Rwanda

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

Country Context

Rwanda has made remarkable progress since the tragedy of the 1994 genocide, with growth in real per capita income averaging nearly 5% and accelerating to an average of over 8% in the period 2006–2010 (NISR, Statistical Yearbook 2011). However, Rwanda remains one of the world's poorest countries, and is ranked 166 out of 187 countries on UNDP's Human Development Index 2011. According to the 2011 household survey, 45% of the population lives below the poverty line of $1.30 per day with 24% falling below an extreme poverty threshold of about $0.90 per day (NISR, 2012). Although Rwanda has made significant progress in improving the health status of its population, much work remains. Females have a life expectancy of 53.8 years, while males have a life expectancy of 49.4 years (NISR, 2011). The burden of disease in Rwanda is similar to that of other developing countries. Acute respiratory infections (ARI) accounted for 36% of all illnesses in 2011, followed by intestinal parasites (9%) (Rwanda MOH Annual Health Statistics Booklet, 2011). Cases of malaria have dropped from 8% in 2010 to 3% in 2011 but account for 6% of total deaths in 2011 as compared to 13% in 2010. In 2011, HIV and associated opportunistic infections was the fourth leading cause of hospital mortality with 7% of deaths after premature birth (11%), ARIs (9%) and cardiac diseases (9%).

Epidemiology of the HIV Epidemic

Rwanda is the most densely populated country in sub-Saharan Africa and faces a multitude of health and development challenges. An estimated 3.0% of the population aged 15-49 is infected with HIV (3.7% of women and 2.2% of males) [RDHS 2010], which has stabilized since the 2005 DHS. Out of a population of approximately 10.5 million, 185,746 Rwandan adults and 25,756 children are estimated to be living with HIV (EPP Spectrum, 2012). The repercussions of the 1994 genocide, in which up to a million Rwandan citizens were killed, combined with HIV, have resulted in more than a million orphans and vulnerable children. The annual deaths due to HIV-related illness were estimated to be approximately 6,000 in 2012 (EPP Spectrum, 2012).

According to epidemiological models, Rwanda's epidemic is primarily driven by heterosexual contact (95%), 5% MSM in adults (Modes of Transmission Report, 2013). Populations most-at-risk for HIV in Rwanda include: discordant couples; out-of-school youth; commercial sex workers (CSWs), their clients and partners; military and police personnel; long distance truck-drivers, and prisoners. Key statistics related to the HIV epidemic in Rwanda are shown below.

HIV Related Data

- Estimate of discordant couples, as a percentage of all cohabitating couples: 2.2%*
- HIV prevalence for CSWs: 51%**
- Percentage of youth (15 – 24 yrs) reporting ever having sex: 31%***
- Median age of sexual debut*
  - Males: 21.6 yrs
  - Females: 20.7 yrs
- Estimate of youth living with HIV/AIDS, as percentage of all those living with HIV/AIDS: 12.1%+
- Estimated HIV/AIDS orphans: 220,000++
- Estimated percentage of TB/HIV co-infection: 32%+++

*2010 Rwanda DHS
**2010 CSW Behavioral Surveillance Survey
***2009 Youth Behavioral Surveillance Survey
+November 2013 EPP Spectrum
++UNAIDS Report on the Global AIDS Epidemic 2008
+++WHO Global Tuberculosis Control, 2011

Status of the National HIV Response

The HIV prevalence rate in Rwanda has remained relatively stable, with an overall decline since the late 1990s, partially due to improved HIV surveillance which provides information for better interventions. The GOR is committed to fighting HIV/AIDS and takes a proactive role in prevention, care, and treatment (with national ART coverage at 94% of adults and 50% of children in need). PEPFAR's FY 2013 COP was developed with and will be carried out with close cooperation between the GOR, the USG, and local and international partners. Key priorities of this year's program include continued support for the sustainable transition of activities to national ownership, initiating increased GOR financial ownership of the program, and increased coordination with the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) to support to the national HIV/AIDS program. Rwandan leadership has demonstrated the political will to achieve these goals.

Coordination with Other Donors and the Private Sector

Over the past eight years, PEPFAR has supported the national capacity to plan, lead, manage, and deliver quality health services across Rwanda. The US is the largest HIV/AIDS bilateral donor in Rwanda. Other major donors supporting Rwanda's HIV/AIDS program include: the Global Fund; UN agencies; the Great Lakes Initiative on HIV/AIDS; Belgium Technical Cooperation; European Union; Netherlands Embassy;

Swedish International Development Agency; Korean International Cooperation Agency, and the UK Department For International Development. Health-focused non-governmental organizations (NGOs) operating in Rwanda include Partners in Health, the Clinton Health Access Initiative, and other international NGOs.

To date, the Global Fund has approved 12 grants to Rwanda totaling over $690 million. Rwanda's Global Fund HIV/AIDS National Strategy Application (NSA) and the PEPFAR Partnership Framework directly adopted national goals from the GOR's Health Sector Strategic Plan II and HIV/AIDS National Strategic Plan to ensure coordination by the two largest donors in support of national goals. This coordination also includes the multiple national government entities working to support the fight against HIV/AIDS, including the Ministries of Health, Education, Finance and Economic Planning, Youth, Gender and Family Promotion, and Local Government.

The USG actively participates in donor coordination and harmonization, especially through the two main bodies that coordinate health activities undertaken by donors and civil society in Rwanda: the Health Sector Working Group, chaired by the MOH Permanent Secretary and co-chaired by the USG, as represented by USAID; and the Global Fund Country Coordinating Mechanism (CCM), chaired by the MOH Permanent Secretary and co-chaired by the WHO Country Representative. These bodies include substantial representation from the GOR, donors, and international and local civil society organizations (CSOs) that support the health sector. In addition, the USG co-chairs multiple technical working groups under an MOH-led health sector coordinating structure.

PEPFAR Focus in FY 2013

USG's Priorities

The following strategic priorities were identified for FY 2013:

- Maintaining gains in PMTCT, with an emphasis on scaling up pediatric care and treatment
- Expanding prevention, care and treatment with key target populations
- Ensuring commodities are available while strengthening Rwanda's supply chain
- Supporting OVC programs, including through local CSOs
- Maintaining the military-to-military and Peace Corps programs
- Providing support to the Human Resources for Health (HRH) Program and ensuring joint MOH-USG monitoring of program results
- Continuing increased coordination and collaboration with the Global Fund

Major changes from FY 2012 include:

- Overall shift in prevention program from general population to key populations (including MSM, CSW & clients, mobile populations, and youth).
- Evidence-based reduction in support to the TB program based on decreasing cases seen at USG-supported facilities.
- Increased support to pediatric treatment and care.
- A gradual reduction of USG support for recurrent costs begins in COP13. Recurrent costs decreased by 7% in COP13; this includes facility operating expenses (primarily travel and per diem), MOH staff salary and individual performance-based funding, as well as laboratory consumables.

The PEPFAR/Rwanda team supports the strategic priorities from the FY 2013 Planned Country Allocation memo and is making changes as outlined above and in the Program Overview section below. Specifically, areas of focus include:

- Plans to prepare for district services transition in FY 2013 focusing on up to 5 of 14 districts currently supported by international partners. These transition plans will be jointly developed with the GOR in order to transition remaining districts expeditiously and responsibly.
- Ongoing support to the OVC program, with assistance to local CSOs.
- Increased harmonization with the Global Fund in advance of the implementation of the new funding model.

Partnership Framework (PF) and PF Implementing Plan (PFIP) Monitoring

Rwanda's PF and PFIP ended in 2012, along with Rwanda's Health Sector Strategic Plan II (HSSP) and National Strategic Plan (NSP) for HIV/AIDS. Rwanda currently has a final draft of the next HSSP, and is developing their next NSP. PEPFAR will be working with GOR, MOH, civil society and other partners to align programs to these important overall health sector guiding documents during the implementation of COP12 and COP13. The USG has been engaged in the development of these new policy documents, and the COP13 program is designed in that context.

The USG portfolio in Rwanda complements the activities of the GOR and other donors in the development of local capacity in monitoring and evaluation (M&E) by providing technical and financial assistance for the achievement of the government's objectives. A web-based Partner Reporting and Performance Monitoring System (PRPMS) is used to enable monitoring and reporting of PEPFAR results presented in semi-annual and annual reporting. Activities are underway to further harmonize PEPFAR reporting with other USG and GOR-supported national information systems.

In preparation for COP14 planning, PEPFAR Rwanda will be working closely with GOR and her partners, including the Global Fund, to review the PF, identify areas that still need to be addressed, map priorities to an AIDS-free Generation Blueprint, and define a long term strategy for the next six years in support of Rwanda's forthcoming NSP. Based on Rwanda's national plan (Vision 2020), Rwanda will achieve middle income status by 2020, and greatly reduce dependence on donor funding. Currently the USG is in dialogue with GOR to define a plan to increase GOR's national financing for the HIV/AIDS response. This is a critical area for PEPFAR programming over the next six years, as while Rwanda is a long-term strategy country, it is also confronting reduced resources from both the Global Fund and PEPFAR, the two primary funders of its national response.

Country Ownership Update

A continued focus of the USG program is to support the sustainable transition of activities to national ownership. To date the USG has strengthened the capacity of host government institutions to manage high quality PEPFAR-supported HIV programs and to report results to the USG, with an increase in the activities transitioned to national ownership in COP12. In addition, USG has begun and will continue to improve the capacity of local NGOs to manage and implement HIV programs. Currently, four local CSOs are receiving direct PEPFAR funding. The USG will also continue supporting the long-term sustainability of the health sector in Rwanda under the HRH activity, intended to strengthen medical education and health care management.

The GOR is deeply committed to implementing the principle of country ownership, despite a continued reliance on external funding. The GOR is fully engaged with donor partners, NGOs and international organizations and directs all programs within the country. From the beginning of PEPFAR, the USG and the GOR have worked closely on the coordination and implementation of HIV/AIDS programs. The PEPFAR program is aligned with GOR strategies, goals and priorities. PEPFAR strategies are planned and coordinated under the leadership of the MOH. The MOH convenes members of GOR, USG, other donors, civil society, and implementing partners to establish technical priorities and share information about the COP process. The USG and GOR jointly develop COPs. In addition, in preparation for Rwanda's Vision 2020 and goal of decreasing reliance on foreign aid, USG and GOR have agreed to gradually shift financial responsibility for recurrent costs. During COP13 implementation, the GOR will take on payment of 7% of salaries, individual PBF, and facility operating expenses currently supported by USG in COP12. In addition, USG will work with the GOR (Ministries of Finance and Health) to develop a transition plan for GOR's increased financing for the national HIV/AIDS program, especially regarding recurrent costs covered by PEPFAR. Also in COP13, activities around clinical services and commodities will continue to focus increasingly on building capacity in order to better support and prepare for transition.

The need for continued influx of donor resources does not indicate any lack of country ownership in the area of health. As discussed above, the GOR is fully engaged and plays the leadership role in coordinating health programs. The transition process has been a collaborative effort involving all stakeholders, and a comprehensive M&E plan is being implemented to ensure the long-term continued delivery of quality services.

Trajectory in FY 2014 and Beyond

The PEPFAR program in Rwanda is undergoing frequent change, to mirror the rapid pace of progress. However, key changes, challenges, and programmatic needs anticipated in moving towards increased country ownership include:

- Gradually decreasing support to recurrent costs, in line with Rwanda's commitment to a reduced dependency on external development aid in financing its public sector. USG and GOR will jointly develop a multi-year plan for a responsible, phased and transparent reduction before developing COP14.
- Health financing mechanisms should be further strengthened to support the decreased reliance on external funding.
- USG and GOR will need to prioritize technical assistance and M&E to ensure quality is maintained in transitioned activities.
- Capacity building for local CSOs will continue so that USG can increase direct support for them in the future.
- Continuing to harmonize clinical services provided by USG agencies and Global Fund, so that one package of services is managed by GOR once transition is complete, thus easing their management burden.

Program Overview

Care

In COP13, the USG will continue to support a comprehensive package for adult and pediatric care at PEPFAR-supported sites. The support provided by the USG is aimed at keeping PLHIV healthy and living in dignity, reducing transmission of HIV and assessing PLHIV for clinical treatment eligibility. Specifically, the USG will continue to support integrated service delivery in primary care services at health centers and hospitals in 22 of the 30 districts of Rwanda where USG is the lead donor for HIV services. By October 2014, it is envisioned that through direct financing, the GOR will assume responsibility for the management of approximately 120 facilities offering care and support services, including the 76 facilities that transitioned to GOR in COP12. The exact number of facilities will depend upon the specific districts identified with the GOR to be transitioned.

The USG will continue to support access to a broad range of basic care and support services at both facility and community levels. To date, the majority of prevention, care, and treatment services for PLHIV are provided in the health facility setting, with linkages to the community level for related support services. The USG will continue to promote a linkages model of service provision, utilizing 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 to minimize loss to follow-up of patients, particularly in pre-ART services.

USG will continue to build the capacity of government, local non-governmental, faith- and community-based organizations to ensure the smooth transition and sustainability of services by host institutions. The USG will continue to leverage family planning (FP) and maternal and child health (MCH) funds to support integration of services in all USG-supported sites. Specifically the USG will continue to integrate reproductive health, FP, MCH services and HIV in supported sites and at the community level in supported districts, hence providing a continuum of care and a minimum package of care and support services. In COP13, USG support for cervical cancer screening and treatment will be scaled down, and provision of nutritional supplements for pregnant women and HIV-exposed infants will be discontinued.

Assistance for pediatric care and support will increase in COP13 and will be a priority at all PEPFAR-supported sites. It is estimated that 22,240 HIV-positive children under 15 years of age currently live in Rwanda, with most of these infections being acquired vertically (Epi Update, April 2010). According to the FY2012 APR, 7,304 children under age 15 were receiving clinical care services at 241 USG-supported sites. USG will continue to support scale-up of adolescent-friendly services at PEPFAR-supported sites. USG implementing partners will continue to 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.

In COP13, care and support for OVC will remain a priority, with a focus on continuing assistance to local CSOs to provide comprehensive assistance to OVC and their households. In Rwanda, the USG, as the primary donor for OVC programs, is responding to GOR goals and priorities to reach OVC with an integrated focus of service provision and psychosocial support. USG support includes providing direct support to OVC and their households to increase the socio-economic resilience of their families and assisting the GOR to strengthen its district and sector-level support to OVC through children's forums and orphan care committees. These interventions ensure the coordinated participation of children and local leaders in OVC activities and services. USG will continue to provide support for OVC education and for the strengthening of referral systems, including linkages between community services, health facilities and

other supportive organizations that enable OVC to access a full spectrum of services. USG assistance related to supportive care (including school materials and supplies) and social protection and legal support will be scaled down; provision of food commodities will be discontinued.

In COP13, while the overall budget for TB/HIV activities will be reduced to reflect a decrease in the number of TB cases reported at USG-supported facilities, TB/HIV will continue to be a critical component of USG support to Rwanda. Almost all TB diagnostic and treatment centers in USG-supported districts provide ART, and all health facilities in Rwanda offer TB treatment. Directly-observed treatment, short-course (DOTS) is practiced countrywide at the health center and community levels. Key strategies for TB/HIV programming in COP13 will include systematic screening for TB among HIV-positive patients within HIV services and systematic screening for HIV among TB patients within TB clinics. In COP13, while technical assistance for INH preventative therapy (IPT) implementation at three pilot sites supported in COP12 will be discontinued, USG staff will still work with MOH to monitor the program. Supervision at the district and site levels for TB will be scaled down in COP13; support to rehabilitation for TB infection control and GeneXpert implementation will be discontinued.

The USG will continue to procure basic care related commodities in coordination with the GOR's Medical Procurement Division (MPD). USG will support the procurement of drugs for the prevention and treatment of OIs. The USG will continue to promote coverage of key clinical interventions (Co-trimoxazole, safe water products, etc.) which have been demonstrated to reduce morbidity and mortality among PLHIV.

Treatment

In COP13, treatment will remain a priority and major focus for USG support to Rwanda. While the Global Fund support will be responsible for approximately half of ARVs, along with the entirety of HIV test kits to be purchased with COP13 funds, USG's overall budget for commodities will increase in order to meet the increasing number of individuals on treatment. GOR is expanding treatment for all children under 5, has adopted PMTCT Option B+, and plans to treat all discordant couples regardless of CD4 count. The USG's ARV procurement will be increased from COP12 levels and will complement Global Fund support for first- and second-line drugs. USG will continue to support the GOR's decentralization efforts for ART delivery at central level institutions and extending to community level health facilities. Additionally, the USG will continue enrolling patients in ART services at currently supported sites, and will work with GOR and other donors to evaluate and ensure the quality of commodities.

In COP13, the USG will maintain 70,000 clients on ART and will initiate 9,700 new clients on treatment. The USG continues to support GOR's efforts to provide care and treatment to all eligible patients in accordance with national guidelines. The total number of patients currently on ART in USG supported sites is 67,980 (APR12), accounting for 61% of national ART coverage. Through the contributions of USG and other

funders, national ART coverage (based on WHO 2009 eligibility criteria) is 94%, one of the highest coverage rates in the world (EPI update 2010). This level of coverage along with access to treatment has socially and clinically improved the lives of PLHIV and reduced HIV/AIDS related deaths.

By October 2014, the management of approximately 40 additional facilities offering treatment services will be transitioned to the GOR under direct financing. The exact number of facilities will depend upon the specific districts identified with the GOR. In districts where the lead donor supporting HIV-related clinical services is not the USG, the USG will help to ensure continuity of care across sites and services. The USG supports direct mentoring and capacity building for district health teams, thus building capacity to decentralize supervisory and quality assurance activities. Following a tiered approach to service delivery, USG partners will provide broad 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.

At the community level, the USG will ensure continuity of care and adherence support through case managers, CHWs, and peer support groups. Through community mobilization activities, home visits, community-based registers, referral slips, patient cards and other tools, CHWs 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.

While the proportion of children on ART continues to lag behind adult ART coverage, increased support for pediatric HIV care and treatment activities at all levels of the health care system will be a priority for USG and MOH in COP13. Strategies include reinforcing a family approach using an index of positive patients to identify all family members with particular emphasis on children. Of all 9,524 HIV-positive patients newly enrolled on treatment in fiscal year 2012, 627 were children up to 15 years. This includes 114 HIV-exposed infants in PMTCT who tested positive and immediately were enrolled into care and treatment. The USG, the Global Fund, and UNICEF are some of the major stakeholders working with the GOR to develop and implement programs for HIV-affected and infected infants, children and adolescents. Presently, 440 sites offer ART services in Rwanda. The USG supports HIV treatment services for adults and children at 211 of these sites (48% of all ART service sites).The USG has supported MOH in the revision and dissemination of the pediatric care and treatment guidelines based on the new WHO recommendations. The revised guideline to treat all children under 5 is expected to be fully implemented in COP13.

Some of the challenges facing the pediatric treatment program include lack of sufficient numbers of nurses trained in task shifting and with experience in pediatric HIV care and treatment service provision; lack of fully implemented PITC for the pediatric population; and limited active pediatric HIV case-finding among families of persons enrolled in care and treatment or identified through VCT. There is also a need to

improve ART adherence especially for adolescents. In COP13, there will be a particular emphasis on the provision of psychosocial support to improve treatment adherence in children and adolescents. Moreover, USG will increase procurement of pediatric formulations of antiretroviral drugs to support the new guidelines. However, overall COP13 funding for technical assistance for the adolescent care and treatment program will decline; the program will be transitioned to GOR during COP13.

Prevention

For two decades, HIV has constituted a major public health problem in Rwanda. The GOR's key policies and documents guide implementation of health programming in the country with HIV/AIDS prevention as a key priority. Although Rwanda is on track to achieve its MDG target for 2015 of stabilizing HIV prevalence at 3% (RDHS 2010), Rwanda's challenge is balancing interventions for its mixed epidemic. The USG, therefore, supports combination prevention approaches where biomedical, behavioral and structural interventions work together to complement and reinforce one another.

In COP13, USG will continue to support an integrated HIV prevention package, with an overall shift in prevention programming from a focus on the general population to an emphasis on key populations, including MSM, CSW and their clients, mobile populations, and youth. Reaching these populations with testing and counseling and sexual prevention activities will be a priority. Behavior change communication prevention messaging will target key populations and surrounding communities, and USG support for mass campaigns for prevention will be discontinued. Social marketing activities and support for socially marketed condoms will be scaled down. In COP13, the USG will scale-up support for the capacity building of local CSOs to implement and manage prevention programs.

The 2010 Rwanda DHS estimates the HIV prevalence rate in women of reproductive age in Rwanda at 3.7%. The GOR aims to reduce the HIV MTCT rate below 2% by 2015. Rwanda's PMTCT program provides a comprehensive package: counseling and testing for pregnant women; preventive ARV regimens to prevent MTCT (Option B+); counseling and support for safe infant feeding practices; safe labor and delivery practices; family planning counseling or referrals; as well as referrals for long-term ART for infected children and eligible mothers identified at ANC or maternity. GOR and partners are working to improve uptake of PMTCT services, reaching women with ANC services through community outreach, sensitizing local authorities and displaying strong leadership. Provision of optimal PMTCT services will be made possible through improved M&E, staff mentoring and integration of PMTCT activities into existing MCH programs. Systems will be reinforced for post-natal follow-up of HIV-positive mothers and HIV-exposed infants to ensure women and children receiving care through PMTCT programs are linked to ongoing care and treatment services.

In COP13, USG will seek to maintain and advance gains achieved in PMTCT, with a focus on improving

quality and sustainability while addressing remaining gaps to achieve eMTCT. Additionally, efforts to integrate PMTCT into MCH services will help achieve HIV-free survival for infants and children as well as increased quality of life for mothers. Activities to address these challenges include continued sensitization of pregnant women and mobilization of CHWs and local leaders for early ANC and to minimize loss to follow-up during pregnancy and the breastfeeding period. Furthermore, to tackle the high staff turn-over, mentorship for health care providers will continue, although at a reduced funding level.

USG's clinical and non-clinical partners will continue to employ confidential testing and counseling approaches that minimize stigma and discrimination and link infected individuals to care and treatment programs. Currently, HTC is conducted by trained clinical providers; however, with continued training for and expansion of finger-prick TC by counselors, the USG will support the training of additional counselors. In COP13, the USG will sustain support to existing HTC sites with clinical and non-clinical partners, assist GOR to roll-out finger prick testing and continue to support other approaches to HIV testing. HTC services will continue to identify prevention needs of re-testers for targeted risk-reduction counseling. HIV testing in campaigns among the general population and unnecessary repeat testing at facilities will be scaled down.

While the USG will continue to support HTC activities for the general population and couples in facilities, in COP13 there will be an increased focus on testing among key populations in all settings. In order to reach high prevalence populations who are unlikely to access HTC services at clinical sites, as appropriate, USG efforts will continue to target key populations with outreach HTC services in venues where HIV positivity rates are demonstrated to be higher than in the general population. USG will continue to support innovative ways to improve access to HTC among key populations. For HIV-positive individuals identified through HTC services, the program will emphasize documentation of linkages and referrals to care and treatment. Coordination of these activities will be crucial to avoid duplication and maximize coverage to key populations. This targeted promotion of HTC services will identify those most likely to be infected and ensure they are referred to sites where they can receive testing, counseling, referral to appropriate care and condoms.

With a low male circumcision rate and a mixed HIV epidemic, MOH developed a policy that recognizes VMMC as an added effective HIV prevention method when combined with other proven methods. USG is working closely with Rwanda's MOH and other donor partners in a national program to circumcise 500,000 men by 2014. In COP13, USG will continue working towards this goal by performing 20,000 VMMC procedures. This will contribute to the realization of USG's World AIDS Day targets for VMMC. USG supports VMMC activities in military health facilities for the provision of the minimum package, on-site training, mentorship, supervision support, infrastructure development, and M&E. These facilities provide services to members of the Rwandan Defense Forces as well as surrounding communities.

The USG will continue support to the MOH 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. In COP13, there will be an increased effort to ensure that necessary technical skills are transferred to the national program to ensure its sustainable operation. The goal of the USG's Safe Injection Program is to support the GOR 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. The focus of USG support will be inside and outside clinical environments. Similar to the Blood Safety program, in COP13, at a reduced funding level, the USG will support the MOH's national program, as they have assumed responsibility for managing injection safety and medical waste management activities, supported by USG, since COP12. In COP13, technical assistance for the Blood Establishment Computer System and blood bank accreditation and support to injection safety will be scaled down. The purchase of new equipment, construction of multipurpose waste pits, and rehabilitation activities for blood banks will be discontinued.

HSS

Rwanda is a dynamic country, characterized by the rapid adoption of new approaches, strategies and programs, yet Rwanda also has critical deficits in human resource capacity and health financing mechanisms. In turn, these issues compound systemic deficits, contributing to low levels of institutional capacity at all strata of the health system, hindering decentralization of the health system and evidence-based decision making as well as ensuring long-term sustainability of the health system. The full transition of USG-supported activities to national ownership is dependent on the capacity of Rwandan institutions and individuals to assume these responsibilities.

USG supports institutional and human capacity building in the GOR from the central to the community level. The USG employs three strategies to achieve its objective of increasing human and institutional capacity in Rwanda: 1) leverage established coordination structures; 2) develop and strengthen relationships with national partners; and 3) integrate capacity building across all health assistance. Using a systems approach, efforts will continue to focus on increasing efficient utilization and integration of the workforce at the district, sector and community level, strengthening national management of service delivery, management of financial resources, leadership of human resources as well as staff training and deployment.

In COP13, USG support for all HSS program components, outside of the HRH program, will be reduced. USG is investing in the HRH Program, which brings individuals from US universities to provide long term in-country medical training to Rwandan doctors, nurses, and students with the goal of creating an efficient, self-sustaining, and comprehensive medical training system that by the end of US support will be staffed, run, and funded by Rwanda .. [REDACTED] USG will collaborate with other donors and stakeholders to ensure effective and efficient training, deployment and management of HRH across Rwanda, using

evidence-based decisions in program implementation. In pre-service education, the USG will continue to provide support to key educational institutions in Rwanda to increase the country's capacity to provide pre- and post-graduate training in nursing, midwifery, medicine, public health management, field epidemiology, program management, and strategic information. In partnership with US academic institutions, the GOR will continue to strengthen the capacity of Rwandan health sciences institutions, as well as provincial and district hospitals, to produce a well-trained health workforce capable of responding to Rwanda's health needs. USG will work closely with GOR to monitor and evaluate the HRH program.

USG will continue to strengthen the capacity of the national HIV/AIDS strategic information network to plan, collect, manage, and make use of integrated data from a variety of sources as outlined in the eHealth Enterprise Architecture. Assistance will continue to support the implementation of Rwanda's National e-Health Strategic Plan and National HIV/AIDS Monitoring and Evaluation (M&E) Policy and Strategy.

USG assistance will continue to focus on capacity building of national and district-level managers in order to improve HIV program data quality and reporting. During COP13, GOR will take responsibility for the management of TRACnet and its continued integration with national health information systems. During COP13, support for the USG's PRPMS will also be reduced, as an increasing amount of USG reporting is envisioned to come from TRACnet.

The COP13 USG laboratory strategy continues to build on a tiered national laboratory system for creating sustainable infrastructure to support care and treatment of PLHIV. COP13 support for the national laboratory policy and strategic plan will include: establishing national laboratory policies; integrating clinical diagnostic services; harmonizing and maintaining equipment; managing inventory and national forecasting of supplies, reagents and test kits; supporting quality assurance programs and human capacity development; and setting standards for and implementation of a Laboratory Information System. In COP13, USG support will include the national system linked from NRL to regional sites to district hospital sites to primary care sites. The USG plans to continue to support NRL to improve the financial, coordinated procurement, overall quality assurance, laboratory networks and referrals. USG will also continue to support human capacity development, with special emphasis on training non-laboratory personnel to perform rapid HIV testing using the finger prick method of blood collection.

In COP13, the USG will support MOH to ensure that essential health services are provided in a high quality and financially accessible manner to the entire Rwandan population. Particular emphasis will be placed on promoting an equitable, efficient and sustainable health financing framework based on results. Activities designed to strengthen the national community-based health insurance mechanism will continue, and USG assistance will support the development of robust national health financing mechanisms that increase the accessibility and affordability of high quality health services.

There is strong country ownership of Rwanda's supply chain.[REDACTED]. The USG will provide procurement and financial management support to MPD, including technical assistance to build their capacity as they assume direct financing. The USG collaborates closely with GOR and the Global Fund as well as other development partners to identify synergies in donor inputs. The Coordinated Procurement and Distribution System, a coordinated forecasting and quantification exercise, is conducted on a yearly basis with quarterly updates and brings together all stakeholders to review assumptions and inputs.

Central Initiatives

USG continues to work with the CCM and provide support via the GF Collaboration Grant. USG is working with the CCM Secretariat to improve progress reporting by developing a dashboard, providing technical support to the Single Project Implementation Unit (the financial coordination function for the Global Fund Principle Recipient-MOH), and other support for capacity building of local community-based organizations who are sub-recipients of Global Fund grants.

Coordination with GHI Strategy

The GOR and the USG health team identified human and institutional capacity building and gender equality as GHI priority areas. The first priority area is specifically "to strengthen the human and institutional capacity of the public health system to plan, manage, implement and monitor sustainable health programs at all levels." In COP13, this priority will be supported through the HRH activity, trainings and technical assistance, and an overall capacity-building approach incorporated into activities. This will be especially true with regard to clinical services and commodities activities, in preparation for the transition to direct financing in these areas. The second priority area is "to set the Rwandan society free from all forms of gender-based discrimination and see both men and women participate fully and enjoy equitably from the development process." In COP13, a gender sensitive lens is applied to all activities providing equitable opportunities for both women and men to benefit from USG supported programs. In addition, more attention will be paid to monitoring for gender outcomes, especially by disaggregating targets and results where appropriate.

Program Integration

USG health programs in Rwanda also include the President's Malaria Initiative; Feed the Future; and funding for MCH, FP, and water. USG seeks to leverage all resources in the health sector using a health systems strengthening approach. Many activities are jointly funded in order to support the system as a whole. The GOR delivers services in an integrated package, and the USG supports this whenever possible.

Consistent with this approach, behavior change messaging is integrated in order to deliver comprehensive health messages to maximize each contact.

Mapping to PEPFAR Blueprint

Through the GOR's leadership in promoting an integrated health service delivery model across Rwanda, PEPFAR fits into a clearly defined national continuum of the HIV response. Rwanda has a strong network of health centers that provide the general population with HIV, MCH, FP, nutrition and other primary health services. There are few standalone HIV testing or treatment sites. While all HIV services are not provided at every facility, linkages and referrals are provided to nearby facilities when a patient's need cannot be accommodated at a facility. In addition, USG-supported prevention and OVC programs refer individuals to HIV and other services provided at nearby health facilities, which may be supported by the GOR, USG, or another development partner. An example of how HIV and other health sector services are linked is through the strong national PMTCT program that tests 95% of women for HIV during antenatal care visits and over 80% of their partners and connects antenatal care services with HIV prevention, treatment, and care services. Similarly, there is a counseling and referral process in place for FP for PLHIV. Through OVC and prevention projects, PEPFAR supports economic and household strengthening and education activities in order to address the broader needs of PLHIV and their families as people, not just patients. In both clinical and community settings, psychosocial and emotional care services are provided by trained professionals and through networks of PLHIV.

The GOR has encouraged all development partners to support the roll out of high-impact interventions to save lives. They have recently adopted new treatment guidelines to treat all children under 5, adopt PMTCT Option B+ (in an effort to achieve eMTCT), and treat all discordant couples. In addition, they are scaling up efforts to use VMMC as a prevention tool. In TB/HIV integration, a focus will remain on screening and testing in both HIV and TB settings, while work on IPT in pilot sites is closely monitored in order to make an evidence-based decision about its further rollout. COP13 continues to support a large OVC program that incorporates seven of eight priority interventions, excluding social protection. GOR policies supporting OVC are strong, and, therefore, PEPFAR focuses on the remaining seven interventions. In COP13, USG will be shifting support for sexual prevention and testing and counseling from the general population to key populations. In addition, with the HIV prevalence almost 70% greater among Rwandan women compared to men, addressing the needs of girls and young women continues to be a priority across our entire program. In particular, our behavior change and prevention programs look to address their needs and gender norms, while clinical service programs aim to increase male involvement and address gender-based violence through support to victims and increasing awareness.

PEPFAR/Rwanda has been making smart investments and will continue to work towards sustainability,

efficiency and effectiveness in FY 2013. As described above, Rwanda has demonstrated strong country ownership and, in order to promote sustainability and efficiency, USG is planning to continue to transition support to direct government financing, both for clinical services and commodities. With that transition, technical assistance to maintain the quality of services delivered at the facility level and a strong supply chain, along with the HRH workforce necessary to support them, will remain a priority in COP13. USG will continue to work closely with MOH to strengthen national health financing schemes to increase the effectiveness and sustainability of domestic health financing.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	180,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	03	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	27,000	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	6,400	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	8,400	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	10,000	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	438,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV	11,000	2011	WHO			

needing ART for PMTCT						
Number of people living with HIV/AIDS	210,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	170,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	117,691	2011	WHO			
Women 15+ living with HIV	110,000	2011	AIDS Info, UNAIDS, 2013			

Partnership Framework (PF)/Strategy - Goals and Objectives

Number	Goal / Objective Description	Associated Indicator Numbers	Associated Indicator Labels
1	Strenthening the human and institutional capacity of the public health system to plan, manage and implement sustainable health programs at all levels.		
1.1	The Rwandan health sector is sustainably and equitably financed, and managed efficiently and transparently.	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

How is the USG providing support for Global Fund grant proposal development?

The United States Government (USG) works closely with The Global Fund (GF) Country Coordination Mechanism (CCM) and the Government of Rwanda (GOR) to assist with grant proposal development. Technical assistance (TA) has been provided to the CCM Secretariat and various MOH departments to

assist in grant proposal development for both HIV and TB. These activities have resulted in the CCM's submission of Phase II grant proposals. Additionally, USG has supported the GOR's development of national strategy reviews and development; these strategies form the basis of Rwanda's grant submissions.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?
Yes

If yes, please indicate which round and how this may impact USG programming. Please also describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).
Rwanda's current National Strategy Application (NSA) is in the 3rd year of a three-year grant. Rwanda submitted a Phase II application for a 24-month bridge funding in late 2012 before applying for another NSA under the new funding model. Rwanda's Phase II grant application will soon be reviewed; congruently the MOH is developing the next HIV/AIDS National Strategic Plan (NSP) with its health partners.

USG is working closely with the GF Fund Portfolio Manager (PFM) to strengthen the alignment and harmonization of GF supported elements of Rwanda's national HIV response. In addition, USG is working with UNAIDS as they lead the initiation of the new financial framework tool's application in Rwanda.

USG has initiated discussions with GOR-MOH, the CCM Secretariat and other key partners to develop a harmonized costing of the next NSP and ensure that the financial framework is applied. These new approaches will help to ensure that there is increased alignment with the GF and increase the clarity with which elements of the national response will be financially supported by GOR. Coupled with the reduction in PEPFAR's support for MOH staff and other recurrent costs in COP13, these conversations and financing plans should be completed to help support USG's planning for COP14. USG is actively involved in the development and costing of the new NSP to ensure that PEPFAR support informs and aligns with the programming of both GOR and GF resources.

Redacted

To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?
Yes

If yes, how have these areas been addressed? If not, what are the barriers that you face?
Redacted

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Survey	2nd Evaluation of National Adult ART Program	AIDS/HIV Case Surveillance	Other	Other	05/01/2013
Survey	Analysis of Clients Attending Three Types of Voluntary Counseling and Testing Services in Rwanda, August 2009 – September 2010	Evaluation	General Population	Data Review	09/01/2013
Survey	Antimicrobial Resistance to Neisseria Gonorrhea in outpatients with genital discharge in Rwanda	Evaluation	General Population	Development	12/01/2013
Survey	Assessment of barriers to ANC and Family Planning for HIV positive women	AIDS/HIV Case Surveillance	Pregnant Women, Other	Implementation	04/01/2013
Survey	Assessment of MCH/HIV integration (EGPAF)	Other	General Population, Pregnant Women, Other	Implementation	06/01/2013
Survey	Assessment of Quality of Care in PMTCT Program in FHI 360 -Supported Health Centers in Rwanda	Other	General Population	Implementation	04/01/2013

	(FHI/ROADS				
Surveillance	Barriers and Motivations towards Condom Use and HIV Voluntary Counseling and Testing among Men who Have Sex with Men (PSI)	Behavioral Surveillance among MARPS	Men who have Sex with Men	Implementation	04/01/2013
Surveillance	Behavioral Surveillance Study among motorcycle drivers (FHI/ROADS)	Behavioral Surveillance among MARPS	Mobile Populations	Other	09/01/2012
Surveillance	Behavioral Surveillance Survey among Youth 15-24	Population-based Behavioral Surveys	Youth	Development	09/01/2014
Surveillance	BSS among men who have sex with men	Behavioral Surveillance among MARPS	Men who have Sex with Men	Development	06/01/2013
Survey	BSS FEMALE SEX WORKERS	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Development	12/01/2013
Survey	Determinants of HIV Acquisition in Serodiscordant Couples Identified through Prevention of Mother to Child Transmission (PMTCT) Programs in Rwanda, 2008-2009	TB/HIV Co-Surveillance	Other	Implementation	06/01/2013
Survey	Evaluating and Understanding Living Positively and Secondary Prevention among People Living with HIV (PSI)	Evaluation	General Population, Other	Implementation	04/01/2013
Survey	Evaluation of GeneXpert MTB/RIF Assay for	Evaluation	Other	Development	06/01/2013

	Diagonosis of Mycrobacterium TB in Rwanda				
Survey	Evaluation of Rwanda Exposed Infants follow-up services in PMTCT program	Evaluation	Other	Development	12/01/2013
Survey	Evaluation of TB Risk Among HCWs	TB/HIV Co-Surveillance	Other	Data Review	09/01/2013
Survey	Evaluation of the performance of Cobas Taqman Real-Time PCR for viral load determination in ARV's (NRL)	Laboratory Support	Other	Implementation	09/01/2013
Survey	Evaluation of the Task Shifting Intervention in HIV management in FHI 360-Supported Health Centers in Rwanda (FHI/ROADS)	Evaluation	General Population, Other	Implementation	06/01/2013
Survey	Fellowship program evaluation	Evaluation	Other	Other	12/01/2012
Surveillance	HIV and Syphilis Serosurveillance among pregnant women attending ANC-PMTCT services in Rwanda (January 2012 - June 2012)	Behavioral Surveillance among MARPS	Female Commercial Sex Workers, Pregnant Women	Data Review	09/01/2013
Surveillance	HIV Behavioral Study Amonges the Rwandan Defence Forces	Behavioral Surveillance among MARPS	Other	Other	09/01/2012
Survey	HIV Drug Resistance Early Warning Indicator Survey COP 8	HIV Drug Resistance	Other	Other	07/01/2012
Surveillance	HIV drug resistance surveillance surveys	HIV Drug Resistance	Other	Other	06/01/2013

Survey	HIV Drug Resistance Threshold Survey	HIV Drug Resistance	Other	Planning	10/01/2013
Surveillance	HIV Serosurveillance among pregnant women	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Development	09/01/2013
Surveillance	Identification of MARPs attending VCT services using risk-score algorithm	Behavioral Surveillance among MARPS	Mobile Populations	Data Review	06/01/2013
Survey	Mapping study investigating the availability of condoms and sur'eau (point of use water purification)	Other	General Population	Other	07/01/2012
Survey	National Pediatric ART Program Evaluation	Evaluation	Other	Data Review	09/01/2013
Survey	Non communicable disease risk factors assessment in Rwanda (MOH)	Other	General Population	Implementation	04/01/2013
Survey	OVC Program Evaluation	Evaluation	Youth	Planning	09/01/2014
Survey	Program Data Analysis in Seven Districts Eliminating Pediatric HIV in Rwanda	Other	Other	Other	09/01/2012
Survey	Retrospective Analysis of Treatment Outcomes for Infants and Yound Children Starting ART at Less Than 24 Months of Age	AIDS/HIV Case Surveillance	Other	Other	09/01/2012
Survey	RWANDA DEMOGRAPHIC HEALTH SURVEY	Population-based Behavioral Surveys	General Population	Planning	10/01/2015
Survey	TB and TB-HIV Prevalence Survey in Prisons	Population-based Behavioral	Other	Data Review	09/01/2012

		Surveys			
Survey	Validation of TB screeening approaches and use of IPT for children living with HIV/AIDS in Rwanda	Evaluation	Other	Development	12/01/2013
Surveillance	Youth HIV Prevention Behavioral Intervention Tracking Survey (BTS), Rwanda 2010	Behavioral Surveillance among MARPS	Youth	Publishing	04/01/2012

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		2,952,091		**2,952,091**
HHS/CDC	3,328,008	40,566,557	0	**43,894,565**
PC		1,203,445		**1,203,445**
State		212,136		**212,136**
State/PRM		236,456		**236,456**
USAID		46,929,685		**46,929,685**
Total	**3,328,008**	**92,100,370**	**0**	**95,428,378**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency							Total
	State	DOD	HHS/CDC	PC	State/PRM	USAID	AllOther	
CIRC		768,067	56,984					**825,051**
HBHC		310,366	2,795,855		40,897	2,056,117		**5,203,235**
HKID						5,596,084		**5,596,084**
HLAB		84,220	1,685,698			9,420,874		**11,190,792**
HMBL			2,334,710					**2,334,710**
HMIN			192,341					**192,341**
HTXD			3,022			13,149,561		**13,152,583**
HTXS		776,303	6,671,352		90,880	1,272,470		**8,811,005**
HVCT		364,899	1,847,046		27,363	2,647,906		**4,887,214**
HVMS	175,067	69,146	5,828,223	1,123,445		2,848,486		**10,044,367**
HVOP		253,101	860,945	80,000	10,727	1,858,023		**3,062,796**
HVSI	37,069	22,500	2,529,595			929,561		**3,518,725**
HVTB		82,676	2,307,717		22,097	499,636		**2,912,126**
MTCT		71,220	1,977,505		30,354	1,615,236		**3,694,315**
OHSS		14,146	12,010,520			3,320,479		**15,345,145**

PDCS		59,146	1,132,946		4,497	892,626		**2,089,215**
PDTX		76,301	1,660,106		9,641	822,626		**2,568,674**
	212,136	**2,952,091**	**43,894,565**	**1,203,445**	**236,456**	**46,929,685**	**0**	**95,428,378**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Access to high-quality, low-cost medications						
Policy: National Pharmaceutical Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done			
Completion Date						
Narrative						

Policy Area: Access to high-quality, low-cost medications						
Policy: National Procurement Law						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date				December 2012		
Narrative	done					
Completion Date						
Narrative						

Policy Area: Access to high-quality, low-cost medications						
Policy: Public Procurement and Disposal of Assets						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Counseling and Testing
Policy: Change in age of consent for VCT in young people (from current age of 18 to 15)

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Counseling and Testing						
Policy: Finger-prick testing policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done		
Completion Date						
Narrative						

Policy Area: Counseling and Testing						
Policy: Guidelines for couples counseling and the follow-up of discordant couples						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	done	in process
Completion Date						
Narrative						

Policy Area: Counseling and Testing						
Policy: Policy on provider initiated testing for HIV						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	

Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: Law on Prevention and Punishment of Gender-Based Violence						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: Manual on the management of victims of gender-based violence						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	in process	done	in process	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: National Gender Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: National Policy Guidelines on Male Circumcision (MC) in the HIV Prevention Framework						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative					done	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: Strategic Plan for the Implementation of the National Gender Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Community Health Strategic Plan						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)

Policy: HRH Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done		
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: HRH retention strategy and deployment policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	in process			
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: HRH Strategic Plan 2009-2012						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done		
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: National Community Health Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion						December

Date						2012
Narrative	done	done	done	done (never validated)	in process	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: National training policy for the health sector						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	stalled			
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Reform and expansion of performance based financing						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	done	done
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Revision of HRH management tools for each level						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	in process	

Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Revision of laws governing health professional regulatory bodies and associations						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date				December 2012		
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Task Shifting Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	2009-06-30	2009-08-31	2009-12-31	2010-01-31	2010-02-28	2013-03-31
Narrative	Done	Done	Done	Done	In process	
Completion Date	06-2009	08-2009	12-2009	01-2010	02-2010	
Narrative	Achieved consensus regarding identification of the problem through analysis of HRH stock and workload	Developed framework and roles and responsbilities regarding development of policy with all stakeholders	Drafted, revised and validated draft document	Approved by Ministry of Health	Disseminated plan and provided training to health care workers in order to carry out new responsbilities	

Policy Area: Laboratory Accreditation						
Policy: Laboratory accreditation policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done		
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Child Status Index						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Early Infant Diagnosis Guidelines						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Guidelines for Identification of the Most Vulnerable Children						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**

Estimated Completion Date					December 2012	
Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Minimum Package of Services for OVC						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: National Plan of Action for OVC						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Pediatric Treatment Guidelines						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	done	

Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: e-Health Strategy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Health research policy and strategy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	in process	done		
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Improvement of the Human Resources for Health information system						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Major revision of PMTCT guidelines						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Monitoring and Evaluation Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	in process	expired	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Monitoring and Evaluation Strategy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	in process		
Completion Date						
Narrative						

Policy Area: Other Policy
Policy: National Policy and Strategy for Quality Management

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date					December 2012	
Narrative	done	done (limited)	done	done	done	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Policy on Injection Safety, Prevention of Transmission of Nosocomial Infections, and Healthcare Waste Management						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done		
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National strategy for supervision of health facilities						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	done	being reviewed
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Policy on data sharing and confidentiality						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**

Estimated Completion Date					December 2012	
Narrative	done	done	done	done		
Completion Date						
Narrative						

Policy Area: Post Exposure Prophylaxis: occupational and non-occupational						
Policy: Post-Exposure Prevention guidelines (included in ART guidelines)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					December 2012	
Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Laws to protect people living with HIV against discrimination (provisions that specifically mention HIV in addition to general non-discrimination pro						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			December 2012			
Narrative						
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: People Living with HIV Stigma Index						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						

Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Policy on access to HIV/AIDS services for most-at-risk populations (commercial sex workers, men who have sex with men, prison inmates)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date				December 2012		
Narrative	done	done	in process			
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Policy on greater involvement of people living with or affected by HIV/AIDS						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date				December 2012		
Narrative						
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Strategy to reduce HIV-related stigma and discrimination						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			December 2012			
Narrative						
Completion Date						

Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Decentralization strategy for the health sector						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date				December 2012		
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Deliver as one to meet development needs and rights of Rwandan adolescents and youth 2009-2011						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						
Narrative	done	done	in process			
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: National Behaviour Change Communication (BCC) Policy for the Health Sector						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						
Narrative	done	done	done		done	

Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: National Operational Guide for Implementation of BCC Programmes in Fight Against HIV/AIDS to Priority Target Groups						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						
Narrative	done	done	done	in process		
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: National Protocol for Food and Nutritional Care and Support for People Living with HIV/AIDS in Rwanda						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						
Narrative		done	done	done		
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: National strategic plan for the control of tuberculosis						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012

Narrative	done	done	done	done	done	done
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Policy and Strategic Plan for Child Survival 2008-2012 (Politique Nationale de la Santé de L'Enfant, Plan Stratégique d'Accélération de la Survie de l						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						
Narrative	done	done	done	done	in process	
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Policy Statement on TB/HIV Collaborative Activities						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	done	
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Rwanda National Policy on Condoms, and National Strategic Plan for Comprehensive Condom Programming in Rwanda 2009-2012						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion					December	

Date					2012	
Narrative	done	done	done	done	in process	done
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Rwanda National Strategic Plan on HIV and AIDS 2009-2012						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						December 2012
Narrative	done	done	done	done	done	done
Completion Date						
Narrative						

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	5,203,235	0
HKID	5,596,084	0
HVTB	2,912,126	0
PDCS	2,089,215	0
Total Technical Area Planned Funding:	**15,800,660**	**0**

Summary:

I. Introduction

At the end of September 2011, the USG supported 238 health facilities to provide basic care and support services to 100,686 PLHIV, representing approximately 62% of all PLHIV in Rwanda enrolled in care programs, and 73,510

OVC. In COP12, the USG will evaluate the merits of using Co-trimoxazole pick-up as a proxy for numbers of PLHIV accessing care services.

