

Approved



Rwanda

Country Operational Plan

FY 2014

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 is one of the smallest mainland African countries (26,338 Km²) and is bordered by Uganda, Tanzania, Burundi and the Democratic Republic of Congo. Rwanda has made remarkable economic and social development progress since the tragedy of the 1994 genocide, with real income per capita in 2012 nearly 50% higher than the pre-genocide level. Economic performance has been particularly strong over the last decade, with a 5.4% compound annual growth rate of real GDP per capita.

However, Rwanda remains one of the world's poorest countries. According to the 2011 household survey, 45% of the population lives below the national poverty line of \$1.09 per day PPP. Rwanda has a 63% poverty rate at the international standard \$1.25 per day PPP and is ranked 167 out of 186 countries on UNDP's Human Development Index 2012. As part of the Government of Rwanda's (GoR's) Vision 2020 objective to move the country to middle income status, the nation is focused on achieving rapid, private sector lead economic growth by transforming the economy from a primarily agricultural base to a broad service based economy, welcoming investors and creating new employment opportunities (UNDP Rwanda, 2013).

Rwanda is the most densely populated African country with 11.46 million people (NISR, 2012) and an estimated population density of 407 persons/square km (NISR, 2011). The current population annual growth rate is 2.6%. The GoR supports a voluntary family planning program that has achieved considerable success, with the total fertility rate dropping from 6.1 in 2005 to 4.6 in 2010 (RDHS, 2010). It is estimated that 53% of the population is below 20 years of age (NISR, Statistical Yearbook 2011).

Although Rwanda has made significant progress in improving the population's health status, much work remains. Life expectancy is estimated at 55.7 years (UNDP, 2012). The burden of disease 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 Ministry of Health Annual Health Statistics Booklet, 2011). Cases of malaria have dropped from 8% of all illness in 2010 to 3% in 2011 and accounts for 6% of total deaths as compared to 13% in 2010. In 2011, HIV and associated opportunistic infections were the fourth leading cause of hospital mortality with 7% of deaths (Rwanda Ministry of Health Annual Health Statistics Booklet, 2011).

Rwanda faces a multitude of health and development challenges. An estimated 3% of the population aged 15-49 is infected with HIV (3.7% of women and 2.2% of males) [RDHS 2010], and HIV prevalence has stabilized since 2005. Out of Rwanda's population of 11.5 million, about 190,000 adults and 20,000



children are estimated to be living with HIV (EPP Spectrum estimations, 2013). The repercussions of the 1994 genocide, in which up to a million Rwandan citizens were killed, combined with HIV, resulted in more than a million orphans and vulnerable children. The annual deaths due to HIV-related illness are estimated to be 5,000 and there is an estimated 100,000 AIDS orphans (EPP Spectrum estimations, 2014).

Rwanda's epidemic is primarily driven by heterosexual contact (95%) with 5% attributed to MSM (Modes of Transmission Report, 2013). Populations at higher risk for HIV infection include; women, youth, CSW, MSM, mobile populations, and discordant couples.

The GoR is committed to fighting HIV/AIDS and takes a proactive leadership role in prevention, care, and treatment (with national ART coverage at 94% of adults and 50% of children in need). In 2013 a new National HIV/AIDS Strategic Plan (2013-18) (NSP) was developed with broad stakeholder participation and an international Joint Assessment of National Health Strategies review (JANS). A two-year rolling NSP Operational Plan (OP) is also being developed. PEPFAR remains the largest bilateral funding source for Rwanda's national HIV and AIDS program. In 2013 the GF developed a new results based financing (RBF) pilot grant agreement for Rwanda, which is based on six HIV indicators that are part of the NSP. The agreement was signed in February 2014, and provides two years of funding (July 2013-June 2015) to support the NSP. Coordinated planning of all activities is to be through the OP. The OP provides a visual of what sources are funding each intervention as well as unfunded interventions. The plan will be reviewed periodically with the GF Country Coordinating Mechanism (CCM) and the PEPFAR Steering Committee (PSC). In practice, the OP will help to find efficiencies as the overall donor funding envelope continues to decline and Rwanda diversifies funding of its HIV program towards the realization of Vision 2020 and greatly reduced donor funding. The OP provides a management tool to help Rwanda meet its NSP objectives and the realization of an AIDS-free Generation. Increasingly PEPFAR Rwanda collaborates with the GF. Rwanda's current HIV GF grant will end in June 2015 and the above structures are working together to support Rwanda in its development of next GF funding application under the GF's New Funding Model (NFM) concept note process. The HIV/TB concept note was submitted in August 2014, and Rwanda is working with the PEPFAR funded Grant Management Systems project to help ensure its CCM's eligibility under the NFM. Under the GF RBF agreement, enhanced coordination is required, and USG will have a full-time liaison starting in COP14 to help assist in further harmonizing PEPFAR and PMI activities and funding with the GoR and others supporting the national HIV and malaria programs.

