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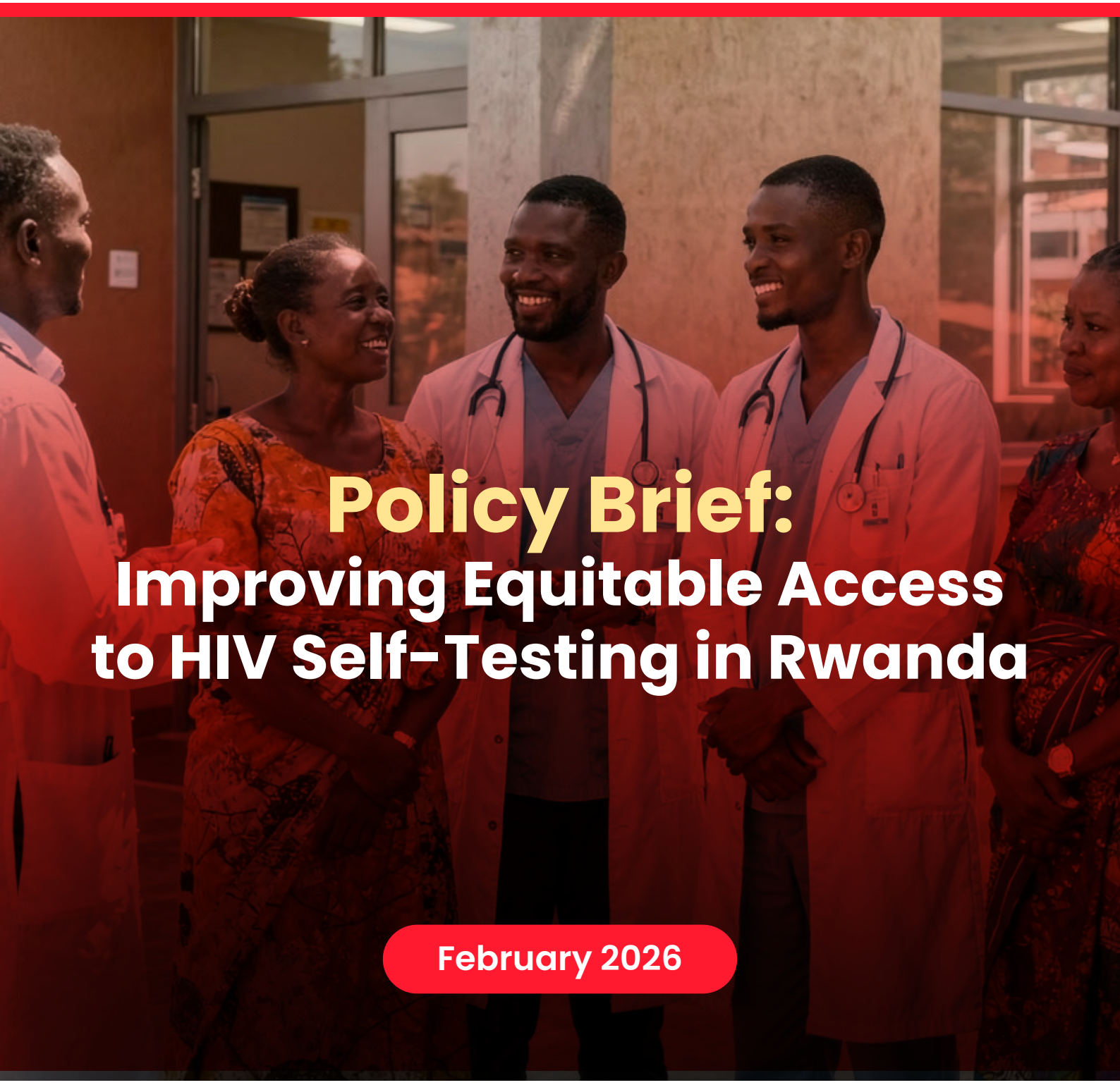


Policy Brief:
Improving Equitable Access to HIV Self-Testing in Rwanda

February 2026

EXECUTIVE SUMMARY

HIV self-testing (HIVST) is an important tool to reach populations who avoid conventional facility testing due to stigma, confidentiality concerns, distance, and service inconvenience. In Rwanda, HIV incidence has stabilized, but transmission remains concentrated among key populations, especially men who have sex with men, female sex workers, and adolescent girls and young women. Persistent gaps in early diagnosis affect progress toward national 95-95-95 targets.