Major achievements in the last two years include, but are not limited to:

- *Improved pediatric care outcomes as a result of roll out of revised PMTCT and pediatric treatment guidelines based on 2009 WHO recommendations.*
- *Roll out of Co-trimoxazole for all HIV positive patients, regardless of CD4 counts.*
- *Policy change that provides ART for PLHIV with active TB regardless of CD4 count.*
- *Introduction of GeneXpert for TB diagnosis, which is being piloted in FY 2012.*
- *Implementation of task-shifting, couples counseling, scale up of PwP program, and roll-out of fingerpick testing.*
- *Development and implementation of palliative care guidelines.*
- *Reinforced psychosocial support for HIV-positive children and adolescents through promotion of support groups to address issues around status disclosure and adherence support.*
- *Development of a comprehensive national cervical cancer prevention, care and treatment strategy.*
- *Support for laboratory accreditation and long-term training of pathologists to support HIV-related cancers including cervical cancer among HIV positive women and diagnosis of extra-pulmonary TB.*
- *Transition of oversight for care services from international partners to the MOH, which is expected to lead to efficiencies.*

In COP12, the USG will continue providing financial and technical support to 238 health facilities offering care and support services in 22 of Rwanda's 30 districts.

The support provided by the USG is aimed at keeping PLHIV healthy and living in dignity, reducing transmission of HIV among PLHIV and assessing PLHIV for clinical treatment eligibility. Specifically, the USG will continue to support integration of HTC and provider initiated testing (PIT) into primary care services in health centers and hospitals in 22 of the 30 districts of Rwanda where the USG is the lead donor for HIV services. The USG will continue to support access to a broad range of basic care and support services both at facility and community levels. To date, the bulk of prevention, care, and treatment services for PLHIV are provided in the health facility setting, with linkages to community for related support services. Clinical services include: CD4 testing and clinical staging; diagnosis and treatment of common opportunistic infections (OIs), especially TB screening; adherence counseling; clinical monitoring; provision of Co-trimoxazole. The program will continue to improve early diagnosis of HIV for exposed infants, growth monitoring for children and nutritional support for those eligible according to national care and support guidelines. Psycho-social support and disclosure for adolescents living with HIV continue to be priority areas for the GOR and the USG will continue to support training to improve the requisite skills. The USG will continue to support capacity building for integration of mental health into HIV services. Development of screening tools and national guidelines by TRACPlus to support this integration has been completed. Social care services will continue to be provided primarily through community-based activities, with strengthened referrals to and from clinics. Non-clinical support includes prevention counseling "positive health dignity and prevention for PLHAs and their family members", and referrals to community-based care and support services, including income generating activities.

The USG will continue to support community health insurance (Mutuelles de Santé) for eligible HIV patients and their families to enable them to access broad primary health care services. Eligibility for support is determined by the community leaders according to established guidelines for Mutuelles. In addition partners help support patients' transportation costs, and promote income generation initiatives through PLHIV associations. Nutrition education, counseling and kitchen gardens are supported by all partners to ensure nutrition support. Food-by-prescription, and food to support newly initiated ART patients, continue to be areas of need for USG 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 PLHIV, 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, the USG 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 COP12, the USG will continue to support improved monitoring of community-based activities so that the number of family members receiving support is captured in program reporting. Additionally, the USG 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. In COP12, emphasis is being placed on building capacity of Rwandan organizations to provide nonclinical support services at a relatively lower cost, compared to international NGOs. In COP12, the USG will continue to use a family-centered approach as the priority for care. The USG supported the development and implementation of a palliative care policy, as well as tools to support its implementation. Pain management at the facility and community levels and counseling will add great value to the care program. The following interventions are critical in the PEPFAR program: couples counseling, follow-up of discordant couples, family planning in HIV services, and providing access to services for MSMs and STI patients. Additionally, support for caregivers, improving linkages and referrals (community to clinic, within clinical services and wrap-arounds) and leveraging other funding sources to provide a broad package of services are critical in the program.

The USG will continue to procure basic care related commodities 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. The USG will continue to promote coverage of key clinical interventions (Co-trimoxazole, safe water products, etc.) which have been demonstrated to reduce morbidity and mortality among PLHIV. Leveraging support provided through PMI and other USG non-HIV funds, the USG will promote use of bed-nets by PLHIV and their families and use of point-of-use water purification such as "Sûr'Eau".

Continuing wraparound activities in COP12 include: the provision of bed nets (through PMI), IGA initiatives, support for economic growth and livelihoods, and links to services for gender based violence. Since FY10, Rwanda has been receiving development assistance (DA) water funds that will support access to safe water for households and communities as well as health facilities and schools. This support will also include developing policies and strategies for the community to support access to safe water in a more sustainable way. The USG will continue to leverage family planning and MCH funds to support integration of services in all USG supported sites. Specifically the USG will continue to integrate reproductive health, family planning, MCH services and HIV in supported sites and at the community level in supported districts, hence providing a continuum of care and a minimum package of care and support services. A brief description of the package of care and support services is provided in the subsections.

The USG will continue to support basic program evaluation activities. Envisioned for 2012 is an assessment to determine the retention of patients in pre-ART and in ART services, to improve programming. Additionally, the TRACNet indicators will be expanded to include Positive Health Dignity which will also contribute to the information available for improved planning. The following sections summarize critical components of the care program that merit program specific discussion.

II. Pediatric Care and Support

It is estimated that 22,240 HIV-positive children under 15 years of age currently live in Rwanda, with most of these infections being acquired vertically (Epi Update, April 2010). According to the FY2011 APR, 8,893 children (under age 15) were receiving clinical care services at 238 USG supported sites.

In FY 2009, the USG supported TRACPlus in the revision of the pediatric care and treatment guidelines based on the new WHO recommendations. Implementation of the revised guidelines is ongoing. Emphasis continues to be on

follow-up of exposed children, early infant diagnosis (EID), and provision of Co-trimoxazole from 6 weeks of age until a negative diagnosis is made. Regular screening for TB (with introduction of GeneXpert, diagnosis of TB among children will be more effective, may become easier), PITC especially among malnourished and hospitalized children, integration of HIV and MCH services to improve identification of children lost to follow up in PMTCT services, and nutritional education in PMTCT services will continue to support eligible exposed children and improved linkages to community services. USG implementing partners will continue to 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. In COP12, TRACPlus, with TA from USG implementing partners and other stakeholders, will implement improved child and adolescent care and support guidelines with an emphasis on disclosure counseling and positive living for HIV-positive adolescents.

In COP10, the USG supported the development of infant and young children feeding (IYCF) tools and related IEC materials that carry integrated health messages. USG will also continue to support integration of health services, 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 Global Fund and the PMI; referral to community based organizations and other community partners for distribution of water purification kits and for hygiene education; health education; and legal support.

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. Only 8.8% of PLHIV in care are children below 15 years of age. Some of the challenges include: insufficient numbers of trained health professionals with experience in pediatric HIV care and treatment; slow pace in scaling up implementation of PITC and limited availability of EID services – to identify HIV-positive children in a timely manner and enroll them on treatment. Only two laboratories perform this function which increases the turnaround time for results. Progress has been made in shortening the turnaround time for delivering results to health centers using SMS technology, however transporting samples from sites across country to the two laboratories where PCR will be possible is still a problem. The integration between PMTCT, MCH services and care and treatment programs needs strengthening particularly for standalone PMTCT facilities. There is 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; however this is expected to change as Rwanda implements EMTCT strategies in COP12. The USG partners will continue to strengthen the existing linkages and sensitization campaigns at all levels. Similarly, the inability and inadequacy of skilled providers to initiate treatment once a diagnosis is made is being addressed through task shifting with supportive supervision and clinical mentoring. It is not yet clear how the budget reduction will impact integration and linkages to community services.

There is limited data on quality of pediatric HIV services, including retention, adherence, treatment failure rates, adequacy of clinical and laboratory monitoring and appropriate use of second-line treatment. Since COP10, the USG has been supporting data quality assessments at the national and decentralized levels, and supportive supervision and mentoring that includes data quality and data use. This support will continue in COP12 including systematic reviews of program data to ascertain retention rates, loss to follow-up and adherence. At the district and facility level, the USG supports salaries and training for data managers and at the community level the USG supports the Community Health Information system that feeds into the HMIS. Over time, improvements have been registered in the data reported and in data use at the central level. In COP12, emphasis will be on data use at the facility and community levels. In COP11, TRACNet is being expanded to capture care and support indictors which will contribute to accountability and program improvement.

Through a partnership with SCMS, Rwanda Biomedical Center/Medical Procurement Division (MPD), 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.

Potential new activities for the program in COP12 include the revision of pediatric care and treatment guidelines to place all HIV-positive children below 5 years on ART.

III. TB/HIV

TB/HIV continues to be a critical component of the USG support in Rwanda. Key strategies include systematic screening for TB among HIV-positive patients within HIV services and systematic screening for HIV among TB patients within TB clinics. Almost all TB diagnostic and treatment centers in USG supported districts provide ART, and all health facilities in Rwanda offer TB treatment. DOT is practiced countrywide at the health center and community levels. During COP11, there was a policy change to support the following new interventions: use of GeneXpert for diagnosis of TB in six district hospitals, provision of ART treatment to all PLHIV diagnosed with TB regardless of their CD4 cell counts, and support for IPT for PLHIV in USG supported facilities. The USG will also continue to support existing activities that include:

- *WHO Three Is: Intensified case finding for TB, including enhanced training and supervision, and strengthening of laboratory capacity for diagnosis; strengthening and scale-up of infection control (IC), including health facilities renovation and continued implementation of INH prophylaxis that is in pilot phase.*
- *Improving the capacity to diagnose EPTB, (extrapulmonary TB) including training and supervision of clinicians and improved laboratory capacity to diagnose TB.*
- *Increasing availability and capacity for performing Drug Sensitivity Testing (DST) to diagnose multi-drug resistance and extremely-drug resistant (MDR-XDR) TB.*
- *Monitoring and evaluation of TB infection control policies; IPT and GeneXpert MTB/RIF implementation.*
- *Strengthening TB screening in PMTCT and MCH services.*
- *Supporting M&E and harmonization of TB indicators as collected in the TB program and PEPFAR reported indicators, also collected in the TB program and in HIV services, and regular data quality audits.*

In COP12 the USG will continue to build the capacity to diagnose EPTB and HIV-related cancer diagnosis in-country. This support will also contribute enormously to SGBV initiatives, one of the two priorities areas for the GHI strategy in Rwanda.

Other donors contributing to TB control in Rwanda include the Global Fund, the World Bank, and USAID/TB CARE supported out of USAID East Africa. These activities are complementary and are in no way duplicative. While the USG focuses on TB/HIV and supporting accreditation for 5 laboratories, Global Fund focuses on the general population TB diagnosis and treatment while the World Bank is building capacity for regional laboratory networks to implement infection control policies. The USAID/East Africa Mission, through TB CARE, supports a regional Center of Excellence (CoE) in Rwanda for programmatic management of multi drug resistance TB. The CoE serves as a training center for East and Southern Africa region and contributes to capacity building for TB services in Rwanda.

IV. Food and Nutrition

Food and nutrition services are important components of comprehensive HIV care aimed at improving the quality of life, productivity, and survival of PLHIV. In COP12, USG partners will continue to provide food and nutritional support to PLHIV particularly exposed infants and their mothers in PMTCT and in pediatric services. Nutrition assessment, nutritional counseling and education, and food support for eligible clients will continue to be part of the package for care and treatment for PLHIV as per the national nutrition policy and the national guidelines on nutritional care and support for PLHIV.

Due to a high level of malnutrition among under-fives in Rwanda, growth monitoring is a routine activity at community and facility levels at every clinic visit. All moderately malnourished HIV exposed infants and their mothers receive food support and appropriate messages on infant feeding practices and maternal nutrition. Food by prescription will be provided to support clients on ART to increase their adherence to treatment and to address malnutrition. Working with UNICEF and other donors, the USG supports district level planning to alleviate malnutrition in a sustainable way. In COP10, the USG supported development of IYCF tool and job aids that have integrated health messages and these are being implemented in COP11. Nutrition indicators are entered in the HMIS from ART and Pre-ART registers. To ensure the continuum of nutritional care and support, patients will benefit from various community nutrition activities such as kitchen gardening and cooking demonstrations, and are linked to health facilities by community health workers for appropriate care as needed. The program will address the

vulnerabilities of HIV/AIDS affected households and communities by improving nutrition and food security, stabilizing household assets, generating income, and fostering market linkages. Food support under the USG will be complemented by nutrition support from other USG-supported nutrition programs.

V. Orphans and Vulnerable Children

The double impact from the genocide and HIV/AIDS has resulted in Rwanda having one of the highest proportions of orphans in the world. According to the Rwanda Country Progress Report released in March 2010 for the UN General Assembly Special Session on HIV and AIDS, there are approximately 1,350,800 OVC below 17 years of age in Rwanda. The report also estimates approximately 270,000 of those OVC are affected by HIV/AIDS.

In Rwanda, the USG, as the primary donor for OVC programs, is responding to GOR goals and priorities to reach OVC with an integrated focus of service provision and psycho-social support. USG support includes providing direct support to OVC and their households to increase the socio-economic resilience of their families and assisting the GOR to strengthen its district and sector level support to OVC through their children's forums and orphan care committees. These interventions ensure the coordinated participation of children and local leaders in OVC activities and services. UNICEF, the other international donor working with OVC in Rwanda, focuses on central level TA and does not provide direct services to OVC or their families.

As of September 2011, USG assistance reached 73,510 OVC with a menu of services that includes: school fees and materials, vocational training, health insurance, child protection, psychosocial support, shelter and care, and HIV prevention education. In COP12, USG support will reach 55,000 OVC and implement a focused phase-out strategy with local capacity strengthening and direct funding to Rwandan civil society organizations along with a plan for hand-over to host country counterparts. The decrease in the number of OVC to be served is a result of reduced funding since COP11 as well as close-out of two implementing mechanisms. In COP12 USG education support for OVC will leverage GOR's 12-Year Basic Education (12-YBE) system by phasing out tuition fees payments for secondary school students. While existing students will not be dropped, new entrants at Ordinary and Advanced levels will be supported only through the 12-YBE.

VI. Gender

In Rwanda, epidemiological data indicate that women are more likely than men to be infected with and affected by HIV. While the overall prevalence of HIV in Rwanda is estimated to be 3.0%, the prevalence among women 15-49 years as 3.7%, compared to 2.2% for men of the same age (RDHS 2010). Sexual and gender- based violence (SGBV) is a significant health concern and risk factor for HIV. More than 41% of women in Rwanda have experienced violence since the age of 15 years (RDHS 2010), and as of early 2007, rape was the single most frequently reported crime in the country (NSP 2009).

The GOR emphasizes in the Constitution, Vision 2020, the EDPRS, the HSSP II, National Gender Policy and other documents that improving the status of women and girls and promoting gender equality are top priorities for the country in the coming years. In early 2010, with support from the PEPFAR Special Initiative on SGBV, the Ministry of Health (MOH) finalized protocols for the clinical management of cases of SGBV and developed a scale-up plan for the implementation of the new strategy. In addition, over the past year, the National Police have scaled up efforts to combat human trafficking and prostitution by increasing the numbers of arrests and prosecutions of traffickers, as well as by educating men on women's rights and gender norms. Although the GOR and its partners have made impressive progress in addressing SGBV and other gender issues, much work remains to be done.

In order to achieve gender equality, women and girls have to be empowered, not just as beneficiaries of development, but as agents of transformation. The USG is therefore placing a strong emphasis on women and girls across all of the areas of its development work through gender mainstreaming and integration into its strategies, development objectives, programs, and projects. In COP12, the USG plans to promote gender equality and mainstreaming while building the capacity of implementing partners and local entities to mainstream gender into all program areas. Using additional resources from the Gender Challenge Fund, USG will continue to support the national plan for prevention, care and treatment of SGBV; expansion of SGBV services in military and police health facilities; breaking

the silence around SGBV among people living with disabilities through advocacy and education; training of teachers to recognize the signs of SGBV, neglect and abuse among children; and a behavior change communication campaign on male norms and gender equity. In addition, the USG will work on strengthening and integrating SGBV referral systems; reaching out to community initiatives; promoting couples VCT; providing information on the dangers of cross-generational sex and concurrent relationships; encouraging increased male involvement in MCH, FP/RH, PMTCT and ANC; promoting HIV prevention and health-seeking behavior among MSM; and actively linking low-income women and child- or female-headed households to income-generating and social welfare programs. Additionally, there will be cross-border collaboration on, and harmonization of, legal policies and procedures related to gender by police and military organs.

The effectiveness of gender programming will be robustly monitored by USG and all implementing partners through program indicators, evaluations, and surveys, and surveillance using gender sensitive indicators. Currently planned or implemented assessment activities, leveraging both PEPFAR and other funding sources, include: an assessment of barriers to uptake of family planning; analyses of sexual risk behavior in CSW, youth, and other vulnerable populations; a pilot project on the health-seeking behavior and provider perceptions of MSM; and an assessment of the readiness of providers to provide post-abortion care.

VII. Most-At-Risk Populations

Rwanda's epidemic is primarily driven by heterosexual contact; eighty-five percent of predicted new infections occur in married and/or steady couples, concurrent sexual partnerships, casual sexual encounters, or transactional sex (MOT, 2011). Although the national HIV prevalence rate remains steady at approximately 3% (RDHS, 2010) among adults aged 15-49, January 2011 modeling, in addition to partner level data, suggests higher HIV prevalence rates among vulnerable and/or most-at-risk populations (MARPs) such as female commercial sex workers (FCSW) and their clients, men who have sex with men (MSM), mobile populations, prisoners and young women aged 15 - 24. In 2008, a USG funded case study among prisoners indicated high sero-prevalence (~7%) among this population who have frequent community interaction. With country commitment to monitor the epidemiological trends of HIV acquisition and transmission, the unique nature of the HIV epidemic in Rwanda is better known; and, more targeted efforts are being made to 'head-off' new infections by addressing the specific needs of MARPs. To this end, Rwanda and the USG are placing a greater emphasis on country programs for MARPs. There are currently programs supporting HIV prevention for mobile populations (e.g. truckers), low income women, FCSW, people living with HIV/AIDS, and in and out-of-school youth, prisoners, MSM, and people with disabilities.

The USG supports a core set of interventions for MARPs (i.e., truckers, FSWs, youth, low income women and PLHIV) in and around the transport corridor; this package includes trainings, risk reduction, including partner reduction, counseling, condoms, skills building, HIV and STI screening and management, family planning and reproductive health services, sexual and gender based violence sensitization, social support, and economic strengthening activities. Other MARPs related activities include HIV prevention programming for prisoners, PLHIV, youth, people with disabilities, MSM and FCSWs. In the last year, for example, due to HIV prevalence data on FCSWs, there has been significant scale-up of programming for this population.

In COP12 stronger emphasis will be placed on bringing HIV programming to scale for all defined MARPs in Rwanda especially prisoners, people living with disabilities, youth and MSM with MOH as the national coordinating body for HIV prevention activities. The USG will support policies that create a human rights-based enabling environment for MARPs. Rwanda is in the final stages of completing a national policy on a standardized minimum package of services for MARPs (i.e., FCSW, in and out-of-school youth, MSM, mobile populations, prisoners, and people with disabilities). Such policies will provide national guidelines on the basic provision of MARPs friendly services, STI screening and management, referrals for HIV testing and counseling including adherence support, male and female condom promotion and distribution, as well as appropriate training for providers. This package will be complemented by a full range of integrated social and behavior change communication activities. Moreover, country programs are looking to improve linkages to appropriate, accessible and friendly HIV care, support, and treatment services for MARPs, reaching out to civil society organizations supporting MARPs. Finally, Rwanda, is looking to strengthen links between strategic information and prevention to develop data-driven programs that characterize

MARPs and other vulnerable populations, as well as advocating for national policies and/or laws that ensure and protect the health of MARPs as a basic human right.

VIII. Human Resources for Health

The USG supports human resources for health, in capacity building and salary support within the GOR at the central and community levels, in CSOs and in the private sector. All USG implementing partners have a focus on human and institutional capacity building aligned with national plans. Expected results include increased high quality health professionals (nurses and specialists), quality improvement, increased uptake of health services, expanded access to HIV, AIDS and EMTCT services, lowered HIV incidence, and long-term achievements such as reduced mortality and lower HIV prevalence. In COP12 USG support will continue to promote task-shifting for the country's nurses to undertake ART eligibility assessments and provision of ART (under the supervision of physicians). To ensure quality of services the USG funding supports the continuous professional development, clinical supervision, and mentorship of these nurses, as well as of other key health care workers.

The USG will begin supporting a new priority established by the GOR to improve the quality and quantity of high-skilled health care professionals in Rwanda. Along with other donors, the USG will support the GOR to recruit, train and mentor physicians, nurses, midwives, dentists, and health managers. In partnership with US academic institutions, the GOR will strengthen the capacity of Rwandan health sciences institutions, as well as provincial and district hospital which will serve as teaching sites, to produce a well-trained health workforce capable of responding to Rwanda's health needs.

The USG's clinical partners, including the Ministry of Health, work to build the capacity of multi-disciplinary teams (MDTs) to review standards of care, and identify and resolve challenges related to the provision of clinical services. In addition, a major area of emphasis in COP12 among clinical partners will be the strengthening of communication and referral systems, particularly among facility-based providers, social workers, and CHWs. Joint patient tracking and the further integration of services will greatly reduce the loss to follow up of PLHIV, particularly among pre-ART patients.

The recently approved continuous professional development (CPD) plan for physicians will be implemented in COP12 with technical support from USG. Support will also be provided to the Rwanda Council of Nurses and Midwives to develop and implement a similar plan. These CPD plans will allow for a more coordinated and strategic approach to upgrading and reinforcing the skills of clinical providers on key HIV care issues. HRH capacity-building is a cross-cutting component integrated across all HIV and AIDS programs, including support for training institutions such as the schools of nursing and midwifery and the new Rwandan University of Health and Medical Sciences. Under COP12, support to health workforce training programs, such as health economics and finance, epidemiology, clinical and laboratory services and community health workers will continue. Using a systems approach, efforts will focus on training and deployment, increasing efficient utilization and integration of the workforce at the district, sector and community level, and on strengthening GOR's management of service delivery, management of resources and leadership. At the community level, the USG has contributed to the training and deployment of 60,000 community health workers (CHWs), who in turn collaborate with local leaders to promote health-seeking behavior and provide basic home-based care.

Rwanda has been implementing an innovative Performance-Based Financing (PBF) system at health facilities over the last several years. In 2011, this program was extended to Community Health Workers (CHWs), who are volunteers with six months of training in basic primary care. The PBF system will reward CHW for their efforts to detect and refer cases of malaria, malnutrition, and other common illnesses to health centers, as well as to follow women and infants during the antenatal and postnatal stages. CHWs will also be supported in their work to provide prevention services including family planning services for repeat users, nutrition services, community IMCI services and basic palliative care to PLHIV. In COP12, PBF for CHWs will be scaled up nationally, with technical support from USG. A rigorous evaluation will accompany the program in order to ensure that both the quality of services improves and that the incentives function as an effective retention mechanism, as intended.

IX. Laboratory Infrastructure and Services

The COP12 USG 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 COP11 will provide support and technical assistance to key GOR institutions. The program plans to work with the MOH to further develop this plan in cooperation with the President's Malaria Initiative (PMI), Global Fund, 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 development of standards for and implementation of a laboratory information system.

In COP12, activities supporting care of patients with HIV and TB are similar to those of previous years. The USG will continue to provide financial and technical support to the National Reference Laboratory and the national laboratory network to improve and expand laboratory infrastructure and capacity for TB /HIV testing, microscopy fluorescence and Ziehl Neelsen staining, TB culture using solid and liquid media and drug susceptibility testing (DST) to first and second line drugs. In COP12, the USG will support rapid diagnosis of drug-resistant TB using GeneXpert MTB/RIF being piloted in 6 sites. The EQA program for TB will add panel testing to complement supervisory visits and retesting that are already in place.

In COP12, the USG 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 and in developing a system for the transport of laboratory samples within the laboratory network. At five regional clinical diagnostic laboratories, the 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 and will support pre-service education programs at Kigali Health Institute for laboratory scientists. The USG will also continue bolstering management and financial capacity at the NRL by maintaining the long-term laboratory management advisor position to provide technical assistance in grants management and financial accountability.

In COP12, SCMS will be responsible for the procurement of all laboratory equipment purchased by the USG through direct support to CAMERWA. This direct funding approach is expected to increase cost savings and improve efficiencies in procurement and distribution of commodities. SCMS will also continue support for 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.

X. Strategic Information

Rwanda has made tremendous progress in increasing capacity to collect and to a limited extent manage and use integrated data from different sources for planning, with support from the USG, Global Fund, PMI, and other partners. The USG participated in the development and implementation of the Rwanda national M&E policy and strategy, in developing capacity for M&E in HIV services from the central to the community level in that order. The USG supports data quality assessments in HIV services (care, treatment, and OVC). HIV AIDS program aggregated data are integrated into the national M&E data bases (HMIS, TRACnet, PBF). Additionally efforts have been made to implement the electronic medical record (EMR) into 30 health facilities. The EMR hosts HIV patient-level data and will facilitate information sharing within facilities, better follow-up of patients and linkages to other social services. In COP12 the USG will continue to support the maintenance and upgrade of the Rwanda national repository of HIV AIDS data (TRACnet).

While capacity for reporting has been developed, data analysis and use at the community level and site level is still an

area of need. The national program does not currently provide a unique identifier and include pre-ART HIV positive patients in TRACnet, creating a major gap in patient follow-up and retention in care. In COP10, the USG supported the development of pre-ART registers that have improved monitoring of patients in care services.

In COP12, the USG will support innovative ways of analyzing program level data and simple assessments with limited geographical scope to determine retention in the program, constraints that negatively impact care and support and best practice that could be scaled up. The USG will continue to promote harmonization of indicators, data use and targeted surveys to improve planning. Emphasis in COP12 will be on data analysis and use. In 2008, the USG supported an exploratory qualitative study on HIV risk among MSM in Kigali. This survey confirmed the existence of MSM and documented self-reported HIV-related risk behaviors. In an effort to design and implement a broad program targeting the hard to reach population, a national MSM Behavioral Surveillance Survey (BSS), including HIV testing, was conducted in COP11.

The USG's support for SI ensures evidence based decision making, facilitates accountability and improves our ability to better plan care and support interventions and retain patients and clients in the program.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	11,190,792	0
HVSI	3,518,725	0
OHSS	15,345,145	0
Total Technical Area Planned Funding:	**30,054,662**	**0**

Summary:

I. Introduction

The USG works closely with other development partners, civil society organizations, private sector actors, and government institutions to address critical issues within the Rwandan health system. While various elements of the national health policy have been discussed and debated since the early post-genocide years, it was not until the Rwanda Health Sector Strategic Plan (HSSP I 2005–2009) and the complementary National Health Policy were developed in 2004 that the country had an updated blueprint for its health system. Rwanda is a dynamic country, characterized by the rapid adoption of new approaches, strategies and programs, yet Rwanda also has critical deficits in human resource capacity, which is the result of its limited pool of highly educated individuals and the regular movement of staff within and outside the health sector. In turn, this situation has compounded systemic deficits, contributing to low levels of institutional capacity at all strata of the health system. The full transition of USG-supported activities to national ownership is dependent on the capacity of Rwandan institutions and individuals. This has been recognized by the GOR and is prioritized in multiple GOR health-related strategy documents as a key area of focus, including the Rwanda Vision 2020, the Economic Development and Poverty Reduction Strategy (EDPRS) and the HSSP II. Increased investment in Rwandan staff, processes and systems, as well as introduction of new technologies, is required to ensure the high quality and sustainability of health services provided in Rwanda.

II. Global Health Initiative (GHI)

Through the GHI, the USG will continue to leverage established relationships to promote greater emphasis on health systems strengthening by all stakeholders, develop new partnerships with national organizations to support country ownership, and integrate capacity building as core components of all USG health assistance. In particular, the USG will continue high-quality, coordinated technical and financial assistance to Rwanda to increase human and institutional capacity at all strata of the health system, in line with national plans and objectives. With a stronger

health system, Rwanda will be able to achieve its ambitious targets for the improved health of its population, including those for the GHI target areas. At the policy level, the USG is closely involved in the review and revision of decision-making processes and coordination of donor and sector activities through an improved Sector-Wide Approach (SWAp). In addition, the USG works closely with the GOR as the sole principal recipient of Global Fund grants to ensure efficient and non-duplicative investments in HIV, malaria and TB programs and health systems strengthening. The USG will continue to work to ensure harmonized implementation with the Global Fund National Strategy Applications for HIV/AIDS and TB to support national health objectives. For example, the USG will continue to work closely with Global Fund on its new awards to civil society organizations (CSOs) focused on the shared goals of capacity building and community-level outreach, and support for HSSP III, and review of the TB SSF through the USG/CCM Collaboration Grant.

The USG advances the GOR goal of integrated health services in policy formulation and strategic planning by providing support to MOH units responsible for integration and decentralization, community health, and MCH among others. At the district level, the USG provides financial and technical support to district authorities to plan, manage, monitor and sustain integrated service delivery and progress towards improved health outcomes. At the facility and community level, the USG supports health providers to deliver essential health interventions in a timely manner and in compliance with quality standards of care. Under the GHI, the USG continues to support Rwanda's smart integration, including the development of tools for integrated supervision, the promotion of integrated training for health care workers in both pre-service and in-service settings, and investments in infrastructure improvements (e.g., solar energy equipment, supply chain management) that benefit the Rwandan health system as a whole.

III. Leadership and Governance and Capacity Building
At present, the USG supports institutional and human capacity building in the GOR from the central to the community level, in CSOs and in the private sector. At the policy level, the USG is closely involved in the review and revision of decision-making processes and coordination of donor and sector activities through an improved Sector-Wide Approach (SWAp). In addition, the USG provides technical assistance in drafting key national strategy and policy documents related to capacity building. The USG supports technical assistance to key staff at national and district levels to provide effective supervision and oversight, establish and promote evidence-based policies, programs and practices and identify and guide the strategic direction of the health sector. The USG utilizes institutional twinning and technical assistance to assist Rwandan institutions to assume primary responsibility for strategic planning and management, implementation, and monitoring and reporting. For example, the USG supports institutions of higher learning in health education to become effective managers and leaders in research, training and community outreach programs.

At the community level, the USG has contributed to the training and deployment of 60,000 CHWs, who in turn collaborate with local leaders to promote health-seeking behavior and provide basic home-based care. The USG provides technical assistance to CSOs, who are active in the health sector, but need improved capacity to directly manage donor funds and to implement high-quality sustainable programs. The USG has also supported the GOR in private sector engagement with both HIV and non-HIV funds, for example, the USG completed an assessment of private sector readiness to provide family planning (FP) commodities.

Through PEPFAR, the USG team continues to support the GOR, civil society and private sector to strengthen human and institutional capacity and to utilize this increased capacity by investing in host country systems and processes. The expectation is that all partners focus on human and institutional capacity building aligned with national plans. The expected results in the medium-term are improved quality and increased uptake of health services and increased production of high quality health professionals including nurses and medical specialists. Long-term achievements should include reduced maternal and child mortality and lower prevalence of HIV/AIDS, TB and malaria.

The USG employs three strategies to achieve its objective of increasing human and institutional capacity in Rwanda: 1) leverage established coordination structures; 2) develop and strengthen relationships with national partners; and 3) integrate capacity building across all health assistance. The USG will continue to leverage established arrangements, for example as shadow co-chair of the Health Sector Working Group (HSWG) and as co-chair and

members of national Technical Working Groups, to promote a greater policy-level emphasis on, and investments in, capacity building by all stakeholders in Rwanda. The USG will also continue to promote opportunities for new and strengthened relationships with local Rwandan partners. A main component of this will be the continued focus on country ownership through increased direct funding to the GOR and local civil society. Capacity-building will continue to be integrated as a core component across all health assistance, including continued support for training institutions for physicians, nurses, midwives, laboratory technicians, and other paraprofessionals. Using a systems approach, efforts will continue to focus on increasing efficient utilization and integration of the workforce at the district, sector and community level, strengthening national management of service delivery, management of financial resources, leadership of human resources as well as staff training and deployment. The USG will continue to support leadership and capacity-building in health finance, particularly in the further transfer to the GOR of the capacity to develop, maintain and use the national resource tracking database in planning and program management at national and district levels. The USG will continue to support capacity building for operational research and data collection with key local institutions and continue to support the development of a national laboratory network that meets international accreditation standards.

IV. Strategic Information
The USG will continue to strengthen the capacity of the national HIV/ AIDS strategic information network to plan, collect, manage, and make use of integrated data from a variety of sources as outlined in the eHealth Enterprise Architecture. Assistance will continue to support the implementation of Rwanda's National e-Health Strategy and National HIV/AIDS Monitoring and Evaluation (M&E) Policy and Strategy. These activities align with the PEPFAR Partnership Framework and Partnership Framework Implementation Plan.

In previous years, the USG supported the harmonization of various data collection systems and facilitated the adoption of international disease classification standards (ICD10) for the Rwanda health information systems. In addition, program monitoring and reporting systems and patient level information systems have developed and implemented with USG support over the past several years. In COP11, the USG supported the initiation of the National Health Enterprise Architecture which will shape the interoperability framework of various information systems. During COP12, Rwanda, with support from the USG, will implement a virtual private network (VPN) linking all health centers providing HIV/AIDS services. The VPN will contribute to reduced internet-related costs and facilitate connections between the central and district levels. In addition, in COP12 the MOH will continue the roll out of a national electronic medical records system (EMR) to additional sites with support from USG. In COP12 other national strategic information systems to be supported will continue to include: TRACnet; the community information system (mUbuzima); and the Health Management Information System (HMIS). The USG will also continue to support the Partner Reporting and Performance Monitoring System (PRPMS) to consolidate and report results from USG implementing partners for reporting to OGAC. During COP12, capacity building of GOR staff and organizations, as well as other local entities, will be the core activities to achieve the sustainability of the various systems USG has been supporting.

HIV/AIDS indicators are integrated into the national monitoring and evaluation databases. The focus is now to ensure data quality and strengthening the national monitoring and evaluation systems. The USG's strategic information emphasis in COP12 will be increasing analysis and use of routine data. Additionally, work in developing a national monitoring and evaluation framework and support of community level monitoring and evaluation data collection through umbrella organizations will help to complement the package of USG SI activities. Further, mapping exercises and building the national capacity in the use of Geographic Information Systems to support program implementation will also be a focus of USG SI work in COP12.

Results from a national Men who have Sex with Men (MSM) Behavioral Surveillance Survey (BSS), including HIV testing, conducted during COP11, will inform a broad program targeting MSM, a traditionally hard to reach population. Since 2004, the USG has been supporting annual antenatal (ANC) sentinel surveillance, and during COP12 the USG will support the use of routine PMTCT and VCT programmatic data for HIV surveillance. The USG will continue to support the HIV drug resistance surveys through the MOH's Rwanda Biomedical Center Institute of HIV/AIDS, Disease Prevention and Control. Representative estimates on behavioral, clinical, and biological

HIV/AIDS indicators are critical for evaluating the country's response to the HIV/AIDS epidemic.

V. Service Delivery

Rwanda's health services are provided mainly through public sector facilities and facilities run by faith-based organizations, which are also supported by the government; private clinics play a small role in the health system. The public health care system is a standard tiered district health system with four levels of service delivery: the community, the health center, the district hospital and the tertiary hospital level.

The USG supports the continuum of care through all four service delivery levels. Community level interventions are largely preventive but also provide some primary care. The health center and district hospital levels offer predominantly clinical care. Complex cases are referred to the tertiary level, although it receives minimal USG resources. Services are delivered in an integrated way to optimize resources and promote increased health care service uptake during a single visit. With USG support, there is an established coordinated reporting system across all implementing partners and across all health facilities through the national HMIS. Based on the information reported through these databases as well as programmatic data, GOR leads strategic planning through technical working groups (TWGs).

In COP10, the USG supported explorative studies in MARPs, including MSM and in COP12, additional work is planned to better understand the magnitude of the problem, and the services required. In COP12, the USG program in Rwanda will provide limited clinical services to MSM and will continue to provide services to commercial sex workers, truckers, their clients and families.

The USG supports the GOR and GHI principle of providing integrated services using complementary USG funds from funding accounts like MCH and Family Planning. At the service delivery level, the USG supports integrated in-service training of providers to update their skills. The USG resources support PMTCT within ANC clinics in supported districts, referral of patients across HIV services and across different facilities, and follow-up and support of HIV positive individuals in pre-ART and ART services, at the facility and community levels. In the context of the new PMTCT protocol, in COP12 the USG will continue support for GOR to integrate ART into PMTCT services and maximize family care and treatment. In addition, the USG will support capacity building at the central level, and the strengthening of district health networks at the administrative district level. This activity will increase the capacity of the MOH and its organs to coordinate the development and implementation of health policy, and of local government to plan, coordinate and manage health programs in the districts. This is the basis for the sustainability of Rwanda's achievements in health in general, and in HIV services specifically, that have been realized so far.

The USG also utilizes multiple funding sources to support policies and interventions that facilitate the availability of maternal, neonatal and child health (MNCH) services at facilities that offer HIV services. The USG supports training for providers on the integrated management of neonatal and childhood illness (IMNCI) to facilitate follow-up of exposed infants. Similarly, with family planning resources, providers in PMTCT, care and ART services are trained on family planning service delivery, and family planning commodities are made available at the clinic and community levels.

Quality assurance for service delivery is a critical component of the USG support in Rwanda, and while there are not yet harmonized quality assurance tools, a quality assurance policy and strategic plan exist. The USG supports slightly different models for quality assurance and improvement and have contributed to the development of the policy and strategic plan and provides QA/QI technical assistance to the clinical services program as well as the national laboratory program. In the long term, the GOR's goal is have all health facilities and laboratories accredited to international standards, while in the short term, tertiary hospitals and the national reference lab are in advanced stages of preparing for accreditation. Norms and guidelines for service delivery and program management for district hospitals are being finalized for district hospitals, which is a critical step towards standardization and ultimately accreditation. Rwanda has a successful national performance based financing (PBF) system that rewards performance both quantitatively and qualitatively, and has contributed significantly to scaling up of service delivery, increased uptake of health services and improved health outcomes.

VI. Human Resources for Health

The USG activities for COP12 are aligned with the goals and objectives of the HSSP II, HRH Strategic Plan 2011-2016, GHI Strategy, and Partnership Framework and Implementation Plan. These activities will support the entire HRH life cycle, from planning to education, recruitment to management, and retention to retirement.

As co-chair of the national Technical Working Group for HRH, the USG will continue to complement the support to Rwanda's health workforce by other donors. The USG will collaborate with other stakeholders to ensure effective and efficient training, deployment and management of HRH across Rwanda, using evidence to inform all decisions about program implementation. Furthermore, the USG will continue to build the capacity of the MOH to plan and manage the health workforce more successfully and productively, with maximum synergy among resource flows.

