FY 2010

RWANDA COUNTRY OPERATIONAL PLAN (COP)

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TABLE OF CONTENTS

ACRONYM LIST 1
BUDGET 7
SUMMARY BUDGET BY TECHNICAL AREA 7
TECHNICAL AREA NARRATIVES 9
PREVENTION 9
Prevention of Mother to Child Transmission (PMTCT) Overview Narrative 9
Sexual Prevention Overview Narrative 12
Biomedical Prevention Overview Narrative 16
Blood Safety 16
Injection Safety 17
Male Circumcision 18
Counseling and Testing Overview Narrative 20
CARE AND TREATMENT 22
Adult Care & Treatment Overview Narrative 22
Adult Care and Support 24
Adult Treatment 25
Pediatric Care & Treatment Overview Narrative 26
ARV Drugs Overview Narrative 30
TB/HIV Overview Narrative 32
OVC Overview Narrative 35
OTHER 37
Laboratory Infrastructure Overview Narrative 37
Strategic Information Overview Narrative 40
Health System Strengthening Overview Narrative 43
Human Resources for Health Overview Narrative 47
Gender Overview Narrative 50
ANNEXES 55
COP TARGETS 56
National Level Targets 56
Technical Area Summary Targets 57
COP Targets Justification 61

ACRONYM LIST

AABB	American Association of Blood Banks
AB	Abstain/be faithful
ABC	Abstain, be faithful, and, as appropriate, correct and consistent use of condoms
ACM	Atelier Central de Maintenance
ADEPE	Action pour le Développement du Peuple
AFASS	Acceptable, feasible, affordable, safe and sustainable
AHA	African Humanitarian Action
AFB	Acid Fast Bacilli
ANC	Antenatal Care
APHAR	Association of Pharmacists in Rwanda
APHL	Association of Public Health Laboratories
APR	Annual Performance Review
ARBEF	Rwandan Association for the Well-Being of the Family
ARC	American Refugee Committee
ARCT	Rwanda Association of Trauma Counselors (acronym from French name)
ARPCDH	Association pour la Recherche, la Promotion et la Connaissance des Droits de l'Homme
ARPHA	Association Rwandaise des Pharmaciens
ART	Anti-retroviral therapy
ARV	Anti-retroviral drugs
ASCP	American Society of Clinical Pathologists
AVEGA	Association des Veuves du Genocide d'Avril 1994
AVSI	Associazione Volontari per il Servizio Internazionale
AZT	Azidothymidine (zidovudine)
BCC	Behavior change communications
BF	Breast Feeding
BHC	Basic Health Care
BMI	Body Mass Index
BSS	Behavioral Surveillance Surveys
BTC	Belgian Technical Cooperation
BUFMAR	Rwandan Faith-based Medical Stores
CAMERWA	Central d'Achats des Medicament, des Consommables et Equipments Medicaux au Rwanda
CBJ	Congressional budget justification
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CCP	Central Commodity Procurement
CDC	Centers for Disease Control and Prevention (USG)
CDLS	District AIDS Control Commission
CDT	TB Diagnostic and Treatment Center
CHW	Community Health Worker
CHAI	Clinton HIV/AIDS Initiative
CHAMP	Community HIV/AIDS Mobilization Program
CHF	Community-Habitat-Finance International
CHH	Child-headed households
CHK	Central Hospital of Kigali

CHUB	Centre Hospitalier Universitaire de Butare (Butare University Teaching Hospital)
CHUK	Centre Hospitalier Universitaire de Kigali (Kigali University Teaching Hospital)
CN	Congressional Notification
CNLS	National AIDS Control Commission
CNTS	National Blood Transfusion Center
COP	Country Operational Plan
COPED	Compagnie Pour le Developpement et Environnement
CPDS	Coordinated procurement and distribution system
CRS	Catholic Relief Services
CSB	Corn Soy Blend
CSI	Child Status Index
CSP	Community Services Project
CSW	Commercial sex worker
CT	Counseling and testing
CTX	Co-trimoxazole
DBS	Dried Blood Spots
DBS DNA-PCR	Dried Blood Spots Deoxyribonucleic Acid – Polymerase Chain Reaction
DCA	Development Credit Authority
DESCD	Division of Epidemiology and Surveillance Capacity Development
DfID	Department for International Development
DH	District hospital
DHF	Decentralization and Health Finance
DHS	Demographic and Health Surveys
DHT	District Health Team
DIC	Drug Information Center
DMS	Directorate of Medical Services
DOD	Department of Defense (USG)
DOTS	Directly Observed Therapy Short-Course
DPS	Dried plasma spot
DRC	Democratic Republic of the Congo
DRI	District Response Initiative
DSS	Directorate of Health Services
DTC	Drug Therapeutic Committee
DQA	Data quality analysis
EBF	Exclusive breastfeeding
ECSA	East, Central, and South African Health Community
EDL	Essential Drug List
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	Early Infant Diagnosis
EIS	Epidemic Intelligence Service
EMR	Electronic medical record
EPI	Expanded Program for Immunization
FBO	Faith-based organization
FELTP	Field Epidemiology and Laboratory Training Program
FHI	Family Health International
FOA	Funding Opportunity Announcement
FP	Family planning
FSN	Foreign service national

FTE	Full time equivalent
FY	Fiscal year
GAP	Global AIDS Program
GBV	Gender-based violence
GFATM	Global Fund for AIDS, TB and Malaria
GIS	Geographic Information System
GLIA	Great Lakes Initiative for HIV/AIDS (World Bank)
GOR	Government of Rwanda
GTZ	German Society for Technical Cooperation
HAART	Highly Active Anti-Retroviral Therapy
HBC	Home-based care
HC	Health center
HD	Health district
HIV	Human immunodeficiency virus
HMIS	Health management information system
HPV	Human Papilloma Virus
HQ	Headquarters
HRH	Human Resources for health
HIS	Healthy Schools Initiative
HR	Human Resources
ICAP	International Center for AIDS Care & Treatment Programs (Columbia)
ICT	Information, Communication and Technology
IDP	Internally displaced persons
IEC	Information, education and communication
IGA	Income generating activities
IMCI	Integrated management of childhood illness
INH	Isoniazid
IPT	Intermittent presumptive therapy
IPTp	Intermittent preventive treatment for pregnant women
IT	Information technology
ITN	Insecticide-treated bed nets
IYCF	Infant and young child feeding
JSI	John Snow Inc.
KAP	Knowledge, attitudes, practices
KfW	Kreditanstalt für Wiederaufbau (a German assistance organization)
KHI	Kigali Health Institute
KIST	Kigali Institute of Science and Technology
LLITNs	Long Lasting Insecticide Treated Nets
LMIS	Logistic management information system
LES	Locally Employed Staff
M2M	Mother to Mother
M&E	Monitoring and evaluation
M&O	Management and Oversight
MAP	Multi-sectoral AIDS Program (The World Bank)
MARP	Most At-Risk Population
MC	Male Circumcision
MCC	Millennium Challenge Corporation
MCAP	Multi-Country Columbia Antiretroviral Program

MCH	Maternal child health
MDR TB	Multi-drug resistant TB
MIGEPROF	Ministry of Gender and Family Promotion
MINALOC	Ministry of Local Government and Social Affairs
MINEDUC	Ministry of Education
MININTER	Ministry of Internal Security
MMIS	Making Medical Injections Safer (project)
MOD	Ministry of Defense
MOH	Ministry of Health
MOJ	Ministry of Justice
MOU	Memorandum of Understanding
MPH	Masters of Public Health
MSH	Management Sciences for Health
MSM	Men who have sex with men
MTCT	Mother to child transmission
MTCU	Mobile Treatment and Care Unit
MUAC	Mid-upper arm circumference
NDA	National Drug Authority
NGO	Non-governmental organization
NHA	National Health Accounts
NRL	National Reference Laboratory
NUR	National University of Rwanda
NVP	Nevirapine
OGAC	Office of the U.S. Global AIDS Coordinator
OHSS	Health System Strengthening
OI	Opportunistic Infection
ONAPO	Rwandan National Office of Population
OP	Other prevention
OVC	Orphans and vulnerable children
PAQ	Partenariat pour l'Assurance de Qualité (Quality Assurance Partnership, a community partnership)
PBF	Performance-based financing
PCR	Polymerase chain reaction
PC/R	Peace Corps/Rwanda
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PFSCM	Partnership for Supply Chain Management
PIT	Provider-initiated testing
PLWHA	People living with HIV/AIDS
PMI	Presidential Malaria Initiative (USG)
PMIS	Pharmacy management information system
PMTCT	Prevention of mother-to-child transmission of HIV
PMU	Program Management Unit (MOH)
PNILT	National Tuberculosis and Leprosy Control Program
PNLIP	Rwanda National Malaria Control Program
PSI	Population Services International
PT	Preventive therapy
PTF	Pharmacy Task Force

PV	Pharmacovigilance
PwP	Prevention with Positives
QA	Quality assurance
QA/QC	Quality assurance/quality control
QAP	Quality Assurance Project
RAMA	La Rwandaise d'Assurance Maladie
RDF	Rwandan Defense Forces
RDHS-III	Rwanda Demographic and Health Survey – III
RH	Reproductive health
RHPIF	Rwanda HIV/AIDS Public Interest Fellowship
RMU	Rational Medicines Use
ROADS	Regional Outreach Addressing AIDS through Development Strategies
RPM+	Management Sciences for Health/Rational Pharmaceutical Management Plus
RPO	Rwandan Partner Organization
RPR	Rapid Plasma Reagin (syphilis test)
RRP+	Rwandan Network of People Living With HIV/AIDS
RWN	Rwanda's Women's Network
SAPR	Semi-Annual Performance Review
SCMS	Supply Chain Management System
SD	Single Dose
SD-NVP	Single Dose Nevirapine
SFR	Staffing for Results
SGBV	Sexual-Gender Based Violence
SI	Strategic Information
SPS	Strengthening Pharmaceutical Systems
SO	Strategic Objective
SOP	Standard operating procedures
SPA	Service provision assessment
SPH	School of Public Health (Rwanda)
SPREAD	Sustaining Partnerships to Enhance Rural Enterprise and Agribusiness Development Project
STD	Sexually transmitted disease
STI	Sexually transmitted infections
SWAA	Society of Women Against AIDS
TA	Technical assistance
TB	Tuberculosis
TBA	Traditional birth attendant
TBD	To be determined
TC	Testing and Counseling
TLC	Thin-Layer Chromatography
TOT	Training-of-trainers
TRAC Plus	Center for Treatment and Research on AIDS, Malaria, TB and Other Infectious Diseases
TWG	Technical working group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNC	University of North Carolina
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees

UNICEF	United Nations Children's Fund
UNITAID	International Drug Purchase Facility being established by Brazil, France, Chile, Norway and the United Kingdom
UR	University of Rwanda
USAID	United States Agency for International Development
USD	US dollar
USG	United States Government
USPSC	United States Personal Services Contractor
VCT	Voluntary counseling and testing
WB	World Bank
WE-ACTx	Women's Equity in Access to Care and Treatment
WFP	World Food Program
WHO	World Health Organization

BUDGET

Summary Budget by Technical Area

Budget Code Number	Budget Code	Budget Code Name	FY09 Budget	FY09 PF	FY10 Budget	*FY10 Budget + FY09 PF*	% of budget
01	MTCT	Prevention of Mother to Child Transmission	$5,433,843	$3,649,123	$5,019,411	*$8,668,534*	5.55%
02	HVAB	Abstinence and Be Faithful	$5,906,700	$104,000	$3,517,897	*$3,621,897*	2.32%
03	HVOP	Other Prevention	$5,664,000	$965,000	$5,873,864	*$6,838,864*	4.38%
04	HMBL	Blood Safety	$3,635,001	$1,949,999	$3,267,001	*$5,217,000*	3.34%
05	HMIN	Injection Safety	$1,253,935	$276,737	$1,537,825	*$1,814,562*	1.16%
07	CIRC	Male Circumcision	$1,250,000	$575,000	$1,361,250	*$1,936,250*	1.24%
12	HVCT	Voluntary Counseling & Testing	$5,299,878	$1,651,655	$5,650,081	*$7,301,736*	4.68%
		PREVENTION SUBTOTAL	*$28,443,357*	*$9,171,514*	*$26,227,329*	*$35,398,843*	*22.68%*
08	HBHC	Adult Care & Support	$10,873,667	$2,032,762	$12,487,165	*$14,519,927*	9.30%
14	PDCS	Pediatric Care & Support	$2,501,435	$340,045	$2,215,873	*$2,555,918*	1.64%
10	HVTB	TB/HIV	$5,183,937	$826,217	$4,702,636	*$5,528,853*	3.54%
11	HKID	OVC	$13,315,591	$50,000	$12,157,200	*$12,207,200*	7.82%
		CARE SUBTOTAL	*$31,874,630*	*$3,249,024*	*$31,562,874*	*$34,811,898*	*22.30%*
09	HTXS	Adult Treatment	$24,488,267	$1,342,596	$21,913,758	*$23,256,354*	14.90%
13	PDTX	Pediatric Treatment	$2,343,199	$290,960	$2,291,760	*$2,582,720*	1.65%
15	HTXD	ARV Drugs	$10,860,593	$0	$11,490,309	*$11,490,309*	7.36%
		TREATMENT SUBTOTAL	*$37,692,059*	*$1,633,556*	*$35,695,827*	*$37,329,383*	*23.91%*
16	HLAB	Laboratory Infrastructure	$5,402,948	$1,222,692	$10,070,097	*$11,292,789*	7.23%
17	HVSI	Strategic Information	$6,793,712	$2,379,164	$6,575,622	*$8,954,786*	5.74%
18	OHSS	Health Systems Strengthening	$6,435,154	$6,994,050	$8,356,246	*$15,350,296*	9.83%
		OTHER SUBTOTAL	*$18,631,814*	*$10,595,906*	*$25,001,965*	*$35,597,871*	*22.80%*
19	HVMS	Management & Oversight	$6,355,453	$0	$12,959,318	*$12,959,318*	8.30%
		Total	**$122,997,313**	**$24,650,000**	**$131,447,313**	***$156,097,313***	
		*PF TA = $350,000	Controls	$24,650,000	$131,447,313		

By Agency Summary

	FY 2010	FY 2009 PF
DOD	$3,998,478	$712,000
HHS/CDC	$34,538,471	$13,128,511
HHS/HRSA	$4,389,056	$4,000
Peace Corps	$824,571	$0
State	$2,768,000	$0
State/PRM	$386,402	$13,282
USAID	$84,542,335	$10,792,207
TOTAL	**$131,447,313**	**$24,650,000**

By Funding Account Summary

Central GHCS-State	$6,240,074
GHCS-State (2010)	$124,072,239
GHCS-State (2009)	$24,650,000
GAP	$1,135,000
TOTAL	**$156,097,313**

TECHNICAL AREA NARRATIVES

PREVENTION

Prevention of Mother to Child Transmission (PMTCT) Overview Narrative

FY 2010	*$5,019,411*
FY 2009 Partnership Framework	*$3,649,123*
TOTAL	*$8,668,534*

What are the most important activities being undertaken in this technical area?

The most important activities that PEPFAR Rwanda is undertaking in the Prevention of Mother to Child HIV Transmission technical area include:

- Continue to support existing 184 PMTCT site to offer comprehensive PMTCT package.
- Revision and dissemination of new guidelines, tools, and training materials used in PMTCT program.
- Refresher training for trainers and Training of Providers in PEPFAR -supported health facilities.
- Maintain and reinforce quality of services through supervision and mentorship.
- Integrating PMTCT services into existing MCH programs with other MCH services, emphasis on FP.
- Support counseling on infant feeding and procurement of fortified weaning foods that will be provided to all PEPFAR-supported sites (for HIV-exposed infants ages 6-18 months and pregnant and breastfeeding women who need nutritional support).
- Improve HIV exposed infant follow-up, by supporting the implementation of the revised national immunization card which includes HIV-exposure status.
- Support the implementation of the national HIV early infant diagnosis scale-up plan.
- Sustainability of services and improvements in program outcomes.

What are the key differences from last year?

The key differences from last year's PMTCT program include a stronger focus on integration of PMTCT services into existing MCH programs with other MCH services, with an emphasis on FP, as well as improving early infant diagnosis and HIV-exposed infant follow up.

Narrative

The 2005 Rwandan Demographic Health Survey-III (2005 DHS) determined that the mean HIV prevalence rate in women of reproductive age was 3.6% (ranging from 8.6% in urban areas to 2.6% in rural areas). Data from the Interim Demographic and Health Survey 2007 (2007 I-DHS) report shows that 96% of pregnant women attend at least one antenatal care (ANC) visit. The proportion of total births delivered by a health professional increased from 39% in 2005 to 52 % in 2007 (ranging from 70% in urban areas to 49% in rural areas). An HIV sero-surveillance survey among pregnant women attending ANC conducted in 2007 at 30 sentinel sites showed an HIV prevalence of 4.3%. The Government of Rwanda (GOR) has developed a five-year National Strategic Plan on HIV and AIDS 2009 - 2012 (NSP) and one of the goals is to halve HIV incidence in the general population by 2012. PMTCT has been identified as an important intervention which will contribute to achieving this goal.

Each year the GOR develops estimates of the burden of HIV infection and updates the HIV and AIDS Epidemiologic Bulletin using the Estimation and Projection Package (EPP) and Spectrum software. According to these models the number of HIV-positive pregnant women eligible for PMTCT in 2008 was

10,540 (range 4,990-16,780). According to TRAC Plus reporting, 68% of HIV-positive pregnant women received prophylactic antiretroviral prophylaxis in 2008. The estimated number of HIV-positive pregnant women eligible for PMTCT services in 2010 is 10,600 (range 4,940-17,210), out of 381,300 pregnancies.

As of September 2009, 363 sites (70.3% of all health care facilities) were providing PMTCT services for pregnant women in Rwanda. With FY 2009 funds, PEPFAR will be directly supporting 184 of these sites in 22 districts. Global Fund was directly supporting 187 of these sites and UNICEF supports 20 of these sites. Of the PEPFAR-supported sites, 115 have PMTCT and antiretroviral therapy (ART) services at the same venue.

The acceptance rate for HIV-testing was 98.3% among pregnant women attending ANC, resulting in 336,623 pregnant women being tested at PMTCT sites from September 2008 to October 2009. Of those tested, 9355 were HIV-positive. In total 9,492 mothers, including seronegative women who have had a seropositive partner received ARV prophylaxis (of whom 38.2% received highly active antiretroviral therapy (HAART), 44% AZT+ Sd-NVP during labor then AZT+3TC for 7 days after delivery and 17.8% Sd-NVP during labor then AZT+3TC for 7 days after delivery). During the same period, PMTCT sites reported 192,619 births (75% of all expected births), including 7,468 births from HIV-positive women. Almost all (90.5%) infants born to HIV-positive women were delivered at a health care facility in a PMTCT site. About 96% of infants born to HIV-positive mothers received NVP/AZT nationally (current Rwanda policy for HIV-exposed infants).

Nationally, partner testing has increased from 13% in 2003 to 84% in September 2009, with approximately 2.64% of partners testing positive. The discordant couple rate is 2.3% among tested couples. Approaches used to encourage partner testing included invitation letters, special week-end VCT days for men, mobilization of men through community health workers and political leaders.