This assessment has shown that HIVST is widely accepted but not equitably accessed. Approximately 76% of health facilities had kits available, with full availability in hospitals but a lower availability in pharmacies and some districts. However, only about 55.6% of individuals aware of HIVST reported that kits were easy to obtain. Limited awareness in rural settings and cost barriers in private outlets remain major barriers.

Acceptance is high across all groups. Over 90% of respondents would recommend HIVST, and most trust the results. Comfort is highest among MSM and lower among adolescent girls and young women, who also have the lowest awareness levels. This is an indication that Rwanda does not face a demand problem but an equity and delivery problem.

To accelerate progress toward the national 95-95-95 targets, Rwanda should shift from facilitycentered distribution to targeted access. Priority actions include expanding peer-led and community distribution for key populations, subsidizing private-sector access, integrating HIVST into youth and reproductive health services, strengthening national awareness campaigns, and ensuring linkage to confirmatory testing and care.

Why Does Rwanda Still Have a Testing Gap?

Rwanda has made strong progress in HIV control, with stabilized incidence and continued advancement toward national 95-95-95 targets. However, HIV transmission remains concentrated among key and vulnerable populations, particularly men who have sex with men, female sex workers, and adolescent girls and young women. Higher positivity rate patterns in Kigali and the Eastern Province show that infections persist in specific geographic and social networks rather than the general population.

Current HIV testing approaches rely heavily on facility-based services. While these services are widely available, they do not adequately reach populations facing stigma, confidentiality concerns, or mobility barriers. Many individuals avoid health facilities due to fear of disclosure or discrimination, and younger women often lack youth-friendly entry points into testing services. As a result, people most at risk remain the least likely to test early.

The Structural Gap in Testing Access

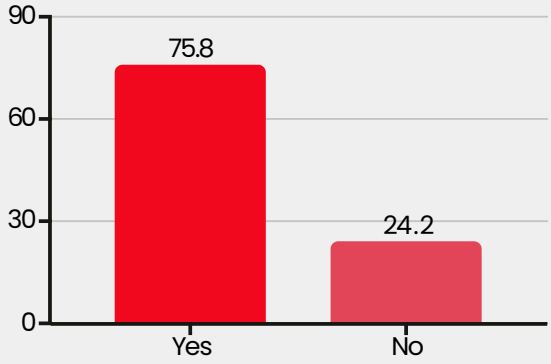
HIV self-testing was introduced to address these barriers, yet distribution remains largely linked to formal health channels. The assessment shows that availability does not translate into access. Kits may be available in facilities, but populations disconnected from the health system do not receive them. This creates a structural gap: the testing system primarily serves individuals already engaged in care, while missing hidden populations that drive transmission.

The remaining testing gap in Rwanda is therefore not due to insufficient services but to a mismatch between delivery platforms and population realities. Closing it requires shifting from facility reach to population reach.

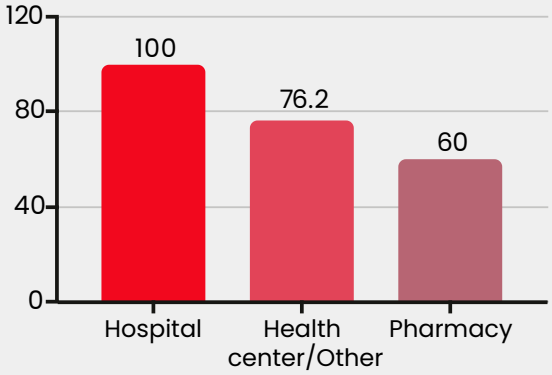
What the Evidence Shows: Availability

HIV self-testing kits are available throughout much of the formal health system, with about threequarters of health facilities reporting stock at the time of assessment. Availability is highest in public hospitals and health centers supported by government and partner supply chains, while private pharmacies have lower, less consistent stock levels. There is variation across districts: some maintain a continuous supply, while others experience periodic shortages.

Availability of HIV Self-Test Kits at Health Facility



Availability of HIV Self-Test Kits by Combined Facility Type



What the Evidence Shows: Availability

Public Hospitals

Full availability with consistent government and partner supply chains

Health Centers

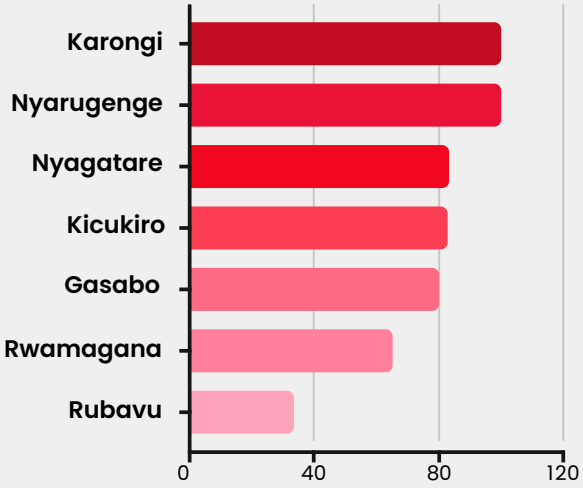
About 76% report stock availability at assessment time

