HIV-AIDS in Rwanda

2008 Epidemic Update

This study was conceived by A. Binagwaho1, M. Kramer2, A. Asiimwe2, L. Munyakazi3, A. Rwakunda1, J. Mugabo2, E. Munyana2, A. Kabeja2, N. Umutoni3, E. Pegurri3, F. Sobela6, and E. Gaillard7. All contributed to the analysis of the data.

1CNLS, 2TRAC Plus, 3NIS, 4MOH, 5UNAIDS, 6WHO, 7USAID | Health Policy Initiative

HIV and AIDS estimates and projections

Methodology

The HIV and AIDS epidemiological estimates of January 2008 as were those of 2005 were made with the «Estimation and Projection Package» (EPP) and «Spectrum» models, which are a suite of mathematical models used for making national HIV estimates and projections. Information on the models can be found on the UNAIDS and the USAID | Health Policy Initiative websites.

Demographic data: The 1978 census data (population size by age group) were used as a baseline. Known demographic indicators, such as total fertility rates and life expectancy at birth, were used to project the population to 2012. These projections were subsequently calibrated to the 2002 census data to account for the effect of the war.

Epidemiology: HIV prevalence data come from sentinel surveillance studies. The first three rounds of surveillance were conducted in 1988, 1991, and 1996. For this period, the median HIV prevalence was 25.7% in Kigali, 9.9% in other urban sites, and 2.6% in rural sites. In 2002, the surveillance system was reinforced and more sites were added. In urban sites, the median of HIV prevalence went from 6.9% in 2002, to 6.3% in 2003, and 5.4% in 2005. In rural sites, the median went from 3.0% in 2002, to 2.8% in 2003, and 2.1% in 2005. The median prevalence at urban and rural sites was subsequently calibrated with the DHS prevalence data points for the general population in 2005 (Figure 1) which were 7.3% in urban areas, 2.2% in rural areas, and 3.0% at the national level.

The curves were created in EPP with the median prevalence because some data points appeared to be extraneous outliers. In addition,
uncertainty analysis on urban and rural prevalence data were modeled (Figure 2) to provide a range of results.

**Programs:** Historical data from PMTCT (number of HIV+ pregnant women by treatment regimen, and infant feeding methods), care and treatment programs (number of adults and children receiving ART), and target coverage for 2012 (Universal Access) were introduced into Spectrum to obtain the estimates presented in this report.

**HIV Estimates**

Total population is expected to increase from 9.5 million in 2007 to 11.3 million in 2012. For the next 5 years, the EPP model predicts a decrease of HIV prevalence from 2.7% [2.3%-3.1%] in 2008 to 2.3% [1.8%-2.9%] in 2012 (Figure 1 and Table 1).

The number of adults (15+ years) living with HIV would increase from 131,962 [113,803-151,521] in 2008 (of which 77,478 are women) to 134,959 [105,116-165,297] in 2012 (Table 1).


As shown in Table 2, the number of children (0-14) living with HIV would decrease from 17,212 [15,258-19,262] in 2008 to 11,376 [9,429-13,670] in 2012. The number of new infections among children (0-14) would decrease from 599 [380-838] in 2008 to 189 [41-380] in 2012.

**Key Results and Targets**

**Mother to Child Transmission (MTCT)**

In 2006, there were an estimated 430,000 pregnancies. Out of the total number of pregnant women who sought antenatal care, 93.9% were tested for HIV and received the results, and 55% of all facilities offered integrated MTCT prevention services (PMTCT). As a consequence of the scale up in services, the number of pregnant women agreeing to be tested for HIV increased from 11,478 in 1999-2001 to 219,507 for 2006 alone.

According to the model, the number of HIV+ pregnant women in 2007 was 12,685. Since 15% (global data) of pregnancies do not reach their term, only 10,782 needed PMTCT. Out of these, 55% (5,945) received a prophylaxis regimen through September 2007. Based on a target coverage of 95% for 2012, 9,477 out of 9,976 HIV+ would receive prophylaxis regimen.

These estimates are based on additional targets such as treatment regimens and infant feeding methods.

In 2012, the majority (56%) of HIV+ pregnant women would be under dual prevention, 28% under triple prevention and 11% under the nevirapine regimen. Infant feeding methods for HIV+ mothers would remain at 83% for mixed feeding, 12% for replacement feeding, and 5% for exclusive breastfeeding.