The integration of PMTCT and family planning (FP) contributed to service delivery this year. USG supported the development of the 2009 national level FP/HIV integration work plan, including offering indicators for its monitoring, and scale up of FP/HIV integration at district level. After delivery, HIV-positive women received counseling on FP and as a result, many take contraceptives in the post-natal period. From January to September 2009, 75% of HIV-positive pregnant women identified at PMTCT sites delivered at health facilities and 6,091 (97.8%) mothers received ARV prophylaxis for PMTCT. ARV prophylaxis coverage has improved from 2003 to 2008. As of September 2009, 75% of PMTCT sites were offering more efficacious PMTCT regimens nationally (AZT+Sd-NVP during labor then AZT+3TC for 7 days after delivery for HIV-positive pregnant women or HAART as prophylaxis for pregnant women accessing ANC after 34 weeks; and Sd-NVP for infants at birth or within 72 hours and AZT for 4 weeks after birth).

The GOR, USG, and Global Fund are supporting Early Infant Diagnosis (EID) programs at their sites in order to identify HIV-positive children and link them with treatment as early as possible. Nationally, as of October 2009, 349 sites were offering EID (86%of all PMTCT sites, 51% of PEPFAR-supported sites) and sending dried blood spot (DBS) samples to the National Reference Laboratory (NRL) for processing. From January 2009 to September 2009, 3,905 infants age 6 weeks to 9 months were tested using DBS PCR. At 18 months of age 2,373 out of 2,810 children were tested, of which 4% were HIV-positive.

In FY 2007, PEPFAR started to provide nutrition support to HIV-exposed infants during the weaning period. As of Septembers 2009, a total of 6,000 exposed infants (age 6-15 months) had received the

fortified weaning food supplements (corn and soya blend).

Each PEPFAR-funded partner provides a standard comprehensive PMTCT package comprised of same day, opt-out testing and counseling using HIV rapid tests; infant feeding counseling and support; clinical and CD4 count-based staging; provision of HAART for eligible HIV-positive pregnant women; and, combination ARV prophylaxis regimens for non-eligible HIV-positive women. In addition, PEPFAR partners support the use of safe obstetric practices during delivery, HIV testing in labor and delivery wards for women of unknown status, infant and mother follow-up, co-trimoxazole for prevention of opportunistic infections in infants and mothers, infant HIV testing and diagnosis when possible, and community-based services. Partners also promote family testing, work to strengthen linkages and referrals between PMTCT and ART programs, and integrate PMTCT services into existing MCH service deliver.

Despite these achievements, the PMTCT program in Rwanda still faces many challenges. These include the need to increase program coverage at various levels of the health system and improve the quality of services (including provision of more effective ARV regimens), relatively low facility deliveries, weak (but increasing) linkages and integration between PMTCT services and MCH and ART clinics, and sub-optimal access to CD4 counts, infant follow-up and EID (including long turn-around times for DBS PCR tests from the NRL to sites). Although Rwanda has high rates of breastfeeding, HIV-positive mothers have difficulty adhering to the recommended exclusive breastfeeding and early weaning, partly because they cannot afford weaning foods. They also lack knowledge of alternative nutrition options for infants and young children and are not receiving sustained infant feeding and nutrition counseling and support.

The Rwandan program will increase efforts to address these challenges in FY 2010. The GOR will extend PMTCT services to all health facilities by end of 2012, provide HIV testing and counseling to 98% of pregnant women, and provide ARVs for PMTCT to 90% of HIV-positive pregnant women. In FY 2010, PEPFAR will maintain direct support to existing sites and support 17 new sites, providing PMTCT services to an additional 15,167 pregnant women. PEPFAR will also continue to support TRAC Plus the GOR and TRAC Plus to update policies and guidelines based on the recent WHO guidelines, implement the new guidelines, improve program coordination and management (including support to decentralization and district involvement), and strengthen capacity.

In line with GOR and PEPFAR goals, PEPFAR partners will ensure that all PMTCT clients receive the standard package of comprehensive PMTCT services at all sites (detailed above). In line with the NSP, the program will support reorganization of districts to increase access to CD4 counts, EID and other lab services. In line with task shifting, the capacity of nurses at PMTCT sites will be increased to effectively conduct ART eligibility assessments and provide ART under the supervision of rotating physicians.

In FY 2010, as part of the first year of transition of Track 1.0 partners' activities, ICAP-CU and AIDS Relief will transition 23 PMTCT sites to GOR. District Health Teams and site level teams will be supported through training and formative supervision to better coordinate PMTCT and other HIV and health clinical and preventive services. This will maximize effective referrals between HIV/AIDS services, improve integration with other MCH services (e.g., distribution of bed nets to prevent malaria, family planning counseling and referral, syphilis screening, nutrition counseling and support) and improve the quality of care at the most decentralized level.

Infant feeding and nutrition will support program models for improving postnatal follow-up, counseling on infant feeding and procurement of fortified weaning foods that will be provided to all PEPFAR-

supported sites (for HIV-exposed infants ages 6-18 months and pregnant and breastfeeding women who need nutritional support). This initiative will be linked with on-going clinical assessments of mothers and growth monitoring and clinical assessment of early-weaned infants and will leverage OVC and other food programs.

PEPFAR will further expand child follow-up and EID services, in collaboration with the EPI unit within the MOH by supporting the implementation of the revised national immunization card which includes HIV-exposure status and support to the implementation of the national EID scale-up plan.

PEPFAR and GOR will also strengthen the systematic follow-up of HIV-positive mothers and target the high number of home deliveries by collaborating closely with community workers, political leaders and associations of people living with HIV/AIDS (PLWHA) to promote PMTCT services in their communities, encourage early ANC attendance and promote delivery in health facilities using different models.

Case managers will continue to coordinate facility and community linkages and refer HIV-positive children from PMTCT sites and nutrition centers to ARV services. Male involvement in PMTCT activities will also continue to be supported. Women who are victims of violence will be referred to appropriate care and support.

Sustainability of services and improvements in program outcomes will be promoted through a combination of input technical assistance and output performance-based financing (PBF). Procurement, forecasting and distribution of ART, CTX and other PMTCT commodities will be further strengthened through SCMS, the MOH and the Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda (CAMERWA).

PMTCT and pediatric care and treatment will be included in the HEALTH-QUAL model, which is an integrated model for quality improvement across communicable disease control programs in Rwanda, and in the joint supervisory visits and appropriate laboratory quality assurance for CD4 and HIV testing. TRAC Plus is currently finalizing new indicators which include co-trimoxazole, ARV regimen types, pregnant women on ART and other key program indicators. PEPFAR will continue to support TRAC Plus in the improvement of national M&E capacity for PMTCT and link with other national quality improvement initiatives.

Sexual Prevention Overview Narrative

FY 2010	*$9,391,761*
FY 2009 Partnership Framework	*$1,069,000*
TOTAL	*$10,460,761*

What are the most important activities being undertaken in this technical area?

Targeting groups and geographic locations with highest prevalence, but also programs that employ evidence-based interventions. Activities include a range of behavior change and risk reduction activities, health communication campaigns, life skills building, prevention with positives (PwP), and infrastructure development to transition and to support the GOR in maintaining sustained prevention activities.

What are the key differences from last year?

The approach includes a stronger focus on MARPs with the goal of averting as many new infections as possible to reach the national benchmark of halving HIV incidence by 2012. Specific MARPs include

Commercial Sex Workers (CSW), Clients of CSW, prisoners, Men who have Sex with Men (MSM), and young women aged 15-24 years.

Narrative

The 2009 HIV and AIDS Epidemiologic Update estimated the median number of infected individuals (adults and children) in Rwanda at 172, 673 (lower: 137,512 and upper: 213,173) with urban areas having a higher prevalence than rural areas (7.3% versus 2.2%, 2005 DHS) and higher levels of risk behaviors. Approximately 3.0% (95% CI: 2.6-3.5) of the Rwandan population between the ages of 15 – 49 are HIV-positive (DHS, 2005). Modeling of DHS data further suggests that over 90% of new heterosexually acquired HIV infections in Rwanda occurred within couples in cohabitation (Dunkle et al, Lancet 2008). HIV prevalence appears higher among those with, at least, secondary school education and tend to vary by employment status; those who are employed showed a slightly higher prevalence than those unemployed (2005, DHS). Compared to the general population, youth (15 – 24) have lower HIV prevalence rates; however, in both adult and youth populations, females carry the burden of HIV.

The differences in HIV prevalence between men and women are striking; for adult women, 3.6% prevalence rate compared to 2.3 % for men; female youth have a 3.9% prevalence rate versus 1.1% for male youth (NSP 2009-2010). Furthermore, for the 20-24 age groups, young women are at even greater risk, likely due to cross-generational sex. Other risk groups include mobile populations who have frequent separation from a main partner or family support structure, men in uniform (military or police), and street or other vulnerable children/youth. Conservative estimates suggest that approximately 1,264,000 vulnerable children live in Rwanda, of whom 820,000 are orphans (2005 DHS and 2002 GOR Census); furthermore, youth comprise 14.7% of PLWHA (Triangulation Training Workshop, 2008).

A June 2009 Modes of Transmission (MOT) model, for the National AIDS Control Commission (CNLS) of Rwanda, predicted that most-at-risk-populations (MARPs) may account for the majority of new infections (27-53%). Identified MARPs include sero-discordant couples (an estimated 7.6% of stable heterosexual couples, in Kigali, are sero-discordant (NSP on HIV & AIDS 2009-2012), female sex workers and clients, prisoners, and MSM. Key factors, that seem to drive the epidemic, are marginalization of MARPs, punitive penal codes affecting MARPs, stigma and discrimination, gender inequity, multiple concurrent partners, non-protective social norms and/or networks, violence against women and girls, lack of comprehensive health services for people living with HIV, low condom use and low male circumcision.

PEPFAR recognizes effective HIV prevention is critical to reversing the global spread of HIV and to safeguarding a sustainable response to the demands of this epidemic. Subsequently, understanding of the behavioral, biomedical, and structural drivers of HIV/AIDS continues to evolve.. The USG approach, therefore, continues to develop strategies to understand and help individuals and communities protect themselves from new HIV infections and live positively if already infected. USG primary and secondary prevention programs combine the core constructs of evidence-based and theory driven interventions with innovative and promising practices to best address HIV/AIDS in Rwanda.

Multiple sexual prevention interventions are being used in Rwanda with the intention of changing behavioral and social structural characteristics related to risk by influencing attitudes, skills, normative perceptions, and other mediators. Beneficiaries of sexual prevention activities include the general population, but also focus on risk groups and MARPs; for example, there are prevention activities targeting OVC, in and out of school youth, low income women, sex workers and clients, truckers and

other mobile populations, seasonal workers, men in uniform, and other community members in identified 'hot spots.'

Worrisome trends continue to emerge from certain high risk groups. Recent mobile VCT with CSWs from Kigali showed very high prevalence rates of HIV. A model of optimum program targeting and selecting the appropriate mix of interventions will be developed. The program will employ a mix of condom promotion, one-on-one risk reduction counseling, periodic screenings and treatment for sexually transmitted and HIV testing.

In order to understand the magnitude of the CSW population, strategic SI activities to determine size (size estimation) and locations (mapping) of sex worker hotspots. For this to be effective interventions will improve the enabling environment for sex workers. Clients of CSWs are among the drivers of the epidemic. However, they make a diverse group to understand. Anecdotal evidence suggests that key groups include: truckers, uniformed corps, mobile men with disposable income, prisoners, etc. In FY 10, programs will continue to provide risk reduction products and services for clients of sex workers.

MSM are 4 times more likely to be infected than the general population. In other African countries, HIV prevalence found to be up to 43% among men reporting sex with other men exclusively. Rwandan HIV policy has not addressed HIV prevention among MSM, primarily due to a lack of data, MSM has been included as a priority risk group in the new NSP 2009-12. A recent study conducted by the National AIDS Control Commission (CNLS) to describe the population of MSM in Kigali and explore the nature of sexual activity between MSM found them to be a very high risk group. In FY2010, a comprehensive package of prevention services for MSM will be developed. Sensitization and training of healthcare providers to provide 'MSM-friendly' services is planned. Male sex work is prevalent in this population, and targeting male sex workers for interventions will be initiated alongside other CSW programming.

Additional prevention activities include community-based alcohol counseling, interventions to address SGBV, job creation as an HIV intervention, promotion of abstinence, fidelity, partner reduction, and related social norms influencing behaviors, targeted behavior change communication (BCC), male circumcision in the military; positive prevention, as well as wrap-around programs with health components and integrated health promotion strategies with family planning services, increasing male involvement, and scaling up VCT (esp. for MARPs), including couples CT, and enhanced condom distribution and promotion.

USG funded sexual prevention programs focusing on abstinence and fidelity (HVAB) have targeted the following key groups: youth 10-18 years old with delayed sexual debut messages and youth 15-29 years old with abstinence and/or partner reduction. Rwanda is unusual in that it is a conservative society where the age at sexual debut among females is 20 years. The USG AB program tries to reinforce this early abstinence occurrence. Outreach to young people is done in a variety of community settings (churches, drop-in centers, rehabilitation centers, schools, associations, and cooperatives). HVAB activities include provision of information on HIV risks and the importance of abstinence as an HIV prevention strategy complemented by life skills to build self-esteem and self-efficacy. These activities also promote partner reduction among MARPs and fidelity among married couples, as well as improved communications skills. In addition, programs include messages that promote gender and male involvement. Both youth and adults have been trained as peer educators to promote HVAB. In FY 2009, for example, 6,800 people were trained to provide AB messages; 1,025,093 people were reached through AB messaging and 1,551,693 individuals were reached through abstinence and/or fidelity messages. The specific interventions used included a range of mass media activities (including, but not

limited to, mobile cinema, radio dramas, public service announcements and community theater), interpersonal peer communication and education, outreach to opinion leaders such as teachers, clergy, local leaders and parents (to increase their capacity to support youth in maintaining abstinence), and strengthening of youth clubs, cluster groups to implement BCC activities and schools. AB programs were also extended to the military through AIDS support clubs and counseling and testing services.

Other sexual prevention (HVOP) activities include trainings, condom promotion to prevent HIV transmission, STI management, BCC to reduce risk and improve self-efficacy, as well as other relevant health promotion strategies. Other sexual prevention programs target the following: alcohol use; at risk youth; young women in transactional or cross generational relationships; MSM; mobile populations; members of the military, sex workers and clients, PLWHA and discordant couples. The activities include: provision of quality condoms and information on their use; promotion of counseling and testing- including couples counseling and testing; strengthening of youth friendly centers; male circumcision in the military; positive prevention; and, integration of family planning, gender issues and livelihood into routine prevention activities. During FY 2009, PEPFAR reached more than 1,100,000 individuals with other prevention messages beyond AB and trained 8,849 people to promote condoms and other prevention. In addition, over 8,000 condom service outlets were created/supported to increase access to condoms, especially in 'hot spots' frequented by MARPs. USG, in keeping with MOHs determination to intensify condom promotion, supported a test of condom vending machines in 'hot spot' zones. Other prevention interventions include: a range of high-profile mass media campaigns, interpersonal communication and peer education; community outreach vis-à-vis sports and art competitions; economic empowerment opportunities; capacity building of community clusters and associations (including low income women, PLWHA, youth, fisherman etc.) to implement integrated health services while also addressing underlying factors that exacerbate risks.

Evidence that new HIV infections and/or risk factors are higher among certain groups (e.g. uncircumcised men, married couples, young women etc), USG strives to support the National BCC strategy to encourage consistent condom use, especially as dual protection. Currently, USG contributes 48% of the total funding cost for male condoms in the country and 85% of the total cost associated with social marketing of condoms. There are more than 20 million branded and non-branded condoms in Rwanda with the majority of those being male condoms. There is little current demand for female condoms due to cultural stigma. USG and GOR collaborate to ensure national availability of condoms, limited distribution problems, and clear policies for national uptake. In FY 2009, condom stock remained solid and there are no foreseeable stock-outs. USGs vision is that cost-efficient effective private sector, public sector, and community-based distribution channels are capable of meeting the demand for high quality, affordable branded and non-branded condoms, and other health products.

USG also supports efforts to promote male circumcision combined with condom usage, responsible behavior, and knowledge of HIV status, to prevent new infections. Rwanda's male circumcision (MC) rate ranges between 2 – 5%. PEPFAR, through the DOD, supports MC within the military and hopes to see future roll out of similar programs among the general populations. Clinical training marked the beginning of the PEPFAR funded MC program. To date 21 counselors have also been trained including extensive site preparation, which included equipment and the provision of supplies;, 8 sites have been visited and are ready to roll-out MC. To illustrate the targeted, comprehensive MC strategy, during mobile CT pre- and post-test counseling sessions, individuals testing positive are linked to HIV treatment and community care and those who tested HIV negative (in the military) are counseled on advantages of MC. MC is offered as part of an expanded approach to reduce HIV infections in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted

infections, promotion of safer-sex practices and condom distribution. MC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package.

USG supports the GOR's National Strategic Plan for HIV/AIDS 2009 – 2012 (NSP). The NSP exemplifies the countries dedication to clear health outcomes, shared accountability, results based approaches, targeted interventions that are evidenced-based, address stigma, provide comprehensive packages, and prevention programs, ensure continuity, and reach MARPs. GOR is committed to understanding the dynamics of HIV to gain clear insights into the unique challenges that the epidemic poses to the country, to lead countrywide integration, coordination and harmonization of prevention activities, to identify and address prevention gaps, successes and lessons learned, as well as to ensure that the national strategic plan is based on the most robust epidemiological data to date. Rwanda has set ambitious targets to address HIV/AIDS with the goals of (1) halving HIV incidence in the general population by 2012; (2) reducing morbidity and mortality among PLWHA; and (3) ensuring HIV-positive and affected people have equal opportunities. PEPFAR programs are geared at helping GOR reach its national goals.
In FY 2010, PEPFAR will continue to support integrated prevention activities with key target groups, using emerging evidence and best practices. Increased focus will be on averting new infections by targeting MARPs and 'hot spots' where MARPs are often hidden and harder to reach. To complement prevention activities, increased emphasis has been placed on building national capacity to sustain prevention activities. USG, supports technical and institutional capacity building for a range of RPOs to design, manage, and implement PEPFAR funded activities over time.

Biomedical Prevention Overview Narrative

FY 2010	*$6,166,076*
FY 2009 Partnership Framework	*$2,801,736*
TOTAL	*$8,967,812*

Blood Safety

What are the most important activities being undertaken in this technical area?

- Rehabilitating and equipping blood collection sites.
- Strengthening blood donor recruitment.
- Processing and testing blood for transfusion transmissible infections.
- Distributing, storing and utilizing blood by district hospitals properly.
- Training of blood transfusion personnel.
- Supervision and monitoring of blood collection sites and of blood use in facilities.
- Improving quality assurance.

What are the key differences from last year?

Activities supported in FY 2010 are the same as in FY 2009 but with an emphasis on donor notification of test results, improving quality assurance and the appropriate use of blood by facilities.

Narrative

The goal of the National Center for Blood Transfusion (CNTS) of Rwanda is to reduce the risk of medical transmission of HIV and other blood-borne pathogens and to ensure adequate supplies of safe blood and blood products. CNTS is also responsible for all transfusion services in the country. The American Association of Blood Banks has been working in Rwanda since 2006 providing technical assistance to CNTS to improve blood safety. Working in close partnership, AABB and CNTS have been able to improve infrastructure by renovating the main blood transfusion center in Kigali and two regional

facilities (Huye and Musanze), and to increase the capacity of CNTS to organize trainings in different areas of transfusion medicine. These areas include: immunohematology, biohazard preventive maintenance, validation of equipment, implement quality management systems, monitoring and evaluation, component preparation, blood safety practices and cold chain management. To support these projects in FY 2009, AABB hired a Blood Transfusion Medicine specialist who is seconded to CNTS to provide technical assistance on a daily basis. It is expected that this position will transfer to CNTS as AABB transitions activities to CNTS in the coming years.