With regard to pre-service education, the USG will continue to 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, midwifery, medicine, public health management, field epidemiology, program management, and strategic information. Support will include expansion of the physical and IT infrastructure of existing educational facilities, with additional support from GOR and other donors. Emphasis will also be placed on increasing the capacity of faculty and staff to employ innovative pedagogic methods to improve the quality of teaching and learning, as well as to improve their clinical mentorship and supervision skills.

In COP12, the USG will begin supporting a new priority established by the GOR to improve the quality and quantity of high-skilled health care professionals in Rwanda. Along with other donors, the USG will support the GOR to recruit, train and mentor physicians, nurses, midwives, dentists, and health managers. In partnership with US academic institutions, the GOR will strengthen the capacity of Rwandan health sciences institutions, as well as provincial and district hospital which will serve as teaching sites, to produce a well-trained health workforce capable of responding to Rwanda's health needs.

Furthermore, 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. The USG will 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 II 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, responsibilities will be shifted progressively towards Rwandan ownership. Examples of such benchmarks include the existence of published academic calendars and summary student course evaluations, and consistently accurate and timely invoicing of research grants and contracts.

The USG will continue to support HRH management through the development of additional policies that improve health workers' ability to safely and effectively perform their roles. This includes the development of 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, and as such, support will be provided for the continued implementation of a Human Resource Information System. In addition, the USG will support the development of training modules on data analysis and use to improve the GOR's capacity to utilize data for decision-making.

VII. Laboratory Strengthening

The COP12 USG laboratory strategy continues to build on a tiered national laboratory system for creating sustainable infrastructure to support care and treatment of PLHIV. The program plans to work with the MOH to

further develop the five year strategic plan of the National Reference Laboratory (NRL) in cooperation with the President's Malaria Initiative (PMI), Global Fund, World Health Organization (WHO), World Bank (WB) and other in-country stakeholders.

COP12 support for the national laboratory policy and strategic plan will include, but not be limited to: establishing national laboratory policies for each tier of the laboratory network; integrating clinical diagnostic laboratory services; harmonizing and maintaining laboratory equipment; managing inventory and national forecasting of laboratory supplies, reagents and test kits; supporting quality assurance programs and human capacity development; and setting standards for and implementation of a Laboratory Information System (LIS).

In COP12, USG support for the national tiered laboratory system will include laboratories in the national system linked from NRL to regional sites to district hospital sites to primary care sites. The laboratory network in Rwanda is comprised of 433 health centers, 42 district hospitals, 5 regional laboratories, 2 university teaching hospital laboratories, and numerous private laboratories. The USG plans to continue to support NRL to improve the financial, coordinated procurement, overall quality assurance, laboratory networks and referrals, and laboratory information systems. USG will also continue to support human capacity development through specialized training and ongoing technical assistance. During COP12, special emphasis will be on training non-laboratory personnel to perform rapid HIV testing using finger prick method of blood collection. In addition, the USG will support training of new lab technicians for the diagnosis of opportunistic infections and continue to improve quality assurance programs for HIV prevention, care and treatment.

Despite significant reductions to USG funds to support the accreditation of laboratories at the request of the GOR, the USG will continue to provide assistance to NRL in its effort to take over the accreditation activities in COP12. In COP10 and COP11, five laboratories began the Strengthening Laboratory Management Toward Accreditation (SLMTA) program. The GOR plans an additional five laboratories to join the program in the next year. In COP12, the USG will provide limited technical assistance through USG agency staff support to NRL, who will be primarily responsible for continued laboratory accreditation. For COP12, a major point of emphasis will be the implementation of a new LIS for the management of laboratory data and to inform clinical programs improvement.

In COP12, with reduced laboratory program funding for technical assistance, the USG will continue to support sustainable laboratory systems by continuing to providing TA at a reduced level for training in OI diagnosis with emphasis on MDR, extra pulmonary TB, cancers in HIV patients and parasitic infections and in developing a system for the transport of laboratory samples within the laboratory network. At five regional clinical diagnostic laboratories, the 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 technical positions at the NRL to assure quality HIV-related laboratory services through training and day-to-day mentorship of NRL staff and will support pre-service education programs at Kigali Health Institute for laboratory scientists. The USG will also continue bolstering management and financial capacity at the NRL.

VIII. Health Efficiency and Financing
In alignment with the HSSP II and GHI Strategy, in COP12, the USG will support MOH to ensure that essential health services are provided in a high quality and financially accessible manner to the entire Rwandan population. Particular emphasis will be placed on promoting an equitable, efficient and sustainable health financing framework based on results.

In COP12, the USG will continue in strategic leveraging to increase the impact and reach of PEPFAR funds, and will support national partners to identify alternative financing options and innovative funding schemes to support long-term sustainability and growth of programs. More specifically, in COP12 the USG will build on its record of success in supporting performance based financing (PBF) as a strategy to increase access and improve efficiency on the supply side of health care services. Strengthening the national community based health insurance (CBHI) mechanism will also continue. In COP12, the USG will develop and use a financial/actuarial model to assist the MOH, districts and individual insurers to project their revenues and expenses based on elements such as membership

levels, premiums, administrative costs, expected utilization levels and facility reimbursement mechanisms and levels, thereby increasing cost-efficiencies and program sustainability. The USG will utilize past successes and lessons learned to help address remaining bottlenecks and to build the capacity of relevant MOH units as a means ensure the solvency and sustainability of these systems.

Capacity building efforts will be directed towards Rwandan institutions responsible for conducting cost and other economic analyses and using these data to guide program decisions. Currently, the MOH is in the process of institutionalizing a costing exercise in health facilities that will help determine the cost of health services for planning and budgeting purposes. The USG will continue supporting this effort through capacity building, knowledge transfer, and coaching activities to equip the national team with an understanding of appropriate costing methodologies, applications, and tools. Results from the costing activities will allow for the preparation of better action plans and budgets at facility and district levels. In addition, the institutionalization of these activities will support health facilities to improve their financial management systems and allocate resources more efficiently by aligning facility and district budgets with projected costs.

IX. Supply Chain and Logistics

In COP12, the USG will continue to procure commodities through SCMS. In addition, USG will provide technical assistance to the MOH Medical Procurement Division (MPD) to build their capacity and to prepare them for eventually assuming direct financing. The evolving roles of MPD, the Pharmacy Task Force (PTF), and District Pharmacies under the newly restructured health system will be clearly articulated in the supply chain strategic planning exercise to be conducted in COP11. The USG will continue to provide support to GOR in clarifying roles and responsibilities and identifying the appropriate skills mix for each GOR entity to meet its identified short and medium term goals for commodity availability.

The USG collaborates closely with GOR and the Global Fund as well as other development partners to identify synergies in donor inputs. The Coordinated Procurement and Distribution System (CPDS), a coordinated forecasting and quantification exercise is conducted on a yearly basis with quarterly updates and brings together all stakeholders to review assumptions and inputs.

The USG also leverages support provided by the Global Fund for an automated Logistics Management Information System (LMIS). Through USG support, the PTF has successfully rolled out a paper based data collection system. With that system now in place, MPD is planning an automated process. In collaboration with the e-Health Technical Working Group and the MPD, development of the system will take place in COP11 with rollout to be completed during COP12. The USG currently is providing a project manager to help GOR manage and implement the automated LMIS.

X. Gender

In Rwanda, epidemiological data indicate that women are more likely than men to be infected with and affected by HIV. While the overall prevalence of HIV in Rwanda is estimated to be 3.0%, the prevalence among women 15-49 years as 3.7%, compared to 2.2% for men of the same age (RDHS 2010). Sexual and gender- based violence (SGBV) is a significant health concern and risk factor for HIV. More than 41% of women in Rwanda have experienced violence since the age of 15 years (RDHS 2010), and as of early 2007, rape was the single most frequently reported crime in the country (NSP 2009).

Rwanda's Constitution, Vision 2020, EDPRS, HSSP II, National Gender Policy and other documents emphasize as top priority improving the status of women and girls and promoting gender equality. In early 2010, with support from the USG's Special Initiative on SGBV, the Ministry of Health (MOH) finalized protocols for the clinical management of cases of SGBV and developed a scale-up plan for the implementation of the new strategy. During COP10 and COP11, the National Police have been supported in their scale up of efforts to combat human trafficking and prostitution by increasing the numbers of arrests and prosecutions of traffickers, as well as by educating men on women's rights and gender norms. Although the GOR and its partners have made impressive progress in addressing SGBV and other gender issues, much work remains to be done.

In order to achieve gender equality, women and girls have to be empowered, not just as beneficiaries of development, but as agents of transformation. The USG is therefore placing a strong emphasis on women and girls across all its supported programs through gender mainstreaming and integration into its strategies, development objectives, programs, and projects. In COP12, the USG plans to promotion of gender equality and mainstreaming while building the capacity of implementing partners and local entities to mainstream gender into all program areas. USG will continue to support the national plan for SGBV clinical care package of services and its implementation across the supported districts, including prevention, care treatment and support of SGBV victims as well as training, TA and supervision for care providers to handle SGBV cases, including the training of teachers to recognize the signs of SGBV, neglect and abuse among children. In addition, the USG will support the GOR in strengthening and integrating SGBV referral systems; reaching out to community initiatives including positive masculinity; promoting couples VCT; providing information on the dangers of cross-generational sex and concurrent relationships; encouraging increased male involvement in MCH, FP/RH, PMTCT and ANC; promoting HIV prevention and health-seeking behavior among MSM; and actively link low-income women and child- or female-headed households to income-generating and social welfare programs. Additionally, there will be cross-border collaboration on, and harmonization of, legal policies and procedures related to gender by police and military organs.

The effectiveness of gender programming will be robustly monitored by USG and all implementing partners through program indicators, evaluations, surveys, and surveillance using gender sensitive indicators. Currently planned or implemented assessment activities, leveraging both USG and other funding sources, include: an assessment of barriers to uptake of family planning; analyses of sexual risk behavior in CSW, youth, and other vulnerable populations; a pilot project on the health-seeking behavior and provider perceptions of MSM; and an assessment of the readiness of providers to provide post-abortion care.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	10,044,367	0
Total Technical Area Planned Funding:	**10,044,367**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	825,051	0
HMBL	2,334,710	0
HMIN	192,341	0
HVCT	4,887,214	0
HVOP	3,062,796	0
MTCT	3,694,315	0
Total Technical Area Planned Funding:	**14,996,427**	**0**

Summary:

I. Introduction

For two decades, HIV has constituted a major public health problem in Rwanda. The USG team's response is rooted in the GOR initiatives, frameworks, and policy documents, many developed with USG support. The GOR's key policies and documents guide implementation of health programming in the country with HIV/AIDS prevention as a key priority; for example, reaching the Economic Development and Poverty Reduction Strategy (EDPRS) target of 0.5% HIV incidence by 2012 ensures that Rwanda stays on track to achieve its MDG target for 2015 of stabilizing HIV prevalence at 3%. Although HIV remains endemic at 3.0 percent (RDHS 2010), Rwanda's challenge is balancing interventions for its mixed epidemic. The USG, therefore, supports combination prevention approaches where biomedical, behavioral and structural interventions work synergistically to complement and reinforce one another within a contextualized approach to address epidemic patterns, social norms and structures, sexual and gender-based violence (SGBV), and human rights. The USG will continue to focus on gender equality in HIV prevention. HIV prevalence rates for young women aged 15-24 are five times that of young men, and women bearing the burden of the disease. The USG supported programs include HIV monitoring, surveillance and evaluation to capture information about the gender dimensions of the epidemic; developing and tracking targets and indicators to measure gender-related outcomes; and scaling up specific interventions to address the gender dynamics of HIV. During COP12 the USG will continue to scale-up outreach to women and girls, with targeted inventions addressing commercial sex work, MSM, intergenerational sex, HTC promotion, condom use, and income generation. In COP10, for example, 2,279 female sex workers were reached (up from 282 in 2009) with an integrated HIV prevention package. Other key accomplishments include improvements in HTC, especially among men, with cumulative numbers of people tested in HCT by the end of 2010 at 5,229,817 tests completed, and plans to support the expansion of finger-prick TC. In addition, condom promotion and uptake in Rwanda remains strong; in 2010, approximately 24 million private and public sector condoms were available with an average consumption of 1.5 to 1.8 million per month and USG funded socially marketed male condoms being the most widely available condom in Rwanda boasting a national coverage level of 84%. For VMMC, the USG works closely with Rwanda's MOH and other donors in a national program to circumcise two million men by December 2013. To date, the USG has supported TA, commodities, and the VMMC of 5,500. In COP12, the USG role will decrease with MOH assuming more responsibility, and Global Fund resources. In COP12, the USG programs will target at-risk youth, MARPs, PLHIV and other vulnerable populations with evidenced-based HIV prevention programs primarily delivered by civil society organizations. Under PMTCT in COP12, the USG will directly support 209 of 412 health centers in 22 out of 30 districts to provide PMTCT services. From July 2009 to June 2010 the USG supported 290,910 pregnant women attending ANC of which 286,073 (98%) were counseled, tested for HIV and received their results. PMTCT activities have been integrated into existing MCH interventions. Rwanda's PMTCT program provides a comprehensive package and as programs mature the USG will continue to support quality improvement and sustainability while helping Rwanda addressing remaining gaps to achieve the elimination of MTCT (EMTCT).

II. Preventing Mother-to-Child Transmission (PMTCT)

The 2005 Rwandan Demographic Health Survey-III (2005 RDHS) 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). An HIV sero-surveillance survey conducted in 2007 at 30 sentinel sites reported an HIV prevalence of 4.3% among pregnant women attending ANC. The recently released 2010 Rwanda Demographic and Health Survey (RDHS 2010) shows that the HIV prevalence rate in women of reproductive age has not changed significantly at 3.7% (ranging from 8.7% in urban areas to 2.8% in rural areas). The GOR aims to reduce the HIV MTCT rate below 2% by 2015. With the support of the USG and other donors, considerable progress has been made over the past decade to scale up services for pregnant women, their male partners and HIV exposed children. Data from the RDHS 2010 show that 98% 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 69 % in 2010 (ranging from 82% in urban areas to 67% in rural areas). The proportion births delivered in a health facility has increased substantially in the recent past, from 28% in the 2005 RDHS to 69% in the 2010 RDHS.

PMTCT activities have been integrated into existing MCH interventions such as ANC, integrated management of

childhood illnesses, expanded programs of immunization, and sexual and reproductive health. As a result, Rwanda's PMTCT program provides a comprehensive package: counseling and testing for pregnant women; preventive ARV regimens to prevent MTCT; counseling and support for safe infant feeding practices; safe labor and delivery practices; family planning counseling or referrals; as well as referrals for long-term ART for infected children and eligible mothers identified at ANC or maternity. From July 2009 to June 2010, the number of pregnant women attending ANC was 290,910, of which 286,073 (98%) were counseled, tested for HIV and received their results. A total of 7,677 (2.7%) pregnant women were tested HIV positive. Of the women who accepted the test, 84% were tested with their partners.

As of December 2011, 412 sites (84% of all health care facilities) were providing PMTCT services for pregnant women in Rwanda. In COP 11 USG was directly supporting 196 of these sites in 22 out of 30 districts.

The national PMTCT program started in 2001, using a single dose nevirapine (NVP) regimen. In 2005, Rwanda transitioned to a more efficacious dual therapy protocol combining zidovudine (AZT) and Nevirapine (NVP). Since November 2010, Rwanda has adopted option B of the recent WHO recommendations; all HIV infected pregnant women, who are not eligible for HAART receive triple antiretroviral (ARV) prophylaxis starting at the 14th week of gestation, and continuing during the entire breastfeeding period until the infant is 18 months old or until one week after breastfeeding has ceased.

While significant progress has been made in PMTCT services, it is still challenging to reach pregnant women who need services, thus hindering the elimination of mother-to-child HIV transmission. GOR and partners are working to improve uptake of PMTCT services, reaching women with ANC services through community outreach, sensitizing local authorities and displaying strong leadership. Furthermore, to address geographic accessibility, all "stand-alone" sites (those that do not currently offer ART services) will be equipped with adequate laboratory tests and provide antiretroviral therapy. Provision of optimum PMTCT services will be made possible through improved monitoring and evaluation, staff mentoring and integration of PMTCT activities into existing MCH programs. Systems will be reinforced for post-natal follow-up of HIV-positive mothers and HIV-exposed infants to ensure women and children receiving care through PMTCT programs are linked to ongoing care and treatment services.

In COP12, as Rwanda's PMTCT program matures, more attention will be directed to improve quality and sustainability while addressing remaining gaps to achieve elimination of MTCT. According to preliminary results from the 2010 RDHS, only 35% of pregnant women attend four ANC visits and 31% of deliveries are not attended by a health professional, suggesting that effort should be made to promote early ANC attendance and institutional deliveries for effective PMTCT. Additionally efforts to integrate PMTCT into MCH services will help achieve healthy, HIV-free survival for infants and children as well as increased quality of life for mothers. Activities to address these challenges include continued sensitization of pregnant women and mobilization of community health workers and local leaders for early ANC and to minimize loss to follow-up during pregnancy and the breastfeeding period. Furthermore, to tackle the high staff turn-over, continuous mentorship for health care providers will be implemented.

PMTCT programs serve as an entry point for full family ART services, for a stronger family-focused approach. Forthcoming data from the 2010 RDHS and results from the HIV sero-surveillance survey among pregnant women attending ANC will help to inform program planning. Currently there is also an ongoing national survey to evaluate the effectiveness of the Rwanda National PMTCT program using six-week infant HIV transmission as the main outcome. It is critical to conduct an evaluation that would examine HIV transmission rates in infants aged 18 months to two years to assess overall program effectiveness including interventions during the breastfeeding period given that Rwanda has revised its guidelines.

III. HIV Testing and Counseling (HTC)

USG's clinical and non-clinical partners will continue to employ confidential testing and counseling approaches that minimize stigma and discrimination and link infected individuals to care and treatment programs. Currently, HTC is conducted by trained clinical providers; however, with the expansion of finger-prick TC by counselors (from venous puncture by laboratorians), the USG will support the training of additional counselors. USG technical assistance in

Prevention with PLHIV will help to ensure that high quality prevention counseling is being routinely provided to all HIV-positive clients by all USG-supported partners. The USG will continue to support HTC activities for the general population, couples, and most-at-risk populations (MARPs) (i.e. commercial sex workers, truckers, uniformed corps and clients of commercial sex workers). Through an array of partners, the USG will also support HTC activities targeting families of PLHIV and discordant couples.

In COP12, the USG will sustain support to existing HTC sites with clinical and non-clinical partners, assist GOR to roll-out finger prick testing and continue to support other approaches to HIV testing such as Provider Initiated Testing (PIT) in health facilities. Programs will also support mentorship and implement QA/QC on the newly implemented finger prick testing. From 2005 through the end of 2010, the cumulative numbers of HTC testing sessions is 5,229,817. Anecdotal evidence suggests that there could be high rates of re-testing. The USG will also support GOR to implement the new WHO Guidelines for delivering HIV tests results and messages for re-testing and counseling in adults. The USG will continue to support programs to identify clients at higher risk for re-testing, but also discourage low risk repeat testers based on the new WHO recommendations. HTC services will continue to identify prevention needs of re-testers for targeted risk-reduction counseling. Uptake of male participation in HTC programs has been successful in Rwanda. Over 80% of women who receive HIV testing in ANC/PMTCT sites throughout Rwanda also bring their male partners for testing. In COP12, the USG will support activities to monitor and evaluate this initiative, implement prevention interventions for the negative partners in discordant relationships, and support follow-up interventions for discordant couples.

In order to reach high prevalence populations who are unlikely to access HTC services at clinical sites, as appropriate, the USG efforts will continue to target MARPs with outreach HTC services in venues where HIV positivity rates are demonstrated to be higher than in the general population. Complementary HTC activities will include: HTC services for long distance truck drivers, sex workers and other mobile populations; initiatives to identify high risk negatives using a risk score algorithm and follow-up interventions; HTC in 20 USG supported districts; and broad HTC and prevention services at six youth centers reaching more than 30,000 high-risk youth through the centers and night-time outreach services to high risk youth and MARPs. The USG will continue to support innovative ways to improve access to HTC among MARPs. For HIV-positive individuals identified through HTC services, the program will emphasize documentation of linkages and referrals to care and treatment. Military members and their families will be able to access HTC services within the military brigade clinics.

Coordination of these activities will be crucial to avoid duplication and maximize coverage to MARPs. HTC provided in mobile settings will follow national guidelines and ensure linkages and referrals to care. The USG community partners will continue to support the promotion of HTC among targeted populations. This targeted promotion of HTC services will identify those most likely to be infected and ensure they are referred to sites where they can receive testing, counseling, referral to appropriate care and condoms.

IV. Condoms

Despite recent advances in HIV prevention (e.g. male circumcision, pre-exposure prophylaxis), male and female condoms remain the most effective prevention technology currently available and the only prevention method capable of preventing both HIV and pregnancy. Studies demonstrate that for condoms to be effective they must be used correctly and consistently; however, consistent condom use is dependent upon condom availability and access. In Rwanda, as in most of sub-Saharan Africa, condoms are made available to end-users through public sector distribution, social marketing and the commercial/private sector. Rwanda's Logistics Committee is the coordinating body for managing condom programming and the Medical Procurement and Distribution (MPD) division, under the Rwanda Biomedical Center Department of Medical Production, Procurement and Distribution, procures and distributes public sector condoms. MPD distributes to district pharmacies where 70% of Rwanda's public sector condoms are made available to health facilities, secondary posts and other public sector distribution points.

Current funding for Rwanda's male and female condoms is channeled through the United Nations Population Fund (UNFPA), Global Fund and the USG - the largest individual donor to Rwanda. In addition, the MOH procures condoms. In 2010, approximately 24 million private and public sector condoms were available in country with an

average consumption of 1.5 to 1.8 million per month. Although there is national coverage of public, private and socially marketed condoms, Kigali city has the best coverage for all condoms, that is condoms are available in most cells within Kigali. The USG funded socially marketed male condom, Prudence, is the most widely available condom in Rwanda boasting a national coverage level of 84%. The provincial coverage rate varied between 100% in Kigali City, 58% in the Western province, and from 90% to 94% in the Northern and Eastern provinces (USAID Rwanda 2010 Map Study). While private sector and/or socially marketed condoms rarely, if ever, experience stock-outs or shortages, from 2008 to 2010 Rwanda has experienced stock-outs or shortages in public sector male condoms. The duration of Rwanda's public sector condom stock-out has ranged from one to five months. There have been no stock-outs of female condoms. One key barrier and problem, possibly contributing to problems in the availability and supply of public sector male condoms, may be weaknesses in the last mile public sector supply chain system and location and hours of operation for distribution points for public sector condoms. The MOH, subsequently, would like to take on the procurement of male condoms; however procurement attempts thus far have been delayed. To address problems contributing to condom accessibility, the USG, in close collaboration with the Rwandan MOH and other key stakeholders, will continue to provide technical assistance and capacity building in condom forecasting, procurement and distribution.

V. Voluntary Medical Male Circumcision

In countries where HIV rates are high and circumcision rates are low, WHO encourages no-cost voluntary male medical circumcision (VMMC) for men aged 13-30. With a low male circumcision rate (only 15% of men are circumcised) and a mixed HIV epidemic, MOH developed a policy that recognizes VMMC as an effective HIV prevention method when combined with other methods. The primary goal of this policy is to reach men or boys before they acquire HIV, irrespective of marital status. The USG works closely with Rwanda's MOH and other donor partners in a national program to circumcise two million men by December 2013.

The national program for VMMC services will be extended to the police, adolescents, adults, and newborns through support from the MOH, Global Fund and WHO. The MOH has also requested continued support for VMMC services for the Rwanda military. MOH has already invested in VMMC activities including a National Health Service assessment to identify the capacity of public and private health facilities to provide safe and accessible VMMC services. In collaboration with the national VMMC TWG and other partners, MOH developed a national guideline and trained health providers to provide VMMC services in two district hospitals. With support from WHO, MOH also procured supplies and equipment for service delivery in these hospitals.

VMMC in Rwanda is offered as part of an expanded HIV prevention strategy 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. The USG supports VMMC activities in the military health facilities. The USG support is provided for the provision of the minimum package, support for infrastructure development, and monitoring and evaluation (M&E).

VI. Positive Health Dignity and Prevention

Prevention with People Living with HIV/AIDS (Positive Health Dignity and Prevention/PwP) will be implemented across both clinical and non-clinical partners in COP12. Clinical partners will continue to implement the following interventions that constitute the national minimum package: assessment of sexual activity and provision of condoms/lubricant and risk reduction counseling; assessment of partner status and provision of partner testing or referral for partner testing; assessment for sexually transmitted infections (STIs) and provision of or referral for STI treatment and partner treatment; assessment of family planning needs and provision of contraception or safer pregnancy counseling or referral for family planning services; assessment of adherence and support or referral for adherence counseling; and assessment of need and referral or enrollment of PLHIV in community-based programs such as home-based care, support groups, and post-test-clubs.

USG partners will ensure that all clinic/facility-based and community/home-based programs serving PLHIV include a package of behavioral and biomedical prevention interventions that are consistent with the guidelines outlined in the PwP technical considerations and the GOR PwP National Guidelines. These interventions will continue to be

provided at each client encounter and delivered either onsite or through a referral program in which the client is enrolled. Programs will endeavor to provide PLHIV with an adequate supply of condoms/lubricant and risk reduction counseling which addresses condom use, partner reduction, and alcohol reduction. Negative or unknown status partners of PLHIV will be tested at least annually. Discordant couples will be identified through couples HTC and provided with appropriate prevention counseling and services in line with MOH guidelines, including condoms, family planning, STI screening and partner retesting. Clinical partners will ensure that when patients and partners of PLHIV come for regular visits, they are offered screening and treatment for STIs as part of routine care.

Adherence to ARVs and all medications is also important for maintaining low viral loads and reducing risk of transmission. Clinical and community based partners serving PLHIV will ensure that adherence counseling is part of a standard of care. Finally, the USG will ensure that all interventions delivered through clinics/facilities are reinforced through community-based programs and linkages and referrals from community programs to clinics will be incorporated into all community programs serving PLHIV. The GOR will continue to ensure that all the components of the minimum package of PwP are reported through the site-level aggregate reporting system.

VII. Most-at-Risk Populations (MARPs)
The USG, in partnership with the MOH, has placed a greater emphasis on targeted HIV prevention, especially for MARPs. Within the Rwanda context, key target groups for MARPs HIV prevention include FSW and their clients, youth, young women 15-49 years, discordant couples, PLHIV, people with disabilities, MSM, prisoners and mobile populations (National TWG, 2011). The USG, therefore, has supported an integrated HIV prevention package for these populations that addresses the proxal and distal determinants of risk behavior. The HIV prevention package has included sexual and behavior change communications, condom promotion, HTC, HIV and STI screening and management, FP and RH integration and linkages to services, risk reduction programs, trainings, skills building, sexual and gender based violence sensitization, social support, and economic strengthening activities. In COP12, while the USG will continue to support an integrated HIV prevention package, the focus of efforts will be on those MARPs with the highest risk; for example, based on a 2010 BSS on FSWs, the overall HIV prevalence in the Kigali cohort was 59% while in the 15-49 age group HIV prevalence was 37%.

As a result, there has been significant scale-up of programming. A new recruitment approach, for example, has allowed access to a hidden population of younger, more vulnerable FSWs allowing our programs to reach 2,279 FSWs in 2010, up from 282 in 2009, with an integrated HIV prevention package.

During COP12, increased emphasis will be placed on providing integrated HIV prevention for MARPs with the highest risk factors. The USG will no longer support in-school youth activities. With MOH as the national coordinating body for HIV prevention activities, the USG and other key stakeholders will continue to work in collaboration to support programs and policies that create a human rights based, enabling environment for MARPs.

Youth Programs
Compared to the general population, youth aged15-24 years have lower HIV prevalence rates, with differences in HIV prevalence between young men and women. Female youth have a 3.9% prevalence rate versus 1.1% for male youth (NSP 2009). Furthermore, within the population aged 20-24 years, young women are at even greater risk, likely due to cross-generational sex. USG funded sexual prevention programs focusing on abstinence and fidelity have targeted 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 program reinforces this delayed debut. Outreach to young people is done in a variety of community settings (churches, drop-in centers, rehabilitation centers, schools, associations, and cooperatives). 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. The USG also supports programs to provide youth with market-relevant life and work readiness training and links with the employment and self-employment job markets.

VIII. General Population
In mixed epidemic countries like Rwanda, HIV prevention programming efforts are complex; as HIV transmission will

continue unless it is interrupted in both MARPs and the general population. With Global Fund grants primarily focused on HIV prevention in the general population, the USG HIV prevention efforts will continue to target MARPs and higher-risk populations with integrated programming that addresses condom use, HCT promotion, FP and RH, STI screening and management, adherence support, alcohol use, gender-based violence, mass media campaigns, interpersonal communication and appropriate referrals and linkages to care and support for disease prevention and health promotion. The USG interventions targeting MARPs which may have applicability to the general population include a range of supportive activities that seek to optimize biomedical and behavioral interventions employing a variety of channels (i.e., community-level interventions, interpersonal communication and counseling) to communicate a range of integrated messages to reduce risk of HIV transmission and acquisition.

IX. Health Systems Strengthening/Human Resources for Health
Rwanda implements task-shifting across the HIV/AIDS treatment program as nurses conduct ART eligibility assessments and provide ART under the supervision of physicians. In order to maintain the quality of these services, the USG supports the continuous professional development, clinical supervision, and mentorship of these nurses, as well as of other key health care workers. The USG support plays an active role in the development of policies related to the training and management of these providers. Beyond clinical facilities, the USG is building the capacity of local community-based organizations to provide and manage prevention activities for key populations, such as MARPs, OVC, and women. In COP12, the USG will scale-up support to local organizations to implement programs.

In COP12 the USG will continue supporting health systems strengthening at five key levels/sectors: national, district, facility, community, and civil society. USG will support GOR and civil society to implement priorities identified for health system strengthening and capacity building. These include: human resources for health; health financing; and governance and strengthening the systems for systems, medicine and technologies to provide the most effective sustainable response to HIV/AIDS. During COP12, the USG will continue addressing these priorities focusing on the individual, system and organizational capacity building needs which are critical to the current program management and direct funding to the GOR. The USG continues to work closely with GOR to identify the potential weaknesses and the best strategies to address these priorities.

Rwanda has been implementing an innovative Performance-Based Financing (PBF) system at health facilities over the last several years. In COP11, this program was extended to Community Health Workers (CHWs), who are volunteers with a few weeks of training in basic primary care. PBF for CHWs will be scaled up nationally, with technical support from USG. A rigorous evaluation will accompany the program to ensure that both the quality of services improves and the incentives function as an effective retention and performance improvement and sustainability mechanism.

X. Medical Transmission
Preventing the transmission of nosocomial infections, injection safety and improvements and management of medical waste systems are efforts critical to sustainable HIV prevention. All levels of health care personnel must be trained to monitor and manage the proper use of blood and injecting equipment.

In COP12, the USG will continue to support the MOH 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. In COP12, there will be an increased effort to ensure that all technical skills are transferred to the national program to ensure that a sustainable operation is in place. Future goals and strategies include providing technical assistance to plan at the national level, strengthening testing for blood transmissible infections, advancing quality assurance to ensure the quality of blood and blood products, supporting the accreditation process of the blood transfusion service, rolling out the plan for the rational use of blood and blood products, and developing a cost recovery plan for sustainability and implementation of the computer system at central and regional blood transfusion centers.

The goal of the USG's Safe Injection Program is to support the GOR 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

morbidity and mortality of patients who seek healthcare services. Mismanagement of injections and other sharp objects result in the transmission of HIV, Hepatitis B and C to patients and health care providers. The focus of USG support will be inside and outside clinical environments. Similar to the Blood Safety program, in COP12, the USG will support the national program to take over the responsibility of managing injection safety and medical waste management activities.

XI. Gender

In Rwanda, women are more likely than men to be infected with and affected by HIV. While the overall prevalence of HIV in Rwanda is estimated to be 3.0%, the prevalence among women aged 15-49 years as 3.7%, compared to 2.2% for men in the same age bracket (RDHS, 2010). Sexual and gender- based violence (SGBV) is a significant health concern and risk factor for HIV. More than 41% of women in Rwanda have experienced violence from the age of 15 years (RDHS, 2010), and as reported from early 2007, rape was the single most frequently reported crime in the country (National Strategic Plan for HIV/AIDS, 2009).

Women and girls have to be empowered, not just as beneficiaries of development, but as agents of transformational change. USG Rwanda in consultation with the GOR has selected gender equality and mainstreaming as a focus area in the GHI Country Strategy. The emphasis is to increase innovative approaches while supporting the GOR in applying its gender strategy and policies. The GOR has well-developed policies and guidance for improving gender discrepancies. This commitment is clearly stated in its Constitution, the Vision 2020, the Economic Development for Poverty Reduction Strategy (EDPRS), the Health Sector Strategic Plan (HSSP II) and the National Gender Policy, among other documents. The USG will continue to support its international and local implementing partners to strengthen gender equality and mainstream activities during planning, implementation and reporting with a focus on sustainable interventions for maximum impact.

In early 2010, with support from the OGAC Special Initiative on SGBV, the MOH finalized protocols for the clinical management of cases of SGBV and developed a scaled-up plan for the implementation of the new strategy. Over the past year, the National Police have increased efforts to combat human trafficking and prostitution by increasing the numbers of arrests and prosecutions of traffickers and by educating men on women's rights and promoting gender equality. Although the GOR and its partners have made impressive progress in raising awareness about SGBV and other gender issues, much work remains. USG will continue to support the training of education Peace Corps Volunteers to recognize and address the signs of SGBV, neglect, and abuse among students.

The USG team is committed to supporting the country in expanding its activities to provide quality services and gender mainstreaming in Rwandan institutions. These efforts are supported by including gender equality as a central pillar of the country's GHI strategy and as a common goal of all USG-supported health and other cross cutting sectorial projects. The USG team has a gender focal person to coordinate PEPFAR planning, implementation and mainstreaming of gender equality. Also, USG's partners promote capacity building of their staff and country programs in gender equality. Using additional Gender Challenge Funds, USG will continue to support the scale-up and integration of sexual and gender-based violence (SGBV) prevention and treatment available in health services. These activities include the scale up of MOH's plan for prevention, care and treatment of SGBV; expansion of MOH's plan for SGBV to military and police health facilities; breaking the silence around SGBV and people with disabilities (PWD) through advocacy and education of teachers to recognize the signs of SGBV, neglect and abuse; a social and behavior change communication (SBCC) campaign on male norms and gender equity; strengthening and integrating SGBV referral systems; reaching out to community initiatives; promoting couples VCT; providing information on the dangers of cross-generational sex and concurrent relationships; encouraging increased male involvement in MCH, FP/RH, PMTCT and ANC; and promoting HIV prevention and health-seeking behavior among MSM and actively linking low-income women and child- or female-headed households to income-generating and social welfare programs.

The effectiveness of gender programming will be robustly monitored by USG and all implementing partners through program indicators, evaluations, and surveys, and surveillance using gender sensitive indicators.

XII. Strategic Information

The USG works to strengthen the capacity of the national HIV/AIDS strategic information network to plan for, collect, manage, and make use of integrated data from a variety of sources. The USG will continue to provide support for the implementation of ambitious Rwanda National e-Health Strategy and National HIV/AIDS Monitoring and Evaluation (M&E) Policy and Strategy. These activities align with the PEPFAR Partnership Framework and Partnership Framework Implementation Plan.

In previous years, the USG supported the harmonization of various data collection systems and the development of international disease classification standards for national health information systems. Subsequently, program monitoring and reporting systems, as well as patient level information systems were developed and implemented. In COP11, the USG supported the initiation of the National Health Enterprise Architecture which will promote the interoperability of various information systems. During COP12, Rwanda, with support from the USG, will implement a virtual private network (VPN) linking all health centers providing HIV/AIDS services. The VPN will reduce internet-related costs and facilitate connections between the central and district levels. In addition, in COP12 the MOH will continue the roll out of a national electronic medical records system (EMR) to additional sites with support from USG. Other national strategic information systems to be supported by the USG in COP12 will include: TRACnet; the community information system (mUbuzima); and Health Management Information System (HMIS). The USG also supports the Partner Reporting and Performance Monitoring System (PRPMS) to consolidate and report results from USG implementing partners for reporting to headquarters. Capacity building of GOR staff and organizations, as well as other local entities, will be at the core of COP12 activities as a strategy to achieve the sustainability of the various systems USG has been supporting.

HIV/AIDS indicators have been integrated into the national monitoring and evaluation databases. The focus is now to ensure data quality and strengthen the national monitoring and evaluation systems. The USG's strategic information emphasis in COP12 will be on routine data analysis and use. Additionally, work in developing a national monitoring and evaluation framework and support of community level monitoring and evaluation data collection through umbrella organizations will help to complement the package of USG SI activities. Further, mapping exercises and building the national capacity in the use of Geographic Information Systems to support program implementation will also be a focus of USG SI work in COP12.

A national Men who have Sex with Men (MSM) Behavioral Surveillance Survey (BSS), including HIV testing, was conducted in COP11 based on 2008 USG supported exploratory qualitative study on HIV risk among MSM in Kigali. The results will inform a broad program targeting MSM, a traditionally hard to reach population. Since 2004, the USG has been supporting annual antenatal (ANC) sentinel surveillance, and during COP12 the USG will support the use of routine PMTCT and VCT programmatic data for HIV surveillance. Representative estimates on behavioral, clinical, and biological HIV/AIDS indicators are critical for evaluating a country's response to the HIV/AIDS epidemic.

XIII. Capacity Building

At present, the USG supports institutional and human capacity building in the GOR from the central to the community level, in civil society organizations (CSOs) and in the private sector. Benchmarks have been established to measure institutional capacity in these areas; as capacity is demonstrated consistently over time, responsibilities will continue to shift progressively towards Rwandan ownership. At the policy level, the USG is closely involved in the review and revision of decision-making processes and coordination of donor and sector activities through an improved Sector-Wide Approach (SWAp). In addition, the USG has provided technical assistance in drafting key national strategy and policy documents related to capacity building. The USG supports technical assistance to key staff at national and district levels to provide effective supervision and oversight, establish and promote evidence-based policies, programs and practices and identify and guide the strategic direction of the health sector. The USG utilizes institutional twinning and technical assistance to assist Rwandan institutions to assume primary responsibility for strategic planning and management, implementation, and monitoring and reporting. For example, the USG supports institutions of higher learning in health education to become effective managers and leaders in research, training and community outreach programs.

At the community level, the USG has contributed to the training and deployment of 60,000 CHWs, who in turn collaborate with local leaders to promote health-seeking behavior and provide basic home-based care. The USG provides technical assistance to CSOs, who are active in the health sector, but need improved capacity to directly manage donor funds and to implement high-quality sustainable programs. The USG has also supported the GOR in private sector engagement with both HIV and non-HIV funds, for example, the USG completed an assessment of private sector readiness to provide family planning (FP) commodities.

Through PEPFAR, the USG team will continue to support the GOR, civil society and private sector to strengthen human and institutional capacity and to utilize this increased capacity by investing in host country systems and processes. The expectation is that all partners will focus on human and institutional capacity building as aligned with national plans. The expected results are medium-term achievements, such as high quality health professional including nurses and specialists, quality improvement and increased uptake of health services, and long-term achievements such as reduced maternal and child mortality and lower prevalence of HIV/AIDS, TB and malaria.

The USG plans to employ three strategies to achieve its objective of increasing human and institutional capacity in Rwanda: 1) leverage established coordination structures; 2) develop and strengthen relationships with national partners; and 3) integrate capacity building across all health assistance. The USG will leverage established arrangements, for example as shadow co-chair of the Health Sector Working Group (HSWG) and as co-chair and members of national Technical Working Groups, to promote a greater policy-level emphasis on, and investment in, capacity building by all stakeholders in Rwanda. The USG will also explore opportunities for new and strengthened relationships with national partners. A main component of this will be the continued focus on country ownership through increased direct funding to local entities. Finally, capacity-building will continue to be integrated as a core component across all health assistance, including continued support for training institutions for physicians, nurses, midwives, laboratory technicians, and other paraprofessionals. The USG will support leadership and capacity-building in health finance, particularly in the transfer of the management and capacity to develop or maintain the national resource tracking database to the MOH. The USG will continue to support capacity for operational research and data collection with key local institutions and continue to support the development of a national laboratory network that meets international accreditation standards. In COP12, the USG plans to continue to support health workforce training programs, such as health economics and finance, epidemiology, clinical and laboratory services and community health workers. Using a systems approach, efforts will not focus solely on training and deployment, but on increasing efficient utilization and integration of the workforce at the district, sector and community level, and on strengthening national management of service delivery, management of financial resources, and leadership of human resources.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	13,152,583	0
HTXS	8,811,005	0
PDTX	2,568,674	0
Total Technical Area Planned Funding:	**24,532,262**	**0**

Summary:

I. Adult Treatment

As of September 2011, the USG was the lead donor in 22 of Rwanda's 30 districts, supporting HIV treatment services in 172 out of Rwanda's 344 facilities providing ART. This support will continue in COP12.

In COP12, the USG will continue to support the GOR's decentralization efforts for ART delivery at the central level institutions and extending to community level health facilities. Additionally, the USG will continue enrolling patients in ART services at currently supported sites, and work with GOR and other donors to evaluate and ensure quality. Programs are designed to provide site and program-level feedback regarding quality of clinical services and support at central levels; this input in turn helps update guidelines, training materials and job aids. The USG 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 RBC/IHDPC, the National Reference Laboratory (NRL), and other key units in MOH. In COP12, the USG will support the MOH to carry out joint supervisory visits to clinical sites in collaboration with the district health teams (DHTs) to improve data quality and use. At the district level, the USG will provide financial and technical support to their respective DHTs to strengthen linkages, referrals, transportation of patients and specimens, communications, forecasting, drugs and commodities distribution, financial systems and planning. In addition, the USG will strengthen district level supervisory, management, mentoring and reporting capabilities.

In districts where the lead donor supporting HIV-related clinical services is not the USG, the USG will help to ensure continuity of care across sites and services, as well as provide TA and resources for supportive supervision. The USG supports direct mentoring and capacity building support to district health teams, thus building capacity to decentralize supervisory and quality assurance activities.

In COP12 at each site, the USG will support national efforts to define a standardized basic package of ARV services through support and development of a coordinated network of HIV/AIDS programming linking ART with PMTCT, TB, FP, MCH and other services. Following a tiered approach to service delivery, USG partners will provide broad 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. The USG will continue supporting task shifting by strengthening pre-service and in-service training for nurses and implementation of simplified protocols. District hospital physicians will support nurses in managing ART cases through regular mentoring visits and remote support via telephone for urgent questions.

At the community level, the USG 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. The USG will provide training and materials to those volunteers and link them to case managers at facilities for better referrals between facility and community.

In COP12, the USG will continue its efforts to provide nutritional support to eligible adults, pregnant and lactating women, and provide supplementary foods to HIV exposed and moderately malnourished infants. The USG will also support basic program evaluation activities to guide best program outcomes.

The USG continues to support GOR's efforts to provide care and treatment to all HIV eligible patients in accordance with national guidelines. The total number of patients currently on ART in USG supported sites is 61,875, accounting for 62 percent of national ART coverage. While the proportion of children on ART continues to lag behind, the USG has increased support to GOR to enroll more children on ART. Strategies include reinforcing a family approach using an index of positive patients to identify all family members with particular emphasis on children. Of all 9,936 HIV-positive patients newly enrolled on treatment in fiscal year 2011, 862 were children up to 14 years. This includes 131 HIV-exposed infants in PMTCT who tested positive and immediately were enrolled into care and treatment. Currently all health facility staff have been trained to enroll and initiate ART for an HIV-exposed infant

following the first positive test, even pending a confirmatory PCR tests.

