United States Department of State

Washington, D.C. 20520

FY 2015 Rwanda Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Rwanda.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

Rwanda Country Operational Plan

COP 2015

Strategic Direction Summary

Final SDS version for submission and posting on PEPFAR.gov

Final Draft 14 August 2015, revised with SI Advisor's comments/questions addressed (20 Aug 2015).

Post DAR COP15 22-26 June review and funding approval

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Goal Statement

In COP15, PEPFAR will work closely with the GoR[1] to achieve antiretroviral therapy (ART) saturation in all districts by Annual Program Report (APR) 2017[2]. In 2014, 67% of all PLHIV were on ART and 12 of Rwanda's 30 districts achieved saturation. By APR2015, 15 districts are projected to be saturated and FY16/APR2016 is projected to end with 19 saturated districts; the remaining 11 to be saturated by the end of APR17[3]. In COPs 14 and 15, PEPFAR will focus resources towards achieving epidemic control in the nine districts with the highest HIV prevalence and unmet need, with emphasis on hot spot sectors and improved linkages between facilities and community funded programs. In collaboration with the GoR, PEPFAR will continue to identify and implement efficiencies to respond to lower levels of HIV program funding while continuing to increase numbers of PLHIV on ART and reduce numbers of new infections. These approaches will include deploying additional HIV resources to ART saturation scale-up areas while ensuring coverage of ART and combination prevention services in sustained areas. To fund this shift, decreased expenditures in the sustained districts will make resources available for saturation scale-up districts and sectors. Emphasis on hot spots, sectors and related sites will support the overall epidemic control focus on highest prevalence regions and populations. In 2016, Rwanda is expected to increase total ART clients by 14,833, achieving 80% ART coverage for all Rwandan PLHIV. PEPFAR's share of the total PLHIV on ART is expected to be 59%[4].

PEPFAR Rwanda's program pivots include working in partnership with MoH to maximally focus HIV program resources (PEPFAR, GoR, GF, others) on saturation towards epidemic control targeting key (CSW, MSM) and priority populations in areas of highest prevalence and unmet ART need, while maintaining basic services in areas at or approaching >80% ART coverage for ART clients and nonaggressive enrollment of new clients. The COP15 approach acknowledges PEPFAR's and the GoR's roles, and GF and GoR's own resource allocation towards achieving nation-wide saturation by APR2016. In COP15 and beyond, increased reliance on evidence-based decision making and rigorous disciplined implementation, including quarterly performance monitoring and redirection as needed, will be required. The forthcoming DHS, RHAIS[5], BSS, and other studies and secondary analysis coupled with routine program information and SIMS will allow the PEPFAR and MoH program leadership to focus on achieving saturation in all districts, and attention on areas of highest prevalence and unmet need.

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[1] In alignment with the Government of Rwanda's (GoR's) National HIV Strategic Plan 2013-18.
[2] Based on joint USG-GoR analyses to meet at least 80% ART coverage of all PLHIV, Rwanda is projected to have saturation in all 30 districts by Annual Program Reports (APR) 2017. This represents the first and second of UNAIDS 90-90-90.
[3] Estimations of unmet need for ART and priority scale-up districts will be reviewed and recalibrated as needed based on the forthcoming epidemic estimations from DHS and AIS, as well as program results data.
[4] In APR14 PEPFAR provided ART to 82,677 out of a total of 132,045 nationally reported ART clients. In APR16, PEPFAR is expected to provide ART to about 94,373 Rwandans, out of a total of 167,298 projected national ART clients, which will bring Rwanda to national level ART saturation. At the end of COP15, 54 sites with approximately 5,000 ART clients will transition to GoR support; thus in COP16, PEPFAR will support closer to 50% of ART clients.
[5] Rwanda HIV/AIDS Incidence Survey

PEPFAR and GoR worked jointly with civil society and other partners to develop COP15 and determined the feasibility of achieving progress toward saturation by the end of COP15. PEPFAR and MoH, as the GF Principal Recipient and lead PEPFAR clinical services implementing partner, will align resource allocation to scale-up to saturation districts while ensuring coverage in sustained areas with proportionate reductions reflective of lower targets and differential estimated unit expenditures. During 2015, PEPFAR and GoR will develop a long-term strategic plan based on epidemiologic data and financial analysis to inform the CHP and maximize epidemic control. At the end of COP15 implementation, 54 low volume sites[6] will transition from PEPFAR funding to the MoH and GoR's financial ownership along with the sites' share of HIV commodities.

[6] Sites with less than 150 ART clients as of APR2014 (Sept. 2014). The plan and schedule for the COP15 transition of the 54 sites will be determined during COP14 implementation.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Rwanda's 2012 Census reported a population of 10,513,973, with 41% under the age of 15 and an annual population growth rate of 2.6%. HIV prevalence is currently 3% and there is an estimated 206,449 persons living with HIV (PLHIV). Based on the COP15 data pack estimations and projections, 67% of PLHIV are on ART. Twelve[7] of Rwanda's 30 districts have already achieved 80% ART saturation with another three districts projected to achieve saturation by APR15. To reach 80% coverage nationally, it is estimated that at the end of APR15, an additional 9,027 new HIV+ individuals will need to be on ART.

Information on the proportion of PLHIV who know their HIV status will become available from the RHAIS[8] in 2015. The 2010 DHS reports that 92% of all HIV positive respondents had been tested previously indicating high levels of testing amongst PLHIV. At the start of COP15 it is estimated that 83% of all PLHIV will be in care. [9] In the absence of more specific information, these data may indicate that 83% to 92% of of all PLHIV know their status. The forthcoming 2015 DHS data will provide additional information on the testing status of PLHIV. Based on COP15 projections and plans, by APR16, 89% of PLHIV are targeted to be in care, likely reaching the UNAIDS goal of 90% of PLHIV knowing their status.

With rapid scale up of clients receiving ART, measuring viral suppression is of increasing importance in Rwanda's efforts to control the epidemic by ensuring that clients have less morbidity and mortality and are less likely to infect others with the virus. Two studies[10] conducted in 2009 and 2013 assessed the proportion of those on ART with an undetectable viral load (<40 copies/ml) at 83% and 82% respectively. These studies were prior to full rollout of routine viral load (VL) testing, which is still in progress[11].

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[7] The twelve districts are: Bugasera, Gakenke, Gatsibo, Gisagara, Kirehe, Ngororero, Nyagatare, Nyanza, Nyarugenge, Nyaruguru, Ruhango and Rulindo.

[8] Rwanda HIV/AIDS Indicator Survey (RHAIS)

[9] Using the PEPFAR data pack and national health management information (RHMIS) projections.

[10] The following two studies: Elul B et alHigh Levels of Adherence and Viral Suppression in a Nationally Representative Sample of HIV-Infected Adults on Antiretroviral Therapy for 6, 12 and 18 Months in Rwanda. PLOS ONE 2013 DOI: 10.1371/journal.pone.0053586, Nsanzimana S et al. HIV care continuum in Rwanda: A cross-secional analysis of the national programme. Lancet HIV Mar 2015

[11] Rwanda currently has nine viral load testing sites, a tenth will be added beginning in 2016. Previously only the National Reference Lab and the University Teaching Hospital Laboratory (Butare) were offering VL testing but, currently nine (10 by 2016) public facilities conduct VL testing. Viral load testing is now routinely required for all Rwandans on ART, six months after initiation, and then annually after that. In 2015, VL testing was added to the list of performance based financing indicators (PBF), which in combination with decentralized VL testing facilities has increased the number and proportion of VLs being done. COP14 is the first year that PEPFAR and the MoH will be routinely collecting, analyzing and using VL data to plan and monitor the HIV response. PEPFAR provides support to national lab services

HIV program donor funding has decreased significantly in the past year, a trend over the past four years that is expected to continue. PEPFAR is working closely with GoR/MoH to re-focus HIV program resources (PEPFAR, GF, and GoR) on core activities as well as to scale-up services in high prevalence and unmet need areas, targeting key and priority populations to rapidly achieve epidemic control. Rwanda's Gross National Income is 630 USD per capita, and significant financial barriers remain to achieve a sustained domestically-funded HIV response.

Rwanda's HIV epidemic is generalized, has higher key population/KP infection rates, and an urban prevalence of 7.1% compared to a 2.3% rural prevalence, with hot spot prevalence estimated at 8.3% in Kigali. Women have a higher prevalence than men (3.7% vs. 2.25% nationally, 7.3% vs. 2.3% in Kigali) and young women aged 20-24 have infection rates five times higher than young men of the same age (2.4% compared to .5%). Sixty-five percent of transmission is estimated to be in stable heterosexual relationships, while 20% of new infections are attributed to sex workers, their clients and their partners[12]. FSWs have an estimated HIV prevalence of 51%[13], while MSM prevalence is not available at this time[14].

Over 27% of PLHIV (56651) are estimated to be in the three districts of Kigali City (Gasabo, Kicukiro and Nyarugenge) due to their high prevalence and larger populations[15]. More than 50% of PLHIV live in nine[16] of Rwanda's thirty districts. These districts represent the areas with highest HIV prevalence[17], and contain 74% of all PLHIV with unmet ART need.

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strengthening, including systems to improve the quality of testing, delivery of results to facilities and implementation of information systems to aggregate quality usable data for national planning. Given that the 83% and 82% undetectable VL estimates from the prior research were completed prior to the decentralization and PBF initiatives, and that routine viral load testing in comparison to targeted testing due to suspected failure, the proportion of clients who are virally suppressed is expected to be higher than 82%.

[12] UNAIDS Modes of Transmission Study (MOT) 2013.

[13] Female Sex Worker Behavorial Sentinel Survey (BSS) 2010. Preliminary findings from the BSS report ~41% FSW national HIV prevalence.

[14] Previous MOT MSM estimated prevalence is 5%, there is currently a MSM BSS in process and will provide prevalence estimations by the end of 2015. Preliminary findings from the BSS report ~3% MSM national HIV prevalence.

[15] District prevalence (DHS 2010) and 2012 Census data were used to calculate district PLHIV from the 2014 national EPP Spectrum estimates.

[16] In addition to the three Kigali districts the other six include Rwamagana, Nyamasheke, Gicumbi, Kayonza, Huye and Burera.

[17] The HIV prevalence in the nine districts ranges between 3.4% and 8.3% based on the 2010 DHS. The data pack will be updated with new prevalence estimates from the 2015 DHS and 2014 AIS when these data become available at the end of CY2015.

Table 1.1.1 Key National Demographic and Epidemiological Data												
		Total		**<15**				**15+**				***Source, Year***
				Female		**Male**		**Female**		**Male**		
		N	%	N	%	N	%	N	%	N	%	
Total Population	2012	10,515,973	100%	2,179,173	20.70%	2,148,910	20.40%	3,271,932	31.11%	2,915,958	*27.73 %*	NISR Census, 2012. p 10.
	2016 (project-ions)	11,533,446	100%	2,292,297	19.88%	2,287,070	19.83%	3,658,625 3	31.72%	3,295,454	*28.57 %*	NISR Census, 2012. p139
Prevalence (%)	2010		1.8	0.60 (.52-.7)					3.7		2.2	DHS, 2010 (Based on 15-49yr old)
	2014		1.9	0.45 (.37-.53)				2.86 (2.5-3.23)				EPP Spectrum, 2014/2012 Census projection
	2016		1.8	0.39(.32-.46)				2.69 (2.35-3.06)				EPP Spectrum, 2014/ 2012 Census projection
AIDS Deaths (per year)	2014	3587 (1,880-6,457)		624 (450-816)				2,963 (1530-5641)				EPP Spectrum, 2014
	2016	2668 (1,395-4,907)		526 (405-655)				2,142 (990-4252)				EPP Spectrum, 2014
PLHIV	2014	206,450 (180,390-232,399)		19,940 (16,708-23,791)				115,301 (101,622-131,011)		71,208 (61736-79188)		EPP Spectrum, 2014
	2016	211,788 (183,567-239,891)		17,423 (14,624-20,709)				121,005 (105,541-137,601)		90.783 (78,026-102,290)		EPP Spectrum, 2014

Incidence Rate (Yr)	2014							0.16 (0.08-0.2)					Epp Spectrum, 2014 (Adults 15-49)
	2016							0.14 (0.07-0.2)					Epp Spectrum, 2014 (Adults 15-49)
New Infections (Yr)	2014	7,398 (5,292-9,335)											
	2016	6,429 (4,713-8,255)											Epp Spectrum, 2014 (Adults 15-49)
Annual births	2012	321,506											NISR Census, 2012. p143
	2015	343,077											NISR Census, 2012. p144 (2015 & 2017 estimates available. No 2016)
% >= 1 ANC visit	2010		98%	Not Available	Not Available				98%				DHS, 2010
Pregnant women needing ARVs	2014	8,372 (6,371-9,718)	2.9%										EPP Spectrum, 2014 (Mothers needing ARVs) and 2014 Program data and PEPFAR APR14
	2016	8,188 (6,029-9,611)	Not available										EPP Spectrum, 2014 (Mothers needing ARVs)
Orphans (maternal, paternal, double)	2010	674,556		75,728		75,157		262,810		260,861			NSP 2009, (DHS 2010, Table 2.12)

TB cases (Yr)	2014	5,981		166		162		1,830		3,823		HMIS, 2014 (TB Division RBC)
TB/HIV Co-infection	2014	1,495	25%	44	27%	38	23%	544	30%	869	23%	HMIS, 2014 (TB Division RBC)
Males Circumcised	2010	Not Available	Not Available			Not Available	Not Available			336,129 (ages 15-59)	13%	DHS 2010
Key Populations												
Total MSM*	Not Available	Not Available	Not Available									
MSM HIV Prevalence	Not Available		Not Available									
Total FSW	2010	12,500										BSS Female Sex Workers, Rwanda 2010
FSW HIV Prevalence	2010		51%									KYE Estimates NSP (BSS Female Sex Workers, Rwanda 2010)
Total PWID	Not Available	Not Available										
PWID HIV Prevalence	Not Available		Not Available									
SD/Couples (Prevalence)	2010	Not available	3.43%									RDHS 2010
Prisoners (Prevalence)	Not Available	Not Available	Not Available									

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression* 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	10,515,973	3.0%	208,497	167,614	138,471	135,424	Data quality insufficient	3,747,694	13,689	11,541
Source	NISR 2012	DHS, 2010	EPP Spectrum (2014)	Rwanda HMIS Sept 2014	Rwanda HMIS Sept 2014	Rwanda HMIS Sept 2014		Rwanda HMIS Sept 2014	Rwanda HMIS Sept 2014	Rwanda HMIS Sept 2014
Population less than 15 years	4,328,083	0.37 (0.3-0.46)	17,270 (13,936-21,426)	10,017	8,065	7,588	Data quality insufficient	Not available	Data quality insufficient	Not Available
Source	NISR 2012	EPP Spectrum (2014)	EPP Spectrum (2014)	Rwanda HMIS Sept 2014	Rwanda HMIS Sept 2014	Rwanda HMIS Sept 2014				
Pregnant Women	341,082	2.9	8,372 (6,371-9,718)	Not available	9,582	Not available		351,516	4,218	3,754
Source	Census 2012	Rwanda HMIS, Sept 2014	EPP Spectrum (2014)		Rwanda HMIS, Sept 2014			Rwanda National HIV Annual Report 2013-2014	Rwanda National HIV Annual Report 2013-2014	Rwanda National HIV Annual Report 2013-2014

1.2 Investment Profile

In FY14, Rwanda's HIV response was funded primarily by three sources – PEPFAR (49%), the Global Fund (42%), and the national government (9%)[18]. Overall donor funding for the Rwanda HIV program continues to decrease; since FY 2009, PEPFAR funding to Rwanda has decreased annually by an average of 10%. In FY15, GF HIV funds decreased from $102m to $59m[19] and PEPFAR from $90m to $80m[20], while GoR funding is planned to increase from $17m to $20m; the total planning level of $159m signifies a 24% decrease from the previous year. Decreases in GF and PEPFAR funding create particular challenges with Rwanda's HIV program dependency and places pressure on Rwanda's health system's resilience. The MoH's ability to secure additional GoR funding to compensate for human resources and other system costs no longer funded by GF or PEPFAR in the long-term is yet to be determined.

PEPFAR and GF are coordinating with the MoH to maximize USG and GF investment, and strategically align with domestic and other available resources to achieve epidemic control. Rwanda is the first country to participate in GF's Results Based Financing (RBF) Model and is the largest PEPFAR implementing partner through the USG's government-to-government funding program.

[18] PEPFAR 2014 Expenditure Analysis; Rwanda HIV Consolidated Operational Plan, 2013-2015; National HIV Annual Report, 2013-2014. Note that various sources with non-aligned time frames are used for the investment profile analysis. Depending on the timeframe/data view, Rwanda's national HIV response is funded roughly 45% PEPFAR, 45% GF, 9% GoR, and 1% other sources.
[19] GoR fiscal year 2015/16, July 2015 to June 2016.
[20] PEPFAR COP14 was $90m, COP15 planning level is $80m.

Table 1.2.1 Investment Profile by Program Area[21]

Program Area	Total FY 14 Expenditures	% PEPFAR[22]	% GF[23],[24]	% GoR[23],[24]	% Other[23],[24]
Clinical care, treatment and support	$67,192,210	62.0%	37.3%	0.6%	0.1%
Community-based care	$3,384,287	42.5%	57.5%		
PMTCT	$14,498,839	22.3%	49.3%	25.3%	3.0%
HTC	$8,425,037	82.9%	17.1%		
VMMC	$3,415,342	45.8%	54.2%		
General population prevention	$13,583,762	15.9%	61.0%	18.2%	4.9%
Key population prevention	$1,488,728	100.0%			
Other vulnerable populations prevention	$407,400	100.0%			
OVC	$14,035,918	74.6%	25.4%		0.1%
Infection Control	$1,560,704	97.4%	2.6%		
Blood Safety	$5,743,861	48.0%	36.9%	15.1%	
Laboratory	$28,824,217	49.2%	50.8%		
SI, Surveys and Surveillance	$2,701,848	52.2%	43.0%	4.7%	0.2%
HIV Coordination	$6,916,236		80.3%	19.7%	
HSS	$13,115,226	1.5%	34.6%	63.7%	0.1%
HRH	$12,996,167	59.2%	40.8%		
Total	**$198,289,782**	**49%**	**42%**	**9%**	**1%**

[21] Note that various sources with non-aligned time frames are used for the investment profile analysis by program area. Depending on the timeframe/data view, Rwanda's national HIV response is funded roughly 45% PEPFAR, 45% GF, 9% GoR, and 1% other sources.
[22] PEPFAR 2014 Expenditure Analysis
[23] Rwanda HIV Consolidated Operational Plan, 2013-2015
[24] National HIV Annual Report, 2013-2014

Table 1.2.2 Procurement Profile for Key Commodities[25]

Commodity CateGoRy	% PEPFAR	% GF	% GoR	% Other	Comments
ARVs	48%	52%	0%		Includes drugs for adults and pediatrics; third-line drugs are only funded by the GF HIV grant.
Rapid test kits	52%	48%			Following the quantification, PEPFAR informed GoR that COP14 excluded rapid test kit procurement as all PEPFAR funded commodities were in C and T cateGoRies.
OI drugs	99.6%	0%[26]		0.3%	OI drugs, mostly CTX, quantified for HIV program. GoR procures CTX separately for Essential Medicines program. Pfizer donates Fluconazole only, less than 1% of total program cost.
Lab reagents	49%	51%			Assumes all lab commodities for HIV program except RTKs, as quantified.
Condoms	24%	31%		45%	Socially-marketed condoms are provided through PEPFAR and GF. Public sector condoms are quantified through the FP program and procured by USAID/POP/FP, UNFPA, and GoR. Annual breakdown of costs varies significantly per year. This is only inclusive of male condoms. Female condoms are procured by UNFPA.
VMMC kits	30%	70%			GF, PEPFAR, and GoR historically contribute to the procurement of surgical and Prepex VMMC kits and other necessary consumable supplies. This figure is based on PEPFAR procurements under one-time scale-up funding and GF funded shipments shared by GoR.

