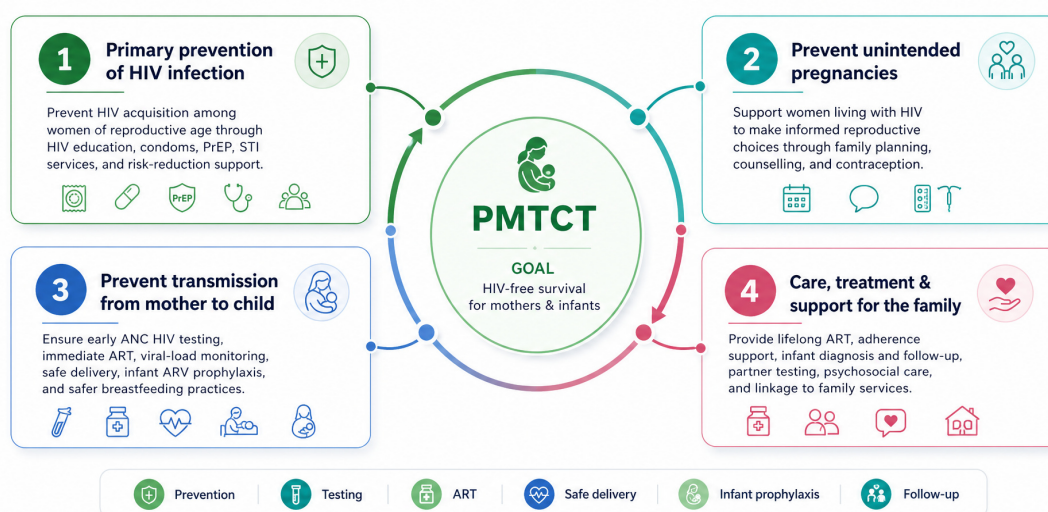


Figure 17: Four pillars of prevention of mother-to-child transmission (PMTCT)

2.5.2. HIV testing and continuum of care for pregnant women with HIV

HIV Testing Services remain a cornerstone of Rwanda's PMTCT program. All pregnant women attending their first ANC visit, together with their male partners whose HIV status is unknown or who previously tested negative, are routinely offered HIV testing. This strategy enables early identification of HIV infection and timely initiation of treatment. Pregnant

women diagnosed with HIV are immediately enrolled in care and initiated on lifelong ART to prevent vertical transmission and improve maternal health outcomes. Male partners diagnosed with HIV are similarly enrolled in HIV care and initiated on lifelong ART.

During FY 2025-2026, a total of 362,208 pregnant women attended their first ANC visit at health facilities providing PMTCT services. Among them, 3,793 were already known to be living with HIV. Of the remaining eligible women, 345,634 (96.4%) received an HIV test, and 1,151 were newly diagnosed with HIV, yielding an HIV positivity rate of 0.33%. ART coverage among pregnant women living with HIV reached 98%, reflecting sustained performance in timely linkage to treatment and adherence to national PMTCT guidelines.

Male partner engagement in ANC continues to be a key challenge. During the reporting period, 214,133 male partners were tested for HIV, of whom 471 (0.2%) were newly diagnosed with HIV. Notably, 225 (48%) of these men had pregnant partners who tested HIV-negative, underscoring the importance of strengthening male partner testing and engagement to identify undiagnosed HIV infections and reduce the risk of HIV acquisition during pregnancy and breastfeeding.

Rwanda has continued to make significant progress in reducing HIV prevalence among pregnant women attending ANC. Between July 2020 and June 2026, the HIV prevalence declined from 2.08% to 1.36%, reflecting the impact of sustained prevention, testing, and treatment interventions. HIV testing and counselling were also provided to women presenting in labor or at delivery who were not previously tested. During FY 2025-2026, 328,232 women were tested at labor, and 258 were newly diagnosed with HIV. Among these newly identified women, 57% were aged 25 years and above, while 31% were aged 20-24 years. Nearly all women diagnosed with HIV in maternity (99.9%) were initiated on ART immediately, ensuring timely implementation of PMTCT interventions.

During the reporting period, 121 women living with HIV delivered at home, of whom the majority (89%) were aged 25 years and above. Home delivery among women living with HIV remains a concern because it may limit access to timely PMTCT interventions for both mothers and newborns, thereby increasing the risk of mother-to-child HIV transmission. Continued efforts are needed to promote skilled facility-based deliveries and strengthen follow-up of pregnant women living with HIV throughout pregnancy, delivery, and the postpartum period.

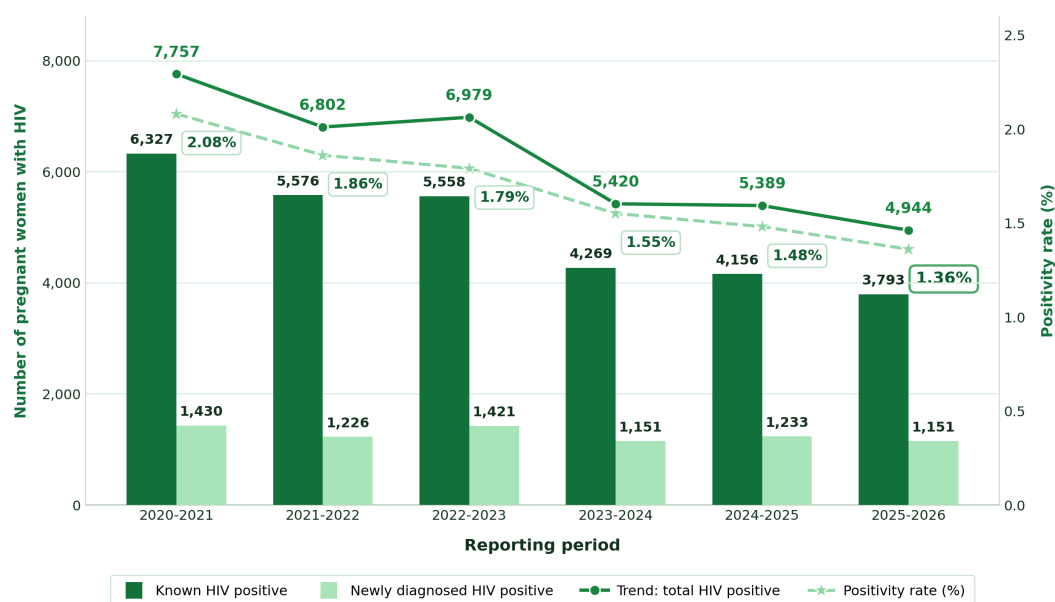


Figure 18: Trend of HIV prevalence in ANC among Pregnant women from 2020-2026

2.5.3. Triple Elimination of mother-to-child-transmission of HIV, Syphilis and Hepatitis

Rwanda continues to demonstrate strong commitment to the Triple Elimination Initiative for HIV, syphilis, and hepatitis B in line with global elimination targets. Since its launch in 2023, the initiative has strengthened the integration of maternal and child health services by ensuring that all pregnant women attending antenatal care (ANC) are routinely screened for HIV, syphilis, and hepatitis B. Women diagnosed with any of these infections receive timely and appropriate treatment according to national guidelines, while exposed infants are provided with the necessary preventive interventions, including antiretroviral prophylaxis for HIV, hepatitis B birth-dose vaccination, and close clinical follow-up.

During the 2025-2026 reporting period, Rwanda maintained high coverage of ANC screening services across the three diseases:

Hepatitis B: A total of 308,977 (85.3%) pregnant women were screened for hepatitis B among 362,208 women attending their first ANC visit. Among those screened, 1,636 were HBsAg positive, 332 (0.11%) had detectable viral loads, 116 were eligible for antiviral treatment, and 101 newly initiated antiviral therapy according to national treatment guidelines.

Syphilis: A total of 340,841 (94.1%) pregnant women were screened for syphilis, of whom 2,742 (0.8%) tested positive. All women diagnosed with syphilis were linked to appropriate clinical management in accordance with national guidelines to reduce the risk of congenital syphilis.

HIV: Among 358,415 pregnant women with unknown HIV status, 345,634 were tested for HIV and 1,151 women were newly diagnosed with HIV infection. The continued integration of HIV, syphilis, and hepatitis B screening within routine ANC services has strengthened early case detection and timely initiation of treatment. High screening coverage and linkage to care reflect Rwanda's sustained progress toward achieving the elimination of mother-to-child transmission of these three priority infections.

The figure shows strong ANC screening performance in 2025-2026, with high coverage for HIV (96.4%), Syphilis (94.1%), and HBV (85.3%). Syphilis had the highest positivity yield (0.80%), highlighting the greatest case detection burden.

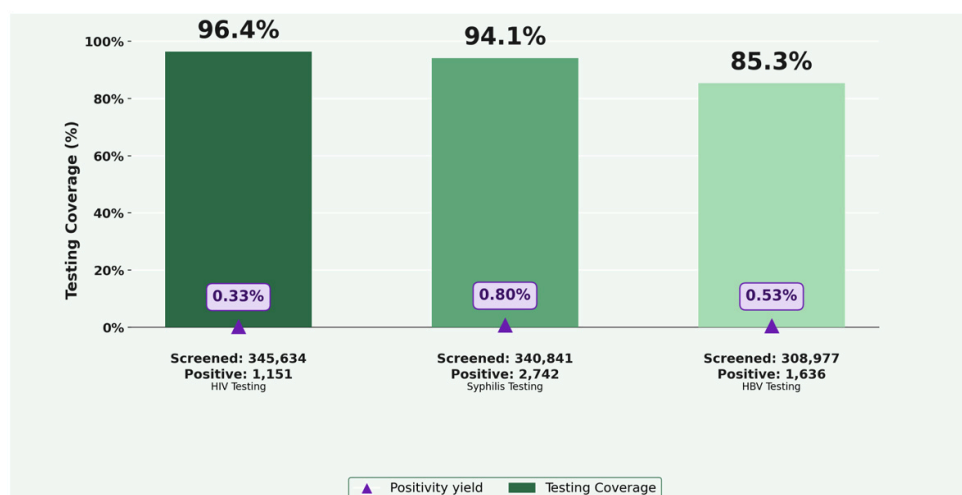


Figure 19: Proportion of PW tested for HIV, HBV and Syphilis in ANC and the positivity yield.

2.5.4. Follow-up of HIV-exposed Infants

Close and continuous follow-up of HIV-exposed infants is an essential component of the prevention of mother-to-child transmission of HIV, as it enables timely monitoring, early identification of HIV infection, and prompt linkage to appropriate care and treatment. In Rwanda, follow-up of HIV-exposed infants is primarily conducted on a monthly basis through primary health care facilities, particularly health centres, while a smaller proportion of infants are followed up at private health facilities. All infants identified as HIV-exposed are enrolled in the PMTCT program immediately after birth, before discharge from the maternity or

postnatal ward, to ensure continuity of care and access to scheduled HIV testing and follow-up services. During the 2025-2026 reporting period, 3,981 HIV-exposed infants were included in the PMTCT follow-up cohort, with monitoring conducted through the recommended testing points during infancy. The follow-up and HIV testing data were used to assess HIV transmission outcomes and the effectiveness of PMTCT interventions among HIV-exposed infants.

Among them, PCR testing was conducted at different follow-up points, with 3,981 infants tested at 6 weeks, 3,979 at 9 months, 3,981 at 18 months, and 3,980 at 24 months. This high level of testing coverage demonstrates strong adherence to the recommended HIV testing schedules and support early identification of HIV infection among exposed infants.

The overall MTCT rate among the infants followed at health facilities remained low at 0.6%, highest at 9 months and lowest at 18 and 24 months. Compared with the previous year, MTCT declined from 1.1% to 0.6%, indicating continued progress toward elimination while requiring sustained follow-up vigilance.

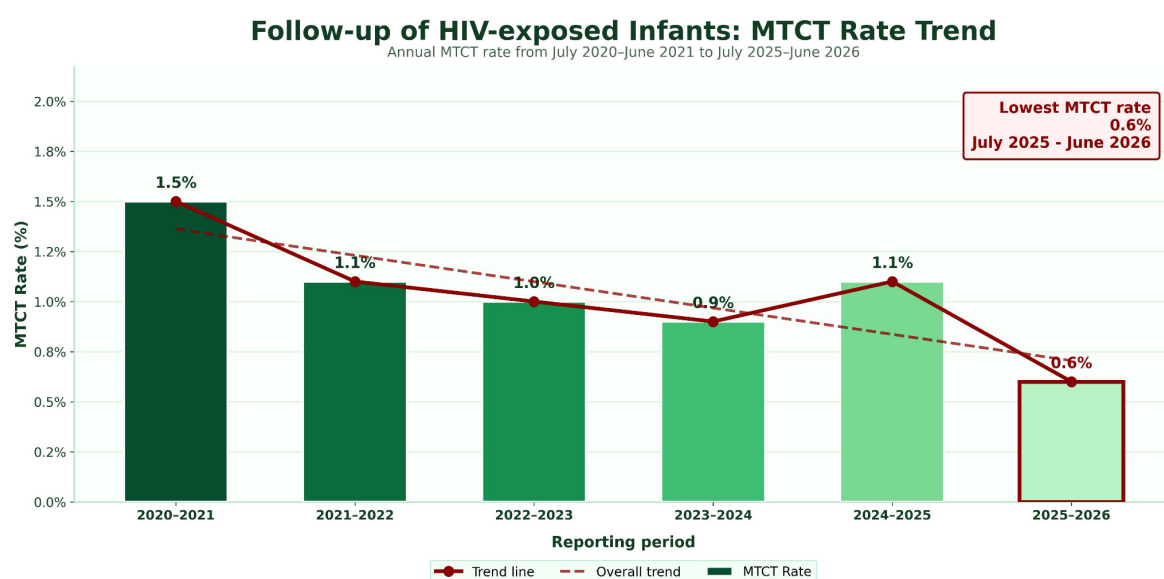


Figure 20: Trend of HIV MTCT rate for the last 6 years

2.6. Voluntary medical male circumcision

Voluntary Medical Male Circumcision, endorsed by WHO and UNAIDS, remains an important component of Rwanda's HIV prevention strategy. The intervention reduces the risk of female-to-male HIV transmission by about 60% and contributes to broader prevention goals when implemented alongside testing, condoms, risk-reduction counselling, and linkage to additional services.

Rwanda has strengthened VMMC service delivery through task-shifting, infection prevention measures, quality assurance, and demand-generation approaches. These efforts help expand access while maintaining safety, quality, and client-centered care.

In the reporting period of 2025–26, VMMC program showcased a continued performance where 296,517 circumcisions were completed nationwide, representing 71.9% of the annual target of 412,373. Below are the program’s key achievements over the years.

The recent Demographic Health Survey (DHS 2025) showed that 72% of men aged 15-49 reported being circumcised, showcasing a constant increase of coverage of the years as shown in the figure below.

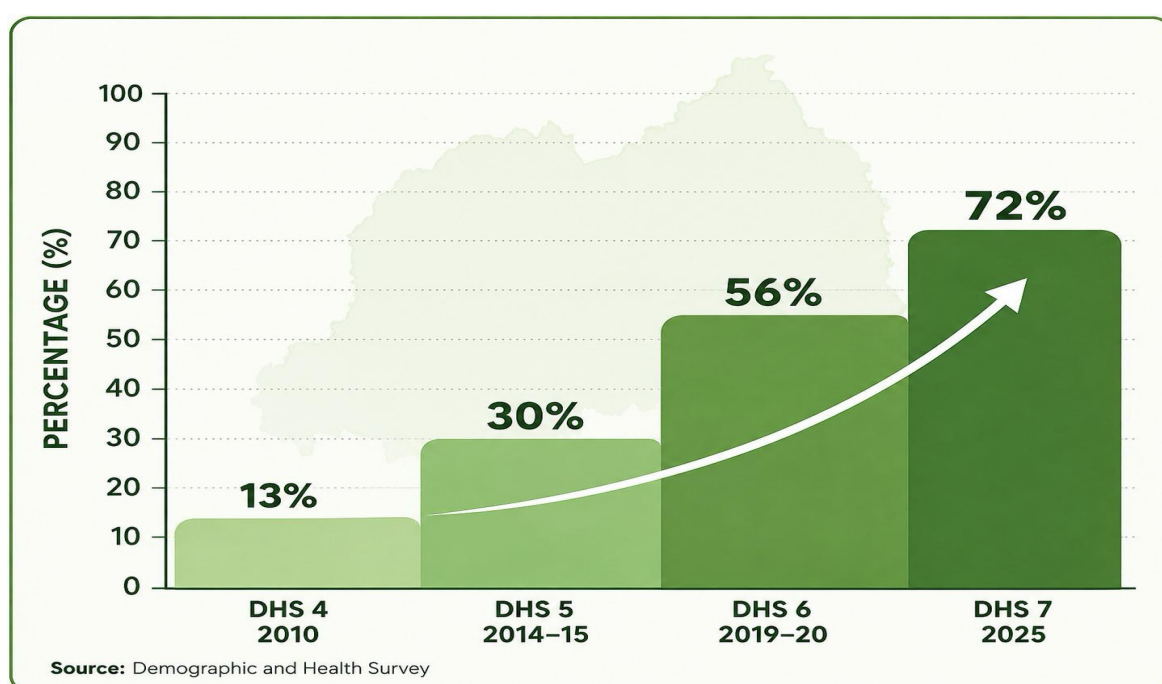


Figure 21: Trend of Male circumcision prevalence (DHS 2010-2025).

An analysis of male circumcision uptake reveals significant regional disparities across Rwanda’s five provinces. The Western Province achieved the highest performance, with approximately 100,000 procedures exceeding Kigali City’s lowest total of under 30,000 by more than threefold.

Male circumcision uptake is concentrated almost entirely among adolescents aged 10-14 and 15-19 years (100,293 and 100,612, respectively), with uptake declining sharply in older and younger age groups. Surgical circumcision remained the dominant method across all age categories, with medical-device circumcision playing only a minor role throughout.

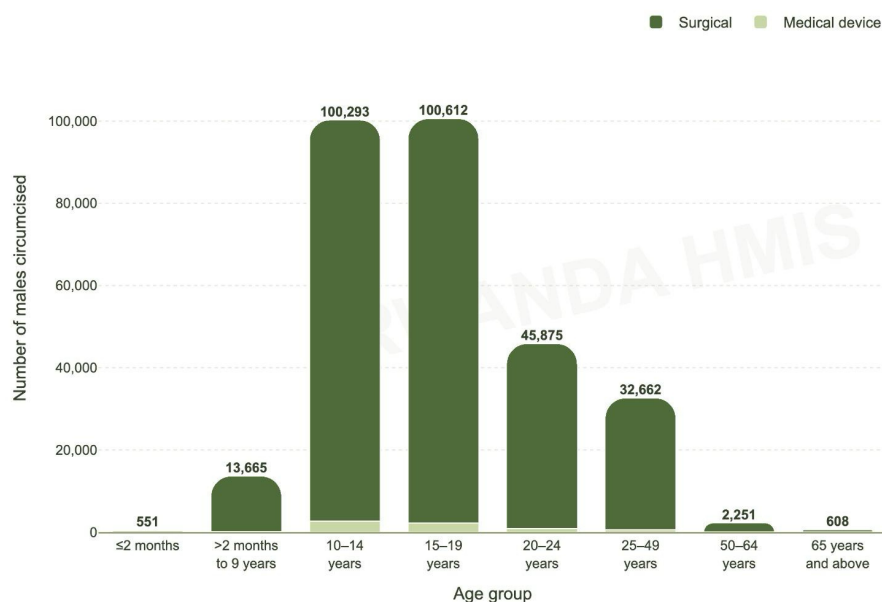


Figure 22: Total male circumcised by age (HMIS 2025-2026).

VMMC service delivery varied across the reporting period, with volumes peaking in August 2025 and declining to their lowest point in January 2026. The 10-19 years age group consistently accounted for the majority of procedures performed each month, reflecting the program's sustained focus on adolescent service delivery.

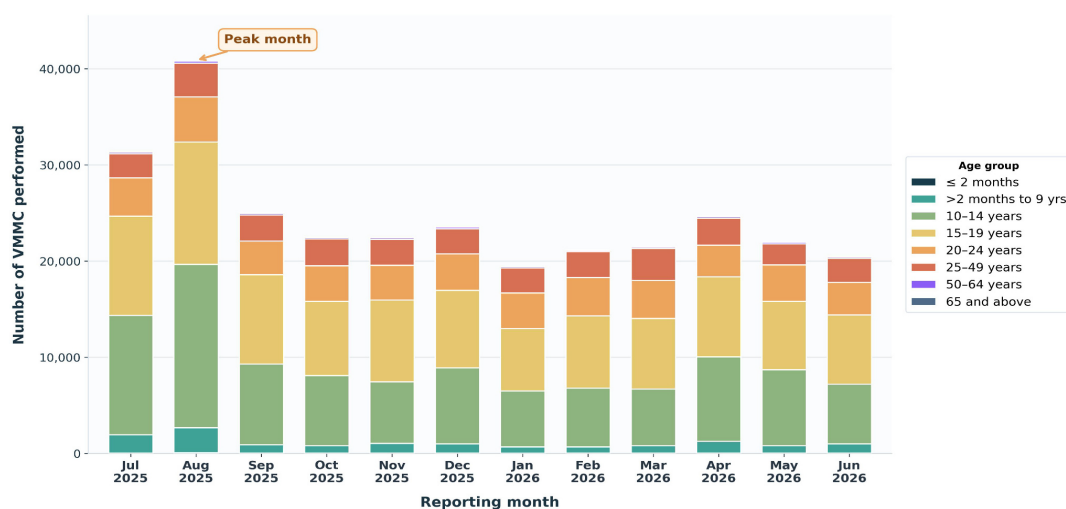


Figure 23: Number of VMMC performed by age group, July 25-June 26

Surgical circumcision anchored service delivery across the five years, consistently accounting for the vast majority of procedures performed annually. Medical-device circumcision, though a minor share by comparison, followed a far more uneven path, falling sharply between FY 2021-2022 and FY 2023-2024, then steadily regaining ground to reach 6,894 procedures by FY 2025-2026.

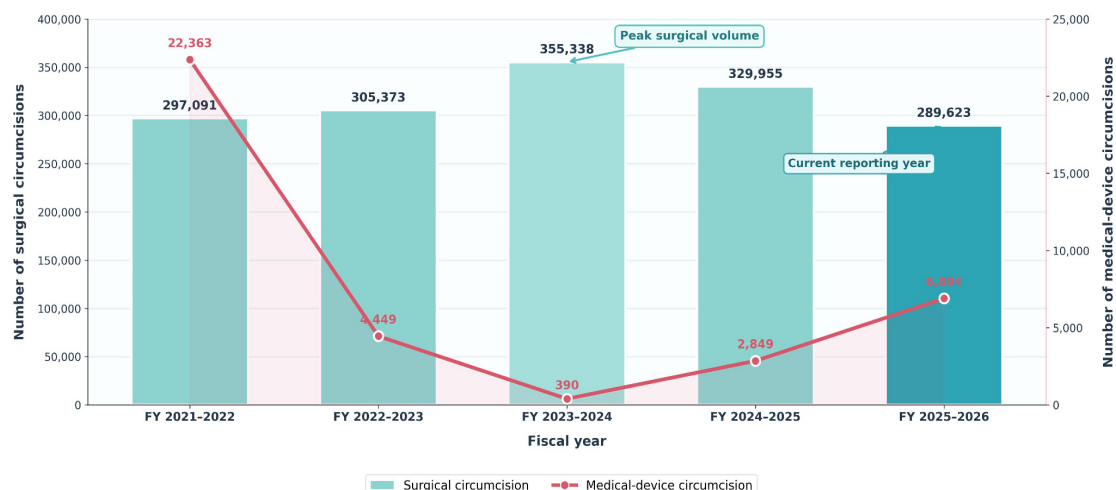


Figure 24: Trend of male circumcisions for the last 5 years by either surgical or device methods (HMIS).