Through the contributions of USG and other funders, national ART coverage (based on WHO 2009 eligibility criteria) is 94%, one of the highest coverage rates in the world (EPI update 2010). This level of coverage along with access to treatment has socially and clinically improved the lives of PLHIV and reduced HIV and AIDS related deaths. According to the Epidemic Update, the number of patients who died from AIDS related causes in 2010 was 2580 compared to 4181 in 2009. During COP11, USG continues to support capacity building for healthcare providers through decentralized and harmonized trainings. In addition, the USG supports facility based mentorship services that include supporting quality of care assessments. Health facility staff are able to clinically and efficiently assess and diagnose ART patients with poor clinical progress (e.g., treatment failure) and provide a second line treatment option. Task shifting has also contributed to patients more efficiently initiated on ART and this has improved overall programmatic performance.

While the USG program registered these notable accomplishments in 2010, there have been a few programmatic challenges. The linkage between testing points and enrollment sites in facilities without ART services is a challenge and presents a potential risk for loss to follow up. The USG will continue to support the implementation of strategies to reduce the number of patients lost to follow-up in entry points and ART programs, improving linkage and referral systems. Specifically, and in context of new PMTCT guidelines, the USG will closely work with TRACPlus to revise the minimum requirement for PMTCT stand-alone sites to enable them to offer ART at no additional cost. This would increase the number of facilities providing ART in the country. In addition, the adherence rate in Pre-ART patients who are not yet eligible for ART and where their clinical status does not require frequent clinical visits make their follow-up difficult. Staff turn-over at health facilities poses a great threat for quality service provision and decelerates national efforts for adequate healthcare provision and requires retraining of staff. While task shifting is viewed to increase the pool of trained healthcare workers, the USG will continue to support a mentorship strategy to improve quality of care and treatment as well as training and supportive supervision at different levels.

Access and Integration: In 2009, the USG contributed technical and financial support to the revision of national care and treatment guidelines based on the new WHO recommendations. The current eligibility criteria for initiation of ART are based on three patient related criteria: the clinical stage, the immunologic state, and social status for adherence purposes. Clinical and immunologic criteria for ART eligibility are: patients with WHO clinical stage 4 regardless of CD4 count; and those with stages 1,2, and 3 with CD4 cell count less that 350/mm3. These are supplemented by social criteria that aim to reinforce adherence of the patient and minimize loss to follow up. One big shift during this guideline revision was the introduction of tenofovir (TDF) as the first-line drug replacing zidovidine (AZT) with program implications for cost (TDF), lab (biochemistry) investigations and increased number of people on ART as the threshold was raised from CD4 200 to 350.

In COP12, with declining budgets, the USG program is not planning program scale up but rather consolidating efforts made in care, prevention and treatment. The USG will support the GOR to reinforce a service integration model that patients in care can readily access broad integrated services: ART, Co-trimoxazole, screening for sexually transmitted infections and psychosocial support. More than 90% of all HIV positive patients are screened for TB and IPT implementation has been initiated with COP11 funding. Nutrition support is provided to those eligible for the first 6 months after initiation of ART. Currently all USG supported care and treatment sites are offering family planning services in support of GOR's vision to achieve 80% coverage.

Quality and Oversight: National treatment guidelines and job aids exist at all treatment levels to facilitate providers with proper guidance on case management. In addition, national HIV and AIDS entities and implementing partners organize a periodic joint supervision visits to the health facilities to ensure quality service delivery. At decentralized levels, the USG together with the DHTs organize one-on -one or group mentorship and supportive supervision and participate in quarterly data quality audits. Such mentorship sessions provide a forum to identify, manage or refer complicated cases including 1st line treatment failure. One of the challenges identified for 2nd line drugs are the cost implications with Global Fund currently supporting all patients in need.

With more patients accessing ART, in COP12 the USG is supporting the development of pharmacovigilance and a law that is likely to be passed soon. The MOH provides quality control of all pharmacy related issues through its pharmaceutical regulatory arm, the Pharmacy Desk. Currently, forms for reporting adverse drug reactions have been distributed to ART sites for tracking and reporting ARV-related side effects. While Rwanda's current ART coverage can be admired, there is a likely potential for slowdown in the event of unforeseen emergencies since Rwanda has been dependent on donor support for ARV procurement and its sustainability plans for ARV are not likely to be achieved with declining budgets. Models of subsidizing and integrating ARV costs to the national health insurance scheme and exploring private sector engagement in health procurement systems are still in the conceptual stage.

Sustainability and efficacy: With close collaboration between TRACPlus and procurement institutions, quantification and procurement information from CAMERWA and SCMS are being used to inform future national planning including considering possible changes in guidelines and protocols and treatment regimens. GOR has also coordinated partners to leverage resources in order to adequately respond to the HIV epidemic at all levels. Through the Coordinated Procurement and Distribution System (CPDS), effective procurement of reagents and consumables is now ensured and the USG engages with national and other stake holders to look for efficiencies while responding end users' needs.

The National drug formularies were updated to include more generic drugs and payable to the community health insurance to increase OI treatment option. During COP12, the USG will support GOR to identify potential areas for cost-savings including facility-based VCT versus mass campaign testing, and will provide clearer guidance to low-risk repeat testers where not warranted.

II. Pediatric Treatment
Each year the Government of Rwanda (GOR) develops estimates on 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 this model the number of HIV-positive children under 15 years of age in 2011 was 22,470 (range 11,412-33,750). Based on the same model, 8775 and 8997 children will be eligible for ART respectively in 2011 and 2012 (July 2011-June 2012 quantification report).

From July 2011–to June 2012, 99% of eligible children are forecast to be on the following treatment regimes: 42.9% on a zidovudine (AZT) based regimen; 36.6 %, on stavudine (D4T) -based regimen; and 17.3% on abacavir (ABC). GOR's National Strategic Plan for HIV/AIDS 2009-2012 sets ambitious target to achieve for pediatric treatment, with 90% coverage of children in need of ART receiving it by 2012. In addition, the GOR has prioritized early detection of HIV-positive infants in this plan to provide optimal care and treatment for children.

The USG, the Global Fund, UNICEF and the Clinton Foundation are some of the major stakeholders working with the GOR to develop and implement programs for HIV-affected and infected infants, children and adolescents. Presently, 344 sites offer ART services in Rwanda. The USG supports HIV treatment services for children at 183 of these sites (53% of all ART service sites).

As of September 30, 2011, 7,708 HIV-positive children under 15 years of age were currently receiving ART in Rwanda (7.7% of all patients on ART). Sixty-eight (68 %) or 5,248 children under age 15 were enrolled in programs supported by the USG, and of those 1.4% were <1 year of age. From October 2010 to September 2011, 862 children were newly enrolled on ART at USG supported sites, and of those enrolled 15% were <1 year of age.

The USG has supported MOH in the revision and dissemination of the pediatric care and treatment guidelines based on the new WHO recommendations. Implementation of the revised guidelines is ongoing.

The USG, in collaboration with the GOR and other partners, 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).

The USG supported the GOR to develop and implement a national advanced pediatric HIV training program to enhance the practical knowledge and skills of district hospitals and multidisciplinary teams in the provision of high quality services for children using a quality of care model to assess standards of care (SOC). From September 2009 to May 2011, 13 training sessions of two weeks each were organized for 87 care providers (30 MDs, 42 Nurses and 15 Social workers) from 37 districts. As well, 36 supervisors, 18 MDs, 14 Nurses and 4 Social workers from RBC/IHDPC, DI/ Ministry of Health MOH and 7 implementing partner organizations were provided with capacity building training to supervise, mentor staff, and monitor pediatric program implementation at sites. Preliminary assessment of the training outcomes suggests that the number of HIV infected children enrolled for care increased by 5% and that of ART initiation in children by 11% at sites with trained staff.

USG support to the NRL has enabled the lab to develop and increase the capacity of the health care system to provide EID services for HIV-exposed infants. The delay in obtaining PCR test results from the NRL impedes early infant diagnosis (EID) and early ART initiation. To shorten this delay, in 2009, the USG in collaboration with MOH supported the development and implementation of an EID notification system using SMS-based technology with the MOH. Currently, EID notification is built on Rwanda's existing national web-based HIV-reporting system, TRACnet. Since its initiation in March 2010, EID notification operates in all PMTCT and ART sites. As of March, 2011, NRL received 10,547 specimens and 10,547 results were sent to health facilities, of which 395 (3.1%) tested HIV positive. HIV results were provided to caregivers within 6 days on average compared to 90 days at baseline. To evaluate the comprehensive pediatric ART program, the USG supported the MOH to carry out a national pediatric ART program evaluation with the ongoing data collection.

Some of the challenges facing the Pediatric treatment program include lack of sufficient numbers of nurses trained in task shifting and 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. There is also a need to improve ART adherence especially for adolescents. In COP12, there will be a particular emphasis on the provision of psychosocial support to improve treatment adherence in children and adolescents. Moreover, increased pediatric formulations of antiretroviral drugs will be made available.

In COP12, the MOH identified the pediatric HIV program as a key priority, and in support, the USG will undertake the following activities:

- *Continue to support task shifting by strengthening nurse training through in-service training, and district hospital physicians to support nurses in managing ART pediatric cases.*
- *Improve the quality of HIV pediatric ART service through regular mentoring visits from central level to DH, DH to HC, and remote support via telephone for urgent as well as formative supervision.*
- *Improve the capacity of MOH to collect and analyze data on pediatric care and treatment indicators.*
- *Revise guidelines, data collection and reporting tools as needed.*
- *Implement strategies to reduce the number of patients lost to follow-up in entry points and in ART programs.*

The USG will continue to support pediatric HIV care and treatment activities at all levels of the health care system. At the central level, cooperative agreements and other funding mechanisms support the relevant MOH units—RBC/IHDPC, NRL, UDPC, Maternal and Child Health—to build capacity for system strengthening, human resources development, and improved quality of health service delivery for women and children. At RBC/IHDPC, the USG provides support for the development and revision of HIV Pediatric guidelines and training materials, and mentorship of district staff.

In COP12, 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 and transportation. The USG will continue to work with the NRL, RBC, CHUB and its implementing partners to expand EID access to all PMTCT sites in Rwanda and to further reduce the turn-around time of test results.

For COP12 the USG's strategic approach is to support implementation of HIV care and treatment services in an integrated manner for children at all existing USG supported ART sites in Rwanda. The USG will put in place provider initiated testing at all pediatric inpatient and outpatient settings. In addition, the USG will implement systematic testing of family members of HIV-positive patients currently enrolled in care and treatment clinics. In collaboration with RBC, the USG will reinforce psychosocial support for HIV-positive children and adolescents through the promotion of children and adolescent support groups in order to address issues around treatment adherence.

III. Supply Chain/ARV Drugs

Currently, the USG supports the procurement of more than 55% of HIV-related commodities in Rwanda, with Global Fund supporting the remaining needs. The Medical Procurement and Distribution Division (MPD) has benefitted from significant investments in technical assistance and institutional capacity in the last 3 years from the USG, and the Global Fund. Other donors, such as UNAIDS have also supported supplemental products for HIV care.

Rwanda's Coordinated Procurement and Distribution System (CPDS) conducts a yearly quantification exercise and forecasts HIV commodity needs for anti-retrovirals, laboratory products, and opportunistic infection treatment. Patient data from the information system TRACNet has been used to forecast needs, however, as of March 2011, consumption data down to facility level has been collected using a paper-based LMIS. This data will likely supplement information available through TRACNet for the quantification exercise. The CPDS meets quarterly to update the quantification. CPDS leads this entire process, with minimal technical assistance from SCMS when necessary.

In COP10, the USG supported the development of a paper-based LMIS, collecting logistics data across commodity categories. Global Fund has committed to supporting an automated LMIS during COP11 and USG funds will be leveraged with technical assistance for the project management and rollout of the new system.

There is strong country ownership of Rwanda's supply chain. Logistics courses have been integrated into pre-service curriculum of pharmacists, and will soon be integrated into the nursing program as well. The USG will provide procurement and financial management support to build capacity of MPD to prepare for future government-to-government support. The Logistics Management Office (LMO), being set up through USG support in cooperation with the Pharmacy Task Force (PTF), is responsible for assuring that health facilities and district pharmacies report on logistics data including potential stock outs and consumption data. The Active Distribution process will also help to ensure district pharmacies receive deliveries from MPD on a set monthly schedule.

Pharmaceutical quality assurance is being addressed through USG assistance in developing and implementing a Rwandan drug regulatory authority. The development of this entity will begin in COP11, and support will continue into COP12.

The USG is in regular communication with GOR and the Global Fund as well as other development partners to identify synergies in donor inputs in drug and commodity procurement. The CPDS now requires only minimal technical assistance. This annual coordinated forecasting and quantification exercise and quarterly updates brings all stakeholders together to review assumptions.

Preliminary evidence has shown that improved collection has decreased the incidence of over-stocks. Stock outs are minimal among HIV products in Rwanda.

With an LMIS system now in place, MPD is now prepared to automate that system. In collaboration with the Global Fund and the MPD, development of the system will happen in COP11 with rollout to be completed during COP12. USG will leverage support provided by the Global Fund for software procurement and implementation, by providing a project manager to help ensure the automated LMIS activity is on schedule and within budget.

IV. Laboratory

The COP12 USG laboratory strategy continues to build on a tiered national laboratory system for creating sustainable infrastructure to support care and treatment of PLHIV. The program plans to work with the MOH to further develop the five year strategic plan of the National Reference Laboratory (NRL) in cooperation with the President's Malaria Initiative (PMI), Global Fund, World Health Organization (WHO), World Bank (WB) and other in-country stakeholders.

COP12 support for the national laboratory policy and strategic plan will include, but not be limited to: establishing national laboratory policies for each tier of the laboratory network; integrating clinical diagnostic laboratory services; harmonizing and maintaining laboratory equipment; managing inventory and national forecasting of laboratory supplies, reagents and test kits; supporting quality assurance programs and human capacity development; and setting standards for and implementation of a Laboratory Information System (LIS).

In COP12, USG support for the national tiered laboratory system will include laboratories in the national system linked from NRL to regional sites to district hospital sites to primary care sites. The laboratory network in Rwanda is comprised of 433 health centers, 42 district hospitals, 5 regional laboratories, 2 university teaching hospital laboratories, and numerous private laboratories. The USG plans to continue to support NRL to improve the financial, coordinated procurement, overall quality assurance, laboratory networks and referrals, and laboratory information systems. USG will also continue to support human capacity development through specialized training and ongoing technical assistance with special emphasis in COP12 on training non-laboratory personnel to perform rapid HIV testing using finger prick method of blood collection and new lab technicians for the diagnosis of opportunistic infections.

Despite significant reductions to USG funds to support the accreditation of laboratories at the request of the GOR, the USG will continue to provide assistance to NRL in its efforts to take over the accreditation activities in COP12. In COP10 and COP11, five laboratories began the Strengthening Laboratory Management Toward Accreditation (SLMTA) program. The GOR plans an additional five laboratories to join the program in the next year. In COP12, the USG will provide limited technical assistance through USG agency staff support to NRL, who will be primarily responsible for continued laboratory accreditation. For COP12, a major point of emphasis will be the implementation of a new LIS for the management of laboratory data and to inform clinical programs improvement.

In COP12, the USG 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 and in developing a system for the transport of laboratory samples within the laboratory network. At five regional clinical diagnostic laboratories, the USG will support 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 technical positions at the NRL to assure quality HIV-related laboratory services through training and day-to-day mentorship of NRL staff and will support pre-service education programs at Kigali Health Institute for laboratory scientists. The USG will also continue bolstering management and financial capacity at the NRL.

V. Gender

In Rwanda, epidemiological data indicate that women are more likely than men to be infected with and affected by HIV. While the overall prevalence of HIV in Rwanda is estimated to be 3.0%, the prevalence among women 15-49 years as 3.7%, compared to 2.2% for men in the same age bracket (RDHS, 2010). According the APR10, among children <15 years old newly enrolled into ART 53% were girls while of the adult newly enrolled, 60% were female patients. Sexual and gender-based violence (SGBV) is a significant health concern and risk factor for HIV. More than 41% of women in Rwanda have experienced violence from the age of 15 years old (RDHS, 2010), and as reported from early 2007, rape was the single most frequently reported crime in the country (National Strategic Plan for HIV/AIDS, 2009).

Women and girls have to be empowered, not just as beneficiaries of development, but as agents of transformation. USG Rwanda has selected gender equality and mainstreaming as a focus area in the USG/Rwanda's GHI country strategic plan. Focus is on increased innovative approaches while supporting host country counterparts in applying

their gender strategies and policies.

The GOR has well developed policies and guidance to improving gender discrepancies. The GOR's commitment is clearly stated in its Constitution, the Vision 2020, the Economic Development for Poverty Reduction Strategy (EDPRS), the Health Sector Strategic Plan (HSSP II), and the National gender Policy among other documents.

In early 2010, with support from the OGAC Special Initiative on SGBV, the Ministry of Health (MOH) finalized protocols for the clinical management of cases of SGBV and developed a scale-up plan for the implementation of the new strategy. In addition, over the past year the National Police have stepped up efforts to combat human trafficking and prostitution by increasing the numbers of arrests and prosecutions of traffickers, as well as educating men on women's rights and promoting gender equality. Although the GOR and its partners have made impressive progress in addressing SGBV and other gender issues, much work remains to be done. In COP10 USG started to support the training of Peace Corps Volunteers serving as teachers on how to recognize and address the signs of SGBV, neglect, and abuse among students and will continue these interventions through COP12. The USG is committed to supporting the country in expanding its activities to provide quality services and gender mainstreaming in Rwandan institutions.

VI. Strategic Information

In previous years, USG supported the harmonization of data sets collected through the various HIV reporting systems, as well as defining disease classification standards for Rwanda health information systems. USG has supported the development and implementation of program monitoring and reporting systems, as well as patient level information systems. In COP11, the USG supported the initiation of the national e-health enterprise architecture that promotes the interoperability between the various subsystems implemented in Rwanda. In COP12, a virtual private network (VPN) will be implemented to link all health centers providing HIV/AIDS services. The VPN will contribute to reduce internet-related costs and facilitate connections between the central level and districts. Also in COP12 the MOH will be rolling out the national electronic medical record (EMR) system with support from USG. Other national strategic information systems to be supported by the USG in COP12 will include: TRACnet; the community information system (mUbuzima); and Health Management Information System (HMIS). The USG also supports the Partner Reporting and Performance Monitoring System (PRPMS) to consolidate and report results from USG implementing partners for reporting to headquarters. Capacity building of local entities will be at the core of COP12 activities to pave the way for sustainability of the various systems USG has been supporting. An evaluation of the new TRACnet modules (e-IDSR, PMTCT and VCT) will be completed in COP12.

HIV/AIDS indicators are integrated into the national M&E data bases, thus, the focus now is to ensure the quality of this data and strengthen the national M&E systems. Emphasis in the COP12 will be on data analysis and use, including conducting special studies to inform programmatic decisions.

The USG will continue to support the ARV drug resistance survey through the MOH's Rwanda Biomedical Center's Institute of HIV/AIDS, Disease Prevention and Control.

VII. Capacity Building

At present, the USG supports institutional and human capacity building in the GOR from the central to the community level, in civil society organizations (CSOs) and in the private sector. At the policy level, the USG is closely involved in the review and revision of decision-making processes and coordination of donor and sector activities through an improved Sector-Wide Approach (SWAp). In addition, the USG has provided technical assistance in drafting key national strategy and policy documents related to capacity building. The USG supports technical assistance to key staff at national and district levels to provide effective supervision, mentorship and oversight, establish and promote evidence-based policies, programs and practices and identify and guide the strategic direction of the health sector. The USG utilizes institutional twinning and technical assistance to assist Rwandan institutions to assume primary responsibility for strategic planning and management, implementation, and monitoring and reporting. For example, the USG supports institutions of higher learning in health education to become effective managers and leaders in research, training and community outreach programs.

In COP12 the USG will continue to support the GOR, civil society and private sector to strengthen human and institutional capacity and to utilize this increased capacity by investing in host country systems and processes. All USG supported partners have a focus on human and institutional capacity building as aligned with national plans.

In COP11 and COP12 the USG will maintain the number of government institutions and increase the number of local non-governmental institutions that receive direct support. The USG will continue to provide support to the MOH and health facilities to ensure that the quality of care at transitioned sites remains high.

As a cross-cutting component, capacity-building will continue to be integrated as a core component across all health assistance, including continued support for training institutions such as the schools of nursing and midwifery and the new Rwandan University of Health and Medical Sciences. The USG will continue to support capacity for operational research and data collection with key local institutions, such as the RBC and the National Institute for Statistics of Rwanda (NISR). The USG will continue to support health workforce training programs, such as, clinical and laboratory services and community health workers, using faculty and professional mentors and other high qualify professional to build and transfer capacity and reinforce its pre-services and in-services educational system.

VIII. MARPs

USG supports a new recruitment approach that has allowed access to a hidden population of younger, more vulnerable FCSWs, in COP10 outreach increased from 282 in 2009 to 2,279. In COP10 innovative best practices have been used to reach an often stigmatized cohort and then provide a minimum package of care and support (health/peer education, social support, social services, STI screening and management, condoms, HIV counseling and testing, and access to economic activities, as well as adherence support for those who are positive-with appropriate linkages to HIV care, support and treatment). The USG funding supports activities to improve the health of MSM by supporting the provision of stigma-free clinical services that meet their unique health needs and promoting these services to increase their health-seeking behavior. The USG is supporting training and mentoring of staff from three health centers in Kigali on sensitivity, confidentiality, HIV testing, care and treatment for MSM. The USG is also supporting MSM peer educator programs to sensitize MSM about their risk for HIV and STIs and to encourage them to seek HIV testing, care and treatment services from these health facilities. Strategies include monthly community meetings with MSM to discuss the available services and offer HIV testing in order to connect positive MSM to care and treatment.

IX. Human Resources for Health

Rwanda implements task-shifting across the HIV/AIDS treatment program, as nurses conduct ART eligibility assessments and provide ART under the supervision of physicians. In order to maintain the quality of these services, the USG supports the continuous professional development, clinical supervision, and mentorship of these nurses, as well as of other key health care workers. The USG also plays an active role in the development of policies related to the training and management of clinical providers.

Rwanda has also been implementing an innovative Performance-Based Financing (PBF) system at health facilities over the last several years. In COP10, this program was extended to Community Health Workers (CHWs), who are volunteers with six months of training in basic primary care. The PBF system rewards CHW for their efforts to detect and refer cases of malaria, malnutrition, and other common illnesses to health centers, as well as to follow women and infants during the antenatal and postnatal stages. CHWs are also supported in their work to provide prevention services and basic palliative care to PLHIV. In COP12 PBF for CHWs will be scaled up nationally, with technical support from the USG. A rigorous evaluation will accompany the program in order to ensure that both the quality of services improves and that the incentives function as an effective retention mechanism, as intended.

The USG's clinical partners, including the Ministry of Health, work to build the capacity of multi-disciplinary teams (MDTs) to review standards of care, and identify and resolve challenges related to the provision of clinical services. In addition, a major area of emphasis in COP12 will be the strengthening of communication and referral systems, particularly among facility-based providers, social workers, and CHWs. Joint patient tracking and the further integration of services will greatly reduce the loss to follow up of PLHIV, particularly among pre-ART patients.

The USG will begin supporting a new priority established by the GOR to improve the quality and quantity of high-skilled health care professionals in Rwanda. Along with other donors, the USG will support the GOR to recruit, train and mentor physicians, nurses, midwives, dentists, and health managers. In partnership with US academic institutions, the GOR will strengthen the capacity of Rwandan health sciences institutions, as well as provincial and district hospital which will serve as teaching sites, to produce a well-trained health workforce capable of responding to Rwanda's health needs.

The recently approved continuous professional development (CPD) plan for physicians will be implemented in COP12 with technical support from USG. Support will also be provided to the Rwanda Council of Nurses and Midwives to develop and implement a similar plan. These CPD plans will allow for a more coordinated and strategic approach to upgrading and reinforcing the skills of clinical providers on key HIV treatment issues.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P1.1.D	P1.1.D Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	145,223	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	94 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	4,085	
	Number of HIV-	4,344	

	positive pregnant women identified in the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	4,085	
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	0	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	0	
	Single-dose nevirapine (with or without tail)	0	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)	2,076	
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)	2,009	
	Sum of regimen type disaggregates	4,085	
	Sum of New and	4,085	

	Current disaggregates		
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia	23,710	Redacted
	By Age: <1	0	
	By Age: 1-9	1,142	
	By Age: 10-14	1,410	
	By Age: 15-19	8,478	
	By Age: 20-24	8,837	
	By Age: 25-49	3,812	
	By Age: 50+	31	
	Sum of age disaggregates	23,710	
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.	2,199	Redacted
	By Exposure Type: Occupational	300	
	By Exposure Type: Other	1,143	

	non-occupational		
	By Exposure Type: Rape/sexual assault victims	756	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	100,052	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are	347,907	

	based on evidence and/or meet the minimum standards required		
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	0	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive	n/a	Redacted

	interventions that are based on evidence and/or meet the minimum standards required		
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	144,543	
	By MARP Type: CSW	7,924	
	By MARP Type: IDU	0	
	By MARP Type: MSM	140	
	Other Vulnerable Populations	53,179	
	Sum of MARP types	61,243	
P8.5.D	Number of individuals from target audience who participated in community-wide event	279,782	Redacted
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	1,759,944	Redacted
	By Age/Sex: <15 Male	92,632	
	By Age/Sex: 15+ Male	601,367	
	By Age/Sex: <15 Female	106,666	
	By Age/Sex: 15+	959,279	

	Female		
	By Sex: Female	1,065,945	
	By Sex: Male	693,999	
	By Age: <15	199,298	
	By Age: 15+	1,560,646	
	By Test Result: Negative	1,741,236	
	By Test Result: Positive	18,708	
	Sum of age/sex disaggregates	1,759,944	
	Sum of sex disaggregates	1,759,944	
	Sum of age disaggregates	1,759,944	
	Sum of test result disaggregates	1,759,944	
P12.1.D	Number of adults and children reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS	32,287	Redacted
	By Age: <15	3,893	
	By Age: 15-24	8,424	
	By Age: 25+	19,970	
	By Sex: Female	8,817	
	By Sex: Male	23,470	
P12.2.D	Number of adults and children reached by	236,595	Redacted

	an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS		
	By Age: <15	9,071	
	By Age: 15-24	28,932	
	By Age: 25+	198,592	
	By Sex: Female	97,366	
	By Sex: Male	139,229	
P12.4.D	Number of adults and children who are reached by an individual, small-group, or community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS	42,595	Redacted
	By Age: <15	0	
	By Age: 15-24	0	
	By Age: 25+	0	
	By Sex: Female	0	
	By Sex: Male	0	
C1.1.D	Number of adults and children provided with a minimum of one	270,602	Redacted

	care service		
	By Age/Sex: <18 Male	46,408	
	By Age/Sex: 18+ Male	64,667	
	By Age/Sex: <18 Female	48,350	
	By Age/Sex: 18+ Female	111,177	
	By Sex: Female	166,871	
	By Sex: Male	103,731	
	By Age: <18	94,960	
	By Age: 18+	175,642	
	Sum of age/sex disaggregates	270,602	
	Sum of sex disaggregates	270,602	
	Sum of age disaggregates	270,602	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	100,932	Redacted
	By Age/Sex: <15 Male	3,964	
	By Age/Sex: 15+ Male	34,192	
	By Age/Sex: <15 Female	4,146	
	By Age/Sex: 15+ Female	58,630	
	By Sex: Female	62,774	
	By Sex: Male	38,158	
	By Age: <15	8,112	
	By Age: 15+	92,820	
	Sum of age/sex disaggregates	100,932	

	Sum of sex disaggregates	100,932	
	Sum of age disaggregates	100,932	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	98 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	98,959	
	Number of HIV-positive individuals receiving a minimum of one clinical service	100,932	
C2.3.D	C2.3.D Proportion of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	n/a	Redacted
	Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period.	65	
	Number of clients who were nutritionally assessed and found to be clinically	0	

	malnourished during the reporting period.		
	By Age: <18	65	
	By Age: 18+	0	
	Sum by age disaggregates	65	
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	95 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	95,908	
	Number of HIV-positive individuals receiving a minimum of one clinical service	100,932	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	1 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	640	
	Number of HIV-positive individuals receiving a	100,932	

	minimum of one clinical service		
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	88 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the reporting period	3,816	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	4,359	
	By timing and type of test: virological testing in the first 2 months	0	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	0	
C5.1.D	Number of adults and children who received food and/or nutrition services during the reporting period	69,699	Redacted
	By Age: <18	40,425	
	By Age: 18+	29,274	
	By: Pregnant Women	2,788	

	or Lactating Women		
	Sum of age disaggregates	69,699	
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	9,475	Redacted
	By Age: <1	53	
	By Age/Sex: <15 Male	267	
	By Age/Sex: 15+ Male	2,826	
	By Age/Sex: <15 Female	281	
	By Age/Sex: 15+ Female	6,101	
	By: Pregnant Women	2,076	
	Sum of age/sex disaggregates	9,475	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	74,842	Redacted
	By Age: <1	769	
	By Age/Sex: <15 Male	2,796	
	By Age/Sex: 15+ Male	25,234	
	By Age/Sex: <15 Female	2,820	
	By Age/Sex: 15+ Female	43,992	
	Sum of age/sex disaggregates	74,842	
T1.3.D	T1.3.D Percent of	93 %	Redacted

	adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy		
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	9,395	
	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.	10,139	
	By Age: <15	913	
	By Age: 15+	8,682	
	Sum of age disaggregates	9,595	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	523	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international	4	Redacted

	standards		
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	383	Redacted
	By Cadre: Doctors	30	
	By Cadre: Midwives	89	
	By Cadre: Nurses	200	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	2,898	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	9,376	Redacted
	By Type of Training: Male Circumcision	160	
	By Type of Training: Pediatric Treatment	668	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7158	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State	25,391,434
7160	Population Services International	NGO	U.S. Department of Defense	GHP-State	623,325
7162	U.S. Agency for International Development (USAID)	Other USG Agency	U.S. Agency for International Development	GHP-State	150,000
7335	American Refugee Committee	NGO	U.S. Department of State/Bureau of Population, Refugees, and Migration	GHP-State	144,911
7336	CHF International	NGO	U.S. Agency for International Development	GHP-State	4,902,054
9826	Voxiva	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	350,000
9978	FHI 360	NGO	U.S. Agency for International Development	GHP-State	1,687,592
9984	Emory University	University	U.S. Department of Health and	GHP-State	401,600

			Human Services/Centers for Disease Control and Prevention		
10193	Treatment and Research AIDS Center	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,421,039
10825	Ministry of Health, Rwanda	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	26,044,381
10827	American Association of Blood Banks	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	200,000
10954	Drew University	University	U.S. Department of Defense	GHP-State	1,498,766
10981	United Nations High Commissioner for Refugees	Multi-lateral Agency	U.S. Department of State/Bureau of Population, Refugees, and Migration	GHP-State	91,545
12133	National Center for Blood Transfusion, RBC	Host Country Government Agency	U.S. Department of Health and Human	GHP-State	2,092,369

	NCBT/CNTS		Services/Centers for Disease Control and Prevention		
12137	National AIDS Control Commission, Rwanda (CNLS)	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
12140	Rwanda School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	579,616
12141	Kigali Health Institute	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	256,087
12882	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	1,640,000
12968	National Reference Laboratory	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	977,218
13172	Population	NGO	U.S. Department	GHP-State	838,696

	Services International		of Health and Human Services/Centers for Disease Control and Prevention		
13598	JHPIEGO	University	U.S. Department of Defense	GHP-State	485,000
13704	University of Maryland	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	808,000
14287	Chemonics International	Private Contractor	U.S. Agency for International Development	GHP-State	5,976,861
14426	TBD	TBD	Redacted	Redacted	Redacted
16857	African Evangelistic Enterprise	FBO	U.S. Agency for International Development	GHP-State	720,000
16858	Caritas Rwanda	FBO	U.S. Agency for International Development	GHP-State	685,000
16859	Society for Family Health	NGO	U.S. Agency for International Development	GHP-State	1,105,000
16860	Francois Xavier Bagnoud Center	University	U.S. Agency for International Development	GHP-State	660,000
16966	TBD	TBD	Redacted	Redacted	Redacted
16967	New Partner	TBD	U.S. Agency for International Development	GHP-State	50,000

16986	TBD	TBD	Redacted	Redacted	Redacted
17016	Columbia University Mailman School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	424,640
17074	U.S. Peace Corps	Other USG Agency	U.S. Peace Corps	GHP-State	80,000

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7158	Mechanism Name: SCMS
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 25,391,434	
Funding Source	**Funding Amount**
GHP-State	25,391,434

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SCMS supports the Medical Procurement and Distribution Division (MPD), Pharmacy Task Force (PTF), National Reference Labs (NRL), and others. In COP12 SCMS' goal is to assist the Coordinated Procurement and Distribution System (CPDS) in forecasting and procurement planning for HIV/AIDS products, strengthen MPD's procurement processes, and capacity to procure commodities and contribute to the establishment of the Logistics Management Office (LMO). Key objectives are: quantification of national HIV/AIDS commodities' needs, improvement of LMO's capacities and capabilities to collect and ensure data quality for guiding logistics decisions, identify and pursue opportunities to strengthen procurement of commodities to meet scale-up requirements; and procure essential laboratory equipment and supplies.

In COP12 SCMS will provide first and second-line ARV drugs for 61,331 adults and 6,058 pediatric patients in 191 USG supported ART sites. This is 55% of all Rwandans currently on ARVs; the Global Fund covers the remaining 45%. During COP12 SCMS will continue to act as the procurement agent for a limited amount of commodity categories including ARVs until MPD is ready to procure USG funded products. SCMS will also provide TA to MPD and CPDS in procurement and quantification. Through SCMS support, MPD is preparing to receive direct USG

funding. SCMS has assisted MOH in the establishment of a LMO to take over logistics activities currently managed by SCMS. In addition to the monitoring and supervision activities, during COP12 SCMS will closeout and there will be a final supply chain assessment to evaluate the availability of HIV/AIDS commodities, and identify any transitioned areas of critical need.

3 vehicles were purchased under previous COPs; no vehicles planned in COP12.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	11,083,429

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**7158**		
Mechanism Name:	**SCMS**		
Prime Partner Name:	**Partnership for Supply Chain Management**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	630,000	0
Narrative:			
The recently rolled out logistics management information system (LMIS) now collects consumption data at the facility			

level for many HIV related products, including opportunistic infections (OI) drugs. The CPDS will be able to use this data to make more accurate quantifications. SCMS will procure products related to adult care.

SCMS will continue to provide technical assistance to MPD to assist them in storage and distribution of OI drugs for all PLHIV at USG-supported sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

In COP11 SCMS procured laboratory equipment, consumables, reagents, teaching materials and containers to transport histopathology samples from district hospitals to referral laboratories. In COP12 SCMS will continue to support laboratory diagnosis of extra pulmonary TB through procurement of histopathology reagents and consumables for two teaching hospitals (CHUK and CHUB) and 42 district hospitals. It is expected that histopathology laboratories of CHUK and CHUB will analyze 7,200 samples from patients at district hospitals and teaching hospitals.

During COP12 the procurement of TB testing reagents and consumables will also be funded. Funds will also be used to procure $100,000 in Isoniazid for treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	70,000	0

Narrative:

The GOR has made early detection of HIV-positive infants a priority in its plan to provide optimal care and treatment for children. The National HIV and AIDS Strategic Plan has set a target for 90% of children eligible for ART will be provided ART by 2012. Funds will be used for the procurement of pediatric ARV drugs. These drugs will help provide treatment for a targeted 6,058 pediatric patients through 191 USG supported ART sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	9,420,874	0

Narrative:

An assessment of the laboratory network was completed in 2011. In COP12 SCMS along with the CPDS, NRL and implementing partners will analyze the laboratory equipment gaps among USG supported sites. During COP12 PMTCT/lab equipment will be procured to support the expansion of USG supported PMTCT sites. SCMS will ensure continuity in lab supplies and reagents through consolidated forecasting, quantification, supply planning and continuing to build MPD's and CPDS' advocacy to increase resource mobilization for procurement. SCMS will

procure all the biochemistry, hematology, and CD4 supplies for an estimated 76,493 patients needed in COP12. The revised National ART Guidelines call for viral load testing in cases of suspected treatment failure. To meet the need for viral load testing, SCMS will quantify (jointly with MPD) and procure viral load reagents sufficient to cover the estimated needs of all USG-supported patients. SCMS may procure supplies and reagents for specific central-level activities and functions, including: 1) kits and supplies for PCR tests for the national EID program; 2) additional viral load kits and associated supplies for the laboratory component of the national ART program impact evaluation; 3) test kits and supplies for continuing HIV serology and CD4 testing Quality Assurance (QA) and training systems; 4) PCR supplies and reagents for expansion of PCR capacity to CHUB and as backup for the National Reference Laboratory (NRL); 5) supplies and reagents for opportunistic infections diagnostics for regional and district-level laboratories, as well as supplies for ongoing microbiology.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	850,000	0

Narrative:

Since 2007, SCMS has been supporting the GOR in strengthening the national supply chain for HIV/AIDS commodities (ARVs, OIs, and laboratory commodities). SCMS works closely with MPD, HIV-Division, NRL-Division, PTF, and District Pharmacies to establish the Coordinated Procurement and Distribution System (CPDS), the Logistics Management Office (LMO), and Active Distribution (AD). SCMS technical support to MPD will scale down in COP12 as previous support has significantly improved the operations of MPD. During COP12, limited support to MPD will focus primarily on building capacity of the procurement unit in preparation for it to eventually take on the procurement of USG funded commodities. In COP12 there will no longer be support to district pharmacies through SCMS, as this work will transition to the LMO in COP11. During COP 12, support for HIV & AIDS quantification will be limited to the participation of one or two technical advisors participating in the quantification and minor logistical support for the workshop. During COP12 SCMS will reduce external technical assistance, trainings, workshops, conferences and related costs to allocate funds with an emphasis on efficient, effective programming.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,330,560	0

Narrative:

Through the Coordinated Procurement and Distribution System (CPDS) and jointly with MPD, SCMS will continue to ensure the quantification and procurement of rapid test kits (RTKs). As part of the plan to build national capacity to quantify laboratory supplies at all levels of the system and ensure smooth functioning of the CPDS system, SCMS will continue to work closely with the CPDS and MPD to ensure the integration of rapid test kits into the system, including development of a supply plan incorporating RTKs, that will be updated on a quarterly basis. As Rwanda continues to strengthen its counseling and testing strategy and implementation, MPD will use the logistics management

information system (LMIS) data to analyze and report on district pharmacy and health facility stock levels on a regular basis to monitor consumption trends, potential stock outs, and make any revisions to procurement plans and projections. In COP12, the projected number for routine VCT will be 1.6 million.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	13,090,000	0

Narrative:

During 2009, MOH revised the ART Guidelines to progressively begin moving away from D4T and AZT-based regimens because of their long-term irreversible side effects, towards tenofovir (TDF) or ABC-containing regimens. During COP12 the gradual transfer of patients from D4T and AZT-based regimens to the TDF and ABC-based regimens will continue. Current levels of use of first-line regimens show that 28% of adults are on D4T-based regimens, 37% on AZT-based regimens and 34% on TDF-based regimens. It is anticipated that by the end of COP12, the level of use of D4T-based regimens will go down to 17%, AZT-based regimens will go down to 26%, and the level of use of TDF will rise to 52%.

During COP12, SCMS will purchase ARV drugs to continue and increase the provision of ART therapy for eligible adult and pediatric patients. SCMS will continue to provide first-line and second-line ARV drugs for approximately 61,331 adults and 6,058 pediatric patients in 191 USG supported ART sites. In addition to the existing patients, SCMS will provide first-line ARVs to an estimated 6,043 anticipated new patients initiating ART during COP12.

Improvements to the Rwanda supply chain have led to a significant one-time savings in commodities needs as the supply chain becomes leaner. These savings were passed on to other activities for COP 12. Patients supported by USG will still receive the care afforded them in previous years. Savings realized for COP12 are a one-time savings; COP13 HIV and AIDS drugs and commodities funding needs are expected to return to previous amounts.

During COP12 SCMS will work closely with MPD to support coordinated ARV drug procurement for USG supported sites. A consolidated approach for quantification and supply planning with the Rwanda's Global Fund support will increase cost savings, improve the efficiency of current procurements, and allow for building MPD's capacity through limited mentoring.

Implementing Mechanism Details

Mechanism ID: 7160	**Mechanism Name: PSI-DOD**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 623,325	
Funding Source	**Funding Amount**
GHP-State	623,325

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goals of the project are to reduce HIV incidence by increasing safer sexual behaviors among members of Rwanda Defense Forces (RDF) and their partners and to mitigate the impact of the HIV/AIDS epidemic by increasing access to and use of VCT and care and support services. PSI and Directorate of Medical Services (DMS) will reinforce the BCC messages transmitted through a peer education approach to military personnel and civilians surrounding military camps. These messages include: correct and consistent condom use, VCT and VMMC. Messages are communicated through IPC sessions and anti-AIDS clubs. These messages include the link between SGBV, alcohol abuse and HIV acquisition.

PSI is building the capacity of the DMS staff to assume leadership in HIV prevention, VCT and HIV care among the military. PSI has initiated joint supervision of the VCT team with the DMS personnel as a way of mentoring them in supervision and quality assurance. In collaboration with DMS, PSI has developed M&E tools which are used to collect data from BCC and VCT activities. PSI has trained DMS staff in data analysis using SPSS and DMS is now conducting analysis of the military VCT data. Similarly, military anti-AIDS clubs now lead in the implementation of HIV BCC and condom sales and distribution among the military. In COP12, PSI will develop the ability of the DMS to implement high quality VCT programs, and scale up their ability to provide a comprehensive package of HIV and STI prevention, diagnosis and treatment services through the brigade clinics. Cost savings will be achieved by shifting to decentralized programming, reducing travel expenses, and by use of DMS counselors for VCT instead of hired counselors.

Two vehicles were previously purchased; no additional vehicles are planned.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Military Population
Mobile Population
Family Planning

Budget Code Information

Mechanism ID:	**7160**		
Mechanism Name:	**PSI-DOD**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	120,000	0

Narrative:

New VCT counselors will be trained on the VM MC IEC materials (counselor flipcharts, male and female pamphlets, take home post-operative pamphlets). VCT counselor training will integrate VMMC content into pre- and post-test counseling using the appropriate IEC materials. PSI will produce playing cards (using already-approved messages) about condom use after MC to increase the knowledge on continued condom use after circumcision. Joint supervision visits will be carried out by DMS and PSI to provide guidance and encouragement to public opinion leaders and/or PEs in each anti-AIDS club. VCT QA Managers at PSI will carry out supportive supervision of DMS VCT Supervisors and counselors to ensure that MC is integrated into VCT services. New VCT counselors will be trained on MC IEC materials (counselor flipcharts, male and female pamphlets, take home post-operative pamphlets). These VCT counselors will integrate MC content into pre- and post-test counseling using the appropriate IEC materials.

PSI/Rwanda will train 200 PEs and military anti-AIDS club members on MC communications in order to create demand, educate about the procedure, and promote sustained safer sexual behaviors after MC (partner reduction and/or consistent condom use).