[25] Estimates for commodities seen in Table 1.2.2 are based on the December 2013 quantification report (CPDS 12/CPDS 8) and subsequent planning meetings for the period of 2014. Additional inputs are from the Medical Procurement and Production Division regarding received Global Fund shipments or received UNFPA shipments. Future year changes anticipated include a reduction in the overall percentage of PEPFAR's contribution to the program, VMMC kits, and laboratory commodities.

[26] GoR's own resources are also used for OI drugs under the Essential Medicines Program that may be provided to PLHIV.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID Non-HIV	$45,711,000	$12,587,015	7	$14,624,887	Focus on key populations and OVC; improve access to service delivery and commodities availability, including family planning.
Kabeho Study	$1,119,608	$1,119,608	1	$0	To determine the 18 and 24 month HIV-free survival in a cohort of children born to HIV-positive pregnant women in selected high volume antenatal clinic sites in Kigali.
CDC Influenza	$400,000	$0	0	$0	Sustaining Influenza Surveillance Networks and Response to Seasonal and Pandemic Influenza by National Health Authorities
CDC NPHI	$250,000	$250,000	1	$22,507,981	Strengthen Institutional capacity of RBC/IHDPC to address critical public health problems facing Rwanda trough Strengthening of the NCD division
CDC eHealth Systems Implementation	$494,223	$0	0	$0	Evaluating the performance, impact, and costs of a large-scale eHealth system
PEPFAR Central Initiatives: HRH	$2,000,000	$2,000,000	1	$22,507,981	
PEPFAR Central Initiatives: VMMC	$1,200,000	$1,200,000	2	$26,829,020	VMMC funds support the scale up of VMMC activities in Rwanda (one-time funds)
PEPFAR Central Initiatives: Waste Management	$880,185	$880,185	1	$22,507,981	Support the injection safety and waste management program (one-time funds)
PEPFAR Central Initiatives: Global Funds	$61,635	$61,635	1	$22,507,981	To improve the coordination between PFPFAR and GF program
PEPFAR Central Initiatives: Local Capacity Initiative	$740,000	0	0	0	Strengthen PLWDs local organizations to advocate for and to ensure long-term sustainability of HIV, Care and Treatment services and integration into Rwanda's National Health system (3-year project)
Total	**$52,856,651**	**$18,098,443**	**14**	**$131,485,831**	

1.3 National Sustainability Profile

Rwanda's Sustainability Index and Dashboard (SID) workshop was organized jointly with GoR/MoH in February 2015 and was attended by 65 participants from 40 organizations. Seven of the nine total SID domains were identified as sustainable or approaching sustainability, with notable strength in the domain "Enabling Environment" with regard to laws, policies, and planning. The SID identified the critical element of Domestic Resource Mobilization: Resource Commitments as the only weak and unsustainable area requiring significant focus. Other components identified as emerging sustainability[27] and needing further investment were Epidemiological and Health Data, Human Resources for Health, Commodity and Supply Chain, Allocative Efficiency, Technical Efficiency, Public Access to Information, and Oversight and Stewardship.

Specific priority areas identified within these domains which require strengthening for continued progress towards epidemic control were:

- Ability to measure progress towards epidemic control
- Reaching saturation of ART (80% of all PLHIV on ART)
- Salary support for human resources providing HIV services
- Analysis of financial expenditure/efficiency, improving unit cost estimates
- Available data on pediatrics and key populations
- Domestic financial resources available and allocated for health and HIV
- Geographic allocation of resources relative to unmet need
- International standardized nurse training on HIV

The concern about HIV resource commitments stems predominantly from the low level of domestic revenue allocations to the HIV program. While there is political will to fund the HIV response there is limited domestic budget to do so at this time and rapidly reducing reliance on donor funding is a challenge.[28] PEPFAR and Global Fund have invested substantially in Rwanda's HIV response and both funding sources are reducing. Nearly 50% of PEPFAR funding and all GF support is delivered through direct government support, which demonstrates the capacity of the GoR and MoH systems. However, challenges remain for funding for health workers, commodities, and other components with limited domestic resources[29].

[27] SID Guidance, December 14, 2014 refers to 'emerging sustainability' as areas needing some investment (p.12).
[28] GoR/MoH is responding in part to decreased donor HIV program funding for HSS by directing GoR funding towards strengthening the health system which also supports the HIV program sustainability.
[29] Based on the proposed GoR resources of about $20m for the 2015/16 HIV program: 52% is allocated to human resources to support HIV program services delivery (PMTCT, ART, HTC, VMMC, etc); 12% is allocated to infrastructure and other equipment; 10% is allocated to living support to clients; and, the remaining 24%, about $5m is allocated across support to the supply chain ($2.4m), planning and

Five of the eight domains identified needing improvement and key for continued progress are included in COP15, in particular the focus on reaching epidemic control and saturation as well as improved measurement of epidemic control through supporting the effective implementation of the electronic medical records system, and the geographic allocation of resources relative to unmet need. [30] The DHS and other surveys results are expected in late 2015 and will enrich the strategic information environment for better planning and program implementation during COP15 through provision of district level pediatric prevalence data, as well as an incidence study and key populations HIV prevalence.

1.4 Alignment of PEPFAR investments geographically to disease burden

Figure 1.4.1 compares PEPFAR USD/PLHIV expenditures in 2014 to estimated numbers of PLHIV by district. PEPFAR spent on average $570.16 per PLHIV in Rwanda in 2014.[31] Spending per PLHIV across districts varied from $131.17 to $1,129.69. Some of this variation may be explained by allocations for the HRH Program as well as supplemental external or domestic funds for HIV activities. These data were used to support the analysis and allocations of COP15 PEPFAR funding for the next year. Given universal ART availability in Rwanda, and PEPFAR's role in supporting just over half of the clients, varying from 2% of ART clients in a district to nearly all, examination of PEPFAR expenditure alone does not account for the full picture of support for PLHIV in Rwanda.

Three districts stood out with low spending compared to high HIV prevalence: Gasabo, Kicukiro, and Nyamasheke. Gasabo and Kicukiro largely make up the Kigali city area, where GF funds much of the HIV response. The Huye, Rulindo, and Nyaruguru districts all exhibit high PEPFAR investments with comparatively low disease burden. There was a large one-time investment made in equipment for the HRH Program that together totaled $4m in Huye at the teaching hospital. About 50% of the FY14 spending in Rulindo was towards the closeout of an OVC program. In Nyaruguru, PEPFAR also invested more heavily in HSS activities in FY14 through the HRH Program.

The lower relative disease burden in these and other areas were taken into consideration in the geographic prioritization exercise described in Section 3.0.

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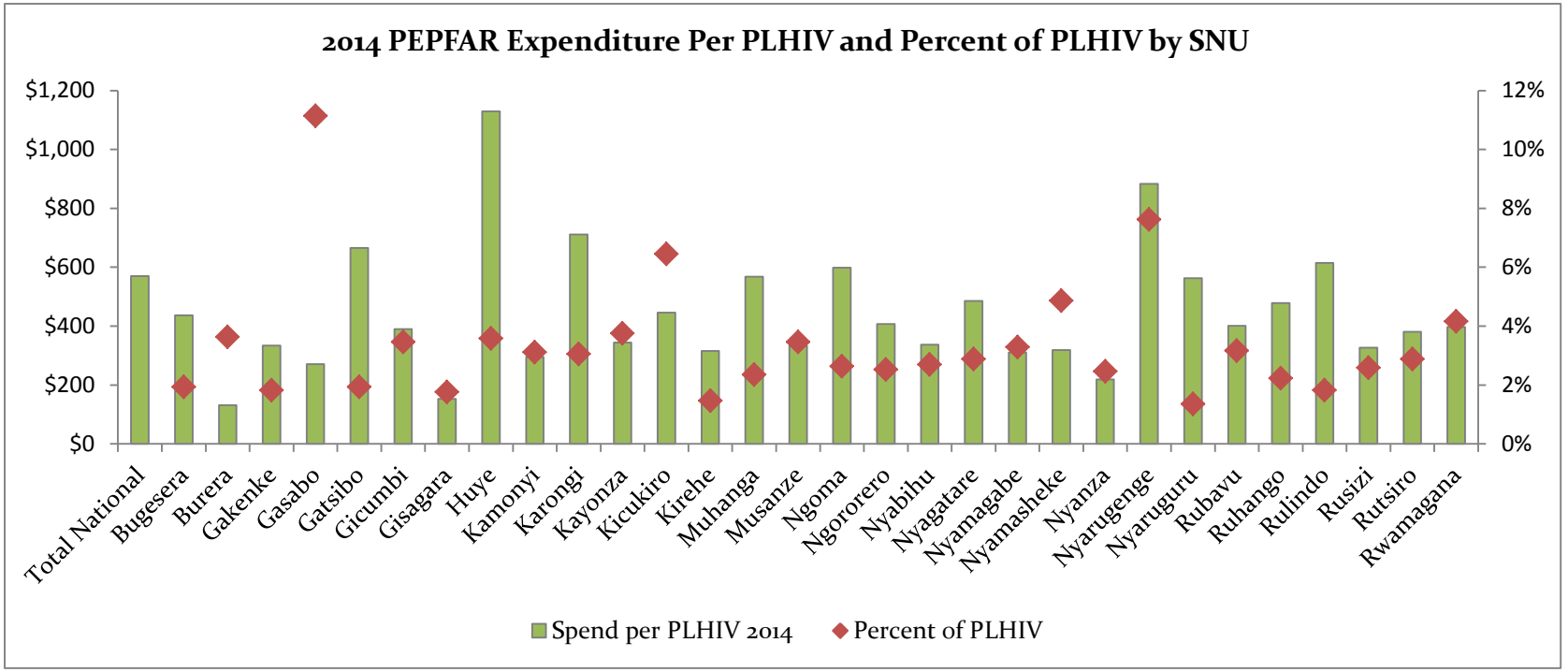
administration ($.4m), monitoring and evaluation ($.2m), technical support ($1.4m) and overheads ($.48m). (Source: 2015/16 HIV program budget as presented at CCM, 15 April 2015.)

[30] Other partners should be identified for additional areas including supporting analysis of HIV program financial expenditure, and needs for the GOR's plan to establish standardized nurse training on HIV.

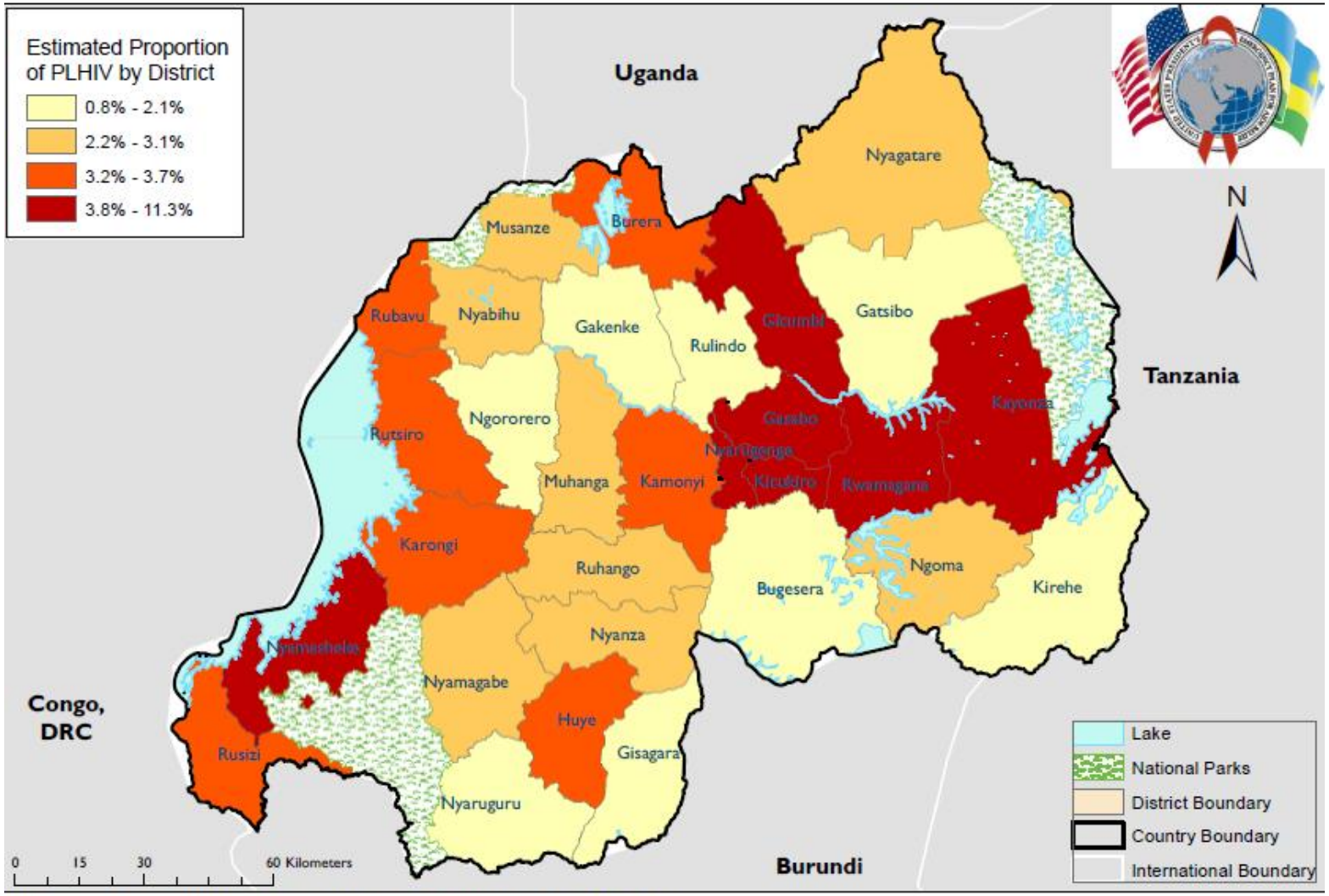
[31] Based on the PEPFAR FY14 EA, this estimation also includes prevention and HSS funding.

Figure **1.4.1**


2014 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU
$1,200
$1,000
$800
$600
$400
$200
$0
12%
10%
8%
6%
4%
2%
0%
Total National
Bugesera
Burera
Gakenke
Gasabo
Gatsibo
Gicumbi
Gisagara
Huye
Kamonyi
Karongi
Kayonza
Kicukiro
Kirehe
Muhanga
Musanze
Ngoma
Ngororero
Nyabihu
Nyagatare
Nyamagabe
Nyamasheke
Nyanza
Nyarugenge
Nyaruguru
Rubavu
Ruhango
Rulindo
Rusizi
Rutsiro
Rwamagana
Spend per PLHIV 2014
Percent of PLHIV

Rwanda District HIV overview		
District	**HIV Prevalence** 2010 DHS	**Estimated PLHIV** 2014 National PLHIV (EPP Spectrum) weighted by District prevalence (DHS2010) and population (2012 Census)
NATIONAL	3.0%	206,449
Bugesera	1.0%	3,457
Burera	3.5%	7,140
Gakenke	1.4%	2,989
Gasabo	6.4%	22,991
Gatsibo	0.9%	3,793
Gicumbi	3.4%	8,373
Gisagara	1.1%	2,175
Huye	3.5%	7,461
Kamonyi	3.1%	6,705
Karongi	3.3%	6,782
Kayonza	3.7%	7,735
Kicukiro	7.9%	17,374
Kirehe	1.0%	2,926
Muhanga	2.9%	5,991
Musanze	2.7%	6,246
Ngoma	2.6%	5,404
Ngororero	2.1%	4,243
Nyabihu	2.7%	4,796
Nyagatare	1.9%	5,333
Nyamagabe	2.8%	5,914
Nyamasheke	3.6%	8,507
Nyanza	2.1%	4,245
Nyarugenge	8.3%	16,287
Nyaruguru	0.9%	1,695
Rubavu	2.8%	6,819
Ruhango	2.5%	5,021
Rulindo	1.7%	3,264
Rusizi	2.8%	6,961
Rutsiro	3.4%	6,680
Rwamagana	4.6%	9,140

Rwanda: Estimated Proportion of PLHIV by District (2014)



Data Source: EPP Spectrum/PEPFAR & GoR SDS COP15 Planning/PEPFAR APR 2014 Program Data