Goals and strategies for FY 2010 will include technical assistance to plan at the national level, strengthen donor mobilization, increase the number of donors, improve recruitment and retention strategies, and implement the MAK computer system. AABB will support increased donor mobilization and expanded blood safety services in all five regions of the country through a knowledge, attitudes and perceptions (KAP) survey. This survey was started in FY 2009 and will be completed in FY 2010. The survey will provide valuable information on potential donors that will allow CNTS to effectively and efficiently mobilize and retain donors who have low risk related to HIV and other transfusion transmitted infections. AABB will provide technical support for the development of processes and procedures on rational blood utilization and component therapies, as well as the training of physicians on these policies.

Injection Safety

What are the most important activities being undertaken in this technical area?

- Training of health care personnel in injection safety practices.
- Procurement of injection safety supplies.
- Improving health care waste management.
- Improving monitoring and evaluation for program improvement.

What are the key differences from last year?

Activities supported in FY 2010 are similar to those supported in FY 2009 but with an emphasis on healthcare waste management and improving monitoring and evaluation to improve program performance.

Narrative

The goal of the PEPFAR Safe Injection Program is to prevent the transmission of HIV and other blood borne pathogens by reducing the number of unsafe and unnecessary injections and minimizing contact with infectious medical waste. Epidemiological modeling indicates that hospital-acquired infections contribute to the prevalence of morbidity and mortality of patients who seek healthcare services in Rwanda. Mismanagement of injections and use of other sharps may result in the transmission of deadly infections, such as HIV, Hepatitis B and Hepatitis C to patients and health care providers. However, there has been considerable improvement in the area of injection safety and waste management in health facilities. According to the national cross-sectional survey conducted in July-August 2004 in Rwanda, approximately 28% of the injections observed were about to be administered with un-sterile needles and/or syringes. Following inception of MMIS/JSI project, the situation has improved greatly, although there remains much room for improvement, as 38% of recently visited health facilities had sharps and other wastes in the compound, thus exposing the community to needle-stick injuries. Many health facilities are inadequately equipped with knowledge on injection safety and medical waste management and do not have proper waste disposal facilities.

With PEPFAR support, Rwanda will continue its safe injection activities by reducing blood-borne HIV transmission both inside and outside clinical environments. In FY 2010, the Environmental Health Desk (EHD) of the Ministry of Health will collaborate with JSI/R&T to develop terms of reference in areas which require capacity building. In addition, EHD will organize the training of healthcare workers and waste handlers on injection safety and healthcare wastes. Incinerator operators and their supervisors will also be trained on the use and maintenance of the equipment. The beneficiaries of this training program will be those who have never received training before, particularly newly employed staff. A strategic plan for prevention of infections will be developed to enable healthcare workers and waste handlers to protect themselves against HIV and Hepatitis B. EHD will identify the required materials, consumables and equipment for injection safety and healthcare waste management and link them to the procurement organization SCSM, which will in turn ensure the procurement of needed items in sufficient quantities and of the appropriate quality.

EHD, in association with JSI/R&T and key partners, will begin the construction of multipurpose waste pits and the installation of appropriate incinerators for the disposal of medical waste. Guidelines and specifications for waste pits and incinerators will be provided through a joint effort by EHD, the World Health Organization and John Snow, Inc. EHD will also organize training workshops for Community Health Workers throughout the country and equip them with the knowledge necessary for them to sensitize communities on injection safety and best practices for medical waste.

In FY 2010 JSI/R&T, the USG and EHD will conduct joint supervisory visits to assess injection safety and medical waste management practices in health facilities and district hospitals. Monitoring and evaluation will be carried out to ensure the smooth and successful implementation of activities as well as determining areas which require immediate action. Data collected will be used for an analysis of program performance as well as for the preparation of management documents for program officers. Given that EHD will soon be taking over the responsibility of managing injection safety and medical waste management activities from JSI/R&T, EHD will be deeply engaged in all aspects of the implementation and evaluation of this program.

Male Circumcision

What are the most important activities being undertaken in this technical area?

- Develop tools and guidelines related to MC.
- Train providers on MC.
- Customize appropriate messages to the populations targeted for MC.
- Develop indicators for program effectiveness.

What are the key differences from last year?

- Stronger focus on training more providers on MC.
- Integrating MC messages into a comprehensive HIV prevention package.
- Procure supplies and equipment.
- Perform M&E of MC program activities.

Narrative

The World Health Organization (WHO) and UNAIDS recommend that male circumcision (MC) be made available in countries highly affected by HIV/AIDS to help reduce transmission of the virus through heterosexual sex. According to published studies conducted in Uganda and Kenya, routine MC could reduce a man's risk of HIV infection through heterosexual sex by 65%. According to WHO, implementing

MC programs in sub-Saharan Africa could prevent about 5.7 million new HIV cases and three million deaths during the next two decades if combined with condom usage, responsible behavior, and knowing the HIV status of one's partner. WHO encourages countries in Southern and Eastern Africa where HIV rates are high and circumcision rates are low to provide access to no-cost MC, for men age 13-30 and to consider adopting MC as "an important and urgent" health priority. Rwanda would benefit from MC as an additional HIV prevention strategy because it has a low male circumcision rate (2-5%) and a generalized HIV epidemic (3.1%).

The Rwanda PEPFAR five-year strategy focuses on primary prevention, especially among most at-risk populations. The strategy includes promotion of CT services, prevention and treatment of STIs, integration of the role of alcohol and GBV into HIV/AIDS messages and MC promotion in the Rwanda military. To illustrate this targeted, comprehensive strategy, during mobile CT pre- and post-test counseling sessions, individuals testing positive are linked to HIV treatment and community care and those who tested HIV negative (in the military) are counseled on advantages of MC. MC is offered as part of an expanded approach to reduce HIV infections in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted infections, promotion of safer-sex practices and condom distribution. MC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package.

The USG has worked closely with the Rwandan Ministry of Health (MOH) and other donors in a national task force to develop policy that recognizes MC as an effective HIV prevention method alongside the ABC strategy. The MOH has also requested donor support for the initiation of MC services beginning with the Rwanda military (one of Rwanda's most at-risk populations) with subsequent provision of services to university students and neonates. MOH has already embarked on different activities which include conducting a national health service assessment for male circumcision with a goal of identifying the capacity of health facilities, both public and private, that can provide safe circumcision services and that are also geographically accessible to the general population. The data on health service assessment for MC are being analyzed and the results will be compiled in a report and shared with all stakeholders. In collaboration with the MC TWG and other partners, MOH developed a national Guideline for MC.

In FY 2009, correct communication and messaging to the Rwanda Defense Force (RPF) that benefits accrue over time and that MC does not provide complete protection was emphasized. Communication approaches occurred at the national level through media campaigns that encouraged safe male circumcision as part of a complete approach to prevention, as well as local and inter-personal communication strategies. Attention was paid to socio-cultural context, human rights and ethical principles, health services strengthening, training, gender implications, service delivery and evaluation. Conducting MC in the Rwanda military is considered vital since the military is predominately male, typically young, highly mobile and is considered a high risk group. MC was conducted on voluntary basis on HIV-negative soldiers since preliminary results from a study conducted in Uganda and presented to UNAIDS and WHO officials found that HIV-positive men undergoing circumcision might be more likely to transmit the virus to their female partners if they have sex before the circumcision wounds have healed. TRAC Plus is also conducting a national Knowledge, Attitudes and Practices (KAP) study on male circumcision. The study aims at providing baseline evidences on the knowledge, attitudes and practices regarding MC in the Rwanda general population in order to guide medium and long term strategic program planning. TRAC Plus is developing trainers' and providers' manual on MC as per WHO guidelines on MC to be extended to health facilities which normally don't provide MC in their minimum package.

In FY 2010, correct communication on MC will continue in the RDF and in addition, TRAC Plus will continue trainings of trainers for all district hospitals, training for all providers in military health facility, rehabilitation of infrastructure, supply equipment for military health facilities and conduct M&E/Data collection. DoD will provide TA to conduct a quick research study on the "Circumcision status of military recruits". In collaboration with Drew University and the Centrale D'Achat des Medicaments Essentiels, Consommables et Equipments Medicaux du Rwanda (CAMERWA), SCMS will quantify and procure male circumcision (MC) kits for Rwandan military personnel. Drew University forecasts that an average of 50 males per week in five sites (250 total procedures per week) will be circumcised. It is thus estimated that 15,000 MC kits per year will be needed. The demand for MC procedures and kits could vary and will be closely monitored. As CPDS increasingly expands to include other commodities, SCMS will support the CPDS to ensure appropriate integration of male circumcision kits into the system, including quantification support, the development of a supply plan, and procurement of male circumcision kits.

These activities address the key legislative issues of gender, especially male norms, and stigma reduction and support the PEPFAR plan by collaborating with the GOR to implement MC as a key strategy of both Partnership Framework and the National Strategic Plan.

Counseling and Testing Overview Narrative

FY 2010	*$5,650,081*
FY 2009 Partnership Framework	*$1,651,655*
TOTAL	*$7,301,736*

What are the most important activities being undertaken in this technical area?

- Support the expansion of finger-prick testing and task shifting.
- Support HCT for the general population.
- Emphasize HCT services including access to mobile HCT for drivers of the epidemic such as discordant couples, youth, commercial sex workers and their clients, military and police, and truck drivers.
- Support HCT for families of PLWHA and discordant couples, including follow-up programs for discordant couples.
- Identify high-risk HIV negative persons attending HCT and develop and implement follow-up interventions for this population.
- Enhance linkages for PLWHA and discordant couples to care and treatment services.
- Employ provider-initiated testing for groups at high risk of HIV infection.
- Identify potential HIV incidence hotspots, and intensify delivery of evidence-based interventions for these target populations in areas with high HIV prevalence.

What are the key differences from last year?

- Increased emphasis on task-shifting.
- Emphasis on mobile HCT for itinerant MARPs.

Narrative

In FY 2010, PEPFAR partners will continue to provide counseling and testing services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. Currently, HIV counseling and testing (HCT) is conducted only by trained clinical providers. In order to expand access to service, PEPFAR will support the expansion of finger-prick testing and task shifting in all supported facilities. Support for prevention activities among people living with HIV and

AIDS (funded in the HVOP and HBHC program areas) will help to ensure that high quality prevention counseling is routinely provided to all HIV-positive clients.

PEPFAR will continue to support HCT activities for the general population coupled with an emphasis on drivers of the epidemic such as discordant couples, youth, commercial sex workers and their clients, military and police, and truck drivers. PEPFAR will also support HCT activities targeting families of PLWHA and discordant couples.

It is estimated that 2% of heterosexual couples in Rwanda are serodiscordant (DHS 2005). Modeling of DHS data indicates that over 75% of new heterosexually-acquired HIV infections occurred within co-habiting couples (Dunkle et al, Lancet 2008). In FY 2010, PEPFAR will continue to support and expand Couples HIV Counseling and Testing (CHCT). Over 80% of women attending ANC services in PMTCT were accompanied by their partners who were also tested for HIV. Approximately 187,000 couples were tested in 2008. Of these more than 5,800 were identified as discordant, with more than 1,000 in Kigali. PEPFAR will support an evaluation of this initiative and the development of prevention interventions for the negative partners in these discordant couples. All clinical partners will implement a follow-up package of interventions for discordant couples including periodic HIV retesting for the negative partners, provision of condoms and risk reduction counseling, messages for circumcision for male negative partners, linkage to care and treatment for positive partners and options for family planning services. PEPFAR will continue to support performance-based financing to increase both the quality and quantity of testing services being provided to couples.

In order to reach most at risk populations who are less likely to access HCT services at clinical sites, PEPFAR efforts will continue to support outreach HCT. A number of complementary activities with different points of emphasis are planned: 1) Population Services International (PSI) mobile teams will focus on military members, their spouses and families, and will also conduct outreach to high risk youth; 2) through the Transport Corridor Initiative, Family Health International (FHI) will ensure HCT services at SafeTStops for long distance truck drivers, sex workers and their clients, and other mobile groups; 3) FHI will also develop HCT initiatives to identify high risk negatives using a risk score algorithm, and design follow-up interventions for these high risk negatives; 4) PSI, through the Prevention Interventions for Youth and MARPs will provide comprehensive HCT and prevention services at six Youth Friendly Centers (YFC) reaching more than 30,000 high-risk youth through the centers and outreach mobile HCT to MARPs.

Clinical partners will continue to implement HCT in health facilities in 23 PEPFAR-supported districts. Partners will use proven HIV testing approaches like Provider Initiated testing (PIT) for populations with high likelihood of HIV infection. Use of simple innovative testing methods such as finger-prick will be emphasized. Clinical partners will also enhance linkages with community partners for better referrals to prevention, care and treatment services.

These activities will be coordinated to avoid duplication and maximize coverage to most at-risk populations. Counseling and testing provided in mobile settings will follow national guidelines and ensure linkages and referrals to care. Mobile counseling and testing programs will reach 80,000 individuals. PEPFAR community partners will continue to support the promotion of HCT among OVC and their caregivers, partners and families of PLWHA, out of school youth, and truck drivers. This targeted promotion of HCT services will identify those most likely to be infected and ensure they are referred to sites where they can receive testing, counseling, and referral to appropriate care. These activities will contribute to increasing the number of people served by both community and clinical partners.

In FY 2010, PEPFAR will continue its technical and financial support to TRAC Plus for the development of policies, guidelines, and tools. Tools for follow-up interventions for discordant couples will be developed from a formative program evaluation, adapted and disseminated.

With support from PEPFAR and under the coordination of the GOR, partners working in high prevalence areas (such as Kigali) will collaborate to review PMTCT and VCT data suggestive of potential HIV incidence hotspots. Once geographically delimited high-risk populations are identified, GOR (TRAC Plus and CNLS) will coordinate the enhanced delivery of evidence-based prevention interventions to these target groups using existing clinical services. In addition, GOR will intensify and improve outreach through ongoing mobile interventions to these groups.

TRAC Plus will continue to conduct training of trainers and trainings for district supervisors. Quality Control (QC) for HIV testing is performed on 10% of all testing samples throughout the country and is managed and supervised centrally by the National Reference Lab (NRL). PEPFAR provides technical and financial support to the NRL for these activities, which are further detailed in the HLAB program area. In FY 2010, SCMS will continue to support the procurement and distribution of test kits and laboratory supplies for all PEPFAR-supported HCT activities, including lancets to implement the finger prick specimen collection method.

CARE AND TREATMENT

Adult Care & Treatment Overview Narrative

FY 2010	*$34,400,923*
FY 2009 Partnership Framework	*$3,375,358*
TOTAL	*$37,776,281*

What are the most important activities being undertaken in this technical area?

- Building capacity of and empowering local institutions at the central & decentralized levels is paramount in FY10.
- Diagnosis of OIs, specifically extrapulmonary TB, cervical cancer in HIV-positive women, cryptococcal meningitis & sexually transmitted disease are very much an area of focus.
- Training in histopathology for Rwandans & laboratory accreditation processes to make this a reality & sustainable. (see Laboratory Infrastructure section)
- Focus on couple counseling & follow-up of discordant couples, prevention with positives, & delivery of integrated services & promoting of one stop centre services to improve access to care & improve retention in care.
- Emphasis on diagnosis of treatment failure & targeted viral load testing.
- Moving patients to second line regimens.
- Intensified & decentralized clinical trainings & mentoring.
- Improved quantification of commodities.

What are the key differences from last year?

- Shift in focus from scaling up of additional care & treatment sites to improving the quality of current sites.
- Working on task-shifting in order to improve the ability of current sites to oversee additional patients.

- Integration of services to support the “one stop shop “model, which is client friendly & reduces referrals & subsequent loss to follow-up.

Narrative

According to the 2009 Rwanda HIV/AIDS Epidemiological Update, the median estimate of the number of HIV-positive individuals in Rwanda is 172,673. Of these, 79,877 are estimated to be in need of ART (Source: 2009 Epidemic Update; MOH & CNLS).

Cumulative national totals for 2009 show:

- As of September 2009, 73,769 patients in Rwanda were receiving ART, including 46,341 at 157 PEPFAR supported sites (PEPFAR FY09 APR).
- Of the total number on ART, 5,689 (12.27%) are children below 15 years old (PEPFAR FY09 Annual Performance Report).
- Approximately 1% of adult patients were on second line regimens (Source: TRAC Plus, HAS Unit).
- There were an estimated 8,196 new adult HIV infections (Source: 2009 Epidemic Update; MOH & CNLS).
- Approximately 4,181 adults died of AIDS (Source: 2009 Epidemic Update; MOH & CNLS).
- The national ART coverage is estimated at 76%. (Note: Rwanda National Guidelines for ART set threshold for initiating ART at 350 CD4 cell/ml.)
- The 2009 National Epidemiological Update Plan aims to extend ART treatment services to 89% of all HIV positive people in need by December 2011.
- There is no reliable data available regarding the coverage of co-trimoxazole prophylaxis among eligible HIV-positive patients, either nationally or within PEPFAR-supported clinical settings.

Key Policy Changes during FY08-09:

During FY08 and FY09, Rwanda’s National HIV Strategic Plan was developed and disseminated that defines the national objectives, priorities and areas of interest for all HIV programs. In 2009, the National Guidelines for HIV management were updated and identified a Tenofovir-based regime as the first option among first-line ARV treatments. The Guidelines also call for universal ART for HIV-positive children under 18 months. The national HIV projections developed in 2009 are higher than those of previous years and estimate the total adult population expected to be HIV positive by Dec 2011 at 184,994 persons.

Transition of Track 1.0 partners

PEPFAR, under the Track 1.0 mechanism grants, started its transition process to local partners in FY 2009. A Transition Task Force was created with the leadership of the Rwanda Ministry of Health (MOH) and the USG. Clinical partners participated in the regular meetings of this task force and contributed to the transition plans developed for the various projects supported by Track 1.0 grants. The first phase of this transition will involve a limited number of sites which will be selected through a detailed and participatory assessment. These health facilities to be transitioned in March 2010 to the management of the GOR, which will continue to receive TA and support from the international implementing partners in order to ensure the quality of services is maintained. Every six months an intensive monitoring of the quality of services will be performed, the results of which will guide the next phases of the transition and its expansion to non Track 1.0 grants.

PEPFAR clinical partners are currently supporting the Performance Based Financing system at the health facility level. Track 1.0 grantees will transition this support to the MOH in FY 2010.

Adult Care and Support

As of the end of FY09, PEPFAR supported 247 health facilities which provide basic care and support services to 120,757 PLWHAs. PEPFAR will continue to support existing sites and to integrate, to the extent possible, VCT in to primary health care services in the 22 districts where PEPFAR is the lead donor. USG partners will continue to support access to a comprehensive range of basic care and support services, including clinical and non-clinical (prevention, psychological, spiritual, and social) interventions, both at the facility and community levels. To date, the bulk of prevention, care, and treatment services for PLWHA have been provided in the health facility setting, with linkages to community care for other support services offered. Clinical services include: CD4 testing and clinical staging; diagnosis and treatment of common opportunistic infections (OIs); adherence counseling; clinical monitoring; provision of co-trimoxazole, which according to the revised national guidelines will now be offered to all HIV positive people regardless of CD4 cell counts; nutritional assessment and support; prevention counseling, including “prevention for positives”; and referrals to community-based care and support services. In FY09, integration of mental health into HIV services was initiated in a few sites, and this will be scaled up in FY10, with development and dissemination of screening tools and national guidelines by TRAC Plus. Social care services will continue to be provided primarily through community-based activities, with strengthened referrals to and from clinics.