Description of the targets: 15 New VCT counselors and 100 PEs will be trained, 100% of uncircumcised men tested HIV negative will be referred to military hospitals for MC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	292,663	0

Narrative:

In COP12, PSI/Rwanda will build the capacity of the DMS to train the VCT teams in eight brigade clinics to provide quality VCT services to RDF, their spouses and surrounding community members (eight brigade clinics will be rehabilitated and their VCT staff trained to provide out-reach VCT services). A human resource development approach will include the provision of refresher training for RDF health care providers. This approach will help ensure ownership and sustained health impact at the end of the funding period. PSI/Rwanda will support the ongoing, regular data collection and analysis of client intake forms at DMS. Family planning (FP) and Voluntary Male circumcision (VMMC) messages will be integrated into pre- and post-test counseling using already-developed IEC materials on FP and VMMC. Additionally, a booklet promoting couples' testing in the military will be produced. HIV negative, uncircumcised soldiers will be referred to VMMC services, when and where available in the location soldiers are operating. Messaging about the importance of continued correct and consistent condom use after voluntary medical male circumcision (VMMC) will be highlighted. Joint supervision will be carried out by DMS and technical PSI staff (VCT QA Manager and Counselor Supervisors) to provide support to VCT counselors and ensure high quality counseling and data collection, with renewed focus on the client intake form. PSI/Rwanda will mentor DMS staff trained in SPSS in Phase 2 (Option Year 1) to carry out routine VCT Data analysis and publish the results in a report before the end of this phase.

Description of targets: 15 VCT counselors will be trained this year, and 8,000 individuals and 100 couples will be tested.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	210,662	0

Narrative:

PSI/Rwanda will transfer skills to the RDF to enable them to provide a comprehensive HIV prevention program to the Rwandan military and the community immediately surrounding the military barracks. PSI will train the RDF to use PSI's DELTA program planning process to use data generated through research and M&E to inform the development of a comprehensive BCC campaign that includes both interpersonal communications (IPC) and mid-media (e.g. print

materials, events and video). This training will give the RDF the tools needed to design and implement their own BCC program with decreasing support from partners like PSI over time. PSI will further develop the capacity of the RDF to train, support and supervise 100 military, civilian and commercial sex worker (CSW) PEs from anti-AIDS-clubs. The RDF will ensure that PEs are equipped with condom demonstration kits and are able to deliver high quality individual and small group IPC sessions. Messages disseminated by PEs will focus on correct and consistent condom use, VCT/STI services and care and treatment. These IPC activities will be supported by print materials and mobile video unit (MVU) events. PSI will build the capacity of RDF staff to implement MVU events independently, and to maintain their MVU equipment. *PSI/Rwanda will support the RDF to train military anti-AIDS clubs in retail outlet creation for condoms and community-based distribution of Prudence condoms and Sur Eau point-of-use water treatment solution. These efforts will ensure the availability of condoms in retail outlets and hotspots in communities surrounding military camps. Revenues will be used to strengthen anti-AIDS clubs. PSI Rwanda will continue to produce military-specific "camouflage" condoms to create demand, encourage military personnel to use condoms and to increase consistent condom use. The military condom will be supported by promotional materials including branded polo and regular t-shirts and playing cards promoting correct and consistent condom use.* *Description of targets: 50,000 individuals will be reached with OP messages through small groups and 30,000 individuals will be reached through special events, 100 PEs will be trained and 1,000,000 condoms will be distributed.*

Implementing Mechanism Details

Mechanism ID: 7162	**Mechanism Name: Central Contraceptive Procurement**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: U.S. Agency for International Development (USAID)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 150,000	
Funding Source	**Funding Amount**
GHP-State	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USG continues to procure condoms for the private sector while the GOR has begun procuring condoms for the public sector. Condom use is increasing as distribution of public sector condoms expands through community health workers. In COP11, USG supported the distribution of approximately 9.7 million condoms through the private sector marketed under the brand "Prudence". Additionally, approximately 850,000 of condoms under the brand "Plasir" were procured by the Global Fund supported program. Use is expected to increase at a rate of 5% per year in the private sector, while public sector condoms are anticipated to increase significantly as distribution is expanded through the community health worker level and as private pharmacies are now requested to distribute public sector condoms for free. Purchasing condoms supports the HIV/AIDS prevention program.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**7162**
Mechanism Name:	**Central Contraceptive Procurement**
Prime Partner Name:	**U.S. Agency for International Development (USAID)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	150,000	0

Narrative:

In COP12, this activity will provide for the shipment of approximately 12 million condoms. The population targets for procured condoms are youth (15-29 years old), men with discretionary income, other MARPs, PLHIV, discordant couples, and general population nation-wide.

Implementing Mechanism Details

Mechanism ID: 7335	**Mechanism Name: ARC**
Funding Agency: U.S. Department of State/Bureau of Population, Refugees, and Migration	Procurement Type: Contract
Prime Partner Name: American Refugee Committee	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 144,911	
Funding Source	**Funding Amount**
GHP-State	144,911

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In COP12, ARC Rwanda will continue to strengthen its comprehensive HIV/AIDS Prevention, Care and Treatment programs in the Gihembe and Nyabiheke Refugee camps. Each of the nine PEPFAR program areas will be addressed with full and consistent community participation in the program planning, implementation and review process.

The goal of ARC's HIV/AIDS program in Rwanda is to decrease the rate of HIV infection among the targeted population and provide quality care and treatment services for infected individuals. Monitoring and evaluation of all program activities will be done at the field level via weekly and monthly reporting and data quality control.

No vehicles have been purchased, leased or planned under this mechanism

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	1,449
Food and Nutrition: Policy, Tools, and Service Delivery	1,449
Gender: GBV	2,898
Human Resources for Health	99,492

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**7335**
Mechanism Name:	**ARC**
Prime Partner Name:	**American Refugee Committee**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	30,874	0

Narrative:

The funding for this activity will support the provision and expansion of palliative care and clinical services, as well as the training of health providers, laboratory technicians, PLHIVs, Home-Based Care Providers and community volunteers. ARC will ensure the provision of in-patient and out-patient clinical services, including diagnosis and treatment of opportunistic infections. ARC will provide palliative care services including routine psychosocial support, home-visits, identification and training of Home-based Care Providers (HBCPs), PLHIV Associations, and routine trainings for PLHIV and HBCPs that include information on nutrition, positive living, ARV adherence and self-care. In partnership with WFP, ARC will provide supplemental food to all PLHIV in the camps regardless of their ART status. ARC will monitor and evaluate basic care activities through ongoing supervision, QA, and data quality controls. ARC will also continue to build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS basic care activities through ongoing strengthening of routine data collection and data analysis for basic care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	15,403	0

Narrative:

In FY 2007 ARC began implementing the national TB/HIV policy and guidelines at their two supported sites. ARC's goal is to ensure that 100% of TB patients are tested for HIV, and 100% of those who are eligible receive Co-trimoxazole and 100% of those eligible receive ART. In addition, at ARC HIV care and treatment sites, 100% of patients enrolled in HIV care will be routinely screened for TB, with the continued priority in COP12 to ensure regular TB screening for all PLHIV, and for those with suspected TB, ensuring adequate diagnosis and complete treatment, as well as appropriate referral for all cases of multi-drug resistant TB. ARC will continue to build the capacity of national health staff by providing refresher trainings on TB and TB/HIV. ARC will monitor all TB activities through ongoing supervision, QA, and data quality controls, as well as national-level reporting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	2,991	0

Narrative:

The funding for this activity will support the provision of early infant diagnosis and the expansion of palliative care and clinical services, as well as the training of health providers, laboratory technicians, PLHIVs, Home-Based Care Providers and community volunteers. ARC will ensure the provision of in-patient and out-patient clinical services, including diagnosis and treatment of opportunistic infections, as well as OI prophylaxis including provision of Co-trimoxazole. In addition, ARC will provide palliative care services including routine psycho-social support, home-visits, identification and training of Home-based Care Providers, PLHIV Associations, and routine trainings for PLHIV and HBCPs that include information on nutrition, positive living, and self-care. In partnership with WFP, ARC will provide supplemental food to all PLHIV in the camps regardless of their ART status, and ARC will

also provide supplemental milk to all infants born to HIV-positive mothers (from 6-24 months). Infants born to HIV-positive mothers will be provided with CTX; early infant diagnosis through PCR; and ongoing clinical monitoring and staging for ART. ARC will monitor and evaluate basic care activities through ongoing supervision, QA, and data quality controls. ARC will also continue to build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS basic care activities through ongoing strengthening of routine data collection and data analysis for basic care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	15,249	0

Narrative:

ARC will reach more refugees with CT by strengthening provider initiative HIV testing (PIT) for patients at the consultation level, as well as all TB and STI patients, malnourished and non-thriving infants, and patients presenting with HIV-related illnesses. In line with a revised strategy for a family-centered approach to CT, ARC will provide training for staff in approaches for reaching family members of HIV-positives including improved counseling techniques to increase disclosure and encourage partners and family members to get tested, and contact tracing through care coordinator at the refugee facility. Ongoing community-based campaigns will utilize refugee groups, refugee community leaders, and PLHIV to communicate HIV/AIDS stigma reduction messages and promote CT. Health providers will receive training and refresher training on PIT, as well as in counseling for youth, male partners, and other targeted populations in refugee camp settings. Counseling will emphasize partner reduction, stigma, and alcohol reduction to sensitize clients to issues related to GBV, as well as confront social norms that contribute to these issues. To ensure quality CT service delivery, ARC will provide supportive supervision of CT staff through QA, monitoring provider performance, and routine quality reviews and will continue to support and strengthen the capacity of refugee health care providers to monitor and evaluate CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	6,306	0

Narrative:

The 2004 UNHCR BSS and the FHI-supported Reproductive Health assessment found high risk behaviors among refugee camp populations, including multiple partners, transactional sex, male cultural and societal norms that encourage high-risk behaviors and GBV, low condom use, and alcohol abuse. ARC will program for Prevention with Positives (PwP), targeting HIV-positive refugee patients, including discordant couples. ARC will strengthen the existing condom distribution programs, by further increasing the number of condom distribution sites throughout the camp, and ensuring that information on condoms is included in all HIV-related trainings and discussions. Target populations for condom messages include VCT clients who test negative, non-married and unemployed men/women, out-of school youth at-risk, STI clients, community health workers, and refugees with demonstrated high-risk behaviors such as alcohol abuse. ARC will monitor and evaluate prevention activities through ongoing

supervision in all sectors as well as routine QA of all prevention activities. ARC will also continue to build the capacity of local refugee staff to monitor and evaluate HIV/AIDS prevention activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	16,412	0

Narrative:

ARC will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, ARV prophylaxis using combination ARV regimes and HAART for eligible women, close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis. Overall this will further ensure that PMTCT clients and their families have access to a comprehensive network of services, linking PMTCT services with other HIV and MCH interventions, including integrated FP counseling, and assure an effective continuum of care by increasing patient involvement and community participation. In partnership with the World Food Program (WFP) supplemental food will be provided to all pregnant and breastfeeding women and ARC will supply supplemental milk to all infants born to HIV-positive mothers (from 6-24 months). Health center staff will receive refresher on-the-job training in the expanded national PMTCT protocol as well as refresher training on family planning (FP). In addition, ARC will conduct performance improvement and quality assurance of PMTCT services through regular supervision of sites, coaching and strengthening capacity of sites in monitoring and evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	52,053	0

Narrative:

HIV treatment for eligible adults will be implemented according the national guidelines, with routine clinical monitoring, including CD4 counts every six months, viral load counts for patients on HAART every 12 months, management of ARV drug side effects, and ongoing adherence counseling. ARC also supports nationally certified training for health care workers in the camps in provision of ART, adherence counseling, ongoing clinical monitoring, management of ART-related side effects, and referrals. ARC will strengthen communication and referral linkages between services provided at the camps and the local district hospital as well as ensure transportation of specimens for all laboratory tests not available in the camp.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	5,623	0

Narrative:

HIV infected infants and children will be provided with ART according to national guidelines, with routine follow-up clinical monitoring, CD4 count every six months, viral load counts for clients on HAART every 12 months,

management of ARV drug side effects, ongoing adherence counseling, patient referral to palliative care services. ARC also supports nationally certified training for health care workers in the camps in provision of ART, adherence counseling, ongoing clinical monitoring, management of ART-related side effects, and referrals. In addition, ARC will strengthen the network of services offered between the camps and the district hospital as well as ensure transportation of specimens for all laboratory tests not available in the camp, and strengthened communication and referral systems.

Implementing Mechanism Details

Mechanism ID: 7336	**Mechanism Name: Higa Ubeho**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: CHF International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,902,054	
Funding Source	**Funding Amount**
GHP-State	4,902,054

Sub Partner Name(s)

Caritas Rwanda	Catholic Relief Services	Eglise Episcopal au Rwanda, Diocese de Shyira (EER)
Eglise Presbyteriénne au Rwanda (EPR)	Icyuzuzo Womens Group	

Overview Narrative

CHF/Higa Ubeho will continue to support stability and resiliency for up to 72,000 HIV/AIDS affected and other vulnerable Rwandan households in 20 districts. Strategic objectives include: increasing vulnerable household access to quality health and social services; improving household resilience through economic, nutritional and educational investments; and strengthening civil society capacity for health and social service provision. The program is supportive of both USG and GHI strategic objectives. In COP12, Higa Ubeho will continue to support household resilience (economic strengthening, food security, nutrition, and health and social services), care and support and

HIV prevention to OVCs and their families. In COP12, Higa Ubeho will begin to implement transition and handover strategies to its Rwandan civil society partners, GOR, and households themselves, ensuring that household revenues will be leveraged towards more household responsibility for school fees, school material, and health insurance payments. The program will also begin transitioning from international to local partners. Proposed budget levels may require a review of planned targets and partnerships for COP12.

A total of three vehicles will be purchased throughout this mechanism (one in COP10 is already purchased, and two are planned for COP11 time period).

Cross-Cutting Budget Attribution(s)

Economic Strengthening	784,329
Education	2,451,027
Food and Nutrition: Policy, Tools, and Service Delivery	196,082
Gender: GBV	98,041
Human Resources for Health	147,062

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Child Survival Activities
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	7336		
Mechanism Name:	Higa Ubeho		
Prime Partner Name:	CHF International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	455,750	0

Narrative:

In COP12, Higa Ubeho will continue its approach to economic strengthening by increasing revenues of targeted households through integration into profitable markets and value chains; increasing employment opportunities for 1,500 child-headed households (CHH) and other vulnerable youth (18-22 years old) through marketable vocational training and apprenticeships; and increasing household savings through greater participation in the more than 2,000 already established Internal Savings and Lending Groups (ISLG). The program will also provide targeted food security assistance to vulnerable households through promotion of more than 300 Farmer Field Schools, in addition to improved household nutrition through an estimated 300 PD Hearth groups and media-based behavior change outreach efforts . Higa Ubeho will continue to work with well-organized and established cooperatives which serve as models for more nascent business groups. The program will not establish new ISLGs; rather it will continue to consolidate the existing ones by strengthening them and supporting their evolution towards functional business organizations where relevant and feasible. ISLG members will be encouraged to save money for their household's health and education expenses, with the program linking them to formal banking institutions such as Umurenge, SACCOs (Saving and Credit Cooperatives) and Micro Finance Institutions (MFIs) as means of accessing credit.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	4,286,304	0

Narrative:

In COP12 Higa Ubeho will continue to provide financial and technical support to at least 10 Rwandan Partner Organizations (RPOs) supporting activities in 20 districts, reaching up to 50,000 OVC with a menu of services including education support, health insurance, psychosocial support, HIV prevention, and SGBV prevention activities. The program will continue support at the primary and secondary school level, with a focus on transition to increased program implementation by RPOs, including leveraging gains in household revenues through economic strengthening activities to reduce the subsidies being provided towards school fees and materials, both for sustainability measures and greater cost effectiveness within this reduced budgetary environment. No new students in S1 and S4 (first year and fourth year high school, respectively) outside of the 9YBE education system will be supported in COP12. Continued emphasis will be placed on technical and vocational training, in support of priority GOR strategies in this area, and towards marketable employment skills recommended by the Rwandan Workforce Development Authority. Higa Ubeho will also continue to support under 5 OVC through play groups coordinated at the sector level and nutrition support (PD Hearth groups). Special attention will be given to child-headed households

through the support of youth ISLG. The program will also continue to support national OVC strategies and priorities through close collaboration with the Ministry of Gender and Family Promotion (MIGEPROF); however, resources will no longer be allocated for seconded staff to the ministry.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	80,000	0

Narrative:

In COP12, Higa Ubeho will continue to provide financial and technical support to at least 10 Rwandan Partner Organizations (RPOs) to reach up to 50,000 OVC and up to 72,000 most vulnerable households in the intervention catchment areas. In addition, these RPOs will deliver "Live a Productive Life" messages to program beneficiaries through existing community intermediaries (CI), existing Internal Savings and Lending Groups (ISLGs), Famer Field School (FFS), and Positive Deviance Hearth Groups. Higa Ubeho will continue to build the institutional capacity of RPOs and mobilize community intermediaries to improve and expand vulnerable groups' access to essential health and social services, and to build more resilient families through economic and social coping mechanisms. Higa Ubeho will continue to work with these local organizations to build their capacity to manage programs, finances, and human resources with the goal of directly receiving donor funding in the future. Following the annual capacity assessment of each RPO, the program will agree on a capacity building and implementation plan tailored to each organization's particular needs. Formal trainings will be very limited and RPO capacity building will focus more on TA and one-on-one mentoring and coaching towards transitioning more program ownership to these organizations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	80,000	0

Narrative:

In COP12, Higa Ubeho will target vulnerable OVC and PLHIV households with organized communication activities to influence preventative community and social norms. Other Prevention messages will be delivered through a variety of approaches including interpersonal communication, radio and community events. Higa Ubeho's weekly radio program will continue to mobilize program beneficiaries and other community members and promote behavior change. These messages will give voice to PLHIV and their families, as well as service providers, providing practical, immediate actions that they can take to improve their quality of life. Messages will focus on the full package of community-based health, social and economic development services provided by Higa Ubeho, as well as other wrap-around programs such as malaria prevention and sexual and gender based violence prevention. The program will also continue to look towards leveraging Internal Savings and Lending Groups (ISLG), Famer Field School (FFS), and Positive Deviance (PD) Hearth groups as channels through which communication can be delivered.

Implementing Mechanism Details

Mechanism ID: 9826	Mechanism Name: HIV/AIDS Reporting System/TRACNet
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Voxiva	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 350,000	
Funding Source	**Funding Amount**
GHP-State	350,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TRACnet is a national HIV/AIDS and infectious disease electronic reporting system deployed in more than 465 health facilities in Rwanda. The goal by the conclusion of the TRACnet project is to improve quality of care through effective and efficient use of health data by health care providers, program managers and political leaders in Rwanda. This will be achieved through four main objectives: build local human capacity to manage, sustain and expand TRACnet; maintain and upgrade TRACnet; improve TRACnet data quality; and promote TRACnet data use. This project will contribute to the achievement of the Partnership Framework Goals in Strategic Information, so that evidence-based policies and plans are developed, updated, monitored and evaluated, and a culture of data use is promoted and instilled. Data will be collected from and feedback provided to all health facilities across the country and by September 2012, there will be more than 3,500 trained users routinely accessing the system to monitor and report on HIV/AIDS, Early Infant Diagnosis and Integrated Disease Surveillance and Response (IDSR) Programs. The TRACnet system will support nationwide surveillance of HIV and 18 epidemic prone diseases under surveillance in Rwanda. Five modules – IDSR, ART, VCT, PMTCT and PCR – will be using the same platform. Voxiva will monitor and provide regular status on system usage; human capacity development; data use & data quality. The activities will be monitored through regular meetings with CDC activity manager. No vehicles were purchased since the onset of the project however; a car was leased for TRACnet activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	105,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9826		
Mechanism Name:	HIV/AIDS Reporting System/TRACNet		
Prime Partner Name:	Voxiva		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	350,000	0

Narrative:

In COP12, Voxiva will work in support of RBC/IHDPC. The TRACnet project will focus on:

• Building local human capacity to manage, sustain and expand TRACnet. This will be done by supporting skills and experience development of the local core team at RBC/IHDPC (the Project Director and Project Manager) and additional human resource as identified by the MoH. The focus will be to enhance the capacity of the core team on different knowledge areas to ensure that Rwanda can sustain and build on TRACnet to meet the ongoing needs of the health sector.

• Working with RBC/IHDPC and the E-health department of MoH to maintain and upgrade TRACnet. Additionally, Voxiva will continue to host, provide communications, software maintenance and application management services to keep TRACnet operational and available in the production environment. It is intended that this capacity will be built within RBC/IHDPC for long-term sustainability of TRACnet.

• Working with the GOR and key stakeholders to continue improving data quality in TRACnet. Voxiva will still monitor and address issues related to data quality checks and validation rules on the TRACnet system. It is intended

that this capacity will be built within RBC/IHDPC for long-term sustainability of TRACnet.

Implementing Mechanism Details

Mechanism ID: 9978	**Mechanism Name: ROADS II**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,687,592	
Funding Source	**Funding Amount**
GHP-State	1,687,592

Sub Partner Name(s)

Abishizehamwe: Bugarama PLHAs Clstr Comm Pall Prog	ADESPCR: Kigali Youth Cluster HIV/AIDS Program	ASOFERWA: Kigali Low Income Wmn Cluster HIV/AIDS Prog
ASSETAMORWA: Kigali Motorcyclists' HIV Prev Prog	Bugarama Islamic Health Center	Byumba Diocese: Gatuna Church Clstr for Comm HIV
CODEPEK: Rusizi Fishers' Federation HIV/AIDS Program	COFEM: Rusizi low income HIV/AIDS Program	COODIPRIB-Duteraninkunga: Bugarama Low income HIV/AIDS
DAI	Gihogwe Health Center: Gatsata Mobile C&T	JHU/CCP/AFRICOMNET-
Kigufi Health Center, Rwanda	Masaka Health Center, Rwanda	Muganza Health Center
Ngoboka Dufatanye Rusizi PLHAs Cluster Comm.	PACE	Program for Appropriate Technology in Health
Rusizi Health Center St Francois: Outreach C&T svcs		

Overview Narrative

ROADS II's goal is to stem HIV transmission and mitigate its impact among most-at-risk populations (MARPs) along

the transport corridors and in cross-border communities. ROADS II harmonizes and coordinates with GOR priorities identified in the Partnership Framework related to prevention, care, support, impact mitigation, and community-based health systems strengthening. ROADS II fulfills transition and long-term sustainability objectives through strengthening community capacity in leadership, management, health information and health service delivery, community-led & owned activities, facilitative and TA roles vis-à-vis local institutions; and, assuring social and financial risk protection. ROADS II will continue to focus on high visibility Safe-T-Stop centers where transient populations access services; income generating activities like LifeWorks© dedicated to reducing socio-economic vulnerabilities; organizational strengthening and capacity development of cooperatives; outreach VCT; care and support to OVC and PLHIV; community-based Positive Prevention through PLWH associations to reduce risky behaviors, promote condoms, treat and manage STIs, and access counseling and support for VCT, family planning and reproductive health; and full integration of FP, MCH, child survival messages and linkages to all health services. In COP12, ROADS II will strengthen RPOs to implement activities and reinforce organizational competencies of the "clusters" of community-based organizations to ensure sustainability, increase cost efficiencies and conduct an end-of-project evaluation.

From the start of the mechanism through COP11, one vehicle and three motorcycles were purchased for project use. No new purchases are planned in COP12.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	219,387
Education	286,891
Food and Nutrition: Policy, Tools, and Service Delivery	118,131
Gender: GBV	50,628
Human Resources for Health	84,380
Key Populations: FSW	421,898

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities
Mobile Population
Safe Motherhood
Workplace Programs
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**9978**
Mechanism Name:	**ROADS II**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	206,470	0

Narrative:

During COP12 ROADS II will support local civil society to target care and support services to 22,163 PLHIV and their family members. The services will include income generating activities, psychosocial, spiritual, shelter, water and sanitation, legal aid and nutrition through kitchen gardening and the introduction of urban and rural organic farming technology. ROADS II implementation strategy is focused on building local PLHIV civil society group capacity to address community care and support for HIV prevention. In COP12, ROADS II will continue to assist PLHIV clusters in Kigali city, Gatuna, Rusizi, Bugarama and Gisenyi. ROADS II will reinforce mentoring systems and conduct continuing education for 350 existing volunteers in basic palliative care including, ART adherence, HIV and STI prevention, referrals for clinical services and various forms of support (psychosocial, spiritual) as well as nutrition education and food security services, reproductive health services, water and sanitation. The income generating activities will enable PLHIV to assure social and financial risk protection so that no PLHIV becomes impoverished as a result of their status while building resilience to support basic needs such as paying health insurance. In total, 11,000 PLHIV and household members will be targeted with a minimum package of care.

Regular monthly meetings for volunteers and cluster technical staff will be used to ensure program fidelity and

ROADS II sites-based data managers will continue to provide mentorship to clusters for quality improvement as they continue to assess the efficiency and effectiveness of data-management systems.

ROADS II will continue to monitor the performance of PLHIV clusters. The established quarterly coordination meeting for performance review will be used and strengthened. Data will be collected by the volunteers, validated at the cluster level then by the ROADS II site coordinators before being entered into an existing database at the cluster level for analysis at the Kigali level by the ROADS II M&E technical officer. Finally, in-depth data analysis and program evaluation will be done to document the outcomes of the intervention on the individual and household.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	350,000	0

Narrative:

ROADS II provides technical and financial support to local civil society partners to support under 18-years old OVCs in five sites: Kigali city; Gatuna, Rusizi, Bugarama and Gisenyi. Key activities includes efforts to improve health care through health insurance subscriptions, food and nutrition support, and education of tutors and caregivers on balanced nutrition, psychosocial support, HIV prevention, child protection through children rights education. At the end of September 2011, a total of 4,506 OVC were provided services. In COP12, ROADS II will: strengthen its caregiver mentoring system through community clusters; provide at least one service to 3,475 OVCs ; and strengthen the capacity of household and local community groups to ensure program effectiveness. Services will be linked closely through a strong referral network including health facilities and CBOs, FBOs, and local NGOs to meet the daily needs of OVC as part of the transition strategy. In COP12, ROADS II will continue to address sustainability by addressing the longer-term needs of orphans through use the Lifework strategy to support OVC households to use identified economic opportunities to increase their income to help many OVC to graduate from ROADSII's support.

Regular monthly meetings for care givers and cluster technical staff will be used to ensure quality of services and achievements. Sites based data managers will involve cluster members to conduct a data quality audit at IP levels to assess the efficiency and effectiveness of data-management systems and provide constructive feedback. The Child Status Index tool previously used to assess the quality of OVC services offered by the program will continue to be the reference of community care givers for quality services improvement.

The activities of this project will fit into the overall ROADS II M&E framework. The project will document results as well as impact achievements and local civil society partners' technical staff will be trained on effective results reporting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Governance and Systems	OHSS	253,720	0

Narrative:

In line with the GOR's policy to make CBOs more self-sustaining, ROADS II will support local civil society organizations through capacity building, financial management, monitoring and evaluation, data utilization and basic planning. In COP12, ROADS II will continue to work with local implementing partners through cluster management team training (technical staff and cluster steering committee members) on program and cooperative management and empowering cluster group members, especially women, in improved decision making to better respond to health system gaps in health and HIV/AIDS.

During COP12, the ROADS II project will provide technical assistance to 372 community based civil society organizations through 17 established clusters of community organizations to facilitate the empowerment of communities to understand and solve their own problems around health and determinants of health. ROADS II will continue to mentor civil society cluster steering committees to lead overall strategic design, coordination and planning of cluster activities and will continue to support efforts for cluster management, technical, administration and finance staff to oversee the daily operations, coordination and execution of cluster activities with the objective of promoting ongoing decision making beyond the life of the project and promotion of civil society in the national response to public health issues.

During COP12, ROADS II will conduct institutional capacity assessments of all local community implementing partners. Based on the results, a capacity building plan will be developed. During COP12, ROADS II will reinforce the capacity of civil society organizations, who will be currently implementing community interventions, based on capacity building plans to support civil society graduation to independently seek donor funds. In addition, ROADS II will train 91 civil society boards of directors and technical staff in proposal development and project management to ensure sustainability and support the transition from sub-grantee to independent grantee. For monitoring and Evaluation, ROADS II will conduct quarterly progress reviews based on the key benchmarks that will be fixed after the first evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	283,720	0

Narrative:

During COP12 ROADS II will continue to reach most-at-risk groups and stop-over site communities that include the female sex workers whose HIV prevalence is estimated at over 50% (Rwanda BSS 2010), truckers, youth between 15-24 years, as well as other risk groups with less access to existing CT services. ROADS II will facilitate integrating CT services in outreach strategies from fixed CT services.

During COP12, ROADS II will continue to support outreach CT services in Kigali City; Gisenyi, Rusizi, and

Bugarama to reach trucks drivers and their assistants, commercial sex workers and their partners, in-street youth, OVC, motor bikers and mechanics, low-income women, men and other community members. The innovative approach of systematic HIV testing for those MARPs screened for sexual transmitted infections and MARPs tracking-notification cards introduced in COP11, will continue to be supported. In total, ROADS II plans to reach 17,000 high-risk individuals with CT services in seven CT service outlets.

The quality of services being offered in the CT outlets will be assessed by using the client exit form and results analyzed on a semi-annual basis to assess client satisfaction; and as part of quality control 10% of all client lab samples will be sent to the national reference laboratory for verification and ROADS II will continue to work with district hospitals for formative supervision of the CT sites.

In COP12 ROADS II will continue to ensure evidence-based programmatic decision making by facilitation of on-going monitoring of CT service delivery.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	593,682	0

Narrative:

ROADSII continues to serve MARPs in Kigali City, Gatuna; Rusizi; Bugarama, and Gisenyi. The targeted groups are truckers, motor bikers, fishermen, mechanics, in-street youth and other stop-over site communities that include high-risk youth, low income women, PLHIV, and sex workers. In addition to social networking used by peer educators (PEs), specific groups such as female sex workers are reached for STI screening and management by trained PEs and health centers. In COP12 ROADSII will reinforce HIV prevention for MARPs through PEs, the social networks model, and community mobilization aimed to promote HIV prevention behaviors like consistent and proper use of condoms, reduction of alcohol consumption, and reduction in sexual gender-based violence. During COP12, interventions targeting FSW, in-street youth, PLHIV and girls will continue as well as MARPs tracking-notification cards introduced in COP11. The MARPs bar-based interventions initiated in COP11 will be strengthened and documented. ROADS II will also reinforce linkages with health services to ensure MARPs receive the MOHs prescribed minimum package of care. In COP12 linkages with the private sector and ROADSII's Lifeworks to create and provide opportunities for increasing access to income generating activities and markets, as an HIV prevention strategy will also be strengthened. In COP12 these combined strategies will target 137,500 people with individual and/or small group level evidence-based interventions. In addition, 128,000 individuals will be targeted through community wide events in support of PE interventions.

Continuing education and appropriate supervision will continue to ensure activity fidelity to maintain quality and achieve results. Site-based data managers with cluster members will continue to conduct data quality audits to assess the efficiency and effectiveness of data-management systems.

Implementing Mechanism Details

Mechanism ID: 9984	Mechanism Name: Project San Francisco
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Emory University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: Both	
G2G: No	Managing Agency:

Total Funding: 401,600	
Funding Source	**Funding Amount**
GHP-State	401,600

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Since 1986, Emory University's Project San Francisco (PSF) has been Rwanda's national leader in the effort to identify & respond to the HIV/AIDS epidemic through Couples HIV Counseling and Testing (CHCT). The great majority of new HIV infections in Rwanda are acquired from an HIV-positive spouse or cohabitating sexual partner. In these "discordant couples" (where one partner is HIV-positive and the other is HIV-negative), CHCT reduces HIV transmission from 12-20% per annum (for un-counseled couples that do not know their sero-status) to 3-8% per annum (for those couples that are counseled and observed following joint testing). PSF has developed curricula and trained health professionals in the most effective techniques of this intervention. PSF proposes to continue to provide technical assistance (TA) to the Institute of HIV/AIDS, Disease Prevention and Control (IHDPC), implementing partners, and health care facilities in CHCT and follow-up of discordant couples.

PSF will continue to partner with the HIV Prevention Team at IHDPC to provide TA for implementation of CHCT. In COP12 PSF will provide mentorship to health centers in the city of Kigali for the follow-up & monitoring of the discordant couples follow-up program. In addition, PSF proposes to provide direct TA and mentoring to an additional 15 high volume clinics in Kigali to document incident infection. The selected health centers will provide data on the incidence of HIV infection among discordant couples. PSF will also provide TA to IHDPC and stakeholders to implement CHCT indicators developed in COP11, & train supervisors at the district-level on the monitoring &

evaluation of CHCT services and follow-up of discordant couples in clinics throughout Rwanda.

The project does not plan to purchase or leas

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	20,080
Human Resources for Health	120,480

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**9984**
Mechanism Name:	**Project San Francisco**
Prime Partner Name:	**Emory University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	366,000	0

Narrative:

More than ninety percent (90%) of new HIV infections in Rwanda are acquired from an HIV-positive spouse or

cohabitating sexual partner. PSF will continue to partner with IHDPC and other HIV implementers to provide technical assistance for implementation of CHCT and follow-up of discordant couples in at least 15 health centers. A technical support will also be provided for training and deploying 60 Trainer-of-Trainers (TOT) who are equipped to conduct additional CHCT trainings and provide TRAC-Plus with Monitoring and Evaluation of CHCT operations in clinics.

In COP12, PSF will support the National Program to develop, institutionalize and ensure data collection and use related to outcome indicators on the Discordant Couples Services in accordance with the Guidelines for Discordant Couples. PSF will also support the National Program in documenting HIV incidence in cohorts of discordant couples in the National Program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	35,600	0

Narrative:

Evidence suggests that the majority of new HIV infections in Sub-Saharan Africa occur within stable cohabiting relationships, and that there are high rates of sero-discordance among heterosexual couples. In Rwanda, it is estimated that about 55% of new infections or ~6000 new infections (27 – 92%) occur in stable, cohabiting sero-discordant couples.

Couples HIV counseling and testing (CHCT) is one HIV prevention initiative addressing this gap whereby couples receive joint HIV counseling and testing (HCT) and supported mutual disclosure of their HIV status. CHCT is associated with increased condom use and reduced HIV transmission among discordant couples receiving the intervention. Through the USG support, a Couples HIV Counseling and Testing (CHCT) Intervention and Training Curriculum was developed in response to increased demand for interventions and training that would help address the complex issues related to HIV counseling and testing with couples.

Family planning is viewed by the GOR as a key intervention to reduce poverty and maternal and infant mortality. The Ministry of Health aims to increase the prevalence of modern contraceptive use by increasing the demand in the population, and by increasing and improving the supply of services offered by health care institutions. Using Couples HIV Counseling and Testing (CHCT) CDC approved curriculum, PSF will integrate HIV couples counseling and testing with family planning services presents an important opportunity to involve men in family planning decisions, and it has been shown to reduce the incidence of unplanned pregnancies by fifty percent (50%). The combination of family planning and couples HIV counseling and testing services is also an important strategy for prevention of mother-to-child transmission of HIV.

PSF will assist health centers to integrate family planning services in CHCT services. The training for

nurse/counselors will emphasize the voluntary nature of family planning, the importance of informed choice, the reasons for family planning, the full range of methods available and the advantages and disadvantages of each.

Implementing Mechanism Details

Mechanism ID: 10193	**Mechanism Name: TRAC Cooperative Agreement**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Treatment and Research AIDS Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 3,421,039	
Funding Source	**Funding Amount**
GHP-State	3,421,039

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Following the recent MOH restructuring and creation of the Rwanda Biomedical Center (RBC), TRACPlus has been merged into the Institute of HIV/AIDS and Disease Prevention and Control (IHDPC), an institution within the RBC. The former TRACPlus received PEPFAR support for activities that are now within the HIV, TB, and Epidemic Infectious Diseases Divisions under RBC/IHDPC. The mission of RBC/IHDPC/HIV Division is to provide evidence-based, technical leadership for the prevention and control of HIV & AIDS, through independent applied research, multi-stakeholder participation, and for improved quality of services and strengthened health systems. In addition, RBC/IHDPC ensures quality of services for HIV/AIDS, STIs and blood-borne diseases at health facilities through trainings, formative supervision, clinical mentorship, and data reliability and validity assessments. The overall goal of this project is to improve national surveillance capacity and the planning, implementation and evaluation of HIV/AIDS prevention, care and treatment programs. RBC/IHDPC is also in charge of developing, updating, printing and distributing guidelines and protocols, strengthening the community DOTS approach, MDR TB suspect identification and improving sample transportation. RBC/IHDPC has the mandate to improve integrated

disease surveillance and to conduct capacity building activities for health care providers, including activities through the Field Epidemiology and Laboratory Training Program. Following national regulations, RBC contracts a company that provides vehicles for field work. Request for those vehicles are made on an as needed basis. Two trucks for the transportation of mobile X-ray machines were purchased in 2011 for the TB prevalence study. No vehicles are planned for purchase.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	2,394,727

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**10193**
Mechanism Name:	**TRAC Cooperative Agreement**
Prime Partner Name:	**Treatment and Research AIDS Center**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	451,742	0

Narrative:

RBC/IHDPC will implement prevention with positives (PwP) activities and integrate them into national care and treatment programs. The activities will reinforce programs started in COP2009, by assuring training of physicians and community counselors who will be providing prevention counseling for HIV positives. The activities will also reinforce the Five Prevention Steps for HIV Infected individuals. In addition, they will assure training to incorporate Prevention with Positives interventions as a standard of care in ART sites. This will help ensure that people living with HIV benefit from tailored interventions to reduce transmission rates to HIV uninfected populations. Clinical and Lay Community Counselors will promote couples counseling and testing and also provide PwP messages to all their clients.

In COP13, RBC/IHDPC HIV division will work with MOH to scale up mental health and HIV services Integration.

RBC/IHDPC . RBC/IHDPC will coordinate revisions and updates, and will ensure printing and national distribution of OI and STI guidelines as needed. The HIV division in collaboration with other stakeholders will provide timely and accurate data to the Coordinated Procurement and Distribution System (CPDS) on OI and STI drug and diagnostics supply consumption, as well as OI and STI-related morbidity and mortality. Lastly, RBC will support activities related to food by prescription for PLHIV presenting with moderate or severe malnutrition.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	541,243	0

Narrative:

In COP12, RBC/IHDPC/TB division will strengthen the TB/HIV monitoring and evaluation system by revising M&E tools based on WHO recommendations and by improving data analysis and its utilization for decision making. PEPFAR will continue supporting the TB Division within RBC for the development of training guidelines and tools to increase the capacity for extrapulmonary TB (EPTB) diagnosis.

The TB Division will continue scaling up provision of Isoniazid Preventive Therapy in People living with HIV. TB infection control policy in health facilities will also be extended through development of infection control plans, supervision, and monitoring & evaluation. COP12 funding will continue to support the MDR and X-DR TB surveillance and laboratory networking for sample transportation and ensure that MDR TB patients adhere to their treatment regimens.

In order to improve TB detection and adherence to TB treatment, TB Division will strengthen community DOTS

approach by supervising the community health workers. One evaluation is proposed to be conducted through this grant: the Evaluation of the implementation process and preliminary impact of Isoniazid preventive therapy (IPT) program in adult PLHIV in Rwanda.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	130,000	0

Narrative:

In COP11, in collaboration with implementing partners and district hospitals, through mentorship and trainings, the IHDPC/HIV Division has been scaling up psychosocial care and support services for children and adolescents. These services include HIV diagnosis disclosure counseling, pediatric support groups and ongoing individual psychosocial consultations in more than 187 ART health facilities. Guidelines, tools and job aids will be revised for care and support of children infected by HIV.

In COP12, with TA from PEPFAR implementing partners, IHDPC/HIV Division will focus on care and support of HIV-positive adolescents including mental health, adherence, sexual and reproductive health and psychosocial support. A model of care of HIV-infected adolescents will be developed and extended in several health facilities. The psychosocial care for children and adolescents will be reinforced with specific focus on problems surrounding adherence and disclosure. The development of needed tools (nutritional, mental health screening, adherence measurements tools, and reproductive health job aids) will be supported. The diagnosis and treatment of OIs in children will be reinforced through integrated trainings and mentorship. Nutrition formative supervisions and trainings will be conducted for nutrition evaluation and care of children with moderate and severe malnutrition. To ensure quality of care, providers will be trained in the provision of comprehensive care and treatment services to HIV-infected adolescents and early infant diagnosis and treatment guidelines for HIV-exposed children will be reinforced. The care and support of children and adolescents will be integrated in both mentorship and monitoring and evaluation systems to ensure the follow up and retention in care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	836,242	0

Narrative:

RBC/IHDPC interventions within the Strategic Information area cover the three major areas: surveys and surveillance; HMIS; and Monitoring and Evaluation. RBC/IHDPC will conduct HIV surveillance using PMTCT data, female sex workers, HIV drug resistance (HIVDR) early warning indicators abstracting, indicators of HIVDR from patient files, HIVDR Threshold Survey exploring transmitted HIVDR and HIV Monitoring exploring HIVDR acquired after 12 months of ART initiation in sentinel sites. Integrated Disease Surveillance and Response will be strengthened at all level (central, district, health centers and community). At the same time; RBC/IHDPC will continue to ensure TRACnet system and electronic Integrated Disease Surveillance and Response (eIDSR) module administration by

carrying out routine system administration tasks, providing end-users helpdesk and technical assistance in line with the system operations. RBC/IHDPC will also implement activities related to Open MRS. To support ICT infrastructure, the ICT equipment, network, centralized power systems and software at RBC/IHDPC licensed tools will be acquired, applied & maintained.

The focus of M&E activities in COP12 will be on the improvement of data quality, planning, reporting, and utilization of data for program management & service delivery. The M&E Unit will conduct data analysis and improve use as it relates to clinical prevention, care, treatment, to monitor the quality of services provided. As far as HMIS is concerned, RBC/IHDPC efforts will focus on maintenance, upgrade and implementation of the TRACnet system.

RBC/IHDPC/HIV Division will continue to emphasize improving data quality reported into the TRACnet system through decentralized trainings of district supervisors, data managers and M&E officers. Feedback mechanisms will be enhanced. TRACnet data quality audits and integrated supervisions will be continued and quarterly dissemination meetings will held on achievements to monitor TRACnet reporting completeness and timeliness.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	146,608	0

Narrative:

Through USG support, the Rwanda Biomedical Center (RBC, formerly TRAC Plus) is implementing activities around human resources and information systems, two of the essential building blocks of the Health System Strengthening. During FY2014, RBC will be training 160 health care workers to support the smooth implementation of the Rwanda HIV/AIDS program through an integrated training protocol that covers prevention, care, treatment and social mitigation program areas. Guidelines and training materials will continue to be developed to support these activities. RBC in collaboration with the School of Public Health will be supporting the implementation of Rwanda public health leadership capacity building and improved epidemiological and laboratory skills to better the HIV/AIDS program and other health programs

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	53,962	0

Narrative:

The biomedical prevention program within the Prevention department has the objective of scaling-up activities related to male circumcision (MC) and prevention with positives (PwP). These activities entail a comprehensive prevention strategy including: development of programs to assist PLHIV to take measures to avoid exposing other people to infection and provision of male circumcision comprehensive services. In COP12, activities include provision of supervisory and technical support to districts and health care facilities in the provision of services for male circumcision and PwP.

In COP12, Biomedical prevention desk in collaboration with other USG partners such as Drew University, will continue to support MC activities in military health facilities, police and in their catchment areas while ensuring availability and use of reusable male circumcision kits, supplies and equipment to facilitate provision of services and enable the scaling up of services in the health facilities. Renovation of existing health facilities' infrastructure will also be continued in line with PEPFAR and HHS/CDC guidance to ensure quality of HIV services.