Private Pharmacies

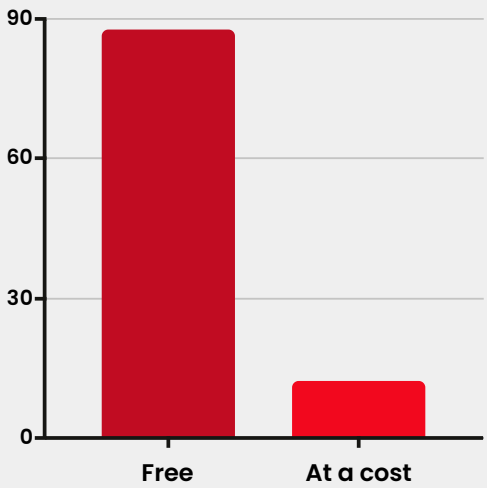
Lower and less consistent stock levels across districts

Availability of HIV Self-Test Kits by District

Availability of HIV Self-Test Kits at Health Facility



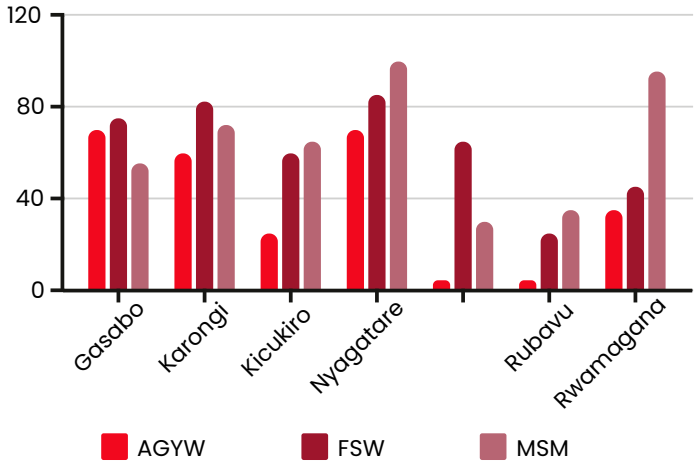
Availability of HIV Self-Test Kits at Health Facility



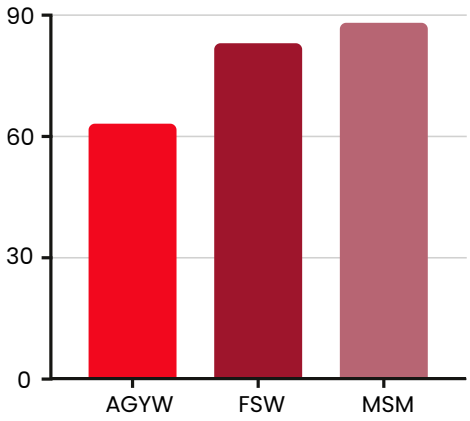
What the Evidence Shows: Accessibility

The physical presence of kits does not necessarily lead to effective access. Among those aware of HIV self-testing, only about half report being able to get a kit easily. The main inequities are based on population groups rather than geography alone. Female sex workers and men who have sex with men tend to access kits more often through peer and community networks, while adolescent girls and young women face more obstacles due to stigma, fewer youth-friendly entry points, and lower awareness.

Awareness of HIV Self-Test Kits by Key Population Group Across Districts



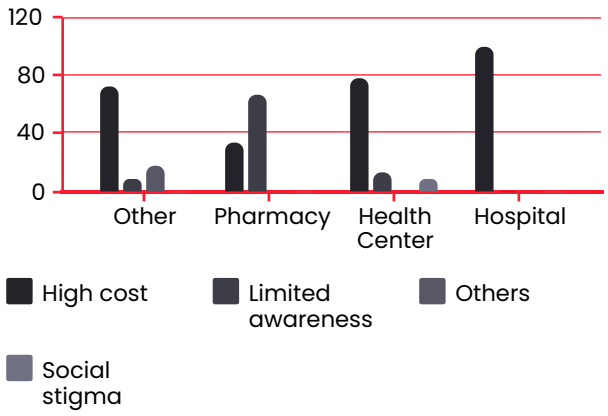
Awareness(%) of HIV SelfTest Kits by Key Population Group