Clinical partners will continue to support community health insurance (Mutuelles de Santé) for eligible HIV patients and their families to enable them to access primary health care services. In addition the partners help support patients’ transportation costs, and promote income generation initiatives through PLWHA associations. Nutrition education, counseling and kitchen gardens are supported by all partners to ensure nutrition support. Food by prescription and food to support newly initiating ART patients continue to be an area of need for PEPFAR programs at a national level.

Prevention, psychological, social, and spiritual services in the community are provided through national and international faith- and community-based organizations, as well as associations of PLWHAs, which are present in all of Rwanda’s 30 districts. All health care providers (facility- and community-based) will continue to integrate prevention messages and appropriate prevention counseling into their activities, particularly for HIV-positive individuals and their families. Specifically, PEPFAR will continue to promote a linkages model, which utilizes facility-based staff, community volunteers, Community health Workers (CHWs) and existing health committees at the health facility level. The model focuses on improving communication and coordination to guarantee a continuum of care for HIV-positive individuals and their families and minimize loss to follow-up of patients, particularly in pre-ART services. Robust supervision, monitoring and evaluation of these linkages are essential to ensuring the quality of care.

In FY10, PEPFAR will continue to support community-based partners in improving their monitoring so that numbers of family members receiving support are captured in program reporting. In addition to the provision of services, PEPFAR will continue to build the capacity of Rwandan non-governmental, faith- and community-based organizations to ensure the smooth transition and sustainability of services by host institutions.

PEPFAR will continue to procure basic care related commodities through PFSCM, in coordination with the GOR’s central procurement agency, CAMERWA. These supplies include drugs for the prevention and treatment of OIs, and laboratory and diagnostic kits for improved and expanded OI diagnosis. PEPFAR will continue to promote coverage of key clinical interventions (co-trimoxazole, bed-nets, safe water products, etc.) which have been demonstrated to reduce morbidity and mortality among PLWHAs. In

collaboration with PMI, PEPFAR will continue to support the provision of bed-nets for PLWHA and their families through JSI/DELIVER. Provision of point-of-use water purification, "Sûr'Eau", will be supported in FY10 and clinical partners will work towards the integration of safe water into basic care services. With additional resources, some clinical partners will use MCH funds to ensure safe water in facilities supported by PEPFAR. All USG Partners will continue to support integration of family planning and MCH initiatives in supported sites, and introduce mental health services according to national guidelines.

In FY10 PEPFAR priorities for care include the use of a family-centered approach for care; improvement of pain management; improved prevention counseling for HIV-positives through the provision of targeted risk reduction and behavior change messages (in both clinical and community settings); support for caregivers; and improved linkages (community to clinic, within clinical services and wrap-arounds). Continuing wrap-around activities in FY10 include: the provision of bed-nets (through PMI), IGA initiatives; support for economic growth and livelihoods; and links to services for gender based violence. Improvement of psychosocial support, including mental health screening and treatment within HIV services, is a rising priority for the GOR and one that PEPFAR plans to support in FY10. Finally, PEPFAR Rwanda will support basic program evaluation activities, including assessment of patient outcomes in pre-ART settings and the impact of community-based clinical services.

Adult Treatment

PEPFAR supports HIV treatment services in 23 districts but is the lead donor in 22 out of 30 districts in Rwanda. In FY 2010, PEPFAR will continue to support all levels of the decentralized ART network, starting from central level institutions and extending to community level health facilities. In addition, PEPFAR partners will continue enrolling patients in ART services at currently supported sites and will expand its services to a limited number of new ART facilities. As the number of patients continues to grow, PEPFAR will carry on its work with GOR and other donors to evaluate and ensure the quality of HIV-related services. This includes programs designed to provide site and program-level feedback regarding quality of clinical services and support at central levels to update guidelines, and the development of training materials and job aids. PEPFAR will also continue to provide training and clinical mentoring to assist clinicians to identify patients in need of second-line regimens by evaluating clinical, adherence-related and immunological criteria, as well as the use of targeted viral load testing.

At the central level, the USG will continue working with the national Center for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics (TRAC Plus) (TRAC Plus) of the MOH, the National Reference Laboratory (NRL), and other key units in MOH through cooperative agreements and other implementing partners. PEPFAR will continue to provide support to MOH to revise national guidelines, tools, curricula, and conduct training of trainers for adult HIV care and treatment. In FY 2010, with PEPFAR funding, MOH will coordinate joint supervisory visits to clinical sites in collaboration with the district health teams (DHTs) to improve data quality and use. At the district level, PEPFAR partners will continue providing financial and technical support to their respective DHTs to strengthen linkages, referrals, transportation of patients and specimens, communications, forecasting, drugs and commodities distribution, and financial systems. In addition, PEPFAR partners will strengthen district level supervisory, management, mentoring and reporting capabilities.

In districts where the lead donor supporting some HIV-related clinical services is not PEPFAR but another donor, like GFATM, PEPFAR partners still support establishment of functional linkages that support continuity of care across sites and services, as well as provide TA and resources for supportive

supervision. Each partner also is charged with providing direct mentoring and capacity building support to their DHT, thus building capacity to decentralize supervisory and quality assurance activities.

At site level, PEPFAR partners will support national efforts to define a standardized basic package of ARV services through support and development of a coordinated network of HIV/AIDS services linking ART with PMTCT, TB, FP, MCH and other services. Following a tiered approach to service delivery, USG partners will provide comprehensive ART services at larger facilities and basic ART services at satellite health centers. Nurses will serve as the primary HIV service provider at health centers through the implementation of task shifting, and have physician back-up based at the district hospital. PEPFAR will continue supporting task shifting by strengthening nurse training through pre-service and in-service training, implementation of simplified protocols, and district hospital physicians to support nurses in managing ART cases through regular mentoring visits and remote support via telephone for urgent questions.

At the community level, PEPFAR partners will ensure continuity of care and adherence support through case managers, community health workers (CHWs), and peer support groups. Through community mobilization activities, home visits, community-based registers, referral slips, patient cards and other tools, community health workers will facilitate transfer of information within and between facilities and communities to improve patient retention. CHWs will provide adherence counseling, patient education, and referrals for drug side effect management. PEPFAR partners will provide training and materials to those volunteers and link them to case managers at facilities for better referrals between facility and community.

In FY 2010, PEPFAR will continue its efforts to provide nutritional support to eligible adults and pregnant and lactating women, as well as provide supplementary weaning foods to HIV exposed infants. PEPFAR will also support basic program evaluation activities, such as an evaluation of patient outcome in the national HIV care and treatment program.

Pediatric Care & Treatment Overview Narrative

FY 2010	*$4,507,633*
FY 2009 Partnership Framework	*$631,005*
TOTAL	*$5,138,638*

<u>What are the most important activities being undertaken in this technical area?</u>
The most important activities that PEPFAR Rwanda is undertaking in the HIV Pediatric care and treatment technical area include:

- Continued support to existing care and treatment sites to offer a comprehensive package of pediatric HIV care and treatment services.
- Revision and dissemination of guidelines, tools, and training materials used in HIV pediatric care and treatment programs.
- Refresher training for trainers and training of providers on task shifting in PEPFAR -supported health facilities.
- Maintain and reinforce quality of services through supervision and mentorship.
- Support two pediatric HIV care and treatment centers of excellence (COEs) located at the University teaching hospital in Kigali (CHUK) and at the Butare University teaching hospital (CHUB).
- Support provider-initiated testing at all pediatric in- and outpatient settings at PEPFAR supported sites.

- Reinforce psychosocial support for HIV-positive children and adolescents through promotion of children and adolescent support groups in order to address issues around status disclosure and adherence support.
- Integrate HIV pediatric care into guidelines related to the integrated management of childhood illness.
- Continue to give nutrition support to HIV-positive infants, children and adolescents through nutrition counseling using the food by prescription model.
- Support referrals for all HIV-positive children to malaria prevention services, including referral for the provision of long-lasting insecticide-treated nets (LLIN) and integration of home-based management of malaria, in collaboration with GFATM and PMI; referral to CBO's and other community partners for distribution of water purification kits and for hygiene education; health education; and legal support.

What are the key differences from last year?

The key differences from last year's HIV pediatric program include a stronger focus on:

- Improvement of quality of HIV pediatric program.
- Improvement of psychosocial support for HIV-positive children and adolescents.
- Reinforce CHUK and CHUB as training centers for pediatric care and treatment.

Narrative

It is estimated that 22,020 HIV-positive children under 15 years of age currently live in Rwanda. Most of them have acquired the infection through vertical transmission. In the 2007 sentinel surveillance of women attending antenatal clinics, the prevalence of HIV among pregnant women in Rwanda was 4.3% [3.8-4.5] of pregnant women. According to the 2009 Epidemiologic Update on HIV and AIDS in Rwanda, the projected number of HIV-positive pregnant women in 2010 is 10,600. All infants born to HIV-positive mothers are in need of follow-up services.

Approximately 6,278 HIV-positive children under 15 years of age are currently receiving ART (8.5% of all patients on ART). The USG, the Global Fund, the World Bank and the Clinton Foundation are some of the major donors working with the Government of Rwanda (GOR) to develop and implement programs for HIV-affected and infected infants, children and adolescents. Presently the USG supports HIV care and treatment services at 370 sites in Rwanda, and PMTCT services at 282 sites distributed throughout 23 of the 30 districts in the country. ART services for children are available at 190 of the 282 USG-funded PMTCT sites.

Twenty implementing partners are funded by the USG to provide care and treatment services to children in Rwanda. Approximately 62% of all children receiving ART are enrolled in programs supported by the USG.

The USG, in collaboration with the GOR and Columbia University, has provided funding for the development of two pediatric HIV care and treatment centers of excellence (COEs) located at the University teaching hospital in Kigali (Centre Hospitalier Universitaire de Kigali, or CHUK) and at the Butare University teaching hospital (Centre Hospitalier Universitaire de Butare, or CHUB). CHUK and CHUB are the two largest referral centers in the country. Renovations for the CHUK pediatric HIV center of excellence were completed in 2008. 5 physicians, 5 trained pediatric HIV nurses, one data manager and one administrative staff work at this outpatient clinic that provides services to 319 HIV-positive children of which 129 are currently receiving ART. 163 HIV-exposed infants are also followed at this site.

Approximately 201 children are in care at CHUB (142 on ART). Personnel from the COEs conduct provider-initiated testing and counseling (PITC) for children admitted to various pediatric wards at both CHUK and CHUB, and it links HIV-positive children and their families to care and treatment services at the COE or at ART facilities closer to their homes. Since FY08, both COEs have been fully operational. They provide clinical services for complicated pediatric HIV cases, and long-distance patient management advice and mentoring. The COEs are also a major training resource for the national pediatric HIV program, addressing the gaps in practical pediatric training for HIV care and treatment providers in the country. Through ICAP, the implementing partner, the two centers will be equipped with libraries in FY 2010.

In FY 2009, PEPFAR has supported TRAC Plus in the revision of the pediatric care and treatment guidelines based on the new WHO recommendations. Implementation of the revised guidelines is ongoing. While progress has been made in scaling up services for children, the pediatric HIV program in Rwanda is still lagging behind in achieving the goal of having children represent 15% of people on treatment. Some of the challenges faced include: lack of sufficient numbers of trained health professionals with experience in pediatric HIV care and treatment service provision; lack of fully implemented PITC for the pediatric population; limited active pediatric HIV case-finding among families of persons enrolled in care and treatment or identified through VCT; limited availability of early infant diagnosis (EID) services; lack of finger-stick blood collection for rapid HIV antibody testing in children; inadequate maternal and infant follow-up services; weak linkages between PMTCT, MCH and ART programs and sites; insufficient emphasis on pediatric HIV in community mobilization activities; and limited linkages between facilities and communities to support follow-up and retention into care of children.

EID and PITC need to be improved and scaled up. The USG will work with the MOH to update, develop and disseminate HIV testing and counseling materials and job aids to support the implementation of PITC for children in Rwanda. There is also a need to improve the management of adolescent care, to support children's nutrition when necessary, to update guidelines for opportunistic infections (OIs) in children, and to systematically screen HIV-positive children for TB. Particular emphasis will be put on the provision of psychosocial support to improve treatment adherence in children. Moreover, pediatric formulations of antiretroviral drugs will be made available in collaboration with Supply Chain Management System (SCMS).

Other identified priorities include: increase the focus of the Ministry of Health (MOH) on the pediatric HIV program; provide additional human resources to the care and treatment unit within TRAC Plus to address the needs of pediatric HIV care and treatment; improve the capacity at TRAC Plus to collect and analyze data on pediatric care and treatment indicators; and harmonize data collection and reporting tools. Data on outcomes of pediatric HIV in Rwanda are lacking, and very limited information is available on the quality of pediatric HIV services, including information on retention, adherence, and treatment failure rates, the adequacy of clinical and laboratory monitoring, and on the appropriate use of second-line treatment.

The USG supports pediatric HIV care and treatment activities at all levels of the health care system. At central level, cooperative agreements and other funding mechanisms with relevant MOH units—TRAC Plus, National Reference Laboratory (NRL), UDPC, Maternal and Child Health units of the MOH—are designed to build capacity for system strengthening, human resources development, and for improved quality of health service delivery for women and children. At TRAC Plus, the USG provides support for the development and revision of HIV-related guidelines and training materials. Recently updated

pediatric HIV treatment guidelines based on WHO recommendations have been disseminated nationally. Training materials with updated pediatric HIV treatment modules have been developed and implementation has begun.

Support to TRAC Plus, UPDC, and district health teams through direct assistance to the MOH and through USG implementing partners will enhance the expansion of quality pediatric services to more decentralized levels of the health care system. The development of integrated management of childhood illnesses (IMCI) training materials by the MCH unit of the MOH in collaboration with BASICS has supported this process. Integration of IMCI in other health services at health facilities will be reinforced during FY 2010 through capacity building and mentoring by health providers.

USG support to the NRL has enabled to develop and increase the capacity of the health care system to provide EID services for HIV-exposed infants. The NRL currently receives dried blood spot (DBS) samples from 346 sites in the country, and it processes approximately 2,064 samples every month. In FY 2010, the USG will continue to provide funding to support EID capacity building by strengthening the NRL and the logistics system, and by ensuring the supply of reagents and sample collection materials. It is anticipated that by January 2010, Butare University Laboratory will become functional as a second lab to process DBS samples for EID. In FY 2010, this lab will be supported to reach full capacity to process DBS samples. EID data collection will be updated and improved. A program evaluation planned for FY 2009 will serve to support further program expansion. Moreover, the USG will continue to work with the NRL, TRAC Plus, the UPDC, and its implementing partners to expand EID access to all PMTCT sites in Rwanda and to reduce the test results turn-around times. The NRL will also receive support from the USG to further expand CD4 testing capacity throughout the country (at present 22 districts have the capacity to process CD4 samples). 15 new CD4 machines will be purchased in 2010 and placed at strategic sites in Rwanda to increase access to CD4 testing for pregnant women and children. The USG will work with the GOR and other donors to secure the provision of EID and CD4 reagents and other commodities for FY 2010 after the ending of UNITAID support to the Clinton Foundation (see laboratory section).

For FY 2010, the USG's strategic approach is to support implementation of HIV care and treatment services for children at all existing and planned USG-supported ART sites in Rwanda. USG-supported implementing partners will be asked to put in place provider-initiated testing at all pediatric in- and outpatient settings at their sites. In addition, USG partners will be asked to implement systematic testing of family members of HIV-positive patients currently enrolled in care and treatment clinics. In collaboration with TRAC Plus, USG implementing partners will reinforce psychosocial support for HIV-positive children and adolescents through promotion of children and adolescent support groups in order to address issues around status disclosure and adherence support. One child counselor per ART site will be trained to organize children support groups.

USG will continue to give nutrition support to HIV-positive infants, children and adolescents through nutrition counseling. Using the food by prescription model, food will be provided in conjunction with HIV treatment and care services in order to increase the effectiveness and coverage of these services and to improve clinical outcomes. This initiative will be linked with ongoing clinical assessments of mothers and growth monitoring of children, and it will leverage nutritional support to OVC and other food programs.

Through a partnership with SCMS, CAMERWA (Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda), the national pharmaceutical warehouse, and district

pharmacies, USG will provide health facilities with appropriate ARV drugs, opportunistic infection drugs and reagents, and support for the development of stock management and distribution.

USG will also support referrals for all HIV-positive children to malaria prevention services, including referral for the provision of long-lasting insecticide-treated nets (LLIN) and integration of home-based management of malaria, in collaboration with GFATM and the PMI; referral to CBO's and other community partners for distribution of water purification kits and for hygiene education; health education; and legal support.

ARV Drugs Overview Narrative

FY 2010	*$11,490,309*
FY 2009 Partnership Framework	*$0*
TOTAL	*$11,490,309*

What are the most important activities being undertaken in this technical area?
The most important activities that PEPFAR Rwanda is undertaking in the anti-retroviral drugs technical area are relative to providing technical support to the Coordinated Procurement and Distribution System that improve the quantification/procurement of ARVs, pharmacovigilance involving adverse drug reaction notification system and harmonizing the logistics management information system(LMIS).

What are the key differences from last year?
The key differences from last year's ARV program include a stronger focus on monitoring and report through improved forecasting for ARVs and accounting for consumption rates through the LMIS. The increased focus on the National Pharmacovigilance and Medicines Information Center and District Therapeutic Committees will enable for improved capacity building at both national and district levels. The elevated performance of these systems and their functioning are paramount to the success of this program area.

Narrative
The Government of Rwanda (GOR) and its USG partners are committed to scaling up quality HIV/AIDS treatment services to allow universal access to ARVs. Per calculations based on the number of ART supported sites, the USG contributes 55% of funding of ARVs and Global Fund give 45% (7th Coordinated Procurement Distribution System Quantification Report). The many successes realized to date have resulted in reduced HIV transmission and many saved lives. Yet Rwanda's continues to have an ambitious ART scale-up plan to provide high-quality and accessible care to its HIV-positive citizens. Estimation of the future needs and resources required should be done regularly, in order to account for unanticipated changes in (1) the care and treatment program, (2) donor and government committed funds, and (3) the price of inputs due to global markets (The Projected Cost of HIV Care and Treatment in Rwanda 2009–2015).

As of the end of June 2009, 70,234 patients (64,236 adults and 5,998 children) were on ARV medications (TRAC net report data). Each month an average of 1,100 additional individuals are placed on ARVs in Rwanda (over 13,000 per year). In 2008, it was estimated that approximately 150,000 persons in the country are living with HIV (EPP Spectrum Epidemiology 2008).

Adding to the HIV/AIDS treatment challenge, effective July 2009, the use of new and not significantly more expensive Tenofovir (TDF) than the AZT-containing regimen which was used as the first line treatment. This regimen is to be administered to all new patients as well as those already on first-line

treatment regimens who experience treatment failure. As many as 13,200 or more patients per year could be on the TDF regimen within a year after it is implemented. According to various projections, the number of adults on ART are expected to rise from about 73,500 in 2009 to 132,000 in 2015 (HIV/AIDS in Rwanda: 2009 Epidemic Update, The Projected Cost of HIV Care and Treatment in Rwanda 2009–2015, EPP Spectrum Epidemiology 2008).