Prepared by: CDC & PEPFAR Program Office - July 2015

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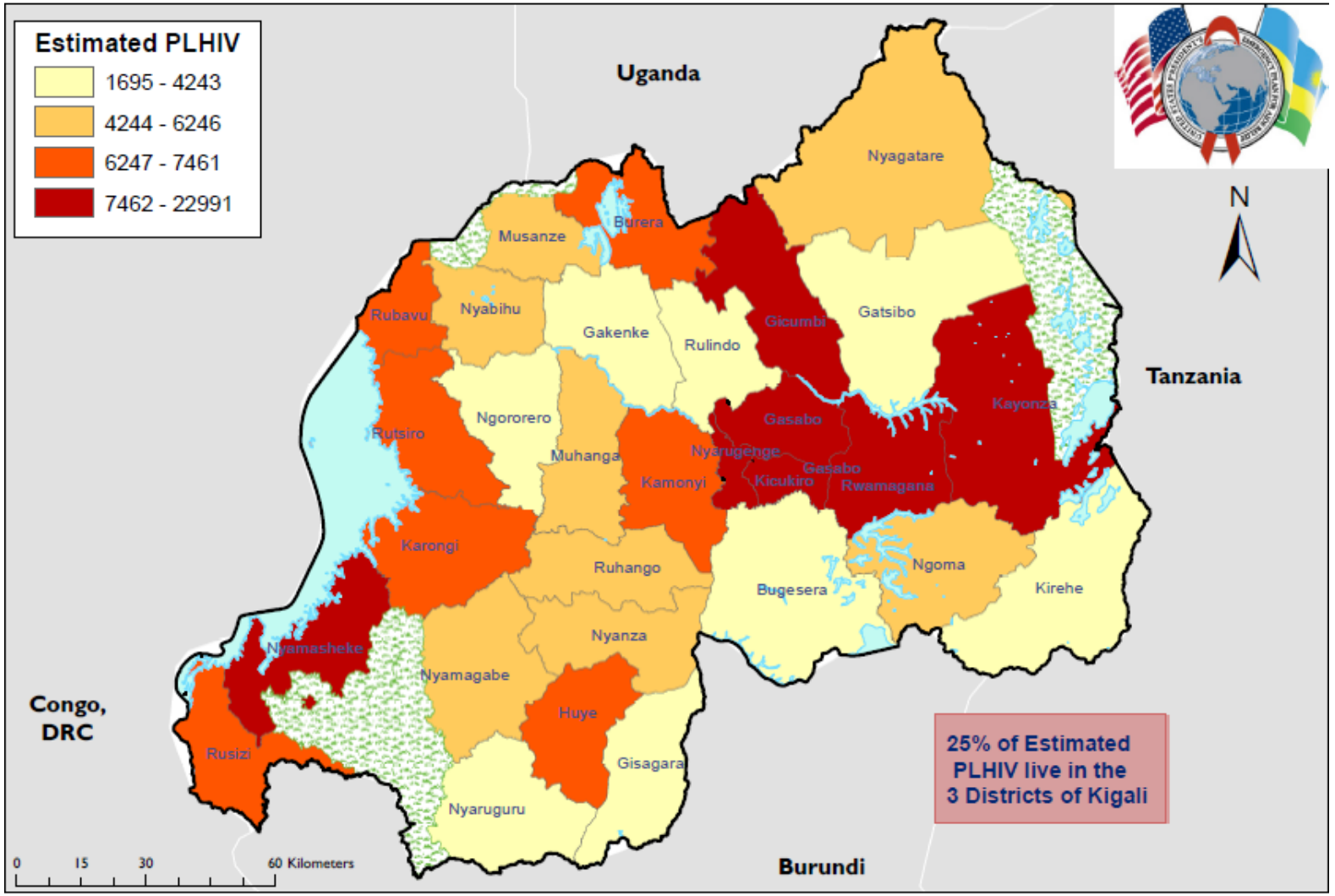
Rwanda: Estimated Distribution of PLHIV by District (2014)



Data Source: EPP Spectrum/PEPFAR & GoR SDS COP15 Planning/PEPFAR APR 2014 Program Data

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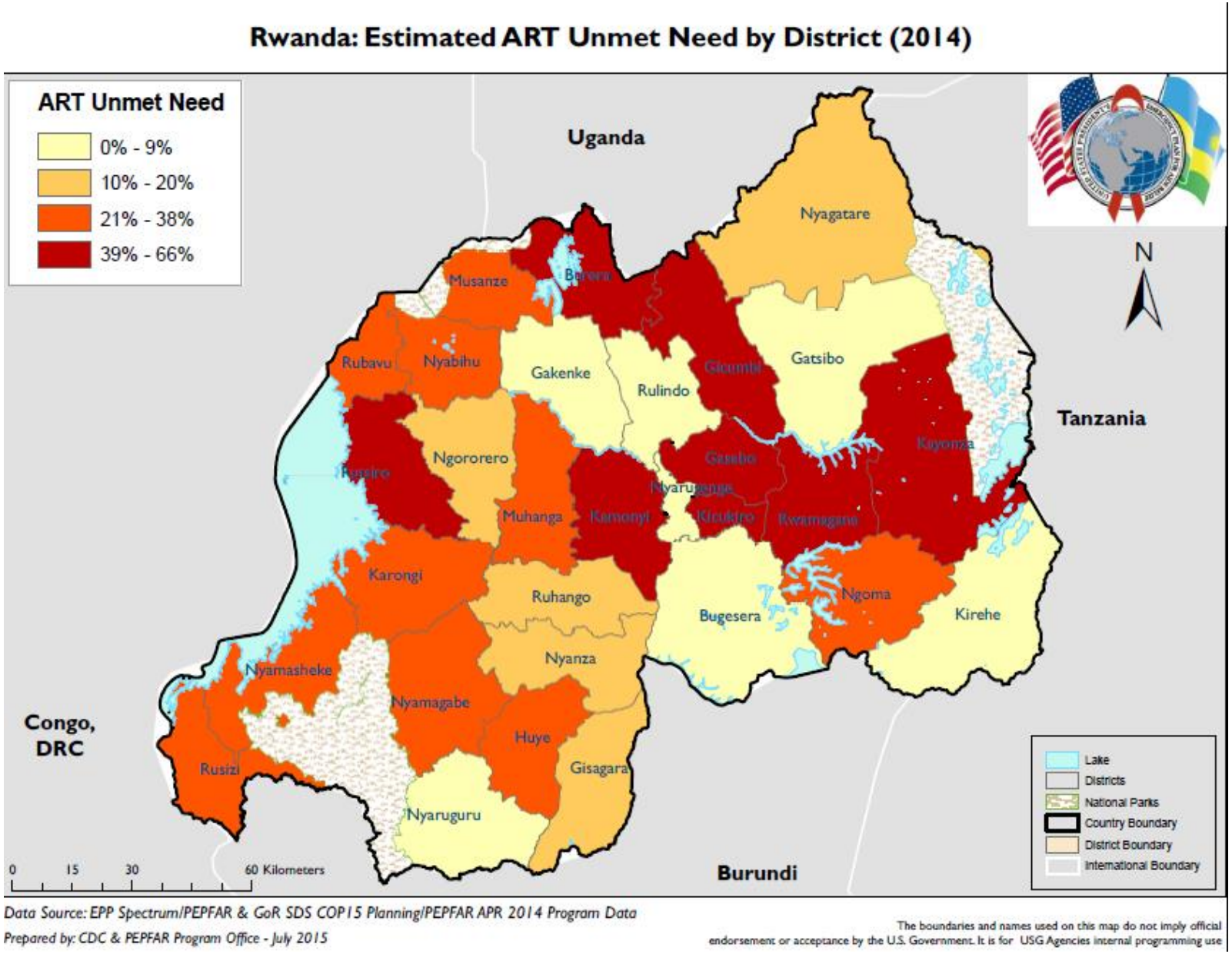
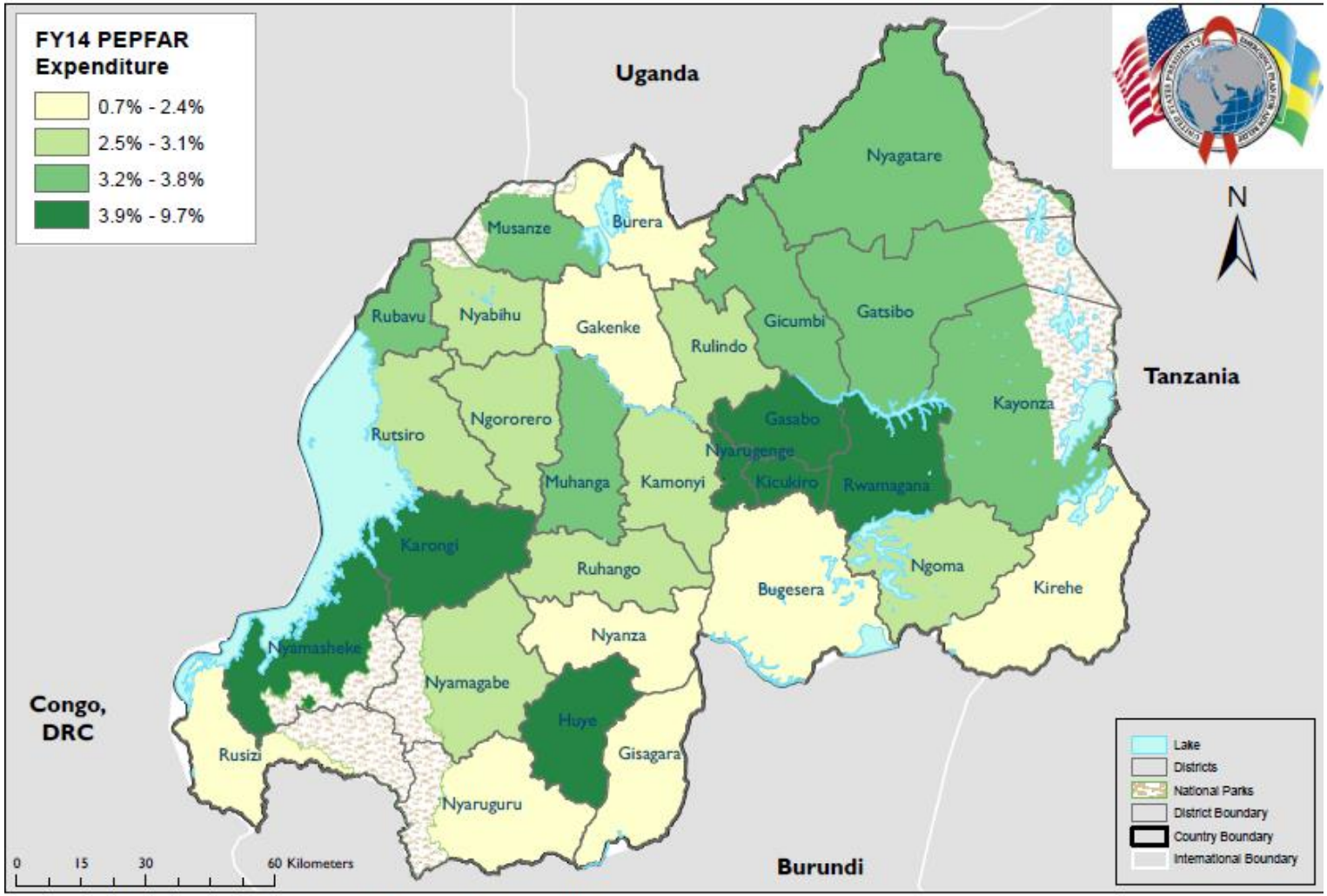

Rwanda: Estimated ART Unmet Need by District (2014)
ART Unmet Need
0% - 9%
10% - 20%
21% - 38%
39% - 66%
Uganda
Tanzania
Congo, DRC
Burundi
N
Nyagatare
Musanze
Burera
Rubavu
Nyabihu
Gakenke
Rulindo
Gicumbi
Gatsibo
Kayonza
Rutsiro
Ngororero
Gasabo
Nyarugenge
Muhanga
Kamonyi
Kicukiro
Rwamagana
Karongi
Ruhango
Ngoma
Kirehe
Bugesera
Nyamasheke
Nyanza
Nyamagabe
Huye
Gisagara
Rusizi
Nyaruguru
0 15 30 60 Kilometers
Lake
Districts
National Parks
Country Boundary
District Boundary
International Boundary
Data Source: EPP Spectrum/PEPFAR & GoR SDS COP15 Planning/PEPFAR APR 2014 Program Data
Prepared by: CDC & PEPFAR Program Office - July 2015
The boundaries and names used on this map do not imply official endorsement or acceptance by the U.S. Government. It is for USG Agencies internal programming use

Rwanda: FY14 PEPFAR Expenditure by District (2014)



Data Source: EPP Spectrum/PEPFAR & GoR SDS COP15 Planning/PEPFAR APR 2014 Program Data

Prepared by: CDC & PEPFAR Program Office - July 2015

The boundaries and names used on this map do not imply official endorsement or acceptance by the U.S. Government. It is for USG Agencies internal programming use

1.5 Stakeholder Engagement

COP15 was jointly developed with GoR/MoH.[32] Joint planning working groups (WGs) developed the SNU analyses of prevalence, hot spots, sites and unmet need to identify scale-up to saturation and sustained districts. These WGs will strategically design and oversee COP15 implementation and alignment of GoR/GF and other resources' focus on epidemic control, and more effective deployment of HIV program funding to priority areas and populations. Rwanda's GF HIV grant is a results-based funding model (RBF), and the GoR/MoH oversees the allocation of the grant within the frame of the HIV NSP. [33] USG is represented on the CCM and has engaged on the NSP Operational Plan.

Civil society and the private sector provided inputs for the COP15 working groups through participation in a CSO Consultation held in February 2015. The meeting engaged numerous community partners and their affected/infected constituencies. With UNAIDS, the NGO umbrella groups for health CSOs and PLHIV, as well as the CCM Secretariat and MoH/Rwanda Biomedical Center, PEPFAR organized and hosted a two-day civil society consultation. Following on the CSOs' Consultation, PEPFAR will continue to develop a regular practice of consultation with these groups.

Rwanda was one of the first three countries announced in September 2013 to develop a CHP. PEPFAR Rwanda worked with S/GAC and GoR/MoH to prepare a framework MOU during 2014. Rwanda's CHP finalization was paused with the COP14 required resubmission due to pipeline readjustments in October 2014.

Joint COP15 development, adaptation of planning tools, emphasis on epidemic control and priority regions, and the required increased efficiencies in resource deployment in focused SNUs will help to prepare Rwanda for the COP15 quarterly reviews. The PEPFAR Oversight, Accountability and Response Team (POART) quarterly reviews will be merged within the context of Rwanda's own quarterly HIV NSP reviews. Given the GF HIV funding decline of 40% in 2015/16, and PEPFAR's funding continued decline over the near term, elaborating Rwanda's HIV program sustainability plan is critical. Rwanda's HIV sustainability plan will expand on COP15 efforts to target scale-up services and jointly review data and results to make tactical mid-course corrections towards ending the HIV/AIDS epidemic in Rwanda by 2030.

[32] COP15 planning processes included joint data analysis, and priority setting, while the USG team set the budget elements and reviewed them with GoR/MoH.

[33] The GOR/MoH is the GF HIV, TB and Malaria grants Principle Recipient (PR).MoH is also PEPFAR's lead clinical implementing partner and is responsible for nearly all COP15 clinical results. The RBF grant is disbursed based on the overall achievement of seven indicators which PEPFAR also contributes to the reported results.

2.0 Core, Near-Core and Non-Core Activities

The USG interagency team developed and then vetted the core, near-core, non-core (CNN) analyses with the joint USG/GoR COP15 working groups. (The full CNN analyses are provided in Appendix A). The CNN analysis considered activities required to achieve sustained epidemic control, the current COP14 program and activities, and challenges to achieving epidemic control. SID and SIMS data were considered alongside DQA/SQA and other relevant program context. The CNN analysis was used to prioritize PEPFAR's COP15 supported activities and helped to emphasize the need to focus resources on core epidemic control activities. The CNN analysis was also used in the definition of program core packages for prevention, care and treatment, OVC, labs and supply chain. In the case of near-core blood services the CNN was used to define what activities are proposed for COP15 support, and which activities will transition over the next two years to non-PEPFAR funding. Through the USG development of the CNN analysis the HRH Program was identified as non-core and it will not be funded after COP15. Overall, the CNN analysis helped align both the USG agencies and MoH regarding priorities for PEPFAR COP15 funding for both site and above site systems strengthening activites for achieving epidemic control.

3.0 Geographic and Population Prioritization

The USG and GoR team are focused on the UNAIDS 90-90-90 targets to reach epidemic control quickly. While Rwanda is on track to reach ART saturation nationally by APR16, epidemiological estimations and program performance data suggest that with more focused planning and resource allocation, saturation (90% of identified PLHV on ART) in all districts is achievable by APR17[34]. Without this approach, projections indicate that success would take longer in the areas with the greatest unmet need. Rwanda's funding for the HIV epidemic decreased 24% between FY15 and FY16, due primarily to reductions by both the Global Fund and PEPFAR totaling $53m. With declining donor resources, and a slowly increasing number of PLHIV, Rwanda is in a positon where rapid and focused action to break the epidemic is critical.

Prevalence in Rwanda has remained at 3% for nearly 10 years, and new infections are reducing at an estimated 6.8% per year. However, the total number of Rwanda's PLHIV continues to increase by 1% annually (EPP Spectrum 2014). According to the national HMIS system data, as of September 2014 (APR14), 67% of all Rwandan PLHIV were on ART; five months later at the end of February 2015, after accounting for an estimated 1.3% increase in total PLHIV, 70% were on ART. At present there are an estimated 68,000 Rwandan PLHIV not on ART, 40,000 of who are eligible

[34] Based on available program data, the HIV prevalence from 2010 DHS is higher than expected in Burera and Gicumbi Districts. PLHIV estimates will be recalculated using 2014 RHAIS and 2015 DHS data, and these districts are expected to reach saturation by 2017.

for ART according to current guidelines. By APR14, 12 of the 30 districts already had more than 80% of their PLHIV on ART. Thirty-one percent of the estimated PLHIV with unmet need for ART (20,904) live in the districts that make up Kigali city.

USG and GoR planning teams jointly set geographic priority areas.[35] Unmet need for ART was the most important determinant of prioritization and resource allocation because Rwanda's shift to achieve epidemic control relies heavily on ART saturation. The available population prevalence data from the 2010 DHS estimates for PLHIV are only available at the district level. Additionally, 23% of ART patients still receive their ART from district hospitals despite service decentralization, and hospitals have an overlapping catchment area with health centers, making the district the lowest subnational unit (SNU) at which a client's origin can be determined. Districts in Rwanda are relatively small geographically, with an average of 844 square kilometers and a range of 134-1937km, having on average population of 350,532. Given the small geographic size and inter-district movement between the three districts of Kigali, unmet need estimation and target setting was done by combining the three districts into one unit. Given the information available and the relatively small district size USG and GoR were able to target planning at the district level, making use of national, district and sub-district information. Size estimations for some key populations are available at the sector level in areas with hot spots, with sectors having on average just under 20,000 people, and these data were used to inform prioritization decisions for targets, resources and service-delivery package planning.

Nine districts were identified for ART saturation scale-up service packages in order for them to reach ART saturation by APR17. Twenty-one districts were identified as sustained districts based on current ART saturation or a trajectory for ART saturation by APR17. Additionally, 22 sectors in the nine scale-up to saturation districts and 19 sectors in five of the sustained districts with the highest numbers of key populations were identified for key population services, recognizing the impact that unmet need in high prevalence and high risk populations can have on new infections as well as elevated morbidity and mortality. Prioritization was done nationally, without regard for the funding source of the facilities. Thirty-one percent of all PEPFAR-supported ART facilities are located in the nine scale-up to saturation districts. The process also reviewed site level yield and volume data. During implementation site level funding will be determined based on yield and volume and APR16 targets.

Rwanda has a strong national HIV program administered predominantly by the government and financially supported by PEPFAR, GF, and GoR. Site-level analysis and joint strategic planning with the GoR determined that the most effective way to reach epidemic control given declining funding is to have a nationally targeted approach, with PEPFAR and GF resources shifting in synchronicity to support this. The current focus for reaching epidemic control is in the ART

[35] These prioritized areas will be updated as needed based on quarterly, semi and annual review of program results and epidemiological data. Originally in COP15 development joint USG-GoR analysis identified 16 priority districts, these were reduced to 9 after the COP15 review in Dar es Salaam. The reduction from 16 to 9 was based on refocusing aggressive scale up in highest unmet need districts and assuming that lower unmet need districts would achieve saturation without aggressive intervention.

scale-up to saturation districts that need to reach PLHIV with ART at an accelerated pace, as well as the key population scale-up districts where at-risk populations are more likely to live, require services, and contribute to transmission.

