United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 14, 2020

INFORMATION MEMO FOR AMBASSADOR VROOMAN, Rwanda

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction

Dear Ambassador Vrooman:

First, I wanted to personally thank you and Deputy Chief of Mission for your dedication to PEPFAR and working every day to achieve the most possible with the United States taxpayers' dollars. The ability to translate these resources into effective and impactful programming has and continues to be core to our collective progress. The Rwandan PHIA is an example of the speed and quality of your work and the PHIA results clearly indicate the amazing progress. Your PEPFAR team in country is extraordinary and we are fortunate to witness their passion and compassion. We are very excited about your progress in several areas.

Remarkably, Rwanda has achieved 76% viral load suppression among the total estimated number of people living with HIV (PLHIV) in country. In practical terms, this means that the country has attained the original 90-90-90 benchmark and is well on its way toward the 95-95-95 goals. That achievement is attributed to successful case-finding, and even more impressive efforts at linking PLHIV to treatment and supporting them to adhere to therapy and achieve individual viral load suppression. These successes have led to the attainment of HIV epidemic control. After a slow start with VMMC, the over-achievements of the program over the past three years are commendable as this is a central part of the groundwork needed to consolidate these gains and maintain epidemic control.

Together with the Government of Rwanda and civil society leadership we have made tremendous progress. Rwanda should be proud of the progress made over the past 16 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

We did want to highlight overarching issues we see across PEPFAR and a few specific to Rwanda. Full details will follow in a more comprehensive letter from your S/GAC Chair and PPM.

Throughout the PEPFAR family of supported countries and communities, five gaps are shared across the globe holding us collectively back from achieving Sustainable Development Goal 3 related to controlling the HIV AIDS epidemic:

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services

3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed (net new on treatment and treatment current growth, (retention surrogate))
5. Ensuring all children are diagnosed and are on the best treatment regimens and virally suppressed

Now that Rwanda has achieved overall epidemic control, the program needs to strengthen programming activities geared toward maintenance by improving index testing (and other highly targeted testing strategies), continuing to refine the surveillance network to detect outbreaks early, successfully transitioning the procurement and supply management to the Rwanda Medical Supply Ltd and ensuring excellent prevention programming for those at high risk of HIV acquisition. As the program looks toward building sustainability and providing comprehensive care for PLHIV, it is critically important to review workplans and budgets to ensure money is budgeted for maximum impact.

In a recent Office of Inspector General audit around PEPFAR coordination there were four draft preliminary recommendations based on their discussions with PEPFAR staff in the field from four countries; three of their recommendations are relevant to this Country Operational Plan planning cycle related to target setting, tool development, and timelines. Although we just received the draft report a few days ago we did not want to wait another COP cycle to make substantive changes related to the recommendations. The first was around targets and target-setting and the need for a clear and transparent understanding and dialogue in establishing targets. PEPFAR targets are not PEPFAR's but flow directly from the UNAIDS Fast Track Strategy of 2016. Since 2016, both the PEPFAR strategy and targets were directly derived from the global communities of UNAIDS, WHO, and specifically Heads of State in their commitment to SDG 3 and are aligned to support the country's specific ambition towards those goals. The global community in 2015, through their Heads of State, committed to achieving SDG 3.3 by 2030 which for HIV is ending the HIV/AIDS epidemic as a public health threat. This was followed by a United Nations High Level Meeting on HIV/AIDS in June 2016, whereby these Heads of State committed to the 90/90/90 Fast Track Strategy. Essential to the strategy was 73% community viral load suppression (VLS) by 2020 and 86% community VLS by 2030 combined with increased prevention interventions and zero stigma and discrimination to ensure all ages, genders and risk groups have access to life saving prevention and treatment services.

Also, in 2016, 22 PEPFAR-supported high HIV burden countries committed to the three Frees of Start Free, Stay Free, AIDS Free with 2020 targets of a decrease in new infections in children to 20,000, 85% of pregnant women on ART, AGYW new infections to < 100,000, 90% of children on ART and 25 million VMMCs. Since 2016, PEPFAR and the GF resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries in 2016, 2017, and 2018 to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Rwanda is on track to achieve the 2020 and 2030 goals.