RBC/IHDPC has developed a minimum package of male circumcision services and will continue M&E of the circumcision program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	111,242	0

Narrative:

In COP12, the VCT program through USG funding will continue to support existing VCT sites nationwide. It will also continue to support PITC (provider initiated counseling and testing) implementation in existing USG sites. In COP12, HIV testing using finger prick method (rather than venous blood draw) will be rolled out and the HIV division will conduct trainings and mentorship for implementation. Quality assurance (QA) and quality control (QC) for tests conducted using finger prick method will be undertaken in conjunction with the National Reference Laboratory.

The VCT desk within the RBC/IHDPC HIV division will organize decentralized training and mentorship on the follow-up package for discordant couples and will conduct M&E activities to document HIV incidence. It will also continue to support outreach VCT (HTC) for key populations with emphasis on mobile populations (truck transporters, men in uniform, commercial female sex workers, MSM) and people with disabilities. The VCT program in collaboration with the care and treatment program will support sites to strengthen linkages between VCT services and pre- ART services.

RBC/IHDPC/HIV Division will continue to update national HTC norms and tools (e.g. client forms, reporting forms, registers, educational and supervision tools) and will disseminate them to all health facilities providing CT services. Ongoing revisions are necessary in order to address new approaches to HTC and PITC, couples testing and discordant couple follow-up as new strategies of the national HTC program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	320,000	0

Narrative:

Rwanda and its partners are committed to achieving elimination of mother to child transmission by 2015. In COP12, the HIV division will continue to provide support to existing PMTCT sites through decentralized trainings and

mentorship and supervision of all districts to maintain high quality of services. To ensure continuum of care and the family-centered approach in the PMTCT program, the HIV division will provide training for PMTCT standalone sites to provide HIV clinical services to other family members. The HIV division will reinforce mentorship and supervision of PMTCT standalone sites, provide training on task shifting, and support capacity for EID testing, including improved sample transportation. To maintain and improve the quality of PMTCT services, the HIV division will revise and update national guidelines, continue to conduct refresher training of trainers and supervisors (TOT and TOS) and support training of providers at the decentralized level on the expanded PMTCT protocol. In addition, nutrition support will be given to HIV exposed infants according to revised protocols as well as to HIV exposed infants in categories 1, 2 and 3 of the household income classification. In COP12, the HIV division will continue to reinforce the M&E system for the PMTCT program and ensure continuous availability of reporting tools and job aids.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	550,000	0

Narrative:

In COP12, the HIV division in RBC/IHDPC will continue supporting HIV care and treatment sites to provide ART services according to national and international evidence-based guidelines, including immunological and virological laboratory monitoring and management of ART complications and treatment failure.

The HIV division in collaboration with the National Reference Laboratory (NRL) will provide mentorship to improve detection and management of treatment failure. The HIV division will provide training to clinicians to identify patients in need of VL testing, and will work to improve viral load capacity at sites through improved sample transportation, and coordinate with NRL for timely results.

The HIV division in RBC/IHDPC will also reinforce active surveillance of HIV drug side-effects and set up a national register for ARV side-effects. In addition, in collaboration with MOH/Decentralization and Integration Unit, the HIV division will conduct country-wide periodic evaluations of treatment outcomes of ART patients to identify factors influencing failure of ART and will implement strategies to reduce the number of patients lost to follow-up in entry points and in ART programs. RBC/IHDPC HIV division will continue to support task shifting and mentorship activities.

RBC/IHDPC will lead the process of developing cost effective treatment guidelines and tools according to priority areas. It will also be responsible for printing and dissemination of updated guidelines, tools, and job aids related to HIV treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	280,000	0

Narrative:
The main goals of the Pediatric HIV treatment program are to increase the number of pediatric patients on ART and to improve the quality of pediatric care at all sites. In COP12, RBC/IHDPC will emphasize: quality improvement in pediatric care and treatment at ART sites and early diagnosis and treatment in children according to existing national guidelines. RBC/IHDPC will also seek to increase coverage for pediatric patients enrolled in the treatment program, reduce the number of patients lost to follow-up at any entry point, and in collaboration with other PEPFAR implementing partners, improve the management of long-term ART-related complications including metabolic complications. *RBC/IHDPC will continue to support: age appropriate approaches to care and treatment of children living with HIV including a program for HIV infected adolescents; the development, dissemination and implementation of monitoring and evaluation tools, including registers, supervision tools and check lists according to national guidelines; the implementation of a harmonized mentorship program to improve the quality of pediatric HIV care, treatment and support at the district hospital level; the development, printing and dissemination of new or updated HIV and OI guidelines and tools according to needs; and the implementation of cost effective trainings, workshops, and conferences in priority areas.* *To expand the capacity to provide ART services at the national level the RBC/IHDPC/HIV Division, in collaboration with the MOH/Decentralization and Integration Unit, will support pediatric task shifting from central level to district hospitals and from district hospitals to health centers.*

Implementing Mechanism Details

Mechanism ID: 10825	**Mechanism Name: MoH CoAg**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health, Rwanda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: Both	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 26,044,381	
Funding Source	**Funding Amount**
GHP-State	26,044,381

Sub Partner Name(s)

AVEGA	Carrefour Urban Health Center	

Overview Narrative

In COP12, with USG support, the MOH will provide direct support for comprehensive HIV service delivery as well as support for national programs including activities to strengthen health systems at all levels, provide training and mentorship for clinical services, injection safety, laboratory capacity, TB/HIV services, support health information systems and improving human resources for health (HRH). MOH will provide a comprehensive package of PMTCT, HTC, adult and pediatric C&T, and TB/HIV services at the 76 sites transitioned during COP11. MOH will ensure quality of care, continuum of care via effective linkages and referrals, and sustainability of services using performance-based financing (PBF). MOH will continue to support the revision and dissemination of FP/HIV integration guidelines and tools as well as training of district health teams (DHTs); coordinate the integration of SGBV and mental health services in HIV programs; support implementation of cervical cancer screening and treatment programs; organize training of health care workers and waste handlers on injection safety and waste management; implement construction of multipurpose waste pits and installation of appropriate incinerators; build human capacity for histopathology and diagnosis of cancers in HIV-positive patients, support the Medical Maintenance Division (MMD) to develop a central merchandizing of spare parts for laboratory equipment and establish a national quality system for laboratory tests as well as clinical services.The MoH is launching a program to train a critical number of HRH to be able to respond to the HIV epidemic in a sustainable way. Finally, the national disease surveillance system will be enhanced and the eHealth Enterprise Architecture will be implemented. No vehicles purchased.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	66,624
Gender: GBV	88,832
Human Resources for Health	16,878,066

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support

Child Survival Activities

Safe Motherhood

TB

Family Planning

Budget Code Information

Mechanism ID:	**10825**
Mechanism Name:	**MoH CoAg**
Prime Partner Name:	**Ministry of Health, Rwanda**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	1,874,477	0

Narrative:

The MOH will ensure provision of a comprehensive package of HIV clinical services at 76 transitioned sites. The package includes clinical staging & baseline CD4 count for all patients, follow-up CD4 every six months, management of OIs & other HIV-related illnesses including OI diagnosis & treatment, & routine provision of CTX prophylaxis for all eligible adults based on national guidelines, prevention with positive (PwP) interventions, nutritional counseling & support, positive living & risk reduction counseling & palliative care. Linkages from entry points for HIV testing & treatment will be supported . Pre-ART patients will be closely followed to maintain high retention rates & treatment initiation when eligible. Work with SCMS will ensure that sites have reliable forecasting & stock management systems & provide accurate reporting to RBC/MPPD/MPD on commodities for adult HIV care & support. The MOH will emphasize quality and continuum of care through effective linkages, & sustainability of services through PBF. MOH will support referrals for all PLHIV & their families, particularly children under 5 years of age & pregnant women, for malaria prevention services, including provision of LLINs & referral to community providers for water purification kits & health education on hygiene for reduction of diarrheal diseases. . Psychological support for PLHIV at clinic & community levels will be strengthened through training for all 76 health facilities & community-based providers. Moreover in collaboration with IHDPC and Ndera hospital, MOH will provide technical assistance to all district hospitals for HIV/mental health integration. in collaboration with the

National Police, the MOH-MCH unit will coordinate the scale-up plan for the HIV/SGBV initiative at all district hospitals including capacity building of health care providers in SGBV client management & strengthening of SGBV M&E systems; In addition MOH will provide technical assistance to Gisenyi one stop center. The MOH will coordinate the implementation of the cervical cancer screening & treatment programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,648,522	0

Narrative:

In COP12, the MOH will continue to support the 76 transition sites in the delivery of quality TB/HIV services, while supporting the national TB/HIV program. The priority in COP12 will be to expand HIV testing to all TB suspects and enroll those who test positive in HIV care and treatment, expand implementation of regular TB screening for all PLHIV, ensuring adequate diagnosis of TB and completion of TB treatment with DOTS programs. In COP12, the MOH will continue to support sites to increase case detection rates, as well as provide quality case management and follow-up. In addition, the MOH will support scale-up of the implementation of the TB infection control policy as well as the national PIT policy at the MOH- supported ART sites. MOH will ensure high quality recording of individual patient information, collect high quality data, and report and review these data. Efforts will be made to progressively transition the supervision and mentoring of the TB/HIV activities at site level to the district teams. This will be done through a collaborative approach based on evaluation of TB/HIV standards of care, district evaluation meetings and supportive supervision and mentorship of the district team. Infrastructure improvement is crucial in TB prevention and management. As outlined in the Partnership Framework, in COP12, the MOH in collaboration with the TB Division will continue to implement TB infection control guidelines in order to reduce TB transmission in health care facilities. These activities will include rehabilitating three health facilities according to national TB infection control requirements, including rehabilitating patient waiting areas and TB wards. In addition, the MOH will improve and expand its current District-level supervision activities to include activities relating to the quality of diagnosis of TB suspects.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	881,201	0

Narrative:

In COP12, the MOH will continue to strengthen the capacity of districts to plan, implement, supervise and coordinate pediatric HIV care and support activities. The provision of support for the expansion of quality pediatric services at decentralized levels will also continue through mentoring and supervision of health care providers working in hospitals and health centers in pediatric clinical HIV care and support. MOH will support the provision of a comprehensive package of pediatric HIV care and support services at the 67 Track 1.0 HIV care and treatment sites, This package of services includes Co-trimoxazole prophylaxis, nutrition counseling, food support, and safe water interventions. In addition, all pediatric patients will be screened for TB at enrolment and at each follow-up visit.

Children suspected of having TB will be further investigated, and if infection or exposure is confirmed, they will be put on TB treatment or INH prophylaxis based on current national guidance. At the MOH-supported sites, HIV-positive children will be staged clinically and using CD4 (counts or percentages as appropriate), and eligible infants and children will be enrolled in ART. Sites will link with malnutrition and TB centers within their facilities or at specialized sites located in the vicinity to provide HIV testing to all pediatric in- and outpatients and enroll the infected children into care and treatment services. Moreover, sites will establish and strengthen linkages with PLHIV cooperatives in the local network, administrative district authorities and health teams to support activities aimed at increasing awareness in communities on issues related to pediatric HIV with a view of increasing pediatric HIV testing and enrollment into care. The MOH will also strengthen the EID program at health facilities and reinforce capacity of district health teams to ensure that samples collected at the sites are transferred in time to the NRL. All pediatric patients will have regular anthropometric evaluations to identify early signs of malnutrition and to ensure prompt initiation of nutrition rehabilitation interventions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	150,000	0

Narrative:

In COP12, PEPFAR will continue to support the MOH to strengthen its histopathology program in extrapulmonary tuberculosis and cancers in HIV patients by developing a histopathology laboratory at the University Teaching Hospital of Kigali (CHUK) and by sending four medical doctors abroad for specialty training in pathology. The USG is providing a pathologist to facilitate the functional development of the laboratory at CHUK and to train histotechnicians working in the laboratory. In addition, the USG pathologist will mentor the four medical doctors as they complete their training program and work with other pathologists at King Faisal Hospital and the University Teaching Hospital of Butare to develop a laboratory network in histopathology. The SCMS will work with the MOH to provide needed laboratory reagents and equipment for a functional histopathology laboratory

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	968,323	0

Narrative:

The Ministry of Health has a five-year eHealth strategic plan which encompasses all activities related to Strategic Information systems. In addition, a large part of the HMIS strategic plan deals with the development and roll out of the electronic system and these activities are subsets of the eHealth strategic plan. The Ministry of Health will continue the implementation of various components of the eHealth Enterprise Architecture and a selected number of end-user applications such as the roll out of the electronic medical records. The Ministry of Health will also continue to strengthen the capacity of district level managers to increase the performance of health facilities in data management. Capacity building of about 800 data managers at both national and district levels is a cornerstone of human resource capacity enhancement. The MOH will develop guidelines on data production and dissemination as

well as training curricula for data management and feedback. These documents will be widely distributed to provide clear guidance on data management at all levels of the health system. These will also be useful for district authorities given their roles in the decentralization process. Data managers and information officers at district levels will be trained in data management with USG financial support. In COP12, steps will be taken to conduct regular formative supervision to district hospitals that in turn will provide assistance to health centers in their respective catchment areas. A supervision protocol and tools will be developed for district managers to improve both service delivery and data use for decision making at the district and health facility levels. During COP12, the MOH will harmonize reporting at all levels-community, facility and national, and across the various programs of the Ministry in an attempt to have a harmonized HMIS. The health sector cannot deploy the various technologies without appropriate infrastructure to support this deployment. In addition to the funds from the Ministry's ordinary budget, the COP12 funds will also be used to make capital investment in IT infrastructure especially at decentralized levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	11,000,000	0

Narrative:

The Rwanda Biomedical Center/Medical Maintenance Division (MMD) is the institution within the MOH in charge of healthcare technology, infrastructure management and equipment maintenance. In previous years USG supported the MMD in terms of personnel and technical assistance; the purchase of toolkits, equipment for maintenance, generators and spare parts; and training of MMD staff on new medical technology and maintenance techniques. In COP12 USG funds will be used to support MMD to develop a central mechanism for procurement of spare parts and to establish a national control quality system. Specific activities will include the purchase of spare parts and quality control tools and equipment; training of staff on quality control measures; and the revision of key policies and procedures.

The MoH is launching a program to establish a critical number of Human Resources of Health (HRH) to be able to respond to the HIV epidemic in a sustainable way. Rwanda wants to ensure good access to quality health services for HIV patients at all levels of the health system, from the referral hospitals to the community level.

Rwanda's health system is decentralized which means that most of the health care takes place in health center and district hospital level. Therefore the only way to ensure access of essential services for all patients, included HIV-infected patients, is to train a sufficient number of qualified health providers in order to be able to deploy them across all 30 districts. With support from the USG, the MoH will equip some district hospitals to function as teaching sites and to upgrade the available services and clinical mentors at five Provincial Hospitals.

In the HRH Program the focus is on building the capacity of Rwanda's health professionals in the following areas: Surgical Care (including associated services); Pediatric and Peri-natal Care; Women's Health; Anesthesia Care;

General, Internal Medicine and Specialty Care (including community/public health care); Radiology Care; and Health Management.

Warehousing support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	150,000	0

Narrative:

With USG support, Rwanda will continue its safe injection activities by reducing blood-borne HIV transmission both inside and outside clinical environments. In COP12, the Ministry of Health Environmental Health Desk (MOH-EHD) will organize the training of healthcare workers and waste handlers on injection safety and healthcare waste management. Incinerator operators and their supervisors will also be trained on the use and maintenance of the equipment. A strategic plan for prevention of infections will be implemented 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 SCMS, which will in turn ensure the procurement of needed items in sufficient quantities and of the appropriate quality. The USG and MOH-EHD will conduct joint supervisory visits to assess injection safety and medical waste management practices in health facilities. 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 preparation of management documents for program officers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,017,522	0

Narrative:

During COP12, the MOH will ensure continuity of counseling and testing services at all 76 transitioned sites. The MOH will provide counseling and testing services to clients including patients from TB services as well as those tested through PITC. The approach of PITC will target adult and pediatric patients with HIV-related OIs such as TB, malnourishment for children, known HIV-exposed infants, STI patients and all admitted patients. A system to ensure coordination between the different counseling and testing units has been developed and will be reinforced to enhance adherence and minimize loss-to-follow-up. This will be achieved through integration of various approaches including community-based mobilization for counseling and testing in collaboration with local authorities, an enhanced referral to health facilities and follow-up as well as maximization of all entry points within health care facilities. These include ordinary HTC, ANC and general consultation rooms plus nutritional centers and admission wards using PITC and provided in a manner that respects human values, ensures confidentiality, and reduces stigma and discrimination. In COP12, the MOH will continue to support couples testing at transitioned sites and reinforce the

follow-up of discordant couples. In addition, the MOH will strengthen counseling and testing M&E systems (documentation, utilization of tools, data analysis and reporting) in all services. In order to maintain the quality of services, the MOH will continue to support integrated formative supervision of district teams. Health center staff will receive new and refresher in-service training on VCT and PITC guidelines. The MOH will continue to support counseling and testing indicators embedded in Performance-Based -Financing (PBF) as a way to improve both the quality and quantity of service provision. The MOH will support the quality of data and its utilization for improving the quality of care through regular data quality audits, data analysis training, and data sharing workshops and feedback. Procurement of rapid test kits.

Note: 1,563,625 added from the USAID TBD Commodities and Warehous proposed mechanism.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,475,139	0

Narrative:

In COP12, MOH will ensure continuity in the provision of the comprehensive PMTCT package at 52 transitioned PMTCT sites. MOH will support human resources by providing high-quality training of PMTCT providers. Task-shifting instruction is being implemented at PMTCT sites in order to decrease loss to follow up, which must be avoided during pregnancy in particular. Supportive supervision and mentorship will further be reinforced. The MOH will also promote integration with other MCH services (including malaria interventions, nutrition support, IMCI) and linkages with OVC services. MOH will reinforce the district outreach teams in order to track PMTCT defaulters and conduct home visits as needed. The MOH will also identify and refer victims of gender-based violence (GBV) to appropriate care. MOH will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing male partner involvement and community participation in PMTCT services. MOH will sustain the PMTCT follow-up systems through PMTCT integration with other services. To ensure the FP/HIV integration, in COP12 MOH will support the update of guidelines and tools as needed. Moreover, the MOH will assist district teams in training health providers on FP//HIV integration. MOH will collaborate with Ibyringiro to distribute nutritional supplements to people infected and affected by HIV and AIDS including weaning food supplements in PMTCT as well as nutrition support to eligible pregnant and lactating mothers. To improve HIV exposed infant follow-up, MOH will facilitate the implementation of the updated immunization card containing HIV information by printing and disseminating this card nation-wide. With the leadership of the PBF Unit within the Ministry of Health, MOH will continue to support the financing based on site performance with the aim of improving key national PMTCT performance and quality indicators.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	5,735,497	0

Narrative:

In COP12, the MOH will support the provision of ART at the 67 Track 1.0 transitioned care and treatment sites. The package of services will include treatment with ARV drugs, routine CD4 follow-up, viral load testing, management of ARV drug side effects, and adherence support. In COP12 the MOH will emphasize quality of clinical services, continue support to district health teams, increase sustainability through quality assurance and capacity building of district and health center teams through supervision and mentorship. The MOH will also continue to support district hospitals and health centers to initiate treatment in HIV positive patients based on national guidelines and current eligibility criteria. In collaboration with district hospital teams, adherence support will be provided to prevent loss-to-follow-up. To support a high quality of service, clinicians from the district team will review complicated cases with providers at health centers. District Hospital team will mentor the health center providers on provider-initiated testing, follow-up of patients, and the detection and referral of complicated cases to district hospitals. The MOH will continue to promote quality improvement through reviews of indicators, medical dossiers and viral load measurements. The results of these reviews will be used to develop and strengthen clinical capacity for more efficient and high-quality patient management. In addition, the MOH will also work to improve reporting linkages with RBC/MPPD/MPD and to mentor health center staff on strategies to effectively receive, manage, and forecast the need for ARVs. PBF is a major component in the PEPFAR Rwanda's strategy for ensuring long-term sustainability and maximizing performance and quality of treatment services. MOH will support PBF by participating in health facility performance evaluations. Staff will also be trained to recognize the early signs of immunologic and clinical failure, and to initiate second-line treatment regimens based on national guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,143,700	0

Narrative:

In COP12, the MOH/DI will continue to strengthen the capacity of districts to plan, implement, supervise and coordinate pediatric HIV care and treatment activities. The provision of support for the expansion of quality pediatric services at decentralized levels will also continue through mentoring and supervision of health care providers working in hospitals and health centers in pediatric clinical HIV care and treatment. During COP12, the MOH will ensure provision of a comprehensive package of pediatric HIV treatment services at 67 transitioned sites. The package includes treatment with ARV drugs, routine CD4 follow-up according to national guidelines, viral load testing, screening and management of ARV drug side effects, treatment adherence counseling, and patient referral to community-based care. The MOH will also work with health facilities on the implementation of updated pediatric HIV treatment guidelines. Providers will receive regularly planned in-service training and coaching. The MOH supervisors will carry-out monthly site visits for staff mentoring during which support will be provided in improving service provision, strengthening children support group activities, and for active tracking of follow-up defaulters. Through the Supply Chain Management Services (SCMS), MOH will ensure the provision of ARVs, CD4 tests, and other commodities and laboratory supplies for clinical monitoring of infants and children on ART. Work with SCMS

will also ensure that sites have reliable forecasting and stock management systems in place. In addition, the MOH will continue to train and mentor managers and health service providers in the use of the IQChart software as well as open MRS. With improved management of data on pediatric HIV care and treatment, the MOH, in collaboration with RBC, the PBF program, and quality management program will support health facilities to build and sustain a system of quality performance measurement and improvement.

Implementing Mechanism Details

Mechanism ID: 10827	**Mechanism Name: Technical Assistance to the National Blood Transfusion Center**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Association of Blood Banks	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Full Implementation of Blood Establishment Computer System (BECS): Continued implementation of BECS, with functionality supporting donor blood, blood product testing, and patient management; supporting quality management systems; and reporting and compliance for accreditation. BECS will be extended beyond Kigali headquarters center to regional centers in Karongi and Rwamagana. Implementation requires following stringent quality management system requirements for validation, ensuring backup systems and training of users and management staff. BECS Project will bring together NCBT Computerized system to a multisite computer system with a single data center to manage blood bank activities nationally and improve management and reporting, quality systems compliance, and improvement of operations.

International Accreditation of NCBT; AABB will continue to support the implementation of robust quality

management systems and standard operating procedures according to the "Road Map" for NCBT to achieve accreditation developed in response to 2009 gap analysis performed against international blood bank standards. A critical finding of the assessment was the need for additional policies, procedures and training for NCBT quality officers and other key NCBT management and staff, with need for on-site mentoring in the implementation of quality systems across all areas of operation and facilities nationwide.
Alternative Financing Mechanisms: NCBT, MOH and CDC have initiated discussion to pursue alternative financing mechanisms to establish NCBT as a self-supporting department.
No vehicles have been or will be purchased under this mechanism.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10827		
Mechanism Name:	Technical Assistance to the National Blood Transfusion Center		
Prime Partner Name:	American Association of Blood Banks		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	200,000	0
Narrative:			
Full Implementation of Blood Establishment Computer System (BECS): Continued implementation of BECS, with functionality supporting donor blood, blood product testing, and patient management; supporting quality management systems; and reporting and compliance for accreditation. BECS will be extended beyond Kigali			

headquarters center to regional centers in Karongi and Rwamagana. Implementation requires following stringent quality management system requirements for validation, ensuring backup systems and training of users and management staff. BECS Project will bring together NCBT Computerized system to a multisite computer system with a single data center to manage blood bank activities nationally and improve management and reporting, quality systems compliance, and improvement of operations.International Accreditation of NCBT; AABB will continue to support the implementation of robust quality management systems and standard operating procedures according to the "Road Map" for NCBT to achieve accreditation developed in response to 2009 gap analysis performed against international blood bank standards. A critical finding of the assessment was the need for additional policies, procedures and training for NCBT quality officers and other key NCBT management and staff, with need for on-site mentoring in the implementation of quality systems across all areas of operation and facilities nationwide. Alternative Financing Mechanisms: NCBT, MOH and CDC have initiated discussion to pursue alternative financing mechanisms to establish NCBT as a self-supporting department.

Implementing Mechanism Details

Mechanism ID: 10954	**Mechanism Name: HIV Care and Treatment to the Rwanda Defense Forces (RDF)**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: Drew University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,498,766	
Funding Source	**Funding Amount**
GHP-State	1,498,766

Sub Partner Name(s)

Drew Cares International		

Overview Narrative

Members of Rwandan Defense Forces (RDF) remain one of the highest-risk groups for HIV/AIDS infection in Rwanda because they are typically young, single and highly mobile. RDF has 3 military hospitals and 8 brigade clinics. In COP12, Charles Drew University (CDU) will ensure that HIV/AIDS support is integrated within existing RDF health

service delivery systems with the aim of building capacity, human resource development, country ownership and sustainability. Consistent with the Partnership Framework, CDU, in partnership with the RDF, will continue in COP12 to provide TA in human resource development that includes pre-service and in-service training of RDF health personnel, as well as rehabilitation of RDF facilities. These efforts will improve the capacity of the RDF to provide quality HIV prevention, care and treatment services for military personnel, their families, and the surrounding communities. Services include HIV Counseling and Testing, PMTC, Pediatric Care and Treatment, HIV Palliative Care and Treatment, Laboratory services, TB/HIV Interventions, PwP, MC services through TA focusing mainly on in-service training of RDF health personnel, and M&E. The objectives are: 1) Improve HIV prevention services, ensuring in-country ownership and sustainability, and 2) Improve the quality, availability and sustainability of HIV treatment options for RDF personnel, family, and surrounding communities. CDU will provide technical support (training & supervision), human resource development (data managers placed at facility levels), as well as material support to the M&E activities at facility level in order to ensure data quality.

Three vehicles have been purchased previously; no new vehicle purchases are expected at this time.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Military Population
Mobile Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**10954**
Mechanism Name:	**HIV Care and Treatment to the Rwanda Defense Forces (RDF)**
Prime Partner Name:	**Drew University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	275,000	0

Narrative:

In COP12, CDU will work to improve the capacity of RDF to provide quality HIV treatment & care for RDF personnel, their partners & families and community members living in surrounding areas at all 8 RDF health facilities throughout the country. The palliative care package will be integrated within existing health service delivery systems and offered to 4390 patients that includes clinical staging, CD4 count, OIs prevention through prophylaxis with CTX based on national protocols, psychosocial support and referrals of PLHIV to community based BCS services. A human Resource development focus will continue with the training of 110 RDF health care providers on HIV palliative care and 112 peer educators & lay counselors to provide psychosocial support at community levels through periodic inter-brigade/community interactive, experience-sharing discussions, meetings & workshops to increase treatment adherence and share success stories. To improve the health of RDF members deployed in remote, hard to reach areas, CDU will continue to support outreach services through MTCU along with monthly ARV drug distribution as a bridge to the achievement of full sustainability of HIV services for these deployed troops. MTCU services include: basic HIV lab tests, STIs/OIs screening &treatment, provision of CTX, ART, ART adherence support, psychosocial support, FP, nutrition counseling, PwP, spiritual care, bereavement care and hygiene education. CDU will continue to provide TA & material support to 14 Anti-AIDS clubs to sensitize & mobilize RDF personnel and community members on HIV/AIDS, prevention, care and support & adherence to treatment. At the brigade level, CDU will support: 1) formation of support groups of PLHIV and train members in the provision of home-based care services and referrals as appropriate (including PwP), 2) access to locally available nutritional support & Income Generating Activities. CDU will provide TA (supervision and M&E) to RDF to strengthen linkage between community-based & clinic-based HIV care services. CDU will intensify its support in retention of clients through quality services delivery.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	82,676	0

Narrative:

In COP12, CDU will continue to support integration of HIV and TB services at all the 8 RDF facilities as per the national TB/HIV Protocol and supporting facilities to strengthen referral mechanisms within the same facility and between facilities which will enable patients diagnosed with TB and HIV adhere to TB treatment via DOTS, and have

access to CTX prophylaxis and follow-up of CD4 and ART services if eligible as it has been done in COP11. In line with National Health Strategy, all 4390 HIV+ patients (100%) will be screened for TB and provided TB prevention services. All patients identified with TB will be counseled and tested, and all co-infected patients with will also receive TB treatment. A Human Resource Development approach will be used by the provision of training of 110 RDF health care providers in partnership with RBC/TB program. In addition, CDU will ensure through regular supervision to all RDF sites TB/HIV data is recorded & reported using the next generation TB/HIV indicators provided by PEPFAR. M&E will be provided using the national TB and HIV M&E framework and tools. To ensure ownership and sustained health impact, CDU will ensure that TB clinical care continues to be part of a continuum of a comprehensive HIV/AIDS care strategy by improving infrastructure at RDF hospitals and brigade clinics, as well as training RDF health providers to diagnose, treat monitor and report TB progression trends. In addition, CDU will ensure 100% of HIV+ TB patients eligible for ART will be immediately offered ART and TB treatment, and followed-up through existing RDF health delivery systems. To ensure successful TB prevention, CDU will provide patients with education regarding infection control strategies. At the brigade/community-level, Anti-AIDS clubs and support group activities will include TB awareness-raising activities. These activities support the Rwandan National Health Strategy for TB/HIV in preventing, diagnosing and treating patients with both TB and HIV patients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	45,000	0

Narrative:

In COP12, CDU will utilize a human resource development approach in continuing to train health care providers in all 8 supported RDF health sites that ensures the provision of an integrated package of care and support for 100% of HIV exposed and infected children. Care and support for HIV-exposed infants identified in PMTCT will include access to early infant diagnosis using DBS, provision of CTX prophylaxis, and tracking of mothers and infants lost-to-follow-up for re-engagement in care. CDU will also continue earlier enrollment of mothers in PMTCT, regular clinical assessments & staging, baseline CD4 count for all HIV-infected children, control CD4 count, viral load monitoring, management of other HIV-related illnesses (OIs, TB), INH & CTX prophylaxis and ART for eligible children and HIV-exposed infants. CDU will ensure the provision of integrated management of childhood illness, distribute long-lasting insecticide treated nets, safe water interventions, provide basic hygiene education and community outreach services including referral for complimentary food support and linkage to poverty alleviating programs at existing RDF health delivery sites. CDU will also provide training for 110 health care providers in psycho-social care for children and adolescents living with HIV/AIDS that assist adolescents in transitioning to adult care at all RDF sites. Nutritional support at CDU supported sites will include nutritional education, counseling to HIV positive mothers during pregnancy and after delivery regarding best feeding practices. CDU will ensure programmatic linkages to the Title II food support for all clinically eligible PLHIV (including children) in selected sites which provide complementary food support for HIV-exposed and affected infants. Existing RDF health delivery sites will establish HIV community outreach services by working with existing trained community health care workers

to provide key HIV messages emphasizing care and referral for pediatric HIV cases. RDF liaisons collaborating with community health workers in surrounding communities constitutes an effective system to ensure continuity of care, retention into HIV care, and improved quality and sustainability of pediatric HIV services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	63,000	0

Narrative:

In COP12, CDU will provide TA to laboratories at all existing RDF health care sites located throughout the country that serve military personnel, their partners and family members and community members living in surrounding communities. All CDU supported laboratory sites will continue to collaborate and work within the National Referral Laboratory system and follow their policies. In addition, CDU will continue to work closely with other cooperating partners on key issues, particularly those pertaining to accreditation. All RDF laboratories will continue to provide the minimum package of HIV-related tests such as hematology and biochemistry, as well as provide other tests such as malaria testing and stool exams. Laboratories at the 2 military hospitals will also continue to provide CD4 count tests. The Rwanda Military Hospital laboratory will be supported to provide services at a referral hospital level. With quality laboratory infrastructure in place, the Rwanda Military Hospital laboratory will continue to receive TA from CDU with the goal of achieving full accreditation as a referral laboratory. The use of PEPFAR II indicators will be used for measuring quality in laboratory services. Following a human resource development approach, CDU will train 18 laboratory technicians on quality assurance protocols and Good Laboratory Practices. Laboratory support provided by CDU will continue to be integrated within existing health service delivery systems, staffed by medical personnel within the RDF health facilities, thereby ensuring cost effectiveness, continuity and sustainability of the program. This approach ensures increased ownership and facilitates a smooth transition of laboratory services to the RDF at the end of the funding period.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	22,500	0

Narrative:

In COP12, CDU will continue to assist existing RDF health facilities to improve their IT infrastructure. In addition, CDU will provide support for quality data collection methodologies, analysis, reporting and use through ongoing training and supervision. The RDF will receive assistance with implementing continuous quality improvement process. Specific activities include improving existing data collection methodologies, processes and systems, as well as data analysis. These improve data collection processes will assist the RDF in evaluating the effectiveness of HIV treatment and care services provided in existing RDF health care delivery facilities. Specifically, CDU will 1) provide material and TA support to improve the existing military data systems, 2) update data reporting tools to monitor HIV care and treatment activities, 3) improve the capacity of existing RDF health care facilities through HMIS and OpenMRS in order to meet the national standard for monitoring & evaluation, as well as accuracy of patient records,

4) ensure that the national coding system for all patients receiving care in RDF health care facilities is implemented to, and 5) offer TA to improve hospital information management systems at the 2 existing military hospitals. Following a human resource development approach, CDU will conduct refresher training for 15 health service providers from all RDF sites on data collection, analysis, use and reporting according to the national HMIS guidelines. CDU will also work closely with the MOH/Monitoring and Evaluation Taskforce to ensure compliance with National HMIS plan. All CDU Strategic Information activities will be conducted within existing RDF health service delivery sites in a manner that will transfer knowledge to RDF staff, increase ownership and sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	120,628	0

Narrative:

The overall goal of this activity is to decrease new HIV infections through male circumcision in the Rwanda Defense Forces (RDF). In COP12 CDU will offer circumcision as part of an expanded approach of HIV services embedded in existing RDF health facilities that also include HIV Testing and Counseling, treatment for STIs, promotion of safer-sex practices and condom distribution. VMMC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package. Sensitization meetings will be conducted regarding the role of circumcision in HIV prevention, including the fact that there is need to continue to practice abstinence, have fewer sex partners and use condoms. It is important that VMMC is provided to men who are HIV negative, emphasizing that it is important to know one's HIV status prior to receiving VMMC services. Emphasis will be made on abstinence from sexual activity for the recommended period after VMMC to allow complete healing of the wound. CDU will ensure that VMMC activities go hand in hand with HIV care and treatment and all VMMC clients will be counseled and tested for HIV. In COP12, 30 RDF health care providers trained on VMMC and appropriate infection control practices. CDU will also provide regular supportive supervision to all RDF VMMC sites across the country and follow-up to soldiers who have been circumcised in order to prevent infection and ensure compliance with VMMC management protocols. Together with PSI, IEC/BCC messages will be tailored to sensitize circumcised soldiers on basic hygiene, safe sex practices and the need for medical follow-up to monitor infection. In COP12, CDU will ensure that VMMC efforts are integrated in existing RDF health delivery facilities as an additional method for HIV Prevention. Together with JHIPEGO, CDU will take steps to ensure that providers are well trained in VMMC. CDU will also ensure that physical & clinical infrastructures are enhanced, and demand created for maximum utilization of VMMC services by RDF soldiers and surrounding community members. VMMC will be conducted on a voluntary basis with all socio-cultural considerations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	36,870	0

Narrative:

In COP12, CDU will continue to work with the RDF and other partners to ensure that VCT services are available in

all 8 RDF health settings located throughout the country. CDU will employ counseling techniques that ensure confidentiality, minimize stigma and discrimination according to national guidelines and reach those individuals most likely to be infected. Couples Voluntary Counseling and Testing (CVCT) in ANC will be expanded and integrated with VCT services as a Prevention Intervention and PIT will be rolled out as a testing strategy. CDU plans to reach 9000 clients during COP12 with counseling that includes messages on alcohol reduction, prevention for positives, GBV, disclosure of status to partner, partner testing, and counseling for negatives and provision of condoms. A human resource development approach will include the provision of refresher training for 30 RDF health care providers. This approach will help ensure ownership and sustained health impact at the end of the funding period. Male circumcision will also be a pillar in the VCT program and all MC clients will be tested. An emphasis will be made on prevention counseling and follow-up for HIV positive clients, discordant couples and other high risk groups. HIV+ individuals will immediately be enrolled in HIV care and treatment to minimize the risk of lost to follow up. These activities will be coordinated to avoid duplication and maximize accessibility to the most at-risk populations. CDU will coordinate its activities with other partners, such as PSI, to avoid duplication, strengthen referral linkages and continue the promotion of TC among most at risk populations, including the military. CDU will provide TA, mostly in the area of in-service training and supportive supervision to ensure quality of VCT services that follow the standard testing algorithms and ensure the efficiency of the program and transition to RDF. CDU will also use new PEPFAR indicators to ensure the quality of all services delivered. In this regard, CDU plans to undertake operational research to assess the effectiveness of the referral system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	50,000	0

Narrative:

In COP12, CDU will continue to work with RDF and RBC to increase access to PMTCT services in 8 RDF health delivery sites located throughout the country through referral and follow-up of identified VCT and PIT clients to PMTCT services. The PMTCT interventions will be implemented as per the National Strategic Plan and fully integrated within existing RDF health service delivery systems. CDU and RDF will continue to use RDF HIV+ males as "entry points" to their families, maintaining a comprehensive demographic data base of each soldier and their family that is updated through MTCU implementation. This approach enables tracking and implementation at the brigade level via targeted training sessions for identified at-risk spouses of HIV+ soldiers, with HIV CT conducted simultaneously. CDU will promote full utilization of PMTCT and support the spouses of identified HIV+ soldiers to bring their children for HIV testing. CDU will strengthen the community outreach services through home visits to encourage HIV+ women to have their children tested. CDU will also work closely with potential health centers in targeted areas through training, linkages, referrals and sharing of clinical records to ensure follow-up and continuity of services of the identified HIV+ soldiers' spouses. Couple CT will be an important tool for improving utilization of PMTCT services. CDU will ensure delivery of standardized PMTCT services to 2300 pregnant women attending ANC services and provide ART prophylaxis to 92 HIV exposed women at all RDF health settings. During COP12, an

emphasis on Human Resource development will continue in order to maximize ownership and sustained health impact at the end of the funding period. Toward these ends, CDU will train 110 health service providers on PMTCT service delivery skills, ensure provision of necessary material & equipment, and provide supervision and M&E. CDU will also continue to provide nutritional support to 50 pregnant women in need of support in targeted RDF facilities while making linkages with other Title II USG partners to ensure access to adequate nutritional support and linkage to poverty alleviating programs for pregnant and lactating mothers & infants in other facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	740,937	0

Narrative:

In COP12, CDU will work to improve the capacity of 8 RDF health delivery sites to provide quality HIV treatment & care for military personnel, their partners & family members, as well as community members who live in surrounding areas. The package will be delivered within existing RDF health service delivery systems to 3650 individuals in a manner that ensures sustained health impact at the end of the funding period. The package includes clinical staging, CD4 count, viral load, OIs diagnosis, treatment and prevention through prophylaxis with CTX per national protocols, TB screening & treatment, and referrals of PLHIV to community-based care services. CDU will continue an emphasis on human resource development with the provision of refresher training on full package of HIV Care & Treatment to 110 RDF service providers. To improve the health of HIV-positive RDF personnel, CDU will support a Mobile Treatment and Care Unit (MTCU) for HIV-positive patients in hard-to-reach areas. The MTCU will provide comprehensive medical evaluations, basic HIV lab tests, STIs/OIs screening and treatment, provision of CTX, ART, ART adherence support, psychosocial support, FP, nutrition counseling, PwP, spiritual care, bereavement care, hygiene and malaria education. CDU will provide supportive supervision and M&E using new PEPFAR indicators to ensure quality data that will inform decision making. Peer educators and lay counselors will be trained to provide social support to patients through periodic inter-brigade/community interactive sessions. Peer-to-peer experience sharing discussions & workshops will be organized to increase treatment adherence & the sharing of HIV treatment success stories. CDU will also provide TA to RDF to strengthen linkages between community-based and clinic-based HIV care services. At the brigade and/or community level, CDU will support 1) the formation of support groups of PLHIV & train its members in the provision of home-based care services and 2) access to locally available nutritional support resources.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	62,155	0

Narrative:

In COP12, CDU will scale up pediatric care and treatment by providing TA in the form of training, regular supervision and M&E at existing RDF health delivery sites in line with national policies and sustainability strategies. Data will be collected using the new PEPFAR & National indicators to ensure quality. CDU will provide an

integrated package of care & support services for 100% of HIV-exposed infants and HIV-infected children. CDU's support to pediatric HIV treatment activities will ensure access to early infant diagnosis using DBS, provision of CTX prophylaxis and ART, tracking of mothers & infants lost-to-follow-up, regular clinical assessments, baseline CD4 count & percentages for all HIV-infected children, regular CD4 and viral load monitoring, management of other HIV-related illnesses (OIs and TB) and psychosocial support. Suspected TB cases will be investigated to establish a diagnosis and begin treatment as per national guidelines & INH prophylaxis provided to those exposed to active TB. Referral systems will be developed to ensure quality care. Following a human resource development approach, CDU will collaborate with RBC in the training of 110 health care providers in pediatric HIV/AIDS palliative and psycho-social care, with an emphasis on adolescent transition into adult care & treatment. All CDU supported RDF health deliver sites will establish HIV community outreach services by working with trained community health care workers to provide HIV education that emphasizes pediatric HIV care and treatment, and increased awareness and utilization of services. The collaboration of military liaison with community health workers in surrounding communities constitutes an effective system to ensure continuity of quality pediatric HIV care and treatment services, increased retention in care & treatment, as well as increased ownership and sustained health impact at the end of the funding period.

Implementing Mechanism Details

Mechanism ID: 10981	**Mechanism Name: UNHCR**
Funding Agency: U.S. Department of State/Bureau of Population, Refugees, and Migration	Procurement Type: Grant
Prime Partner Name: United Nations High Commissioner for Refugees	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 91,545	
Funding Source	**Funding Amount**
GHP-State	91,545

Sub Partner Name(s)

Africa Humanitarian Action		

Overview Narrative

KIZIBA Refugee Camp: According to the most recent UNHCR statistics hosts 18,952 refugees from North and South Kivu, and eastern DRC. HIV transmission among Congolese refugees depends upon numerous competing and interacting factors. Some of the factors specific to the Congolese refugees residing in Rwanda include: a relatively high amount of cross-border traffic amongst refugees due to geographic ease; the length of stay of refugees in Rwanda, with some camps being open for more than 15 years; and no sign of the conflict abating in DRC. KIZIBA camp is located in the highest HIV prevalence district (Karongi) in Rwanda.

UNHCR works through African Humanitarian Action (AHA) in order to implement HIV/AIDS activities in the Kiziba refugee camp. AHA has been implementing HIV program interventions in the camp with PEPFAR funding since 2007. There has been a steady increase in the number of people arriving for HIV testing, inclusive of couples testing during antenatal care. At the same time, HIV prevention and awareness messages targeting youth, boys and girls, men and women, and religious leaders have been disseminated in the community, and treatment for adults and children has been expanded benefiting both refugees and locals. AHA focuses its attention on 10 programmatic areas: PMTCT, community awareness on condom promotion, HIV care and support for adults and children, palliative and integrated TB/HIV care, HTC, treatment for adults and children, and coordination, monitoring, and evaluation mechanisms.