2.7. Condom programming

Condoms remain the only multipurpose prevention intervention capable of simultaneously protecting against HIV, other sexually transmitted infections (STIs), and unintended pregnancy, making them a cornerstone of HIV and reproductive health programming. When used correctly and consistently, male and female condoms provide up to 98% protection against unplanned pregnancy and significantly reduce transmission of HIV and most STIs, including gonorrhoea, chlamydia, and syphilis. This dual-protection capacity distinguishes condoms from other prevention methods such as oral or injectable PrEP, which address HIV risk alone but offer no protection against pregnancy or other STIs.

Over the past six fiscal years, total condom distribution in Rwanda has followed a declining trend, falling from 33,461,867 pieces in 2020/2021 to 24,223,159 pieces in 2025/2026. The most notable movements include a sharp drop to 22,191,059 units in 2022/2023, likely reflecting waning post-pandemic distribution momentum, followed by a rebound to 29,794,225 condoms in 2023/2024, and a subsequent decline to 24,414,839 in 2024/2025 that has since stabilized at 24,223,159 in 2025/2026. This plateau over the last two fiscal years suggests that while distribution volumes remain well below pre-2022 levels, the program has reached a relatively steady baseline, underscoring the need for renewed demand-generation and expanded access efforts to reverse the multi-year downward trajectory. Figure 21 provides further information.

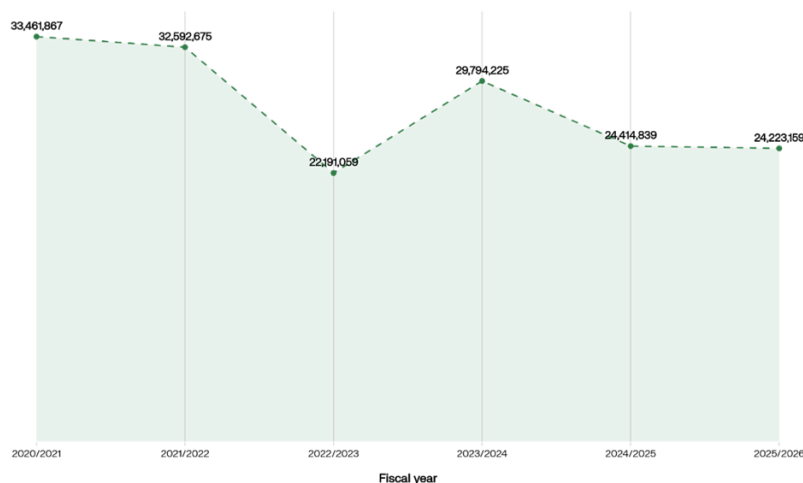


Figure 25: Trends in the number of condoms distributed over the past five years in Rwanda

Of the 24,223,159 condoms distributed between July 2025 and June 2026, health facilities accounted for the majority at 17,002,625 condoms, representing 70.2% of total distribution nationally. Outreach programs contributed the second-largest share at 3,126,470 condoms (12.9%), closely followed by condom kiosks and university-based distribution at 3,073,680 (12.7%), together indicating that community-level and youth-targeted channels play a meaningful complementary role alongside facility-based services. Social marketing accounted for the smallest share at 1,027,242 condoms, or 4.2% of the total, suggesting this channel remains underutilized relative to its potential reach in the broader distribution mix. This heavy reliance on health facilities as the primary distribution point underscores the continued centrality of clinical settings in condom access strategy, while also highlighting an opportunity to strengthen community-based and social marketing channels to diversify access points and improve reach among populations less likely to visit health facilities.

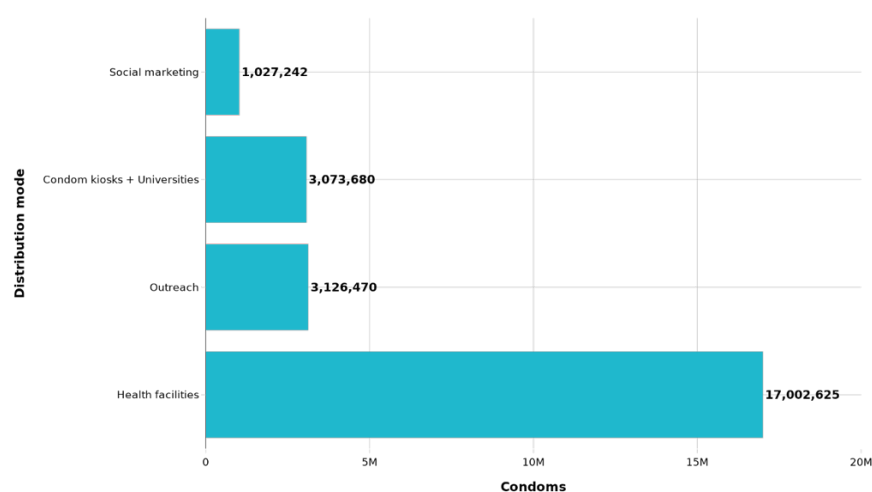


Figure 26: Condom distribution from July 2025 to June 2026

2.8. Key and priority populations

HIV responses prioritize population groups that face disproportionately higher risk of infection due to behavioural, biological, or structural factors. Key populations, including female sex workers (FSWs) and men who have sex with men (MSM), experience elevated risk through higher-risk sexual networks, while priority populations face heightened vulnerability linked to age or relationship-based exposure. Priority populations encompass a broad range of groups, including sero-discordant couples (SDCs), adolescent girls and young women (AGYW), fishing communities, mobile populations, and cross-border truck drivers, among others; however, only SDC members and AGYW are systematically followed and tracked through health facility-based services. The following sections present data on numbers of followed population groups and PrEP usage across FSWs, MSM, SDCs, and AGYW.

2.8.1. Key population services

By June 2026, the two key populations comprised 41,085 individuals altogether, with female sex workers (FSWs) making up the majority at 92%. Both groups share a similar age structure, with the 25-49 bracket dominating (71.2% of FSWs and 65.5% of MSM), followed by the 18-24 age group, while those aged 50 and above make up a small minority in both populations. Among FSWs, West province records the highest total (10,382), followed by Kigali City (9,927) and East (8,522), while Northern province has the lowest (4,411). The 25-49 age group drives this distribution everywhere, ranging from 2,981 in North to 7,423 in Kigali City, indicating that FSW engagement is concentrated among economically active adult women rather than younger entrants or older individuals. This geographic spread, with strong presence in West and East rather than a single urban area, suggests FSW activity is tied to trade, transit, or economic corridors rather than being confined to the capital city.

MSM show a markedly different geographic pattern, concentrated mainly in Kigali City (1,091), which alone accounts for nearly double the next-highest province (South, 699) and more than double East (573), West (482), and North (378). Notably, MSM skews younger than FSWs, with 33.1% aged 18-24 compared to 26.3% among FSWs, pointing to a population that may benefit from stronger youth-oriented outreach and digital engagement strategies. Figure 28 illustrates more information.

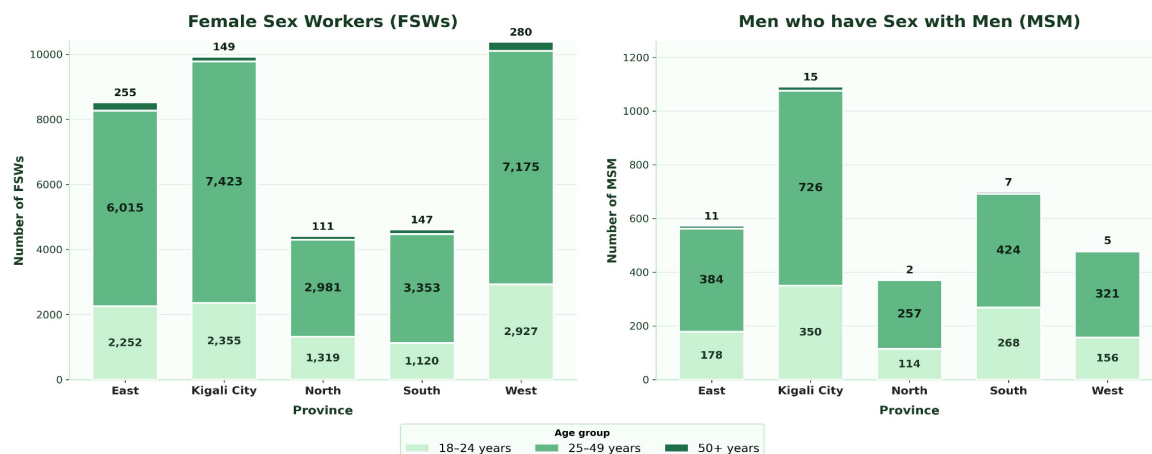


Figure 27: Distribution of key populations served in health facilities by province and age (HMIS data: June 2026)

2.8.2. HIV negative Sero-discordant couples' follow up and Sero-conversion

Sero discordant couple follow-up in health facilities has been generally stable, while seroconversions remain low but show a rising pattern over time. East Province has the highest number of Sero discordant couples followed (5,988), closely trailed by West (5,743) and South (5,211), while Kigali City (4,722) and North (2,974) show notably lower volumes likely reflecting differences in population size and HIV prevalence across regions. Seroconversions are concentrated almost entirely in East (14 cases) and South (7 cases), together accounting for 21 of the 23 national cases, while North and West each recorded only 1 case and Kigali City recorded none. This clustering suggests East and South may warrant closer prevention follow-up, such as enhanced adherence support or more frequent testing for the HIV-negative partner.

The overall number of SDCs followed grew modestly from 23,227 in June 2023 to 24,638 in June 2026, indicating steady program coverage with a slight plateau in the most recent year. Seroconversions rose from 14 in June 2024 to 23 in both June 2025 and June 2026, suggesting the initial increase in new infections has since stabilized rather than continuing to climb. Figure 29 provides further information.

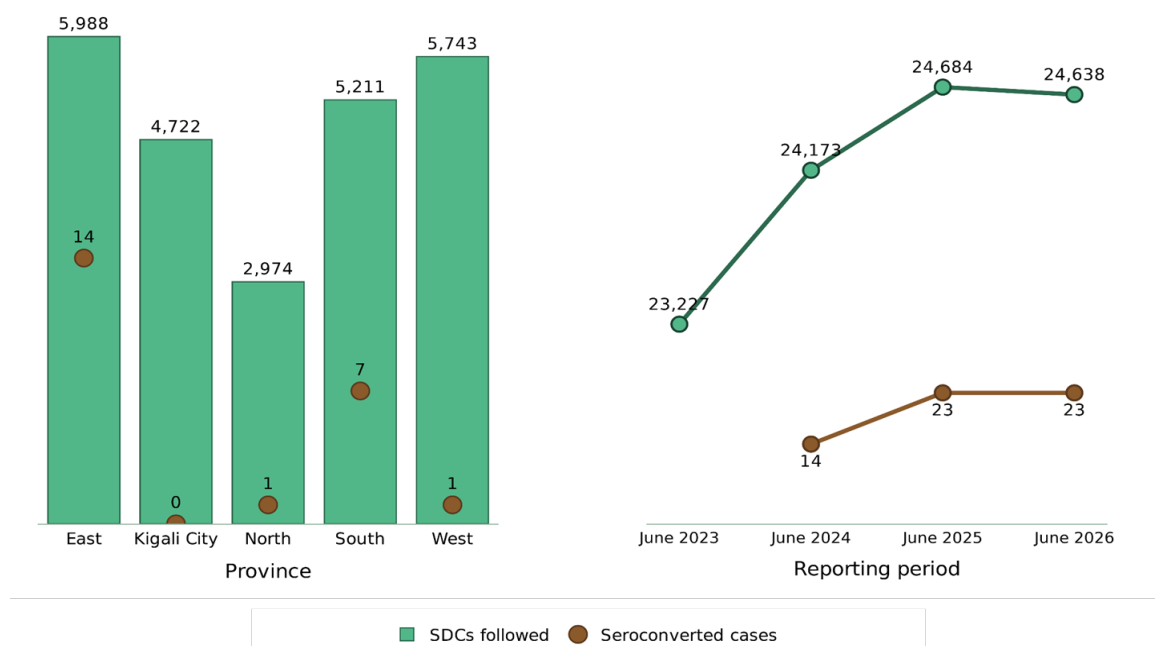


Figure 28: Distribution of Sero discordant couples by province and trend in their HIV seroconversions 2023-2026 (HMIS)

2.8.3. Adolescent Girls and Young Women (AGYW)

During this reporting period, the AGYW Program continued implementing comprehensive HIV prevention efforts aligned with national strategies, including the National HIV Strategic Plan, the AGYW HIV Prevention Strategy, and the minimum package of services for AGYW. The program's focus was on delivering integrated biomedical, behavioural, and structural interventions to reduce new HIV infections, prevent unintended pregnancies, tackle gender-based violence (GBV), promote mental health, and strengthen socioeconomic resilience among girls and young women aged 10-24.

Implementation took place across 30 districts and health facilities supported by trainers-of-trainers, thanks to strong partnerships with the Rwanda Biomedical Centre (RBC), district health authorities, implementing partners, health facilities, community structures, and development partners. Routine supervision, quarterly performance reviews, data quality checks, and ongoing stakeholder engagement improved implementation quality and supported evidence-based decisions. Over four years, the AGYW program has steadily expanded, reflecting Rwanda's ongoing commitment to combination HIV prevention and comprehensive sexual and reproductive health services for this group.

Enrolment rose significantly from FY 2022/23 through FY 2024/25, then stabilized in FY 2025/26, signalling a shift from rapid growth to program consolidation and quality enhancement. The program maintained nationwide coverage across all provinces, progressively reaching vulnerable AGYW through community-based and facility-based services. The Western, Eastern, and Southern Provinces consistently had the highest enrolment, indicating successful implementation in districts with larger populations. Although Kigali City and the Northern Province enrolled fewer beneficiaries, they maintained a strong program presence relative to their population sizes.

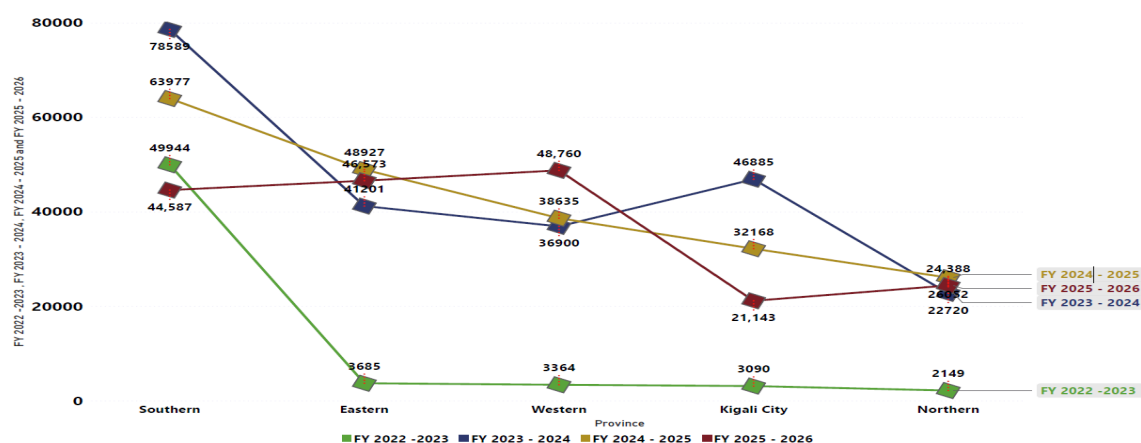


Figure 29: Enrolment progress and follow-up of AGYW by Province

Overall, the program reached 185,451 AGYW with at least one component of the minimum comprehensive prevention package, representing 89% of the annual target (*Defined as an increase of 5% from the previous year's enrolment in the program*). Progress was observed across key service delivery areas, including HIV testing services, HIV risk assessment, pre-exposure prophylaxis (PrEP), sexual and reproductive health (SRH), GBV prevention and response, mental health, and economic strengthening interventions.

2.8.3.1. Adolescent girls and young women Performance against FY 2025/26 Targets

Progress towards FY 2025/26 enrolment targets demonstrates encouraging implementation performance, although notable regional disparities remain. The Eastern Province exceeded its annual enrolment target, achieving approximately 120% of the planned target, reflecting highly effective community mobilization and service uptake.

Northern Province achieved approximately 91% of its target, while Southern Province attained 66%. Western Province reached 89%, indicating good progress with opportunities for accelerated implementation during the remaining reporting period. Kigali City achieved

approximately 63% of its target, indicating slower enrolment than in other regions and highlighting the need for intensified demand creation and targeted outreach among urban AGYW populations.

Overall, programme implementation remains on track nationally, with targeted technical support required in lower-performing provinces to ensure equitable achievement of annual programme targets.

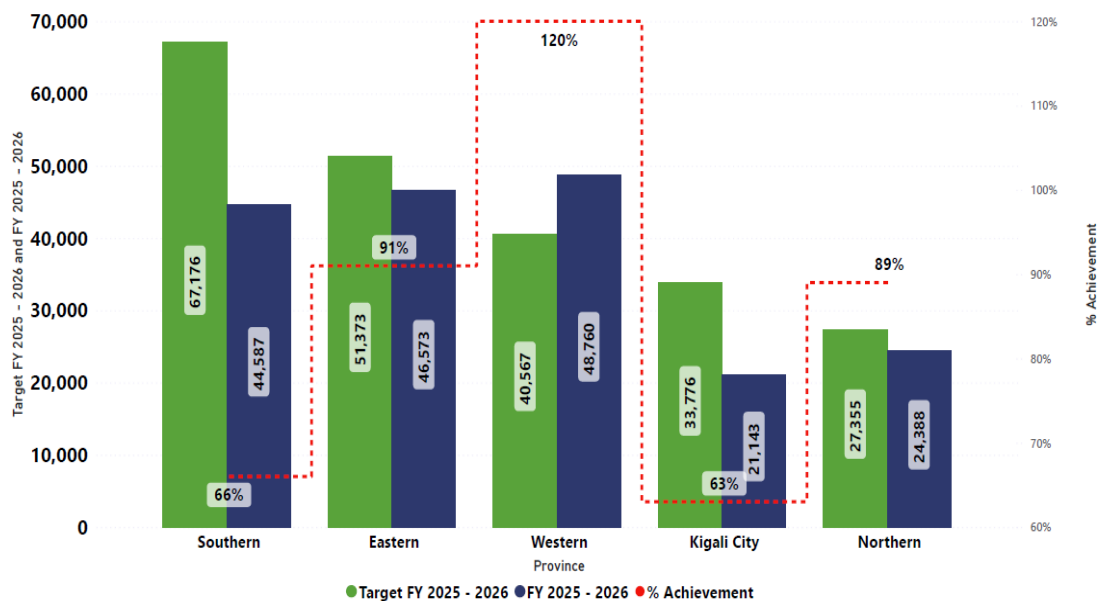


Figure 30: AGYW programme performance against FY 2025/26 Targets

2.9. Pre-Exposure Prophylaxis

Pre-Exposure Prophylaxis (PrEP) remains the single most important biomedical intervention for preventing new HIV infections, and Rwanda currently offers two options: daily oral PrEP (TDF+3TC), available since 2018, and injectable Cabotegravir (CAB-LA), rolled out in December 2024. Monthly HMIS reports track PrEP beneficiaries across key and priority population groups, and Figure 34 summarizes this distribution as of June 2026.

By the end of June 2026, a total of 16,571 people were accessing PrEP services nationally across the four tracked population groups. Female sex workers (FSWs) constituted the largest share at 81.0% (13,421), followed by adolescent girls and young women (AGYW) at 8.7% (1,448) and MSM at 7.9% (1,301), while HIV-negative partners in sero-discordant couples represented 2.4% (401) of total PrEP users.

This distribution underscores that FSWs remain the dominant users of PrEP in Rwanda, accounting for the vast majority of beneficiaries, while AGYW, MSM, and discordant-couple partners represent smaller, more targeted segments of the program that may benefit from expanded demand-generation efforts.

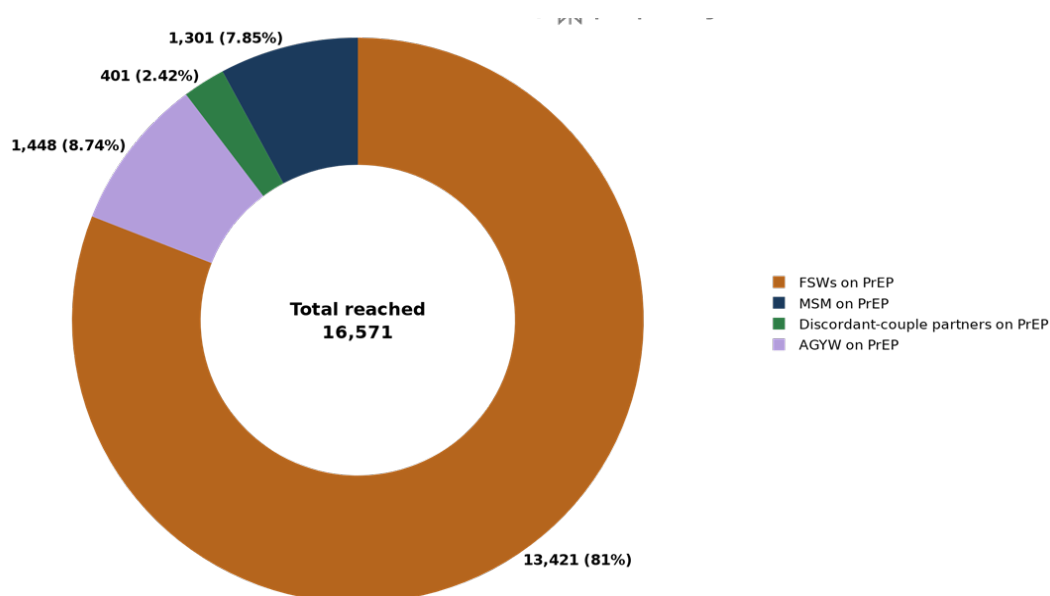


Figure 31: HIV PrEP users by population groups, June 2026 (HMIS data)

Regarding distribution of PrEP users by province and population group, Kigali City reports the highest overall uptake, driven by 4,762 FSWs and the largest MSM enrolment nationally at 836, alongside 512 AGYW. Eastern Province follows with 3,342 FSWs and 156 AGYW, while Western Province shows a similar pattern with 2,535 FSWs and 620 AGYW, the second-highest AGYW figure after Kigali City.