Rwanda will prioritize PLHIV with unknown status who are living in districts with higher levels of unmet need in order to ensure that all PLHIV have an equal opportunity to benefit from lifesaving treatment and to reduce risk of further transmission. Key and priority populations of CSWs and their networks, MSM, and adolescent girls are prioritized based on their prevalence, risk and understanding of modes of transmission in Rwanda. Given the disparity in prevalence and PLHIV between Kigali and the rest of Rwanda, the three districts making up the capital will be prioritized, since reducing prevalence in the capital, through targeting populations as described above, will be pivotal to controlling the epidemic.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Rwanda's COP15 planning and target setting was conducted for the entire country jointly with GoR/MoH, inclusive of PEPFAR and GF/GoR funded sites[36]. The collaborative approach increases the impact of reduced resources to achieve national epidemic control in a coordinated and strategic way and increases the overall sustainability of Rwanda's program. The GoR/USG COP15 planning team set clinical targets with the goal of at least 80% ART coverage in each district by APR17.

Using the datapack tool as a foundation, the joint MoH/USG working groups applied historic trends, program and contextual knowledge to accept or modify automatically produced targets. Data from all facilities was analyzed to examine the trend from the first five months of FY15, in particular to assess and account for the impact that updated guidelines[37] had on ART enrollment. For scale-up to saturation districts, analyses estimating the number of patients needed to reach saturation by APR17 were used for targeting adult ART patients. Reaching 80% of eligible pediatric patients in two years was also considered while the 6.5% annual decrease in pediatric PLHIV was used to set pediatric targets. These targets will be reviewed and revised when Rwanda's first pediatric prevalence estimates become available in late 2015.[38] Adult sustained ART targets were determined through an estimation of nonaggressive enrollment, which was set at an

[36] All 510 HIV sites in Rwanda are either funded through the DHS by PEPFAR or GF/GoR, 263 and 237 respectively. Site allocations are mixed by district and reflect how the program scale-up has evolved. The COP15 targeting exercise adapts from the configuration of sites to apply both PEPFAR and GF/GoR resources focused to achieve epidemic control in all districts by 2017. COP15 PEPFAR funded IM target setting was done by the USG agency teams.

[37] Implementation of updated guidelines in late 2014 increased ART eligibility based on CD4 count from 350 to 500.

[38] Based on epidemic modelling and current EPP Spectrum projections the number of pediatric PLHIV is declining by 6.5% annually (EPP Spectrum 2014). The Rwanda SI team will continue to work withMoH/RBC to update and review estimations and projections against routine program data to update targets as needed.

annual 5% increase of current ART adult patients. The PEPFAR datapack tool was used by the joint planning teams to support the analyses and estimate unmet need, along with review of historic trends, updated Spectrum modelling, and program and contextual knowledge to validate or modify targets estimated via the datapack. The forthcoming 2015 DHS and AIS district prevalence data will allow for corrections to the existing single-point prevalence data. All districts will be monitored regularly to ensure unmet need is understood and addressed based on evidence, with revised projections and an effective implementation strategy.

Prevention targets were determined in concert with the estimated district unmet need, ART targets, and site level presence of key populations. Target reductions made in sustained areas are based on increased efficiencies and a passive approach to testing outside of PMTCT. Site and sector level data was used to set higher targets for focused outreach testing and support, based on key population size estimates from previous studies and from programmatic knowledge of transmission hotspots. Prevention targets were set to ensure that sufficient new ART clients could be identified. Higher positivity yields will be necessary to reflect these efficiencies. VMMC programming is supported through PEPFAR's DOD programming with Rwanda's Defense Forces and to the highest unmet need scale-up to saturation districts. PEPFAR's funded VMMC outreach and campaigns will be coordinated with the MoH. OVC program targets will be focused on scale-up to saturation districts, and proportionally reduced in sustained districts. In scale-up to saturation districts, OVC program targets will reflect enhanced linkages between facility and community programs.

USG technical teams reviewed the planned results against the proposed funding and the allocations of costs in the PBAC[39] tool. Based on the assessment of FY14 EA data, teams determined that the APR16 targets were realistic. Proportionally allocating increased resources to scale-up to saturation districts, and less to sustained districts and sites will help to ensure that COP15 funding is sufficient to achieve saturation in targeted districts. COP15's approach is linked to the GoR/MoH's implementation of both PEPFAR and GOR/GF funded programs; USG will work closely with the MoH to ensure allocations reflect the achievement of saturation in priority districts as described above. Specific details by program area are below.

[39] PEPFAR Budgeting And Costing Tool (PBAC)

These saturation scale-up targets represent an accelerated rate of PLHIV identification and treatment, with an average of 15% on ART increase and a passive enrollment rate for most sustained districts representing a 5% increase of patients on ART. For pediatric treatment, targets were set to either maintain or increase the number of children in care and on treatment in the context of a declining pediatric PLHIV population.

Key population testing for CSW and MSM was prioritized for rapid scale up in scale-up to saturation districts. Within districts, sectors with higher numbers of key populations were targeted for increased outreach and testing. General population testing was also scaled up in scale-up to saturation districts, with implementation of the general population testing to move away from repeat testing of low risk individuals, and employ a targeted approach focused on higher risk individuals to increase positivity yields.

Among PEPFAR-supported facilities in ART scale-up to saturation districts, pregnant women are expected to contribute 10% of the more than 6,402 PLHIV that will newly be put on treatment in FY16. Pre-ART patients are expected to comprise 8% of new ART patients while TB patients make up 1%. Key population outreach testing is anticipated to account for 19% of new positives while VCT, PIT, male partner ANC testing and VMMC will contribute 62% of the new positives.

Assumptions were made based on assessments of FY14 EA data and previous year's budgets against increased efficiencies and reductions in non- and near-core activities previously funded. The PBAC tool was used to review the budget and targets against estimated UEs.

Challenges may include changes in the forthcoming epidemic projections based on new prevalence data from the 2015 DHS and RHAIS. Additionally, the joint national approach requires GoR/MoH to focus their GoR/GF resources with increased focus on scale-up to saturation districts. These challenges may be mitigated through COP15 implementation quarterly monitoring and joint planning. Additionally, the years' funding levels may affect the COP16 and future periods. During COP14, USG hopes to finalize the investment case with GoR/MoH which could result in a CHP MOU with indicative levels of both USG and GoR funding for the national HIV program through COPs 18 and 19.

A critical data gap is the lack of information regarding how many patients are receiving treatment who originate from outside the SNU/district or country. Given Rwanda's small geographic size, and with half of its districts sharing land borders with the four neighboring countries, cross border movement in relation to service delivery makes accurate estimates challenging, particularly considering the recently increased freedom of movement across East African Community borders. This is a challenge because prevalence estimates and population figures derived from demographic surveys and the census are less likely to include foreign residents who may travel only to receive their treatment and return home, while service delivery information will include all those who receive services. This can lead to both under and over estimation of Rwanda's unmet need for ART. Better understanding of service seeking behavior at facilities will support implementation that ensures services are delivered where they are most needed.

Data are currently insufficient for planning for children with HIV and for some key populations. The current 2015 DHS will provide the first assessment of pediatric HIV prevalence, and these data will help to clarify the unmet need for pediatric ART. The CSW and MSM BSS as well as the AIS, the DHS and provincial EPP Spectrum estimates are scheduled to come out in 2015. COP15 estimates are currently based on 2010 DHS prevalence estimates, and will be updated by the end of 2015. These data and other program data will be integrated into ongoing program planning and reviews with the GoR/MoH.

During implementation, efficiency gains from reducing resource allocations to sustained districts and reductions overall in non- and near- core activities will be used to support increased focus in scale-up to saturation districts.

Table 4.1.1 Targets in all COP15 Scale-Up to Saturation Districts for Epidemic Control (PEPFAR and non-PEPFAR funded)

SNU (District)	Total PLHIV	Projected current on ART at APR 15 National (PEPFAR)	Additional patients required for 80% ART coverage at APR 15	Target current on ART at APR16 National (PEPFAR)	Target % increase on ART total between APR15 and APR16	Target newly initiated in FY 16 National (PEPFAR)
Kigali City* [40] (Gasabo, Nyarugenege and Kicukiro Districts)	56,651	39,335 (22,028)	5,986	45,039 (25,222)	15%	6,694 (3,749)
Rwamagana	9,140	5,116 (1,808)	2,196	6,139 (2,170)	20%	1,159 (410)
Gicumbi	8,373	4,325 (3,725)	2,373	4,703 (4,050)	9%	481 (415)
Kayonza	7,735	4,807 (1,306)	1,382	5,650 (1,535)	18%	968 (263)
Burera	7,140	2,587 (512)	3,125	2,824 (559)	9%	299 (59)
Kamonyi	6,705	3,650 (3,387)	1,715	4,416 (4,098)	21%	863 (801)

[40] Kigali City's three Districts have been combined for targeting due to the close promixity and inter-District border care seeking.

Rutsiro	6,680	4,133 (3,796)	1,211	4,796 (4,405)	16%	769 (706)
Total	**102,424**	**63,952 (36,562)**	**17,988**	**73,567 (42,039)**	**15% (15%)**	**11,233 (6,402)**

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in FY16 Scale-Up to Saturation Districts (PEPFAR-supported only)*

Entry Streams for ART Enrollment	**Tested for HIV (in FY16)**	**Identified Positive (in FY16)**	**Newly enrolled on ART (in FY16)**
Clinical care patients not already on ART	n/a	n/a	546
TB-HIV Patients not on ART	1,075	38	73**
HIV-positive Pregnant Women	48,756	711	675
Key population outreach testing	4,021	1,500	1,237
General population (OVC, VTC, Partner ANC, VMMC, EID, PIT)	966,620	5,045	4,096
Total	**1,020,481**	**7,294**	**6,627**

*estimated 6,402 newly enrolled PEPFAR-supported ART patients required to meet national FY16 on ART targets, PEPFAR supports approximately 44% of HTC and 41% of ANC testing

**includes newly identified and known positives newly eligible for ART due to TB status

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

Target Populations	**Population Size** Estimate (priority SNUs)***	**Current Coverage (FY15)**	***VMMC_CIRC* (APR FY16)**	**Expected Coverage (in FY16)**
Males 15-29 GoR	392,940	65,936 (16.8%)	99,771	25.4%
Males, other than 15-29 GoR	914,235	-	-	-
Total/Average	**1,307,175**			
Males 15-29 PEPFAR**	161,168	35,042 (21.7%)	38,094	23.6%
Males, other than 15-29 PEPFAR**	345,396	-	-	-
Total/Average	**506,564**			

** Priority SNUs for VMMC are Burera, Gicumbi, Huye, Kamonyi, Kayonza, Kicukiro, Rutsiro and Rwamagana*

*** Population size estimated using NISR Census2012 and PEPFAR proportion derived from the prevention team Priority SNU worksheet*

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate	PEPFAR Coverage Goal (in FY16)	FY16 PEPFAR Target
Key populations*			
FSW	**8,005**	**80%**	**6,404**
MSM	**N/A**	**N/A**	**816**
Priority Populations**			
Young Women 15-24			**1,500**
Truck drivers			**242**
Refugees			**7,300**
Moto drivers			**1,452**
Uniformed Personnel and surrounding communities			**10,430**
Other priority populations (youth, FSW clients, fisherman)			**1,538**
Total			**29,682**

* Key and priority population work in COP15 is in both Scale-Up to Saturation and Sustained Districts, based on HIV prevalence and key/priority population presence. Priority population size estimates are currently unavailable.

**Given overlap between groups, the total number reached does not equal the total across key and priority populations.

Table 4.1.5 PEPFAR FY16 Targets for OVC and Pediatric HIV Testing, Care, and Treatment

District	Estimated # of Children PLHIV (<15)	Target # of active children in PEPFAR OVC programs	Target # of active child beneficiaries receiving support from PEPFAR OVC programs to access HIV services	Target # of PEPFAR OVC children tested	Target # of children on ART (PEPFAR-supported)
Bugesera	245	1,307	653	523	84
Burera	810	5,473	2,737	2,189	27
Gakenke	302	0	0	0	3
Gasabo	1,846	5,911	2,956	2,365	419
Gatsibo	268	1,939	969	776	187
Gicumbi	881	5,906	2,953	2,362	205
Gisagara	239	0	0	0	0
Huye	692	3,740	1,870	1,496	66
Kamonyi	665	5,225	2,613	2,090	220
Karongi	724	4,063	2,032	1,625	319
Kayonza	872	3,823	1,911	1,529	77
Kicukiro	1311	5,152	2,576	2,061	300
Kirehe	233	0	0	0	0
Muhanga	561	666	333	266	231
Musanze	640	3,304	1,652	1,322	9
Ngoma	583	364	182	145	124
Ngororero	482	1,155	578	462	133
Nyabihu	552	844	422	338	79
Nyagatare	615	825	413	330	142
Nyamagabe	634	2,585	1,293	1,034	175
Nyamasheke	910	3,300	1,650	1,320	396
Nyanza	443	272	136	109	14
Nyarugenge	1,234	4,510	2,255	1,804	664
Nyaruguru	184	1,180	590	472	106
Rubavu	783	1,296	648	519	231
Ruhango	515	1,375	688	550	199
Rulindo	305	0	0	0	72
Rusizi	740	471	235	188	0
Rutsiro	760	4,059	2,030	1,624	296
Rwamagana	912	2503	1,251	1001	86
TOTAL	**19,940**	**71,248**	**35,624**	**28, 499**	**4,864**

Program Area Summaries 4.2-4.10

4.2 Priority and Key Populations Prevention

Epidemiological data show that Rwanda has a generalized HIV epidemic (3% prevalence), with pockets of high HIV prevalence in key populations (KP) such as commercial sex workers (CSWs). CSWs and their clients are considered a key driver of the epidemic in Rwanda. Despite the documented high HIV prevalence among female CSW in Rwanda (51%), considerable information gaps remain for other KPs such as MSM and people who inject drugs (PWID). Two PEPFAR-funded behavioral surveillance surveys among female CSW and MSM populations were completed and findings are forthcoming by the end of 2015. These surveys will provide information on the burden of the HIV epidemic and HIV services coverage in these KPs.

Priority populations (PPs) include adolescent girls and young women (15-24), discordant couples, clients of sex workers, mobile workers, refugees and uniformed personnel. Young women aged 15-24 have HIV prevalence five times higher than men in the same age group. Mobile workers, refugees and uniformed personnel are vulnerable to HIV due to the nature of their work or their living conditions.

As part of the CNN, PEPFAR aligned COP15 activities with Rwanda's NSP 2013-2018 and will invest in the following core prevention interventions for KPs and PPs to accelerate epidemic control:

- Surveillance in targeted geographic areas
- Combination prevention interventions including community and facility-based HTC, condom and lubricant provision and promotion and PEP
- Strategies to improve engagement, linkage and retention along the HIV continuum
- A test and treat model for KPs regardless of CD4
- Postive Health, Dignity, and Prevention (PHDP) package for PLHIV
- Community mobilization to address and transform harmful gender norms and inequities
- Health care provider trainings on offering quality HIV service delivery in a non-stigmatizing manner to facilitate access and adherence to treatment
- Establishment of centers of expertise for KP services within the Kigali sectors to serve as resources for KP service providers across Rwanda

FSWs, FSW clients, MSM, girls and young women, mobile workers, and uniformed personnel will be reached by a combination of focused community outreach and scaled-up facility-based family testing HTC activities. Discordant couples will be reached through scaled-up facility based PMTCT and HTC prevention/treatment activities in scale-up to saturation districts. MoH has committed to providing HIV support to girls and young women as a priority group through the establishment of a new, integrated youth health program under the RBC/MCH Division. In addition, program management capacity at RBC and with CSOs will be built to provide quality services to KPs across the country. To maximize efficiencies, PEPFAR will harmonize targeted community activities across all program areas to strengthen linkages and referral networks for combination prevention coverage for key and priority populations.

Recent surveys show that 80% of FSWs are living in 22 out of the 30 districts. To maximize funding efficiencies, PEPFAR will support KP and PP community prevention interventions in 41 hotspot sectors located in 14 districts, among which, nine are accelerated scaling districts and five are sustained districts. Findings from the ongoing MSM and CSW BSSs will be used to refine KPs program interventions and strategies. Additional new HIV+ KPs and PPs will be identified through scaled-up facility based HTC activities, such as family testing and outreach by peer educators in all scale-up districts.

Saturation will be achieved by targeting Rwanda's core prevention interventions package to 80% of the estimated CSWs and 20% of MSM populations in the fourteen high burden districts. During COP15, PEPFAR will contribute to the national targets in nine accelerated scale-up and five sustained districts.. In those districts, PEPFAR aims at reaching 7,220 individual KPs and 22,462 PPs with HIV preventive interventions (Table 4.1.4).

Interventions targeting KPs and PPs at the facility and community level will be monitored through quarterly site visits. Each intervention point serving KPs will maintain a record of outreach services provided and will track the approximate number of that population in the area it serves.

4.3 VMMC

Rwanda's NSP objective for VMMC is to provide 40% of male adults (15-59 years) with VMMC services by 2016 using surgical method and innovative technologies, such as the Prepex device, which will increase the provision of VMMC in non-clinical settings. VMMC alone cannot provide complete protection against HIV, but is complementary to other prevention methods such as use of male and female condoms, delay of sexual debut, and reduction in the number of sexual partners.

Since PEPFAR Rwanda resources alone are insufficient to meet the need, PEPFAR will prioritize investments in VMMC to maximize epidemic impact through saturation of combination prevention interventions by focusing on the following: both Prepex and surgical service delivery to males between 15-29 years of age; continuing targeting VMMC services to military populations, urban and districts with low MC prevalence and high HIV prevalence; reaching highest risk sub-populations of the VMMC eligible population, including clients of commercial sex workers, males in discordant relationships with HIV-positive partners and males attending STI clinics; and demand creation and service designed on reaching client age groups most immediately at risk of acquiring HIV heterosexually.

During COP13, PEPFAR supported 56,500 VMMC procedureswith additional central funding. Based on COP15 funding projections (with no central funding), PEPFAR will provide

approximately 38,094 MCs. This will leave of balance of 361,906 VMMCs to be completed by the MoH with GoR and GF funding by 2016 to meet the overall NSP target of 400,000.

In COP15, VMMC implementation will continue with Rwanda Defense Forces (RDF) and increasing VMMC coverage in seven identified scale-up to saturation districts with high VMMC unmet need and one sustained district with identified need. PEPFAR will prioritize males 15-29 years of age with supported VMMC services to yield both the highest magnitude and most immediate reduction in HIV incidence for heterosexual transmission.

