SENSITIVE BUT UNCLASSIFIED January 16, 2019

INFORMATION MEMO FOR AMBASSADOR VROOMAN, RWANDA
FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2019 PEPFAR Planned Allocation and Strategic Direction

We are grateful to you, Ambassador Vrooman, and your Deputy Chief of Mission, Richard Michaels, for your engagement in planning, review and implementation, and with the community and Government to enhance PEPFAR program impact. We are grateful for your attention to core policy adoption and holding partners to account and performance for improved outcomes and greater impact. Finally, we are grateful to your incredible PEPFAR staff in country, working together across agencies to ensure the most effective and efficient use of taxpayer dollars.

The U.S. government, through PEPFAR, is proud to partner with the people and Government of Rwanda in accelerating Rwanda's progress towards achieving HIV/AIDS epidemic control. With an investment of $ 1,331,554,427 from FY 2004–2019, PEPFAR's results in Rwanda through September 2018 show that 203,615 individuals have tested positive and know their HIV status. Of that number, 189,362 (93%) are on ART. Viral load (VL) suppression among those with a VL test is at a strong 92%. The PEPFAR Rwanda team achieved 98.7% of their testing targets, but fell short of finding positives through these tests (53.4%). The data indicates that the team needs to revise their testing strategies to test the most at risk using screening algorithms and index testing.

PEPFAR is proud that Rwanda will likely achieve epidemic control in COP18. As control is achieved, the country team must re-align the program towards case-finding and maintenance of control in COP19. This will require a stark improvement in index testing, with robust expansion so that effective index testing becomes the primary testing modality, supported by highly targeted facility and community testing (as warranted). Therefore, Rwanda's largest implementing partner, the Rwanda Ministry of Health (MoH), is expected to greatly reduce conventional testing and increase its index testing yield and scale. In addition, all those who test positive should receive a recency test; this will help identify geographic and demographic hotspots of transmission and permit the program to more strategically target interventions.

The highly anticipated Rwanda PHIA results will determine Rwanda's achievement towards a sustained epidemic. As the program transitions to maintenance of epidemic control, Rwanda should have reliable and transparent surveillance. Therefore, the national implementation of a fully functioning case based-surveillance that utilizes unique identification and electronic data capture is a timely and critical development for COP 2018 and COP 2019. It is important that the Government of Rwanda has functional and reliable procurement capacity; we need to build the

capacity of Rwanda's Medical Procurement and Production Division (MPPD) as it transitions to a parastatal organization. All partners should be fully local partners and the teams needs to evaluate all aspects of the program to maximize effectiveness and efficiency.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) total planning level for Rwanda for the 2019 Country Operational Plan (COP 2019) is **$70,000,000** inclusive of all new funding accounts and applied pipeline.

If you have questions about the priorities and guidance laid out in this letter, please contact your Chair and Program Manager. My office is continually grateful for your team's work on the PEPFAR program, helping us to move towards an AIDS-free generation by supporting the HIV response in Rwanda.

APPENDICES:

1. **COP 2019 PLANNING LEVEL**
2. **COP 2019 BUDGETARY REQUIREMENTS & GUIDANCE**
3. **PAST PERFORMANCE**
4. **COP 2019 DIRECTIVES**

APPENDIX 1: COP 2019 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the FY 2018 Q4 POART and performance information, the total COP 2019 planning level is estimated to be comprised as follows:

Table 1. COP 2019 Budget**

Rwanda TOTAL COP 2019 PLANNING LEVEL: $70,000,000			
Total Base Budget for COP 2019 Implementation			**$ 70,000,000**
Total COP 19 New Funding	$	62,601,700	
of which, VMMC	*$*	*6,941,424*	
of which, DREAMS	*$*	*5,000,000*	
Total Applied Pipeline	$	7,398,300	

***Applied pipeline by agency is provided in chart below.*

Table 2. Applied Pipeline

RWANDA COP 2018 APPLIED PIPELINE BY AGENCY		
Total Applied Pipeline	**$**	**7,398,300**
DOD	$	128,007
HHS/CDC	$	6,703,685
State	$	-
State/PRM	$	-
State/SGAC	$	-
USAID	$	566,609

***Based on agency reported available pipeline from EOFY*

All planning levels are subject to further adjustment, **based upon appropriations**, further analysis determining the availability of excessive pipeline, and other developments during the course of COP 2018 implementation and the COP 2019 review process. The total spend in the implementation of COP 2019 (FY 2020) may not exceed the total COP 2019 planning level of $70,000,000.