Southern Province records 1,983 FSWs and 143 AGYW, with MSM (92) and discordant-couple partners (101) roughly comparable in size, while Northern Province has the lowest numbers across nearly all groups, including just 799 FSWs, 17 AGYW, and 24 discordant-couple partners. Across all provinces, FSWs consistently dominate PrEP enrolment, followed by MSM in Kigali City specifically, whereas AGYW and discordant-couple partners remain a comparatively smaller share nationally, with AGYW enrolment most concentrated in Kigali City and West Province.

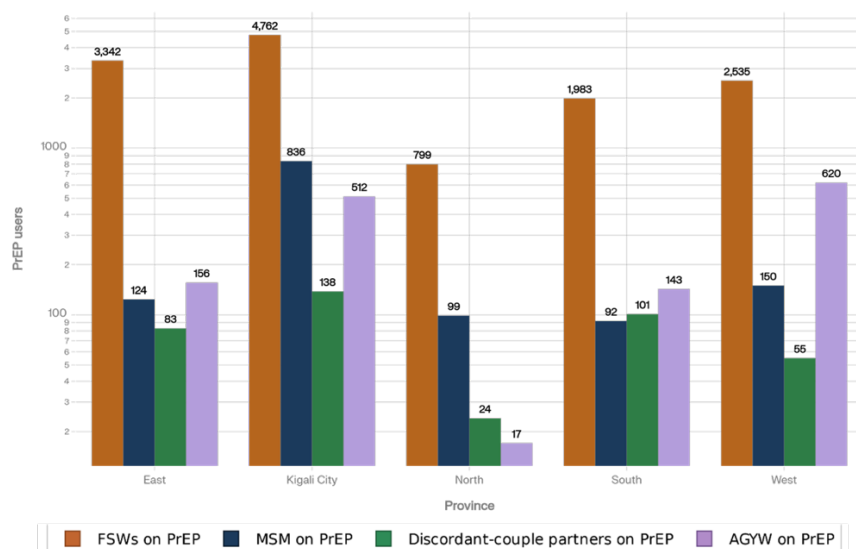


Figure 32: HIV PrEP users by population groups and province, June 2026 (HMIS Data)

2.9.1. Long-acting injectable cabotegravir PrEP service provision

Long-acting injectable cabotegravir (CAB-LA) is a PrEP option administered every two months, offering an alternative to daily oral PrEP for individuals seeking less frequent dosing. Since its introduction in December 2024, CAB-LA has expanded steadily in Rwanda, with 286 individuals having received at least one injection as of June 2026. Initial rollout began at two health facilities, Gikondo and Busanza health centers, and in March 2026 the program expanded significantly with seven additional sites trained to deliver CAB-LA services, bringing the total to nine facilities across Kigali City. The new sites include Gatenga HC in Kicukiro district; Kinyinya, Gihogwe, and Kagugu HCs in Gasabo district; and Biryogo, Cor Unum, and Rugarama HCs in Nyarugenge district, reflecting a deliberate effort to decentralize access across all three Kigali districts.

Monthly initiation data show a clear surge coinciding with the site expansion, with new client enrolment jumping sharply from 4 in June 2025 to 17 in July 2025 and peaking at 47 in August 2025, the highest monthly figure recorded. Following this peak, initiations stabilized at a more moderate but sustained pace, ranging between 10 and 23 clients per month from September 2025 through June 2026, with enrolment dipping to zero in May 2025 before rebounding. The most recent months (April to June 2026) show a modest upward trend, with 19, 17, and 23 new initiations respectively, suggesting growing demand as service delivery capacity broadened across the nine Kigali facilities. By fiscal year, new enrolments rose from 67 in 2024/2025 to 219 in 2025/2026, bringing the cumulative total to 286 enrolments since the launch of CAB-LA in December 2024.

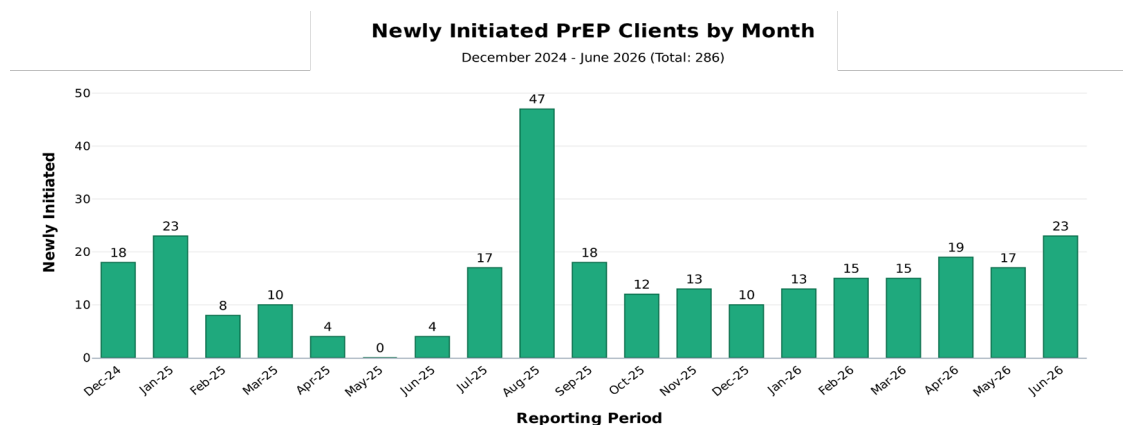


Figure 33: CAB LA New enrolments by month

Adherence to CAB-LA has been marked by intermittent treatment interruptions, with some clients discontinuing injections and others resuming treatment following a period of non-use. Among those who stopped, some discontinued because they were no longer at ongoing risk of HIV acquisition, while others transitioned to daily oral PrEP rather than exiting PrEP care entirely. Reported side effects among Rwandan users, primarily injection site pain and transient generalized weakness lasting up to four weeks, have been managed symptomatically with pain medication, though these experiences appear to be an important contributor to the observed on-and-off adherence pattern. Taken together, retention challenges likely reflect a combination of side effects, changing risk perception, and service-related factors rather than side effects alone.

CAB LA data show a widening gap between clients expected to remain active on CAB-LA and those actually retained, with only 44 of an expected 67 clients active by June 2025, and this gap persisting through June 2026, when just 184 of 286 expected clients (64.3%) maintained active status. This retention pattern mirrors international real-world cohorts, where discontinuation rates have ranged from roughly 15% to 21%, though the shortfall of nearly 36% is somewhat higher, potentially reflecting additional programmatic or follow-up challenges beyond side effects alone.

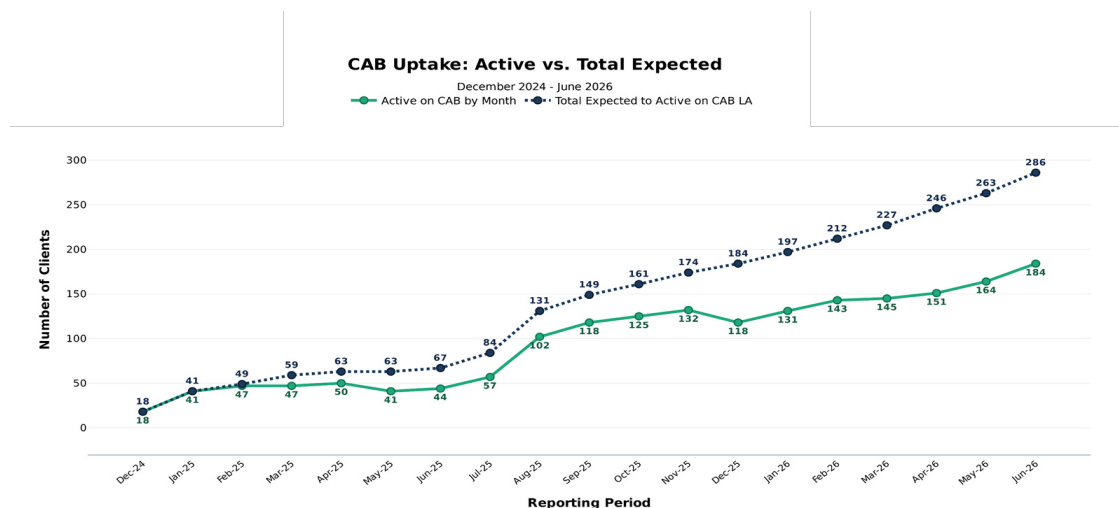


Figure 34: CAB Uptake- Active vs. Total Expected on CAB-LA (December 2024-June 2026)

2.9.2. HIV Case Finding among adolescent girls and young women (AGYW)

HIV positivity yield varied considerably across provinces, providing important insights into epidemic distribution and programme efficiency. Although Western Province enrolled the largest number of AGYW beneficiaries, HIV positivity remained relatively low at approximately 0.6%, suggesting that prevention interventions continue to reach predominantly HIV-negative populations.

Eastern Province recorded the highest HIV positivity yield at approximately 4.0%, substantially higher than all other provinces. This finding indicates potential geographical concentration of HIV risk and underscores the importance of strengthening targeted HIV testing strategies, index testing, social network approaches, and rapid linkage to treatment services in high-burden districts. Kigali City reported a positivity yield of approximately 1.3%, while Southern,

Western and Northern Provinces reported yields below 1%, consistent with lower observed HIV positivity among programme beneficiaries.

These findings support differentiated implementation approaches that prioritize intensified HIV prevention and testing interventions in higher-yield geographic areas while maintaining broad prevention coverage nationally.

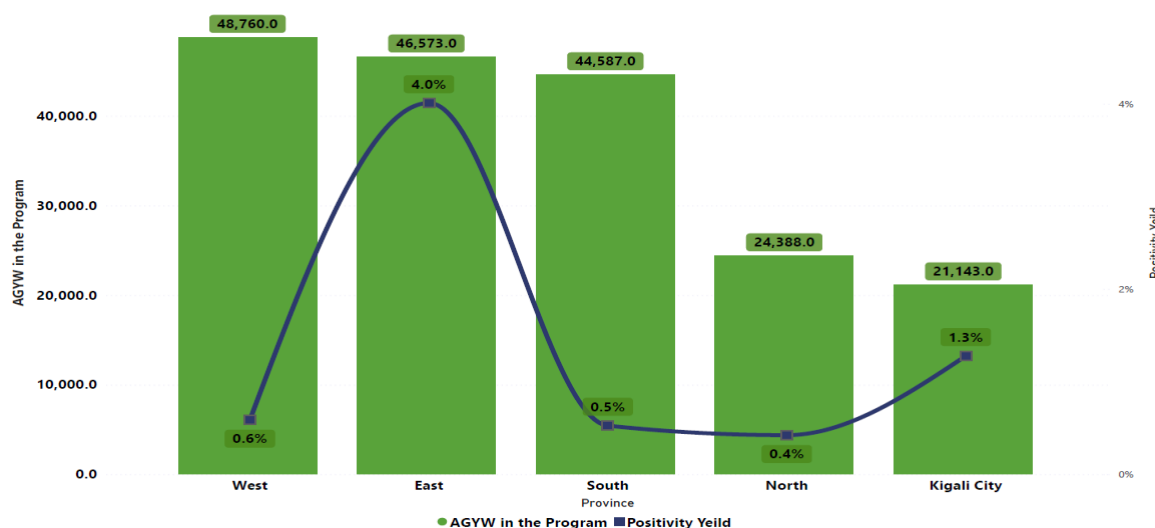


Figure 35: Positivity yield among AGYW by Province

2.9.3. Screening for sexually transmitted infections (STIs) among AGYW

STIs remain an important component of the AGYW comprehensive prevention package. The highest numbers of AGYW who screened positive for STIs were reported in the Western and Southern Provinces, followed by the Eastern Province. Northern Province and Kigali City reported comparatively fewer STI-positive clients. The observed burden of STIs reinforces the importance of integrating STI screening, treatment, behavioural interventions, condom promotion, family planning, and HIV prevention services within the AGYW programme. Early identification and treatment of STIs not only improves reproductive health outcomes but also contributes to reducing HIV acquisition risk among adolescent girls and young women.

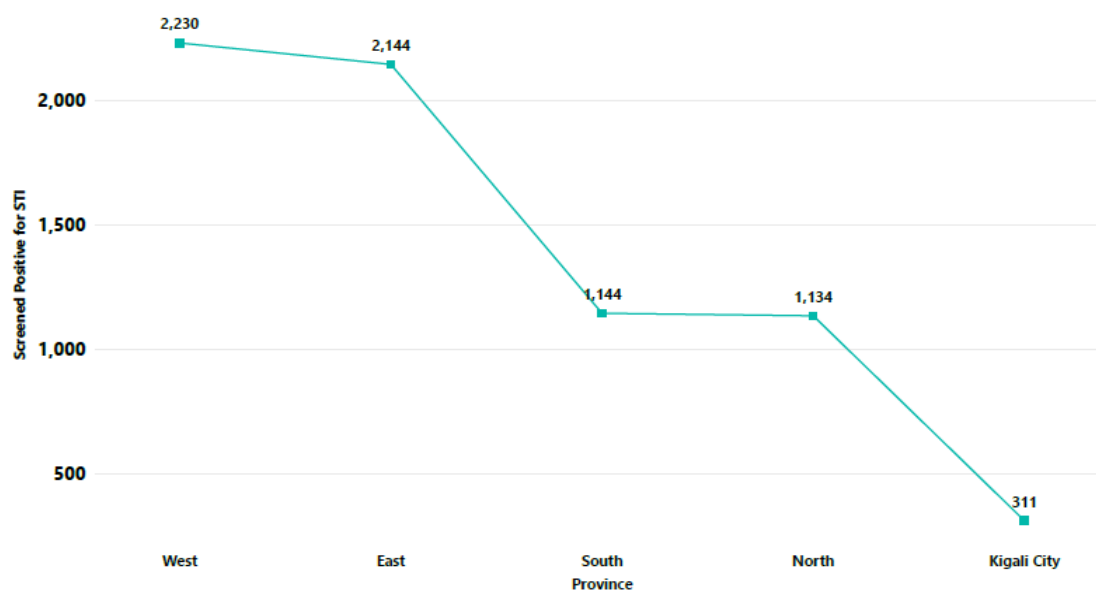


Figure 36: AGYW Screened Positive for STIs

2.9.4. AGYW Program Key Achievements and Challenges

Table 2: AGYW programme key achievements and challenges

Key Achievements	Challenges
Expansion of comprehensive HIV prevention services across supported districts	Variations in program performance across districts and service delivery points
Increased access to integrated HIV prevention and SRH services for AGYW.	AGYW attrition at critical stages of the HIV prevention and PrEP cascades
Strengthened implementation of the AGYW minimum package through coordinated multisectoral partnerships	Operational constraints affecting timely service delivery in selected implementation areas due to funding cuts
Improved HIV risk assessment and linkage to appropriate prevention services	Ongoing need to strengthen demand creation and community engagement among hard-to-reach AGYW populations
Enhanced integration of mental health, GBV, and economic strengthening interventions	Limited human resources in high-volume service delivery sites.

2.9.5. Lessons Learned for AGYW Program Implementation

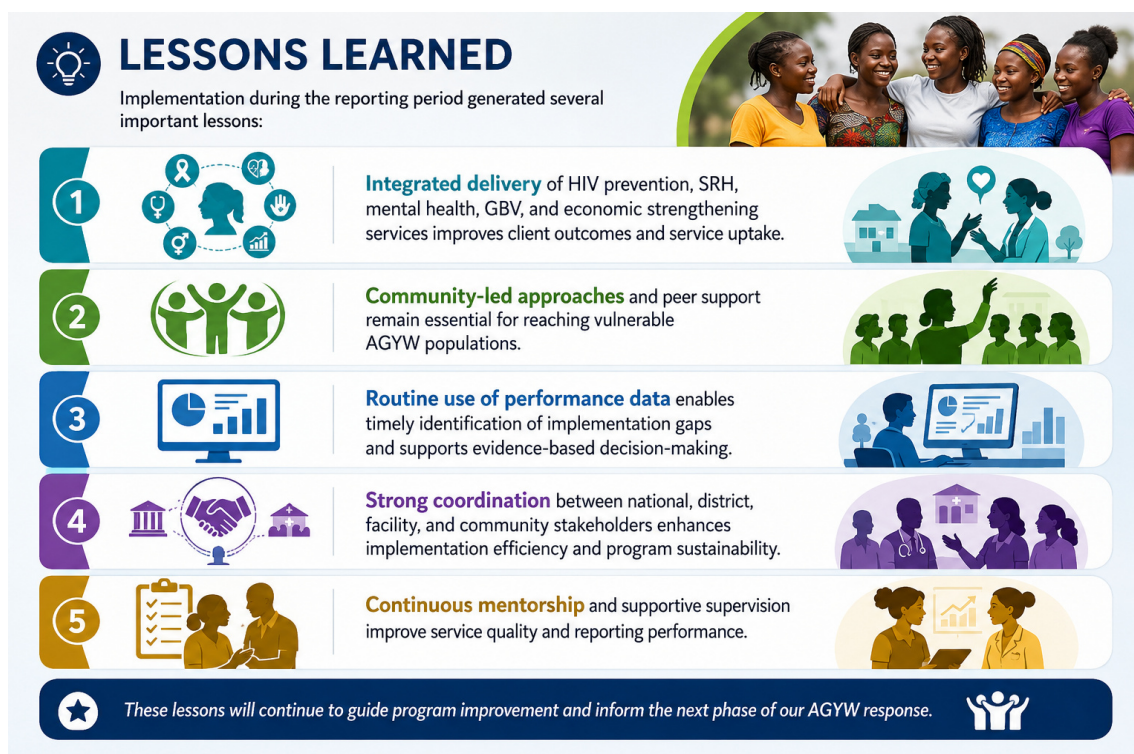


Figure 37: Lessons learned from AGYW programme implementation

2.9.6. Recommendations for AGYW Program Implementation



Figure 38: Recommendations for AGYW programme implementation

2.10. HIV awareness, targeting people at high risk of acquiring HIV infection.

2.10.1. HIV Awareness

HIV awareness remains an important cornerstone to Rwanda's national HIV program strategy. Through sustained, large-scale communication efforts, the program continues working to close knowledge gaps, challenge stigma, and shift public attitudes toward proactive health-seeking behavior. Over the course of the reporting period, this work was carried forward through a combination of mass media outreach and participation in major public events, with a consistent focus on driving testing uptake, supporting treatment adherence, and sustaining engagement with communities across urban, peri-urban, and rural settings alike.

2.10.2. World AIDS Day celebration

Rwanda marked World AIDS Day (WAD) on 1st December 2025 under the theme "Overcoming Disruption, Transforming the AIDS Response," bringing together government officials, civil society representatives, healthcare institutions, and community-based organizations for a national commemorative event. The commemoration featured a roadshow and a car-free day activity, mobilizing public participation and generating visibility for HIV awareness across communities.

The commemoration reached a nationwide audience through live radio and television coverage, while parallel community mobilization efforts in districts hosting WAD-linked outreach activities helped extend visibility and participation down to the grassroots level.



Figure 39: The picture was taken during WAD celebration December 2025 at KINYINYA Health Center (photo credit:RBC)

2.10.3. Mass campaigns

During the reporting period, the program carried out a focused mass media campaign to strengthen awareness of HIV services nationwide. Communication content was developed and broadcast through national radio and television stations, selected for their wide audience reach across both urban and rural communities.

Programs included talk shows, expert-led discussions, and testimonials from community members, designed to close knowledge gaps, dispel misinformation, and encourage greater use of HIV services. Complementing this, short audio and video messages were aired during high-listenership and high-viewership time slots to maximize exposure and reinforce key messages.

Core themes addressed through the campaign included consistent condom use, the availability and benefits of pre-exposure prophylaxis (PrEP), the role of voluntary medical male circumcision (VMMC) in lowering HIV transmission risk, and the importance of routine HIV testing and sustained treatment adherence among people living with HIV. Through targeted content and strategic airtime placement, the campaign strengthened public understanding of HIV services, contributing to positive shifts in health-seeking behaviour among priority populations.

2.11. Key HIV prevention Challenges and Gaps

- **Linkage from HIV Testing Services (HTS) to Prevention Services:** HIV-negative clients who are at substantial risk are not always consistently linked to comprehensive prevention services, including condoms, PrEP, STI screening and treatment, risk-reduction counselling, and partner services. This results in missed opportunities to prevent new HIV infections among people at increased risk.
- **PMTCT Retention and Follow-Up:** Retention in PMTCT services remains a challenge due to late antenatal care attendance, missed appointments, and limited partner involvement. These factors affect timely HIV testing, ART initiation, continued care, and follow-up of mother-baby pairs, increasing the risk of delayed treatment, poor retention in care, and potential mother-to-child transmission.
- **Low Uptake of HIV Prevention and Testing Services:** Uptake of HIV testing, PrEP, and condoms remains low among young people and key populations. This limits early diagnosis and timely linkage to prevention or treatment services, resulting in delayed diagnosis and reduced access to appropriate interventions.

- **High HIV Burden Among Key and priority Populations:** HIV prevalence among key populations remains high and continues to place a significant burden on the national HIV prevention program. This contributes to continued HIV transmission risk and highlights the need for targeted, sustained prevention interventions.
- **Vulnerability of Adolescent Girls and Young Women (AGYW):** Adolescent girls and young women continue to face multiple and overlapping risks, including economic vulnerability, gender-based violence, limited power to negotiate safer sex, school dropout, and limited access to youth-friendly prevention services. These challenges increase their vulnerability to HIV infection and reduce uptake of prevention services.
- **Uneven Demand Creation for VMMC:** Demand creation for voluntary medical male circumcision varies across districts, resulting in unequal uptake of VMMC services and inconsistent coverage of an important HIV prevention intervention across geographic areas.

2.12. Human Right and Gender Equality

Rwanda's HIV response is anchored in a rights-based and gender-responsive legal framework. The Constitution guarantees equality and freedom from discrimination, and health-sector law affirms every person's right to HIV prevention, treatment and care without stigma. In 2025, Law No. 026/2025 of 17 September 2025 Regulating Healthcare Services lowered the age of independent consent from 18 to 15 years, removing a key structural barrier for adolescents seeking HIV prevention, contraception and other reproductive health services without parental consent.

Stigma reduction remained a central priority in 2025-2026, pursued through provider sensitization, stigma-reduction messaging integrated into routine service delivery, and the meaningful engagement of people living with HIV. Gender equality was addressed as both a determinant of and a pathway to better HIV outcomes, with combination prevention, economic-empowerment linkages and the engagement of men and boys targeting the inequalities that heighten vulnerability among adolescent girls and young women. Links between HIV services and gender-based violence response were also strengthened, with survivors supported through integrated post-exposure prophylaxis, testing, psychosocial care and referral to protection and legal services, building on the Isange One Stop Centre model. For key and priority populations, efforts focused on reducing access barriers, sensitizing providers and creating safe, confidential service environments. Community engagement and community-led monitoring were used to identify human rights-related barriers, strengthen accountability and ensure that affected communities inform programme design and quality improvement.