PEPFAR will implement VMMC core activities which include provision of quality VMMC services (PrePex and Surgical) including: HTC, tetanus vaccination, infection prevention, linkage to HIV/AIDS care and treatment for HIV+ tested individuals, age appropriate sexual risk reduction counseling including recommendations for abstinence during wound healing period, MC procedure, clinical follow-up of circumcised clients, adverse event management, and post-operative care. External Quality Assurance (EQA) and Continuous Quality Improvement (CQI) activities related to VMMC will be implemented during the COP15 period.

PEPFAR will prioritize VMMC activities by mapping services to SNUs with highest HIV prevalence and low VMMC coverage and focusing quality services designed on reaching the client age group of 15 – 29, which is most immediately at risk of acquiring HIV. Services will be discontinued at sites in low priority SNUS, at low productivity sites, and at sites reaching a majority of clients in predominately lower priority age groups. While VMMC is capable of reducing HIV incidence among males of all ages, by focusing on the 15 – 29 age band in the RDF members and in eight MC priority districts, the coverage of VMMC with males in those districts with highest HIV prevalence and unmet ART need is expected to double by APR16.

4.4 Preventing Mother-to-Child Transmission (PMTCT)

Since April 2012, Rwanda has implemented Option B+ and is committed to reach the goal of MTCT elimination by 2015. In 2014, 96% of the total 515 government health facilities provided PMTCT (Option B+) as an integrated ANC strategy, and all PMTCT sites offer EID services. In 2014, 97% of pregnant women who attended ANC were tested for HIV.

Since 2010, there has been a corresponding decrease in the HIV positivity rate among women tested in ANC from 2.7% to 1.2%, with a proportionate decrease in positivity among HIV exposed infants from 2.6% to 1.8 % at six weeks. Similar trends have been observed for 18-months test results. Additionally, data from SIMS indicate high rates of linkage to HIV care and treatment of the few identified HIV-infected infants.

Rwanda adopted the international Elimitating MTCT strategy in 2012, aiming to achieve less than 5% maternal-to- child transmission (MTCT) rate by 2015.

To support further reduction in MTCT rates and achieve zero new vertical transmission infections, GoR targets to increase testing of all pregnant women at ANC and increase enrollment of all positives on ART from 89% to 95%.

PEPFAR supports integrated Option B+ in 210 facilities. The service package includes: testing and counseling for pregnant and breastfeeding women, male partner and family-centered testing, family planning counselling, training and mentorship on PMTCT and EID related services, and mother-infant pairs follow-up to minimize lost-to-follow-up. PEPFAR also supports ARV and OI prophylaxis for exposed infants, safer pregnancy, nutrition and infant feeding counseling, education and support groups, peer educators to support adherence, and involvement of community outreach services.

In 2014, PEPFAR funded PMTCT services at 210 sites, of which 11 reported less than four positives in the last 12 months; this represents positivity rates of less than 1%. Of the 210 sites, 156 provided 80% of the positive results. Half of these 156 sites were in scale-up to saturation districts where resources will support achieving higher targets. In order to reach the goal of MTCT elimination, PEPFAR will continue to support the identification and provision of ARV prophylaxis to all HIV+ pregnant women in all PEPFAR-supported sites. Facility level targets are set with a vision to attain epidemic control by 2017. APR16 targets are set towards reaching 97% of all pregnant women with HTC and initiating 95% of HIV-infected women identified on ART in the nine scale-up to saturation districts in the next two years.

Given the greater proportion of otherwise healthy but HIV+ pregnant women initiated on lifelong ARV treatment, PEPFAR will put greater efforts on adherence approaches to maintain women in care and on treatment throughout and beyond the breastfeeding period.

PMTCT services for scale-up and sustained districts support the same interventions and core package of services that will improve PMTCT service delivery to reach and respond to the need of pregnant women, partners, and their exposed infants.

COP15 budgeting includes funding to provide ARVs and HIV commodities to support PEPFAR PMTCT targets and there are no anticipated ARV shortages through 2017. PMTCT program activities are aligned with the CNN analysis, prioritizing delivery of core activities. All efforts will be made to clarify areas co-funded between PEPFAR and GF/GoR to prevent duplication of funding.

4.5 HTC

Rwanda's NSP HIV Testing and Counseling (HTC)objective is to provide access to affordable services for the general population with specific focus on Key and Priority Populations. Ensuring that clients receive their HTC results, providing risk reduction counseling to clients testing HIV-negative, and linking HIV-positive individuals to ART services are key strategies. PEPFAR's COP15 HTC objective is to significantly increase testing efficiency to identify 57% of the national target of 19, 841 newly identified PLHIV.

Through the joint CNN analyses for the HTC program area, in COP15 PEPFAR Rwanda will invest in the following core HTC activities which are closely aligned with the geographic and priority population targets:

- Provide HTC to clients accessing clinical services through EID, PITC and VCT with special emphasis on testing children 0-15 years;
- Outreach HTC services targeting key and other priority populations with emphasis on improving linkages to STI/HIV prevention, care and treatment services;
- EIA (Elisa) HIV testing on all indeterminate HRT results;
- Linkage to treatment for concordant and sero-discordant couples/partners;
- Linkages to reproductive health and family planning services for HIV-positive clients;
- EID testing with rapid turnaround of results;
- Coordinating lab services at facilities to ensure accurate projections of commodities and reagents; quality processing of DBS samples; sample transport to reference labs; accurate databases, and; routine reporting to PEPFAR and MOH;
- Implementation of the Rapid HIV Testing Quality Improvement Initiative (RTQII).

HTC programs will focus on increased efficiency and scaling up HIV testing coverage in nine scale-up to saturation districts for a total of 11,233 (6,402 PEPFAR-supported) newly identified PLHIV with special focus on KPs and PPs during COP15.

In COP15, PEFPAR expects to increase testing efficiency by scaling up in the higher yield scale-up district sites and hotspots through: outreach testing targeting key and priority populations; HTC focused on the family approach to identify more HIV positive children and adolescents in fixed clinics and community outreach, and; expanded PITC in high disease burden areas. Communities will be involved in prioritization of outreach activities. Hard to reach populations will be reached through community outreach strategies.

HTC activities will also focus on generating demand in priority and key populations and increasing the testing of clients at sites for other health services in high burden areas. HTC services will be expanded in hospital children's wards to identify more HIV-positive children and adolescents. Special focus will be put on outreach HTC services targeting key and priority populations to improve linkages to STI/HIV prevention, care and treatment services. HTC services will be reduced in sustained districts to providing facility based HTC services allowing for passive intake of new HIV+ clients.

Efficiency Analysis

PEPFAR supported HTC at 229 sites in 2014, of which 48% of the sites (109) identified 80% of HIV positives. Of the 116 sites identifying the remaining 20% of positives, none has reported zero positives and one site reported fewer than four positives per year. This site is located in a scale-up district and it is the Kibungo Correctional Institution. The site will be prioritized for SIMS visits to identify constraints and assess partner performance and testing models/practices.

4.6 Facility and Community-Based Care and Support

GoR's national guidelines and implementation tools for care and treatment, reflected in the NSP, are aligned with WHO recommendations in all aspects. In 2011, Rwanda modified its ART guidelines to include lifelong ART for all HIV+ clients who are pregnant and breastfeeding, have TB, Hepatitis B or C, or are, CSW, MSM or children <5 years. In 2014, following WHO guidelines, GoR increased ART eligibility from <350 CD4 to <500 CD4, which has decreased the proportion of HIV patients in care who are not on ART. It is expected to decrease the number of PLHIV in pre-ART services.

GoR is increasing its national targets to 187,526 clients in care and treatment in 2016. PEPFAR's COP15 Care and Treatment program, aligned with the NSP, will support 105,755 of these targets resulting from identification of new HIV patients through geographical re-focusing of resources to KPs and priority populations in hotspot sectors and priority populations. In addition, efforts will be placed on improved adherence, reduced loss to follow-up and improved community – facility linkages which scored low in recent SIMS and Service Quality Assessment (SQA) reports.

The PEPFAR facility-based package of core services includes clinical assessment and staging, monitoring, routine provision of CTX prophylaxis, NAC, TB screening, PHDP services, and support groups for children and adolescents. This package of services will be the same in sites in all PEPFAR-supported districts. However, the cost per patient in sustained districts will be reduced, reflecting decreased overhead costs in staffing, training, and program management.

Rwanda has a well-established community health program which plays an important role providing assistance in identifying beneficiaries, identifying and validating volunteers for caregivers, providing home visits, accompaniment to clinical services, and participation in household economic strenthening(HES)/food security activities. PEPFAR will leverage these community linkages to strengthen enrollment and adherence to care and treatment.

PEPFAR delivery of community services will be restricted to sites in priority districts and hotspot sectors to maximize identification and uptake of newly identified HIV+ clients, especially among KPs and priority populations. This package of core services includes: training of community volunteers to support PLHIV, OVC and families, HES, kitchen gardens, health insurance (mutuelles), psychosocial support for PLHIV and families, support for adherence to care and treatment, reduction of stigma, and referrals to clinical services, safe water, and educational support.

PEPFAR and GoR will identify innovative strategies at both community and facility levels to improve adherence and mitigate stigma and discrimination while emphasizing knowledge and observation of clients' rights. Support groups and peer education in the communities will be strengthened to provide assistance for treatment adherence. In order to cater for priority populations in care, innovative approaches will continue to be strengthened including: clinical services reorganization for adolescents, with special days/times dedicated to suit their needs, family testing for reaching children, adolescents and discordant couples, and task shifting to improve access and availability of services.

Current coverage of CD4 counts is sufficient due to decentralization of CD4 machines, and no stock-outs have been reported. However, implementation of viral load monitoring for increased number of clients in care will present a challenge of turnaround time for VL results. PEPFAR will support procurement of reagents and mentorship of health care providers to ensure quality clinical and immunological follow-up and decentralization of VL.

Re-focusing of PEPFAR and GoR resources to achieve epidemic control is reflected by increased community-based services and proportionally higher targets in scale-up to saturation districts coupled with higher unit expenditures (UEs) versus sustained districts. PEPFAR will work closely with GoR to identify and eliminate any duplication of funding where Global Fund supports similar activities.

4.7 TB/HIV

Rwanda's TB prevalence is 89 per 100,000, and nearly 25% of TB patients are co-infected with HIV. It is estimated that 98% of TB patients are screened for HIV and about 79% of patients with HIV/TB co-infections were already on ART.

TB and HIV services are provided at different levels within the decentralized health system. At the community level, Community Health Workers (CHWs) are primarily responsible for identification of presumptive TB cases and referral to the nearest health facility. TB/HIV integrated activities including prevention, screening, and treatment are provided at all health centers, district, provincial, and referral hospitals. HIV testing and initiation on ART services are provided at all health facilities using the "one-stop TB-HIV" model. Similarly, patients are screened for TB and treated, if positive.

COP15 will support core activities of screening and prevention of TB, as well as TB and HIV treatment for co-infected patients as part of a basic package of health services in all PEPFAR-supported sites. The level of effort will be increased in scale-up to saturation districts to contribute towards epidemic control.

PEPFAR is supporting the GoR to implement TB/HIV services including in-service trainings for Intensified TB case finding (ICF), TB infection control (IC), prevention and diagnosis and treatment for TB patients infected by HIV at all PEPFAR supported sites. All clinicians at health facilities working in TB units have been trained on HIV prevention, screening and treatment so that patients receive HIV and TB care in one location for the duration of their TB treatment. Similarly, health care providers (HCP) working in HIV units have been trained in management of TB/HIV co-infected patients to ensure that HIV and TB services are provided within the same unit. In COP15, PEPFAR will continue to work with the MoH/RBC and other stakeholders to build capacity of HCP in management of TB/HIV co-infected patients at all PEPFAR supported sites. The cost per patient will be higher in scale-up to saturation districts due to a larger package of community services and higher number of targets as well as reduced costs in staffing, training, and program management in sustained districts.

COP15 will focus on the following core activities identified through the joint CNN analyses with the ultimate goal of increasing ART coverage of TB/HIV co-infected to 90% by 2016.

- Ensure that 99% of TB cases are tested for HIV infection; 100% of all HIV patients are screened for TB at each health facility and 100% of all TB/HIV patients are initiated on ART over the next two years.
- Support TB IC measures at PEPFAR supported sites to prevent transmission of TB in healthcare and community settings.
- Strengthen integration of TB/HIV care and treatment services in PEPFAR supported sites to improve retention and quality of health care service delivery.
- Continue to support activities aiming to track and report on TB screening of PLHIV, and follow-up for PLHIV that screen positive.
- Continue to support ICF among PLHIV by supporting techniques that include Gene-Xpert, Fine Needle Aspiration, and digital X-ray machines. Those new strategies will enable early TB detection and decrease significantly the TB/HIV related mortality.

Rwanda currently has 16 Gene-Xpert machines, six of which are in districts supported by PEPFAR with high prevalence of HIV/TB. Rwanda adopted new HIV guidelines in 2013, recommending the use of Gene-Xpert into the diagnostic algorithm for all HIV+ patients in addition to those with suspected MDR TB. In COP15, PEPFAR will provide TA to MoH to support TB diagnostics using Gene X-pert along with funding for sample transportation.

4.8. Adult Treatment

Rwanda modified its ART guidelines in 2011 to include lifelong ART for all pregnant and breastfeeding women, all HIV patients with TB infection, all HIV patients with Hepatitis B or C infections and all children <5 years. Recently, the country revised its guidelines to adopt the 2013 WHO guideline recommendations; as of July 2014, the CD4 threshold for ART was increased to <500 CD4 cells/mm3. The proportion of ART coverage for adults is estimated at 73%. The proportion of adults with HIV known to be on treatment 12 months after initiation of ARVs has increased from 91.8% to 93.6% in the past year. Data on ART coverage among priority populations, including FSW, truck drivers, and MSM are not available. These data will be available for FSW and MSM through the BSSs by the end of 2015. The national HIV Drug Resistance (HIVDR) estimates rates of treatment failure to be 12%.

Through COP15, Rwanda targets ART initiation of 19,586 (10,925 PEPFAR-supported)adult patients, of which 55% are from the nine scale-up to saturation districts, and support a total of 157,921 (89,312 PEPFAR-supported) adult patients on treatment, a total estimated increase of 9% from the anticipated 2014/15 program results.

PEPFAR Rwanda will focus on increasing ART coverage efficiency for adult patients in scale-up to saturation districts. In addition, PEPFAR will focus on increased ART for TB/HIV patients, KPs

and priority populations including young women, prisoners, mobile workers, children, and people in uniforms.

PEPFAR jointly procures ARVs with the MoH through GoR's GF HIV grant. Based on current funding, planned procurements, and national treatment targets, there are no anticipated ARV shortages through 2017.[41]

The current national guidelines support monitoring of patients on ART with routine viral load testing (VL) once per year. Rwanda has decentralized VL testing to eight sites. PEPFAR supports procurement of VL and early infant diagnosis (EID) reagents for patients at PEPFAR-supported sites, as well as providing support for the sample transport network for VL and EID specimens. In addition to annual VL testing emphaisis on patients suspected of treatment failure, as well as pregnant and breastfeeding women, adolescents, and children. Greater resources are supporting treatment programs in scale-up to saturation districts due to a larger package of community services, higher number of targets and a higher UE reflecting reduced costs in staffing, training and program management in sustained districts.

At the community level, PEPFAR through the MoH will continue to support Rwanda's network of PLHIV (RRP+) to improve adherence to care and follow up for HIV positive clients including KPs through support groups at the community prioritizing high volume sites.

Additional PEPFAR funded HSS activities critical to the treatment program include; TA for forecasting, procurement and distribution of HIV commodities, distribution of ARVs and lab commodities to the site level, QA activities for HIV rapid testing, and in-service training for nurses on HIV testing, provision of ARVs and clinical management.

As a result of the CNN analysis, a package of core and limited near-core ART services was identified, with non- and remaining near-core activities eliminated. In 2014, PEPFAR supported ART in 246 sites, of which none reported zero patients, while 18 sites had <50 patients. Eighty percent of ART patients were seen in 48% (118) of PEPFAR supported ART sites. With respect to geographic focus in COP15, 44% (39,745) of PEPFAR-supported adult ART targeted patients are at facilities within scale-up to saturation districts. The remaining ART sites in sustained districts will be supported for existing patients and HIV positives as they are identified. During COP15 USG will work with the MoH to transition 54 low volume ART sites' funding and full management responsibility to GoR/GF resources. These 54 sites will serve about 5,000 ART clients by the end of COP15. Implementation of COP15 will include reducing support levels in line with targets for sustained sites and their lower UEs, budget savings will support identification and increased targets in priority district sites. In COP15, sites with high volume patients will be prioritized for SIMS visits to strengthen the quality of services and increase partner performance.

[41] In the even of actual or perceived ARV shortages all available sources (GoR, GF, PEPFAR and other) will be considered for increasing ARV procurements.

4.9 Pediatric Care and Treatment

In 2011, Rwanda modified its ART guidelines to include lifelong ART for all HIV+ children <5 years and in 2014, decreased the threshold for ART eligibility from <350 CD4/mm3 to <500 CD4/mm3, including HIV+ children >5 years. In order to improve identification of HIV-infected children, Rwanda has expanded DNA PCR capacity to two sites, and sample referral systems for laboratory services have been initiated to ensure geographical access countrywide. Given the high risk of treatment failure in children, routine VL monitoring is recommended for all PLHIV receiving ART every 12 months. Currently, 8% of children on treatment are receiving second-line treatment regimens. PEPFAR has supported the MoH to optimize the national pediatric ARV forecasting, procurement and distribution. There have been no reported pediatric ARV stock outs in the last two years. During COP14, GF will continue to support 52% of all pediatric 1st line ARVs and PEPFAR will continue to support 48% of all pediatric 1st line ARVs.

PEPFAR also supported the MoH to develop an integrated HIV training curriculum which involves on-the-job training and clinical mentorship for pediatric HIV treatment. The national HIV program has approved the pediatric task-shifting policy; currently, the MoH is conducting training for nurses to provide ARVs for children.

Based on the current treatment guidelines and EPP Spectrum projections of children in need of ART, the national pediatric coverage remains low at an estimated 40% of all pediatric PLHIV and 78% of those who are eligible. Identification of positive children is a main challenge to Rwanda's HIV program. However, to date no pediatric prevalence data has been available in Rwanda, and this gap remains to be verified and validated though the results of DHS 2015 that will include this information.

Results from DHS2015 will provide information on pediatric HIV prevalence by district which will be used to reassess unmet pediatric ART need. Data from SIMS also highlighted issues with documentation of growth monitoring and adherence. In addition, rates of treatment failure among HIV-infected children are currently unknown, and the national HIVDR survey does not include children.

In COP15, PEPFAR, in collaboration with GoR, will continue to scale up pediatric ART coverage across all PEPFAR supported saturation and sustained districts to achieve epidemic control by 2017. The national goal is to identify more HIV+ children, and link and retain them to care services to reach 80% of pediatric ART coverage for those who are eligible. By APR16, the GoR targets to reach 8,555 and of which PEPFAR will support 4,864.