APPENDIX 2: COP 2019 BUDGETARY REQUIREMENTS

Table 3. COP 2019 Earmarks

Rwanda COP 2019 EARMARK REQUIREMENTS	
Care and Treatment (C&T)	$ 39,439,071
% of base funds allocated to C&T	*63%*
HKID	$ 5,634,153
Gender Based Violence (GBV)	$ 526,375
Water	$ 176,000

Care and Treatment: If there is no adjustment to the COP 2019 new funding level due to an adjustment in applied pipeline, Rwanda's minimum requirement for the care and treatment earmark is reflected in the chart above. Your care and treatment requirement is calculated as the sum of total new FY 2019 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS budget codes, 30% of the total funding programmed to the MTCT budget code, 80% of the total funding programmed to the HLAB budget code, and 30% of the total funding programmed to the HVCT budget code. This minimum care and treatment earmark has been derived based upon a requirement that your country programs a minimum of 63% of all **new FY 2019 Base Funds** to care and treatment of people living with HIV.

HKID Requirement: Rwanda's COP 2019 minimum requirement for the HKID budget code is reflected in the chart above. Your COP 2019 HKID requirement is derived based upon the approved COP 2018 HKID level. The COP 2019 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): Rwanda's COP 2019 minimum requirement for the GBV earmark is reflected in the chart above. Your GBV earmark requirement is calculated as the total **new FY 2019** funding programmed to the GBV cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 GBV earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Rwanda's COP 2019 minimum requirement for the water earmark is reflected in the chart above. Your water earmark requirement is calculated as the total **new FY 2019 funding** programmed to the water cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 water earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of

these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY20, and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each Rwanda agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY 2020 as appropriate through their COP 2019 submission.

COP 2019 Applied Pipeline

All agencies in Rwanda should hold a 3 month pipeline at the end of COP 2019 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2018 implementation (end of FY 2019) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2019, decreasing the new funding amount to stay within the planning level.

The Applied Pipeline amount of $7,398,300 given by S/GAC as a part of the COP 2019 planning level has been calculated to reflect the projected excessive pipeline as of the beginning of the COP 2019 implementation cycle (FY 2020), and is the minimum amount that Rwanda must apply as pipeline in the COP 2019 submission. The distribution of new base funds and Applied Pipeline was calculated to ensure 3 months of pipeline remains with mechanisms, based upon the financial data submitted for the FY 2018 Q4 Obligation and Outlay and FY 2018 End of Fiscal Year (EOFY) reports. Expired funds, funds on expired mechanisms and projected FY 2019 outlays as submitted in the EOFY report were all taken into consideration to inform the projected excessive pipeline and the required COP 2019 applied pipeline amount.

Unliquidated obligations on closed mechanisms identified in the FY 2018 EOFY report should be de-obligated in a timely manner. This will continue to be monitored throughout FY 2019 (COP 2018 implementation) and into COP 2019.

APPENDIX 3: PAST PERFORMANCE TRENDS

Table 4. COP 2017/ FY 2018 Outlays versus Approved Budget*

	Sum of Approved COP 2017 Planning Level	Sum of Total FY 2018 Outlays	Sum of Over/Under Outlays
Rwanda	**$74,800,000**	**$ 72,450,914**	**$ (2,349,086)**
DOD	$ 2,210,475	$ 2,128,570	$ (81,905)
HHS/CDC	$ 33,501,646	$ 32,564,255	$ (937,391)
State and State/PRM	$ 571,867	$ 159,821	$ (412,046)
Peace Corps	$ -	$ 158,801	$ 158,801
USAID	$ 38,516,012	$ 37,439,467	$ (1,076,545)

** State obligations and outlays have not yet been reconciled and the numbers in this table may change based on reconciliation.*

Rwanda's total FY 2018 outlay level of $72,450,914 is under your approved spend level of $74,800,000 (COP 2017 budget). Within this total, Peace Corps spent above their approved FY 2018 budgets and DOD, CDC, State and USAID spent below their approved level. The following Implementing Mechanisms also outlaid at least 125% in excess of their COP 2017 approved planning level.