Other donors supporting Rwanda's HIV/AIDS program include: UN agencies, Health-focused non-governmental organizations (NGOs) include Partners in Health, the Clinton Health Access Initiative, and other international NGOs. There is also an increasing number of local NGOs with independent



and/or diversified funding sources.

Rwanda is a PEPFAR long term strategy country with a decreasing budget. In COP13 PEPFAR provided funding and technical support for about 45% of the national HIV response. PEPFAR's contributions are coordinated through the PSC, CCM and the Health Sector Working Group (HSWG) and Health Development Partners' Group (DPG). USAID represents the USG as the co-chair of the HSWG, and chair of the DPG. PEPFAR Rwanda also works closely with UNAIDS, and the PEPFAR Coordinator represents the USG at the CCM.

In September 2013, U.S. Secretary of State John Kerry identified Rwanda as one of the three PEPFAR funded countries to initiate the Country Health Partnership (CHP). During early FY2015, PEPFAR Rwanda will work with the GoR to design the implementation of the PEPFAR Country Health Partnership (CHP). USG Rwanda has developed COP14 in the context of moving toward a PEPFAR Rwanda CHP, and formal structures will be jointly developed for full integration of the CHP into the COP15 and out year planning and implementation processes. In COP14, there will be increased emphasis on financial sustainability through the development of the CHP three to five-year plan.

PEPFAR Rwanda and the GoR acknowledge the downward donor funding trend. The CHP will help to define the areas of most critical need for PEPFAR funding and support as Rwanda takes on more financial ownership of its national program with a shared focus on maintaining quality and achieving an AIDS-free Generation. CHP will be especially valuable given PEPFAR's declining funding and GoR's increased and diversified funding for the HIV program and health system strengthening.

PEPFAR Focus in COP14

COP14 was developed in consideration of other HIV/AIDS funding sources as well as overall OGAC and USG priorities and USG agency pipelines. Twenty-two clinical sites funded through a USAID implementing mechanism (IM) will have transitioned to the MoH in COP13 and be funded through a CDC IM. By the end of COP14, all 163 sites formerly funded by a USAID IM will have transitioned to the MoH and be funded through a CDC IM. A key priority is to provide support for sustainability, technical assistance (TA), and monitoring to assure that the quality of services is maintained and enhanced. Applied pipeline was used to fund the COP14 planning level of \$90M and support the transition of clinical services. USG agencies are working together to find efficiencies towards reducing their management and operations budgets as the overall Rwanda annual funding level reduces. COP14's planning level was also adjusted to account for a unreimbursed VAT penalty of \$138,000 per OGAC requirements. There are no new activities planned in COP14 and all TBDs represent follow on activities.

PEPFAR has supported Rwanda's increased capacity to plan, lead, manage, and deliver quality health



services. COP14 planning is led by the USG interagency team, PEPFAR Coordination Office (PCO), and PEPFAR USG-GoR Steering Committee (PSC). The PCO also worked with agency leads to host a CSO consultation for COP14 development. Input from 50 Rwanda local civil society participants has been incorporated in COP14, and will continue to be integrated into COP14 work plans.

COP14 will complete the transition of clinical services to the MoH, and focus on key populations and sustainability of Rwanda's HIV response. USG will also increase the use of MoH's own data systems for program management and decision making, as well as for PEPFAR reporting. Beginning with FY15 reporting, MoH systems will become sources of PEPFAR reporting data. USG will continue to also work with MoH continuing to shift general population prevention programming to key populations (including MSM, CSW & clients, mobile populations, and youth). Key COP14 priorities include: continued support for the sustainable transition of activities to national ownership; continued decline in the incidence rate while maintaining the gains made in treatment and PMTCT coverage with an increase in pediatric treatment and care; continued direct funding to civil society organizations and the MoH; improved targeting and services for key populations; continued strengthening of the supply chain management system; and maintaining the military-to-military and Peace Corps programs, while also providing support to the Human Resources for Health Program.