PEPFAR will focus on improving identification of pediatric HIV patients through enhanced PITC for pediatric clients at all entry points including OVC services, as well strengthening linkage and retention into care. In addition, efforts will be made to strengthen follow-up of HIV positive and exposed infants through improved community linkages and longitudinal cohort tracking.

Integrating pediatric HIV training into the broader HIV training curriculum will help achieve efficiencies for all HIV services and minimize off-site trainings.

The pediatric package of services includes the following core activities: provision of cotrimoxazole; improving TB diagnosis by prioritizing Gene-Xpert MTV/RIF[42] access, adherence support, disclosure, CD4, growth monitoring and viral load monitoring, rollout of a standardized adolescent package of care, including provision of adolescent friendly health services covering issues related to school, adherence, disclosure, sexuality/reproductive health and stigma.

At the community level, community healthcare workers will be used to mobilize and refer clients to health facilities for services: immunization, growth monitoring and testing. Facilities will also work with community structures including support groups and peer educators for adherence support promotion. Additionally, outreach interventions including mobilized children testing will be organized to promote access to services for hard to reach populations (children of FSW) and OVC. PEPFAR will also continue to support and improve reporting of age disaggregated data for infants, children, and adolescents.

4.10 OVC

In 2013, Rwanda's National Children's Commission/NCC[43] enumerated 720,619 Most Vulnerable Children (MVC) based on five criteria[44]. PEPFAR's APR14 reported 79,579 children <age 18 served. Rwanda's HIV program estimates 19,940 PLHIV under age 15.

The GoR Joint Action Forums/JAFs coordinate district and sector level development activities to use OVC/MVC resources efficiently and avoid duplication. Rwanda's 2011 Integrated Child Rights Policy (ICRP) provides the framework for children, emphasizing children's participation, protection from abuse, violence and exploitation, priority for children without discrimination and accountability of GoR and "duty bearers[45]". ICRP aims to strengthen families, provide a family environment for all children, and ensure universal access to education and health services. Rwanda's HIV-NSP social mitigation objectives are: (1) ensure economic opportunity and security of PLHIV; (2) protect OVC targeting school attendance >85% in the 10–14 age group, and; (3) reducing stigma and discrimination. COP15's joint Social Mitigation WG agreed on epidemic control priorities and core activities.

[42] Gene-Xpert MTB/RIF is an automated cartridge-based diagnostic test for the presence of mycobacterium tuberculosis (MTB) DNA and MTB resistance to rifampicin (RIF), one of the two major drugs used against tuberculosis.
[43] NCC is a commission under MIGEPROF, Rwanda's Ministry of Gender and Family Promotion
[44] Orphan and vulnerable living with HIV/AIDS; vulnerable child, living with or affected by HIV/AIDS; vulnerable child, orphan of one parent; vulnerable child orphan of two parents; child from a very poor family.
[45] Duty bearers are those actors who have a particular obligation or responsibility to respect, promote and realize human rights and to abstain from human rights violations. The term is most commonly used to refer to State actors, but non-State actors can also be considered duty bearers. (UNICEF)

Forty-five percent of PEPFAR's APR14 beneficiaries are adults reflecting the family centered approach for sustainability through socio-economic empowerment. Children are identified locally through a process that involves community members and local leaders who identify most vulnerable children (MVC) for district authorities. District authorities, through JAF, assign children/families to organizations for support. Each organization dialogues with the community to validate needs of children/families assigned to them. PEPFAR meets approximately 11% of national MVC need.[46] GoR, GF, DCOF (USAID's Displaced Orphans and Childrens Fund), local and international partners provide resources to OVC, though unmet need remains. PEPFAR targets for APR16 are 129,542 OVC_SERV[47] (71,248children<18); half that number (64,771) for total OVC_ACC[48]; and 35,624 for OVC_ACC <18. USG will work with partners to begin reporting on CARE_COMM[49] in COP15.

USG met with CSO partners to discuss the need to focus resources to achieve results in epidemic control and HIV impact mitigation. Changes in COP15 include: 1) a new IM to implement in the nine highest HIV prevalence districts; 2) existing IMs to scale-up only in the designated scale-up to saturation districts and maintain activities in four sustained districts.; 3) CSOs to maintain activities in two districts where Feed the Future-funded nutrition activities are integrated with OVC; and 4) continued consolidation of activities to avoid overlap of partners in sectors. Scale-up to saturation districts will have better linkages to clinical services will reach more HIV-positive beneficiaries. No new beneficiaries will be enrolled in sustained districts.

Family-centered approaches, HES and food security activities and CSO capacity building lead to sustainability, provide messaging on HIV, HTC, ART, parenting skills, *mutuelles,* WASH and early childhood development and use home visiting, Umuganda – Inama (monthly community service/meetings) and Umugoroba W'Ababyeyi (Parents' Evenings). PEPFAR Rwanda uses case management linking to clinical services, protection, HES, food security and nutrition, WASH, education and psychosocial support rather than minimum package of services. These are all core activities; communities, parents and GoR are responsible for non-core activities e.g. school feeding, GBV legal services and child rights campaigns. Communities are involved in all aspects of OVC programming, including identification of children, selection of volunteers and service delivery. Community volunteers using better links with clinical services and their relationships within the community will facilitate access to services for hard to reach populations.

[46] Coincidentaly, Rwanda's 2014 Spectrum AIM estimates about 100,000 HIV attributed OVC.
[47] OVC_SERV: Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS.
[48] OVC_ACC: number of active beneficiaries accompanied or supported for transport to HIV testing, care and/or treatment services at least once every three months.
[49] CARE_COMM: Number of HIV positive adults and children receiving care and support services outside of health facilities.

SIMS identified inadequate referral systems and follow-up for two-way linkages with clinical services for improvement. Other challenges include programming for children under five; graduation from OVC programs and transition planning. A centrally funded impact evaluation is planned for the new IM. PEPFAR will ask OVC partners to report on "percentage of beneficiaries tested and counseled" to increase testing of vulnerable populations. No OVC program community sites received overall red or yellow scores.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

In sustained districts, PEPFAR will continue providing care and treatment services to patients through COP15 in both ART and PMTCT sites. Patients in these districts will receive a minimum package of care for PLHIV and support for new enrollment clients into care and treatment services as per ART national guidelines.

The package includes cotrimoxazole provision, routine clinic visits, screening for opportunistic infections including TB/OIs, and routine laboratory testing including viral load and CD4 as per national ART guidelines. These sites will continue to provide passive HIV testing through PITC and linkage to care in PMTCT and ART services. PEPFAR will not support demand generation for testing and there will be no aggressive scale-up of care, treatment, or PMTCT services in sites in the sustained districts.

In COP15, PEPFAR will maintain existing condom distribution programs, but local VMMC promotion and procedure programing will be discontinued in sustained districts.

The expenditure per patient (UE) in sustained districts will be reduced, reflecting decreased overhead costs in staffing, training and program management. The reduced UEs will result in sites located in sustained districts having their funding reduced proportionately to reflect lower targets.

OVC partners will apply the case-management approach to provide either directly or through referral, HES, food security, parenting skills, community-based health insurance premiums, WASH, early childhood development, clinical services, psychosocial support and protection. Partners will decrease the level of effort focused on providing services to existing beneficiaries until their graduation or transition to GoR's support systems. This graduation will provide space for enrolling new beneficiaries referred from health facilities. OVC maintenance programs consider spillover effects from surrounding high prevalence districts. Most of the sustained districts are located in border areas. They also provide integrated OVC-nutrition wrap-arounds leveraging non-HIV funding.

Sustained district targets for ART were set projecting passive enrollment of 5% from the revised projected APR15 targets. This was based on examination of previous and projected results from FY13-FY15, accounting for a slow down due to ending implementation of active adult case finding and enrollment. District totals were set based on the estimations of unmet need and with the goal of achieving epidemic control nationally by 2017. These sustained district totals were then allocated to sites within the districts. Other clinical targets were set using the same method. Targets were allocated to both PEPFAR and GF/GoR supported sites, based on their previous performance.

Community prevention interventions tailored for KPs and PPs at the district level will be limited to seven of the sustained districts with known SNU hotspots data for KPs. Other prevention targets will reflect passive enrollment, and funding will be proportionately allocated. Sustained district targets for OVC were set primarily based on the APR14 reported beneficiaries, and their estimated 50% graduation rate during APR15. Target estimation and resource allocation is planned for by assigning only one partner in most sustained districts and transitioning existing beneficiaries to that one partner.

The UE differential between sustained and saturation scale-up districts is a reflection of the different packages delivered each of the two types of districts. Resources will be allocated proportionately based on the lower UE and targets in the sustained districts compared to the higher UEs and targets in scale-up to saturation districts. Actual resources allocation will be determined by agencies with their partners for implementation to achieve the COP15/APR16 planned results.

Table 5.1.1 Expected Beneficiary Volume Receiving PEPFAR-supproted Minimum Package of Services* in Sustained Districts

Maintenance Volume by Group	Expected result APR 15	Expected result APR 16	Percent change from APR15 to APR16
HIV testing for pregnant women	***97,854***	**100,527**	**3%**
HTC	***1,123,180***	**698,244**	**-38%**
Current on care (not yet initiated on ART)	***6,741***	**6,508**	**-3%**
Current on ART	***49,661***	**52,334**	**5%**
OVC beneficiaries (PEPFAR-only)	***44,805***	**52,157**	**16%**

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

PEPFAR/CDC has supported the National Center for Blood Transfusion (NCBT) since 2005, which resulted in NBCT's capacity to have and manage community mobilization and retention of a non-

remunerated blood donor base that enabled NBCT to collect over 43,000 units of blood in 2014. PEPFAR/CDC support has also strengthened laboratory testing for transfusion transmissible infections prior to fractionation, storage, and distribution. While quality management systems (QMS) have been established, improvements are still needed. During COP14, CDC will work closely with MoH to finalize a transition plan with a long term sustainability focus for NCBT. During COP15, CDC will begin a transition to be completed during COP16.

The HRH Program activities are considered non-core and PEPFAR funding for these activities will end by March 2017 (end of CDC's COP15 implementation year).

Through the National Children's' Commission GoR has a decentralized structure to coordinate partners' activities and allocate resources to meet the needs of MVC/OVC. PEPFAR will work within this system to transition out of low prevalence areas and scale-up in geographic areas with potential for greater impact on the epidemic. OVC/MVC beneficiaries in the ROADSIII project will transition to other partners in priority districts and sites by the end of project in September 2016. Key population activities under ROADSIII will continue primarily through GoR structures and the new prevention IM to be awarded by CDC. This new mechanism will support epidemic control through interventions with key populations closely linked with clinical services.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory Strengthening

For Rwanda to reach epidemic control laboratory support will be crucial to ensure high quality and accessible HIV related diagnostic testing as per the national guidelines and alignment of laboratory services to high impact strategies in support of 90/90/90. This will require:

1. Implement Rapid Test Quality Improvement Initiative that covers all aspects of quality assurance for HIV testing
2. Continue support on decentralization and sample transportation to ensure infants/children have access and timely results for early infant diagnosis (EID) DNA tests, for PMTCT, PIT, and ANC services. Both children and adult patients on care or on ARVs will receive scheduled clinical monitoring tests for CD4 (at 72 sites), hematology, and biochemistry (approximately 525 sites) from the decentralized testing sites. The expanded and decentralized VL testing (9 sites) will provide monitoring necessary to demonstrate viral suppression for epidemic control. Improvements on results turnaround and aggregated data on viral suppression will be necessary through strengthening information systems from testing sites to clinical care facilities and to the surveillance teams.
3. Support for robust quality assurance programs for core tests (EID, VL) and CD4 at all sites. Ensure laboratories adhere to internal quality assurance/quality control (QA/QC) for all tests including chemistry and hematology tests for accurate and reliable results. In the last SIMS report, the laboratory network needed improvement in the area of quality assurance/quality control for HIV rapid test, hematology, and biochemistry at the health center level
4. Support SLMTA workshops for newly enrolled laboratories to build a viable and sustainable high quality laboratory network
5. Support equipment management and maintenance program for key analyzers and implementation of laboratory equipment and tests harmonization in line with the national Norms and Standards.
6. Support forecasting and procurement of laboratory commodities/consumables to support HIV/AIDS care and treatment laboratory monitoring. This is necessary to ensure core HIV tests are done to identify those who are HIV positive, monitor those in care for toxicity and treatment failure, and assess viral suppression in patients on ARVs.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism (s) ID	7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Laboratory Capacity: Decentralization of test packages	HIV testing (Rapid test, ELISA) (Biochemistry, Hematology, CD4, OIs) decentralized	HIV testing (Rapid test, ELISA) (Biochemistry, Hematology, CD4, OIs) decentralized	HLAB $17,000	HLAB $17,000	TSSS TBD		X	X	X	X	
Provide specialized testing in support of Prevention Care and Treatment (NRL Coordination with 8 sites doing VL and EID)	Lab testing for EID, VL and genotyping decentralized and fully functional; Use of VL DBS sampling and testing validated	Lab testing for EID and VL (plasma and DBS) decentralized and turnaround time improved to 1 week.	HLAB $ 2,000	HLAB $2,000	TSSS TBD		X	X	X	X	X
Laboratory Capacity: Sample transportation	Sample transportation for EID (DBS) to 2 testing sites implemented; VL (plasma) sample transportation to 8 testing sites implemented.	Routine use of DBS VL and plasma implemented; Transportation optimized for EID and VL samples to testing sites	HTXS; HLAB $40,000	HTXS; HLAB $40,000	MoH/ TSSS TBD		X	X	X	X	X
Laboratory information system for coordination and result TAT	LIS implemented in 5 sites supporting regional HIV QA/QC and VL testing	LIS implemented to 5 additional sites supporting VL and EID	$100,000	$100,000							

Laboratory System Strengthening (Accreditation)	Country led SMLTA workshops (3) for 10 newly enrolled laboratories conducted. Accreditation mentorship and assessments for 15 already enrolled completed	Country led SMLTA workshops (3) for 10 newly enrolled laboratories conducted. Accreditation mentorship and assessments for another 15 already enrolled completed	HLAB/HSS $ 42,000	HLAB/HSS $42,000	MoH/ TSSS TBD		X				
Laboratory System Strengthening (Training)	Laboratory technicians trained on viral load and EID; biosafety and quality assurance analyses	Laboratory technicians trained on viral load and EID; biosafety and quality assurance analyses	HLAB $ 14,000	HLAB $ 14,000	TSSS TBD		X				X
Laboratory System Strengthening (HTC/CD4/VL/EID Proficiency Testing)	Country led National Proficiency Testing for HIV Rapid Test and EQA for EID, VL, CD4 for all sites in place	Country led Proficiency Testing for HIV Rapid Test and for EID, VL, CD4 for all sites maintained	HLAB $80,000	HLAB $80,000	TSSS TBD		X	X	X	X	X
Equipment Maintenance Program	Service contracts for core equipment in place;	Strategies to enhance capacity for equipment maintenance developed	HLAB $60,000	HLAB $60,000	TSSS TBD		X				

Laboratory Harmonization	Laboratory equipment purchased for harmonization in line with the "Norms and Standards" implemented	Lab network compliance with Norms and Standards; non-complying equipment phased out in accordance with the Lab Harmonization policy	HLAB $100,000	HLAB $100,000	TSSS TBD		X				
Supply chain core HIV tests	Timely forecasting, and procurement of lab commodities for HIV testing, CD4, EID, VL	Timely forecasting, and procurement of lab commodities for HIV testing, CD4, EID, VL	HTXS, HBHC, PDCS, MTCT, HVCT $4.7M	HTXS, HBHC, PDCS, MTCT, HVCT $4.7M	MoH/ Prevention/ HLAB/SCMS	3.5		X	X	X	X

6.2 Strategic Information

PEPFAR has worked collaboratively with the GoR and other partners to enhance Rwanda's health information systems to collect and make available quality data for HIV/AIDS program management. In COP15, PEPFAR will continue to support systems implementation, with an increased emphasis on activities contributing to the acceleration of epidemic control. Critical data for epidemic control will be collected and support will be focused on planning at the national, district, and site levels.

PEPFAR will collect site-level data on KPs and their behaviors to successfully target hot spots for improved ART coverage and address the needs of high prevalence populations and geographic areas of high HIV transmission. Program data will be analyzed by PEPFAR and MoH/RBC for all districts quarterly and annually at all sites to monitor progress towards saturation. Viral load will be monitored to track progress and make improvements to ensure that 90% of patients on ART are virally suppressed. Additionally, pediatric patient size estimations will be performed using the DHS2015 survey data. Using data in decision-making will be promoted at PEPFAR-supported districts and sites through quarterly program reviews and emphasis on health facility staff use of the information. PEPFAR will also work with MoH/RBC to increase data use practice across MoH/GF supported sites.

Additionally, in 2015, PEPFAR and GoR will use the new RAIHS[50], DHS2015, MSM and FSW BSSs[51] and Spectrum-AIM[52] projections with program data to critically review program implementation and progress towards epidemic control. Secondary analysis of survey data, including DHS2015, RAHIS, and MSM/FSW BSS, will be supported by the USG team given the strategic value of this information to targeting services to highest unmet areas and towards achieving epidemic control. PEPFAR will work closely with the GoR to harmonize the MER indicators/data elements with the GoR reporting system in order to minimize data entry points. In COP15, PEPFAR will support GoR to implement the EMR system to allow improved patient care and follow-up, HIV-patients information sharing within facilities, and linkages to other services at PEPFAR-supported sites. The EMR will be upgraded to improve its use in patient care and to accommodate additional HIV functionalities for viral load monitoring, patient alerts and reminders, and aggregated summary GoR/PEPFAR reporting. During COP14 EMR functioning will be evaluated against documentation on the required system's outputs, including contents to support data quality. One-time activities to support interoperability between health information systems will be discontinued after COP15. Data quality assessments will be conducted collaboratively with the

[50] Rwanda AIDS and HIV Indicator Survey (RHAIS)
[51] Men who have Sex with Men (MSM), and Female Sex Worker (FSW) Behavior Sentinel Surveillance (BSS) studies.
[52] Spectrum AIDS Impact Model (Spectrum AIM)

GoR on a quarterly, semi-annual/annual basis to improve the quality and use of the program data for the management of HIV infected and affected persons along with quarterly SIMS data.

In COP15, PEPFAR, in collaboration with GoR, will conduct size estimation surveys of CSW and with geographical disaggregation to the site level to ensure appropriate resource allocations for these KPs. PEPFAR will support the design and implementation of the Rwanda 2015HIVDR[53] survey that will help the continuous monitoring of the ART drug resistance in Rwanda. Additionally, a pharmacovigilance system will be set up to monitor adverse drug effects and detect problems related to the use of medicines.