The Central Medical Stores for Rwanda (CAMERWA), TRAC Plus and the Pharmacy Task Force (PTF) work together to forecast, procure, warehouse, store, and actively distribute ARV drugs. SCMS has been supporting CAMERWA to strengthen its warehouse management, stock keeping and financial management systems including the installation of computerized management information systems in order to ensure maximum control over inventory management and the roll-out of active distribution of ARVs. These efforts are intended to minimize the risk of stock outs.

ARV drugs are procured through the Coordinated Procurement Distribution System (CPDS) for 151 PEPFAR-supported ART sites and 63,687 patients. Although there were no reported ARV stock outs of ARVs during FY 2008, emergency orders were placed in three instances to prevent stock outs from occurring. The ARVs concerned were nevirapine, lamivudine and tenofovir. These situations were due mainly in part to incomplete consumption data from health facilities. Due to increased viral load testing efforts in order to identify patients with treatment failure, by the end of 2011, as many as 4,071 (5% of total ART patients) patients could be prescribed new and more expensive second line regimens. The two recommended second line regimens (as per the revised national Standard Treatment Guidelines) (AZT/3TC/LPV-r and TDF/3TC/LPV-r) will cost US $12.42 and $13.33 per patient per month respectively. Prescribing the second line regimens to this number of patients could by itself amount to over US $2.5 million. Close monitoring and coordination with other partners whose financial support helps pay for ARV medications in Rwanda's non-PEPFAR-funded ARV sites, along with ongoing evaluation of the impending regimen changes, will be of critical importance for continued ARV treatment success across the country.

Also being scaled up, coordinated, and integrated are rational drug use, pharmacovigilance, and supply chain management programs. Strategies being utilized to enhance the efficiency and effectiveness of ARV treatment include the rehabilitation of several district pharmacies and training of pharmacists to address the need for systems for routine medicine safety surveillance and to ensure that protection of public's health. The training will include pharmacists who are members of the National Pharmacovigilance and Medicines Information Center (NPMIC). The NPMIC is based in the PTF within the Ministry of Health (MOH). The goal of the NPMIC is to develop and implement medicine safety surveillance systems that will provide unbiased information, monitor safety and effectiveness, and improve rational use of essential medicines in Rwanda. Efforts during FY 2009 also resulted in the expansion of the Adverse Drug Reaction (ADR) Notification System to all district hospitals, development of the Rwanda Medicines Safety Guidelines, ADR notification form, patient alert card, and medicines information request form.

Building on existing achievements, for FY 2010 there will be continued support of the MOH/PTF with the expansion and further strengthening of the pharmacovigilance system of Rwanda. Support will be provided in the following areas:

- strengthen and support the NPMIC to fulfill all aspects of its mandates and objectives;
- develop a strategy for the decentralization of pharmacovigilance through the planning and implementation of cascade trainings utilizing the TOT approach and supportive supervision; and

- consolidate and strengthen the approach of District Therapeutic Committees(DTCs) as part of the strategy for the decentralization of pharmacovigilance at the district level by providing trainings and refresher trainings and supportive supervision.

Continued coordination and streamlining of the Logistics Management Information Systems (LMIS) is needed in FY 2010. In order to ensure stock outs do not occur, CAMERWA will be supported in utilizing the newly developed warehouse computer system. In 2008, participants attending a working meeting identified three key functions for LMIS harmonization: forms harmonization, computerization and a Master Product List for coding of drugs and health commodities. The LMIS forms have been harmonized but have not yet been rolled out nationwide. However, the Master Product List has been completed allowing for the initiation of computerization of the LMIS system. LMIS computerization is a large initiative that will involve extensive resources, both financial and human. It needs to be a collective effort, owned by the Ministry of Health with technical assistance from implementing partners. An implementation team has been assembled to address the challenges of establishing and maintaining this system.

TB/HIV Overview Narrative

FY 2010	*$4,702,636*
FY 2009 Partnership Framework	*$826,217*
TOTAL	*$5,528,853*

What are the most important activities being undertaken in this technical area?

- Increase the number of TB diagnoses in persons suspected of having TB, including enhanced training, supervision, and laboratory capacity
- Improve the capacity to diagnose EPTB, including training and supervision of clinicians and improved laboratory capacity at two academic hospital-based laboratories, i.e. CHUK and CHUB
- Increase HIV testing among persons suspected of having TB
- Scale up of baseline assessments of Infection Control
- Scale up implementation of the Infection Control policy
- Support TB prevalence survey
- Implement new national Isoniazid Preventive Therapy (IPT) guidelines (anticipated in FY2009)
- Increase availability and capacity for performing Drug Sensitivity Testing (DST) to diagnose multi-drug resistance and extremely-drug resistant (MDR-XDR) TB

What are the key differences from last year?

Key differences from FY 2009 include the increased emphasis on TB suspects, the implementation of the long-awaited IPT guidelines, and support to the national TB prevalence survey.

Narrative

Tuberculosis (TB) continues to be a significant health problem in Rwanda, particularly for persons living with HIV (PLWHA). Since 1990, expansion and enhancement of Directly Observed Therapy-Short Course (DOTS) as part of the 6-point "STOP TB strategy" has been implemented in Rwanda by the National TB Program ("Programme Nationale Integre de Lutte Contre Lepere et la Tuberculose", or PNILT) currently referred to as the TB Unit of the Center for Treatment and Research on HIV/AIDS, Malaria, TB, and Other Epidemic Diseases (TRAC Plus), Ministry of Health (MOH). In 2008, there were 7,841 new TB cases, of which 4,173 (53%) were sputum smear positive [2008 Annual Report (TRAC Plus)]. In 2008, 96% (7,510/7,841) of all cases were tested for HIV and 34% (2,560/7,510) had positive test results. During 2008, the overall and sputum smear-positive TB case detection rates were 89 and 48 cases per 100,000

persons, respectively (based on historic national TB prevalence data; note that the case detection rate for sputum-positive TB cases as calculated by WHO, which takes into account regional data and the impact of the HIV epidemic, was 29 cases per 100,000).

Of 2,560 TB cases who tested positive for HIV infection in 2008, 2,219 (87%) were initiated on co-trimoxazole prophylaxis and 1,148 (45%) initiated ART. TB treatment success rates have increased from 58% in 2003 to 86% in 2008 (treatment success remain unchanged from 2007). Rwanda currently has 80% DOTS coverage in all health facilities that offer TB services. The "one-stop" TB-HIV integrated services - defined by the provision of ART to patients with active TB disease by CDT staff - has been scaled up to 142 (75%) of all 190 current CDTs (Diagnostic and Treatment Centers).

Addressing co-infection of TB disease and HIV infection (hereafter referred to as TB-HIV) through program collaboration and integration of services remains a priority of the Rwandan government. Implementation and coordination of TB/HIV collaborative activities has been supported by TB and TB-HIV technical assistance and dedicated TB-HIV coordinators in the TB and HIV Units at TRAC Plus. In 2005, the MOH established a national TB/ HIV integration working group and approved a national policy on TB/HIV collaborative activities based on WHO guidelines.

To promote intensified TB case finding, a standardized TB screening tool (checklist) was developed in 2006. This screening tool is used with all patients at the time of enrollment in HIV care and treatment services and at routine 6-month follow-up visits. If patients screen positive, they will be given a TB diagnostic evaluation that consists of two sputum smears and chest radiograph. If active TB is diagnosed, patients are referred for TB treatment, either at the on-site or nearest CT/CDT. The screening checklist has been included in national pre-ARV and ARV registers. A survey was conducted by TRAC Plus at 18 health facilities in September - October 2008, revealing that there were variable rates of TB screening at PEPFAR-supported sites (TRAC Plus; unpublished). In response to these findings, TRAC Plus and partners carried out intensive trainings and supervision to promote routine TB screening of PLWHA. Of 210 HIV care and treatment sites operational during the first quarter of 2009, 190 reported TB screening data at time of enrollment for 12,512 patients. Of the 190 sites reporting, overall 90% of PLWHA were screened for TB; of these, 14% screened positive; and of these, 23% were diagnosed with TB. Overall, 377 (3%) of 12,152 patients screened were diagnosed with TB.

With USG support, the National Reference Laboratory (NRL) has improved culture capacity for detection of resistant mycobacterium tuberculosis strains and drug susceptibility testing. PEPFAR funding is also supporting laboratory technical assistance, infrastructure improvements, and pre-service training for laboratory technicians in Kigali and the Butare regional laboratories. Diagnostic capacity was enhanced by numerous training activities that were carried out and followed-up with regular supervision (these are on-going in FY 2009). Specifically, 113 clinicians and lab technologists from 8 referral and district hospitals and institutions have been trained with technical assistance from the Institute for Human Virology/University of Maryland on collection of fine needle aspiration (FNA) specimens and techniques for FNA slide preparation and interpretation to improve capacity to diagnose extrapulmonary TB. From August -December of 2008, 56 EPTB cases were diagnosed overall, of which 8 were diagnosed with specialized techniques. From January - June 2009, 68 EPTB cases were diagnosed overall, of which 5 were diagnosed with specialized techniques. Columbia University's International Center for AIDS Care and Treatment Programs (ICAP-Rwanda) is providing support to the national laboratory network primarily through NRL at the central level and the 42 health facilities supported in the Western Province, including:

- Empowerment of lab technical working groups to implement national TB/HIV standards.

- Introduction of new TB diagnostic technologies to improve TB detection (MDR TB) and drug sensitivity testing (2nd line).
- Improvement of AFB smear microscopy: Switch from Kinyoun technique to Ziehl Neelsen (ZN) technique, since 1st quarter 2008.
- Training for all District Hospitals on TB External Quality System (TB EQA) in November 2009.

Progress is also noteworthy with regard to the management of multi-drug resistant tuberculosis (MDR-TB). A growing number of health facilities are involved in the follow-up and ambulatory treatment of patients with MDR-TB. Guidelines outlining MDR-TB treatment were published and disseminated in 2007. From 2005 until October 2009, 338 cases of MDR TB were diagnosed; the number of MDR TB cases declined somewhat from 102 in 2007 to 74 in 2008, with 72 cases diagnosed through the end of the 3rd quarter of 2009. In 2008 and the first three quarters of 2009, 15% and 14% of patients died during treatment and 84% and 86% completed treatment, respectively. The median time from drug sensitivity testing to treatment initiation has decreased from 86 days in 2006 to 29 days in 2008 and 14 days during the first three months of 2009. In FY 2010, PEPFAR Rwanda will continue to provide technical assistance to the MDR TB focal point at PNILT.

TB infection control (IC) assessments and training initiated in FY 2009 will continue at district hospitals and will eventually be expanded to include health centers. In FY 2010, these assessments, as well as renovations to improve infection control for the most in-need health facilities, will continue. Routine supervision of TB infection control practices will be implemented and integrated into existing supervision frameworks. Also, in FY 2009, limited provision of isoniazid preventive therapy (IPT) will continue for children as part of a national pilot program supported by ICAP. National IPT guidelines have not yet been finalized; however this is anticipated during FY 2009 and roll-out will commence in FY 2010.

In undertaking FY 2010 planning, the national TB-HIV TWG started by reviewing the recently developed National Strategic Plan and National Strategic Application, including costing. Gaps were identified in existing funding commitments and priority new activities, which included the following, in order of priority:

1. Increase the number of TB diagnoses in persons suspected of having TB, including enhanced training, supervision, and laboratory capacity.
2. Improve the capacity diagnose EPTB, including training and supervision of clinicians and improved laboratory capacity at two academic hospital-based laboratories, i.e. CHUK and CHUB
3. Increase HIV testing among persons suspected of having TB
4. Scale up baseline assessments of IC
5. Scale up implementation of IC policy
6. Support TB prevalence survey
7. Implement new national IPT guidelines (anticipated in FY2009)
8. Increase availability and capacity for performing DST to diagnose MDR-XDR TB
9. Disseminate revised ART National guidelines

In FY 2010, all 9 priority areas will be supported, including partial support for the national TB prevalence survey which will provide a foundation for monitoring and evaluation of TB programmatic activities. This is particularly important given longstanding concerns about the low TB case detection rates based on historic WHO data which are viewed as contentious by the MOH.

In FY 2010, PEPFAR Rwanda support for priority TB-HIV laboratory issues will continue via the Capacity Support to MOH funding to Columbia ICAP-Rwanda. In addition and consistent with the 2nd priority above, capacity building for diagnosis of extrapulmonary TB will continue, albeit in a different structure: CDC Rwanda will hire and second the TA directly to either the NRL or one of the university-affiliated referral hospitals. In addition, funding will be provided to the MOH to hire and train additional Rwandan pathologists, who will also support the incipient cervical cancer screening and management program in HIV care and treatment sites.

OVC Overview Narrative

FY 2010	*$12,157,200*
FY 2009 Partnership Framework	*$50,000*
TOTAL	*$12,207,200*

What are the most important activities being undertaken in this technical area?

- Building the institutional capacity of local CBOs working to give vulnerable groups access to essential services;
- Building more resilient families through economic and social coping mechanisms;
- Building GOR capacity at both central and decentralized levels for better program coordination, monitoring and beneficiary identification; and
- Supporting and strengthening existing natural social linkages in the community for child protection, care and support;

What are the key differences from last year?

- Service provision tailored to the needs of the beneficiaries;
- Market responsive technical and vocational training and education;
- Economic and productive capacity of vulnerable households;
- Beneficiary identification and the creation of an a national OVC database; and
- Sustainable and age-appropriate minimum package of services.

Narrative

According to projections released in July 2009 by the National Institute of Statistics, Rwanda's total population in 2010 will be 10,412,485, of whom 42% will be children under the age of 15 (and 53% under 20). The double impact of genocide and AIDS has resulted in Rwanda having one of the highest proportions of orphans in the world. However, 16 years after the genocide, the majority of orphan cases in 2010 will, according to UNICEF, be attributable to HIV/AIDS. The 2007 Rwanda National Plan of Action for OVC estimates that there are 1,264,000 OVC in Rwanda, of whom 820,000 are orphans of all causes. The UNAIDS country report for 2008 puts the number of orphans due to AIDS in Rwanda at approximately 220,000. An additional 19,000 are children aged 0-14 living with HIV/AIDS.

In Rwanda, PEPFAR is the primary donor in OVC service provision and focuses on beneficiaries aged 0-17 infected or affected by HIV/AIDS. UNICEF, the other major international donor working with OVC in Rwanda, focuses only on central level TA and provides no direct services. As of September 2009, USG assistance had reached 75,040 OVC, a 42% increase from the previous fiscal year, with a menu of services that mirror those of the GOR, including school fees, vocational training, health insurance, protection, psychosocial support, shelter and care, and HIV prevention education.

In FY 2009, a cooperative agreement was awarded to CHF international to implement a 5 year social services for vulnerable populations project, Higa Ubeho ("be determined and live"). Higa Ubeho is playing the lead role in coordinating USG efforts to assist OVC and their families as well as assisting the GOR with strengthening of district and sector level children's forums and orphan care committees. These efforts are ensuring the participation of children and local leaders in OVC activities as well as coordination of services for OVC. In FY 2009, OVC programming is using a model of service delivery through nine Rwanda Partner Organizations (RPOs) that will be scaled up in FY 2010 to include 17 RPOs in 20 districts. This model ensures that identification of beneficiaries is transparent, services are appropriate, and the program is sustainable as local capacity is built and strengthened through on-going skills transfer.

In FY 2009 all Track 1.0 OVC projects (currently serving 9,500 beneficiaries in 14 districts) will close out. To ensure a smooth transition for those still needing support, the Higa Ubeho project is planning to select Track 1.0 beneficiaries in eight districts that overlap its operational zone, while engaging GOR to pick those in the remaining six which overlap Global Fund supported districts. This overlap will ensure continued support to OVC and the retention of PEPFAR targets.

In FY 2009 the NPI funded FXB International implemented a village model of care and support. This model aims to improve the long-term well-being of OVC by reinforcing the capacities of families affected by HIV to meet their own needs and those of OVC in their care. The FXB model ensures that households are capable and committed to gradually meeting their daily needs such as healthcare, nutrition, and education of OVC by assisting them to start and expand micro enterprises and providing them with in-kind resources, training, support and supervision. As a result, FXB plans to reduce healthcare and education support by 25% in FY 2010 since the household businesses will be expected to generate regular income and the caregivers able to make savings and access micro-credit.

The Rwanda Youth Program (RYP), implemented by EDC, commenced its activities in FY 2009 and will expand in FY 2010 to provide 4,000 youth, including OVC, with market-relevant life and work readiness training and support, hands-on training opportunities, and links to the employment and self-employment job market. In FY 2010, RYP will also build the capacity of local partners to ensure that participating youth are linked to sustainable livelihood avenues either through education and training or employment and/or micro enterprise. To ensure OVC access to legal aid, PEPFAR will continue funding Avocats Sans Frontieres in FY 2010 to work with the Rwanda Bar Association and other civil society organizations to provide legal services to vulnerable groups.

In FY 2010, the overall strategy for providing services to OVC will include implementing partners directly providing OVC services or referring them to other care and support programs in PEPFAR districts. All OVC partners will focus on ensuring that as many OVCs as possible have access to and complete the nine-year education cycle at public institutions. Additionally, partners will work to ensure programmatic efficiencies in order to ensure the largest number of OVCs can be reached. PEPFAR and its partners will continue as active members of the OVC technical working group (TWG), which coordinates quality OVC programming with other stakeholders, such as UNICEF, UNAIDS, other international agencies, and local civil society organizations. The OVC TWG will, in FY 2010, scale up the use of the Child Status Index (CSI) following its successful piloting in the previous fiscal year, by training more front-line users from different implementing organizations. Service delivery and quality of care will be improved by analyzing data collected using the CSI, which is expected to provide a more comprehensive understanding of the needs of OVC and their families and better targeted responses. Higa Ubeho will oversee the task of

significantly increasing the number of beneficiaries by providing the needed technical and programmatic assistance to allow local partners and communities to take the lead in providing OVC services.

In FY 2010, OVC partners will work closely with care giver groups, faith-based organizations (FBOs), and PLWHA associations to provide technical training in OVC care and support as well as institutional capacity building for these community-based organizations (CBOs0. Implementing partners will use the household centered approach which links OVC services to the family unit caring for OVC. In an effort to sustain the gains made by PEPFAR, the focus of OVC programming in FY 2010 will be to strengthen households' socio-economic capacity to care for OVC through scaling up of IGAs and saving schemes. Implementing partners will mobilize communities to increase their participation in OVC care, monitoring and evaluation. To ensure that the children most affected by HIV receive a comprehensive package of services tailored to their needs, PEPFAR partners will advance the network model by linking HIV/AIDS clinical and community partners, and by connecting affected families with wrap around activities and with non-HIV/AIDS services which are supported by other funding streams. Through these linkages, the GOR and USG clinical partners will identify, treat and follow-up HIV positive OVC.

To assist in building GOR capacity to coordinate the OVC program, PEPFAR will continue supporting a full-time staff position at MIGEPROF in FY 2010. Capacity-building priorities will include policy and legal reform, government and civil society coordination, service standards, and monitoring and evaluation. PEPFAR will also strengthen GOR's central and local level capacity to coordinate, monitor and evaluate OVC services by supporting the design, development and deployment of a comprehensive electronic beneficiary database to track service provision in the districts. This database will reduce duplication of effort by making it easier for district officials to monitor OVC receiving services, levels of support and the geographic coverage of services being provided by different organizations. PEPFAR support will also help to strengthen and streamline community level OVC identification.