3. SECTION III: CIVIL SOCIETY ORGANIZATIONS ENGAGEMENT

Civil Society Organizations (CSOs) are essential partners in Rwanda's health system, working with the Ministry of Health, RBC, local authorities, health facilities and umbrella networks to extend quality, people-centred HIV services to underserved populations. Through community-based, differentiated approaches they support prevention, testing, adherence and retention, psychosocial support, SRH, stigma reduction, commodity distribution, community-led monitoring and linkage to care, while strengthening the system through capacity building, mentorship, data use and policy dialogue.

In 2025/26, CSOs worked across the prevention and care continuum for key and priority populations, adolescent girls and young women, people living with HIV, children and adolescents, and supported faith-based and disability-inclusive programming. Peer educators, Youth Ambassadors, Community Adolescent Treatment Supporters, community health workers, monitors, religious leaders and KPP representatives served as trusted links between communities and health services.

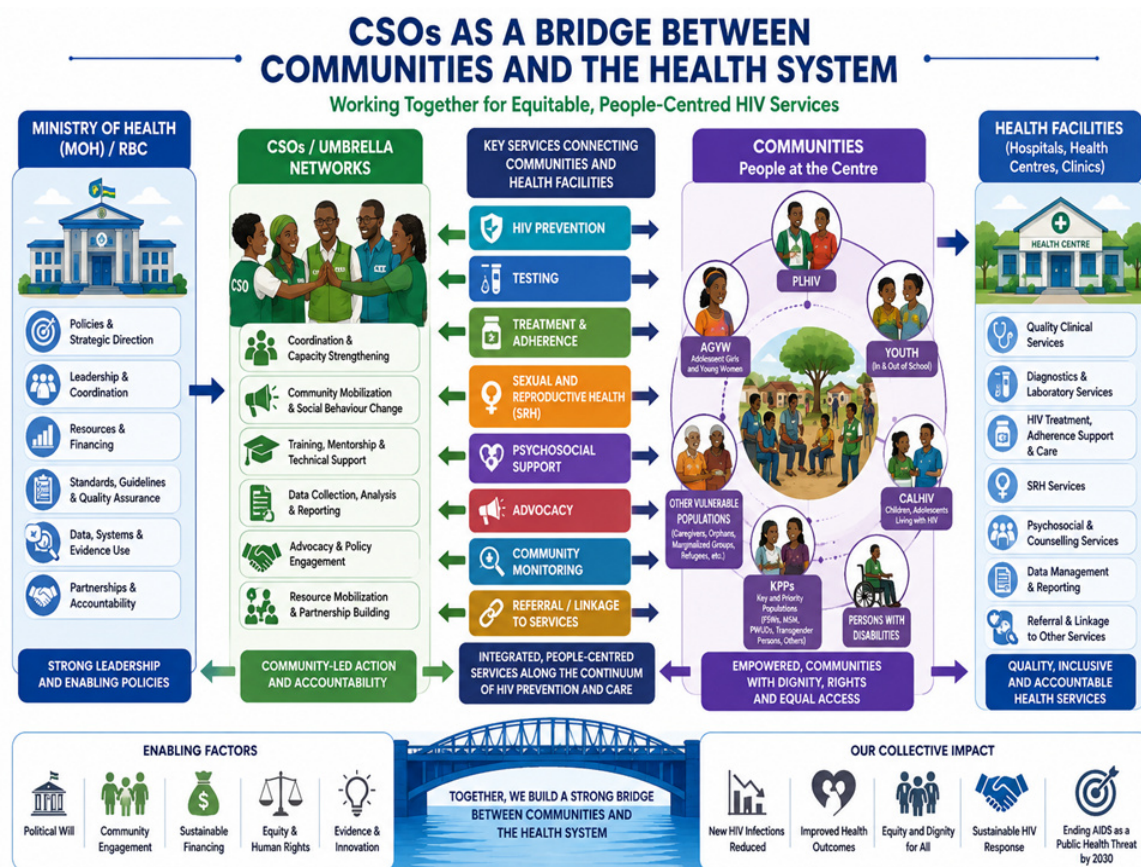


Figure 40: CSOs as a bridge between communities and the health system

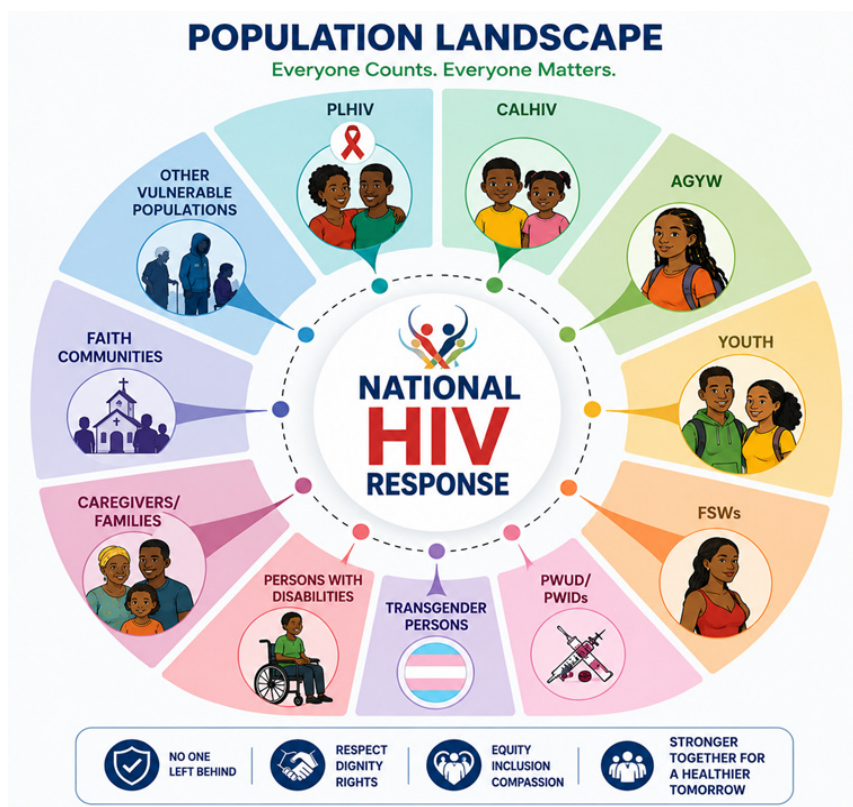


Figure 41: Population groups reached by the national HIV response

3.1. Objective and Goal



Figure 42: CSO strategic framework for the HIV response, 2025/26 and beyond

3.2. Key Achievements in 2025-2026

3.2.1. Strengthening Community Support for People Living with HIV

Community-based services were strengthened through 4,823 peer educators across 547 health facilities. Outreach reached 165,911 recipients of care about 72% of the 230,344 people on ART with 27,677 home visits, 2,971 referrals and re-engagement of clients who had interrupted treatment. A radio campaign reached an estimated 6 million people through 46 radio points, 22 districts and 23 transport hubs, and Youth Ambassadors reached 381,948 people online and 34,000 through outreach. Outreach among 12,282 tea estate workers delivered integrated HIV and STI services with 396,000 condoms, 14,579 self-test kits and 22,500 IEC materials, while the toll-free line 1245 handled 2,062 calls.

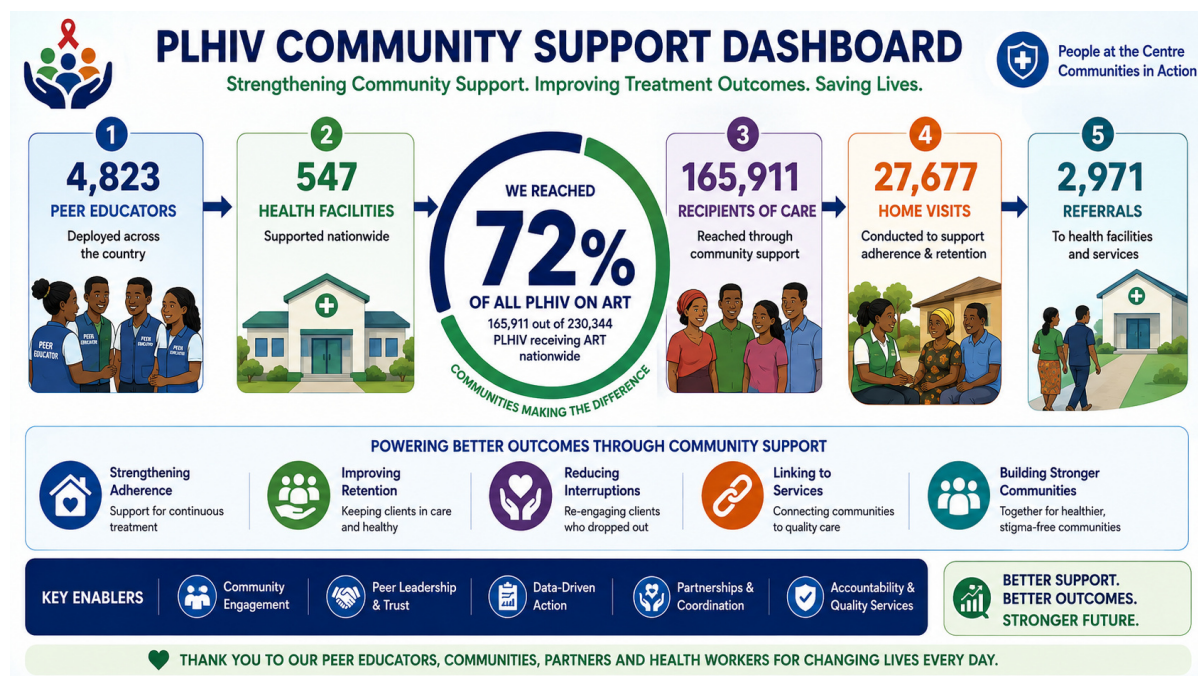


Figure 43: PLHIV community support: peer educator reach and outcomes

3.2.2. Support for Children, Adolescents, and Young People Living with HIV

Support for children, adolescents and young people living with HIV was delivered by 12 Community Adolescent Treatment Supporters across 12 health facilities in Gasabo, Kicukiro and Nyarugenge. A total of 3,582 recipients of care received peer mentorship, disclosure and adherence support, psychosocial care and clinic follow-up, contributing to 84% viral load suppression; 325 children and adolescents were mobilized for testing, 42 newly diagnosed clients linked to treatment and 335 home visits conducted. A qualitative assessment across 7 districts, 14 health facilities and 275 participants identified seven priority actions, confirming

peer mentorship, youth-friendly services, confidentiality and caregiver engagement as enablers, and stigma, disclosure concerns, mental health and socio-economic vulnerability as barriers.

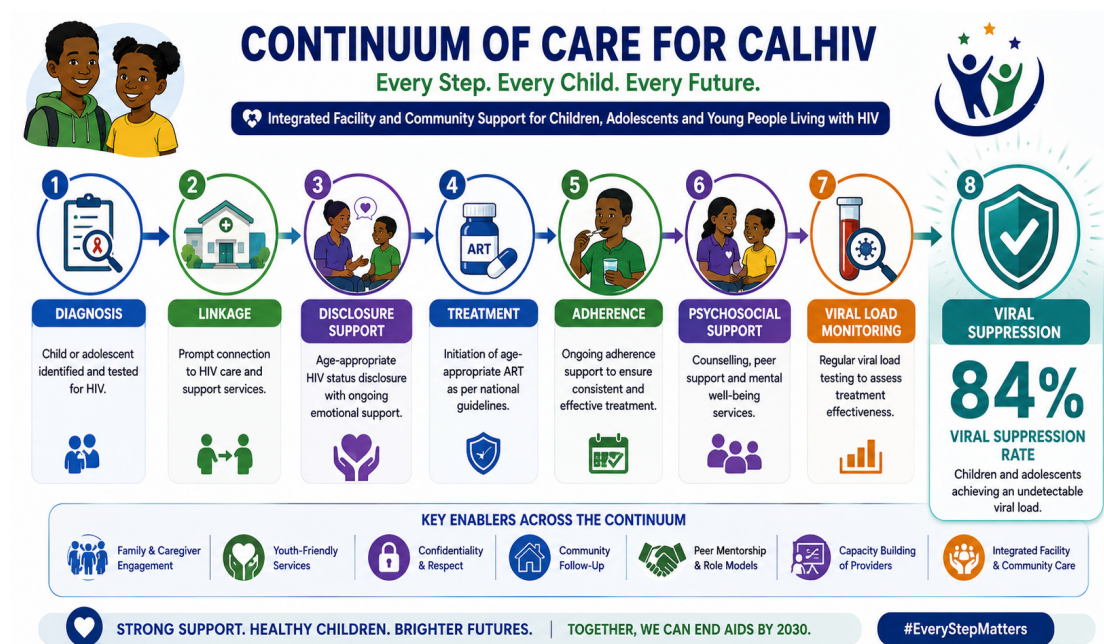


Figure 44: Continuum of care for children and adolescents living with HIV

3.2.3. Advancing HIV Prevention among Adolescent Girls and Young Women

CSOs supported comprehensive HIV prevention for adolescent girls and young women by addressing the behavioural, social and structural drivers of vulnerability, through prevention education, social and behaviour change communication, SRH information, referrals, community mobilization and peer engagement. AGYW were also reached through community, school, faith-based, sports and digital platforms, reflecting the value of combining biomedical, behavioural and structural interventions rather than information alone.

3.2.4. Advancing the National HIV Response through Faith-Based Engagement

Faith-based organizations provided a trusted platform for prevention, adherence, stigma reduction and SRH promotion. A national consultation convened 50 stakeholders; 400 religious leaders, youth representatives and family commission heads were equipped to integrate HIV and SRH messages into faith programmes; and 10 faith-based journalists produced three radio and two television talk shows. Campaigns reached about 8,500 people and 16 monitoring visits confirmed growing integration of HIV messages.

3.2.5. Engaging Young People in HIV and Sexual and Reproductive Health

Between July 2025 and June 2026, integrated interventions across community, school, religious, sports and digital platforms reached 53,158 in- and out-of-school youth with tailored prevention information and commodities. Digital engagement reached 381,948 people and the hotline provided SRH information to 60,008 youth, while 1,016 AGYW were referred for voluntary counselling and testing and 26 for STI screening. Youth Ambassadors led peer education, community dialogues and school outreach, building trust in services and strengthening linkage to youth-friendly facilities.

3.2.6. Advancing Disability-Inclusive HIV Services

CSOs advanced disability inclusion by addressing communication, accessibility and social barriers to HIV and SRH services. Outreach and media campaigns reached 149,600 people with information on HIV, TB, STIs, NCDs and SRH; 545 persons with disabilities living with HIV received assistive devices and 536 parents and caregivers received psychosocial support. In addition, 33 healthcare providers were trained in basic sign language, 5,874 persons with disabilities accessed disability-adapted HIV information and 1,674 benefited from accessible prevention and SRH training materials.

3.2.7. HIV Prevention and care for key and priority Populations

Among key and priority populations, CSOs mapped 1,034 hotspots and identified some 15,106 individuals, including female sex workers, men who have sex with men, people who use drugs and transgender persons. Testing supported 2,927 people and identified 83 HIV-positive cases linked to care, while maternal and SRH interventions reached 1,176 female sex workers. CSOs distributed 8.30 million condoms, 295,130 lubricants and 37,096 self-test kits, and outreach through sports, markets, hotspots and youth platforms reached more than 23,000 people. Advocacy with local authorities, religious leaders and providers promoted the right to health and strengthened referral mechanisms.

3.2.8. Community-Led Monitoring

RBC, with CSOs and key stakeholders, developed, validated and piloted an integrated community-led monitoring (iCLM) model and data system for HIV, structured around Availability, Accessibility, Acceptability and Quality standards. The pilot covered 3 districts (Rwamagana, Gasabo and Bugesera) and 12 health centres, surveying 14,569 respondents 11,210 facility-based and 3,359 community-based, of whom 5,938 were for HIV using tools

developed participatively with partners, CSOs, community representatives and programme managers in line with national M&E frameworks.

The system tracks indicators such as commodity stockouts, client consent, treatment literacy and out-of-pocket expenses across the three disease programmes. Standardized modules trained 38 master trainers and 108 community monitors, and after the pilot the tools and system were refined with artificial intelligence functionality for data validation, automated analysis and visualization, strengthening evidence-based advocacy and decision-making.

3.2.9. Consolidated HIV Prevention Results

Between July 2025 and June 2026, civil society organizations distributed 9,430,225 condoms (96.6% of all commodities and materials distributed), 284,130 lubricants (2.9%), 25,074 IEC materials (0.3%) and 21,967 HIV self-test kits (0.2%). Prevention interventions reached a combined 7,275,298 people: 6,436,948 through media (88.5%), 441,956 adolescent girls and young women (6.1%), 344,451 through outreach awareness activities (4.7%), 28,012 through home visits (0.4%), 15,106 key population members mapped (0.2%) and 8,825 people tested for HIV (0.1%). Together these results combine population-level awareness with targeted community-based delivery across different population groups and settings.

3.3. Key Challenges and Gaps

Despite this progress, cross-cutting challenges persisted. Stigma, discrimination and criminalization of key and priority populations particularly people who use or inject drugs continued to delay access to services, compounded by limited awareness of their health needs and rights among some community leaders and providers. Prevention commodities, including self-test kits, condoms and lubricants, did not always meet demand during high-volume campaigns, and reaching hidden and highly mobile populations remained difficult, underscoring the need for stronger peer-led outreach and differentiated service delivery. Follow-up and linkage mechanisms also require strengthening so that people diagnosed with HIV start treatment promptly and those at ongoing risk are linked to PrEP and other services.

4. SECTION IV: CARE AND TREATMENT

4.1. Objective

- Achieve universal ART coverage and retention above 95%, with viral load suppression above 95% among all PLHIV on ART.
- Strengthen provider capacity to ensure high-quality, consistent service delivery nationwide.
- Empower and support communities affected by HIV to ensure equitable access and full social inclusion.

4.2. Goal

- Ensure timely linkage and retention in care for newly diagnosed individuals through full implementation of the “Treat All” policy and improved coordination between testing and treatment services.
- Optimize ART coverage and retention using safe, well-tolerated regimens, and strengthen paediatric centres of excellence.
- Integrate non-communicable disease, mental health, nutrition, and psychosocial support into routine HIV care through systematic screening, counselling, and follow-up.
- Advance the socioeconomic well-being and human rights of PLHIV by reducing stigma and discrimination and promoting inclusive, community-led service delivery.

4.3. Key Achievements in HIV Care and Treatment, Rwanda 2025-2026

4.3.1. ART Coverage among PLHIV

By June 2026, after adjustment of the monthly reports and validation, the estimated number of PLHIV on treatment was 230,344 people across 601 health facilities. Based on the spectrum estimate of 234,164 PLHIV, national ART coverage reached 98.4% (97.1% among males and 99.1% among females), demonstrating continued progress toward the third UNAIDS 95-95-95 target. Estimated coverage among children aged 0-14 years remains substantially lower, at an estimated 58.9%. Although a high estimated denominator contributes to this

result, the finding also underscores a persistent paediatric treatment gap that will require intensified family-centered case finding.

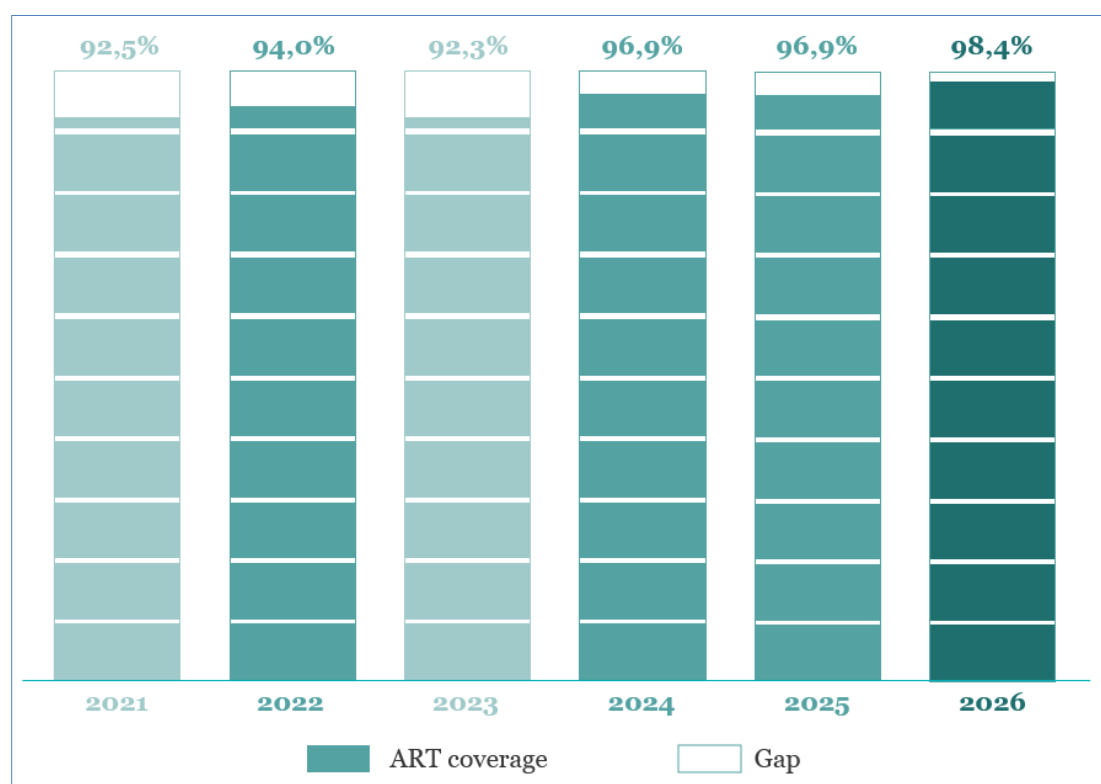


Figure 45: Trend of ART Coverage from July 2021 to June 2026

The figure below presents the distribution of 230,344 PLHIV on ART in Rwanda as of June 2026 by age and sex. Females accounted for 63.8% (146,898) of clients and males for 36.2% (83,446). Adults aged 25–49 years represented the largest group (127,925; 55.5%), with females outnumbering males by approximately 2:1. Clients aged 50 years and above accounted for 36.2% of the cohort, a proportion that continues to rise annually. This trend reflects the aging PLHIV population and underscores the need to strengthen early detection and management of non-communicable diseases among clients receiving ART.