Over the past 4 years, PEPFAR resources were allocated based on need, performance, and specifically on the country's and communities' desire to achieve the SDG, Fast Track Strategy, and Three Free goals and country specific targets. Based on the OIG recommendation, S/GAC will take a different approach this year to target-setting. Our collective hope is that together we use this moment of reflection on progress and challenges along with the realization that the end of 2020 is only 11 months away to address these overarching challenges this year through COP 2019 implementation and use COP 2020 to maintain our progress, address any ongoing challenges and finally fund ambition for greater impact. Thus, S/GAC will not assign targets to countries but only provide notional budget levels. After the PEPFAR country team submits their targets the notional budget will then be adjusted to the presented level of ambition. Additional funding is available as ambition funding for treatment and VMMC.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2020) notional budget is $74,944,000 inclusive of all new funding accounts and applied pipeline and reflects the following:

1. Sustaining the gains in treatment services based on your projected COP 2019 treatment result (FY2020 treatment current funded in COP19) $48,050,000
    a. The care and treatment budget is determined by all of your FY18 C/T expenditure services and commodities (no RTK commodities), including all aspects of the health system inclusive of human resources, laboratory and systems, commodities (exclusive of RTKs), an upward adjustment from FY19 treatment current to the FY2020 treatment current fully burdened cost of treatment services and commodities, and 100% of partner program management costs and data needs
    b. This Budget is broken down by
        i. Care and Treatment services including partner program management costs, FY2020 upward adjustment, EMR and data with surveillance, recency **$27,900,000**
        ii. ARV drugs and treatment commodities (everything except RTKs) **$14,000,000**
        iii. TB preventive treatment **$900,000**
        iv. For earmark purposes 50% of M/O costs **$5,250,000**
        v. Care and Treatment qualifies for ambition funds if addresses gap #3-5
2. Continued orphans and vulnerable children funding to include DREAMS vulnerable girls less than 20-year-old. **$15,350,000**
    a. HKID or $5,800,000 dollars for continued historical OVC services
    b. DREAMS funding of $10,000,000 total, of which 85% is for vulnerable girls under 20 and is counted here **$8,500,000**
    c. 10% of M/O, or **$1,050,000**
3. Continued VMMC funding based on your percent of VMMC in the appropriate age band of >15 years old
    a. Total VMMC **$3,250,000**
    b. VMMC qualifies for ambition requests
4. Dramatic expansion of DREAMS programming as noted above
    a. **$1,500,000** in addition to the $8,500,000 noted above, for a total of $10,000,000

5. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets
    a. Key Population (non-treatment) **$1,100,000**
    b. PrEP total: **$950,000**
6. RTK and service support to ANC HIV testing **$544,000**
7. Remaining 40% M/O based on COP19 **$4,200,000**

Total COP2020 notional budget of $74,944,000 (comprising $74,106,950 new and $837,050 pipeline).

Overall, across the PEPFAR portfolio, we have dramatically increased DREAMS funding to address prevent new infections in adolescent girls and young women. For the first time we find across all districts implementing DREAMS, declines in new diagnoses of HIV in young women. These funds should be used to expand to the highest burden districts not currently covered and saturate in urban areas.

Teams will develop their own targets across PEPFAR program areas described above, with the treatment current target no less than the result that was to be achieved in COP 2019. Testing support outside of ANC should be consistent with any targets above FY2020 treatment current and be submitted with any ambition funding. Targets should reflect continued and expanded OVC and KP programming. For DREAMS, PrEP, cervical cancer and TB Prevention, we expect increased targets consistent with the level of increased budgets.

Again, the team has received a notional budget as noted above; the final budget approval will be contingent on the team's desired targets. As always, funding is associated with a performance target that will be achieved with those resources. Targets and the subsequent approved budget should reflect the level of ambition that the PEPFAR team, in collaboration with the Government of Rwanda and civil society of Rwanda, believes is critical for the country's progress towards controlling the pandemic and maintaining epidemic control.

Additionally, country teams and agencies, independently, can request additive ambition funds in the OU FAST, to be submitted based on their stated increased ambition in Treatment and VMMC, with commensurately increased partner level targets. This funding is available to agency partners with the highest performance with evidence that they are addressing one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and must address one of the gaps in programming #3-5 above. These requests should be discussed with the S/GAC chair and PPM during the January strategy retreat and tentatively approved and be submitted with the DataPack and FAST tool. The final budget and associated country level targets will be discussed and approved during the Johannesburg meeting.

We are hoping this new approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partners accountable to that achievement. In addition, this new approach to target-setting gives high performing partners and agencies with

additional aspirations the opportunity to do more - to achieve even greater impact with additional ambition resources.