[53] HIV Drug Resistance (HIVDR)

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Support GoR to plan/document/implement clinician-focused EMR content (allowing viral load monitoring, patient alerts and reminders)	Requirements specification documents of EMR and road map developed	100% PEPFAR-supported sites equipped with functional EMR and trained EMR users	HVSI $107,500	HVSI $417,700	17625	A1: 11.2		X	X		X
Conduct routine data collection for PEPFAR reporting purposes and program evaluations to improve quality of services delivered	Quarterly, semiannual and annual report available	Quarterly, semiannual and annual report available	HVSI $150,000	HVSI $100,000	17625	A3: 16	X	X	X	X	X
Conduct periodic data quality assessment (DQA), records verification and onsite coaching of health care providers at PEPFAR-supported sites	Quarterly data quality assessment report available Recommendation implementation report available	Quarterly data quality assessment report available Recommendation implementation report available	HVSI $20,000	HVSI $48,400	17625	A3: 16	X	X	X	X	X
Develop Rwanda 2016 HIV Drug Resistance Survey protocol	-	Survey protocol developed, cleared and ready for implementation	HVSI	HVSI $5,000	17625	A1: 11.2			X		
Conduct secondary analysis of BSS MSM, FSW, RHAIS and 2015DHS	-	Secondary analysis report available Manuscripts published in peer review journals	HVSI	HVSI $10,400	17625	A1: 11.2	X	X	X	X	X

Conduct key population size estimation for CSW by province and district (2016)		Accurate and reliable CSW size estimates availed and disaggregated by district		HVSI $100,000	17625	A11: 11.2	X	X	X	X	X
Conduct HIV Sentinel Surveillance through routine PMTCT program data including regular data quality assessment for HIV testing in ANC clinics.		Survey report disseminated		HVSI $55,000	17625	A3: 16	X	X	X		
Support data use/ evidence-based strategic planning for HIV epidemic control at the Rwanda USG, National(GoR) and district levels	Program review report availed	Program review report availed	HVSI $200,000	HVSI $150,940	17623	A3: 16	X	X	X	X	X
Review and reconcile PEPFAR MER indicators on DATIM and GoR indicators on RHMIS	Reduced efforts of duplicated report to PEPFAR and GoR reporting systems (DATIM & RHMIS)	Reduced efforts of duplicated report to PEPFAR and GoR reporting systems (DATIM & RHMIS)	HVSI $5,200	HVSI $5,200	17625	A3: 16	X	X	X	X	X
Support the design and implementation of interoperability interfaces between EMR and RHMIS	Requirement specification documents developed	Interoperability between systems implemented	HVSI $10,000	HVSI $70,000	17625		X	X	X	X	X

6.3 Health System Strengthening (HSS)

To meet new program priorities and the COP15 budget planning level, the PEPFAR Rwanda team eliminated HSS activities that were not core or near-core to sustain epidemic control. Rwanda's PEPFAR HRH Program funding will end with COP15 implementation in March 2017. In COP15 HSS activities will focus on the following work streams:

1) Human Resources for Health (HRH)
2) Supply Chain Management (SCM)
3) Transitioning 54 low volume ART sites to MoH and GoR/GF/other funding
4) Blood supply services and transition to MoH and GoR/GF/other funding
5) Support for laboratory services and quality improvement

Rwanda's health workforce shortage is a constraint to PEFPAR and GoR/MoH's goal to scale-up combination prevention at priority districts. Rwanda has .92 health workers for 1,000 population (far less than the WHO-recommended 2.3: 1,000). Approximately 625 physicians and 10 dentists serve a population of over 10 million. Rwanda has 9,000 nurses, but 91% of them have the lowest level of nursing training available. Participants in the PEPFAR SID national stakeholders meetings reported that: 1) staffing does not meet HIV service delivery needs; 2) 34% of all health workers are paid by external sources; and 3) no plan solidified to transition these salaries to local ownership, including for 2,523 PEPFAR-supported salaries.[54]

In 2012 GoR forged a multi-year partnership with a dozen American educational institutions to transform pre-service education capacity for the sustainable production of health workers to meet Rwanda's population needs. Twenty-two Rwanda teaching institutions of medicine, nurses, surgery, pediatrics, anesthesiology, obstetrics and gynecology, oral health, and more have been capacitated; curricula has been revised, Rwandan faculty recruited and trained, and clinical skills labs refurbished. The GoR also significantly upgraded medical equipment and supplies at nearly 43 district hospitals, improving not only teaching quality but service delivery (including HIV).[55] Among other goals, the GoR will increase the number of: physicians from 625 to 1,182; nurse/midwives to 10,200; A1 nurses from 700 to 4,998; and health managers by 150 fold. In COP15 PEPFAR Rwanda will continue supporting the national Field Epidemiology Training Program (FELTP) at the Rwanda School of Public Health to improve HIV data collection and use and evidence-based public health leadership (SID Domain 1). In 2015, FELTP residents will addresses weaknesses in SID 1.1.3 and 1.1.4 by evaluating HIV surveillance and service utilization in PEPFAR priority districts, assessing HIV lab diagnostics and treatment monitoring (including viral load), and participating in SIMS.

In COP15 PEPFAR will continue to support national SCM strengthening activities with the MoH/RBC Medical Procurement and Production Division (MPPD). SCMS/follow on project will

[54] PEPFAR MoH human resources represent about 15-20% of MoH human resources.
[55] PEPFAR and GF funding was the primary sources for the HRH Program.

provide procurement services and quantification support to the Coordinated Procurement and Distribution System (CPDS) for all HIV/AIDS commodities. In prior years, PEPFAR-supported activities included: formulation of the Supply Chain Strategic Plan and the Logistics Management Office, improving central warehousing space, and development and rollout of the electronic logistics management information system (eLMIS). PEPFAR will continue to strengthen these elements and build GoR capacity, as quantification, procurement, and data management activities are transitioned to the GoR. Capacity building at MPPD will improve the efficiency and functionality of warehouse and supply chain management so that MPPD can perform these functions in a more sustainable manner.

By the end of the COP15 budget period, all PEPFAR support for financial and management responsibilities of 54 sites that have less than 150 patients on ART (as reported in ARP14), will be transferred to GoR. The MoH,in collaboration with the USG team, will conduct assessments to evaluate the gaps and needs of sites to be addressed before the transition and based on assessment findings a transition plan will jointly be developed which includes capacity building for MoH to fund and support these sites fully beginning with COP16.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Transform institutional capacity in pre-service education for physicians, nurses, health managers, OB/GYN, pediatrics, etc.	1. Produced 1155 graduates 2. Equipped 15 district and referral hospitals 3. Plan to track graduates to priority districts	1. Produce 883 graduates: Undergraduates-90, Postgraduates-73, Nurses-576, Midwives-199, Lab-89, Mental health-19 2. Equip 36 district hospitals 3. Mid-term evaluation	OHSS $11,000,000	OHSS $10,500,000	17621	5.1- HRH (Staffing) 5.4.- HRH (Pre-Service Education) 5.5- HRH (In-Service Training)	X		X	X	X
National Epidemiology Training Program (FELTP)	1. Nine (cohort 3) trainees graduated 2. Conducted 5 laboratory quality improvement projects 3. Conducted three data reviews	1. Graduate 14 (cohort 3) trainees 2. Conduct six HIV laboratory quality improvement projects 3. Conduct 10 data quality improvement and HIV service utilization evaluation projects	OHSS $130,260	TBD	12140 (2015) 10193 (2016)	1.1- Epi/ Health Data	X	X	X	X	X
Supply Chain Management Systems Strengthening and	1. Procured HIV/AIDS commodities 2. With CPDS, produced	1. HIV/AIDS forecast accuracy improved 2. Tracer commodities	OHSS $850,000	OHSS $1,000,000	SCMS (7158)	9.1 – Commodity Security and Supply Chain	X		X		

Procurement of key commodities	HIV/AIDS quantification 3. Built capacity of Logistics Management Office (LMO) and Medical Procurement and Production Division (MPPD)	stocked-to-plan									
Development and Implementation of the Transition Plan of 54 Clinical Sites		54 PEPFAR supported sites transitioned to GoR	Under various clinical budget codes, $600,000 and $272,150 is planned for the MoH Clinical Services and TSSS CoAgs respectfully.			B3: 15.4	X	X	X	X	X
Conduct blood donor drives countrywide, community sensitization, donor selection	Blood collected from nationwide low risk non remunerated donor base; transitioning in process	Nationwide low risk non remunerated donor base maintained; transition in advanced stage	HMBL $423,962	HMBL/ $20,000	TSSS/TBD					X	
To procure laboratory reagents and consumables for blood processing including screening and fractionation	100% blood fractionated, screened for HIV, HBV, HCV, syphilis	100% blood fractionate, screened for HIV, HBV, HCV, syphilis	HMBL $582,030	HMBL, $260,000	TSSS/TBD		X	X		X	

To Implement Quality Management System (QMS) for blood safety program at all sites	Quality of services meeting International Standards	Quality of services meeting International Standards	HMBL $7,000	HMBL $7,000	TSSS/TBD		X			X	
To Maintain Blood Establishment Computerized System (BECS)	All blood donors and blood safety data electronically managed and maintained	All blood donors and blood safety data electronically managed and maintained	HMBL $50,000	HMBL $50,000	TSSS/TBD					X	
Establish Haemovigilance system from vein to vein	Safety of blood transfusion services increased and documented	Safety of blood transfusion services increased and documented- activity transitioning	HMBL $ 70,000	HMBL $7,000	TSSS/TBD					X	
Address non-compliances towards international accreditation	Gaps addressed for international accreditation	NCBT meets international standards on blood safety – activity transitioning	HMBL $200,000	HMBL $50,000	TSSS/TBD					X	
Promote efficiency through introduction of new technologies and procedures	Implement Pathogen reduction technologies and procedures	Maintain Pathogen reduction technologies and procedures-activity transitioning	HMBL $170,000	HMBL $76,000	TSSS/TBD					X	
Capacity building through training of laboratory staffs and medical personnel in	-Train health care providers on appropriate use of blood and blood products.	-Train health care providers on appropriate use of blood and blood products.	HMBL $50,000	HMBL $30,000	TSSS/TBD		X			X	

hospitals and clinics on appropriate blood use											
Ensure routine preventive Equipment maintenance program	Train Laboratory staff on testing and routine equipment maintenance/calibration. Service contracts for equipment at the NCBT and RCBT provided	Train Laboratory staff on testing and routine equipment maintenance/calibration. Service contracts for equipment at the NCBT and RCBT transitioned	HMBL $70,000	Transitioned	TSSS/TBD					X	
Monitoring and Evaluation	System set to review blood safety programs for data driven decision making	Routine system in place to review blood safety programs for data driven decision making-Activity transitioned	HMBL $30,000	Transitioned	TSSS/TBD					X	
Develop national and site-specific blood safety policy, guidelines and protocols	Policies and Guidelines developed for the best use of blood and blood products	Good-adherence to National and International standards – Activity transitioned	HMBL $10,000	Transitioned	TSSS/TBD					X	
Pursue alternative sources of funding for NBCT sustainability	Develop blood production cost analyses and cost recovery plan	Implement blood production cost recovery	HMBL $30,000	Transitioned							

7.0 Staffing Plan

The PEPFAR Rwanda team reviewed and assessed the staff programmatic alignment towards sustained epidemic control and the ability of the agency teams to successfully implement the new PEPFAR business model. CDC reduced its staffing by four positions in COP14. Overall, PEPFAR staff percent of time and number of FTEs are aligned to the core and near-core activities as proposed in the COP15 SDS. There is an emphasis on PEPFAR FTE funded staff in technical areas that are key to the Rwanda COP15 approach. These areas include: OVC, community care, clinical care and treatment, PMTCT, HTC, SI, and Lab.

PEPFAR agencies that are managing site-level data have staff skills to conduct necessary data analysis and interpretation as well as data application to program improvement. Overall, the estimated cost of doing business (CODB; agency management and operations) considers a variety of factors. Agencies have anticipated increased ICASS rates as well as staff salary increases. The agencies have also analyzed the impact of SIMS implementation while recognizing that Rwanda's pivot as proposed does not decrease the number of sites requiring visits. After implementing SIMS in FY15, agencies will have better data on what the costs of SIMS implementation are. Agencies have found efficiencies to keep the overall CODB down to accommodate the lower planning level. The PEPFAR team has six vacancies that are planned to be filled. Five vacancies are with CDC and these positions will focus on supporting clinical sites SIMS reporting, data analyses, and the prevention and clinical programs. One vacant position is in the PEPFAR Coordination Office for a Liaison position to support PEPFAR coordination with the MoH/GoR and GF funding. During COP14, PEPFAR and GoR/MoH will work to better align both componets of the national HIV program. Areas of needed coordination improvement will be identified and become considerations for the Liaison's SOW. The Liaison position is anticipated to be filled during COP15 implementation.

All PEPFAR-funded technical staff position SOWs will reflect SIMS responsibilities with an appropriate allocation of time to monitoring and program management. SOWs may also be further refined as COP15 is reviewed and finalized.

APPENDIX A - Core Near Non-Core (CNN)

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Provide systematic HTC to all clients accessing clinical services through EID, PIT and VCT • Enhance linkages to health facilities and community-based outlets for HTC, STI screening, care and treatment and Preventions services for KPs and OVPs ▪ Clinical mentorship for HCP to improve quality services for PLHIV at PEPFAR supported sites including CMEs and CQI, ▪ HIV status disclosure, adherence, and psychosocial counseling and support for PLHIV at PEPFAR supported sites • Intensified TB case finding for PLHIV and quality of TB infection control • Provision of quality VMMC services (PrePex and Surgical) including: HTC, Tetanus Vaccination, Infection prevention, Linkage to HIV/AIDS care and treatment for HIV+ tested individuals, VMMC procedure, Clinical follow-up of circumcised clients, Adverse event management, Post-operative care. • Provide core package of services for ANC and PMTCT services for pregnant and breastfeeding women and exposed infants, including: testing and counseling for pregnant and breastfeeding women; provision of male partner and family centered testing; family planning counselling to prevent HIV transmission services; safer pregnancy, nutritional and infant feeding counseling; provision of ART for HIV positive pregnant women	• Provide technical and financial assistance to health facilities to put in place strategies intended to increase the use of HIV services among KPs and OVPs (High). • Training of HCP at PEPFAR supported sites on management of HIV/AIDS, OIs, STI, HepB, SGBV, cervical cancer and other HIV related diseases, on delivering adolescent friendly services, on new policies, protocols/guidelines and procedures for optimal PLIHV management. • Support to M&E activities at facility level in order to ensure data quality and data use in program management. • Support of blood safety program to ensure safe blood	
Sub-national level	• Laboratory support to enhance sample transportation (from HC to DH and to Reference laboratories). • Roll out adolescent HIV friendly services; especially for adolescent girls and young	• Conduct sensitization meetings for health workers and opinion leaders in the community to reduce stigma and discrimination among key and other vulnerable populations	

	women • Provision of HIV prevention messaging across OVC program activities and improve linkages to HIV Prevention and Care & Treatment services. • Reach Key and vulnerable populations and their partners with HIV Prevention messages through IPC sessions • Support to OVC through provision of access to health and HIV clinical services, case management, WASH activities, food security and nutrition, education, psychosocial support, economic strengthening activities		
National level	• Procurement of commodities, including testing commodities, ARVs, OI drugs, laboratory commodities, condoms and lubricant • Support data use/ evidence-based strategic planning for HIV epidemic control at the Rwanda USG, National(GOR) and district levels • Support EMR planning and implementation at PEPFAR • Longitudinal incidence data collection disaggregated by District and by sex/age • Perform HTC (ELISA, Western blot, RTPCR) in accordance with national guidelines and perform EID, CD4, VL and HIV related tests at NRL and Lab network as per national guidelines; validate use of DBS for VL testing	• Conduct training of trainers • Develop a unique patient ID and tracking system to enhance linkage and retention in care and treatment (High). • Development and distribution of guidelines, training materials, job aids and other tools for all HIV program areas and other OBBI, key populations and adolescent HIV services • Revise an update current training approaches to identify ways to improve the Pediatric HIV Modules and revise training schedule to ensure major emphasis is given to pediatric HIV care and treatment. • Establish routine monitoring and surveillance system in KPs to demonstrate program effectiveness and inform program improvement over time • Conduct secondary analysis of BSS for MSM, FSW , RDHS2015, AIS and HIV drug resistance survey data (MED) • Conduct key population size estimation for MSM and FSW by Province and District (2016) (HIGH) • Provide quality assurance for HIV core tests at NRL and lab network • Provide support for laboratory accreditation application • Build capacity of national response to outbreaks with FELTP	• Build institutional capacity of the medical schools, nursing, health management schools and clinical teaching hospitals to sustain high quality health care service provision

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	**Near-core Activities**	**Non-core Activities**
HTC	• Provide systematic HTC to all clients accessing clinical services through EID, PIT and VCT with special emphasis on testing children 0-15 years. • Procurement of HIV test kits and other testing commodities • Increase and ensure access to HTC services for	• Develop a unique patient ID and tracking system to enhance linkage and retention in care and treatment (High). • Conduct training of trainers to expand access to HTC services (VCT and PITC, EID) at all sites in line with NSP goals (High). • Training providers around screening for GBV/ IPV based on clear protocols that emphasize clients' safety and confidentiality (Medium).	