The PEPFAR OVC strategy will rely heavily on leveraging other sectors to provide optimal services to the affected population, wraparound programming and adopting best practices. PEPFAR activities for OVC will wrap around PMI, microfinance, education, youth employment, food assistance, HIV prevention and testing and counseling (TC) activities to ensure integration and linkages with other USG funded/PEPFAR activities. In FY 2010 the Higa Ubeho, ROADS II, FXB, and Rwanda Youth Program will reach an estimated 63,451 OVC with a need-based, age-appropriate minimum package of services, including healthcare, education and vocational training, protection, psychosocial support, food and nutrition, shelter and care. These partners will also train 8,360 caregivers/mentors on care and support for OVC.

These activities have been developed through a consultative process with all stakeholders under the leadership of GOR and guided by the Strategic Plan of Action for Orphans and other Vulnerable Children 2007-2011 and the National Strategic Plan on HIV and AIDS 2009-2012. The FY 2010 activities have been informed by and are in line with the proposed Partnership Framework between the USG and GOR as well as PEPFAR II vision of sustainable and country-owned interventions.

OTHER

Laboratory Infrastructure Overview Narrative

FY 2010	*$10,070,097*
FY 2009 Partnership Framework	*$1,222,692*
TOTAL	*$11,292,789*

What are the most important activities being undertaken in this technical area?

- National laboratory policies for minimal laboratory standards for each tier of the laboratory network.
- Integration of clinical diagnostic laboratory services.
- Plans for harmonizing and maintaining laboratory equipment.
- Inventory management and national forecasting of laboratory supplies, reagents and test kits.
- Plans for quality assurance programs.
- Human capacity development.
- Standards for and implementation of a laboratory information system.

What are the key differences from last year?

The activities of this plan are similar to those of previous years but with a stronger emphasis in promoting a laboratory information system for data management for program improvement.

Narrative

The FY 2010 PEPFAR laboratory strategy continues to build on a tiered national laboratory system for creating sustainable infrastructure to support care and treatment of HIV-positive patients. The funding from FY 2010 will provide support and technical assistance to four key GOR institutions: 1) National Reference Laboratory (NRL); 2) University Teaching Hospital of Butare (CHUB); 3) University Teaching Hospital of Kigali (CHUK); and 4) Kigali Health Institute (KHI). A five year strategic plan for the NRL was established in 2006 and revised in 2009 and PEPFAR activities support that plan. The program plans to work with the MOH to further develop this plan in cooperation with the President's Malaria Initiative (PMI), Global Fund (GFATM), World Health Organization (WHO), World Bank (WB) and other in-country stakeholders.

The national laboratory policy and strategic plan will include, but not be limited to, the following activities:

- national laboratory policies for minimal laboratory standards for each tier of the laboratory network;
- integration of clinical diagnostic laboratory services;
- plans for harmonizing and maintaining laboratory equipment;
- inventory management and national forecasting of laboratory supplies, reagents and test kits;
- plans for quality assurance programs;
- human capacity development; and
- standards for and implementation of a laboratory information system.

Using this approach will provide a strategic vision and a better understanding of the function of laboratory partner's in-country, appropriate coordination of funding and a dedication of resources for increasing laboratory infrastructure where the greatest needs exist.

In FY 2010, the PEPFAR will continue to support the NRL to strengthen linkages in the national tiered laboratory system. This includes laboratories in the national system that are linked from NRL to regional sites to district hospital sites to primary care site laboratories. The laboratory network in Rwanda is comprised of 364 health centers, 43 district hospitals, numerous private laboratories and 5 regional laboratories and 2 university teaching hospital laboratories. NRL will continue to improve the following infrastructure systems: financial, coordinated procurement, overall quality assurance, laboratory networks and referrals, and laboratory information systems. NRL will continue to support human

capacity development through specialized training and ongoing technical assistance with special emphasis in FY 2010 on new HIV test technologies to define a new HIV testing algorithm using finger prick method for blood collection, training non-laboratory personnel to perform rapid HIV testing using finger prick method of blood collection and new lab technicians for OI diagnosis and continue to improve the HIV prevention, care and treatment, TB and malaria quality assurance programs.

The early infant diagnosis (EID) program currently supports 168 PMTCT sites in FY 2009 to collect dried blood spots (DBS) from children born to HIV-positive mothers. In FY 2010, the program will be scaled up to support a total of 160 PMTCT sites. In FY 2010, the program will train 399 nurses and lab technicians in DBS collection to support the continuation of scale up of infant testing.

The USG will fund the laboratory coalition partners [Association of Public Health Laboratories (APHL), American Society for Clinical Pathology (ASCP), Clinical Laboratory Standards Institute (CLSI) and the American Society for Microbiology (ASM)] to support the NRL. These partners will provide technical assistance to NRL to develop procedures and standards, to obtain international laboratory accreditation and to implement OI and STI diagnostic assays, testing for surveillance and testing to support outbreak investigations. ASCP will be engaged in developing human capacity through curriculum improvements to standardize in-service training materials and to expand support for pre-service training of laboratory technicians at Kigali Health Institute (KHI). ASM will partner with Columbia ICAP and work closely with NRL to improve TB culture laboratories and to strengthen TB and malaria quality assurance and quality control. ASM will also work to improve the laboratory support for the diagnosis of OIs and STIs and testing for disease outbreaks and surveillance. CLSI will work with the NRL to develop laboratory policies and standards and to finalize the new 5-year strategic plan. A CDC consultant will provide technical assistance for better management of the immunology/virology unit and the tiered laboratory system.

In FY 2010, CDC will continue to support sustainable laboratory systems by providing TA for training in OI diagnosis with emphasis on MDR, extra pulmonary TB, cancers in HIV patients and parasitic infections at CHUB and CHUK. At 5 regional clinical diagnostic laboratories, NRL will provide training in new techniques to support program evaluation and surveillance and molecular virology techniques for HIV drug resistance surveillance. The USG will continue to support long-term technical positions at the NRL to assure quality HIV-related laboratory services through training and day-to-day mentorship of NRL staff. The USG will also continue bolstering management and financial capacity at the NRL by maintaining the long-term laboratory management advisor position and implementing a laboratory information system for tracking specimens, data management and reporting functions.

The Government of Rwanda (GOR) is planning to develop a new organizational structure for the Ministry of Health (MOH). This new structure is referred to as the Rwanda BioMedical Center. This new center will encompass all of the institutions within the MOH including the National Reference Laboratory. This new organizational structure will require new infrastructure for the MOH and all of its institutions. The NRL will be able to increase its available space and expand laboratory services. In FY 2009 and into FY 2010, the NRL will develop infrastructure plans for the National Reference Laboratory and for the Rwanda Laboratory Network. This infrastructure plan will be a collaborative endeavor as the World Bank is committed to assisting the East African Community to build laboratory infrastructure and improve laboratory services for the region. With this new collaborative effort, laboratory services will improve greatly in the near future.

In FY 2010, the Partnership for Supply Chain Management (SCMS) will be responsible for the procurement of all laboratory commodities purchased by PEPFAR through direct support to Centrale D'Achat des Medicaments Essentiels, Consommables et Equipments Medicaux du Rwanda (CAMERWA). CAMERWA is responsible for the procurement, storage and distribution of all medicines, equipment and laboratory supplies. This consolidated approach to procurement will increase cost savings and improve efficiencies in procurement and distribution of commodities. It also supports building infrastructure within the country to support distribution of laboratory commodities. SCMS will also continue the support of the Coordinated Procurement and Distribution System (CPDS) and logistics management activities to ensure smooth functioning of the CPDS system, quality data for quantification and strong communication between districts and CAMERWA. SCMS will work with the NRL to develop a logistics management information system that will support the procurement and quantification of reagents and supplies in Rwanda.

The USG is working with NRL to establish standard practices which will facilitate more efficient delivery of services; there are no explicit policy barriers inhibiting development of a highly functional national network.

Strategic Information Overview Narrative

FY 2010	*$6,575,622*
FY 2009 Partnership Framework	*$2,379,164*
TOTAL	*$8,954,786*

What are the most important activities being undertaken in this technical area?

The most important activities that PEPFAR Rwanda is undertaking in the strategic information program area include support to the development of policies, norms, guidelines and tools; development of in-service and pre-service training of personnel in monitoring and evaluation; institutionalization of data quality assurance; upgrading, harmonization and roll-out of electronic information systems; development of interventions for the promotion of information use in decision making; development of capacity in research; and provision of support in conducting studies, surveys and surveillance activities.

What are the key differences from last year?

New activities in the strategic information program area include the provision of support for the formulation of health research and data sharing policies; the development and implementation of PhD programs in public health; the design and introduction of a harmonized system linking data collection to planning; and the development of standard operating procedures for data management and feedback. New modules will be added to two electronic information systems, and interoperability of some systems will be developed. Also, the second Demographic and Health Survey with HIV testing will be conducted.

Narrative

Context and Background:

Rwanda is at the forefront of many e-Health activities in East Africa, yet the various electronic information systems lack interoperability. Currently the routine health management information system includes data from the government and faith-based health facilities that operate under a convention with the Ministry of Health. However, the system does not include data from national reference hospitals, nor from private clinics and dispensaries.

Health workers have been burdened by excessive demands for data that in most cases are not analyzed or used effectively in planning and management. The limited availability of accurate, timely data

combined with a lack of a culture of information use undermines the performance of the health services: managers and service providers are unable to identify needs and problems effectively or make evidence-informed decisions on service development.

The challenges facing the health information system include insufficient human and financial resources for monitoring and evaluation (M&E); the inadequacy of the information and communication technology infrastructure; a lack of a legal and operational framework; a dysfunctional vital registration system; a weak national epidemiological surveillance and response system; and a lack of standardized procedures for data management and of a platform for data sharing.

The USG program has complemented the activities of the government of Rwanda (GOR) and other donors in the development of local capacity in M&E and research by providing technical and financial assistance for the achievement of government's objectives. USG has alleviated the shortage of trained personnel for SI activities by funding M&E positions at the MOH and TRAC Plus. In addition, the USG and the Global Fund have been funding Data Managers at health centers and district hospitals.

In 2005, the GOR conducted a Demographic and Health Survey (DHS) with HIV testing with support from PEPFAR. The next DHS with HIV testing is planned for 2010.

Accomplishments to Date:
With the active engagement of the PEPFAR Strategic Information team and some implementing partners, the MOH drafted a national M&E Policy for the health sector, and also an M&E Strategy for the period 2009-2012. The strategy proposes a conceptual framework for linking performance assessment to a performance improvement cycle. Establishing strong coordination mechanisms for institutionalizing M&E in the health sector is identified as a priority.

An assessment of the national health information system was undertaken using a self-assessment tool developed by the Health Metrics Network. The selection of a manageable set of performance indicators for the health sector with the participation of stakeholders is a critical step in the restructuring of the routine health information system. This activity, however, was repeatedly postponed.

The Government endorsed an ambitious national e-Health strategy. The design of new electronic information systems and the development of existing ones will be based on a foundation of an integrated e-Health architecture enabling the exchange of data among information systems.

The HIV/AIDS phone and web-based reporting system (TRACnet) funded under PEPFAR was upgraded to integrate new features. A module for PMTCT and VCT was built onto TRACnet and will be rolled out in January 2010. System requirements were defined for an electronic Integrated Disease Surveillance and Response system (e-IDSR). A web-based Partner Reporting System was successfully deployed. User training for all PEPFAR implementing partners in the country was provided thus enabling reporting of the PEPFAR semi-annual and annual results through the system.

Employing a participatory approach, M&E operational plans were developed for both the National Strategic Plan on HIV and AIDS 2009-2012, and for the National Strategic Plan of Action for Orphans and Other Vulnerable Children. The revision of data collection and reporting tools was initiated integrating PEPFAR Next Generation Indicators into the national health information system.

The results of the 2007 Service Provision Assessment Survey were disseminated, and the planning of the DHS 2010 was initiated. A mapping of commercial sex workers and a formative assessment of men who have sex with men (MSM) in Kigali were completed. Protocols were drafted for HIV sentinel surveillance among pregnant women, Behavioral Surveillance Surveys (BSS) among youth and truck drivers, HIV drug resistance monitoring, and for an HIV drug resistance threshold survey among VCT clients. The MOH published the first annual health statistics compendium.

Training of individuals in SI was supported at national and district level through various mechanisms. In total 1,540 individuals were trained in monitoring and evaluation, including 27 individuals who completed the Certificate Training Program in SI at the School of Public Health.

Goals and Strategies for the Coming Year:
USG will provide support for the implementation of the national M&E policy and strategy, and the e-Health strategy. While there is growing interest within public health programs to improve data quality and data management and to promote the use of information in decision making, the leadership of the HMIS Unit of the MOH will be crucial to ensure coordination and collaboration in activity implementation. Also, strengthening the linkages of the HMIS Unit with the MOH departments that are responsible for the implementation of the supervision and quality management strategies in the health sector will contribute to the achievement of national goals.

PEPFAR will support the Ministry of Health in the development of policies for research, and for data sharing and confidentiality in the health sector. Data quality control will be institutionalized. Training of health managers in data analysis and use will continue at decentralized levels. Standard planning procedures and guidelines, as well as data use guidelines for facility and community HMIS will be developed and disseminated.

The deployment of a community level health information system is expected to improve the monitoring of community-based interventions. An independent evaluation of the electronic medical record system (OpenMRS) is planned while work on the improvement of the system will continue. New TRACnet modules such as the e-IDSR will be rolled out and other modules (malaria, TB) will be developed. The TRACnet system will be upgraded to meet identified new requirements. An interface will be developed between TRACnet and IQChart, an HIV-patient management information system. The Laboratory Information System will be expanded to new sites, and equipment will be procured for district hospitals to make the system operational. The logistics management information system (LMIS) will be rolled out to support the active distribution of drugs and consumables throughout the country. PEPFAR will also support the establishment of a logistics management desk within the Pharmacy Task Force at the MOH, and the staffing of a new e-Health Secretariat at the MOH with 4 e-Health technicians for a two-year period.

In FY 2009, PEPFAR Rwanda is supporting a number of surveillance- and survey-related activities, including: a Behavioral Surveillance Survey among youth 15-24 years old and a BSS+ (with HIV biomarker) among commercial sex workers and truck drivers; HIV, syphilis, and hepatitis sero-surveillance among pregnant women; HIV drug resistance surveillance and prevention; integrated disease surveillance and response (IDSR) for weekly reporting of notifiable diseases; and the 2010 DHS. These activities are intended to address key gaps in national strategic information, to facilitate planning and programming for health service delivery and to enable effective disease outbreak investigation and management.

In elaborating FY 2010, PEPFAR Rwanda worked closely with GOR counterparts to identify gaps and priority activities based on existing national strategic planning documents and funding. We will maintain support for key surveillance activities, such as IDSR; will expand some activities, such as support for HIV drug resistance surveillance and prevention; and will fund newly identified gaps in strategic information, particularly for most-at-risk populations. For example, in 2010 PEPFAR Rwanda will fund formative assessments among street youth and clients of sex workers, while expanding upon prior formative assessments among MSM in Kigali to incorporate more advanced and representative sampling methods, e.g. respondent driven sampling, and include HIV biomarkers. Finally, FY 2010 funding will support an AIDS Indicator Survey which was identified as a major priority by the national SI TWG primarily based on challenges with estimation of PMTCT and pediatric and adult ART coverage with standard methods, i.e. EPP-Spectrum.

Support will be provided to the National University of Rwanda School of Public Health (SPH) to develop post-graduate degree courses in epidemiology, biostatistics, health informatics, and research in health. Additionally, strengthening the SPH capacity to provide technical assistance to the MOH in the implementation of research activities is a strategy to increase ownership and sustainability.

A mid-term evaluation of the Rwanda National Strategic Plan on HIV and AIDS 2009-2012 will be carried out.

Health System Strengthening Overview Narrative

FY 2010	*$8,356,246*
FY 2009 Partnership Framework	*$6,994,050*
TOTAL	*$15,350,296*

What are the most important activities being undertaken in this technical area?

- Strengthening transition of USG activities to the Ministry of Health.
- Harmonization of resource tracking and planning tools.
- Capacity-building to civil society organizations and local NGOs.
- Technical assistance to the MOH financial unit.
- Strengthening performance based-financing.
- Supporting the health system infrastructure Support to the MOH quality management unit and introduction of an accreditation system.
- Support to the national procurement and distribution system.

What are the key differences from last year?

- Transition activities have been introduced.
- Consolidation of awards and increased funding directly to government entities.
- Harmonizing resource tracking processes.
- Strengthening of maintenance unit to procure and maintain equipment countrywide.
- Introduction of active distribution of commodities.

Narrative

HSS Assessment:

A situational assessment of the health system was conducted in 2009 as part of the development of the second Rwandan Health Sector Strategic Plan - 2009-12 (HSSP II). This assessment identified strengths and weaknesses in the seven cross-cutting programs of the health system: institutional capacity

(including strategic information and governance), human resources (see HRH Technical Area Narrative), financing, geographic accessibility, commodities, quality assurance, and specialized services and research.

HSS Efforts:

Institutional capacity is being strengthened at four levels: national, ministerial, civil society and community. At the national level, decision-making processes and coordination of donor and MOH activities at all levels through an improved sector wide approach are undergoing review and revision. The USG is intimately involved in this process. Civil society and other ministries have a role to play in institutional capacity building of the health sector but require capacity building and improved coordination. Civil society organizations, while active in the health sector, do not have the capacity to manage GFATM or USG PEPFAR funds as primary recipients. The USG plays a major role in providing technical assistance to realize this goal. At the community level, introduction of initiatives, including motivation and training of 30,000 community health workers, is underway.

Currently, the majority of health system financing is provided by external donors. The mini-budget for Jan-June 2009 estimated that development partners provided 67% of financing, excluding sector budget support. While Rwanda is committed to supporting its health system without external support, it is likely that USG and other donor support will be requested for several years. Rwanda introduced performance-based financing (PBF) in 2006, which coincided with an improvement in quality of health services. The USG both supports the development of tools and guidelines at national level and purchases HIV indicators at facility level. The social health insurance scheme, Mutuelle de Santé (Mutuelles), was introduced to increase financial accessibility to health services in Rwanda, and currently covers approximately 68% of the population (DHS 2008).

Initiatives to improve geographic accessibility of the population to health services are aimed at both increasing the services available at static points and increasing the numbers of community health workers who can reach out to those who are not attending the static facilities. The present target of the MOH is for everyone to have access to a health facility within one hour (walking), for all health facilities to have access to electricity and safe water by 2012 and for 60,000 community health workers to be trained and supported. The GOR, along with other partners, continues to invest in construction and rehabilitation to achieve this goal. The major challenge to improving geographic access through improvements in infrastructure, equipment and transportation, is insufficient funding.

Maintenance of equipment, including laboratory and energy equipment, also remains a challenge. A sustainable maintenance strategy that includes innovative public and private partnerships was proposed by the Ministries of Infrastructure and Health in collaboration with USG and other donors. While the installation of a network of fiber-optic internet cable will assist with communication, some health facilities still need reliable access to power to unlock the full potential for electronic health (e-Health), including telemedicine. A national campaign to train and motivate 30,000 community health workers was launched as a complementary approach to improve health service utilization.