COP14 reflects OGAC's guidance to continue the reduction of PEPFAR's funding of GoR's recurrent costs for MoH salaries, individual PBF, and facility operating costs. In COP14, the funding amounts for ARVs and lab commodities are held at COP13 levels, which are a reduced proportion of the total ARVs and lab commodities needed by the GOR, given the increase in the numbers of people on treatment. GoR and GF allocations for the ARVs and lab commodities are expected to increase to ensure coverage of these critical program components. The Coordinated Procurement and Distribution System (CPDS) for lab commodities originally recommended an allocation of \$8 million to PEPFAR for COP14 funding. After review (with the objective to identify cost savings and efficiencies), \$6.8 million was recommended for PEPFAR to fund in COP14. However, the COP14 allocation for HIV lab commodities is \$4.7 million the same amount as in COP13, which the GOR has said leaves a gap of \$2.1 million. The PSC agreed to review the procurement plan, budget execution and consumption of HIV lab commodities in December 2014 after the next lab commodities quantification exercise. This review will identify additional cost savings and all available resources to cover any remaining potential gap. The USG will continue to work with the GoR to identify further cost savings, and provide supply chain TA to ensure critical program needs are met.

As the PEPFAR CHP plan for the next three to five years is developed, the USG will work with GoR to define the strategies and milestones for finding further efficiencies, increase GoR's funding of recurrent costs and investments and determine the areas where USG support will be needed to ensure continuing



quality and sustainability of the national HIV/AIDS program.

In COP14, the USG interagency team will also develop a practice of quarterly pipeline reviews to facilitate COP15 joint planning with GoR under CHP and GoR's use of the OP and required annual HIV program pipeline/expenditures reporting under the GF RBF agreement.

Prevention

During COP14 and 15, the USG will continue to support an integrated HIV prevention package continuing to reduce support for general population prevention programs and increased emphasis on integrated HIV prevention for key populations (KPs) including MSM, CSW and their clients, mobile populations, and youth using evidence based interventions. GoR and the USG will continue to provide KPs with combination prevention approaches where biomedical, behavioral and structural interventions work together to complement and reinforce one another (Test and Link to Care, Treatment as Prevention, promotion of condom use, STI screening and treatment, family planning, reproductive health services, sexual and gender based violence sensitization, social support, and economic strengthening activities).

USG supports Rwanda's NSP Prevention Strategy, through three prongs: eliminating pediatric infections, reducing infections through sexual transmission by 2/3, and maintaining zero levels of blood borne infections. In COP12, PEPFAR and GoR agreed to shift PEPFAR Abstinence and Be Faithful (AB) prevention funds. Subsequently PEPFAR funds have shifted sexual prevention resources to other prevention services focused on KP and OVPs. GoR through on-going community development efforts focus on AB messages.

The GoR aims to eliminate new pediatric HIV infections and improve maternal, newborn and child health (MNCH) and survival by reducing the HIV MTCT rate below 2% by 2015. PMTCT activities are integrated into existing MNCH services such as ANC, integrated management of childhood illnesses, expanded programs of immunization, and sexual and reproductive health. Rwanda's PMTCT program provides a package of: HTC for pregnant women and their partners, ART regimens to prevent MTCT and for maternal health, counseling and support for safe infant feeding practices, safe labor and delivery practices, FP counseling or referrals, and early infant diagnosis and referrals for long-term ART. Rwanda implements Option B+ from 14 weeks of gestation in nearly all health centers.

In COP14 and 15, attention will be directed to improve quality and sustainability while addressing gaps to eliminate MTCT. According to the 2010 RDHS, only 35% of pregnant women make four ANC visits, and 31% of deliveries are not attended by a health professional. Activities to address these challenges include sensitization of pregnant women and mobilization of local leaders and community health workers (CHWs) to promote early attendance at ANC and to minimize loss to follow-up during pregnancy, after delivery



and during breastfeeding.

The USG will continue to support existing HTC sites with clinical and non-clinical partners, assist the GoR to roll-out finger prick sample collection and support approaches to HIV testing such as PIT in all health facilities and a focus on services availability to KPs. USG's programs support mentorship and implementation QA/QC for finger prick sample collection and processes. The USG will monitor and evaluate this initiative, support prevention activities for HIV negative partners in discordant relationships, and support follow-up activities for discordant couples. USG will also work with the MoH to evaluate efficient targeting of PEPFAR support to high yield sites.

The NSP's objectives include ensuring that male and female condoms are available, accessible and used by the general population and KPs. The USG supports the promotion and distribution of condoms and the capacity building of community based organizations in developing and disseminating key health messages. Funding for Rwanda's male and female condoms is provided by UNFPA, GF and the USG. During COP14 and 15, the USG in close collaboration with the MoH and other key stakeholders will continue to provide technical assistance in condom forecasting, procurement and distribution.