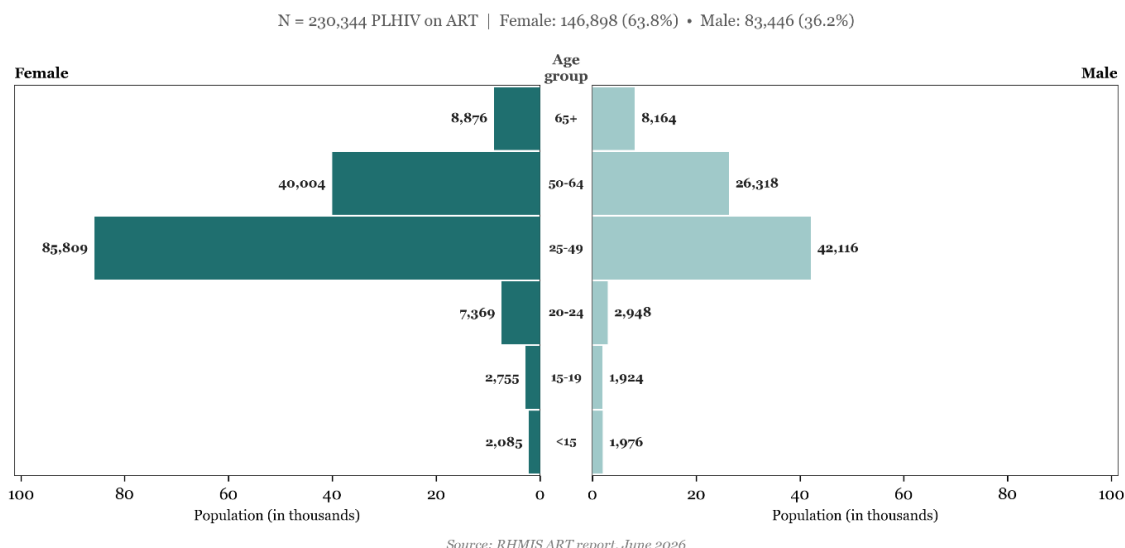


Figure 46: ART distribution by age category and sex, June 2026

Adults aged 20-49 years accounted for 82% of new initiations, with the 25-49 band alone contributing two in three (7,169; 67.8%). Children under 15 and adults 65 and above together made up only 4.7% (492) of new initiations.

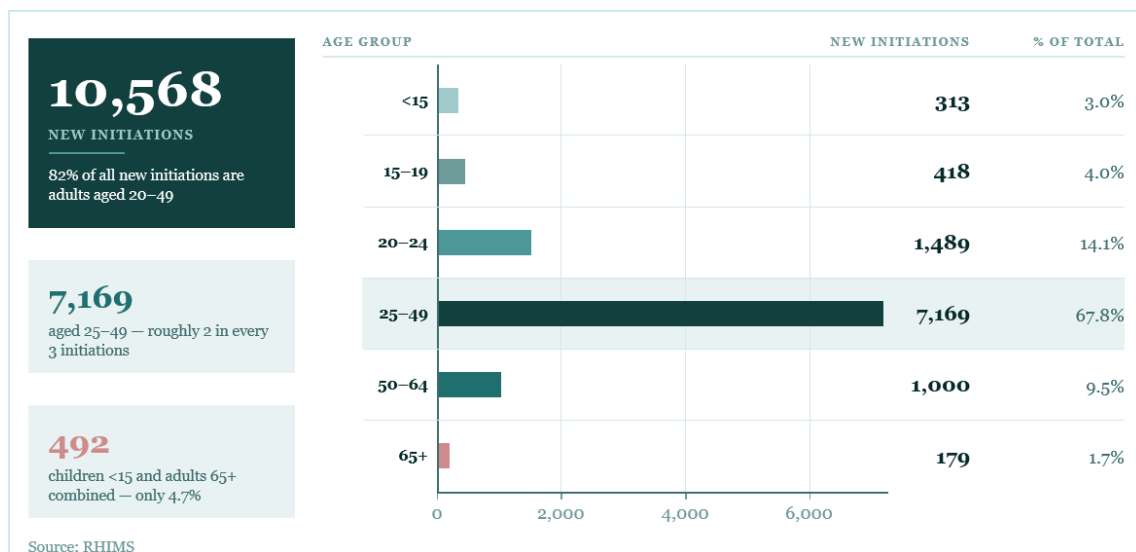


Figure 47: Distribution of new ART initiations by age categories

4.3.2. Linkage and Retention in Care and Treatment

Health facility -based retention was assessed among 8,075 clients who initiated ART between July 2024 and June 2025 across 430 health facilities. At twelve months, 93.8% (7,578) remained engaged in care, while 4.4% (356) were lost to follow-up and 1.7% (141) had died during the first year after ART initiation. This performance was consistent with the 94%

retention recorded in the prior reporting year. Retention remained slightly lower among adolescents and young adults aged 15-24 years (91%) than among adults aged 25 years and above (93%) reinforcing the need for differentiated retention support for young people entering care.

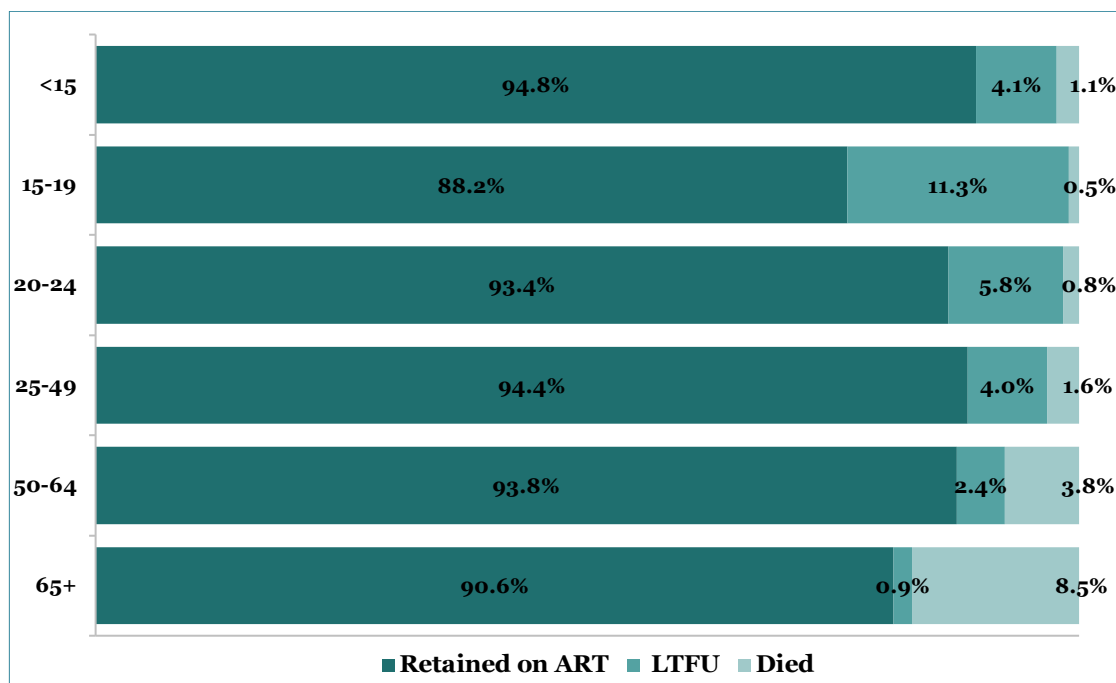


Figure 48: Retention after one year of treatment by age

4.3.3. Clinical monitoring and follow-up

4.3.3.1. Differentiated Service Delivery (DSD)

In line with the 2022 national ART guidelines prioritizing multi-month dispensing (MMD) for clinically stable clients, 67.2% (154,907) of ART clients were on six-month dispensing and 23.6% (54,272) were on three-month dispensing by June 2026. The remaining 9.2% (21,165) continued on monthly dispensing, reserved for newly initiated or clinically unstable clients. This represents a modest expansion of less-intensive dispensing models to support treatment outcomes. The trend reflects Rwanda's continued shift toward differentiated, client-centered

care, reducing routine facility visits for stable clients and enabling providers to focus time and resources on clients requiring closer clinical monitoring.

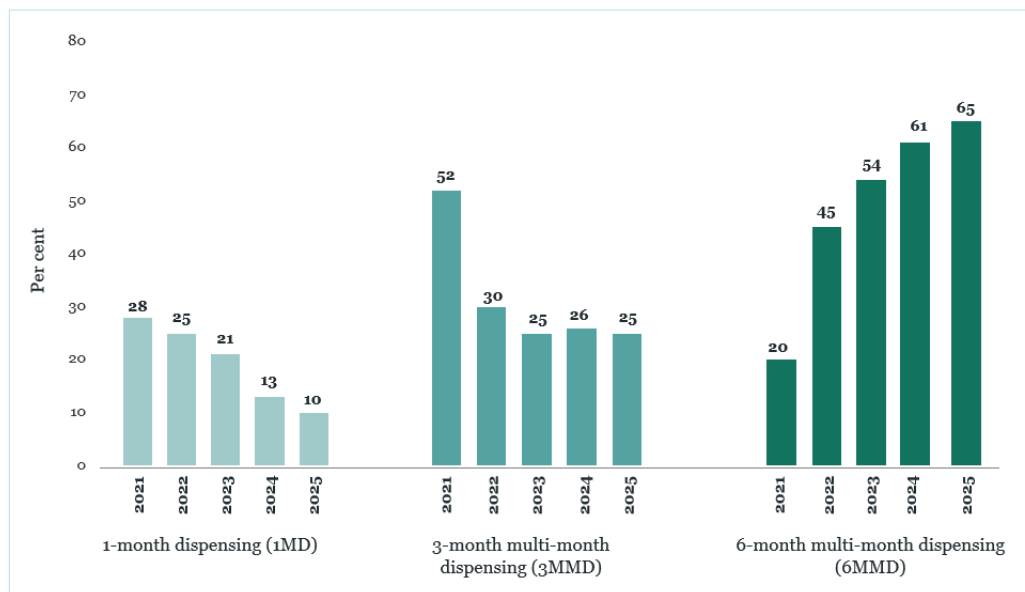


Figure 49: Trends in the scale-up of DSD model categories from July 2020 to June 2026

4.3.3.2. Viral Load Testing and Monitoring

During FY2025-26, 233,918 ART clients were eligible for viral load testing. It is important to note that an individual client may undergo more than one viral load test during the reporting period. Of these, 210,675 (90.1%) were tested, and 195,792 results were returned (92.9% of tests conducted). Although coverage improved compared with the previous year, it remained below the national target of at least 95%.

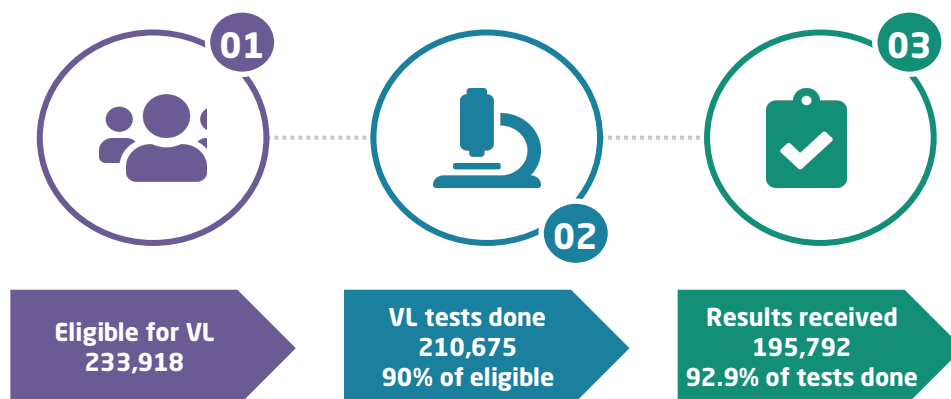
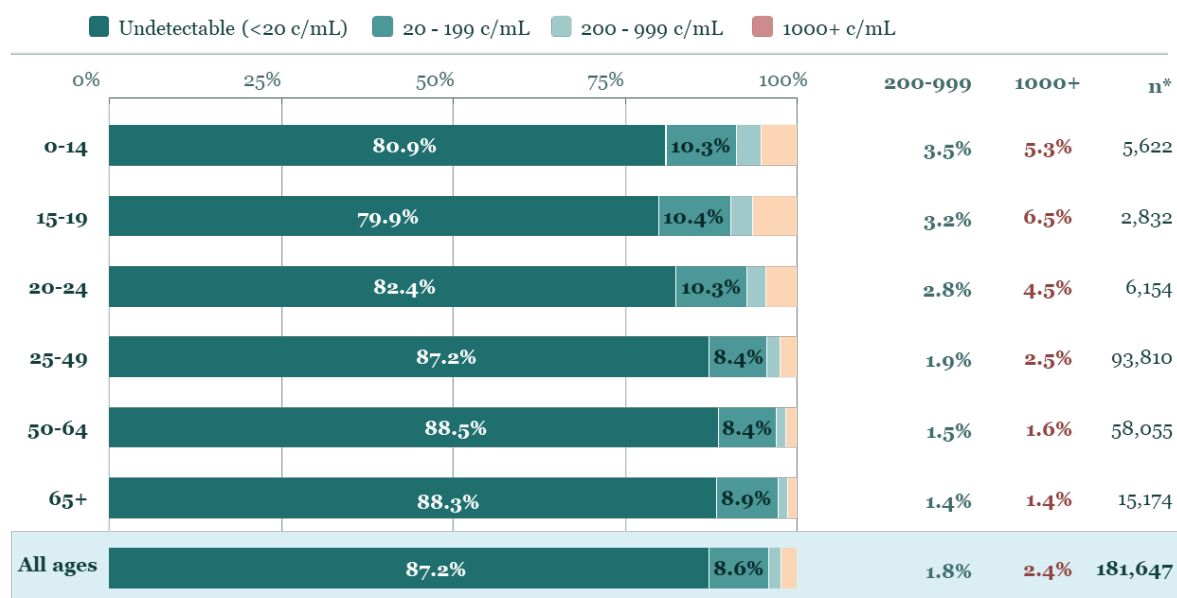


Figure 50: Viral load testing cascade, Rwanda Jun 25 - Jul 27 (Source: RHMIS, VLSMS & LIS)

Among the 181,647 unique patient-level results available in the laboratory system (VLSMS and LIS), 95.8% were suppressed below Rwanda's threshold of 200 copies/mL and 97.6% with <1000 copies/mL (Figure 46). Suppression was consistently lower among adolescents and young adults under 25 years (90.3%-92.7%) than among adults aged 25 years and above (95.6%-97.2%).



Percent of viral load results within each age group. Source: VLSMS & ILS June 2026. *Unique VL results

Figure 51: Viral load suppression among PLHIV on ART by age, Rwanda June 2026 (source: VLSMS & LIS)

Viral suppression was consistently lowest in Eastern Province, which recorded the lowest proportion across all age groups. The lowest single result nationally was observed among adolescents aged 15-19 years in Northern Province (87.1%). Southern Province performed strongest overall, peaking at 98.0% among clients aged 65 years and above. Across all provinces, suppression among adolescents aged 15-19 years remained below 91%.

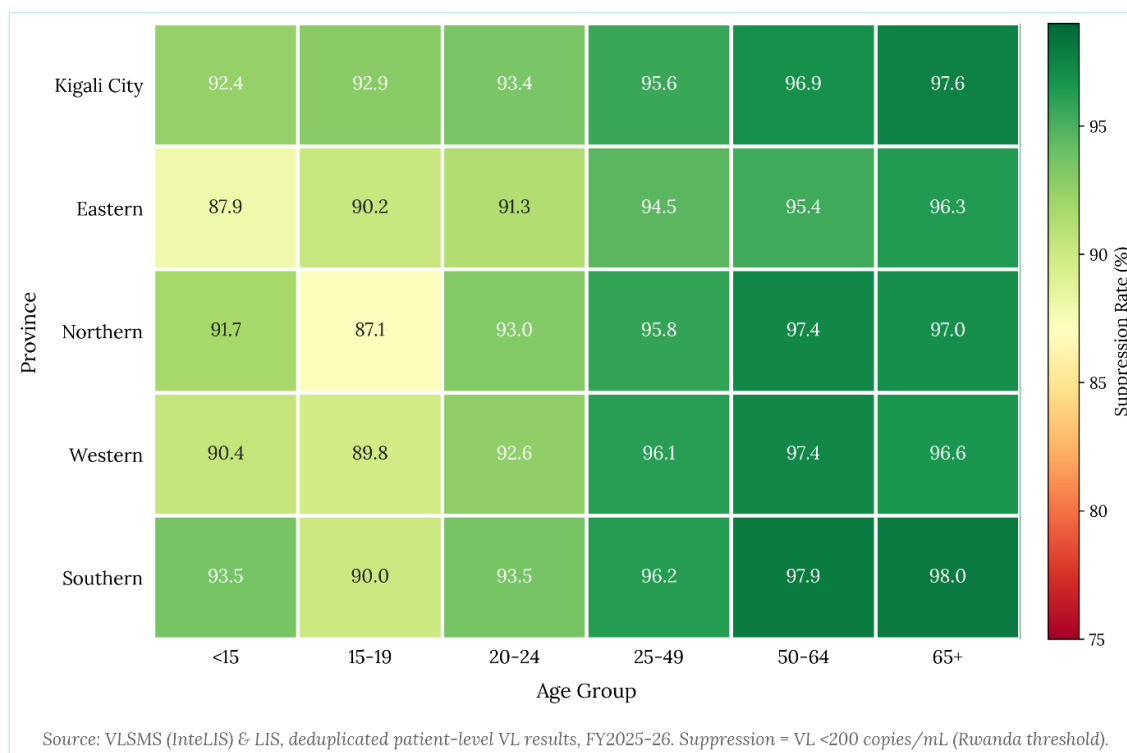


Figure 52: Viral Load Suppression by Province and Age Group, Jul 25-Jun 26

4.3.3.3. Movements in HIV Services

During FY2025-26, the ART program recorded 10,568 new initiations and 1,633 clients retraced after loss to follow-up, compared with 3,204 newly lost to follow-up and 1,724 deaths. Relative to the average cohort size, annualized rates remained low, at 1.4% for loss to follow-up and 0.7% for mortality. These results were broadly stable compared with the prior year and reflect the continued strength of Rwanda's ART retention and patient-tracking systems.

4.3.3.4. Mentorship

Tele-mentorship remained a key strategy for strengthening healthcare-provider capacity and sustaining the quality of HIV service delivery amid funding constraints. During the fiscal year, 31 tele-mentorship sessions were conducted across health facilities, providing continuous technical support and fostering collaborative learning. These sessions enabled providers to discuss complex clinical and programmatic cases, share best practices, review service-delivery challenges, and receive timely guidance on implementing national HIV guidelines. Clinical mentorship visits were also conducted in facilities providing HIV services to review performance, support data collection, and identify service-delivery gaps. Mentorship findings

and key performance indicators were used to identify high-performing hospitals that could serve as models for peer learning and to guide targeted support for underperforming facilities. Furthermore, regular monitoring of clinical indicators, mentorship findings, and facility performance trends strengthened the identification of priority improvement areas, while technical guidance, follow-up support, and recommendations were provided to address identified gaps and improve the quality of HIV service delivery.

4.3.3.5. Continuous Quality Improvement

Key milestones were achieved in strengthening HIV service quality through the implementation of quality improvement (QI) initiatives and the development of the National HIV Quality Standards Assessment Tool. During the fiscal year, 216 health facilities were trained on QI approaches, and 123 implemented QI projects to improve priority HIV service-delivery indicators. These projects focused on case-based surveillance (CBS) follow-up, viral load (VL) testing coverage, early infant diagnosis (EID), clinical follow-up, non-communicable disease (NCD) screening among PLHIV, tuberculosis preventive treatment (TPT) initiation among newly enrolled clients, monitoring of creatinine and glycemia among clients receiving ART, and reduction of loss to follow-up.

To institutionalize quality assurance across HIV services, the National HIV Quality Standards Assessment Tool was developed and piloted in 18 health facilities. The pilot informed refinement of the tool, providing a standardized framework for assessing service quality and supporting continuous quality improvement ahead of nationwide implementation.

4.3.4. Integration of other services into HIV differentiated ART models

4.3.4.1. Mental health

As part of efforts to strengthen comprehensive HIV care and address the broader health needs of PLHIV, the program made progress in integrating mental health services into routine HIV care nationwide. Routine mental health screening continued in HIV clinics using standardized tools, supporting early identification, appropriate management, and timely referral of clients experiencing mental health conditions.

To further enhance the capacity of healthcare providers, onsite clinical mentorship and virtual tele-mentorship sessions were conducted. These capacity-building initiatives strengthened providers' competencies in mental health screening, psychosocial assessment, provision of

basic mental health care, and appropriate referral pathways in line with national guidelines. These combined efforts contributed to improving treatment adherence and retention in care among people living with HIV.

4.3.4.2. TB/HIV Integration

Since FY2015-2016, the TB/HIV co-infection rate has improved substantially, declining from 25% to 12% in FY2022-2023, a relative reduction of more than 50%. However, recent years show a renewed upward trend, with the rate rising to 14% in FY2023-2024, 13% in FY2024-2025, and 15.6% in FY2025-2026. Although the current rate remains 37.6% below the FY2015-2016 baseline, the recent increase underscores the need to sustain TB/HIV service integration and strengthen case detection among PLHIV to preserve earlier gains.



Figure 53: TB/HIV Co-Infection Cases by Age Category, FY2025-26

Cases were concentrated among adults aged 25-49 years (839; 64.9%) and were predominantly male (822; 63.6%). Part of this year's increase in detected TB/HIV cases likely reflects improved case finding rather than a true increase in disease burden. TB LAM testing among HIV-positive TB cases nearly tripled between FY2024-25 and FY2025-26, rising from 8.8% to 22.1% of cases tested, while LAM-positive results accounted for 183 of the 194 additional HIV-positive TB cases identified this year (94%).

Since 2019, tuberculosis preventive treatment (TPT) has been integrated into HIV service delivery for PLHIV through a one-stop-shop model that is now operational across all districts. By the end of June 2026, 230,424 PLHIV were receiving ART, of whom 99.1% (228,364) had ever initiated TPT, indicating near-universal coverage among clients established in care. However, TPT initiation among clients newly starting ART remains suboptimal. During FY2025–2026, 7,752 of 10,568 newly initiated ART clients (73.3%) also started TPT within the same reporting period, improving from 62.2% in FY2024–2025. Despite this progress, targeted interventions are still needed to strengthen timely TPT initiation among newly enrolled clients. Hospital-level TPT coverage is presented below.