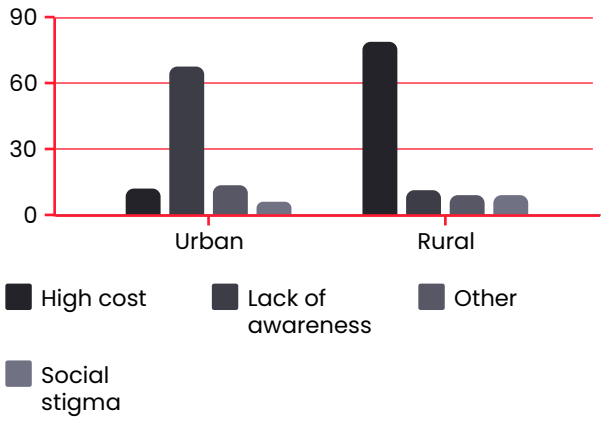
Barriers to Access in Rural and Private Settings

Rural communities often have limited knowledge of the service, and private pharmacies create cost barriers that discourage use among low-income individuals.

Awareness of HIV Self-Test Kits by Key Population Group Across Districts



Awareness(%) of HIV SelfTest Kits by Key Population Group



What the Evidence Shows: Availability

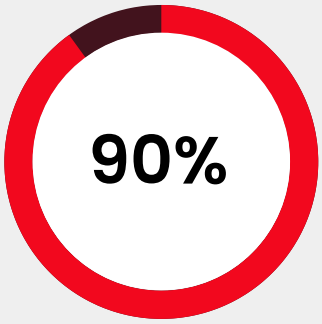
Rural Communities
Limited knowledge of HIVST services and availability

Private Pharmacies
Cost barriers discourage use among low-income individuals

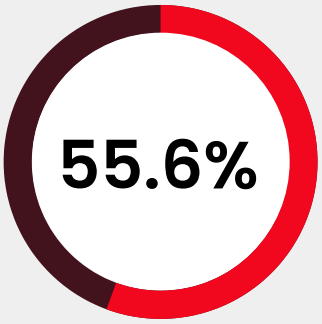
Key Populations
Better access through peer and community networks

What the Evidence Shows: Acceptability

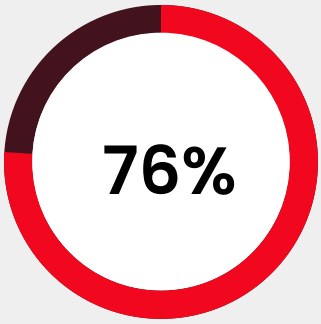
Across all groups, willingness to use HIV self-testing is high, and trust in results is strong. Privacy and autonomy are the main drivers of preference, which highlight readiness for scale if access barriers are removed.