Although the availability of quality drugs, vaccines, and consumables in the health facilities has improved, stock-outs of certain medicines, including those for treating OIs, still occur both at national and district level. These stock-outs are due to several factors, including lengthy procurement procedures, lack of a national Logistical Management Information System, insufficient funds and inefficient financial management. Costs are not always recovered and health facilities cannot provide non-subsidized drugs and consumables. Patients do not always receive correct treatment due to non-

rational use of drugs, which can lead to side effects, resistance, drug dependency, increased costs and prolonged hospital stays. The USG is supporting the national procurement and distribution system (CPDS – discussed under LAB and HTXD) and directly procures HIV related drugs and commodities.

Ensuring high quality of services provided and education of health professionals are key concerns in Rwanda. In addition to results-based financing and social insurance, strategies to improve supervision, accreditation, and quality are in various stages of development and implementation at each level of service delivery. The challenge is to harmonize these efforts and to include quality measurement guidelines in educational institutions.

With the transition of Track 1.0 partners occurring this year (discussed under HBHC and HTXS), it is important that the quality of care in these sites is carefully monitored in order to ensure the continuation of quality care.

HSS Accomplishments to Date:
Since its inception in FY 2004, PEPFAR has invested significantly in the various strata of capacity building. Support has been provided for policy and guideline development, national and sub national planning, the piloting and implementation of these policies and plans and monitoring at all levels. PEPFAR activities are restricted to and support the implementation of the HSSP II in line with the principles of donor harmonization. Cross-cutting capacity building activities have contributed collectively to the dual objectives of building the GOR's capacity for providing HIV services and advancing the sustainability of the PEPFAR program.

Technical assistance has been provided at the national level over the past 5 years in order to support the semi autonomous organizations and units of the Ministry of Health. At the organizational level, PEPFAR has similarly supported capacity building for Rwanda NGOs since FY 2004. The strategies used include financial and management assistance, skills-building in specific technical areas, and development of commodities and logistics systems.

System Barriers to Accomplishing PEPFAR II Goals 4-12-12:
In addition to the barriers described above, challenges exist at each of the levels. While leadership is strong with a keen understanding of challenges, capacity for planning, management and implementation of the national plans remains a challenge. The MOH operates with a skeleton staff unable to implement the ambitious decisions and strategies that are proposed to improve the health system. Planning and resource tracking is conducted with wide representation and transparency, but the multitude of financial reporting systems causes time to be diverted from implementation of the national plans. The MOH procures and installs equipment including energy equipment in its health facilities. The GOR shows commitment to realize the goals of the national plan and strategy to provide all health facilities with water and energy by 2012. However, there is no national infrastructure plan and under-funding and competing priorities prevent the necessary infrastructure development.

Focus Areas for FY 2010:
In FY 2010, PEPFAR will continue to support ongoing capacity building activities. Additionally, new activities will be funded in the areas of governance, financing, infrastructure support and management, and quality assurance. Support for strengthening at decentralized levels will be emphasized. In line with the Partnership Framework 2009-2012 and its Implementation Plan, there will be more focused attention to technical assistance and systems strengthening through all PEPFAR-funded programs in

Rwanda. All technical assistance will have clear terms of reference, objectives, and outcomes that support systems strengthening and transition of USG activities to National ownership.

Governance and financing:

PEPFAR will support health systems strengthening at each of the four levels. Under the recently awarded Integrated Health Systems Strengthening (IHSS) project, MSH will provide support to GOR to strengthen coordination at the central level among national Ministries and offices within Ministries as well as between the central level and the district level in line with the decentralization policy. In support of the Track 1.0 three-year transition, PEPFAR will continue to provide support to the MOH Coordination Unit to ensure that transition activities proceed smoothly and according to plan. To complement these activities, and in collaboration with members of the Expanded Sector Support Donor Group, harmonization of resource tracking and planning tools will be supported in FY 2010. In 2010, PEPFAR will increase its capacity-building support to CSOs and other local NGOs. The objective of this new activity is to ensure that CSOs and other Rwandan organizations have the capacity to work effectively with GOR entities to plan, oversee, and report on HIV services in Rwanda, ensuring meaningful community participation. At the individual level, legal support to PLWHAs will be strengthened through continued training of paralegals.

In 2010, PEPFAR will continue to provide technical assistance to the MOH financial unit through the IHSS project and the MOH cooperative agreement to improve its capacity for cost reduction, revenue generation, and cost-sharing of services. Technical assistance will be provided to the districts for developing improved mechanisms to help them generate, plan, manage, and be accountable for funds. PEPFAR will support the strengthening of Rwanda's performance-based financing (PBF) approach in several ways in FY 2010. In line with the vision for PEPFAR II to ultimately transition activities to national management, PBF HIV indicators for USG-support health facilities will be purchased through direct funding to MOH for the Track 1.0-funded PEPFAR partners. This experience will inform future efforts to transition PBF activities directly to GOR. Support will also be provided for the development of pre-service training modules on PBF for all relevant health professionals. In order to bolster capacity for counter-verification of PBF evaluations, PEPFAR will co-design and work with GOR to reach consensus on a strategy to use civil society organizations for PBF substantiation.

Geographic accessibility:

In FY 2010 PEPFAR will continue to support improvements in the health system infrastructure through procurement of energy, laboratory, and medical equipment and for electrification of all USG supported health facilities that are not catered for by GOR and other donors. Support will also be provided to strengthen the GOR's ability to maintain energy, laboratory and medical equipment through the provision of skill-building technical assistance through the MOH to district technicians. Technical assistance will also be provided to managers at district level to increase their capacity to manage energy at health facilities. Infrastructural development in key areas will be supported in FY 2010 to improve coordination of MOH activities and to improve quality of teaching at the National University of Rwanda.

Quality assurance:

In FY 2010, through the IHSS award, MSH will provide technical assistance to all levels of the GOR health system to support harmonization of quality management strategies. This includes provision of staff and TA to the MOH quality management unit for implementation at the central level. Also at central level, MSH will develop training modules and train a core group of trainers and district staff. PEPFAR will also support implementation of the harmonized quality management model in all health facilities in a manner that ensures engagement of the community as an equal partner in managing quality. TA at the

central level will support the incorporation of QI modules, including leadership and management, into the pre-service curricula of health professionals. To further harmonization, MSH will provide TA to support the integration of quality measures into the routine HMIS.

Other FY 2010 quality assurance support activities are focused on accreditation as well as monitoring and evaluation of the first stage of transitioning HIV/AIDS activities from USG partners to GOR. In FY 2010, PEPFAR will provide technical assistance to GOR for the development of an accreditation system for health facilities and a process to ensure that health facilities adhere to norms and standards. In order to provide the foundation for monitoring the quality of care during the transition of services from the Track 1.0 partners to GOR, PEPFAR will support a baseline evaluation at the district level in FY 2010.

Leveraging and Spillovers:
In Rwanda USG PEPFAR health systems activities support those in the National Plans in tandem with the GFATM NSA. Working through the national Technical Working Groups, gaps in implementation of the national plans, not funded through other donors are identified and supported through PEPFAR. More commonly, however, PEPFAR works in collaboration with other donors and with the GOR. Examples of collaboration include: resource tracking assessments, strengthening and harmonizing quality management, support to the national energy plan, equipment maintenance. The details have been described in the sections above.

Human Resources for Health Overview Narrative

What are the most important activities being undertaken in this technical area?

- HRH needs assessments in collaboration with other donors.
- Support to National University of Rwanda to increase capacity for quality teaching and research activities.
- Inclusion of in-service modules in pre-service curriculum.
- Support to the HR unit of the MOH to improve HR management.
- Coordination with other donors in Capacity Development.
- Continue to train health workers.

What are the key differences from last year?

- More focus on increasing capacity of Rwandan entities through implementing partners and TA as well as provision of direct funding to Rwandan institutions.
- Focus on transferring the need for in-service training by including modules into the pre-service curriculum.
- Increased coordination with other donors in HR needs assessments and National Capacity Development Plans.

Narrative

Context and Background:
Human Resources for Health (HRH) have been declared a priority for the next five years for both PEPFAR and the Government of Rwanda (GOR). Rwanda is a dynamic country, characterized by the rapid adoption of new approaches, strategies and programs. Rwanda also has critical deficits in human resource capacity, resulting in regular movement of senior staff within and outside the Health Sector. Successful transition of activities from direct implementation by USG partners to GOR ownership MOH is reliant upon a foundation of quality human resources. Increased investment in GOR staff, processes and

systems, MOH as well as introduction of new technologies, will be required to ensure the delivery of quality services in a sustainable health system.

The vision of the MOH is to deploy five specialist doctors (obstetrician/gynecologist, pediatrician, surgeon, anesthesiologist and internal medicine) at every district hospital. Given this will take several decades to achieve, discussions have focused on the introduction of Family Physicians to care for the most common conditions seen at health facilities (approximately 85% of demand) with identification and referral of more complicated cases. Currently, doctors are commonly promoted into positions of administration and management, diverting their time from clinical patient management, oversight and training of other health workers.

In Rwanda, health workers are predominantly employed in the public sector. The GOR provides pre-service training for health workers and salary support for 62% of health workers. All health workers, irrespective of source of salary support, are accountable and managed through MOH mechanisms. Although 80% of the health care is provided in rural facilities, just 37% of health professionals are based in these rural sites. The Finance and Internal Resource Management Unit (URPGRI) of the Ministry of Health's planning department (UPDC) recognizes and has developed strategies to address this imbalance.

The medical school does not currently have enough faculty nor adequate library, classroom or laboratory facilities to train the number of health professionals needed in Rwanda. Critical specialists, such as public health nurses, dieticians, nutritionists, medical records administrators, and health system managers are currently trained out-of country. Nurse training has seen major reforms in the past few years resulting in six nursing schools being recognized as competent to conduct nurse training and a single, modular curriculum being introduced in 2007. Enrolled nurses are being phased out. Task shifting of ART prescription has been adopted in the norms and standards. To increase geographic access to health care, community health workers (CHW) have been recruited nationwide and training is ongoing. A CHW policy and performance-based financing indicators are in the final stages of development.

The Human Resources for Health Strategic Plan (2010-2012) was recently developed to provide a comprehensive plan to meet the HRH objectives of the HSSP II and address the challenges described above. The four focus areas are: management and performance of MOH human resources; stabilization of the health worker labor market; education, training and research initiatives; and monitoring and evaluation and systems evaluation. The final approval of the HRH strategic plan is awaiting recommendations from a Human Resources needs assessment currently being undertaken. The Human Resources for Health Policy is at the same stage of development.

Professional Associations for medical and nursing staff are under resourced. Registration, regulation and continuous medical education programs are underdeveloped and require support.

Accomplishments to Date:
In FY 2009, PEPFAR continued to support pre- and in-service training initiatives to help address the acute shortage of health care providers and HIV program managers. Since FY 2005, PEPFAR has actively supported pre-service nursing training and the Rwanda HIV/AIDS Public Interest Fellowship to develop a cadre of program managers. In FY 2009, PEPFAR supported the implementation of the revised nursing curriculum, expansion of the number of participants in the Public Interest Fellowship program, and the continuance of the social work certificate program to strengthen the continuum of care for PLWHA.

PEPFAR also supported expansion and promotion of the initiative to use nurses to oversee ART service delivery. Also in FY 2009, ongoing support for students in the MPH programs was augmented by training in field epidemiology through short courses in Applied Epidemiology at the School of Public Health. PEPFAR has supported the introduction of Family Physician training in Rwanda. Providing quality teaching to the students at District level is an additional challenge.

One of the challenges to supporting training in Rwanda is the scope of the current needs. Prioritization of the most critical needs in human resource pre- and post-graduate training will be facilitated through an ongoing and comprehensive needs assessment. Through the course of FY 2009 USG PEPFAR took a prominent lead in the National Technical Working Group set up by the MOH and development partners as one of the Sector Wide Approach (SWAP) mechanisms. The USG supported the MOH's HR unit to improve planning and management activities. A human resource data base (HRIS) was introduced and maintained. The challenge is to ensure accuracy of data and more critically use of the database in planning and HR deployment.

Goals and Strategies for the Coming Year:
PEPFAR activities for the coming year are aligned with and in support of the goals and objectives of HSSP II and HRH Strategic Plan as detailed in the Partnership Framework and Implementation Plan and were developed in consultation with GOR and other development partners. These activities include support to HRH management and educational institutions and support for assessments and surveys to understand the labor markets, training needs, and recruitment and retention strategies.

HRH Management:
A strong policy framework sets the foundation for effective management of human resources. The HRH portfolio will support the development of additional policies that improve health workers ability to safely and effectively perform their roles. This includes development of HIV workplace safety policies as well as policies to improve healthcare access for health workers and their families, including HIV services. HRH management also relies on accurate and complete information for decision-making. Building on previous efforts to develop a comprehensive human resources database in FY 2010, PEPFAR will support the development of training modules on data analysis and use to improve the GOR's capacity to utilize data for decision-making. PEPFAR will continue to support technical assistance to the MOH planning department in the HR unit.

The MOH and development partners have established a Capacity Development Pooled Fund. The development of a plan and manual to operationalize the fund will allow the USG to coordinate its support for capacity development in a way that complements the work of the MOH and other development partners.

Support to Educational Institutions:
PEPFAR will provide infrastructure and other support to key educational institutions in Rwanda to increase the country's capacity to provide pre- and post-graduate training in nursing, medicine, social work, public health management, field epidemiology, and strategic information. This will include support for expansion of the physical infrastructure of existing educational facilities with additional support from GOR and other donors. With this increased capacity, fewer and fewer students will need to be supported for health professions training outside of Rwanda.

Given that in-service training is both disruptive and difficult to sustain, there will be a focus on integration of in-service trainings into pre-service curricula as appropriate. PEPFAR will also support the

establishment of regional linkages and development of a network for trained post-graduates. These activities will expand the current capacity to train new health workers in Rwanda, thus contributing to the PEPFAR goal of training 140,000 new health workers in HIV/AIDS prevention, treatment, and care.

Institutional twinning and technical assistance will be employed to assist Rwandan institutions of higher learning in the health sciences assume primary responsibility for the planning and design, implementation, monitoring and reporting of education and training, research, and community outreach programs as well as for the strategic direction and financial management of their respective institutions. Benchmarks will be established to measure institutional capacity in these areas and as capacity is demonstrated consistently over time, responsibilities will be shifted progressively towards Rwandan ownership. Examples of such benchmarks include evidence of adequate preparation, planning and delivery of educational and training activities via the existence of published academic calendars and summary student course evaluations. Consistently accurate and timely invoicing of research grants and contracts is another benchmark towards financial and managerial capacity.

Support will be provided to enhance technology-driven learning laboratories and establish cutting edge audio-visual conference centers to improve the delivery of educational and training programs within Rwandan institutions of higher learning. Developing the health workforce through continuing education and training opportunities and creating a 21st century, high-tech learning environment will provide Rwanda's health system with the tools necessary to function efficiently and effectively with reduced external support.

Assessments and Surveys:
As co-chair of the national SWAP Technical Working Group for HRH, the USG will identify, support and complement the support to Rwanda's health workforce by other donors. One of the key activities for FY 2010 is to support the national needs assessment for HRH, allowing for a deeper and broader analysis of the situation against the disease burden. The assessment represents an essential step toward improving the country's capacity to train, attract and retain a productive health care workforce for HIV as MOH address the current lack of information available for HR planning and management.

Gender Overview Narrative

What are the most important activities being undertaken in this technical area?

- Scale-up of GBV prevention and treatment programs
- Strengthening of referral systems among health services
- Development of targeted IGAs for vulnerable women and families

What are the key differences from last year?

As compared to gender-related programming in FY 2009, the activities in the upcoming year will have a greater focus on the mainstreaming of gender into all program areas and the incorporation of gender issues into clinical services. To this end a gender mainstreaming workshop will be held with relevant partners and support will be provided to ensure that programs include a gender strategy. In addition, new initiatives on integrated health care delivery will include GBV prevention, treatment and referral activities, CVCT, and counseling on cross-generational sex and concurrent relationships. Increasing male involvement in PMTCT and CVCT, and actively linking women to IGA programs will also be priorities in FY 2010.

Narrative:

Epidemiological data indicate that women are more likely than men to be infected, and affected, by the HIV epidemic in Rwanda. While the 2005 Rwandan DHS estimated the overall prevalence of HIV to be 3.0%, the prevalence in women 15-49 years was estimated to be 3.6%, compared to 2.3% for men of the same age, with further disparity in prevalence in the 15-24 year age group (1.5% for females and 0.4% for males). Young women in urban areas were reported to have the highest youth prevalence, with a rate of 3.9%. Given that 67% of the population is under the age of 20 (RIDHS, 2007), the high rate of HIV among the country's young women is a point of concern.

The RDHS also suggests the peak prevalence among women occurs earlier than among men: for women 35-39 years at 6.9% and for men 40-44 years at 7.1%. As women in this age group are within the child bearing years, vertical transmission remains an issue. HIV prevalence was also found to vary according to marital status. While 1.6% of never-married women and 2.8% of women who are currently married or in a union are HIV-positive, 10.9% of divorced/separated women and 15.9% of widows are infected (RDHS, 2005).

Using the UNAIDS/WHO Modes of Transmission model, the MOH predicts that sero-discordant couples in stable relationships will be the major contributor of new infections in the coming years, followed by commercial sex workers (CSW) and men who have sex with men (MSM). A recent independent analysis of clinical data supports this theory, finding that up to 90% of new heterosexually-transmitted cases of HIV in urban areas occur among sero-discordant couples in stable relationships (Dunkle, 2008). Among such couples the male partner is more frequently the one entering the relationship already infected, putting the female partner at risk (RDHS, 2005). This arrangement suggests a higher risk of HIV transmission facing women, even those outside traditional risk categories.

The high rate of heterosexual transmission is likely tied to low levels of condom use during sexual encounters with a partner who is neither a spouse nor a cohabitant. Approximately 3.0% of men and 0.5% of women in unions engage in such encounters and the low frequency of condom use makes them extremely risky. Only 9.8% of women who had sexual intercourse with a non-spouse, non-cohabitating partner in the last year reported using a condom; among men 38.6% reported doing so (RDHS, 2005). Couples are also more likely to be sero-discordant and thus at risk of infection if the male partner is significantly older than the female partner, with the frequency of sero-discordance increasing as the age difference increases (RDHS, 2005).

A small scale study on the sexual behavior and sexual networks of MSM in Kigali was recently completed, the initial results of which suggest risk taking behavior, including low condom use during transactional sex, and concurrent sexual relationships with female partners (Binagwaho et al, 2009). However, there is little data on HIV prevalence among MSM, or among CSWs and their partners.

Recent APR results indicate that AB prevention messaging reached women and men equally, as nearly 50% of those reached by AB messages in FY 2009 were women. However, in part due to the focus on condom use and male circumcision (MC), only 33.6% of those reached by messages beyond AB were female. For care and treatment, more women than men are receiving services. Women account for over 60% of all those being provided palliative care, receiving HIV/TB treatment, initiating ART last year, and receiving ART. OVC programs are more equal in their reach, with 48.7% of recipients being male.

A focal person for gender has been identified within the PEPFAR team for the next year and work is beginning on the development of a USG gender strategy. All current gender activities are aligned with the national gender policy and strategy.