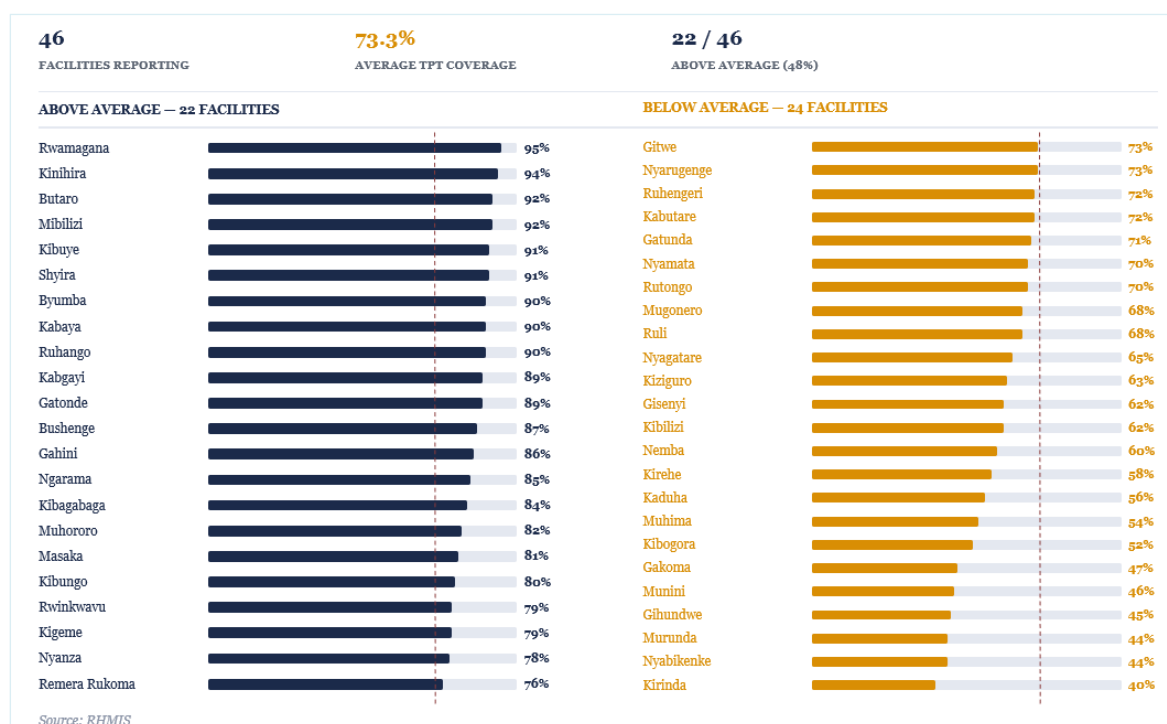


Figure 54: TPT Coverage among new clients initiated on ART, FY 2025-2026

Performance varied widely across the 46 reporting hospitals, from Rwamagana at 95% to Kirinda at 40%, with 24 of 46 facilities falling below the 73.3% national average. This spread suggests the national TPT gap is concentrated in an identifiable set of consistently low-performing facilities, which stand to benefit most from targeted mentorship.

4.3.4.3. Psychosocial Care Support among PLHIV

During the reporting period, psychosocial support services for PLHIV were strengthened through targeted capacity building and mentorship. Heads of selected schools were trained to identify, support, and follow up learners living with HIV, promote HIV prevention, and foster stigma-free learning environments through stronger collaboration with families and health facilities. Health facilities also received mentorship to improve comprehensive psychosocial support, including the identification, assessment, and management of psychosocial needs among PLHIV.

In addition, caregivers were trained on the adolescent HIV care model to strengthen support for adolescents and young people living with HIV (AYLHIV) through integrated peer-led interventions, psychosocial support, and mental health services. The training equipped caregivers with skills to promote adherence, monitor psychosocial well-being, support adolescent transitions, and enhance engagement in HIV care. These interventions contributed to improving the quality and continuity of care for AYLHIV.

4.3.4.4. Nutrition Support

During FY2025-26, nutrition services for PLHIV were strengthened through capacity building and targeted nutritional support. A total of 512 healthcare providers were mentored to assess, manage, and provide nutrition services for PLHIV. To improve nutritional outcomes among clients requiring supplementary feeding, 43,049 PLHIV received 70 metric tons of Corn Soya Blend Plus (CSB+). In addition, 2,337 PLHIV diagnosed with severe acute malnutrition received Ready-to-Use Therapeutic Food (RUTF) to support nutritional recovery and improve treatment outcomes.

4.3.5. HIV-Related Commodities Supply Chain Management

Effective supply chain management remains essential to the HIV program, supporting uninterrupted availability of antiretroviral medicines and other critical commodities for HIV prevention, treatment, care, and viral hepatitis services. This requires accurate forecasting, timely procurement, efficient distribution, and robust monitoring systems to ensure continuous access to life-saving medicines for PLHIV.

During FY2025-2026, the program made significant efforts to strengthen the HIV supply chain. Integrated quantification exercises estimated HIV and viral hepatitis commodity requirements for 2026-2030, and the national supply plan for 2026-2027 was finalized. In collaboration with Rwanda Medical Supply (RMS) and implementing partners, the program

supported procurement planning and coordinated commodity distribution, contributing to improved availability of essential products nationwide. HIV viral load testing transitioned from the Roche COBAS 4800 platform to the Roche COBAS 5800 platform at sites using Roche systems. This transition was implemented to strengthen laboratory diagnostic capacity, improve testing efficiency and reliability, increase throughput, and enhance the overall performance of the HIV viral load testing network.

To strengthen oversight of medical commodities management, the Rwanda Medical Supply (RMS) receiving unit regularly shared lists of commodities received for verification and acknowledgment. In addition, monthly stock status assessments were conducted to monitor stock availability, track commodity consumption, identify products at risk of expiry, and detect supply gaps. Findings from these assessments informed timely mitigation measures and recommendations to optimize stock management and ensure the continuous availability of medical commodities.

As part of these mitigation measures, redistribution of medical commodities was routinely coordinated to improve product availability across the country. Commodities at high risk of expiry or unevenly distributed were transferred from health facilities and RMS branches with excess stock to facilities and branches experiencing stock-outs or at risk of stock-outs. This approach helped reduce wastage due to expiries or treatment interruption while improving equitable access to essential medical commodities.

4.4. Key Challenges and Gaps

Despite continued progress, several challenges affected service continuity, quality and sustainability:

- Funding uncertainty and reductions from external donors constrained the supply plan: by end-May 2026, 36% of planned shipments were unfunded and 11% cancelled. This reduced physical mentorship visits and nutrition commodities, notably CSB+, and drove procurement delays, weak inventory management, intermittent stockouts and commodity expiries.
- Limited digital infrastructure and connectivity constrained tele-mentorship in some facilities.
- Staff turnover and shortages of trained healthcare providers disrupted service continuity and mentorship.
- HIV and mental health stigma, together with few trained mental health professionals, limited access to integrated mental health care for people living with HIV.

- TPT initiation among newly starting ART clients (73.3%) lagged behind established clients (99.1%), ranging from 95% to 40% across the 46 reporting hospitals, a gap concentrated in specific facilities rather than system-wide.

5. SECTION V: VIRAL HEPATITIS AND SEXUALLY TRANSMITTED INFECTIONS

5.1. Introduction

Rwanda has achieved notably low prevalence of viral hepatitis, with recent estimates of 0.26% for hepatitis B and 0.17% for hepatitis C in the last FY 2024-2025. This reflects sustained investment by the Ministry of Health through Rwanda Biomedical Centre in prevention, diagnosis, and treatment, supported by robust monitoring through the DHIS2 and HMIS platforms.

Since the launch of the National Hepatitis C Elimination Plan in 2018, the Ministry of Health and partners have advanced screening, affordable treatment, and integration of hepatitis services into the national health system, including mass screening of high-risk populations. Continued attention to other sexually transmitted infections (STIs) remain essential, as untreated infections can cause infertility, neonatal complications, cancer, and increased HIV risk.

Rwanda has strengthened workforce capacity, infrastructure, and community awareness, while syndromic management and expanded screening have improved case detection. Reducing prevalence among high-risk populations, however, remains a key challenge.

o Objectives

- Strengthen awareness, health education, and behaviour change to reduce risk factors and transmission of STIs and viral hepatitis.
- Improve equitable access to quality services for screening, diagnosis, treatment, and follow-up, with particular focus on high-risk populations.
- Strengthen surveillance, data management and reporting systems to inform policy and intervention strategies.
- Reduce the incidence and prevalence of STIs and viral hepatitis through prevention, early screening, diagnosis and treatment.
- Decrease morbidity and mortality associated with untreated or advanced STIs and viral hepatitis, including cirrhosis, liver cancer, infertility, and adverse pregnancy outcomes.

5.1.1. Key Achievement in 2025-2026

5.2. Telementor ship on Viral hepatitis, STIs management and data quality

The telementor ship sessions on viral hepatitis, sexually transmitted infection (STI) management, and data quality enhanced participants' knowledge and improved healthcare service delivery. The sessions covered current guidelines for viral hepatitis and STI prevention, diagnosis, treatment, and follow-up, emphasizing early detection, appropriate clinical management, and patient counselling.

Participants were also guided on accurate, complete, and timely data recording and reporting to facilitate informed decision-making, effective monitoring, and improved program performance. Interactive discussions and case-based learning clarified challenges and reinforced adherence to national guidelines and best practices. The telementor ship sessions enhanced participants' technical capacity and underscored the critical role of high-quality clinical care and reliable data in achieving better public health outcomes.

5.3. Management of Viral Hepatitis B

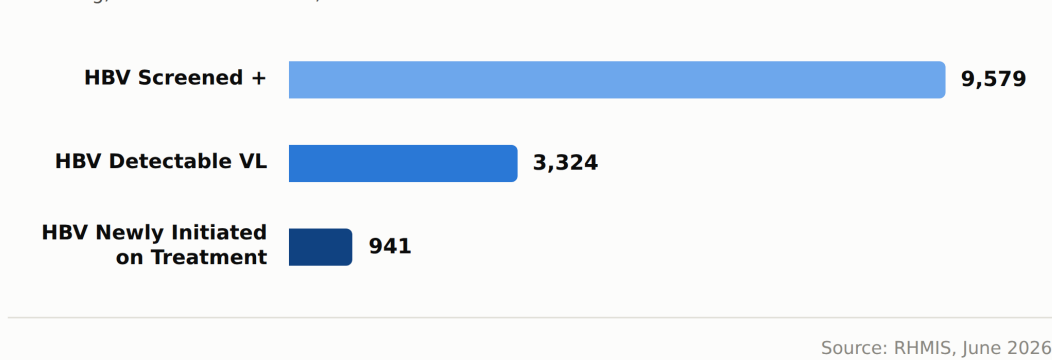
5.3.1. Hepatitis B prevention, care and treatment

The national program scaled up its efforts to prevent, diagnose, treat, and monitor hepatitis B virus (HBV) infection, in alignment with the World Health Organization's (WHO) hepatitis elimination targets. Public awareness remained central to prevention and elimination. During the reporting fiscal year, information on viral hepatitis and sexually transmitted infections (STIs) was disseminated through radio and television programs, including live interactive sessions. These efforts strengthened health-seeking behaviour, increased demand for screening, and improved uptake of preventive and treatment services.

Of 893,278 individuals screened for hepatitis B nationally, 9,579 tested positive (1.07%). Of these, 3,324 (0.37%) had a detectable viral load. Following national treatment guidelines, 941 eligible individuals with a viral load above 2,000 IU/mL began treatment. This cascade demonstrates strong screening coverage, effective identification of active infection, and appropriate treatment initiation. Continued monitoring of detectable but not-yet-eligible cases is crucial for timely treatment.

Hepatitis B cascade

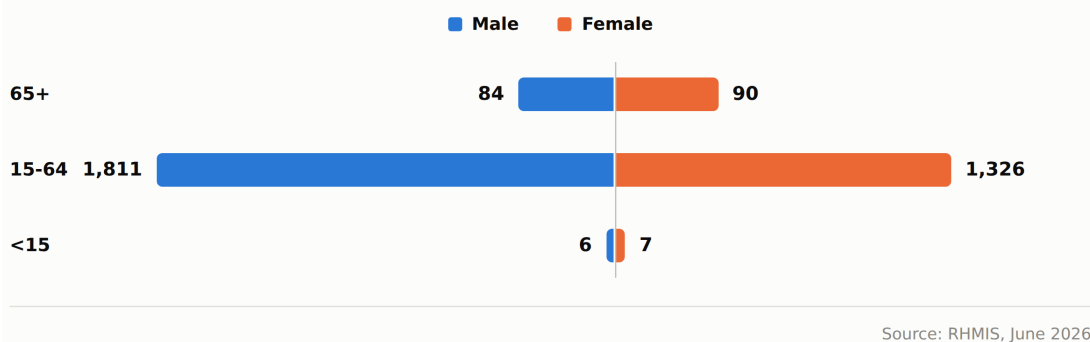
Screening, detectable viral load, and treatment initiation

*Figure 55: Hepatitis B cascade of care from July 2025 - June 2026***5.3.1.1. Hepatitis B infection across gender and age**

Among the 3,324 people with detectable hepatitis B viral load, infection was concentrated among adults aged 15-64, who accounted for the overwhelming majority of cases (0.76% male and 0.24% female). The burden was markedly lower among those aged 65 and above (0.22% male and 0.23% female) and lowest in children under 15 years (0.05% male and 0.04% female). Overall, the distribution shows that hepatitis B detectable viral load is predominantly borne by working-age adults, with a notably higher proportion among males in the 15-64 age band.

HIV cases by age and sex

Newly diagnosed, by age group

*Figure 56: HBV viral load cases across gender and age bands***5.3.1.2. Hepatitis B Cascade of Care across Province and Districts**

The hepatitis B cascade of care varies by province, showing strong case detection and guideline-based treatment. Screening volumes varied considerably, with the Western Province screening the highest number of people (226,104) and the Northern Province the fewest

(123,592). The highest proportion of viral load-confirmed positive cases was recorded in the City of Kigali (1.12%), followed by the Eastern Province (0.39%), while the Northern Province had the lowest (0.10%). Treatment initiation was lower than detectable cases because only individuals with a viral load above 2,000 IU/mL are eligible per national guidelines.

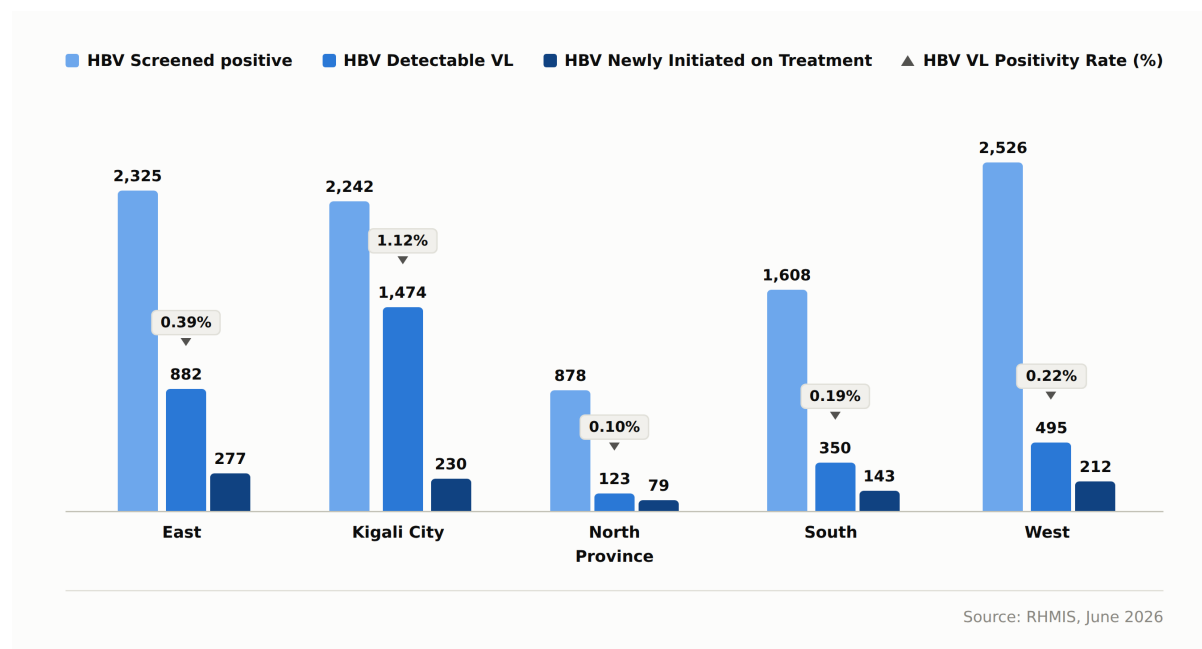


Figure 57: HBV positivity by Province, July 2025 - June 2026

Hepatitis B viral load (3,324 individuals; national average 0.37%) was unevenly distributed across the districts. The highest rates (0.32%–0.48%) were in the City of Kigali (Nyarugenge and Kicukiro), Kayonza, Rwamagana, Huye, Nyamasheke, and Rusizi. The lowest rates (0.06%–0.16%) were in Gakenke, Rulindo, Ruhango, and Nyaruguru. High concentrations in eastern and western border districts suggest cross-border transmission due to population movement and trade. Elevated rates in Kigali are likely due to its dense, mobile population and better access to testing. These patterns highlight the need for targeted screening and prevention in high-burden border districts and the capital.

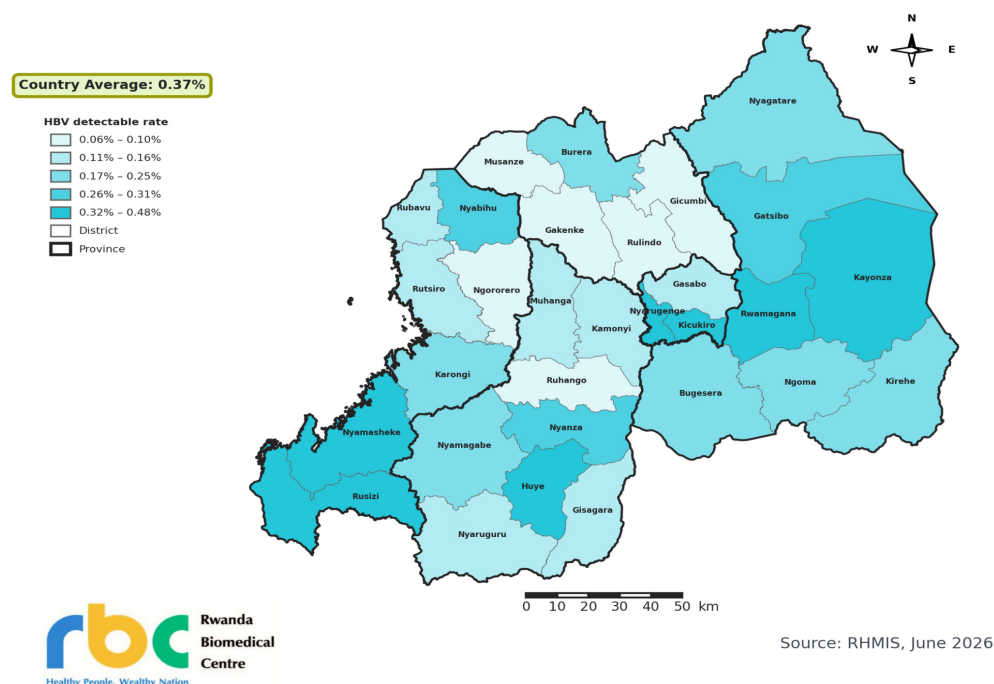


Figure 58: HBsAg positivity rate by District, July 2025 - June 2026

5.3.1.3. Hepatitis B vaccination

The national immunization program prioritizes universal infant vaccination against HBV, maintaining high coverage for the three-dose primary series. The hepatitis B vaccine was integrated into Rwanda's Expanded Programme on Immunization (EPI) in 2002. By 2025, national pentavalent third-dose coverage reached 98% (Rwanda DHS 2025). Following the introduction of the universal hepatitis B birth dose within 24 hours of birth in January of this year, the national average coverage from January to April 2026 is 93%. In addition to routine childhood immunization, targeted adult vaccinations have been administered to 609,216 individuals.

5.4. Management of Viral Hepatitis C

5.4.1. Hepatitis C awareness, testing and treatment

5.4.1.1. Hepatitis C cascade of care

Of 1,035,259 individuals screened for hepatitis C, 13,912 (1.34%) tested antibody positive. Confirmatory viral load testing identified 1,370 individuals with detectable HCV RNA (active infection). Of these, 1,304 were initiated on treatment, a coverage of 95.2% among confirmed cases. This reflects a strong, well-functioning cascade, especially given national guidelines recommend treating all individuals with a detectable viral load. Overall, the results demonstrate

high screening coverage, effective confirmation, and excellent treatment uptake, with a continued focus needed to ensure the remaining detectable cases are promptly treated.

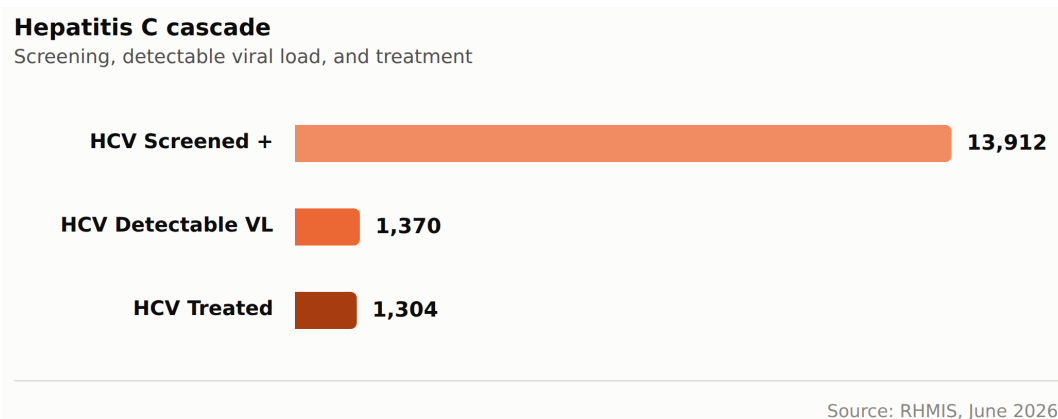


Figure 59: HCV cascade of care, July 2025 – June 2026

5.4.1.2. Hepatitis C infection across gender and age

Of 1,370 individuals with detectable hepatitis C, males accounted for 49.4% and females for 50.6%. Infection was concentrated in the working-age group (15–64 years), representing 65.7% of all detectable cases (34.3% male, 31.4% female). Adults aged 65 and above carried the next-largest share at 33.4% (14.2% male, 19.1% female), with a higher proportion of older females. Children under 15 years contributed less than 1% (0.9% male, 0.1% female). Overall, hepatitis C is predominantly borne by adults aged 15 and above, with a rising share among older women, supporting continued age- and sex-sensitive screening across the adult population.