Would Recommend
Respondents willing to recommend HIVST to others



Easy Access
Individuals aware of HIVST who report kits are easy to obtain



Facility Availability
Health facilities with kits available at assessment

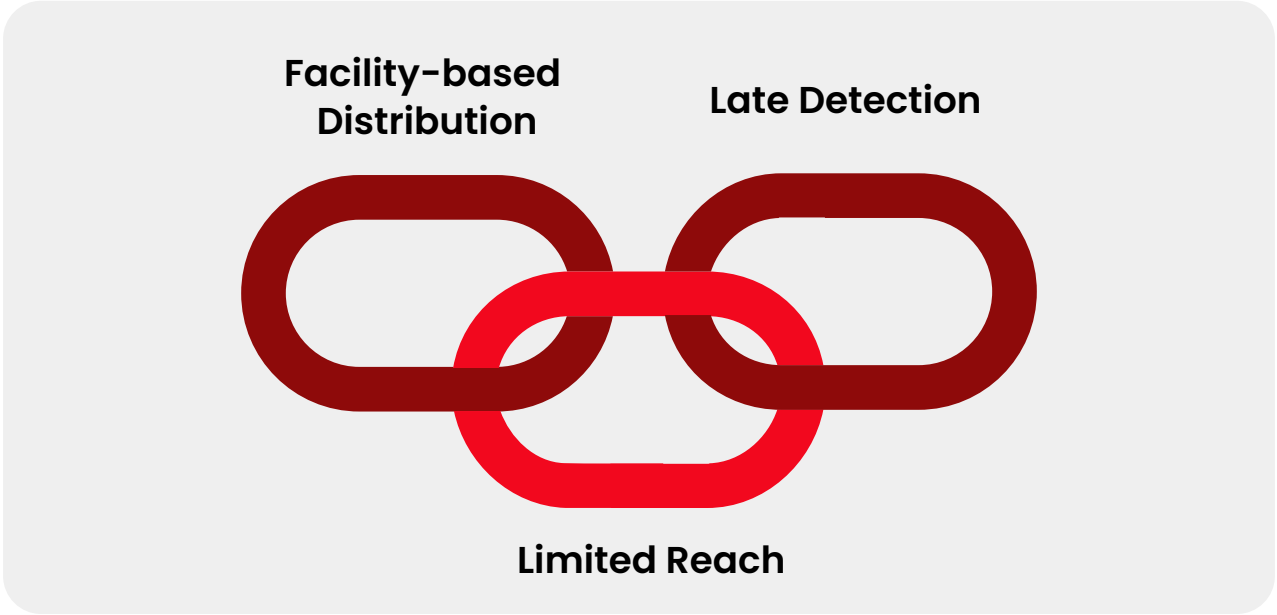
What This Means for the HIV Response

The current HIV testing approach in Rwanda largely reaches individuals already connected to health or prevention programs. Public facilities and targeted interventions serve populations who regularly interact with services, which explains the relatively strong uptake among organized key population networks. However, the same delivery model does not effectively reach individuals outside these structures, particularly younger women and socially hidden populations.

The assessment shows that expanding supply alone will not substantially change testing coverage. When distribution remains facility-anchored, testing continues to depend on a person's willingness and ability to engage with the health system. Populations facing stigma, privacy concerns, or social exposure risk remain outside routine testing pathways even when services exist.

The Structural Mismatch

The physical presence of kits does not necessarily lead to effective access. Among those aware of HIV self-testing, only about half report being able to get a kit easily. The main inequities are based on population groups rather than geography alone. Female sex workers and men who have sex with men tend to access kits more often through peer and community networks, while adolescent girls and young women face more obstacles due to stigma, fewer youth-friendly entry points, and lower awareness.



This creates a structural mismatch between service delivery and transmission patterns. HIV transmission persists within networks that are least likely to interact with facilities, meaning the testing system detects infection late rather than early. In this context, providing more kits through the same channels increases availability but does not improve case finding.

> **HIV self-testing, therefore, changes outcomes only when it changes reach. The policy challenge is no longer introducing self-testing but shifting from distributing commodities to enabling confidential access for people who intentionally avoid the formal system.**

Policy Direction and Priority Actions

Rwanda should reposition HIV self-testing from a facility-distributed commodity to a populationreach strategy. The objective is not to increase the number of kits in the system but to ensure that people who avoid conventional services can test early and confidentially. This requires shifting delivery channels toward discreet, community-based, and youth-friendly access points while maintaining linkage to confirmatory testing and care.

Demand creation, literacy, and stigma reduction

Implement targeted communication using mass media, social mobilization, and community dialogues. Tailor messages to AGYW, low-literacy populations, and rural communities. Empower CSOs and peer networks to lead awareness and trust-building activities and normalize self-testing.

Rural Communities

Train providers and community actors on pre- and post-test counseling and clear next steps. Establish reliable referral, follow-up, and tracking mechanisms to ensure confirmatory testing and treatment after reactive or invalid results.

Digital support and user guidance

Use SMS, mobile platforms, and social media to provide discreet instructions, reminders, and linkage guidance, complementing community-based support channels.

Supply chain and affordability

Strengthen procurement, forecasting, and last-mile distribution to eliminate stock-outs and ensure continuous availability of blood-based HIVST kits in facilities and communities, especially rural areas. Integrate community distribution platforms and key population networks into national supply plans. Provide kits free or subsidized for vulnerable groups to remove financial barriers.

Distribution Infrastructure

- Strengthen procurement and forecasting systems
- Eliminate stock-outs in facilities and communities
- Focus on last-mile distribution to rural areas
- Integrate community distribution platforms

Financial Access

- Provide kits free or subsidized for vulnerable groups
- Remove financial barriers to testing
- Include key population networks in procurement and supply plans

Community distribution and access expansion

Scale delivery beyond facilities by authorizing pharmacies, CHWs, peer educators, CSOs, and key population platforms to distribute kits. Embed HIVST into existing community health programs and outreach services. Conduct mapping of peer-education structures to optimize coverage, coordination, and accountability.

Authorized Distributors

Pharmacies, CHWs, peer educators, CSOs, and key population platforms

Integration Strategy

Embed HIVST into existing community health programs and outreach services

Optimization

Conduct mapping of peereducation structures to optimize coverage, coordination,

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