The long term GoR objective is to provide voluntary male medical circumcision (VMMC) services to 66% of male adults (age 15-49) by 2018. PEPFAR supports Rwanda's VMMC strategy with both COP funding and OGAC's one time funding to support the roll-out of PrePex. PEPFAR works with the national program to ensure uniformity of VMMC guidance and to build the capacity of healthcare providers to delivery safe quality services. During COP14, the USG will continue to support: MC activities in military health facilities and their catchment areas, capacity building, demand creation, quality assurance and M&E. In COP14, an external quality assurance (EQA) assessment will be conducted. PEPFAR will request TA to assist with this assessment.

Care

Rwanda has made significant progress in the provision of care and support services. At the end of September 2013, PEPFAR supported 247 (53%) health facilities to provide clinical services to 97,201 people representing 60% of PLHIV enrolled in care programs and supported 70,213 OVC. In COP 14, PEPFAR will link the OVC program as a key component to the USG's Action Plan for Children in Adversity (APCA), and work with GoR to further sustainability of OVC programming.

Rwanda's National Guidelines for the Prevention and Management of HIV, STIs, and Other Blood Borne Infections, is in line with the WHO 2013 Consolidated ARV Treatment Guidelines, expanding ART eligibility criteria and starting clients on safer, simplified, and more efficacious regimens. The NSP 2013-2018 objectives are to decrease HIV morbidity and reduce annual HIV related deaths from 5,000 to



2,500 per year.

In COP14 and 15, PEPFAR will continue to fund a package for adult and pediatric care and support services at PEPFAR-supported sites. PEPFAR funding and TA is aimed at keeping PLHIV healthy and living in dignity, reducing transmission of HIV and assessing PLHIV for clinical treatment eligibility. By the end of COP14, through direct PEPFAR funding to the MoH, the GoR will assume responsibility for the management of most USG supported sites offering care and support services. The USG will continue to work with MoH and other partners to promote a service provision linkages model, utilizing facility-based staff, community volunteers, CHWs and existing health committees at the health facility level.

In COP14 and 15, the USG will continue to build the capacity of government, local non-governmental, faith and community-based organizations to increase sustainability of services and country ownership. The USG will work with GoR to integrate and prioritize interventions that reflect strong evidence for care and support in multiple areas including reproductive health, family planning, maternal and child health services and HIV in supported sites and at the community level. The USG will continue to procure basic care related commodities in coordination with the MoH/RBC's Medical Production, Procurement, and Distribution Division (MPPD) and the MoH's Logistic Management Office (LMO).

Treatment

In COP14 and 15, treatment remains a priority focus for USG support. In partnership with GoR and GF resources, PEPFAR will work to ensure that ARV and associated lab commodities requirements are met. In COP14, PEPFAR will hold constant the funding amount for ARVs and other HIV commodities, while working with GoR to shift an increasing share of ARVs and commodities to GoR and GF's funding. GoR is expanding treatment for all children under 5, has adopted PMTCT Option B+, and plans to treat all discordant couples, key populations (MSM and CSWs), and people with co-infections including (TB, Hepatitis B, and Hepatitis C) regardless of CD4 count. USG will continue to support the GoR's decentralization efforts for ART delivery at central level institutions and extending to community level health facilities. During COP14 implementation USG will work the MoH on assessing the low volume ART sites and look for further efficiencies in the delivery of ART.

As of September 2013, MoH provided ART at 481 sites nationwide for a total of 125,009 individuals with advanced HIV infection. Of these sites, PEPFAR provided support to 244 accounting for about 60% of these individuals including 5,212 children. Challenges include: low treatment coverage for children, ensuring adherence and monitoring of patients, increasing linkages, increasing and maintaining adherence, and continuing and increasing quality service delivery by improving prevention, early detection, and management of treatment failure.



In COP14, PEPFAR targets enrolling 9,925 new adults and children on ART. As Rwanda shifts from the 350 CD4 cells/mm³ threshold for initiating ART to 500 CD4 cells/mm³ in 2014, the current ART coverage levels will decrease to 80%. To address this, PEPFAR will support the MoH to enhance timely identification, enrollment and retention into care and treatment setting for all eligible clients. It is anticipated that all eligible clients will have access to treatment.

Rwanda has adopted the new WHO Option B+ PMTCT recommendations, thus pregnant women found to be HIV-positive are enrolled on lifelong ART regardless of their CD4 count. With the NSP's focus on key or high risk populations, testing services will target high-risk groups who have been identified as potential reservoirs for new HIV infections. In COP14, identified HIV-positive KPs will be enrolled in ART irrespective of CD4 cell count to reduce further infection, as part of treatment as prevention for KPs.