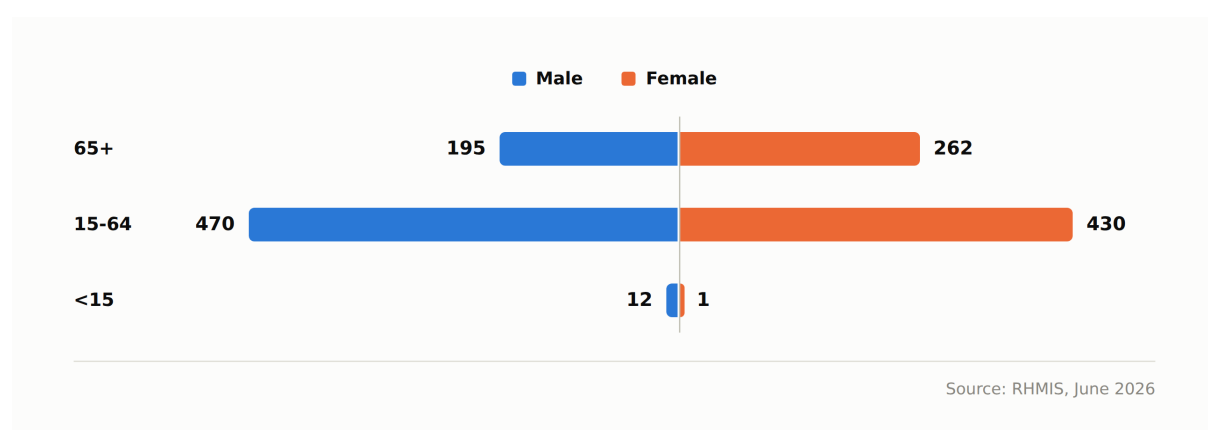


Figure 60: HCV viral load cases across gender and age bands

5.4.1.3. Hepatitis C positivity rate by District

Active hepatitis C infection averaged 0.13% nationally. Kicukiro, Kigali, had the highest burden (0.32%-0.48%). Moderately elevated districts (0.26%-0.31%) included Nyabihu, Gakenke, Muhanga, Karongi, Nyanza, Rwamagana, and Kirehe. Musanze, Burera, Gicumbi, Rulindo, Nyagatare, and Gatsibo reported the lowest rates (0.06%-0.16%). While cross-border transmission impacts some eastern and western districts, HCV distribution is primarily driven by urban and localized factors in the capital, such as population density, mobility, and testing access. Targeted micro-elimination efforts should focus on Kicukiro and moderate-burden districts, with continued monitoring of eastern and western border districts.

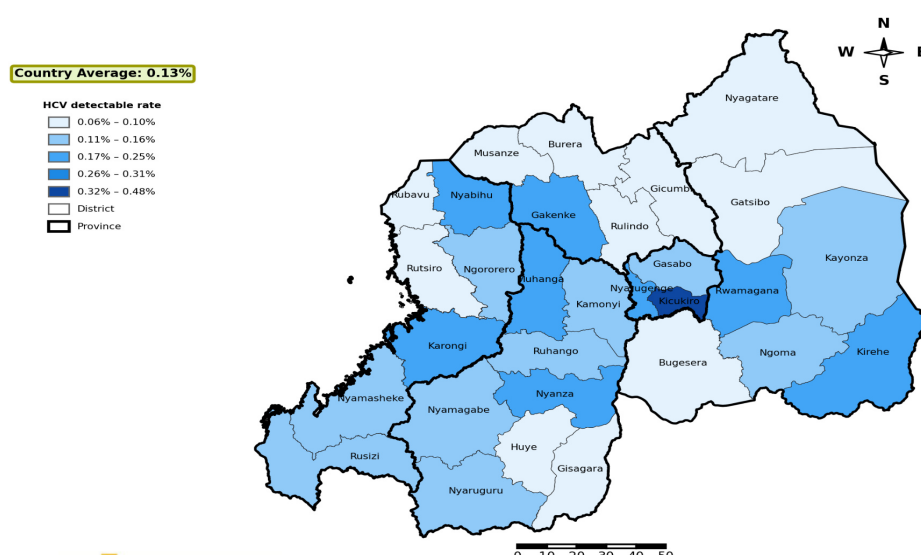


Figure 61: VL Positivity rate of HCV per district

5.4.1.4. Hepatitis C positivity rates by Province

Hepatitis C cascade outcomes varied by province. The Southern (351,073), Eastern (229,794), and Western (226,323) Provinces screened the most individuals; the City of Kigali (110,535) and the Northern Province (117,534) screened the fewest. This resulted in the highest numbers of screen-positive individuals in the South, West, and East, and the fewest in the North. Despite lower screening volumes, the City of Kigali had the highest viral load (VL) positivity rate (0.29%), more than double any other province. The Northern Province had the lowest (0.07%). Treatment numbers largely mirrored detectable viral load caseloads, occasionally exceeding them due to cross-catchment care or treatment of earlier-confirmed cases. Overall, the provincial cascade shows strong screening coverage and near-complete treatment linkage nationwide, with the burden concentrated in the City of Kigali, the South, and the West.

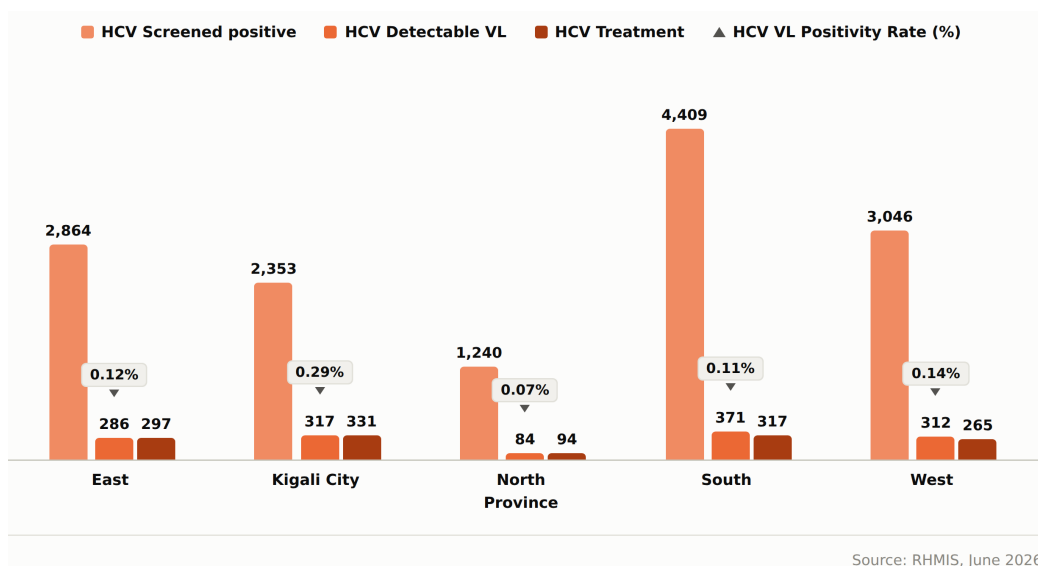


Figure 62: HCV positivity rate by Province, July 2025- June 2026

5.5. Viral hepatitis screening among high-risk populations

From 2024 to June 2026, 65,383 individuals in correctional facilities, rehabilitation centres, and refugee camps were screened for hepatitis C. HCV self-tests accelerated this high screening volume, with positive self-tests referred for confirmatory HCV rapid diagnostic testing (RDT). Of those who underwent RDT, 278 were positive (0.43% of all screened), and confirmatory viral load testing identified 75 with a detectable viral load (0.11% of all screened). Among this population, 27,861 individuals also underwent hepatitis B screening, of whom 455 tested HBsAg positive (1.63%). Of these, 268 had a detectable viral load (0.96% of those screened for HBV). Overall, active hepatitis B infection was proportionally more common than active hepatitis C in these high-risk settings, underscoring the value of sustained, integrated HBV and HCV screening supported by innovative approaches such as HCV self-testing among rehabilitation centres and refugee populations.

5.6. Progress towards Validation of Hepatitis C Elimination

Rwanda is ready for WHO validation of hepatitis C virus (HCV) elimination as a public health threat, aligning with WHO 2023 Guidance. The country meets most WHO programmatic targets for Gold-Tier certification, supported by a decentralized, primary care model that integrates free HCV screening, diagnosis, treatment, and follow-up into the national health system. Following the country level assessment by the National validation committee, Rwanda Ministry of Health submitted its dossier to the WHO Regional Office for the evaluation in July 2026.

Rwanda's status against the WHO path to elimination indicators is as follows:

Table 3: WHO gold-tier elimination requirements and Rwanda's status for viral hepatitis

SN	Indicator	WHO requirements (Gold-Tier)	Country's current status
1	Proportion of persons living with chronic hepatitis C infection who have been diagnosed	≥80%	86.5%
2	Proportion of people diagnosed with chronic hepatitis C infection who have been initiated on treatment	≥70%	96.4%
3	Proportion of blood units screened for blood-borne infections	100%	100%
4	Proportion of safe injections administered in health-care settings	100% of injections safe	99.9%
5	OAT coverage for PWID	OAT coverage for PWID >20%	National harm-reduction guidelines have been developed and implemented in 3 operational sites
6	Establishment of sentinel site		Four sites to monitor HCV related mortality were established

5.7. Management of Sexually Transmitted Infection

5.7.1. STIs awareness, testing and treatment

Rwanda strengthened STI awareness, testing, and treatment through integrated facility-based interventions. Continuous health education promoted early care-seeking and reduced STI stigma. Standardized syndromic screening ensured timely identification of suspected cases. Individuals with STI signs or symptoms were clinically assessed, confirmed, and promptly treated per national guidelines. Integrating STI services within HIV, HBV, and reproductive, maternal, and child health programs improved access to comprehensive prevention and care.

5.7.2. STIs screening and positivity rate by Province

Screening volumes varied: Western, Southern, and Northern provinces screened the most, while the City of Kigali screened the fewest. Positivity rates inversely correlated with screening volume. Eastern Province had the highest positivity (7.89%) despite moderate screening. Western (4.78%)

and Southern (4.51%) provinces, with the highest screening volumes, reported the lowest rates. The City of Kigali (5.15%) and Northern Province (5.22%) were in between. This disconnect underscores the need for targeted screening and prevention efforts in Eastern Province, where the proportion of positive tests is highest.

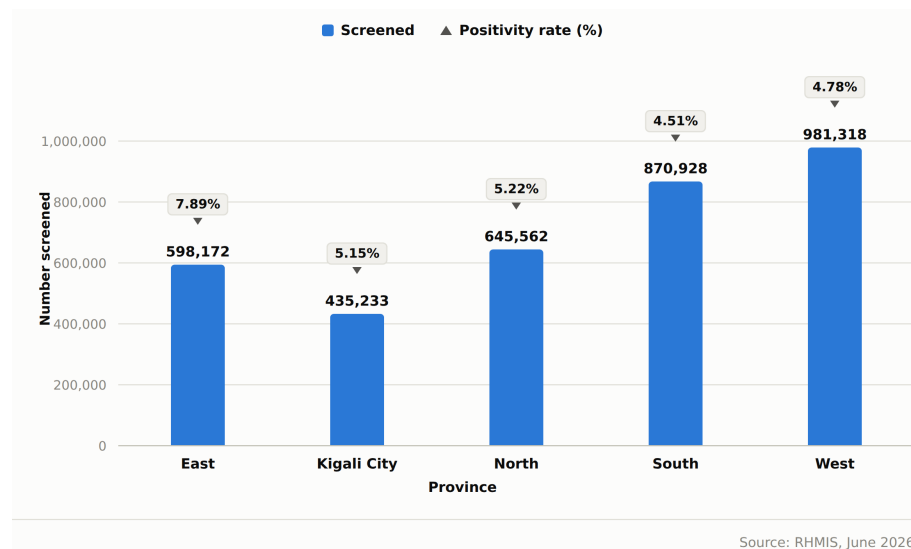


Figure 63: STIs screening and positivity rates by Province, July 2025 - June 2026

5.7.3. STIs positivity rate by age group and HIV co-infection.

Young adults drive STIs positivity and HIV co-infection rises with age. The graph below shows that youth (20-24 years) have the highest positivity rate of 7.1%, followed by the age group 25-49 years with a positivity of 6.4%. Highest HIV co-infection is among people with age of 65 and above. Prevention and testing outreach should target 20-24s, where positivity peaks. Integrated HIV testing matters most for older positives, where co-infection is highest.

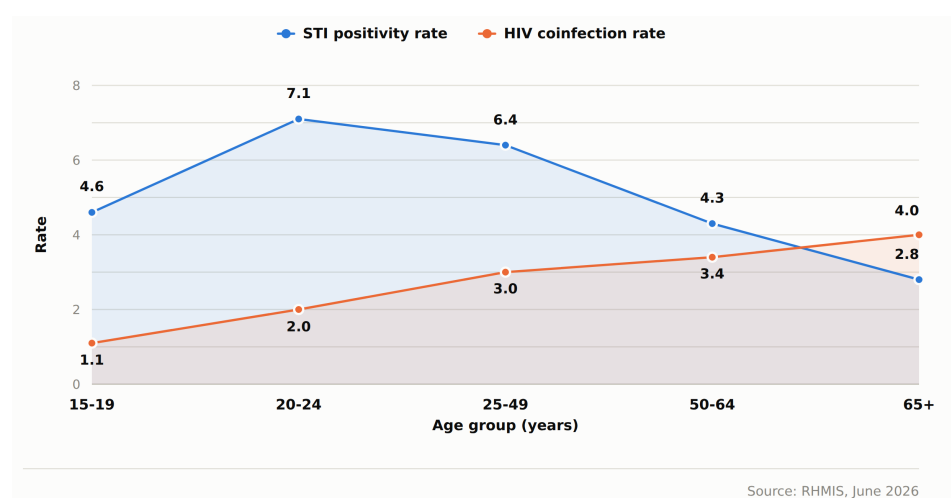


Figure 64: STIs positivity rates by age and HIV co-infection July 2025 - June 2026

5.7.4. STIs syndromic management

From July 2025 to June 2026, vaginal discharge was the most common syndromic management case (47.4%), followed by urethral discharge (24.2%). This highlights the need for increased interventions in partner management, especially given that the 2024-2025 annual report showed urethral discharge among men was higher than vaginal discharge.

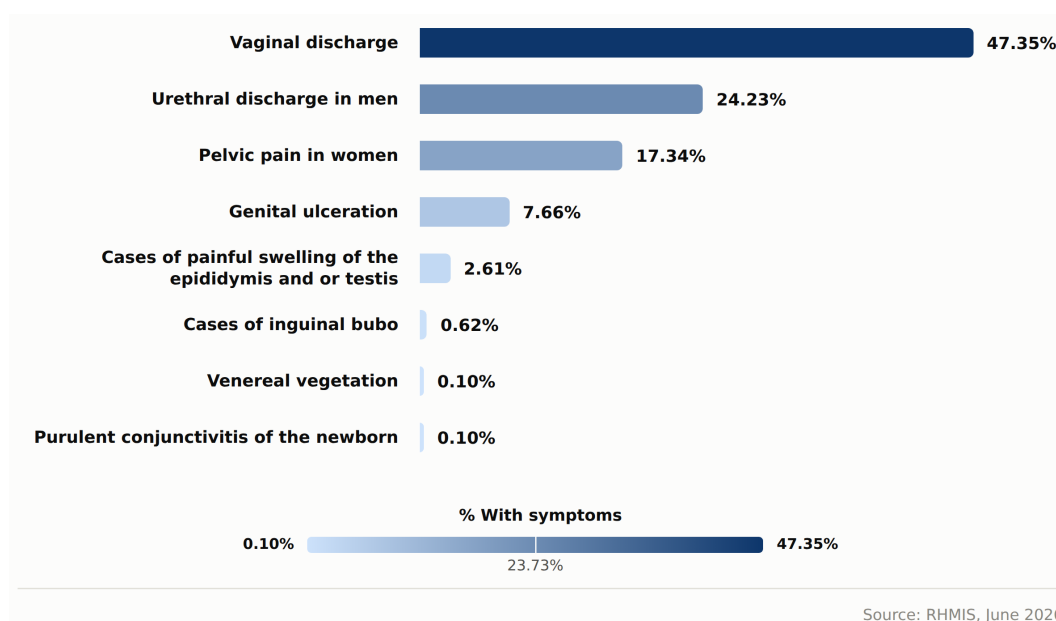


Figure 65: STI infection per syndromes

5.7.5. STIs cumulative cascade of care 2021-2026

Since 2021, many individuals have received counselling and STI screenings. Approximately 4 million people are screened annually, with confirmed cases receiving treatment. Between July 2025 and June 2026, 3,531,213 people were screened for STIs; of these, 189,409 (5.4%) were confirmed STI-positive and treated.

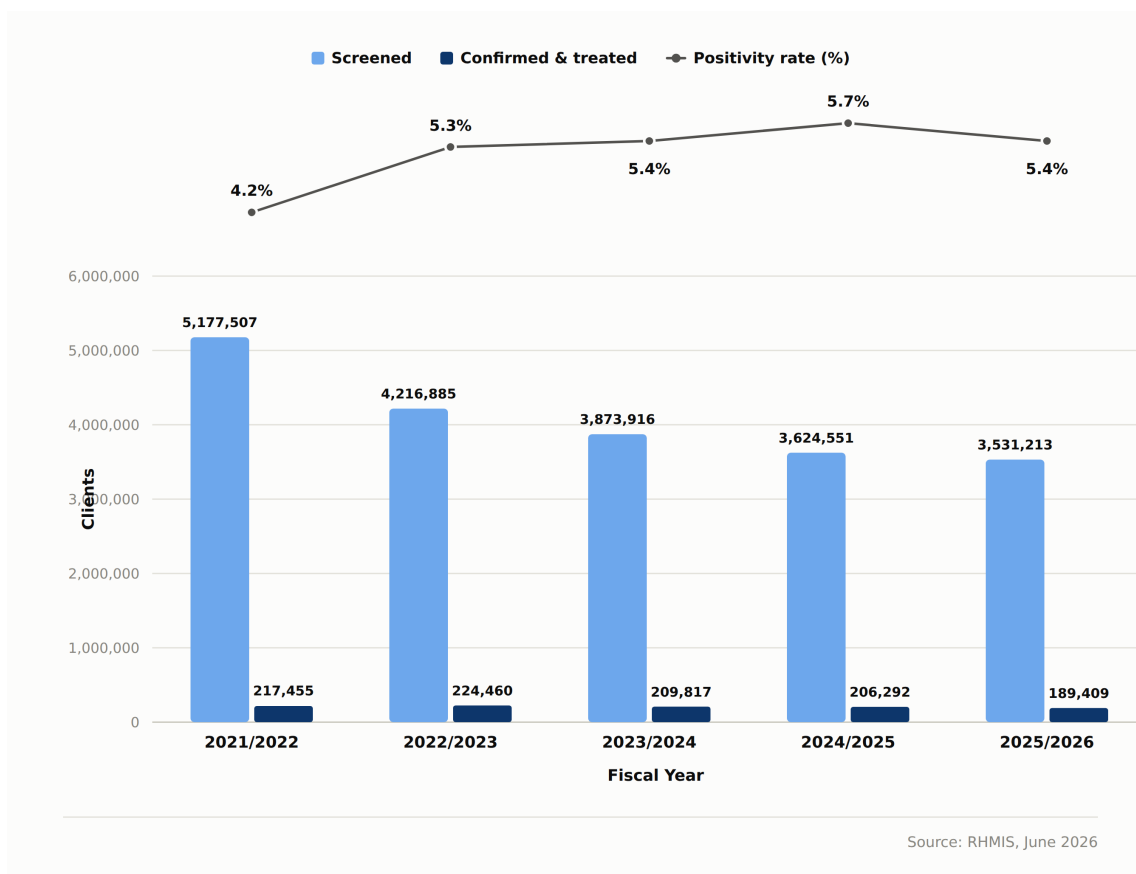


Figure 66: Individuals diagnosed and treated for STIs, 2021-2026

5.7.6. Monitoring and Evaluation of Viral hepatitis and STIs program

Rwanda has invested in a robust monitoring and evaluation system, utilizing the e-Buzima Health Management Information System (HMIS) and District Health Information Software 2 (DHIS2). These platforms digitalize viral hepatitis and STI services, enabling comprehensive tracking of program performance and progress toward elimination goals. Individual viral hepatitis patient data are tracked via DHIS2, while aggregated viral hepatitis and STI service indicators are reported through HMIS. This centralized national database informs evidence-based planning and continuous service improvement, with systems regularly updated for accurate data capture.

From July 2025 to June 2026, regular review meetings, supportive supervision, and mentorship visits were conducted with healthcare professionals including facility managers, hospital mentors, medical doctors, maternity heads, viral hepatitis nurses, data managers, and laboratory personnel. These activities aimed to verify data quality, strengthen data management, and address gaps in viral hepatitis and STI service delivery.

5.8. Key Challenges and Gaps

The principal remaining gap in implementing comprehensive package of harm reduction program for PWID, where opioid agonist therapy (OAT) coverage is still below the WHO threshold, as the program is at an early stage. Incidence and mortality related to Viral Hepatitis are also not yet fully measured through routine systems, though sentinel surveillance and Civil Registration of Vital Statistics-based monitoring are being established to address this.

Sustainable financing remains a cross-cutting gap for the entire program. The HIV, STI and viral hepatitis response continues to depend heavily on external funding, and recent changes in the global health financing landscape have exposed the program to funding volatility that could threaten the continuity of services. Strengthening domestic resource mobilization, integrating services into the broader health system, and securing predictable, multi-year financing will be essential to protect the gains achieved and to sustain epidemic control, disease elimination and prevention efforts across all program areas.

6. SECTION VI: STRATEGIC INFORMATION

6.1. Introduction

Strategic Information is a critical component of Rwanda's HIV response, providing the evidence needed to monitor program performance, guide decision-making and improve service delivery. Through strengthened health information systems, routine monitoring, surveillance and data use, Rwanda continues to generate and apply quality information to track progress toward national and global HIV targets.

6.2. Health information systems

Rwanda continued to strengthen the interoperability of its HIV information systems. The national Electronic Medical Record (e-Buzima) was established as a key source of patient-level clinical information, and the transition from paper-based to electronic systems is being progressively implemented to improve data capture, accessibility and reporting timeliness, reduce provider workload, and interface with other systems, including DHIS2, for routine HIV reporting.

6.3. Monitoring and evaluation systems

Rwanda continues to strengthen its HIV Monitoring and Evaluation (M&E) system to ensure timely, accurate and reliable data for program improvement and evidence-based decision-making. M&E activities are conducted at both facility and community levels capturing service delivery, patient outcomes, prevention interventions and community-based activities supported by electronic medical records and routine tools to track progress toward national and global targets.

6.4. HIV Data monitoring and reporting

Rwanda continues to strengthen HIV data monitoring and reporting to support routine tracking of program performance. HIV data are generated at the facility level through electronic platforms including the national EMR (e-Buzima), DHIS2 and laboratory systems and routine tools such as registers and files, then compiled, reviewed and reported into the Health Management Information System (HMIS) to monitor testing, linkage to care, ART, retention, viral load and treatment outcomes. Routine data review and feedback support timely

Following the 2022 revision of the national HIV guidelines, the HMIS was updated with new and revised indicators for HIV, STIs and viral hepatitis—covering Differentiated Service Delivery Models (DSDM), DTG optimization, AGYW programs, TPT, PrEP, viral load monitoring and HIV, syphilis and hepatitis B triple elimination—disaggregated by age and sex to support more targeted, data-driven decision-making.

A total of 601 health facilities submit monthly HMIS reports on 13 core national indicators, providing the foundation for routine monitoring and evaluation of HIV, STI and viral hepatitis programs at the national level.