Table 5. IP FY18 Outlays

** This table was based off the FY18 EOFY submissions, but edited to reflect OPU's as of January 15th, 2019. Agencies outlaid to the following Implementing Mechanisms 125% or more in excess of their COP17 approved planning level.*

Mech ID	Prime Partner	Funding Agency	COP17/FY18 Budget (New funding + Pipeline)	Actual FY18 Outlays ($)	Over/Under FY18 Outlays (Actual $ - Total COP17 Budget $)
9984	Emory University	HHS/CDC	$ -	$ 19,606	$ 19,606
10954	Drew University	DOD	$ -	$ 633,957	$ 633,957
12134	FHI 360	HHS/CDC	$ -	$ 39,925	$ 39,925
12140	Rwanda School of Public Health	HHS/CDC	$ -	$ 459,251	$ 459,251
13598	JHPIEGO	DOD	$ 207,570	$ 374,847	$ 167,277
13704	University of Maryland	HHS/CDC	$ -	$ 30,127	$ 30,127
18689	University of North Carolina at Chapel Hill, Carolina Population Center	USAID	$ -	$ 607,299	$ 607,299

Table 6. COP 2017/ FY 2018 Results versus Targets*

** Financial and target performance data not a one-to-one correlation as program classification expenditures encompass more than those towards indicator/target presented.*

Funding Agency	Indicator	FY18 Target	FY18 Cum. Results	FY18 %	Program Type	FY18 Expenditure	% Service Delivery
DOD	HTS_TST	93,269	53,414	57%	HTS	$242,859	100%
	HTS_TST_POS	1,817	730	40%			
	TX_CURR	3,372	2,746	81%	C&T	$401,102	100%
	TX_NEW	1,817	483	27%			
	VMMC_CIRC	63,978	81,354	127%	PREV: CIRC	$244,721	100%
					Program Management	$558,475	
HHS/ CDC	HTS_TST	882,249	919,925	104%	HTS	$7,133,701	100%
	HTS_TST_POS	14311	7858	55%			
	TX_CURR	110,041	94,774	86%	C&T	$12,268,045	99%
	TX_NEW	12,878	7,221	56%			
	VMMC_CIRC	33,910	75,338	222%	PREV: CIRC	$763,433	100%
					Above Site Programs	$3,111,027	
					Program Management	$2,481,651	
State/ PRM	HTS_TST	8,997	12,035	134%	HTS	$0	0%
	HTS_TST_POS	60	22	37%			
	TX_CURR	539	440	82%	C&T	$163,716	100%
	TX_NEW	50	19	38%			
					Above Site Programs	$ -	
					Program Management	$100,669	
USAID	OVC_SERV	114,299	117,956	103%	SE: OVC	$4,011,636	89%
					Above Site Programs	$861,661	
					Program Management	$3,391,120	

COP 2017/ FY 2018 Performance

Overall, the program in Rwanda is high-performing, and their progress toward epidemic control over the past few years while maintaining a very high-level of care and treatment serves as a model for other countries with similar epidemics.

- PEPFAR Rwanda underperformed against key indicators in the clinical cascade in FY 2018, achieving 53% of HTS_TST_POS targets and, consequently, initiating just 52% of the targeted individuals on treatment.
- The Ministry of Health (MoH), Rwanda's largest implementing partner, funded by CDC, achieved 50.7% of their HTS_TST_POS targets and 49% of their TX_NEW targets; by comparison, Emory University, also funded by CDC, achieved 76% of their HTS_TST_POS targets.
- HIV positive yields were under 1% in 4 out of 5 provinces; in the North and West provinces, testing yields were 0.4% and 0.6%, respectively, demonstrating the low utility of broad testing.
- Index testing yields are far below what we would expect for an effective HIV program (2.4% overall and 2.0% for the MoH, the largest tester by far), highlighting an urgent need to improve technique and performance.
- Linkage calculations reflect improved performance, with over 91% linkage in COP 2017.
- 12-month retention, which is reliably captured in Rwanda, is over 93%.
- Among those eligible, only 81% had a VL test, highlighting a specific area for improvement. Of those tested, 92% had a suppressed VL.
- TB Preventive Treatment has not been a part of routine HIV care, and outside of a relatively limited pilot, has not been provided to PLHIV.
- In FY 2018, Rwanda over outlaid funds for 7 implementing mechanisms due to adjustments/outlays on expired awards from COP 2017.
- VMMC target achievement for age bands 20-24 and 25-29 was low, emphasizing a need to focus on this immediate at-risk group.