USG will continue to support an integrated care services model including screening and treating HIV+ patients co-infected with TB and Hepatitis B. The USG will also support the MoH to increase clinicians' abilities to link PLHIV to other available support services such as PEPFAR's OVC and PLHIV support programs, where possible.

With USG technical and financial support, Rwanda has been able to efficiently procure and distribute drugs and commodities in a timely fashion under the Coordinated Procurement and Distribution System (CPDS). USG will continue to fund TA and support staff at the central level to improve quantification and forecasting of HIV commodities. USG will also continue to support the national treatment program as it transitions to a combined single pill regimen, and promote efficiencies through targeted and integrated trainings of healthcare workers. USG will support the MoH and National Reference Labs in continuing to develop quality testing and immunological follow up facilities to support the treatment program.

Gender

Epidemiological data indicates that women are more likely than men to be infected with and affected by HIV. While Rwanda's overall prevalence of HIV is estimated to be 3%, the prevalence among women 15-49 years is 3.7%, compared to 2.2% for men of the same age. Sexual and gender-based violence 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.

During COP14 and 15, the USG will continue to promote gender equality and mainstreaming while building the capacity of implementing partners and local entities in all program areas: HIV prevention, care, treatment, and social mitigation. Activities will promote and strengthen gender perspectives so that males and females in target populations are equally able to access and utilize HIV prevention, care, treatment and support services; initiate and practice healthy behaviors; exercise their rights; protect



themselves; improve their health outcomes; and live lives free from violence, stigma and discrimination.

Governance

The 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 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 this systems approach, efforts will continue to focus on increasing efficient use and integration of the workforce at the district, sector and community levels, while strengthening national service delivery management capacities, financial resources management, human resources leadership, as well as staff training and deployment.

Strategic Information

With support from the USG and other partners, Rwanda has made tremendous progress in its capacity to collect, manage, and integrate data from different sources for monitoring, evaluating, planning, and program management. PEPFAR also supports the Electronic Medical Records (EMR) system which hosts HIV patient data and allows information sharing within facilities, patient follow-up, and linkages to other services in 124 health facilities. In COP14 USG will continue to support scale up of the EMR system to additional facilities.

The USG will continue to strengthen the capacity of Rwanda's 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 Policy and Strategy. In FY14 USG began introducing PEPFAR's Monitoring and Evaluation Reporting (MER) indicators, and is working closely with the MoH to review and integrate many of the MER indicators into the MoH's systems to facilitate future PEPFAR reporting.

Human Resources for Health

The USG supports human resources for health through capacity building and salary support for MoH staff at the central and health clinic level. In COP14, the USG will continue to support the GoR's Human Resources for Health (HRH) program to use twinning, coaching and mentorship of Rwandan faculty to increase local capacity to build a sustainable, high quality training program. Teaching efforts are designed to increase the skill level of new and existing health professionals. The improved quality of care across the health system will translate into significant gains in combating the AIDS epidemic. Through the HRH program, local capacity has increased to the point where notable instruction and medical care is being led



by Rwandans with U.S. faculty providing oversight and guidance in new subject areas.

Additionally, USG will continue collaborating with GoR to strengthen existing Professional Regulatory Councils to function, regulate, and promote continuous professional development so that all health professionals meet national and international standards. The USG will continue to support data analysis and information use training modules to improve the GoR's capacity to integrate data in decision-making and program management processes.

GHI, Program Integration, Central Initiatives, and Other Considerations

Institutional capacity building and gender equality are GHI priority areas in Rwanda. In COP14 and 15, these priorities will be supported through the HRH activity, trainings and technical assistance, and an overall capacity-building approach incorporated into all COP activities. To further gender equality, a gender sensitive lens is applied to all COP 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 include: the President's Malaria Initiative; Feed the Future; and funding for MCH, FP, nutrition 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 Rwanda's health 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 also 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, PEPFAR fits into a clearly defined national HIV response continuum. 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 stand-alone 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. In both clinical and community settings, psychosocial and emotional care services are provided by trained professionals and through PLHIV networks and cooperatives.

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, adopted 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, focus remains 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. In COP14 USG will continue to support a large OVC program that incorporates seven of eight priority interventions, excluding social protection. GoR policies supporting OVC protection are strong, and, therefore, PEPFAR focuses on the remaining seven interventions. With 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 the entire USG health program. In particular, behavior change and prevention programs aim to address young women's 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 with COP14 and 15. Rwanda has demonstrated strong country ownership and leadership to promote sustainability and efficiency. USG will continue to work closely with the MoH to strengthen national health financing schemes to increase the effectiveness and sustainability of domestic health financing.