HEALTH FACILITIES OFFERING ART SERVICES IN RWANDA

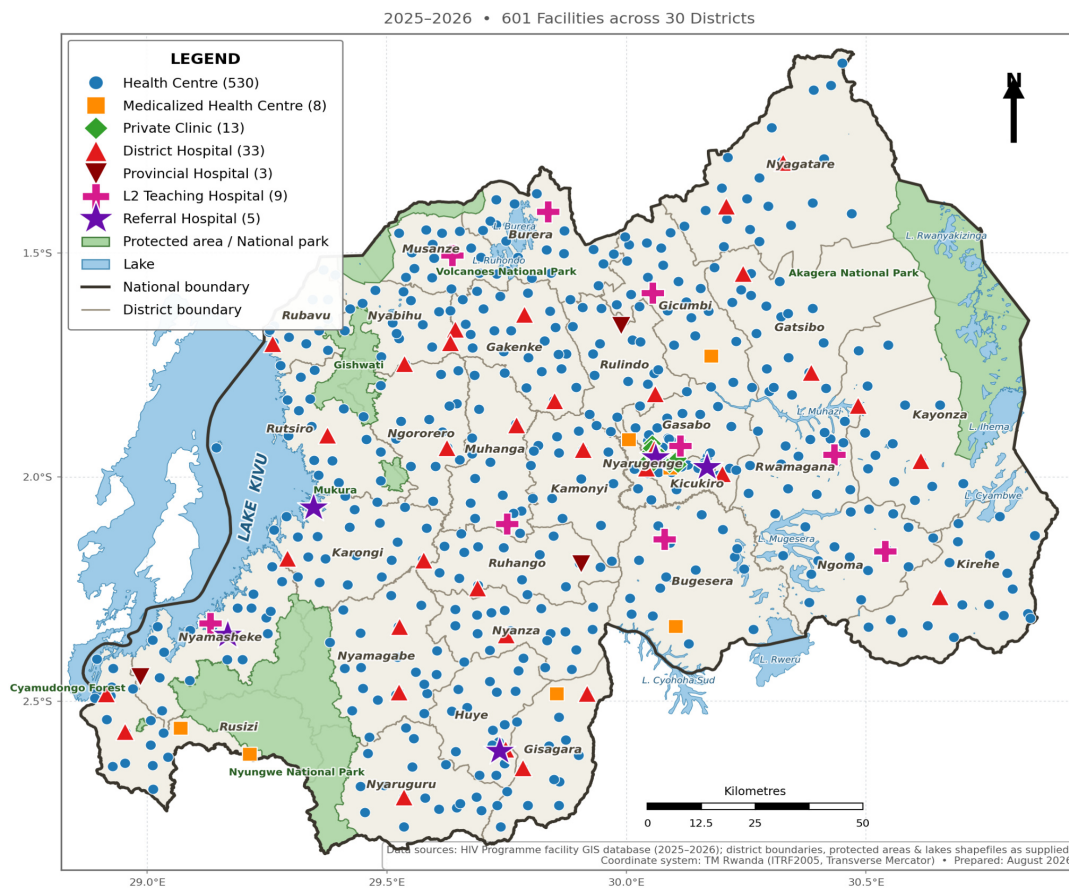


Figure 67: HF with ART services by June 2026

6.4.1. HIV data flow

HIV data are collected daily at health facilities using standardized registers and electronic systems. Each month, data managers distribute reporting forms that providers complete for entry into HMIS, with all data verified and finalized by the 5th of the following month.

From the 5th to the 8th, hospital data managers review the completeness and accuracy of facility reports and resolve discrepancies; from the 9th to the 11th, the central-level team conducts national review and provides feedback, and corrections are made before the reporting system closes on the 15th.

HIV Data Reporting Process

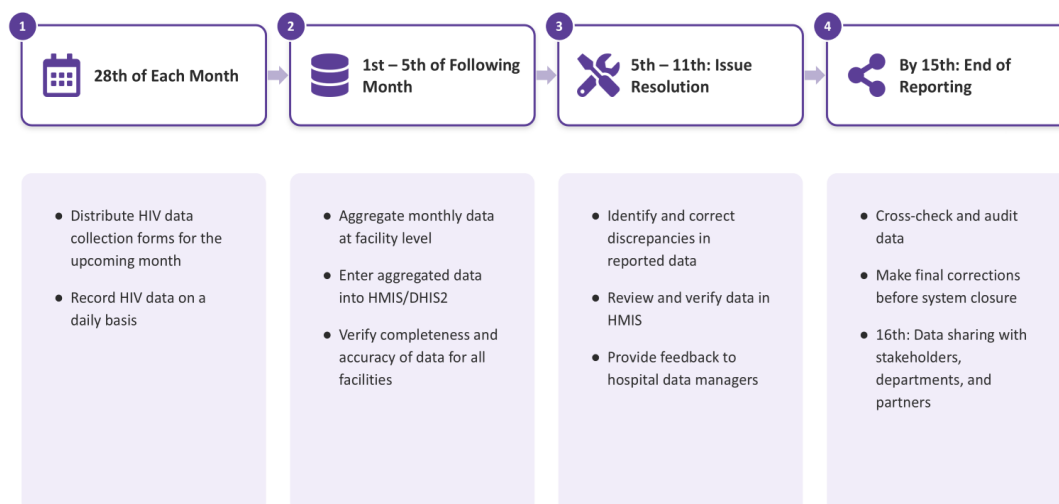


Figure 53: HIV data reporting process

Figure 68: HIV data reporting process

On the 16th, the central-level team finalizes and disseminates validated data to program units, stakeholders and partners. This well-defined process, with clear roles and timelines, ensures timely, high-quality data for evidence-based decision-making at all levels.

6.5. Supportive supervision and data auditing

RBC and partners, in collaboration with hospitals, conducted integrated supportive supervision and data quality audits in 410 public and private health facilities—involving hospital data managers and ART nurse mentors—to ensure data quality and use of standardized tools. RBC also conducted two online tele-mentorship trainings for 60% of hospital data managers on HIV indicators, data collection, reporting and auditing.

6.6. Coordination of HIV Partners in Response

Coordination of HIV partners ensures all stakeholders work within a unified national framework to improve efficiency, reduce duplication and enhance outcomes. The Ministry of Health, through the Rwanda Biomedical Centre (RBC), leads planning, implementation, monitoring and evaluation while aligning partners—government institutions, development partners, CSOs, faith-based and community organizations, the private sector and networks of people living with HIV. Through Technical Working Groups, joint planning, standardized reporting (HMIS and CBS) and the Rwanda Country Coordinating Mechanism (CCM-RW), partners strengthen collaboration, accountability, resource mobilization and evidence-based decision-making.

6.7. Surveys and research

Integrated Behavioural and Biological Surveillance Survey Among Female Sex Workers in Rwanda

The Rwanda Biomedical Centre (RBC), through the HIV, STIs, Viral Hepatitis and OBBI Division, conducted the seventh round of the Bio-Behavioural Survey (BBS) among female sex workers (FSWs) across Kigali City and the four provinces. The survey estimated the prevalence of HIV, STIs and hepatitis B and C, assessed behavioural risk factors,

evaluated service uptake and estimated the national FSW population size, using Respondent-Driven Sampling and biological testing between April and June 2025.

6.7.1. Key Findings

A total of 2,774 FSWs were enrolled, with most participants aged 20–34 years. Nearly all participants (97.1%) had ever tested for HIV, and 78.7% had been tested within the previous 12 months. Condom use at last sex with any client was 77.5%, while only 33.1% reported consistent condom use during the previous 30 days. Overall, 52.5% had heard of PrEP, 55.3% of those aware had ever used it, and 79.6% of PrEP users had taken it within the previous six months. Physical violence was reported by 27.7% of participants during their lifetime and 22.5% within the past 12 months, while 17.0% reported lifetime sexual violence. STI symptoms were common, but only 47.1% of those experiencing symptoms sought healthcare. The overall HIV prevalence was 25.8%.

6.8. E-Learning

During the reporting period, a series of eLearning workshops strengthened and expanded Rwanda's digital HIV training portfolio. Seven HIV e-learning courses were reviewed and validated; recording and deployment on the national e-learning platform are being finalized, alongside a plan for enrolling participants and increasing uptake. The courses include:

1. HIV Care and Treatment for Children and Adolescents
2. HIV Care and Treatment for Adults
3. Quality Improvement in HIV Health Care Services
4. Laboratory Information System (LIS)
5. HIV Case-Based Surveillance
6. HIV Testing Services
7. Minimum Package of HIV Services for Key Populations

7. SECTION VII: STRATEGIC PRIORITIES FOR THE NEXT YEAR AND BEYOND

7.1. Sustaining epidemic control and accelerating diseases elimination

Building on the gains of FY 2025–2026, the programme will sustain Rwanda’s HIV epidemic control while accelerating the triple elimination of HIV, syphilis and hepatitis B and the elimination of hepatitis C. Prevention will be sharpened toward those at greatest risk through expanded case finding: index testing, partner notification, family testing, social network strategies and screening of breastfeeding mothers, wider access to oral and long-acting PrEP and voluntary medical male circumcision, and universal antenatal screening with systematic follow-up of HIV-exposed infants.

7.2. Integrated service delivery, quality of care and commodity security

HIV, STI and viral hepatitis services will be integrated into primary health care to deliver more patient-centered and efficient care. Treatment outcomes will improve through long-acting injectable ART, stronger retention, viral load monitoring, pharmacovigilance, drug-resistance surveillance and differentiated service delivery, with particular attention to children and adolescents, underpinned by continuous quality improvement, clinical mentorship, expanded laboratory capacity and supply chains that keep medicines, diagnostics and prevention commodities available at every service point.

7.3. Community systems and workforce capacity

Communities will remain central to the response, with peer educators, community-led monitoring, youth ambassadors and civil society organizations driving prevention, adherence, stigma reduction and accountability. Workforce constraints will be addressed through continuous professional development, mentorship, supportive supervision, competency-based training and retention strategies for clinicians, laboratory personnel and data managers.

7.4. Strategic information, research and digital health

Strategic information systems will be strengthened to improve data quality, interoperability, routine surveillance, electronic medical records, laboratory information systems and digital dashboards for timely reporting and evidence-based decision-making. Operational research,

epidemiological surveillance, geospatial analysis and artificial intelligence applications will generate evidence to inform policy, programme improvement and resource allocation.

7.5. Sustainable financing, coordination and equity

Sustainability and equity underpin all of these priorities. Domestic resource mobilization, more efficient use of resources, stronger financial accountability and strategic partnerships will secure long-term financing; multisectoral coordination across government, partners, civil society, academia, the private sector and communities will align planning and accountability; and resources will be directed to the districts and population groups carrying the highest burden.

These priorities will guide implementation during FY 2026-2027 and beyond and support Rwanda's continued progress toward ending AIDS as a public health threat by 2030, and strengthening resilient, integrated, and people-centered health systems.

8. ANNEXES

8.1. FINANCING HIV RESPONSE: FISCAL YEAR 2025-2026

8.1.1. Introduction

Financing the national HIV response is a subset of the Health Sector Financing strategy. The aim remains to improve the access of the population to health services, including HIV services. HIV programs continue to benefit funds from government and development partners and technical support. The major funding sources for the Rwanda HIV programs are:

- Government resources, which includes revenues generated from taxes and non-taxes, loans, grants, donations - reported as Government contribution/ budget allocation and part is allocated as earmarked transfers.
- Development partner contributions through sector budget and project support. On the budget, the donor funds are indicated in the development budget. These include the Global Fund for HIV & AIDS, TB and Malaria, USG and contributions from One UN.
- Health insurance pooled funds (Mutuelle de Santé or Community based health insurance) from household expenditures. This is not captured in this report.
- Health related household expenditures are not yet captured in this report.
- Private funds are also not captured in this report.
- Income generated from health facilities services are not captured in this report.

The data collection for the contribution of these sources is conducted on an annual basis. Therefore, the report is focused on funding sources where data were available as at the time of reporting as explained above.

8.1.2. Public and External Sources of funding for HIV/AIDS National Strategic Plan

The Ministry of Health and the Rwanda Biomedical Centre in collaboration with its partners worked on the financial data reported in HIV/AIDS annual report 2025-2026. To facilitate the collection of financial information for this year's report, a separate data collection process was adopted using SMART FMIS (Integrated Financial Management Information System) for Global Fund grants and Government contribution; and directly from the in-country office for USG contribution.

8.1.3. HIV/AIDS Expenditures in Rwanda FY 2025-2026 by Sources of Financing

The Global Fund for AIDS, TB and Malaria (GFATM) contributed the budget of USD 51,399,135 for the FY 2025-2026; the United States Government (USG) contribution for the FY 2025-2026, is USD 25,518,868. The Government of Rwanda contributed the budget of USD 22,106,224. Hence, the total contributions to the National Strategic Plan for the FY 2025-2026 were USD 99,024,227

Table 4: Global Fund contribution to the National Strategic Plan, FY 2025-2026

Source of funding for NSP/HIV	Initial approved budget for FY 2025-2026 in USD	Revised Budget FY 2025-2026 in USD	Actual Expenditures FY 2025-2026 in USD	Variance in USD 30 June 2026	Budget performance rate in %
Global Fund for AIDS, TB, and Malaria	42,059,957	53,356,489	48,652,412	4,704,077	91%
USG	25,518,868	25,518,868	23,322,226	2,196,642	91%
GoR	20,985,345	22,106,224	22,476,673	-370,449	102%
Grand Total	88,564,170	100,981,581	94,451,311	6,530,270	94%

The total revised budget of Global Fund contribution of USD 53,356,489 is composed by USD 30,757,300 revised budget for RBF HIV regular grant; USD 9,339,177 opening balances related to C19RM activities plus USD 9,610,012 C19RM approved budget for Financial 2025-2026; USD 3,100,000 for Climate budget and USD 550,000 for PFM strengthening.

Regarding expenditures in connection to the FY 2025-2026, the Global Fund for AIDS, TB and Malaria (GFATM) spent USD 48,652,412; the United States Government spent USD 23,322,226; the Government of Rwanda spent USD 22,476,673.

The overall total expenditure for HIV NSP was USD 94,451,311 which represents 94% of the allocated budget of USD 100,981,581.

8.1.4. Government contribution to HIV/AIDS National Strategic Plan FY 2025-2026

The GoR funds are allocated to different health programs during the annual planning and budgeting process, which entails sectoral consultations to discuss prioritization and budget allocation between the Ministry/ RBC and decentralized levels based on HSSP V implementation and different disease program strategic plans serve as guiding documents. The planning phase also uses the disease burden and services utilization data from HMIS to inform an effective resource allocation. The expenditure was then extracted and analyzed based on the disease burden.

Table 5: GoR contribution to the NSP per MTEF chapter, FY 2025-2026

MTEF chap	Approved budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures for FY 2025-2026 in USD	Balance in USD	Performance in %
21 Compensation of employees	12,669,904	12,889,932	12,641,602	248,331	98%
22 Use of goods and services	3,140,877	3,663,431	4,708,173	-1,044,742	129%
25 Subsidies	335,524	489,859	541,839	-51,980	111%
26 Grants	834,946	1,058,071	1,026,708	31,363	97%
27 Social assistance	1,015,976	1,012,014	935,570	76,444	92%
28 Other expenditures	209,387	166,818	145,013	21,805	87%
33 Inventory	58,361	79,366	79,366	0	100%
36 Building and Structures	568,241	791,402	258,477	532,924	33%
37 Machinery and Equipment	2,152,131	1,955,332	2,139,925	-184,593	109%
Total	20,985,345	22,106,224	22,476,673	-370,449	102%

From the above table, the revised budget for the financial year 2025 -2026 of USD 22,106,224 a total of USD 22,476,673 has been effectively spent by different budget entities with 102% of budget execution rate.

The medium-term expenditure framework (MTEF) chapter with the highest budget execution was Compensation of employees with USD 12,641,602 followed by Use of goods and services with 4,708,173 followed by Machinery and equipment with USD 2,139,925

As reflected in the table below, the budget is USD 22,106,224 whereas the expenditure is USD 22,476,673. The type of budget agencies with the highest budget ceiling is Districts hospitals with USD 9,335,935; RBC with USD 5,160,443 and Ministry of Health with USD 3,859,695.

Table 6: GoR contribution to the NSP per budget agency, FY 2025-2026

Budget Agency	Budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures in USD	Balance in USD	Performance rate in %
CHUB	722,253	777,742	777,742	0	100%
CHUK	1,016,875	1,248,722	1,248,722	0	100%
Districts	9,769,374	9,335,955	8,949,254	386,701	96%
HNN	230,095	372,374	453,445	-81,071	122%
MINISANTE	3,482,830	3,859,695	4,252,360	-392,664	110%
RBC	4,497,273	5,160,443	5,426,337	-265,894	105%
RMH	782,161	902,219	902,219	0	100%
RWANDA FDA	484,485	449,073	466,594	-17,521	104%
Total	20,985,345	22,106,224	22,476,673	-370,449	102%

8.1.5. The Global Fund contribution

For the Global Fund contribution, the total approved budget C19RM, Climate and PFM budget inclusive is USD 53,356,489 for the financial year 2025-2026. During this financial year, the expenditure was USD 48,652,412. Hence, the total budget execution rate for the FY 2025-2026 was 91%. This total variance of USD 4,704,077 representing 9% will be used during the coming fiscal year 2026-2027 to pay invoices related to Warehouse renovation, invoices of climate activities and final invoice for PFM management.

Table 7: Global Fund budget execution per MTEF chapter, FY 2025-2026

MTEF Chapter	Approved budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures for FY 2025-2026 in USD	Variance 30 June 2026	Performance rate in %
22 Use of goods and services	19,935,333	23,333,200	23,333,200	0	100%
26 Grants	5,080,389	4,547,444	4,547,444	0	100%
27 Social assistance	363,311	61,180	61,180	0	100%
28 Other expenditures	3,420,913	2,815,476	2,815,476	0	100%
Total	28,799,946	30,757,300	30,757,300	0	100%

From the above table, out of the revised budget regular grant of USD 30,757,300 totally has been effectively spent by different budget entities and this represents 100% of budget execution rate.

Table 8: Global Fund budget execution per budget agency, FY 2025-2026

Budget Agency	Approved budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures for FY 2025-2026 in USD	Variance 30 June 2026 in USD	Performance rate in %
CHUB	31,323	31,938	31,938	0	100%
CHUK	60,128	61,307	61,307	0	100%
MOH	1,290,537	1,490,917	1,490,917	0	100%
MINIYOUTH	258,841	244,405	244,405	0	100%
NCDA	88,990	139,536	139,536	0	100%
RNP	30,260	30,260	30,260	0	100%
RBC	26,986,652	28,704,681	28,704,681	0	100%
RCS	23,535	23,996	23,996	0	100%
RMH	29,678	30,260	30,260	0	100%
Total	28,799,944	30,757,300	30,757,300	0	100%

The type of budget entity with the highest budget ceiling is RBC with USD 28,7 millions, MOH with USD 1,4 million as indicated by the table below:

Table 9: C19 RM expenditures per MTEF chapter, FY 2025-2026

MTEF Chapter		Approved budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures for FY 2025-2026 in USD	Variance in USD	Performance rate in %	Comments
22 Use of goods and services	-	3,155,528	3,155,528.41	1,229,884	1,925,645	39%	This variance was reallocated to cover a gap
28 Other expenditures	1,056,906	1,460,990	2,517,896.13	2,981,985	-464,089	118%	Overspend was covered by internal reallocation
36 Building and Structures	1,194,500	4,993,494	6,187,993.78	4,614,243	1,573,751	75%	This variance will be used after finishing of warehouse renovation

37 Machinery and Equipment	7,087,772	0	7,087,772.00	8,731,006	-1,643,234	123%	This gap was covered by internal reallocation
Total	9,339,177	9,610,012	18,949,190	17,557,117	1,392,073	93%	

For the C19RM grant budget, out of the approved budget worth USD 18,949,190 the total of USD 17,557,117 has been effectively spent which represents 93% of budget execution. The remaining balance of USD 1,392,073; representing 7% of total budget will be spent for warehouse renovation before 31st October 2026. The remaining climate budget and IFMIS management will be spent according to timeline planned.

8.1.6. The USG/USG contribution

From 1st July 2025 to 30th June 2026, the US Government contribution was USD 25,518,868; to the National HIV response in Rwanda and this budget was spent with USD 23,322,226 represents 91%.

Conclusion

The overall HIV Program budget execution for Fiscal year 2025-2026 is at 94%.

8.2. KEY PERFORMANCE INDICATORS

Table 10: Key performance indicators

Indicators	Data Source	Results	NSP Targets		
		2025-2026	2024-2025	2025-2026	2026-2027
HIV Prevalence (15 -49)	DHS 2025	2.20%	2.50%	2.50%	
HIV Incidence	RPHIA,2019	0.08%			0.068%
HIV Prevalence among female sex workers	IBBS	25.80%			32%
HIV prevalence among Men having sex with Men	IBBS	5.80%			5%
Number HIV tests conducted	HMIS	1,795,856		NA	NA
HIV sero-positivity rate (Overall)	HMIS	12,839/1,795,856 (0.71 %)	NA	NA	NA
1. VCT/PIT	HMIS	7,560/753 (1%)	0.70%	0.70%	0.70%

2.HIV seropositivity among women in ANC	HMIS	1,151/345,634 (0.33 %)	0.30%	0.30%	0.30%
3. HIV seropositivity among male partners in ANC	HMIS	471/214,133 (0.22 %)	NA	NA	NA
4. HIV seropositivity in VMMC	HMIS	372/71,438 (0.52%)	NA	NA	NA
5. HIV seropositivity in Maternity	HMIS	268 / 328,232 (0.08 %)	NA	NA	NA
6. HIV seropositivity in Index testing services	HMIS	3,017/82,744 (3.65 %)	4%	4%	4%
Pregnant women who received ART to reduce mother to child transmission	HMIS	98.00%	>98%	>98%	>98%
Percentage of exposed infants who are HIV-free by 24 months	HMIS	99.70%	>99%	>99%	>99%
Number of medical male circumcision performed according to national standards.	HMIS	296,517	374,885	412,373	453,610
Surgical circumcision	HMIS	289,623	NA	NA	NA
Medical Device circumcision	HMIS	6,894	NA	NA	NA
Prevalence of male circumcision (Proportion of males circumcised among male population)	DHIS 2025	72%	60%	60%	60%
Number of female sex workers followed at health facility	HMIS	37,842	NA	NA	NA
Number of HIV negative female sex workers on PrEP	HMIS	13,421	NA	NA	NA
Percent of adults and children retained on treatment 12 months after ART initiation	HMIS	93.8%	95%	95%	95%
Percent of adults and children currently receiving ART (ART coverage)	HMIS	98.4%	95%	95%	95%
Percent of people living with HIV and on ART, who have a suppressed viral load (<1000 copies/ml)	HMIS	95.8%	97%	97%	> 97%

Number of new clients initiating ART	HMIS	10,568	NA	NA	NA
Number of condoms distributed	HMIS	24,223,159	NA	NA	NA
Number of People screened for HCV	HMIS	1,035,259	NA	NA	NA
Number of people with HCV RNA positive	HMIS	1,370	NA	NA	NA
Number of people-initiated HCV treatment	HMIS	1,370	NA	NA	NA
Number of People screened for HBV	HMIS	893,278	NA	NA	NA
Number of people screened for HBV positive	HMIS	9,579	NA	NA	NA
Number of people screened for STIs	HMIS	3,532,213	NA	NA	NA
Number of people confirmed with at least one STI.	HMIS	219,856	NA	NA	NA

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