APPENDIX 4: COP 2019 DIRECTIVES

Table 7. COP 2019 (FY 2020) Targets

Based on current progress towards epidemic control and funding level, the following FY 2020 treatment targets are recommended for Rwanda:

	Pediatric (<15) Treatment Target	Adult Women (15+) Treatment Target	Adult Men (15+) Treatment Target	Treatment Target Total[a]
COP 18 (FY 19 Targets)				
TX_NEW (New on Treatment)	434	8,000	5,801	14,235
TX_CURR (Current on Treatment)	5,394	74,887	46,153	126,434
TB_PREV	N/A	N/A	N/A	N/A
VMMC_CIRC	N/A	N/A	N/A	107,234
COP 19 (FY 20 Targets)				
TX_NEW (New on Treatment)	7,250	3,646	2,210	13,106
TX_CURR (Current on Treatment)	12,374	72,911	44,204	129,488
TB_PREV	N/A	N/A	N/A	N/A
VMMC_CIRC	46,400	N/A	113,600	160,000
National Treatment Coverage				
Treatment Coverage	90%	90%	90%	90%

[a]*Targets should be further allocated by age and sex based on disaggregated PLHIV estimates and unmet need for ART.*

These targets were developed based on the following assumptions:

- TX_NEW: Targets for TX_NEW assume that 95% of TX_CURR patients are retained from year to year, and that 90% of the TX_NEW target will be retained and thus contribute to the required TX_NET_NEW to achieve the TX_CURR target. Rwanda

should consider has they move to Epidemic Control how they can exceed these minimum requirements.

- TX_CURR: TX_CURR targets were generated to move Rwanda to 95-95-95 at the country-level based on preliminary program HIV estimates 2018 PLHIV and ART coverage estimates. In order to achieve this target, the team needs accurate reporting and minimization of loss and mortality.
- For Rwanda this means not only reaching 95-95-95 with service delivery at the sites with site level PEPFAR support, but working to assure that 95-95-95 is achieved at a national level.
- TB_PREV: Targets for TB_PREV were calculated using an Excel-based tool that utilized (among other considerations) estimated number of patients expected to be on ART at the start of COP 2019 who would screen negative for TB symptoms, the proportion likely to be ineligible for clinical reasons, the estimated number who would have already received TPT by the start of COP 2019 and projected enrollment and completion rates.
- VMMC_CIRC: Targets for VMMC were developed based on current coverage, past performance, and available funding for prevention activities.

As Rwanda nears epidemic control, PEPFAR's investment will shift to focus on supporting the host country government to sustain its control of the epidemic. Sustained epidemic control will require case-based disease surveillance with use of unique identifiers and electronic data recording and reporting. This needs to include a primary focus on index and self-testing and increased effort to scale programs for marginalized populations. Given the difficulty in finding cases, the program should continue to focus on ensuring high linkages, essential that this improvement continue with a goal of achieving >95% linkage across age and sex groups. In addition, a focus on delivery of quality treatment is critical to ensure maintenance of high rates of viral load suppression. In order to meet the latter at a national level, the program will need to improve upon viral load access.

COP 2019 Minimum Requirements

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements no later than the beginning of COP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs. Failure to meet any of these requirements by FY 2020 will result in reductions to the Rwanda budget.