**Care and Treatment**

Through September 2007, out of the total need for ART (61,545) among adults (15+), more than 43,000 received treatment (70%) (Figure 3); out of these 64% were women. Based on a target coverage of 90%, the number needing ART would increase to 79,899 in 2012.

For children (0-14), out of a total need for ART of 6,489 more than 4,000 received treatment (62%) through September 2007 (Figure 3). Based on a target coverage of 95%, this number would increase to 5,605 in 2012.

**Future Validation of Estimates**

The estimates presented here are based on the best and most recent epidemiological and demographic data available for Rwanda. Every precaution was taken to ensure that the epidemic curve had the most probable fit for Rwanda and reflected observations from the field. Nevertheless, coverage figures inferred from the model for PMTCT and ART could be overestimated when compared to coverage expected from field observations. Thus, for programming purposes, the CNLS has advised national institutions, in the absence of better evidenced-based data, to proceed with previous scale-up targets for 2008 to avoid a shortage of commodities, and to conduct field studies before the end of 2008 to validate the results presented here.

For example, the projected (2005-2012) downward tendency of the prevalence curve (Figures 1 and 2), appears to be in contrast with the increasing number of adults under treatment and the difficulties in getting sustained results from behavioral change interventions (low condom use, fidelity to partners) and from time embedded in implementing a scaled-up circumcision program. As studies from other countries have shown, increased ART coverage could lead to a decrease in adherence to prevention measures. Evidence-based studies from the field will provide critical elements to validate the results of the EPP and Spectrum modeling.

**Figure 3: Care and treatment among adults and children in 2007**
### Table 1: Key HIV and AIDS indicators among adults

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1Information on the models can be found on the UNAIDS and the USAID | Health Policy Initiative websites
http://www.healthpolicyinitiative.com/index.cfm?id=software&get=Spectrum
### Table 2: Key HIV and AIDS indicators among children

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<tr>
<td>Lower (.2.5%)</td>
<td>7,480</td>
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<td>6,801</td>
<td>6,326</td>
<td>5,990</td>
<td>5,779</td>
<td>5,719</td>
<td>5,526</td>
<td>5,266</td>
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<tr>
<td>Median (50.0%)</td>
<td>8,453</td>
<td>8,096</td>
<td>7,677</td>
<td>7,133</td>
<td>6,736</td>
<td>6,489</td>
<td>6,379</td>
<td>6,285</td>
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<td>5,605</td>
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<td>7,939</td>
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<td>6,977</td>
<td>7,083</td>
<td>7,059</td>
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<td>6,781</td>
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<td><strong>Children receiving ART</strong></td>
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<tr>
<td>Actual</td>
<td>468</td>
<td>1,443</td>
<td>2,757</td>
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<tr>
<td>Target</td>
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<td></td>
<td>4,784</td>
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<td>5,188</td>
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<td><strong>Annual AIDS deaths - Children</strong></td>
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<tr>
<td>Lower (.2.5%)</td>
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<td>2,981</td>
<td>2,610</td>
<td>1,993</td>
<td>1,362</td>
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<td>616</td>
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<td>345</td>
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<td>2,310</td>
<td>1,662</td>
<td>1,139</td>
<td>840</td>
<td>712</td>
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<td>3,432</td>
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<td>9,543</td>
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<td>10,782</td>
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<td>10,353</td>
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<td>13,230</td>
<td>12,891</td>
<td>12,583</td>
<td>12,619</td>
<td>12,635</td>
<td>12,562</td>
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<td>12,495</td>
<td>12,596</td>
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<tr>
<td>Actual</td>
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<td>6,611</td>
<td>5,945</td>
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<tr>
<td>Target</td>
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<td>7,602</td>
<td>8,024</td>
<td>8,478</td>
<td>8,969</td>
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<tr>
<td>Lower (.2.5%)</td>
<td>189,245</td>
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<td>194,472</td>
<td>188,277</td>
<td>174,692</td>
<td>157,704</td>
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<td>Median (50.0%)</td>
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<td>227,110</td>
<td>225,663</td>
<td>228,906</td>
<td>224,288</td>
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<td>186,565</td>
<td>170,044</td>
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<td>268,805</td>
<td>264,620</td>
<td>266,263</td>
<td>259,623</td>
<td>249,506</td>
<td>233,722</td>
<td>217,152</td>
<td>203,171</td>
<td>191,200</td>
<td>180,731</td>
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This report was made possible by the generous support of the American people through USAID and PEPFAR, with technical support from: USAID | Health Policy Initiative, Task Order 1 under Contract No. GPO-1-01-05-00040-00

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