No vehicles have been purchased or leased or planned under this mechanism.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	915
Gender: GBV	1,831
Human Resources for Health	63,166
Key Populations: FSW	915

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**10981**
Mechanism Name:	**UNHCR**
Prime Partner Name:	**United Nations High Commissioner for Refugees**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	10,023	0

Narrative:

The goal is to provide HIV care and support to adults in Rwankuba Sector and Kiziba Refugee Camp.
The funding for this activity will support the provision and expansion of palliative care and clinical services, as well as the training of health providers, laboratory technicians, PLHIV, Home-Based Care Providers and community volunteers. AHA will ensure the provision of in-patient and out-patient clinical services, including diagnosis and treatment of OIs and other HIV-related illnesses (including TB), routine clinical staging, systematic CD4 testing to follow progression of HIV and earliest determination of ART eligibility, and routine recording and reporting of programmatic data. In addition, AHA will provide palliative care services including routine psychosocial support, home visits, identification and training of Home-based Care Providers, PLHIV Associations, and routine trainings for PLHIV and HBCPs that include information on nutrition, positive living, ARV adherence and self-care

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	6,694	0

Narrative:

The goal is to provide palliative care and TB/HIV-related services to patients in Kiziba Refugee Camp and Rwankuba Sector. In COP12, the objectives are: to ensure that all TB patients are tested for HIV; all HIV infected patients are screened for TB; all patients identified with active TB receive quality and complete TB treatment; all TB/HIV co-infected patients receive ART per national guidelines; and appropriate referral is ensured for all cases of multi-drug resistant TB. AHA in collaboration with Kibuye Hospital will continue to build the capacity of national health staff by providing refresher trainings on TB and TB/HIV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	1,506	0

Narrative:

The goal is to ensure pediatric care and support to children in need in Kiziba Refugee Camp and Rwankuba Sector. The funding for this activity will support the provision of early infant diagnosis, Co-trimoxazole for HIV-exposed infants per national guidelines; and ongoing clinical monitoring and staging for ART initiation. In partnership with WFP, AHA will provide supplemental food to all PLHIV in the camps regardless of their ART status, and AHA will also provide supplemental milk to all infants born to HIV-positive mothers (from 6-24 months).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	12,114	0

Narrative:

AHA will reach more refugees with counseling and testing by strengthening PIT for patients at the consultation level, as well as all TB and STI patients, malnourished and non-thriving infants, and patients presenting with HIV-related illnesses. Ongoing community-based campaigns will utilize refugee groups, refugee community leaders, and PLHIV to communicate HIV/AIDS stigma reduction messages and promote CT. Health providers will receive training and refresher training on PIT, as well as in counseling for youth, male partners, and other targeted populations in refugee camp settings. Counseling will emphasize partner reduction, stigma, and alcohol reduction to sensitize clients to issues related to GBV, as well as confront social norms that contribute to these issues.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	4,421	0

Narrative:

The goal is to promote correct use of condom and other prevention methods to reduce new infection among refugees in Kiziba Refugee Camp and Rwankuba Sector. AHA will program for Prevention with Positives (PwP), targeting HIV-positive refugee patients, including discordant and married HIV-positive couples; unmarried HIV-positive refugee men and women; and ART patients. Community Health Workers (CHW) and health providers will target condom messages to high-risk populations in the camps-at-large, as well as routine sensitization in the health center. Condoms are made available at different spots in the camp. CHW are involved in this activity.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	13,942	0

Narrative:

The goal is provision of PMTCT services at Kiziba Refugee Camp and Rwankuba Sector. AHA will offer a standard

package of PMTCT services that includes counseling and testing of pregnant women, male partner testing, family testing, ARV prophylaxis using combination ARV regimes and HAART for eligible women, close follow-up of HIV-exposed infants for effective referral to appropriate services including early infant diagnosis, where possible. In addition, during the 2011-2012 funding cycle, AHA will try to scale-up integration of FP services within the PMTCT setting, ensuring that women and their partners receive the necessary information to make informed decisions in regards to family size, child spacing and available contraception methods.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	38,827	0

Narrative:

The on-site package of services includes support to ARV-specific staff to follow all PLHIV from the time of diagnosis and ensure that they receive proper clinical and nutritional counseling and care. It also includes treatment with ARVs according to the national guidelines, follow-up clinical monitoring of CD4 count every six months, viral load counts for patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, ongoing adherence counseling, nutritional counseling, and patient referral to palliative care services. In partnership with WFP, AHA supports supplemental food to all PLHIV on ART. AHA also supports nationally certified training for health care workers in the camps in provision of ART, adherence counseling, ongoing clinical monitoring; management of ART related side effects, and referrals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	4,018	0

Narrative:

The on-site package of services includes support to ARV-specific staff to follow HIV-positive infants and children from the time of diagnosis to ensure they receive proper clinical and nutritional counseling and care. It also includes treatment with ARVs according to the national guidelines, follow-up clinical monitoring, and CD4 count every six months, viral load counts for patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, ongoing adherence counseling, nutritional counseling, and patient referral to palliative care services. Nationally certified trainings are offered for health care workers in the camp's clinic in the provision of ART for children, adherence counseling, ongoing clinical monitoring; management of ART related side effects, and referrals.

Implementing Mechanism Details

Mechanism ID: 12133	**Mechanism Name: Strengthening Blood Transfusion Services**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: National Center for Blood Transfusion, RBC NCBT/CNTS	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 2,092,369	
Funding Source	**Funding Amount**
GHP-State	2,092,369

Sub Partner Name(s)

(No data provided.)

Overview Narrative

CNTS strives to collect, analyze, and distribute safe blood in adequate quantities and quality to 100% of patients. The Regional Blood Transfusion of Rusizi is under rehabilitation by the Global Fund. In COP12, CNTS plans to equip and staff the center to become operational. New medical equipment will be purchased.

During COP12, CNTS will support quality assessments to define and document critical control points of blood collection, testing, component production, storage and distribution, and develop tools for quality improvement and corrective actions. These tools will capture deviations, non-conformances and adverse events. In addition, CNTS will implement quality system essentials, documents and SOPs. CNTS will continue external quality assurance for serology and blood grouping with external laboratories. Quality assurance officers will be trained to ensure efficacy and effectiveness, and quality management systems will be reviewed and updated. CNTS will strengthen a haemovigilance system to ensure the reporting of adverse reactions.

The CNTS is in the process of accreditation in order to ensure the highest standard of care for both patients and donors in blood banking, transfusion medicine and testing. AABB will provide quality TA through onsite mentorship for the implementation of a QA system. The documentation structure is being defined and put in place. Among other activities to be performed sooner is the identification of good manufacturing practice requirements adapted and implemented.

Finally, CNTS will pursue alternative financing mechanisms to establish sustainable blood collection and banking, including: determining the cost/ unit of the blood, and implementing charges for blood products.

No vehicles have been purchased, leased or planned under t

Cross-Cutting Budget Attribution(s)

Human Resources for Health	62,771

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12133**
Mechanism Name:	**Strengthening Blood Transfusion Services**
Prime Partner Name:	**National Center for Blood Transfusion, RBC NCBT/CNTS**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	2,092,369	0

Narrative:

In COP12, the CNTS will support infrastructure, blood collection, blood testing, quality management, accreditation and cost recovery. Infrastructure support will include the purchase of replacement medical equipment. Blood collection activities will be strengthened in order to meet the increasing demand for blood products in hospitals. In addition, the CNTS will continue to strengthen screening for HIV, HBV, HCV and Syphilis markers using automated machine and purchase of reagents; strengthen component preparation (red cells, plasma and platelets).

In the area of quality, CNTS will support quality assessments to define and document critical control points of blood collection, testing, component production, storage and distribution. Based on these assessments, quality improvements and corrective actions will be taken. In addition, CNTS will carry out regularly scheduled quality

control for blood components (platelets) and statistically analyze results. Staff will be trained in good manufacturing principles and quality management principles. The Blood Establishment Computer System (BECS) will also be fully implemented.

The American Association of Blood Banks (AABB) will provide technical assistance to CNTS to implement comprehensive quality management systems to prepare CNTS for the accreditation process. The CNTS quality officers and other key CNTS management and staff will be trained, including subsequent on-site mentoring, in the implementation of quality systems across all areas of the CNTS operation and facilities nationwide.

Cost recovery system: AABB's activities will include determining the cost per unit of the blood bag; exploring other examples of cost recovery systems; supporting blood donor education and implementing cost recovery for blood products to hospitals.

Implementing Mechanism Details

Mechanism ID: 12137	**Mechanism Name: CNLS Coag**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National AIDS Control Commission, Rwanda (CNLS)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: Both	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The aim of this project is to enhance the capacity of the Rwanda Biomedical Center/National AIDS Control Commission (RBC/CNLS) to effectively coordinate, approve and ensure that HIV prevention strategies implemented by partners are derived from proven evidence-based interventions and are appropriate to the epidemiological profile

of the population in Rwanda. Funding is expected to continue to build the capacity of RBC/CNLS to effectively coordinate HIV prevention efforts in Rwanda. The objectives include: coordination of thematic interventions at the district level during World AIDS Day; increase public awareness of HIV and STIs using mass media; ensure adequate human resources for mass media communication; ensure appropriate implementation of PEPFAR activities; support RBC/CNLS and partners to conduct, analyze, write and present HIV prevention programs during HIV national conferences; equip the RBC/IHDPC Documentation Centre with functional equipment; enrich the Digital and Physical library with new resources; and ensure adequate Human Resources for the hotline.

No vehicles or leases are planned under this mechanism.

Cross-Cutting Budget Attribution(s)

Education	14,000
Key Populations: FSW	5,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Workplace Programs

Budget Code Information

Mechanism ID:	**12137**
Mechanism Name:	**CNLS Coag**
Prime Partner Name:	**National AIDS Control Commission, Rwanda (CNLS)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	100,000	0

Narrative:

In OP, RBC/CNLS will continue to coordinate an HIV Prevention Steering Committee and the Most at Risk Populations (MARPs) Technical Working Group (TWG). RBC/CNLS will also continue to support both the bi-weekly radio communications and the hotline. OP communication will be targeted at: 1) increasing knowledge about how to protect oneself from HIV infection; 2) stigma reduction; 3) encouraging access to health services (e.g., HIV counseling and testing, diagnosis and treatment of sexually transmitted infections, use of antenatal and reproductive health services); 4) improving attitudes toward safer sexual practices; 5) delaying onset of sexual debut; 6) decreasing number of partners; 7) reducing use of sex workers; 8) increasing condom sales; 9) promoting recognition of early symptoms of sexually transmitted infections and HIV; 10) promoting recognition of the benefits and limitations of male circumcision for protection against HIV; 11) promoting HIV testing and disclosure of HIV serostatus within couples and families; 12) increasing access to treatment for HIV; 13) promoting the importance of adherence to antiretroviral drugs; and 14) promoting effective prevention of mother-to-child transmission programs.

The MARPs TWG will continue to coordinate activities, including the nationally approved minimum package aimed at preventing HIV transmission in MARPs including Commercial Sex Workers; at risk youth; men having sex with men (MSM); mobile populations, including migrant workers, truck drivers, and members of military and other uniformed services (e.g. police); and persons who exchange sex for money and/or other goods with multiple or concurrent sex partners, including persons engaged in sex work and/or transactional sexual partnerships.

Implementing Mechanism Details

Mechanism ID: 12140	**Mechanism Name: National University of Rwanda School of Public Health**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Rwanda School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 579,616	
Funding Source	**Funding Amount**

GHP-State	579,616

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USG support to the School of Public Health (SPH) of the National University of Rwanda is intended to strengthen the capacity of the SPH to deliver quality pre-service and in-service training and conduct operational research in the field of public health. Increasing the capacity of the SPH, which is the scientific arm of the GOR in the area of public health training and research, will contribute greatly to the Rwanda Partnership Framework agreement and the country's GHI Strategy. The project has three main objectives: Strengthen the capacity of the SPH to provide high quality education and training to national health leadership and district health teams in support of the MOH national health plan; Equip and support the SPH to be able to conduct applied research to improve the effectiveness and impact of health sector interventions and to provide training to lecturers, students and health professionals in research, epidemiology and program evaluation; Improve the physical, financial, and administrative infrastructure of the SPH to support the provision of high quality educational programs. After the emphasis on building the infrastructure of the SPH in the first two years of the project, an emphasis in the third year will be on improving the implementation of key activities in line with the priorities agreed upon with the MOH and the USG. In addition, activities previously funded via Tulane University will be transferred to this award, as will components of the Field Epidemiology and Laboratory Training Program (FELTP). Only one vehicle will be purchased for this project [REDACTED] to conduct supervision of students during field placements.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	579,616

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12140		
Mechanism Name:	National University of Rwanda School of Public Health		
Prime Partner Name:	Rwanda School of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	579,616	0

Narrative:

With USG support, the SPH is planning to implement a broad range of activities in COP12. These activities fall into three main categories: technical capacity building, administrative capacity building, and program implementation. In order to increase the human capacity of the SPH in academic affairs, PEPFAR funds will be used to support instructors and research assistants in all three academic departments. Support will also be provided for activities related to staff motivation and retention, such as performance based financing, teaching incentives, and research-related opportunities. In addition, funds will be used for participation at international conferences that contribute to improved teaching quality and research capacity, albeit at a much lower level than previously, per the PEPFAR guidance.

Capacity building efforts will also be directed to the Information Technology and Administration and Finance departments of the SPH. In addition to salary support for existing key staff members, two new positions will be added to the IT department to assist with the management of the new PEPFAR-supported computer lab.

In COP12, the SPH will use USG resources to support PhD and Master's degree programs, conduct certificate courses, and manage the HIV fellowship program. In conjunction with the RBC/IHDPC and the USG, the SPH will also manage the Field Epidemiology and Laboratory Training Program (FELTP). The SPH will also conduct evaluations of HIV/AIDS, TB, malaria, and other health initiatives to inform the implementation of GOR programs. Funds will also support the maintenance and updating of a knowledge and information dissemination center for publications on research conducted in Rwanda.

Implementing Mechanism Details

Mechanism ID: 12141	**Mechanism Name: Kigali Health Institute**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Kigali Health Institute	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 256,087	
Funding Source	**Funding Amount**
GHP-State	256,087

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Kigali Health Institute (KHI) intends to produce highly qualified medical laboratory technologists to provide quality diagnostic services for HIV testing & clinical monitoring. To ensure the sustainability & quality of medical laboratory training in Rwanda, KHI will recruit & build the capacity of local Rwandan educators to staff the Department of BioMedical Laboratory Sciences. The goals of the project include:

- *Develop human resources, teaching capacity, & a retention strategy to have Rwandan Nationals constitute at least 50% of the permanent teaching staff.*
- *Improve infrastructure & training resources to accommodate a 50% increase in the current number of students.*
- *Review the current training curricula and develop new programs to include all relevant areas.*
- *Establish partnership with other regional and international training institutions.*

KHI plans to renovate existing laboratory space to accommodate an increased number of students & equipment. The BLS department will purchase reagents, laboratory equipment & consumables, modern textbooks, audiovisual training material & electronic equipment, & journal subscriptions. KHI will continue to improve training curricula. The program includes comprehensive training on laboratory management, quality assurance & quality control, hematology, biochemistry, immunoserology, & microbiology. The department will establish linkages with other universities in the country, the region & overseas to increase access to modern health approaches relevant & applicable to the Rwandan context. In addition, KHI is developing an M&E program that will allow it to measure the effectiveness of the training both at KHI & at clinical sites. No vehicles have been purchased or leased or planned under this mechanism.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	205,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12141		
Mechanism Name:	Kigali Health Institute		
Prime Partner Name:	Kigali Health Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	256,087	0

Narrative:

Through support by USG PEPFAR, KHI intends to produce highly qualified medical laboratory technologists to provide quality diagnostic services for HIV and to monitor treatment of adults and children infected with HIV. To ensure the sustainability and quality of medical laboratory training in Rwanda, KHI will recruit and build the capacity of local Rwandan educators to staff the Department of BioMedical Laboratory Sciences. The goals of the project include:

- *Develop human resources, teaching capacity, and a retention strategy to have Rwandan Nationals constitute at least 50% of the permanent teaching staff.*
- *Improve infrastructure and training resources to accommodate a 50% increase in the current number of students.*
- *Review the current training curricula and develop new programs to include all relevant areas.*
- *Establish partnership with other regional and international training institutions.*

KHI plans to renovate existing laboratory space to accommodate an increased number of students and equipment. In addition, the BLS department will purchase reagents, laboratory equipment and consumables, modern textbooks, audiovisual training material, and electronic equipment, journal subscriptions to ensure that the laboratory is

sufficiently equipped with training resources. KHI will continue to improve its curriculum to meet the needs of medical laboratory technicians and technologists. This program will include a comprehensive training program on laboratory management, quality assurance and quality control, as well as core modules on hematology, biochemistry, immune-serology, and microbiology, among others. The department will establish linkages with other universities in the country, the region and overseas to increase access to modern health approaches relevant and applicable to the Rwandan context. In addition, KHI is developing an M&E program that will allow it to measure the effectiveness of the training on the KHI campus and the training received by students at remote site during their clinical attachments.

Implementing Mechanism Details

Mechanism ID: 12882	**Mechanism Name: Integrated Health Systems Strengthening Project (IHSSP)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 1,640,000	
Funding Source	**Funding Amount**
GHP-State	1,640,000

Sub Partner Name(s)

Futures Group		

Overview Narrative

The Integrated Health Systems Strengthening Project (IHSSP) is a 5-year project started in late 2009 that supports the effective and efficient use of scarce health system resources to provide sustainable high quality, client-oriented health and social services to all Rwandans. IHSSP provides technical assistance nationally to improve the capacity of the various GOR units in different components of the health system. IHSSP's expected results are:

- *Improved availability and utilization of data for decision-making and policy formulation*
- *Strengthened health financing mechanisms and financial planning and management for sustainability*
- *Improved management, quality, and productivity of human resources for health (HRH) and related social*

services

- *Improved and strengthened MOH capacity to manage HRH*
- *Improved quality of health services through implementation of a standardized approach to quality improvement*
- *Extended decentralized health and social services to the district level and below*
- *MOH Malaria Unit's M&E system established and effective.*

In COP12 IHSSP will discontinue support for HRH and decentralization in response to the GOR priorities, and activities will focus on transitioning the remaining technical areas to the relevant MOH units assuring that they will be able to continue independently without external assistance. IHSSP will train trainers in relevant skills areas, who will in turn be resources for and train MOH staff.

12 vehicles have been previously purchased under this IM. No additional vehicles will be purchased during COP12.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	656,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	12882		
Mechanism Name:	Integrated Health Systems Strengthening Project (IHSSP)		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	400,000	0

Narrative:

IHSSP will continue supporting and strengthening the MOH's Health and Management Information System (HMIS) as well as other eHealth activities. In COP12 IHSSP will focus on capacity transfer, transition and support for GOR eHealth program enhancements. During COP12 IHSSP will continue to support the enhancements to the DHIS2 platform and eHealth enterprise architecture, the harmonization of the various health sector information systems, as well as full-time TA through a senior HMIS Advisor to MOH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,240,000	0

Narrative:

IHSSP supports the effective and efficient use of scarce health system resources to provide sustainable high quality, client-oriented health and social services. IHSSP provides technical assistance nationally to improve the capacity of various GOR units in different components of the health system.

During COP12, IHSSP's activities will achieve results via:

- *Technical assistance to the eHealth and HMIS Units to implement the National E-health Strategic Plan and rollout of the new Health Management Information System, building MOH capacity at all levels to produce and use high quality data;*
- *Technical assistance to reinforce the functioning of the Health Financing Unit to support usage and expansion of performance based financing (PBF) and Community Based Health Insurance (CBHI) systems; and,*
- *Support for the development, roll-out and capacity building of Rwandan institutions for a system of continuous quality improvement in both provincial and district hospitals via accreditation.*

Implementing Mechanism Details

Mechanism ID: 12968	**Mechanism Name: NRL**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Reference Laboratory	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 977,218	
Funding Source	**Funding Amount**
GHP-State	977,218

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The NRL is now a division in the Institute of HIV/AIDS & other Diseases Prevention & Control (IHDPC) under the corporate structure of the Rwanda Biomedical Centre (RBC) of the MOH. The NRL continues to strengthen the laboratory network's capacity to deliver quality laboratory services for HIV/AIDS prevention, diagnosis, & care & treatment programs. The NRL's objectives include strengthening human resource capacity at NRL & within the national laboratory network (LN), strengthening administrative & management systems, strengthening the LN's provision of logistical & technical support for the provision of the minimum package of laboratory services at each tier of the LN pyramidal structure linked from NRL to referral hospitals, & district hospitals to primary health care site laboratories. Support & TA will be provided to the LN in laboratory infrastructure & services (labs in 4 referral hospitals, 45 district hospitals & over 450 private & public health centers). The MOH & RBC/NRL will continue to work with the Global Fund, President's Malaria Initiative (PMI), World Bank (WB), World Health Organization (WHO) & other stakeholders to further develop & sustain the program.

The NRL will contribute to PEPFAR's 3 major goals by ensuring quality HIV serology nationwide; strengthening capacity for the diagnosis of opportunistic infections as well as a national network of CD4 testing laboratories; widespread hematology & biochemistry capacity for monitoring patients on ART; & the scale up of patient viral load monitoring laboratories as well as ARV drug resistance. The LN will benefit from a stronger sample transportation system & also improve the turnaround time for service delivery within the LN.

No vehicles have been purchased or leased or planned under this mechanism.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	335,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)

TB

Budget Code Information

Mechanism ID:	**12968**
Mechanism Name:	**NRL**
Prime Partner Name:	**National Reference Laboratory**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	977,218	0

Narrative:

In COP12, the NRL will focus on the continuous strengthening of the laboratory network (LN) to provide laboratory services in the screening of HIV (to include rapid HIV testing and early infant diagnosis of HIV using PCR), monitoring the clinical prognosis of patients on antiretroviral (ARVs), the laboratory diagnosis of parasitic and microbial opportunistic infections (OIs) and quality improvement and management programs to include but not limited to laboratory accreditation process for 5 laboratories using the WHO AFRO Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA), external quality assessments, supervision-mentorship and in-service training. The goals include continuous reinforcement of capacities of personnel within the LN, providing NRL and the LN with equipment and reagents, strengthening the QA/QC program in the LN, and ensuring proper transfer of samples and data with the utilization of the Laboratory Information System (LIS). Care and ARV treatment activities are directly supported by ensuring quality HIV serology nationwide, strengthening capacity for the diagnosis of opportunistic infections, as well as a national network of CD4 testing laboratories, widespread hematology and biochemistry capacity for monitoring patients on ART and the scale up of patient viral load monitoring laboratories as well as ARV drug resistance at the NRL. Prevention of infection of critical health workers

will be achieved through training in biosafety precautions and good laboratory practices. Furthermore, by implementing the accreditation process within the LN, laboratory services will be improved to satisfy the clientele's desired quality and working environment. Also, the LN will benefit from a stronger sample transportation system and also improve the turnaround time for service delivery within the LN.None

Implementing Mechanism Details

Mechanism ID: 13172	**Mechanism Name: Youth and MARP Friendly Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: Both	
G2G: No	Managing Agency:

Total Funding: 838,696	
Funding Source	**Funding Amount**
GHP-State	838,696

Sub Partner Name(s)

Eglise Episcopal au Rwanda, Diocese de Shyira (EER)	National Youth Council	

Overview Narrative

The overall goal of the Youth & MARPs Friendly Services project is to reduce HIV & STI prevalence among youth (15-24 years) & MARPs in Rwanda. Averting new infections in this age group is the most sustainable way to reduce HIV/AIDS in Rwanda. Youth and MARP Friendly Services will continue to promote abstinence and safer sexual behaviors, encouraging uptake of HIV Counseling and Testing and STI services, improving access to HIV & STI prevention & treatment referrals through 4 fixed sites, & improving targeted HIV and STI "moonlight" outreach services.

In COP12, activities for Youth and MARP Friendly Services will include targeted youth and MARPs-friendly outreach

& VCT/STI service delivery, promotion of correct & consistent condom use, & peer education. Under this funding, VCT services will improve and strengthen linkages and referrals for HIV positive MARPs to ART services. Youth and MARP Friendly Services will also continue to implement a mix of behavioral strategies aimed at involve increased knowledge about how to protect oneself from HIV infection. VCT messages will emphasize the importance of HIV Testing and Counseling including Couples HIV Counseling and Testing (CHCT) and Provider Initiated Testing (PIT). Youth and MARP Friendly Services will continue to work with local partners to strengthen capacity to manage & implement activities, & support local organizations work in the areas of health impact & social marketing.

M&E activities will support the follow-on behavioral surveillance surveys among youth & MARPs, routine client intake and satisfaction data analysis for VCT service delivery and use of the BTS tracking survey data to inform the national prevention program.

One vehicle was purchased in year 2; & no other vehicles or leases are planned un

Cross-Cutting Budget Attribution(s)

Human Resources for Health	10,903
Key Populations: FSW	79,676
Key Populations: MSM and TG	32,709

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Family Planning

Budget Code Information

Mechanism ID:	**13172**
Mechanism Name:	**Youth and MARP Friendly Services**
Prime Partner Name:	**Population Services International**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	282,720	0

Narrative:

COP12 will continue to support comprehensive voluntary counseling and testing (CT), STI services and family planning (FP) counseling for youth and young MARPs at, and in communities around Youth Friendly Centers (YFCs) with the quality of services supervised by Youth and MARP Friendly Services and district health authorities. COP12 will continue to fully support management and technical implementation at 4 fixed sites and extend MARPs-targeted outreach services to an additional 4 sites, improving youth and MARPs access to high quality CT. VCT centers will be systematically referring to HIV care and treatment services at health facilities convenient for the clients. The program will develop vouchers to link and track referred clients. In COP12, Youth and MARP Friendly Services will also work on analyzing and documenting successfully linked clients as part of the periodic VCT data analysis that is underway. COP12 VCT efforts will continue to emphasize the importance of couples testing.

Supportive supervision and QA: Regular, joint supervision visits will be carried out by district health authorities and technical Youth and MARP Friendly Services staff (VCT QA Manager) to provide support to VCT counselors and ensure high quality counseling and data collection. Client intake and satisfaction forms will be entered by PDA at site level and analyzed regularly to inform program activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	555,976	0

Narrative:

OP messages will focus on the identified factors influencing correct and consistent condom use, including condom stigma, relationship trust, and knowledge of how to use a condom correctly. Delivered by comprehensive youth- and MARPs-friendly services in and around "Dushishoze" centers, these messages will target most-at-risk and out-of-school youth, living in high HIV transmission zones and youth frequented hotspots.

Youth and MARP Friendly Services and Rwandan Partner Organizations will continue implementing "moonlight"(road show "edutainment" interventions at hotspots) to promote correct and consistent condom use and VCT in the evening during weekends. Hotspots will include restaurants, bars and cabarets where MARPs frequent. This strategy will provide integrated youth and MARPs prevention interventions.

All condom outreach activities will employ a condom demonstration kit produced in FY09, which provides a flip chart of demonstration instructions and condom activities, consumer leaflets, and demonstration materials.

To support OP communications efforts, Youth and MARP Friendly Services will work with Rwandan Partner Organizations and existing private networks to increase condom access and availability for youth and MARPs, particularly in areas around hot spots and at night. This includes retail outlet creation efforts, and condom distribution at youth centers and through mobile outreach services. COP12 PE trainings will continue to primarily target out-of-school youth, sex workers and MSM.

Implementing Mechanism Details

Mechanism ID: 13598	**Mechanism Name: Rwanda Defense Health Program for HIV/AIDS Prevention, Care and Treatment in Foreign Militaries**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 485,000	
Funding Source	**Funding Amount**
GHP-State	485,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The overall goal is to strengthen the HIV/AIDS prevention capability within the Rwanda defense forces through safe voluntary medical male circumcision services. In order to align with GOR priorities to strengthen human resource for health, JHPIEGO is committed to: transfer skills and knowledge to Rwanda defense force health care providers by training a pool of trainers and managers who will be able to handle subsequent VMMC program implementation within the RDF (more than 20% of program effort will be dedicated to this area); establish a center of excellence within the Rwanda military hospital that will be used for development of skills and innovations in male circumcision in general; and ensuring an enabling environment for quality and safe services as well as creating demand within the

RDF.
In order to mitigate the issues of staff turnover as well as ownership and sustainability within the defense force, JHPIEGO will work closely with the Directorate of Military Medical Services and Medical Battalion to ensure a staff retention and replacement plan through innovative approaches like on-site training, mentorship, self -paced learning and supervision. Task-shifting/sharing will also be encouraged for efficient and accessible service delivery as per national standards and international guidance. Innovations such as MOVE (Model for Optimization of Volume and Efficiency), collaboration with nearest public health facilities within the Ministry of Health structures and Mobile VMMC Clinics will be promoted in order to meet the national goal of 2 million of the 15-49 year old HIV negative men by June 2013 as part of a comprehensive HIV prevention program. This will not only ensure transfer of skills but also be more cost efficient.
No vehicle purchases are planned in COP12.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Military Population
Family Planning

Budget Code Information

Mechanism ID:	**13598**
Mechanism Name:	**Rwanda Defense Health Program for HIV/AIDS Prevention, Care and Treatment in Foreign Militaries**
Prime Partner Name:	**JHPIEGO**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	485,000	0

Narrative:

The geographic coverage considers all the five provinces with 13 sites in addition to the mobile clinic services reaching 15,000 soldiers including family members to be circumcised. The pool of national trainers and supervisors will be strengthened and used for quality control follow-ups with nationally agreed standards for VMMC. In collaboration with PSI and DMS, IEC materials will be disseminated and messages promoted within the target population. VMMC is not replacing other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package which includes routine counseling and testing for all men and, where possible, their partners attending MC services; age-appropriate sexual risk reduction counseling; and counseling on the need for abstinence from sexual activity during wound healing; and promotion of correct and consistent use of condoms. All trainings will be based on WHO/UNAIDS/JHPIEGO MC reference manual and will be tailored to the Rwanda National MC guidelines. A linkage strategy to other HIV/AIDS and Reproductive health services will be clearly defined.

JHPIEGO in collaboration with RDF will put in place a detailed and focused M&E plan that will rigorously monitor project activities. A management Information system will track inputs and outputs such as number of providers trained, equipment and consumables used and the number of clients seeking and receiving MC. The Rwanda Defense Forces health facilities will require renovation and refurbishment in order to meet the minimum standards to offer safe and quality VMMC services.

Implementing Mechanism Details

Mechanism ID: 13704	**Mechanism Name: PACM**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Maryland	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 808,000	
Funding Source	**Funding Amount**

GHP-State	808,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Partnership for Advanced Clinical Mentorship (PACM) will support the MOH through clinical mentorship, supervision, and continuous quality improvement as well the development of evidence-driven national policies, guidelines, and training materials as needed. The initial goal of this activity is to help sustain quality HIV services at 76 transitioned clinical sites. PACM strives to strengthen the national mentoring program by enhancing the clinical competencies and mentorship skills IHDPC staff and district mentorship teams. PACM will strengthen health facility systems for quality improvement and clinical performance.

A multidisciplinary group of experts including infectious disease specialists (adult and pediatric), quality improvement specialists, and epidemiologists will directly support IHDPC. PACM will also support the new HRH program of the MOH with a focus on the development of the Infectious Disease Specialist Diploma program. Further, PACM will support effective integration of HIV/AIDS with primary care services and will leverage existing HIV care and treatment systems for effective management of infectious diseases such as TB, Malaria, neglected tropical diseases and non-communicable chronic diseases.

A five year Technical Assistance Plan for the MOH will be developed in partnership with the MOH and other partners during the first six months.

No vehicles or leases are planned under this mechanism.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	375,703

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13704**
Mechanism Name:	**PACM**
Prime Partner Name:	**University of Maryland**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	391,000	0

Narrative:

As part of the capacity building plan for the MOH, PACM will identify focal people within IHDPC and healthcare facilities to enhance the quality of care services for HIV-positive patients (both pre-ART and ART patients) including prevention and treatment of opportunistic infections. In order to strengthen HIV care services at the facility and national levels, PACM will support IHDPC to undertake the following activities:
•Development of standards of care for HIV-positive individuals who are not yet in need of antiretroviral treatment,
•Appropriate implementation of these standards of care, and
•Effective tracking of HIV-positive individuals who are in care and not yet on ART to ensure they are not lost to follow up.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	137,000	0

Narrative:

As part of the capacity building plan for the MOH, PACM will identify focal people within the Maternal and Child Health Unit of the MOH and the IHDPC to improve the quality of PMTCT services at all levels of the health care system. Specific activities to be undertaken during the year will include:
•Updating of key PMTCT guidelines and protocols

•Ongoing mentorship of clinicians and other health care workers in implementation of PMTCT guidelines
•Effective integration of PMTCT activities with HIV services at the facility level
•Augmenting efforts for early diagnosis of children born to HIV-positive mothers and ensuring appropriate follow-up care and/or treatment
•Supporting facilities to ensure that standards of care for HIV-positive women are fully implemented including 100% referral to HIV care and treatment services

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	280,000	0

Narrative:

As part of the capacity building plan for the MOH, PACM will identify focal people within IHDPC to improve the quality of HIV treatment services across the country. Specific activities that will be undertaken to strengthen HIV treatment systems will include:
•Increasing clinicians' practical skills for improved management of complex HIV patients,
• Developing a national cascade mentorship system that will ensure sustainable capacity of different levels of care to deliver HIV treatment and related services,
•Updating training materials for integrated management of HIV/AIDS and related infections,
•Implementing continuous quality improvement initiatives at all facilities, and
•Augmenting the capacity of facilities and communities to strengthen the HIV continuum of care system.

Implementing Mechanism Details

Mechanism ID: 14287	**Mechanism Name: Family Health Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Chemonics International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 5,976,861	
Funding Source	**Funding Amount**
GHP-State	5,976,861

Sub Partner Name(s)

Elizabeth Glaser Pediatric AIDS Foundation		

Overview Narrative

FHP is follow-on to USAID's HCSPs, which ends in COP11. FHP will continue to build service delivery capacity preparing for the eventual transition of HIV/AIDS clinical services to the GOR.

Under FHP, USG will support 120 health centers and 10 district hospitals in 12 administrative districts to implement HIV/AIDS programs as part of the Partnership Framework Strategy. Services include: VCT; staging patients in pre-ART services; ART for children and adults; PMTCT; OI diagnosis and treatment with TB screening among PLHIVs and HIV screening among TB patients; psychosocial support; nutrition screening and food supplementation for eligible clients; support for community health insurance schemes for PLHIV identified as indigents; support for income generating activities for PLHIV and OVC; and strengthened linkages to community care services.

FHP will support district health teams and local government with health decentralization. In COP12, FHP will support quality improvement initiatives, improved M&E, planning, program implementation, and capacity building in all supported health facilities to manage quality HIV/AIDS programs. Monitoring and quality services to prepare transition of clinical sites to GOR will be prioritized.

Per GOR's request, USG has shifted $2M in funding for clinical services support to the GOR's HRH activity. Beginning in October 2012, the GOR will assume full responsibility for funding and implementing clinical services at approximately 30 health facilities in three districts. The USG will continue contributions to PBF payments and health facility staff salaries in the three districts, while the GOR will fund all other costs. The USG and the GOR will work together during COP11 to identify the three districts and to implement the transition.

Cross-Cutting Budget Attribution(s)

Gender: GBV	44,826
Gender: Gender Equality	179,306
Human Resources for Health	1,972,364
Water	29,884

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**14287**		
Mechanism Name:	**Family Health Project**		
Prime Partner Name:	**Chemonics International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	239,117	0

Narrative:

In COP11, the USG, through HIV/AIDS Clinical Service Project (HCSP), provides basic HIV care and support to the targeted 46,824 adult HIV clients at 158 clinical sites in 15 admin districts. The package of services includes: WHO clinical staging; baseline and regular CD4 counts; prevention education; screening, diagnosis and treatment of OIs including TB and STIs; adherence support; condom provision; food and nutrition support; and provision of clean water. Under HCSP, the first National Palliative Care (PC) Policy is being rolled out. The package includes pain management, psychosocial and spiritual support in both clinical and community locations, including home-based care. Additionally, HCSP is supporting the national roll out of PC in holistic approach, including support to MOH for national program coordination, development of a palliative care implementation plan, training materials, and curriculum development as well as procurement of related supplies and commodities.

In COP12, FHP in collaboration with other entities such as the National Police, legal and civil society institutions will continue to support SGBV services, including community sensitization, TA (training of site staff to handle SGBV cases at clinical levels) and linkages to community. Through FHP, USG will continue to support HIV care services in existing sites, including provision of Co-trimoxazole and other OI drugs, STIs and TB screening, and wrap around activates that facilitate a one-stop services center for PLHIV. IHSP will continue to emphasize retention of patients in pre-ART services and strong linkages to community services for economic strengthening and/or psycho-social support.

FHP will work closely with the Rwanda Biomedical Center (RBC), in providing required TA for the implementation of evidence-based care and support interventions. FHP will also support community health workers (CHWs) implementing the new palliative care policy, and monitor the quality of services provided

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	469,856	0

Narrative:

In COP10, HCSP supported TB/HIV integration for adults and children across ART sites in 15 districts. Services included TB screening, diagnosis and treatment among HIV positive persons. HCSP supported TB/HIV national guideline revision and its implementation at decentralized levels. In Cop 11, HCSP supported the TB/HIV training curriculum revision, theory and practical trainings as well as TA for supervision at TB diagnostic and treatment centers in the 158 sites across 15 districts.

In COP12, FHP, in collaboration with other stakeholders including MOH institutions, and other implementing partners, will continue to support TB/HIV integration and collaborative activities at the health facility level. Activities will include participating in the national TB/HIV working group for revising and updating guidelines, curriculums, and tools. Supportive supervision for quality TB and HIV service delivery to co-infected patients - particularly to strengthen the implementation of routine HIV counseling and testing, especially in TB suspected cases will also be carried out. Prevention education and referral for HIV care, if indicated, for all patients with TB at the TB/DOT clinics will also be supported. In addition, FHP will support the implementation of standardized symptom-based TB screening and intensified TB case-finding for patients living with HIV. TB/HIV integrated service provision will be improved and the "one stop service" TB care will continue to be supported in order to avoid new co-infections.

Through collaboration with RBC, MOH, and other implementing partners, FHP will strengthen mentorship and supervision capacity at central and district level to improve quality of TB diagnosis in TB suspected cases. TB/HIV integration mentoring, including TA and supportive supervision will also be supported.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDCS	822,626	0

Narrative:

GOR estimates that there are 22,240 HIV-positive children less than 15 years of age currently in Rwanda (Epi Update, April 2010). Most of them acquired HIV through vertical transmission. In COP11 HCSP supported the scale up of Early Infant Diagnosis (EID) in all PMTCT sites. In COP12, FHP will continue to support integrated training in PMTCT, EID and nutrition to improve the capacity of health care workers on cascade testing, nutrition assessment and support, psychosocial support, and linkage to ART units for those who test positive.

Additionally, all HIV positive children will be provided with OI prevention and treatment services as recommended by the national guidelines. FHP will also continue to support EID implementation at the facility level.

FHP will continue to support and consolidate HCSP efforts to enhance adequate pediatric care within national and international recommended guidelines. In COP12 FHP will support efforts to improve and maintain quality through periodic program data reviews, feedback to the facilities and mentorship.
FHP will support PICT at all entry points to ensure testing of more children and strengthen referral of newly diagnosed to ART services. FHP will also support nutrition counseling and supplementation, referrals for all HIV-positive children to malaria prevention services for provision of LLITN, as well enhancement of water purification kits and hygiene education.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	220,426	0

Narrative:

USG has been supporting health systems strengthening through different mechanisms, some of which are typically clinical services projects, drawing money from non-health systems strengthening budgets. Strengthening district pharmacies, training of providers to build skill for quality health services, supporting performance-based financing and community health insurance, putting in place generators or solar panels for energy provision at health facilities and infrastructure renovations have been supported. In COP12, FHP will continue to provide targeted support to the national and district systems strengthening in support of the eventual transition clinical services to the GOR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	633,626	0

Narrative:

In COP11 HCSP supports 158 sites in 15 districts to provide CT services to a targeted 466,053 clients from the general population and provides a package of services that include: voluntary counseling and testing (VCT); couples counseling and testing (CVCT); prevention messages including BCC at health facility and community levels (including sensitization and community service outlets for VCT); as well, as referral of HIV positive cases to care and

treatment programs. Provider-initiated testing and counseling (PICT), involving clients from outpatient departments, ANC, TB clinics, immunization services, hospital admissions, nutritional services, etc., are also supported. HCSP also supports GOR with decentralized trainings including on-the job-training and supportive supervision to improve the quality of services offered to clients and to implement national protocols.

In COP12, FHP will continue to support and consolidate effort made by HCSP in CT services including family-centered approaches and streamlining PICT in all facilities to maximize testing opportunities. FHP will continue to support CT activities including rapid finger prick testing in all 130 supported sites in the 12 districts. FHP will support linkages to other HIV services mainly between PMTCT and ART services and enforce a continuum of care framework to improve enrollments and support adherence to treatment. During COP12 FHP will continue to support improved pre-test and post-test counseling approaches especially for children and adolescents in order to facilitate the disclosure process and prevention (including prevention with PHIV). Human resource capacity will continue to be strengthened, including TA, targeted new and refresher trainings, as well as supportive supervision. FHP will support regular data collection, management, and reporting in order to improve the informed decision making.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,555,675	0

Narrative:

GOR has developed a five-year National Strategic Plan on HIV and AIDS 2009 -2012 (NSP) with a goal to halve HIV incidence in the general population by 2012. USG, has supported the scaling up of PMTCT services to improve geographic accessibility, and by COP11, through USAID, 158 health facilities in 15 districts were providing PMTCT services. From October 2010 to September2011, the number of pregnant women counseled, tested and given their results (including maternity) were 101,233 (99% of those attending ANC). A total of 1,673 (1.65%) pregnant women tested HIV positive. Of the women who accepted the test, 83% were tested with their partners. HCSP provided technical support to the central and decentralized levels through trainings, mentorship and technical supervision and facilitated joint site level monitoring with district health teams as a way of building national capacity. HCSP supported GOR to implement the new WHO PMTCT option B protocol of using more efficacious regimen as well as the current elimination of MTCT strategy of reducing HIV mother-to-child transmission rate below 2% by 2015.

For COP12, FHP targeting considered national goals to target 90,883 pregnant women with known HIV status for PMTCT services for COP12. In COP12 strategies to improve testing in PMTCT including finger prick and provider-initiated counseling and testing (PICT) testing models will be used. FHP's support to GOR will emphasize monitoring implementation and progress of these activities including the establishment of five new PMTCT sites whose support is planned with Partnership Framework money.

FHP will consolidate and reinforce previous efforts to integrate PMTCT into existing maternal and child health interventions, integrated management of childhood illnesses, expanded program of immunization as well as sexual and reproductive health. FHP will continue to support nutrition in PMTCT services and ensure effective use of the infant and young children counseling and training package within a harmonized framework to enhance adherence and mother/infant pair follow-up

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,212,909	0

Narrative:

In COP11 HCSP supports 27,210 adults currently on ART in 13 district hospitals and 145 health centers in 15 districts. The treatment program includes: clinical staging and baseline CD4 count for all PLHA; timely initiation for those eligible for ART according to CD4 cell counts of 350 cells/ µl or WHO clinical staging according to national guidelines; follow-up of patients' CD4 counts every six months; management of opportunistic infections (OIs) and other HIV-related illnesses - including OI diagnosis, preventive therapy with Co-trimoxazole (CTX) prophylaxis regardless of CD4 counts; nutritional counseling and food support; psychosocial counseling and support; positive living and risk reduction counseling; and palliative care for pain and symptom management and end-of-life care.