In the next 48 hours, more detailed descriptions of Rwanda's programmatic successes and challenges will be conveyed to your wider PEPFAR team by the S/GAC Chair and PPM in a phone call, after which the detailed planning level letter will be immediately released.
Again, thank you for your work and we are looking forward to working with you to achieve your Fast Track Strategy and ultimately the SDG 3.3 goal.

Together we can.

Deborah Birx

United States Department of State

Washington, D.C. 20520

UNCLASSIFIED

January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR VROOMAN, RWANDA

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTS and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

The program has demonstrated historical success with:

1. Linking identified cases to treatment
2. Maintaining a high level of treatment adherence and thereby achieving excellent individual viral load suppression
3. VMMC

The program needs to accelerate the transition toward maintenance of epidemic control, which will require:

1. Pivoting away from costly and inefficient case-finding to full reliance on index testing and partner notification, which will require scale-up and improvements in client participation (as index patients), quality of contact elicitation and proportion of contacts tested.
2. Further refinements in and scale-up of case-based surveillance, with incorporation of recency testing to detect HIV outbreaks early and develop interventions.
3. Ensuring those at highest risk have access to comprehensive preventive services, including PrEP.

SECTION 1: COP/ROP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP/ROP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

Table 1. COP/ROP 2020 Total Budget including Applied Pipeline

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	$ 74,106,950	$ -	$ -			$ 74,106,950
GHP-State	$ 72,666,325	$ -	$ -			$ 72,666,325
GHP-USAID	$ -	$ -	$ -			$ -
GAP	$ 1,440,625	$ -	$ -			$ 1,440,625
Total Applied Pipeline				$ 837,050	$ -	$ 837,050
DOD				$ -	$ -	$ -
HHS/CDC				$ -	$ -	$ -
HHS/HRSA				$ -	$ -	$ -
PC				$ -	$ -	$ -
State				$ -	$ -	$ -
USAID				$ 837,050	$ -	$ 837,050
TOTAL FUNDING	$ 74,106,950	$ -	$ -	$ 837,050	$ -	$ 74,944,000

***Based on agency reported available pipeline from EOFY 2019.*

SECTION 2: COP/ROP 2020 BUDGETARY REQUIREMENTS

Countries should plan for the full Care and Treatment (C&T) level of $48,050,000 and the full Orphans and Vulnerable Children (OVC) level of $15,350,000 from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

Table 2. COP/ROP 2020 Earmarks

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 35,000,000	$ -	$ -	$ 35,000,000
OVC	$ 13,300,000	$ -	$ -	$ 13,300,000
GBV	$ 526,375	$ -	$ -	$ 526,375
Water	$ 176,000	$ -	$ -	$ 176,000

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the minimum amounts that must be programmed in the given appropriation year.*

Table 3. Total COP/ROP 20 Initiative Funding

	COP 20 Total
Total Funding	$ 24,050,000
VMMC	$ 3,250,000
Cervical Cancer	$ -
DREAMS	$ 10,000,000
HBCU Tx	$ -
COP 19 Performance	$ 5,000,000
HKID Requirement	$ 5,800,000

SECTION 3: PAST PERFORMANCE – COP/ROP 2018 Review

Table 4. COP/ROP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	**116,272**	**117,467**
TX Current Peds	**4,095**	**5,468**
VMMC among males 15 years or older	**94,589**	**113,600**
PrEP_NEW/CURR	**943/1,160**	**1,398/1,548**
DREAMS	**26,800 (90.4% of total AGYW reached)**	
Cervical Cancer Screening	**n/a**	**n/a**
TB Preventive Therapy	**0**	**44,939**

Table 5. COP/ROP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
OU	**76,119,327**	**64,141,857**	**8,171,503**
DOD	2,803,777	1,812,135	991,642
HHS/CDC	31,172,750		
PC	0	315,975	(315,975)
State	260,000	7,047	252,953
State/SGAC	3,805,966		
USAID	37,860,117	31,708,962	6,151,154
Grand Total	**76,119,327**	**64,141,857**	**8,171,503**

Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

Table 6. COP/ROP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays ($)	125% and over-outlays (Actual $ - Total COP/ROP18 Budget $)
10954	Drew University	DoD	0	58,506	-58,506
18422	University of Maryland	HHS/CDC	714,797	782,897	-68,100

Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

Table 7. COP/ROP 2018 | FY 2019 Results & Expenditures

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	1,005,803	**871,906**	86.7%	HTS Program Area	4,138,865	98%
	HTS_TST_POS	14,863	**7,070**	47.6%			
	TX_NEW	13,407	**6,976**	52.0%	C&T Program Area	13,146,422	85%
	TX_CURR	122,426	**117,095**	95.6%			
	VMMC_CIRC	52,194	**79,622**	152.6%	VMMC Subprogram of PREV	981,054	100%
	OVC_SERV				OVC Major Beneficiary		
DOD	HTS_TST	36,511	**55,968**	153.3%	HTS Program Area	275,666	100%
	HTS_TST_POS	1,623	**603**	37.2%			
	TX_NEW	1,030	**183**	17.8%	C&T Program Area	354,123	92%
	TX_CURR	3,709	**2,853**	76.9%			
	VMMC_CIRC	55,040	**55,773**	101.3%	VMMC Subprogram of PREV	1,135,962	100%
	OVC_SERV				OVC Major Beneficiary		
USAID	HTS_TST				HTS Program Area	1,784,987	100%
	HTS_TST_POS						

	TX_NEW				C&T Program Area	17,299,804	84%
	TX_CURR						
	VMMC_CIRC	52,194	**79,622**	152.6%	VMMC Subprogram of PREV	2,458,072	100%
	OVC_SERV	117,601	**119,901**	102%	OVC Major Beneficiary	3,665,375	90%
				Above Site Programs			4,903,357
				Program Management			6,093,491

COP/ROP 2018 | FY 2019 Analysis of Performance

OU/PSNU Levels

- After years of broad and intensive case-finding, coupled with excellent linkage and remarkable adherence, the program has achieved an impressive community viral load suppression of 76%, as demonstrated by the recent RPHIA.
- VMMC coverage, especially in Kigali, has been a notable success, laying the groundwork that will help lower transmission and position the country well as they transition their programming to maintenance mode.
- Rwanda decreased the volume of testing from Q1 to Q3 in FY19 (COP18), but the program is still engaged in broad facility testing and has struggled to fully scale-up effective index testing; this has delayed the transition to more strategic programming.
- There are still case-finding and ART coverage gaps in the South and East provinces, and among men more broadly, particularly those aged 25-34; these gaps will require focused interventions built around index testing and self-testing and utilizing insights from both the MenStar Initiative and the Faith and Community Initiative.
- The transition to TLD has been somewhat delayed and 6 month dispensing is still not policy; in order to maximize impact and cost-efficiency, and promote a more sustainable program, these will need to be offered to all eligible clients.
- The country has been slow to fully scale-up prevention activities including use of PrEP for those at highest risk.

Partner Performance

- The Ministry of Health (MoH), Rwanda's largest implementing partner, funded by CDC, is performing well at linkage and retention, under-performing at finding positive clients, and overperforming at VMMC.
  - MoH achieved just 44.7% of their HTS_TST_POS targets and 48% of their TX_NEW targets; they overspent the HTS budget by nearly fivefold, spending 3.3M instead of its budgeted 678K, but only spent 82% of its 13.6M Treatment budget.
  - MoH achieved only 45% of the PREP_NEW target.

- Emory University, also funded by CDC, under-performed at finding positive clients (73% of target) despite spending 105% of their budget. In COP19, CDC shifted to a new partner, SFH, for key population clinical services.
- Twiyubake, funded by USAID, is under-performing with DREAMS and OVC.
  - The majority of clients served by the Twiyubake OVC program was over 18 years old and they achieved only 77% of their target for under 18 year olds.
  - The Twiyubake DREAMS program had a low completion rate of the primary package (relative to the other partners), particularly in the 20-24 year old cohort.
- Funding, and therefore implementation, was delayed for SFH, and they reported spending 131% ($198,700) of their HTS budget, with an overall achievement of 15% against their HTS_POS target; AHC, the other DoD partner, spent 116% ($76,966) of their budget and achieved 97% of their HTS_POS target.

SECTION 4: COP/ROP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP/ROP 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.