Table 8. Minimum Requirements

Minimum Requirement	Rwanda Specific Guidance (if applicable in COP 2018 or COP 2019)
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	Given that Test and Start has been fully adopted at all facilities, Rwanda has achieved this minimum requirement.
2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	Viral load eligibility criteria for DSD has been broadened to <200 copies/mL (from <20 copies/mL); transition from 3 month scripting to 6 month scripting by clinical providers is required for COP 2019 program implementation to improve ART coverage.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens.	The country team should plan to meet the April 2019 TLD transition deadline for all 554 PEPFAR sites (currently 527). Informed consent for TLD should be made an option to all women of child-bearing age. In Dec 2018, Rwanda announced plans to transition all patients on Nevirapine to other regimens.
4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.	Index testing is being scaled at all facilities and will be the predominant approach to any community- or facility-based testing. PITC and VCT should be increasingly targeted (with a focus on finding men) as country transitions to maintenance of epidemic control. HTS in low-yield districts should be reduced to only highly targeted, passive testing. Self-testing should be strategically employed to assist with index testing and to reach high-risk populations who do not intersect traditional healthcare or outreach.
5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.	TPT national policy has been adopted and implementation is expected by July, 2019. Implementation should be scaled widely in COP 2019 so that the country is on track to provide TPT to all PLHIV by the end of COP 2020
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	COP 2019 agency implementing work plans are required to reflect fidelity for this minimum requirement; the MoH should continue to monitor selected cohorts to assess level of linkage across PEPFAR and GF.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.	Given that all formal and informal user fees have been eliminated, this does not apply to Rwanda.

8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.	With the completion of the NLR login, the team will to work to improve documentation of VL results in patient records and increase IT infrastructure and personnel computer skills training at health centers.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	As Rwanda reaches sustained epidemic control, PEPFAR funding should support a strong public health response. The objective of the final shift is to establish an active public health surveillance system capable of identifying new outbreaks as they develop and accurately tracking quality of care and subpopulation morbidity and mortality indicators.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.	The PEPFAR Rwanda OVC program should continue to refine itself as the program achieves epidemic control. The OVC program should reflect a focus on 9-17 year old beneficiaries. OVC and DREAMS programming should be coordinated congruently to ensure comprehensive HIV services and sexual violence prevention for AGYW and 9-14 year olds.
11. Evidence of resource commitments by host governments with year after year increases.	The PEPFAR Rwanda team should work closely with the GoR to encourage increased funding towards HIV/AIDS programming and the MPPD. An ongoing consortium; including USAID, CDC, MoF, MoH and US Treasury; will continue to plan eventual transition of financing to GoR.
12. Clear evidence of agency progress toward local, indigenous partner prime funding.	The team should continue to fund the MoH while also continuing to identify additional indigenous partners who can best support PEPFAR programming.
13. Scale up of unique identifier for patients across all sites.	PEPFAR Rwanda should continue the development of the unique patient identifier system to be at scale at the end of 2018.

In addition to meeting the minimum requirements outlined above, it is expected that Rwanda will ensure appropriate progress towards viral load management and improved use of efficient testing strategies.

Table 9. Other Requirements

Requirement	Rwanda Specific Guidance (if applicable in COP18 or COP19)
1. Viral load management: Country policy updated.	Country policy stipulates VL testing 6 months after ART initiation, and yearly thereafter; pregnant women have repeat VL at initial ANV visit and are monitored every 6 months through their breast-feeding period.
2. Screen better and test smarter: Stop over-testing.	Testing should be highly focused and substantially reduced outside of Kigali (using a district-level yield cutoff of <1% as threshold to reduce testing); testing in Kigali will be targeted to those with highly associated risk factors. Community work will focus only on those at highest risk: KPs and their sexual partners and areas/groups identified by recency testing as hotspots.

COP 2019 Technical Priorities

Tuberculosis

PEPFAR OUs are expected to offer Tuberculosis Preventive Treatment (TPT) as a routine part of HIV care, which means that all care and treatment partners are expected to offer TPT and report on it. Programs are expected to fully scale TPT over the next two years, such that all PLHIV who are on treatment and are eligible for TPT have received a course by the end of COP 2020. Therefore, the TB_PREV targets included in this letter were set as described above under the target table. For COP 2019, the number of patients that are expected to complete a course of TPT in Rwanda is 44,939, approximately half the total number of eligible PLHIV, per the mandate from S/GAC to fully scale TPT over the next two years. COP 2020 TB_PREV targets will cover the remaining 50% of the eligible PLHIV on ART, adjusted upward for those that will be newly enrolled in ART during the COP 2019 implementation period. In order to ensure successful programming, it is expected that, at a minimum, $251,659 will be budgeted for TPT commodities.