Accomplishments to Date
Increasing Gender Equity in HIV/AIDS Activities and Services:
During FY 2009, PEPFAR implementing partners' worked to prevent new infections in women through the development and dissemination of messages targeting both men (primarily on AB, condom use and MC) and women (foremost on AB). Using results from behavioral studies to inform the programs, the knowledge transfer was targeted at the most relevant populations and settings, highlighting the cultural and societal norms leading to risky sexual behavior. In response to data indicating HIV infections occur in young men and women, messages in World Relief's Mobilizing Youth for Life and PSI's Healthy Schools programs, as well as youth group and drama projects, were modified to include a gender and family focus. In an effort to increase men's uptake of services, programs were implemented to encourage men to accompany their partners for PMTCT. To improve coverage and strengthen the concept of one-stop services, couples VCT (CVCT) was also integrated into clinical programs by implementing partners, including TRAC Plus. Clinical implementing partners focused their programs for women on the integration of FP and HIV/AIDS services through referral linkages.

Reducing Violence and Coercion:
Rwanda is one of three countries participating in an OGAC pilot program to increase access to post-exposure prophylaxis (PEP) survivors of GBV. Implementation of this program is being done by four clinical partners, all of whom are mainstreaming GBV care, support and treatment activities into their clinical services. In the area of prevention, UNHCR provided life skills and communication training to young, female OVC refugees, as well as referrals to legal services for survivors. Advocats Sans Frontières (ASF) has increased access to legal services as a means of reducing violence and exploitation. Many partners, including CRS, FHI, ICAP, EGPAF, and IntraHealth, conducted community level awareness campaigns on GBV and implemented BCC programs related to reducing and preventing violence and coercion. IntraHealth also continued its engagement of police to enhance access to HIV prevention services for victims of GBV. Peace Corps and DoD carried out targeted GBV awareness activities in FY 2009 as well.

Addressing Male Norms and Behaviors:
Discussions of male norms and behaviors affecting HIV transmission were included in programs targeting migrant workers, park wardens, and military personnel in FY 2009. DoD worked extensively with the Rwandan military on promoting fidelity, VCT, MC, and the concept of men as equal partners. MC programs were carried out by Drew University and TRAC Plus and included components on male norms and HIV prevention. Also in FY 2009, a communication campaign targeted older men, local opinion leaders, and the parents of young girls to shift social norms regarding transactional and cross-generational sex. Using advocacy and mass media strategies, the campaign initiated community dialogues on practices that put young women at greater risk of contracting HIV and supported local leaders in taking a public stance against such behaviors.

Increasing Women's Legal Rights and Protections:
In FY 2009 several partners incorporated GBV awareness raising campaigns into their outreach programs, while others scaled-up their provision of PEP for survivors of GBV. ASF continued its work on GBV, property rights and land distribution policy with the Ministry of Gender and Family Promotion (MIGEPROF). Mobile legal clinics run by ASF increased community knowledge of their rights and provided free pre-trial counseling to OVC, survivors of GBV, and people affected by HIV/AIDS.

Increasing Women's Access to Income and Productive Resources:

ROADS II and CHAMP, two large scale interventions, implemented income generating activities (IGA) in FY 2009. While ROADS II supported IGA for vulnerable border populations, CHAMP provided technical assistance to local NGOs which support cooperatives providing economic opportunities for women, PLWHA, OVCs, and child-headed households (CHH). USG continued its work with thousands of OVCs, offering out-of-school youth basic education and employment opportunities. Incorporated in many of these programs were life skills, negotiation, leadership, health education, and counseling activities. The results of an evaluation of IGAs in the ROADS II program will be available in 2010.

Barriers Encountered:
Although much progress has been made in the expansion of gender-related activities, PEPFAR has encountered barriers which are slowing the development and full implementation of such programs. MIGEPROF is tasked with developing activities to reduce GBV, but it remains understaffed.

Social norms governing relationship dynamics and women's role in Rwanda have been slow to evolve. Concurrent relationships and cross-generational sex remain common practices, even though they increase the risk of HIV transmission, particularly for women. Traditional expectations of women as family caregivers or unpaid agricultural laborers prevent women from earning a stable and sufficient income, without which they remain in poverty or economically vulnerable. Shifting these norms has been challenging but doing so is the key to creating a culture where women are empowered to protect themselves from harm.

A 2008 study conducted on gender mainstreaming in PEPFAR programs found support to implementing partners in mainstreaming gender into their programs to be deficient (CDG, 2009). No formal training on gender mainstreaming has yet been provided.

Information on HIV transmission and behaviors in high risk groups such as young women, HIV-negative co-habiting women, MSM and CSW is insufficient to allow root causes to be addressed.

Goals and Strategies for the Coming Year
Gender Priorities:
In line with the PF objective of reducing HIV incidence by 50% by 2012, programs will focus on prevention of new infections in high risk groups. HIV prevention messages and activities will also include components on GBV, family planning, transactional sex, and VCT.

Approaches and Programming Goals
Increasing gender equity in HIV/AIDS activities and services:
Clinical and civil society partners will build stronger, more integrated referral systems between services in order to meet the complete health needs of women. Emory University and others will begin training nurses on cervical cancer screening and diagnosis, as well as on family planning counseling and care. Data from the upcoming RDHS on men's and women's utilization of VCT will be used to inform outreach efforts and the expansion of clinical services.

Reducing violence and coercion:
Addressing GBV remains a top priority for Rwanda, and in FY 2010 the six clinical partners will receive funds to plan and begin expansion of GBV services to other facilities, utilizing the lessons learned from the OGAC pilot project. Non-clinical partners such as ASF and CHF will provide legal services to survivors, train influential community members on GBV prevention communication methods, and increase the

capacity of local NGOs to incorporate gender into programming. The overall focus of the work on GBV is to expand clinical services and prevention messages and to create linkages to other services.

Addressing male norms and behaviors:
Increasing male involvement in health care is a priority for the PEPFAR team. Partners will undertake activities to engage men more actively in CVCT and PMTCT as well as expanded community-based campaigns on GBV prevention. New campaigns on cross-generational sex, fidelity, and concurrent relationships will be developed and initiated with community and religious leaders. Using the GEM model, PSI will begin an in-depth qualitative analysis on male norms, the results of which will inform future programming on gender roles and relationship dynamics. MC programs will also be scaled-up and include greater counseling on the role of men as partners.

Increasing women's legal rights and protection:
As part of an integrated approach to addressing GBV, ASF and other partners will continue to provide referrals and legal services for violence survivors, as well as other populations. ASF will also scale-up its work on the prosecution of sexual crimes and collaborate with various stakeholders to tackle key legislative issues, particularly equity, access to justice, and sexual exploitation. Recently proposed changes to the penal code that would affect CSWs and MSM have spurred interest in gender-related legislation among partners, and efforts will be made to sustain and harness this interest.

Increasing women's access to income and productive resources:
Although IGAs have been undertaken previously, FY 2010 will see an expansion of these programs and a more concerted effort to direct them towards low-income women and female-headed households. Vocational training activities will also be scaled-up, with CSWs, OVCs, CHHs, and youth as the primary recipients. Initiatives to build the capacity of savings and internal lending groups will allow them to begin their own self-sustaining IGA programs.

Specific Populations:
To avert the highest number of new infections and reach the goal of reducing HIV transmission by half by 2012, the following groups will be targeted: men engaging in risky behavior; young women in urban areas; HIV-negative women in sero-discordant relationships; MSM; women without sustainable livelihoods; CSWs; and victims of GBV.

Evidence of Gender-Related Programming:
Monitoring and evaluation plans have been developed for all activities and partners are encouraged to disaggregate data by sex. This data, along with the results of the upcoming RDHS and BSS, will provide the evidence needed to develop gender-responsive programming in coming years. The gender strategy now in development will also include guidelines for future assessments on the efficacy of gender-sensitive interventions and the equity of services.

ANNEXES

National Targets

Operating Unit:	RWANDA

National Level Reporting Timeframe:	1	2010	to	12	2010

(For example: June 2009 to July 2010 or Jan 2009 to Dec 2010)

Indicator no.	Indicator label	2010	2011	2012	2013	Target Source
P1.1.N	Numerator Only: Number of pregnant women who were tested for HIV and know their results.	307,524	329,220			rom National Institute of Statistics, TRAC
P1.2.N	Numerator Only: Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	7,473	8,000			lus data December 2009 and EPP-Spectru
C1.1.N	Number of eligible adults and children provided with a minimum of one care service	262,233	273,009			
	By Age: <18	84,534	71,740			
	By Age: 18+	177,699	201,269			
T1.1.N	Numerator Only: Number of adults and children with advanced HIV infection receiving antiretroviral therapy	88,950	101,012			data, adjusted downward by 4.2% as pe
H2.1.N	Number of new health care workers who graduated from a pre-service training institution	560	640			Public Health; USG implementing partne

Technical Area Summary Targets

Use this tab to provide your technical area summary targets for those Essential/Reported indicators that are **applicable** to your program. Non-applicable indicators may be left blank. Country teams must provide a minimum of 2010 and 2011 targets, though you may provide later targets if available. Submission of targets for indicator disaggregations is only required for male/female disaggregations and treatment age disaggregations. **Please do not delete indicators or modify the template.**

Operating Unit:	RWANDA

Indicator no.	Indicator label	Fiscal Year Targets			
		2010	2011	2012	2013
P1.1.D	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	140,413	146,425		
P1.2.D	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to child-transmission	5,224	5,895		
P4.1.D	Number of injecting drug users (IDUs) on opioid substitution therapy				
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services	1,500	1,800		
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP)	303	333		
P7.1.D	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions	77,868	78,840		
P8.1.D	Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	527,860	527,484		
P8.2.D	Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	373,679	313,016		
P8.3.D	Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	154,093	262,410		

Indicator no.	Indicator label		Fiscal Year Targets			
			2010	2011	2012	2013
P11.1.D	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results		544,465	616,662		
		By sex: Male	266,788	302,164		
		By sex: Female	277,677	314,498		
C1.1.D	Number of eligible adults and children provided with a minimum of one care service		181,390	206,641		
		By sex: Male	68,928	78,524		
		By sex: Female	112,462	128,117		
		By Age: <18	86,272	103,862		
		By Age: 18+	95,118	102,779		
C2.1.D	Number of HIV-positive adults and children receiving a minimum of one clinical service		106,874	115,482		
		By sex: Male	40,612	43,883		
		By sex: Female	66,262	71,599		
C2.2.D	Percent of HIV-positive persons receiving cotrimoxazole prophylaxis		97%	97%	#DIV/0!	#DIV/0!
	Numerator: Number of HIV-positive persons receiving cotrimoxazole prophylaxis		103,464	111,803		
	Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)		106,874	115,482	0	0
C2.3.D	Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food		11,500	10,000		
	Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings		87%	95%	#DIV/0!	#DIV/0!

Indicator no.	Indicator label		Fiscal Year Targets			
			2010	2011	2012	2013
C2.4.D	Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment settings		92,969	109,189		
	Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)		106,874	115,482	0	0
C2.5.D	Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment		1%	1%	#DIV/0!	#DIV/0!
	Numerator: Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment		1,102	1,344		
	Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)		106,874	115,482	0	0
C5.1.D	Number of eligible clients who received food and/or other nutrition services		28,247	57,234		
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART		11,529	11,367		
		By sex: Male	4,842	4,774		
		By sex: Female	6,687	6,593		
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]		56,828	57,590		
		By age/sex: < 15 Male	2,841	2,880		
		By age/sex: <15 Female	2,841	2,880		
		By age/sex: 15+ Male	19,322	19,581		
		By age/sex: 15+ Female	31,824	32,250		
		Percent children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	0	0	#DIV/0!	#DIV/0!
		Percent women and girls with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	1	1	#DIV/0!	#DIV/0!

Indicator no.	Indicator label		Fiscal Year Targets			
			2010	2011	2012	2013
T1.3.D	Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy		1	1	#DIV/0!	#DIV/0!
	Numerator: Number of adults and children who are still alive and on treatment at 12 months after initiating ART		9,896	10,349		
	Denominator: Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.		12,341	11,529		
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests		175	175		
H1.2.D	Percent of testing facilities (laboratories) that are accredited according to national or international standards		0	0	#DIV/0!	#DIV/0!
	Numerator: Number of testing facilities (laboratories) that are accredited according to national or international standards		0	3		
	Denominator: Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests (H1.1.D)		175	175	0	0
H2.1.D	Number of new health care workers who graduated from a pre-service training institution		299	43		
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program		5,063	10,218		
H2.3.D	Number of health care workers who successfully completed an in-service training program		2,995	4,618		
		By Specific Types: Male Circumcision	268	210		
		By Specific Types: Pediatric Treatment	1,111	1,345		

National Target Justification

Use this tab to provide explanations and justification around your National targets for those indicators that are **applicable** to your program.

Operating Unit:	RWANDA

Indicator no.	Indicator label	Target Justification
P1.1.N	Numerator Only: Number of pregnant women who were tested for HIV and know their results.	This is estimated based on 96% attendance of ANC according to the interim DHS of 2007-08. Based on the population projections data from the National Institute of Statistics, 427,117 births are expected in 2010 and 439,664 in 2011. Based on program data, testing and counseling acceptance has been high in ANC (99%), and 97% of tested women turn up for their results. There is, however, little information available about women who come to ANC when their status is
P1.2.N	Numerator Only: Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	The percentage of women tested in PMTCT settings that are HIV-positive has reduced from 4.5% in 2008 to 2.7% in 2009. This reduction is attributed to scale up of PMTCT services mostly in rural areas where the HIV prevalence is low. This means that the percentage targeted for ART prophylaxis may not increase proportionally to the increase in women tested. This figure was estimated assuming that 85% of pregnant women testing HIV positive (indicator P1.1N) will
C1.1.N	Number of eligible adults and children provided with a minimum of one care service	Being a composite indicator, it was calculated by adding OVCs to number of people that will receive at least one clinical service. Based on the program results, on the national level the ratio of pre-ART to ART is 1:1 although it is 1:2 in USG supported sites. The figure was calculated by assuming that ART clients are 48% of the total number of people in care (There is no pre-ART indicator on national level and this percentage was obtained from a Lost-to-Follow-up study recently
T1.1.N	Numerator Only: Number of adults and children with advanced HIV infection receiving antiretroviral therapy	This number was estimated based on the current achievements (by end of December 2009). The program data by end of December 2009 shows that we are 4.8% below the target figures published in the 2009 Epidemiologic Update. We anticipate that in subsequent years the number of persons on ART will most likely be below the projected figures by almost the same percentage.
H2.1.N	Number of new health care workers who graduated from a pre-service training institution	This was based on the data collected from health professional training institutions that indicated the number of students currently attending pre-service training. We assumed that all students in the relevant cohorts will eventually graduate in 2010 and 2011.

Technical Area Summary Targets

Use this tab to provide explanations and justification around your technical area summary targets for those indicators that are **applicable** to your program.

Operating Unit:	Rwanda

Indicator no.	Indicator label	Target Justification
P1.1.D	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Based on national projections, an increase of 6.1% for 2009-2010 and 7.1% for 2010-2011 is expected for the number of pregnant women counseled and tested and received results. Calculation for each partner: the # of pregnant women who were HIV counseled and tested for PMTCT and received their test results APR09 x 1.061% for 2010 target and estimated target 2010 x 1.071% for 2011 target: □ FY10: APR09 results x 1.061%
P1.2.D	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission	Calculations: HIV sero-prevalence rates as per APR09 reports were applied to the number of women counseled, tested and received results; Assumptions: 85% of all HIV+ pregnant women will receive ART prophylaxis.
P4.1.D	Number of injecting drug users (IDUs) on opioid substitution therapy	No program activities related to this program area.
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services	GOR is planning to institutionalize MC at all health facilities. MC as an HIV prevention intervention is beginning in FY10 and only among military personnel. These targets were based on projections made by partner from current 5 operating sites to 8 sites.
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP)	Being a new indicator, there was scanty historical data. Implementing partners estimate 1-2 clients per site will receive the service.
P7.1.D	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions	GOR conducted training on PwP interventions in FY09, and services are expected to be implemented in FY10. Assumption: At least 80% of care clients to receive PwP services.

Indicator	Description	Justification
P8.1.D	Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	Projections were made based on partners' historical data on similar old generation indicators. An improvement is expected in the quality of data collection hence the lowering of figures compared to APR09 results.
P8.2.D	Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	Projections were made based on partners' historical data on similar old generation indicators. An improvement is expected in the quality of data collection hence the lowering of figures compared to APR09 results.
P8.3.D	Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	This projection was based on partner level categories as per National HIV/AIDS Strategic plan 2009-12; sero-discordant couples, women 20-24 years, CSWs, MSM, Truck drivers, men in uniform, prisoners, refugees, people with disabilities. On top of these MARPS, a few other categories were added: fishermen, wives of truck drivers.
P11.1.D	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results	Most of the partner APR09 results were high due to the national VCT campaign held during the year. Since this is not expected to be repeated this year, most partners made conservatively lower targets than APR09 achievements.
C1.1.D	Number of eligible adults and children provided with a minimum of one care service	Calculations: The total number of OVCs was added to the expected number of adults ≥18 that will receive at least one clinical service (C.2.1.D). It is estimated that 11% of the total care clients will be children or HIV+ OVC (Previous program results have shown that 10% of ART clients are children, and 1% was added to cater for OVC who are HIV+).
C2.1.D	Number of HIV-positive adults and children receiving a minimum of one clinical service	Based on previous program results, the ratio of ART: Care at PEPFAR sites has been 1:2. The target figures were computed by doubling the number of targeted Current ART clients.
C2.2.D	Percent of HIV-positive persons receiving cotrimoxazole prophylaxis	Assuming 95% or more of clinical care clients (C.2.1.D) will receive CTX prophylaxis
C2.3.D	Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	Based on the proportions of pregnant women and current ART clients that received food in FY2009 (APR09 and TRAC+), it is estimated that 11,402 malnourished HIV+ individuals will require therapeutic food. Of these, more than 10,000 will receive food from PEPAFR-supported interventions as the GOR is institutionalizing nutritional services at health facility level. USG will be having a new implementing partner for food by prescription that will contribute a bulk of the target.
C2.4.D	Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings	Assuming 90% or more coverage based on draft TRAC+ report on TB screening activities among PLHIV

C2.5.D	Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	Assuming 1% of all care clients will start TB treatment. This estimate is based on the findings of a TRAC+ study on TB screening activities among PLHIV.
C5.1.D	Number of eligible clients who received food and/or other nutrition services	All clients currently receiving these services will continue to do so in FY10. Expansion is expected in 2011 with a new mechanism that begins in 2010.
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	Targets provided by partners based on the trend seen at PEPFAR supported sites.
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	This was estimated based on the enrollment trends seen at PEPFAR sites. This is calculated by adding previous year's active ART clients to newly enrolled patients. Program data has shown that 5% of ART clients are lost to follow-up or die in a year. This target represents 95% of the old and new ART clients.
T1.3.D	Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	Based on program data from clinical partners, 90% of cohort of new clients will remain on ART the following year . This was applied to figures provided by partners.
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	Actual number of laboratories currently in operation with capacity supported by PEPFAR. No new laboratories will be opened/upgraded in the next FY.
H1.2.D	Percent of testing facilities (laboratories) that are accredited according to national or international standards	The process and systems for accreditation are just beginning in 2010 and no lab is expected to be accredited in 2010. 3 labs including the National Reference Lab are expected to be accredited in 2011.
H2.1.D	Number of new health care workers who graduated from a pre-service training institution	Data sourced from existing student cohorts from the National University of Rwanda, Kigali Health Institute and the School of Public Health.
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	This includes peer educators, community health workers and volunteers to be trained by partners.

H2.3.D	Number of health care workers who successfully completed an in-service training program	This includes all health care workers to be trained in HIV/AIDS prevention, care and treatment as well as in lab management, logistics management, monitoring and evaluation.