For COP/ROP 2020, the failure to meet any of these requirements will result in reductions to the Rwanda budget. (See Section 2.2. of COP Guidance)

Table 8. COP/ROP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from	Attained (fully adopted)	No hindrances

testing to treatment across age, sex, and risk groups.[1]		
2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	In progress. Nevirapine scheduled for removal this month	Policy for TLD to all (including women) is now in place, scale-up among women has only recently commenced.
3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	3MMD is fully implemented (60% of clients participate), 6MMD is not implemented but under consideration	6MMD is not currently policy
4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Initiated at the end of COP18, currently being scaled	No hindrances
5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Attained	No hindrances

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015
[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019
[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016
[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	In progress (index is conducted at all facilities and the program is transitioning to near-exclusive reliance on index testing)	No hindrances
Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	In progress	Need to ensure MoH is in agreement with broader scale-up of PrEP among AGYW at risk
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Attained	No hindrances (need to review all partners' performance and identify and remediate reasons for poor performance)
Policy & Public	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and	Attained	No hindrances

[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

[6] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]		
10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Attained – over 200 initial SIMS visits conducted last year	No hindrances
11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Attained – circulars have been distributed to clinicians	No hindrances (the reduction in testing has diminished community outreach and demand creation for testing; anti-stigma campaigns are ongoing)
12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Attained	No hindrances
13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	In progress	Capacity of GoR is limited, but there are ongoing discussions with US Treasury, OGAC, MoF and MoH
14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Attained (TX_ML is well-reported)	Lack of experience identifying and reporting cause of death
15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	In progress and on-track	No hindrances

[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

In addition to meeting the minimum requirements outlined above, it is expected that Rwanda will:

Table 9. COP/ROP 2020 (FY 2021) Technical Directives

OU –Specific Directives
HIV Case-Finding and Treatment
1. Review of all workplans to ensure maximum cost-efficiency; specifically, money spent on trainings and non-clinical commodities could be used to promote better and more comprehensive patient care, such as diagnosis and treatment of hepatitis C, diabetes and hypertension
2. Similarly, a review of all second- and third-line regimens to ensure that all patients are on optimal therapy; many patients on protease inhibitors are good candidates for TLD, which is better for patients and cost-saving
3. Focused plan to find and retain men on treatment, built upon index-testing and targeted distribution of self-test kits. Guidance from both the MenStar and the FCI initiatives can be helpful in developing interventions
HIV Prevention
1. Increase programming of PrEP, especially for women who engage in transactional sex and their frequent partners, and consider additional groups as identified by analysis of recency data
2. Continue to expand VMMC targets for 15-29 yo and increase targeting of >30 years of age
Other Government Policy or Programming Changes Needed
There is a delay in the issuance of the Prime Minister's Order to launch the transition of the central medical store to the parastatal which needs to be addressed to keep the transition moving.

COP/ROP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and

evaluation of services. OUs must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets should be set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

DREAMS

DREAMS funding is allocated within your COP 2020 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 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

DREAMS is receiving an increase in new funding which should be used for the following:

- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Minimum Requirements for new funds: To receive additional funds, Rwanda must present a strategy and a timeline at the COP meeting for the following:
    - Hire a dedicated DREAMS Coordinator (100% LOE)

- Hire a DREAMS ambassador for each province to support DREAMS coordination and oversight
- Implement approved, evidence-based curricula in line with the current DREAMS Guidance
- Ensure a fully operable layering database with unique IDs across IPs and SNUs
- Ensure a full geographic footprint in all districts
- Address challenges and ensure DREAMS implementation in all districts with fidelity

In addition, DREAMS Rwanda should focus on the following:

- **Layering**: Rwanda appears to be doing well in ensuring that each AGYW in DREAMS is receiving a layered package of services across all age bands. Q4 AGYW_PREV data show that 80% or more of DREAMS AGYW have completed the full primary package and some secondary services.

OVC

To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:

Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0 or complement Global Fund or other donors financing

implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

COP/ROP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)
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/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. 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. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA 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. Specific guidance for the 2020 meeting delegations have been provided

elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, 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/ROP 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Table 10. New Funding Initiative Controls

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	**$ 72,666,325**	**$ -**	**$ 1,440,625**	**$ 74,106,950**
Core Funding	$ 61,866,325		$ 1,440,625	**$ 63,306,950**
COP19 Performance	$ 5,000,000			**$ 5,000,000**
HKID Requirement ++	$ 5,800,000			**$ 5,800,000**

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

Care and Treatment: If there is no adjustment to the COP/ROP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

HKID Requirement: OU's COP/ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP/ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): OU's COP/ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total ***new FY 2020*** *funding programmed to the GBV cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

Water: OU's COP/ROP 2020 minimum requirement for the water earmark is reflected in Table
2. Your water earmark requirement is calculated as the total ***new FY 2020 funding*** *programmed to the water cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 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 OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP/ROP 2019 submission.*

COP/ROP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)
All agencies in Rwanda should hold a 3 month pipeline at the end of COP/ROP 2020 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/ROP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.