DREAMS

Rwanda is allocated $5,000,000 funding for DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programming in COP 2019, of which, $1,096,231 of your COP 2019 HVAB budget code needs to be part of your DREAMS programming. This funding is allocated within your COP 2019 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in

accordance with all DREAMS and COP 2019 Guidance. All new funding allocated to AGYW prevention programming, including DREAMS, must be allocated to the AGYW Prevention cross-cutting budget code.

- PEPFAR Rwanda should ensure that all curricula reaching DREAMS beneficiaries aligns to DREAMS and COP 2019 Guidance and is implemented with fidelity to the original programming. In cases where this is not occurring, work with the AGYW or OVC iSMEs to rectify the situation.
- The team should confirm a plan, including timeline, for standing up a tracking system and when the team will be able to report on AGYW_PREV should be included in the COP submission.

VMMC

Rwanda is allocated $6,941,424 funding for VMMC. As with COP 2018, your total COP 2019 allocation to the CIRC budget code is included in your COP funding determined in this letter. VMMC funding must be used exclusively to support the implementation of VMMC programs in males 10 years and older as pursuant with the CIRC budget code guidance, including the minimum package of clinical and prevention services which must be included at every VMMC delivery point, circumcisions supplies and commodities, communication and demand creation, training, and case finding and linkages for high-risk men.

Rwanda's total VMMC target for COP 2019 is 160,000 and a minimum of 113,600 circumcisions should be done in men over age 14.

	COP19 VMMC					
	target	Total $	VMMC coverage 15-24	VMMC coverage 15-49	Minimum % 15+	Minimum VMMC in 15+
Rwanda	160,000	$ 6,941,424	N/A	N/A	71	113,600

Other technical and programmatic priorities for Rwanda:

National and Regional Strategies

- Effective index testing, in combination with recency testing, demonstrating >40% yield among sexual contacts of PLHIV newly enrolling into care
- Fully implemented active case-based surveillance system to be implemented in all facilities (with use of unique identification and electronic data recording and reporting)
- Fully developed and deployed Quality Management processes
- Recency testing must be done at scale among all newly diagnosed HIV positive individuals.

Facility

- Highly targeted VCT or PITC, testing only those with risk factors that have the highest association with HIV infection (e.g., signs or symptoms of HIV, STI or TB, or those with multiple sexual partners of unknown status)
- Differentiated Service Delivery with multi-month prescriptions extended to 6 months

Community

- Development of community treatment support groups for those at risk of non-adherence
- Continued strong OVC program with strategic coverage targeting all sexually active boys and young men
- Enhanced prevention programming in proven high-burden populations (e.g., KPs and their clients, AYGW at highest risk) with effective incorporation of PrEP

Partner Management

- For COP 2019 planning, we expect implementing agencies to budget for overlays within their budget. For COP18 implementation, we expect implementing agencies to take those steps necessary to avoid late billing of IMs.
- As the largest implementing partner in Rwanda is the MoH, we recommend no change in funded implementing partners in COP 2019 at this time. We plan to conduct further analyses and engage in discussion with PEPFAR Rwanda about the relative costs of the different strategies incurred by partners and will determine the most appropriate funding levels by partner and intervention at the upcoming COP 2019 meeting.

COP 2019 Stakeholder Engagement

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2019 remains a requirement for all PEPFAR programs, and as such the COP 2019 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2018 Q4 and FY 2018 APR results and analyses and the convening of an in-country planning retreat with local stakeholders no later than the week of January 28, 2019 in order to introduce and discuss all COP 2019 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2019. In February, initial COP tools will be submitted to S/GAC for review and feedback. S/GAC will provide feedback prior to the in-person meetings in March and April, and teams should reflect the feedback with their revised submissions. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team.

In March, PEPFAR will convene in-person meetings in Johannesburg, South Africa, where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2019 development and finalization process. As in COP 2018, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2019 Guidance for a full list of requirements and engagement timelines (Section 2.5.3).

Approved:	S/GAC – Ambassador Deborah L. Birx, MD	DLB
Drafted:	S/GAC – Kristen Krystowski, 3-1246	
Cleared:	S/GAC – Angeli Achrekar	OK
	S/GAC – Irum Zaidi	OK
	S/GAC – Mike Ruffner	OK
	S/GAC – Sean Cavanaugh	OK