Currently the majority of patients on ART are on first line drugs, an indication that early diagnosis of treatment failure may still be weak. In COP12 FHP will support capacity building for early diagnosis and management of treatment failure through mentoring and targeted viral load testing according to clinical indications. FHP will support targeted refresher trainings, participate in national TWGs, provide mentorship and supportive supervision to the national treatment program, support program data analysis to inform planning, and link with other stakeholders at the national and decentralized levels to support a sustainable HIV program. In COP12 FHP will continue to use electronic databases that facilitate patient follow-up and support to district health networks and districts administrations to improve planning for health and provide better coordination.

Under FHP, USG will continue to support capacity building for providers, district pharmacies, as well as technical assistance for clinical treatment to enable the eventual transition of services to GOR institutions without any lost in the quality of services provided.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	822,626	0

Narrative:

During COP11, HCSP implementers continue to support the national HIV pediatric program at central and decentralized levels. HCSP supports dissemination of guidelines, tools, & training materials used in HIV pediatric care & treatment programs. HCSP supports GOR to conduct refresher training for trainers and training of providers

on task shifting. HCSP also supports provider-initiated testing at all pediatric in- and outpatient settings at PEPFAR supported sites, laboratory trainings & mentorship to improve diagnostic capacity of facility staff, reinforced psychosocial support for HIV-positive children and adolescents through support groups to address issues around status disclosure and adherence support. *HCSP supports pediatric HIV integration with other services including TB screening, assessment, and provision of nutrition services as well as integrated management of childhood illness. During COP 11, HCSP targeted 400 children under 15 years that were enrolled in care and treatment programs. In COP11 4,663 targeted children are provided with at least a minimum package of care.* *In COP12, FHP will continue to support pediatric treatment integration within the national healthcare system. Efforts will be made to reinforce PICT at all entry points to enroll more children, support capacity building strategies through training, joint supportive supervision, and effective strategies to maintain quality care provision. FHP will support: 1) National roll out of the Mother/Infant/Young Children Nutrition package to all sites and community level that were initiated in COP10; 2) Improved nutritional services at all PMTCT & ART sites, including staff training on infant and young child feeding and maternal nutrition; 3) Improved data quality processes through regular data audits and data reviews in the joint supervision process to enable sites and district staff to appropriately use data and ensure quality; 4) Pediatric treatment adherence through support groups, and 5) Neonatal, infant and child death audits within an integrated model.*

Implementing Mechanism Details

Mechanism ID: 14426	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16857	**Mechanism Name: Ubaka Ejo**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: African Evangelistic Enterprise	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 720,000	
Funding Source	**Funding Amount**
GHP-State	720,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ubaka Ejo program supports OVC, their families, and other vulnerable households to improve their health and social and economic well-being. It is implemented by a Rwandan CSO named AEE, which graduated from one of USAID's NGO IPs as a sub-recipient and can now implement programs with direct funding. AEE will gradually transfer capacity to CBOs and other groups, as well as households, towards complete ownership. Ubaka Ejo plays a key role in identifying and reaching vulnerable populations, providing services, and strengthening referral systems. Over 3 years, the program will serve 18,100 OVC and their families in 9 districts across 4 provinces through a community-led program of sustainable prevention, care & support.

Since COP 12, Ubaka Ejo was focused on a holistic and need-based approach for HIV prevention, as well as other disease prevention and care & support. Activities also strengthened household resilience through health, social & economic service provision and nutritional & educational support. In addition, community sensitization was conducted on social protection, including family law & succession planning, child rights & protection, GBV prevention & support, and referrals for cases in need. In COP 13, Ubaka Ejo will continue these interventions with a more cost-effective approach, where project staff will work with CBOs and other groups as well as households, and in collaboration with local authorities, to reach a larger number of beneficiaries. These groups include internal saving & lending groups, Farmer Field School, anti-AIDS/GBV clubs, psychosocial & peer support groups. In addition, the program will conduct regular internal M&E activities; results will be measured on a semi-annual and annual basis, as well as over the lifetime of the award.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	72,000
Education	216,000
Gender: GBV	43,200
Human Resources for Health	144,000

Water	28,800

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**16857**		
Mechanism Name:	**Ubaka Ejo**		
Prime Partner Name:	**African Evangelistic Enterprise**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	135,000	0

Narrative:

In COP12 Ubaka Ejo program started implementing community-based health care and support and social and economic strengthening interventions, as well as nutrition support including kitchen gardening and other service provision to OVC and other HIV/AIDS infected and affected populations vulnerable to malnutrition and diseases. In addition, the program is integrating access to safe water and its effective use, as well as promotion of hygiene practices including hand washing, to reach at least 65% of the total number of targeted beneficiaries. In COP 13, USG will continue to support the Ubaka Ejo program to increase its level of effort, through which 18,100 adults and children will be provided with a minimum of care service, including 14,600 OVCs to be served by the project with at least one care service.

A total of 1,200 community volunteer care providers will be trained to support beneficiaries, and 3,100 households will be supported with access to formal and informal financial and agricultural extension

services. These services will be provided through CBOs and other community-based groups, such as ISLGs, PD Health. Through these groups, the Ubaka Ejo program will provide health and nutritional support and psychosocial support, including responding to GBV cases and providing referrals to supportive institutions as needed. Specific activities include payment of mutuelles; psychosocial care and support for HIV positive beneficiaries and other persons in need; support for adherence to care and treatment; as well as referrals to health facilities. Regarding nutritional activities, growth monitoring and nutritional status evaluation will be done and referrals for malnourished cases will be provided as needed. Support for access to clean water sources for all OVCs and their families in selected districts will be provided, as well as nutritional education and support including kitchen gardening and small business entrepreneurship. Nutritional education will also be given to OVC, their families and caregivers, who will be strengthened to support and sustain the positive nutritional status of OVC and their families through kitchen gardening and consumption of products. Household strengthening activities will establish income-generating activities to enhance food and nutrition security and will promote economic strengthening through ISLGs and training community volunteers to provide care and other services to OVCs and their families.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	370,000	0

Narrative:

The Ubaka Ejo program's objective is to improve quality health services for 14,600 OVC in families affected by HIV/AIDS by increasing the supportive community response to them. Support will ensure that OVC in selected districts have access to educational & vocational training opportunities. The program will also increase access to and usage of formal and/or informal financial and agricultural extension services to child-headed households and other vulnerable families.

The program will continue to support education, with 14,600 students in primary & lower secondary education, advanced secondary, and in accelerated learning catch-up and/or vocational training programs. Out-of-school youth will also be supported to access short-course training, through which a number will undertake apprenticeships in different areas and market-based enterprises. The program will support technical & vocational training, in accordance with priority GOR strategies in this area, to develop market-based employment skills recommended by the Rwandan Workforce Development Authority. To support 12-year basic education at the primary & lower secondary levels, scholastic & personal materials will be provided to enable OVC to attend school. Other fees (for meals, accommodation & other boarding expenses) will be paid for OVC in boarding schools far from their homes. Special consideration will be given to paying the fees of children that pass their "O" level exams and are posted to schools as a way of motivating them. OVC will be monitored on a bi-term basis, and support given to underachieving students

to help them improve. Assessments will be conducted to identify causes of poor performance and appropriate remedies will be implemented.

The Ubaka Ejo program collaborates with local authorities and CBOs to identify & validate lists of OVC, following the OVC guidance approved by the Ministry of Gender and Family Promotion. Interventions will build on the existing platform of program models, curricula, tools & other local resources, targeting basic education including primary & secondary education as well as vocational training, and leveraging gains in household revenues through economic strengthening activities to reduce the subsidies being provided towards school fees & materials, thus moving towards sustainability and cost-effectiveness.

The support provided to OVC will also consider child-headed households through the promotion of youth ISLG and other economic services. The program will also strengthen 1,200 community caregivers to hold open sessions with OVCs, with the purpose of developing their life skills, personal values and goal setting.

In addition, other services will be provided to OVC, including health education & home visits (HIV prevention, hygiene, adherence to care & treatment, counseling & testing for HIV, peer education) and referrals as needed. These activities will also include the promotion of hygiene & sanitation and the good use of water sources, as well as other good practices such as drinking clean water, hand washing, use & maintenance of good toilets & rubbish disposal. Counseling sessions & psychosocial support for OVC through support groups & peer education will also be supported as well as social protection activities such as building community awareness to prevent child abuse, exploitation including child labor, gender-based violence and domestic violence. Legal support will be facilitated for cases in need through referrals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	125,000	0

Narrative:

As the Ubaka Ejo program has among its objectives to strengthen the capacities of CBOs, including cooperatives, associations, child care committees, anti-GBV committees, ISLGs, anti AIDS clubs, and other groups, the program will continue to implement these interventions. Targeted activities will include provision of financial and technical support to reach up to 3,500 most vulnerable households and community members in the intervention catchment areas. These CBOs will be able to help their members and households to develop more resilience and program ownership, building sustainable health, social and economic development through existing psychosocial support groups, ISLGs, FFS, and PD Hearth Groups. Interventions are mainly focused on training community caregivers and other capable group members on providing disease prevention messaging; promoting access to and use of safe water source; promoting kitchen gardening; detecting signs of malnutrition and referring those in need; disseminating

messaging to fight against HIV, GBV and child abuse; and providing training on social protection, including human rights, with a special emphasis on children. The caregivers will be empowered to provide continuous TA and mentoring to community members towards sustainable social and economic development.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	90,000	0

Narrative:

In COP 13, the Ubaka Ejo program will implement prevention interventions on a need-based, age-oriented and gender-sensitive approach, and in collaboration with CBOs in its catchment area, will provide HIV and other disease prevention messages as well as malnutrition prevention to OVCs and their families. The messages will include sensitization on HIV prevention and referral to health facilities for those who need testing, as well as provision of life skills to OVCs including negotiating healthy sexual relationships and education on reproductive health. The ABC message will also be provided through one-on-one talk sessions as well as promotion of abstinence among students through home visits and group talks. Behavior change messaging to prevent HIV, STIs and other diseases as well as unintended pregnancies will also be provided to youths and couples. In addition, health education will be provided to prevent infancy-related diseases among all CBOs in the program catchment area. Prevention activities will also include education for family and social protection, including child rights and protection, and prevention of gender-based violence (GBV). Communication channels for these messages will be different CBOs and other groups including peer support groups, Positive Deviance (PD) Hearth groups, Internal Savings and Lending Groups (ISLG), FFS and households. With the mentorship and support of trained community volunteers, these groups will then spread the prevention messages to other community members.

Implementing Mechanism Details

Mechanism ID: 16858	**Mechanism Name: Gimbuka**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Caritas Rwanda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 685,000

Funding Source	Funding Amount
GHP-State	685,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID awarded the Gimbuka program at the end of FY 2012 to Caritas-Rwanda, a local civil society organization which was previously a sub-grantee to CHF international, and which has since developed and strengthened its capacity to receive direct funding from USAID. The overall goal of the project is to 1) improve the nutritional status of mothers and children, especially those under two years of age, through community-based nutrition interventions, and 2) improve the well-being of OVC and their families affected by HIV/AIDS. The program covers 14 districts for OVC interventions and 9 districts for nutrition activities, serving a total population of 36,070 OVCs, including their families; 43,200 children under five years; and pregnant and lactating women for nutrition. Gimbuka uses cost-effective, community-based solutions like internal savings and loan groups (ISLG), Farmers Field Schools and the Positive Deviance Hearth (PD Hearth) model. Gimbuka is improving the well-being of OVC and their families affected by HIV/AIDS. Through this program, emphasis will be placed on resilience and empowerment through economic strengthening, food security, nutrition and hygiene, and increased access to health services. To become more cost-efficient over time, the program will continue to seek resources both locally and internationally through its existing networks and partners to achieve its full potential. The program will build upon the successful and functional systems established under CHF International and other projects to ensure a robust approach to monitoring and evaluation. Caritas will collect data on a monthly, quarterly, and annual basis. Both qualitative and quantitative methodologies will be used.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	205,500
Education	205,500
Food and Nutrition: Commodities	47,950
Food and Nutrition: Policy, Tools, and Service Delivery	20,550
Gender: GBV	34,250
Gender: Gender Equality	34,250
Human Resources for Health	20,550

Water	47,950

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Child Survival Activities

Budget Code Information

Mechanism ID:	**16858**		
Mechanism Name:	**Gimbuka**		
Prime Partner Name:	**Caritas Rwanda**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	180,000	0

Narrative:

Gimbuka will promote increased household savings through greater participation in existing internal savings and loan groups (ISLG). The program will work with well-organized and established cooperatives which serve as models for more nascent business groups. The program will not establish new ISLG; rather, it will continue to consolidate the existing groups by strengthening them and supporting their evolution towards functional business groups, where relevant and feasible. ISLG members will be encouraged to save money for health and education costs for their households. Gimbuka will link them to formal banking institutions such as Umurenge savings and credit schemes (SACCOs) and micro finance institutions (MFIs) as a means of accessing credit.

Gimbuka will target OVC household members with moderate malnutrition and living with HIV/AIDS with appropriate community-based nutrition services. They will be recruited into PD hearth groups to benefit

from cooking demonstrations, nutrition counseling and feeding on highly nutritious foods prepared for them and grown locally. These activities will improve the nutritional status of the beneficiaries, and improve their adherence to ART. The project has established strong linkages from community to health facilities to refer cases which are not responding to treatment, with opportunistic infections and severe malnutrition.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	245,000	0

Narrative:

In COP 13, Gimbuka will strengthen the economic capacity of OVCs and their families by increasing the capacity of parents to contribute to the education needs of their children. To ensure sustainability, parents will be trained on saving for payment of health insurance and educational costs for all family members. Services will be extended to the families/households by promoting the use of ISLG, income generating activities and provision of saving kits (boxes, rulers, pencils, pens, registers, padlocks, etc.) in addition to being linked to MFI services. Gimbuka will focus on targeted savings for use towards education and health costs to support OVCs in the households, support and monitor the pre-existing ISLGs, and report on quarterly progress.

Gimbuka will provide scholastic materials to OVCs in primary, secondary and technical and vocational education training (TVET) schools. The program will monitor each beneficiary's school performance to ensure that the maximum number of enrolled OVCs complete their studies and advance to the next school level.

Psychosocial support services will be extended to OVC through established networks of community-based caregivers. Gimbuka will increase the capacity of these caregivers to support targeted OVC to be successful and healthy in schools, and to recognize signs of trauma and sexual gender based violence (SGBV). Child protection in communities will be promoted, via increased sensitization of community leaders and members on child rights. Meetings will be organized with children to promote better understanding of their rights.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	125,000	0

Narrative:

In COP 13, Gimbuka will strengthen capacities of community based organizations (CBOs), cooperatives, associations, child care committees, and ISLGs as well as community health workers (CHWs). With new

knowledge and skills, CBOs will be able to pass on skills to help their members build sustainable social and economic development through existing psychosocial support groups, ISLGs, FFS, and Positive Deviance Hearth Groups for economic empowerment and sustainability.

Gimbuka will build the capacity for CHWs who, in collaboration with Gimbuka staff, will closely follow the implementation of monthly growth monitoring and promotion for early detection and prevention of malnutrition among under-fives. The interventions will mainly focus on training community caregivers and other capable group members on providing disease prevention messages like HIV awareness, improved hygiene practices, access to and use of safe water, kitchen gardening, messaging to fight against GBV, and training on social protection including human rights, with a special emphasis on children's rights.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	135,000	0

Narrative:

Gimbuka will support HIV prevention interventions to reduce the risk of HIV transmission to uninfected partners and children. These interventions will include information/counseling on risk reduction including condom use, limiting number of sexual partners, reducing alcohol use, support for safe disclosure of HIV status to partners, and safe pregnancy counseling.

This program will reach out to youth and sensitize them on HIV prevention through peer education and outreach. Peer outreach will rely on local community members to reach key populations with HIV prevention information and referrals to important services. Peer education and outreach will be accompanied by risk reduction counseling and information linking beneficiaries to appropriate services. Gimbuka will raise HIV awareness by encouraging the youth and families with whom they work to access HIV testing and counseling.

Gimbuka will help communities establish Anti-AIDS clubs to increase awareness of dangers posed by HIV and to help communities make appropriate decisions on risk behaviors. Anti-AIDS clubs will also be extended to the youth in schools and those out of schools. Gender committees will also be established to help fight gender based violence (GBV) in the districts where the project operates.

Implementing Mechanism Details

Mechanism ID: 16859	Mechanism Name: Rwanda Social Marketing Program

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Society for Family Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,105,000	
Funding Source	**Funding Amount**
GHP-State	1,105,000

Sub Partner Name(s)

Population Services International		

Overview Narrative

The Rwanda Social Marketing Project (RSMP) will be implemented by Society for Family Health, a Rwandan CSO. RSMP is a 3-year integrated social marketing project targeting key populations & focusing on HIV prevention; malaria; water, sanitation and hygiene (WASH); nutrition; family planning/reproductive health (FP/RH); child survival (CS); & maternal/child health (MCH). RSMP focuses on 12 districts which have HIV prevalence rates above the national average of 3% among adults aged 15-49.

The objectives are: 1) develop & manage a cost-effective marketing, sales & distribution network that improves access among key populations to branded health products; 2) continue to enhance services & referrals for key populations; and 3) increase availability of data & evidence to inform programming around key issues in HIV/AIDS, malaria, FP/RH and CS. Expected impact is: 1) reduction in risk behaviors; 2) improvement in MCH and RH through increased use of socially marketed products & high quality FP, antenatal & postnatal care services; 3) improved integration & sensitization on stigma, discrimination & gender equality; 4) improved nutrition, WASH, malaria prevention, CS & increased health-seeking behavior for most vulnerable populations; and 5) reduction in risk of HIV transmission through increased HIV testing & counseling.

These activities were previously implemented by an international partner; as a result of the transition to a local partner, they are now more cost-effective.

During FY14, RSMP will transition their paper-based information management system to an electronic monitoring

system to allow the project to accurately record & project sales & stock of products. Entry & exit interviews will be conducted to allow the project to gather accurate, timely data.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	44,200
Gender: GBV	88,400
Gender: Gender Equality	165,750
Human Resources for Health	55,250
Key Populations: FSW	442,000
Key Populations: MSM and TG	110,500
Water	55,250

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Mobile Population
Family Planning

Budget Code Information

Mechanism ID:	**16859**

Mechanism Name:	Rwanda Social Marketing Program
Prime Partner Name:	Society for Family Health

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	75,000	0

Narrative:

In line with USAID Forward and the GOR's policy to make local civil society organizations sustainable, RSMP will receive limited technical assistance from PSI for targeted capacity building in the areas of behavior change and communication, financial management, monitoring and evaluation, data utilization and basic planning. With technical support from PSI, RSMP will implement qualitative, audience centered monitoring of its programs. This will provide insight into how the target audience makes decisions and to identify what will resonate best in the Rwandan context.

During FY 2013, RSMP will use a paper based information management system to monitor program activities and plans to transition to an electronic monitoring system during the beginning of FY 2014. The RSMP team has developed and implemented appropriate forms to record essential data, trained staff on data collection and verification, developed quality assurance checklists and scheduled for routine data validation and verification. Throughout implementation RSMP will leverage existing national and partner data sources to inform decision making.

Entry and exit interviews will be conducted with CSW and MSM group members reached through the interventions which will allow the project to gather accurate, timely data which will allow them to adapt as necessary. RSMP will use smart phones for sales associates to map and input information on retailers directly. This will ensure that the project will be able to accurately record and project the sales and stock of product. This will allow RSMP to ensure that the appropriate resources are allocated to the right outlets while reducing costs which would be associated with a separate survey.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	400,000	0

Narrative:

RSMP's VCT activities will support increased access to, and availability of, high quality VCT services that meet national standards for key populations, including commercial sex workers (CSW) and men who have sex with men (MSM), out-of-school youth and street children over 15. Targets, per population, will be determined in consultation with key stakeholders and after review of the current DHS data. Family planning will be integrated into counseling, and condoms provided to every client for dual protection.

RSMP will train new peer educators and peer education groups will be launched in the districts of Gichumbi, Huye, Namacheke, Ramagana, Berera, Kamonyi and Karongi districts. Training will consist of a workshop on HIV prevention, testing services, appropriate condom use, IPC techniques, MARPs friendly facilitation and data collection. Following the training, peer educators will be empowered to act as local health promoters and engage those in their communities with information on HIV prevention, counseling and testing, and product availability through interactive interpersonal communication (IPC) sessions.

RSMP will collaborate with MOH and clinical partners to provide outreach services to improve referral linkages for care and treatment services. Provision of counseling services will be complemented by IPC to increase demand for VCT among key populations and targeted condom social marketing activities to address factors increasing risk for HIV transmission, such as concurrent partners, gender-based violence (GBV), and alcohol abuse.

Supportive supervision and QA will include regular, joint supervision visits carried out by district health authorities and technical staff to provide support to VCT counselors and ensure high quality counseling and data collection.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	630,000	0

Narrative:

RSMP's other prevention activities will support HIV/AIDS integration into FP/RH, MCH, CS, nutrition, WASH, and malaria services. In addition, HIV prevention activities will address factors influencing condom use as well as other norms and behaviors around HIV risk. Target populations will include high risk sexually active youth, urban men with discretionary income, key populations, PLHIV and couples.

The prevention interventions that will be implemented during COP 13 will address condom stigma, lack of condom knowledge, social norms, and barriers to condom communications. These issues will be addressed through peer education, product sales training, product sales, and linking with income generating activities. Additional strategies include hot-spot activities to increase condom access through outreach; behavior change communications targeting 'high-risk' workers such as bar maids, domestic workers and commercial sex workers, and condom use demonstration kits. Condom communications will integrate gender considerations to empower Rwandan women to access and negotiate condom use.

The RSMP will develop a cost efficient social marketing demand-based condom distribution system by

strengthening commercial distribution networks to reduce dependence upon the mechanism as a direct source of condoms. The RSMP will support onsite and radio wholesaler promotions, promotional support to distribution networks, and retail outlet creation. RSMP's marketing approach will allow public and community distribution of commodities ensuring all Rwandans access through community-based distribution. Supportive supervision and quality assurance (QA) will be conducted to inform condom social marketing activities, directing retail outlet creation and product promotion to areas underserved by the existing commercial distribution networks.

Implementing Mechanism Details

Mechanism ID: 16860	**Mechanism Name: Turengere Abana**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Francois Xavier Bagnoud Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 660,000	
Funding Source	**Funding Amount**
GHP-State	660,000

Sub Partner Name(s)

Francois Xavier Bagnoud International		

Overview Narrative

The Turengere Abana program works to improve the health and social & economic well-being of OVC and their families through sustainable community-based programs for prevention, care & support. The program is implemented by a local CSO named François Xavier Bagnoud (FXB) Rwanda, which graduated from FXB International and can now receive direct funding from USAID. Turengere Abana works with local authorities to identify & reach vulnerable populations with need-based service provision and strengthening of referral systems.

The 3-year goal for this program is to improve the social & economic well-being of 85,000 adults & children, including OVC & their families, affected by HIV/AIDS in 8 districts of Rwanda. Key activities include: livelihood grants & training; nutrition support; health behavior change training; access to health insurance, education support, child protection services & psychosocial counseling; safe water & hygiene; intensive case management; and mentorship & technical assistance. The program also seeks to strengthen household resilience through health, economic & social service provision, nutrition & education support, child protection, and GBV prevention services. In COP 13, Turengere Abana will continue these interventions, targeting 30,000 individuals to be reached with need-based, age-appropriate services. Turengere Abana will reach as many CBOs and households as possible with quality service provision while using fewer resources, as a way to be more cost-effective. To achieve this objective, project staff, in collaboration with local authorities, will provide TA & mentorship to CBOs, other groups & households. Program M&E activities are planned and results will be measured on a semi-annual & annual basis, as well as over the lifetime of the award.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	79,200
Education	132,000
Gender: GBV	33,000
Human Resources for Health	132,000
Water	39,600

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	16860		
Mechanism Name:	Turengere Abana		
Prime Partner Name:	Francois Xavier Bagnoud Center		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	180,000	0

Narrative:

In COP 12, the Turengere Abana program started implementing community-based health prevention, care and support; social and economic strengthening interventions for households; nutrition support including kitchen gardening; as well as other related interventions targeting HIV/AIDS infected and affected populations vulnerable to malnutrition. The psychosocial care and support will mainly focus on individual sessions of counseling for HIV positive clients, adherence to care and treatment for HIV positive beneficiaries, positive living, and secondary prevention. The program will reach out to OVC and their families, as well as other vulnerable households in selected districts, supporting them to access and effectively use safe water and promoting hygiene practices including hand washing. In this area, TA is tailored to different activities that includes nutritional education, kitchen gardening and demonstration, hygiene and sanitation, education sessions on family planning, and promotion of income-generating activities through ISLGs and other activities.

In COP 2013, Turengere Abana program will increase its level of implementation of these same activities, where 30,000 adults and children will be provided with need-based care services, including provision of basic household assets, food and nutritional support to vulnerable households; health care and support including payment of mutuelles; as well as referrals to health facilities and other supportive institutions. In collaboration with the Rwanda National Police and other institutions, the program will also support beneficiaries in need of legal support. To achieve these goals, 380 community volunteer care providers will be trained to support beneficiaries on a day-to-day basis; additionally, 1,120 households will be supported with access to financial and agricultural extension services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	265,000	0

Narrative:

The Turengere Abana program collaborates with local authorities and other CBOs to validate lists of OVC,

following the OVC guidance approved by the Ministry of Gender and Family Promotion. In this area, Turengere Abana supports and ensures that OVC in selected districts have access to educational and vocational training opportunities. The project supplies tuition, uniforms, and other supplies to 3700 OVC in primary, secondary, and vocational training schools based on their needs and ages. Young people who cannot continue their formal education will be eligible for enrollment in community vocational schools. The project will provide tuition fees, supplies, and tools to each student over two years. The program is planning to have 16,000 OVC reached with need-based services in COP 13. Project social workers will monitor students' attendance and performance each semester for those in school and will also follow up on all vocational training courses, as well as other services provided to OVC and their families.

The Turengere Abana program will continue to support technical and vocational training, in accordance with priority GOR strategies in this area, and towards market-based employment skills recommended by the Rwandan Workforce Development Authority. Tuition fees (for meals, accommodation and other boarding expenses) will be paid for OVC in boarding schools far from their homes. Special consideration will be given to paying the fees of children that pass their "O" level exams and are posted to schools as a way of motivating them. Interventions will build on the existing platform of program models, curricula, tools and other local resources, targeting basic education, including primary and secondary education, as well as vocational training.

In addition, Turengere Abana program will support these OVC with payment of mutuelles and provision of health education including hygiene, adherence to treatment, and HIV prevention, including voluntary counseling and testing. Through peer education, the program will also support basic education about reproductive health, child rights and protection, GBV prevention, and psychosocial care and support, as well as referral to different facilities and institutions for those in need. In FY 2013, Turengere Abana will also continue to support child-headed households through health care support and social and economic strengthening, including psychosocial support, nutritional education including kitchen gardening, child rights and protection, prevention messaging against HIV and GBV as well as referrals when needed. The promotion of youth ISLG will be supported to help them build resilience for a better future.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	125,000	0

Narrative:

Turengere Abana provides trainings on social protection, child rights, and prevention of HIV and other common diseases to CBOs, local government partners, teachers, police, and health care workers. Existing local associations and community-based groups will be identified by the project, including ISLGs, youth

clubs, OVC protection committees, and anti-GBV committees; new community based groups of the same kind will also be initiated and will subsequently receive organizational development support. These services will be provided to 1,120 most vulnerable households in the catchment areas. Through these groups, Turengere Abana program will continue to build the capacity of the vulnerable group members with access to essential health and social services, and to build more resilient families through economic and social coping mechanisms. The community caregivers will be empowered to provide continuous TA and mentoring to enable groups towards sustainable development.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	90,000	0

Narrative:

In COP 13, Turengere Abana program will implement prevention interventions and will collaborate with CBOs to provide HIV and other disease prevention messaging, targeting 30,000 OVC and their families as well as other vulnerable households across selected districts. Prevention interventions among beneficiaries include behavior change message to prevent HIV, STIs and other diseases as well as unintended pregnancies. HIV prevention activities include community sensitization and VCT among youth and other beneficiaries. VCT clients are tested through community-level outreach strategies, or will be referred to health facilities. In addition, training focused on prevention will be provided to CBOs and households in the program catchment area, going beyond HIV to include GBV prevention and family law, including succession rights as well as child rights and protection. Activities will also include access to safe water sources and hand washing; provision of nutrition skills including children's growth monitoring and nutritional status evaluation for vulnerable adult beneficiaries; kitchen gardening; and education on maintaining a balanced diet to prevent malnutrition.

Implementing Mechanism Details

Mechanism ID: 16966	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16967	**Mechanism Name: OVC Impact Evaluation**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: New Partner	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 50,000	
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Higa Ubeho project has shown remarkable success in establishing savings groups – currently reporting more than 2,100 groups and 46,000 members, more than any other PEPFAR OVC project. The impending expansion of the project provides a unique opportunity to design and implement an evaluation to understand the impact of its model on targeted families & their children. The potential for an experimental research design would provide the opportunity to attribute observed impacts to the savings group intervention. Using Higa Ubeho's theory of change for its savings group intervention, the evaluation would also aim to identify or validate the mechanisms by which this intervention brings about the observed impacts. The proposed evaluation could also provide an opportunity to enhance the project with better linkages to growth opportunities. Evaluation findings would contribute to global knowledge and PEPFAR policy but, most importantly, they can immediately influence the direction of the OVC response in Rwanda.

The impacts of savings group interventions take time to manifest. Because of the interest in understanding the long-term impacts of savings groups, their sustainability, and their prospects for self-replication, it is both acceptable and desirable for the evaluation to continue beyond the anticipated end of the Higa Ubeho project. The Assets and Market Access (AMA) Collaborative Research Support Program (CRSP) has been identified as a promising partner. AMA CRSP is a research and evaluation partnership with leading U.S. universities managed by USAID's Bureau for Food Security.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	16967		
Mechanism Name:	OVC Impact Evaluation		
Prime Partner Name:	New Partner		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	50,000	0

Narrative:

Care and support for OVC in Rwanda is a priority for USG in COP 13. The goal of the Higa Ubeho Impact Evaluation would be to provide a unique opportunity to design and implement an evaluation to understand the impact of the program's savings group model on targeted families & their children. The potential for an experimental research design would provide the opportunity to attribute observed impacts to the savings group intervention. Using Higa Ubeho's theory of change for its savings group intervention, the evaluation would also aim to identify or validate the mechanisms by which this intervention brings about the observed impacts.

Prior research suggests that unadorned savings group interventions have modest livelihood impacts. The proposed evaluation could provide an opportunity to enhance the project with better linkages to growth opportunities. This pro-growth enhancement could offer insights on relative effectiveness of adorned and unadorned projects.

The findings of this evaluation would contribute significantly to global knowledge and to PEPFAR policy. In its current second phase for response, the wider PEPFAR initiative is committed to increasing the evidence for AIDS-related programmatic and policy interventions. In relation to this shifting focus, more attention and support for robust evidence linking outcomes to programmatic input are being tested. The Higa Ubeho evaluation would contribute to this growing knowledge-base by increasing understanding of promising

approaches relevant to the care and protection of OVC. With economic strengthening, and savings groups in particular, being promoted as an effective, sustainable intervention to positively impact OVC and their families, this evaluation will serve to strengthen our base of evidence for this intervention.

Implementing Mechanism Details

Mechanism ID: 16986	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17016	**Mechanism Name: COLUMBIA UNIVERSITY – UTAP - Rwanda Technical Assistance Projects in Support of HIV Prevention, Care and Treatment Programs**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Columbia University Mailman School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 424,640	
Funding Source	**Funding Amount**
GHP-State	424,640

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this project is to provide technical assistance to national institutions in support of HIV prevention, care and treatment programs. With this project that builds on achievements of the SCMOH cooperative agreement, ICAP

will continue to strengthen HIV related laboratory services through technical assistance to the national reference laboratory (NRL) and the laboratory network. This will include support to improve the quality of laboratory services and the laboratory accreditation process.
In addition, ICAP will continue to provide technical support to increase national capacity to provide quality pediatric HIV care and treatment. For the pediatric program, the main focus will be on continued support to RBC/IHDPC, University teaching hospitals and other MOH institutions to implement and roll-out an adolescent-friendly HIV program, integrating mental health and adolescents sexual and reproductive health (ASRH) services. ICAP will also improve quality of pediatric services by promoting and transferring knowledge and skills for challenging issues as the providers' initiated testing and counseling (PITC) for children, ART initiation of all HIV infected children <5 years, regular growth and development monitoring, pediatric TB cases intensive case finding, TB screening and diagnosis, adherence support, as well as early detection and management of treatment failure in children.
In COP13, ICAP will gradually scale down technical assistance to national institutions in recognition of increased capacity and ownership in the MOH for pediatric HIV care and treatment and laboratory activities.

Cross-Cutting Budget Attribution(s)

Education	5,180
Food and Nutrition: Policy, Tools, and Service Delivery	10,360
Human Resources for Health	225,117

TBD Details

(No data provided.)

Key Issues

Child Survival Activities
TB

Budget Code Information

Mechanism ID:	**17016**
Mechanism Name:	**COLUMBIA UNIVERSITY – UTAP - Rwanda Technical Assistance**
Prime Partner Name:	**Projects in Support of HIV Prevention, Care and Treatment Programs**
	Columbia University Mailman School of Public Health

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	103,600	0

Narrative:

The overall goal of this activity is to support MOH to expand high quality pediatric HIV care and treatment services at all levels.
In COP13, ICAP/UTAP will continue to provide technical support to the CHUK pediatric center to establish adolescent-friendly clinics, implementing a model with more emphasis on psychosocial support, primary and secondary prevention, reproductive health and life skills building through educational sessions and exercises. Lessons learned from the implementation of the adolescent care model at CHUK will guide national scale up of the model at district hospitals.
ICAP will also support RBC/IHDPC HIV Division to expand and strengthen adolescent care at the adolescent model center at Ruhengeri District Hospital through regular supervision and mentorship.
ICAP will continue to support the pediatric center of excellence to manage the pediatric HIV care and treatment practical training program as well as the experience sharing sessions. At CHUK and CHUB, ICAP will support quality improvement with a review of indicators, medical charts and viral load measurements to develop and strengthen clinical capacity for more efficient and quality assured patient management. ICAP will also facilitate stakeholders meetings to assess progress made, share best practices, identify challenges and ways for improvement of the pediatric program. For those activities conducted in conjunction with the center of excellence at CHUK, ICAP will continue to support three staff sat CHUK (Pediatric APSS Coordinator, adolescent nursing officer and the pediatric nursing officer). Those pediatric nurses at CHUK will also help train staff from clinical sites on issues related to testing of children in various clinical settings, on counseling children's parents', and on HIV diagnosis disclosure for children.
Additionally, ICAP will strengthen the capacity of RBC/IHDPC to coordinate and provide technical leadership to the national pediatric HIV program. The support to RBC/IHDPC will include technical assistance to organize regular meetings of the pediatric HIV technical working group to share lessons learnt by different partner institutions involved in the implementation of pediatric program; to promote harmonization, standardization and quality improvement of pediatric care; as well as to jointly seek solutions for identified challenges. Those meetings will be a forum to discuss issues related to pediatric program implementation including ART initiation of HIV infected children below 5 years, providers initiated testing and counseling (PITC) in children, early detection and management of treatment failure, growth

monitoring at all the sites, pediatric TB cases intensive case finding, TB screening and diagnosis in children and other topics specific to adolescent care such as mental health integration and ASRH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	130,000	0

Narrative:

The overall goal of this activity is to strengthen NRL and the national laboratory network to enhance clinical services by expanding access to diagnostic and monitoring tests for HIV positive patients as well as strengthening quality assurance /quality control (QA/QC) programs.
In COP13, ICAP's lab support will focus on supporting NRL and the laboratory network through the WHO/AFRO SLIPTA accreditation process including QA/QC activities at different levels of the lab network (NRL, CHUK, CHUB, DH, HC) and for different diagnostic areas (including areas such as HIV, TB, hematology, biochemistry, bacteriology, parasitology). ICAP will continue to support and facilitate the accreditation process for the five labs at central level (NRL, CHUK, CHUB, King Faysal Hospital and Kanombe Hospital) and also at five labs at district level.
ICAP will also support the implementation of external quality assurance (EQA) for various diagnostic areas (including areas such as HIV, TB, hematology, biochemistry, bacteriology, and parasitology) using panel testing and supportive supervision. ICAP will also ensure that supportive supervisions oriented toward data quality assurance (DQA) and data analysis lead to the implementation of the corrective actions proposed.
In addition ICAP's lab support will include support to NRL to expand other national lab systems including support to expand the national samples transportation system through revision and updating of SOPs, development of a sample tracking system, and establishing a feedback system for sites to get the results back
Finally, ICAP will also support MOH in the elaboration of abstracts to be submitted to national and international conferences and sharing of the Rwanda TB and HIV laboratory experience in different fora.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	191,040	0

Narrative:

The overall goal of this activity is to strengthen national capacity to deliver high quality pediatric HIV services. ICAP technical assistance is expected to improve the clinical skills of health professionals managing pediatric HIV cases at the peripheral level. In COP13, ICAP/UTAP will provide technical support to RBC/IHDPC, the University Teaching Hospital of Kigali (CHUK), the University Teaching Hospital of Butare (CHUB) and Ruhengeri District Hospital for the implementation of an adolescent training curriculum

for training of trainers in order to enhance expansion of high quality adolescent HIV care at decentralized levels.
Moreover, ICAP/UTAP will provide technical support to RBC/IHDPC to update pediatric HIV care and treatment training materials. These materials will emphasize changes in the new guidelines.
In addition to the practical training sessions on pediatric HIV care and treatment for multidisciplinary teams from district hospitals and health centers, ICAP will facilitate trainings for mentors who will be critical in harmonizing the approach of pediatric HIV care best practices for all the sites, and continuously improve overall pediatric care and treatment quality throughout the country.
Finally, ICAP/UTAP will support MOH in the elaboration of abstracts for national and international conferences and sharing of the Rwanda pediatric HIV experience in various fora.

Implementing Mechanism Details

Mechanism ID: 17074	**Mechanism Name: VAST Grants**
Funding Agency: U.S. Peace Corps	Procurement Type: Grant
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 80,000	
Funding Source	**Funding Amount**
GHP-State	80,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In general, VAST grants are used by Peace Corps Rwanda Volunteers to pursue activities in support of HIV/AIDS specific goals & objectives in our Health Project Framework:
Goal 2: HIV & STI Prevention & Impact Mitigation
Rwandan youth, including OVC, will adopt positive behaviors & practices to decrease the spread of HIV, and will have better access to social support to mitigate harmful effects of HIV.
Obj. 2.1: Youth Sexual & Reproductive Health

By the end of 2018, 3000 youth aged 15-24 in 40 communities where PC Volunteers work will adopt healthier behaviors & practices to prevent the transmission of HIV.
Obj. 2.2: OVC Health & Well Being
By the end of 2018, 40 groups of OVCs in communities where Volunteers work will have received training and/or support in at least one of the following areas: economic strengthening, nutrition & psychosocial support.
The Volunteer activities support by VAST grants also track to Partnership Framework Goals 1 (halving HIV incidence along general population); 3 (equality of opportunity for people living with HIV/AIDS); and 4 (strengthening health system capacity). The Volunteer-supported activities under VAST grants take place in every region of Rwanda and target local populations generally, and OVCs specifically. The VAST grant-supported activities are carried out in very low-resource environments, typically with community health center support, and are very cost-effective. The majority of VAST grant-supported activities include local capacity building measures & activities which empower local community health workers to conduct future activities independently. All activities supported by VAST grants require final reports which detail the activities' outcomes under the Health Project Framework and the disposition of all funds.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	12,000
Education	24,000
Gender: GBV	8,000
Gender: Gender Equality	16,000
Key Populations: FSW	4,000
Key Populations: MSM and TG	4,000
Water	12,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support

Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**17074**
Mechanism Name:	**VAST Grants**
Prime Partner Name:	**U.S. Peace Corps**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	80,000	0

Narrative:

Peace Corps Rwanda VAST grant-supported activities are aimed at community members in remote village settings that might not otherwise have ready access to important HIV/AIDS awareness, prevention, and social mitigation information/interventions. Target populations include community health workers, women, children and specifically OVCs; the population size varies significantly based on the nature of the intervention. While Volunteers and their community partners design and conduct the various activities supported by the VAST grants, they are supported by Peace Corps Rwanda through our Grants Manager, who insures that Volunteers are in compliance with both the grant application and reporting mechanisms, and by their respective Program Managers, who can help them with any technical/cultural/communication dimensions of their grant-supported activities. In many cases, Vast grant-supported activities are designed with the help of the Rwandan community health center system and/or other national and international partners who are engaged on HIV/AIDS related issues in Rwanda. The types of activities supported under this funding mechanism include:

- Implementation of prevention interventions and training with MSM and FSW populations
- Economic strengthening, especially income generating activities
- Implementation of educational systems
- Safe water projects
- Gender initiatives, to include GBV awareness and its relation to HIV/AIDS and gender equality education.


PEPFAR
U.S. President's Emergency Plan for AIDS Relief

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		669,250		669,250
Institutional Contractors		780,744		780,744
Management Meetings/Professional Developement		125,600		125,600
Non-ICASS Administrative Costs		433,068		433,068
Staff Program Travel		79,882		79,882
USG Staff Salaries and Benefits		1,403,200		1,403,200
Total	**0**	**3,491,744**	**0**	**3,491,744**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		669,250
Management Meetings/Professional Developement		GHP-State		125,600
Non-ICASS Administrative Costs		GHP-State	[REDCATED]	433,068

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		4,000		4,000
ICASS		45,000		45,000
Non-ICASS Administrative Costs		6,000		6,000
Staff Program Travel		80,000		80,000
USG Staff Salaries and Benefits		210,000		210,000
Total	**0**	**345,000**	**0**	**345,000**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		4,000
ICASS		GHP-State		45,000
Non-ICASS Administrative Costs		GHP-State		6,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Capital Security Cost Sharing		560,934		560,934
Computers/IT Services		204,000		204,000
ICASS		1,063,118		1,063,118
Institutional Contractors	0	1,890,316	0	1,890,316
Management	78,000			78,000

Meetings/Professional Developement				
Non-ICASS Administrative Costs	740,391			740,391
Staff Program Travel	241,293	179,543		420,836
USG Staff Salaries and Benefits	2,268,324	175,000		2,443,324
Total	**3,328,008**	**4,072,911**	**0**	**7,400,919**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-State		560,934
Computers/IT Services		GHP-State		204,000
ICASS		GHP-State		1,063,118
Management Meetings/Professional Developement		GAP		78,000
Non-ICASS Administrative Costs		GAP	[REDACTED]	740,391

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		6,500		6,500
ICASS		45,000		45,000
Management Meetings/Professional Developement		26,000		26,000
Non-ICASS Administrative Costs		8,600		8,600

USG Staff Salaries and Benefits		126,036		126,036
Total	**0**	**212,136**	**0**	**212,136**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State	$5000 for IT equipment; $1500 for internet	6,500
ICASS		GHP-State		45,000
Management Meetings/Professional Developement		GHP-State		26,000
Non-ICASS Administrative Costs		GHP-State	[REDACTED]	8,600

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Non-ICASS Administrative Costs		119,971		119,971
Peace Corps Volunteer Costs		674,440		674,440
Staff Program Travel		16,649		16,649
USG Staff Salaries and Benefits		312,385		312,385
Total	**0**	**1,123,445**	**0**	**1,123,445**

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Non-ICASS Administrative Costs		GHP-State		119,971


PEPFAR
U.S. President's Emergency Plan for AIDS Relief