	Key and Priority Populations through improved partner coordination and supervision. • Perform Early Infant Diagnostic (EID) testing ensuring rapid turn-around times, accurate forecasting on commodities and reagents and quality control. • Establish and maintain a fast track result relay for all positive DBS sample results. • Coordinate services with Lab to efficiently process DBS samples, maintain accurate databases and provide regular reports to the MoH and PEPFAR. • Implement Rapid HIV Testing Quality Improvement Initiative (RTQII): • 1)HTC policies; 2) National HTC alGoRithm; 3) strengthening workforce , (3)supervise the implementation of HTC using finger pricks and certification of HTC providers; 4) Implement a standardized HTC quality log-book and conduct post-market surveillance of RTKs. • Laboratory support to enhance sample transportation (from HC to DH and to Reference laboratories). • Perform HIV EIA (Elisa) on all HRT with indeterminate results. • Conduct outreach HTC services targeting KPs and OVPs • Enhance linkages to health facilities and community-based outlets for HTC, STI screening, care and treatment and Preventions services for KPs and OVPs. • Support HTC activities with logistical and technical support to RDF health providers to provide quality services. • HTC services delivery through mobile unit and Army week activities • Outreach HTC services delivery targeting RDF (couples / partner testing). • HTC linkages for couples/partners to care and treatment services including discordant and concordant couples • Counselling on FP methods for identified HIV positive clients	• Training HTC and PMTCT service providers in how to counsel and appropriately refer women and men who report experiencing GBV/IPV (Medium). • Strengthen existing and explore the possibility of establishing new "recreation centers" for truckers and community members around the truck parks in supported sites and support integration of services including HTC, STI screening and treatment, condom provision and referral as needed (Medium). • Provide technical and financial assistance to health facilities to put in place strategies intended to increase the use of HIV services among KPs and OVPs (High). • Continuous HTC training of Health Care Providers to improve quality of service delivery approaches (Medium) • Joint supervision visits to HTC services including RDF health facilities (High) • Support training of HTC supervisors at RDF health facilities (Medium) • Support the RDF to conduct M&E and program evaluation (High).	
Care and	**Core Activities**	**Near-core Activities**	**Non-core**

Treatment		Activities
	▪ Clinical mentorship for HCP to improve quality services for PLHIV at PEPFAR supported sites including CMEs and CQI, ▪ Effective tracking of PLHIV tested HIV positive and not yet in care; ▪ Psychosocial follow up, adherence assessment and LTFU tracking for PLHIV in care who missed appointments. ▪ Clinical assessment, staging and laboratory monitoring for all PLHIV in care at enrollment and at each follow-up visits, ▪ Screening, prevention, diagnosis and management for TB, OIs, STIs , HepB, mental disorders & other HIV-related illnesses for PLHIV. ▪ Nutrition assessment, counseling and education. ▪ Linkage to OVC and other community programs. ▪ PHDP interventions ▪ HIV status disclosure, adherence, and psychosocial counseling and support for PLHIV at PEPFAR supported sites; ▪ Implementation of support groups for children and adolescents including peer education, disclosure and adherence. ▪ Procurement and provision of ARVs, OIs drugs & laboratory commodities ▪ Management of ARV drug side effect, treatment failure and second line initiation; ▪ Intensified TB case finding for PLHIV ▪ Maintain and improve the quality of TB infection control ▪ Provide high quality of service to the SGBV victims including PEP, psycho social support, and medical care, ▪ Roll out adolescent HIV friendly services; especially adolescents girls and young women.	• Development and distribution of guidelines, training materials, job aids and other tools for all HIV program areas and other OBBI, key populations and adolescent HIV services. • Training of HCP at PEPFAR supported sites on management of HIV/AIDS, OIs, STI, HepB, SGBV, cervical cancer and other HIV related diseases, on delivering adolescent friendly services, on new policies, protocols/guidelines and procedures for optimal PLIHV management. • Quarterly pediatric HIV training and experience sharing meetings for DHs multidisciplinary team-Medical Doctors, Nurses and Social Workers. • Revise an update current training approaches to identify ways to improve the Pediatric HIV Modules and revise training schedule to ensure major emphasis is given to pediatric HIV care and treatment. • • Development of a harmonized approach to establish and implement effective linkages with other community based services for PLHIV. • Support Integrated Supportive Supervision • Support procurement of consumables (VIA, LEEP, cryotherapy) and Implementation of Cervical Cancer screening and management for HIV positive women. • Provide TA in human resource development that includes pre-service and in-service training of RDF health personnel • Provide technical support (training & supervision) at RDF health sites • Support to M&E activities at facility level in order to ensure data quality and data use in program management. • Support Conduct Clinical mentorship and Trainings of healthcare providers, legal officers, and judicial police officers on management of SGBV victims at PEPFAR supported health facilities.	

Prevention	Core Activities	Near-core Activities	Non-core Activities
	• Provision of quality VMMC services (PrePex and Surgical) including: HTC, Tetanus Vaccination, Infection prevention, Linkage to HIV/AIDS care and treatment for HIV+ tested individuals, VMMC procedure, Clinical follow-up of circumcised clients, Adverse event management, Post-operative care. • Provide core package of services for ANC and PMTCT services for pregnant and breastfeeding women and exposed infants, including: testing and counseling for pregnant and breastfeeding women; provision of male partner and family centered testing; family planning counselling to prevent HIV transmission services; safer pregnancy, nutritional and infant feeding counseling; provision of ART for HIV positive pregnant women • Follow up through 18 months of age of HIV exposed infants: CTX prophylaxis, growth monitoring, EID and post weaning RHT (Rapid HIV Testing); • Tracking of HIV Exposed Infants and/or MIPs (Mother Infant Pairs) LTFU (Lost to follow up) prioritizing those with a positive DBS result; • Fast track HIV positive babies/infants to Care & Treatment program; Provide HIV testing (DNA PCR and/or RT), Evaluate and link infants and women to OVC services in the community. • Distribute and promote correct and consistent use of condoms and condom compatible lubricants through the peer networks of key populations, health facilities and community-based outlets. • Condom and lubricants procurement • Conduct core package of behavior change communication (BCC) focusing on: • increasing knowledge on correct and consistent use of condoms and HTC services among Key populations • providing HIV prevention / sexual reproductive health messages through life skills training and other approaches targeting KPs • Reducing the use of alcohol and other substances to reduce risk of HIV infection • Provision of HIV prevention messaging across OVC program activities and improve linkages to HIV Prevention and Care & Treatment services. • Reach Key and vulnerable populations and their partners with HIV Prevention messages through IPC sessions	• Training of Health Care Providers on VMMC techniques (PrePex) (High) • Demand creation and production of IEC materials for VMMC and HIV prevention (High). • Support Health Facilities to conduct VMMC M&E (High) • Improve the process of forecasting, procurement and distribution supplies for VMMC (High). • Integration or referral/linkage to/from other men's health services and programs that promote gender equitable norms (Medium). • Scale up PMTCT continuous quality improvement activities at all MoH/PEPFAR supported sites (High) • Ensure PMTCT data quality by updating data collection and reporting tools (High). • Develop strategies to facilitate linkage of HIV exposed infants to post-natal services including MNCH services (High). • Condom rebranding campaigns (Medium) • Condom packaging, sale and distribution of health products (Prudence) (High) • Conduct monthly coordination meetings of Peer Educators from key populations CBOs and distribute promotional material (Tool Kits) (High) • Conduct sensitization meetings for health workers and opinion leaders in the community to reduce stigma and discrimination among key and other vulnerable populations (High) • Supervision of Anti-AIDS clubs (Low) • Conduct MVU sessions and other special events during Army week activities (Medium). • Develop a system to link and track KPs enrolled in care and treatment program (High) • Establish routine monitoring and surveillance system in KPs to demonstrate program effectiveness and inform program improvement over time (High) •	

OVC	Core Activities	Near-core Activities	Non-core Activities
	• Assessment of child and family needs for enrollment, including children with special needs • Conducting monthly/quarterly monitoring and develop care/case management plans for children and families • Providing identified services or referrals with follow-up to address the needs • Conducting close follow up of referrals from clinical services and the OVC/MVC list from District/Sector authorities • Implementing special studies to identify gaps in programming • Assuring basic health care including ART, therapeutic nutrition, immunizations, HCT • Conducting planning and coordination meetings for enrollment of HIV affected children and families in OVC/MVC programs and service provision as identified in case management. • Support OVC/MVC partners to systematize referrals and follow-up and tracking of HIV testing of beneficiaries • Support peer educators and community volunteers to provide HIV risk reduction education and link to HCT for testing for OVC/MVC, caregivers and family; life skills education and goal setting • Working with clinical service providers, support accompanying beneficiaries to health facilities, provide timely reminders, encourage and support families to respect clinical schedules and appointments to reduce LTFU and adherence to ART • Integration of HIV prevention messaging into all OVC/MVC activities with emphasis on awareness raising on HTC across program activities • Provision of positive parenting skills for all ages • Community volunteers conduct home visits to provide support, facilitate linkages with services and also identify, educate and refer cases of abuse and gender based violence (GBV); protection from violence • Integration of child rights, gender roles and GBV messages into existing structures and program activities • For PLHIV: Awareness sessions on their rights	• Participation in District OVC/MVC Committees to coordinate activities, assure needed services and resources are available for OVC/MVC and families (assures quality) [HIGH] • Developing service directories (facilitates effective referrals and follow-up) [MEDIUM] • Developing and implementing procedures for closing and transitioning children and their families from program support [HIGH] • Provision of mutuelle de santé for OVC/MVC not otherwise able to obtain coverage (ISLG participants are encouraged to pay mutuelle de santé for their households) [HIGH] • Trainings on child rights and gender based violence for caregivers and community volunteers [MEDIUM] • Support to Cooperatives: Financial management trainings, business plan development and project management [HIGH] • Developing an explicit exit strategy or sustainability plan from PEPFAR support [HIGH] • Support external linkages and partnerships between local organizations and service providers and national institutions for supporting GSLA members' initiatives [LOW] • Graduate GSLA groups towards external financial services as a self-sustainability approach [MEDIUM] • Support rehabilitation of water springs [LOW] • Facilitating access to primary and secondary school through long-term or open ended subsidies [MEDIUM] • Provision of start-up kits for TVET graduates [MEDIUM] • Planning for and conducting OVC Essential Indicators special study [HIGH] • OVC impact assessment to examine the extent to which selected Household Economic Strengthening (HES) intervention(s) improve the health, nutrition and well -being of target populations, especially PLHA, OVC and their families [HIGH]. • Identifying and addressing specific data quality issues in OVC/MVC programs [HIGH] •	

- Facilitate birth registration through working with families to assure that OVC/MVC have birth certificates
- Support life skills education for OVC/MVC including Education awareness for community stakeholders on HIV education, child rights, gender, focusing on sexual and reproductive health concerns of adolescent girls
- Support savings and loan associations for priority populations including FSW, PLHIV, and OVC/MVC and their families and household members to increase access to incomes and reduce vulnerabilities
- Support small-business trainings and promote a market readiness orientation among priority populations building on the findings from the Household Economic Assessment (HEA) to enhance household economic resilience, including changes to household assets, dietary and income diversity
- Facilitate parent support groups using peers and Positive Deviance/Hearth approach
- Integration of nutrition related messaging across program activities
- Conducting beneficiary nutrition assessments
- Provision of referrals for nutrition assessment and support
- Establishing and supporting farmer field Schools (FFS). FFSs serve as agricultural learning centers where farmers can "learn by doing" about basic agricultural principles and new techniques such as bio-intensive agriculture. FFSs contribute to strengthening the economic, health and nutrition status of the families.
- Support the integration of WASH messaging into program activities
- Support health facilities and community based organizations (CBOs) to improve water and sanitation (WASH) conditions, especially among most vulnerable PLHA and OVC/MVC households; Water purification, installation of tanks etc.
- Support community ECD centers for vulnerable children including promotion of testing of children and families and support for ART adherence
- Support the integration of ECD into home visiting

and work with parents/guardians to reinforce ECD outcomes, to monitor the child's well-being and to assure referral of children for testing, EID and follow-up

- Facilitating access to primary, secondary and Technical and Vocational Education and Training (TVET) schools through temporary and targeted support for: school materials (uniforms and school materials) for all levels, feeding programs and school fees for boarding secondary and TVET school students
- Provision of adolescent girl-sensitive package to help transition from adolescence to adulthood and HIV risk reduction
- Support psychosocial health/wellbeing among children and their caregivers through individual and group counselling by trained community volunteers or through relationship-based activities (1 volunteer approximately follows 9-15 OVC/MVC), at least monthly
- Documentation of referrals and linkages
- Support psychosocial counseling at schools especially related to cases of abuse or violence at home or in foster families; for adolescents, especially girls, also for out of school youth
- and for families
- Capacity building of local CSOs to provide quality services to OVC/MVC and their families
- Developing systems/registries for tracking linkages with clinical services with OVC/MVC programs
- Identify and map different cateGoRies of KPs in the targeted geographic areas and track mobility.
- Provide comprehensive community-based HIV prevention services through Peer education and outreach for behavioral HIV prevention among KPs
- Provide prevention package of services at facility and community level for HIV negative KPs
- Implement Test, Link and retain into Care for KPs
- Support early enrollment into Anti-Retroviral Treatment (ART) for KPs and monitor viral load (VL) suppression.
- Provide and facilitate access to Post Exposure Prophylaxis (PEP) to KPs in need in all health facilities

- Provide training to Health Care Providers on the minimum package and how to provide quality HIV services to KPs
- Provide comprehensive positive health dignity and prevention (PHDP) interventions for KPs to reduce risk of sexual transmission of HIV.
- Community mobilization efforts aimed at addressing and transforming harmful gender norms and inequities to ensure that the specific dynamics of harmful norms in KPs are integrated.
- Training health care providers on needs and issues affecting KPs that foster non-stigmatizing attitudes in order to facilitate access and adherence to treatment among KPs.

Lab Strengthening	(no core)	• Provide support for laboratory accreditation application. (HIGH) • Support the laboratory network accreditation process according to the national plan; Conduct SLMTA workshops, mentorships and improvement projects in enrolled laboratories (HIGH) • Supervision and mentorship supporting the decentralization of biomedical and immunological monitoring tests/viral load/HIV DNA PCR (EID); including: *Supervise and train EID and Viral Load testing sites other core lab tests (HIGH) • Competence on site trainings, certification of HTC testers and capacity building (HIGH) • Support HIV division in development and implementation of workplace and biosafety program for health professionals. (Infection control in general, for TB, blood borne pathogens) (MED)
Blood Safety	• Implement quality assurance and supervise RCBT to ensure compliance • Establish hemovigilance surveillance system from vein to vein and train transfusion centers on appropriate use of blood and blood products	---------- • Train quality officers for all sites (HIGH) • Maintain BECS and pursue interoperability of BECS with EMR to enhance heamovigilance and lookback for HIV transmission surveillance. (HIGH) • Address non compliances to international standards and pursue full accreditation for the central laboratory and Enroll RCBTs on accreditation process (3/3 star rating)(HIGH) • Support mobilization and retention of non-remunerated blood donor base (MED) • Support screening and fractionation of all blood units, appropriate storage and distribution countrywide(MED) • Train laboratory staff on routine equipment maintenance and calibration. (MED) • Support sustainability activities to prepare for transitioning of Blood safety to GoR (HIGH)
Quality Improvement	(no core)	• Carry out the Integrated Supportive Supervisions (ISS) at health centers including HIV service quality improvement by District teams. • Conduct District level Integrated Supportive Supervision (ISS) including HIV service quality improvement by Central level teams. • Conduct refresher trainings of HCPS on integrated comprehensive management of PLHIV at MoH/PEPFAR supported sites. • Conduct training of HCPs trainings on new HIV guidelines at MoH/PEPFAR supported sites. • Carry out quarterly formative supervision on financial and administrative management in MoH/PEPFAR-supported health facilities

Program Systems Support	**Core Activities**	**Near-core Activities**	Non-Core

Program Systems Support	Core Activities	Near-core Activities	Non-Core
HRH			
(no core)		• Organize Field Epidemiology and Laboratory Program (FELTP) and short courses on research, design and implementation, and publications for health professionals from all levels of the health system (FELTP should include HIV projects) • Training of 1 physician (from CHUK) in histopathology, in Tanzania • ----------	• Build institutional capacity of the medical schools, nursing, health management schools and clinical teaching hospitals to sustain high quality health care service provision, including: *Recruit international experts to support clinical (medical, nursing) and health management teaching activities at 22 facilities and institutions; *Strengthen clinical diagnostic capacity of teaching facilities through the purchase of relevant medical equipment and supplies; *Conduct teaching activities (including mentorship) for medical students and residents in surgery, pediatrics, internal medicine, anesthesiology, OB/GYN; *Carry out teaching activities for nursing, midwifery, and health management students; *Update and develop medical and nursing school curricula; *Provide support for maintenance and repair of medical equipment. *Purchase office supplies and commodities for the HRH program.
Supply Chain	System Strengthening		

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
HRH		10.5m	0	1	30 March 2017	HRH Program will end 30 March 2017 (at end of CDC PEPFAR COP15 funding cycle)
Totals						

APPENDIX B – Resource Allocation

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$US 8,714,299	**$US $71,285,701**	**$US 80,000,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$2,017,625
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$1,940,718
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$500,000
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$897,214
HVCT	Counseling and Testing	$2,655,198
HBHC	Adult Care and Support	$10,831,412
PDCS	Pediatric Care and Support	$2,248,749
HKID	Orphans and Vulnerable Children	$5,389,373
HTXS	Adult Treatment	$13,512,916
HTXD	ARV Drugs	$10,507,385
PDTX	Pediatric Treatment	$1,662,758
HVTB	TB/HIV Care	$1,507,358
HLAB	Lab	$1,920,690
HVSI	Strategic Information	$932,500
OHSS	Health Systems Strengthening	$11,865,541
HVMS	Management and Operations	$11,610,563
TOTAL		**$80,000,000**

B.2 Resource Projections

PEPFAR unit expenditures (UE) from the most recent available data (2014) and the PEPFAR Budget Allocation Calculator (PBAC) were used to calculate the required resources to support targets for HTC, care and treatment, PMTCT, VMMC, priority and key population prevention, and OVC. Adjustments to UEs were made to account for anticipated changes to the program in the coming implementation year, including geographic and site focus, outlier remediation, and changes to models/packages of service delivery and support.

Program Area	UE 2014	Expected UE 2016
VMMC	$17.80	$19.60
MSM	$461.10	$461.09
FSW	$51.99	$67.26*
Priority Population	$14.97	$24.55*
OVC	$73.07	$54.94*
HTC	$4.12	$2.10*
Pediatric Pre-ART		
Scale-Up to Saturation	$332.80	$141.46
Sustained		$103.91
Adult Pre-ART		
Scale-Up to Saturation	$331.02	$127.35
Sustained		$95.18
Pediatric ART		
Scale-Up to Saturation	$205.96	$149.35
Sustained		$109.88
Adult ART		
Scale-Up to Saturation	$197.90	$135.77
Sustained		$97.61
PMTCT		$457.00
Pregnant Women Tested	$4.18	$4.18
Option B+	$332.80	$0**
Infants Tested	$104.23	$0**
Infants Receiving Care	$5,029.99	$0**

*This amount represents a weighted average UE, derived fromtargets by IM and IM-specific UEs.
**Accounted for in PMTCT UE of $457.00

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Rwanda COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Bugesera	20,983	471	3,600	178	1,972
Burera	8,656	52	598	59	559
Gakenke	5,112	9	75	6	68
Gasabo	175,759	414	4,473	790	3,845
Gatsibo	61,868	1,016	5,159	402	4,040
Gicumbi	63,355	307	4,022	414	4,057
Gisagara	-	-	-	-	-
Huye	11,362	232	1,626	132	554
Kamonyi	115,672	459	4,495	828	4,480
Karongi	56,892	478	5,445	474	5,107
Kayonza	56,581	252	1,858	262	1,534
Kicukiro	43,362	763	7,331	1,382	6,717
Kirehe	-	-	-	-	-
Muhanga	25,245	706	5,743	445	4,588
Musanze	11,548	11	161	20	155
Ngoma	31,538	341	3,077	282	2,574
Ngororero	32,944	265	3,488	286	3,036
Nyabihu	12,955	126	1,711	206	1,616
Nyagatare	30,666	784	4,226	344	3,726
Nyamagabe	44,061	311	3,675	436	2,803
Nyamasheke	108,714	555	7,050	619	6,697
Nyanza	8,588	354	362	25	331
Nyarugenge	371,269	1,111	15,688	1,547	14,376
Nyaruguru	11,550	350	2,123	158	1,816
Rubavu	65,826	352	4,647	413	4,388
Ruhango	52,008	479	4,356	371	3,983
Rulindo	17,077	180	2,129	184	2,001
Rusizi	850	-	-	-	-
Rutsiro	157,856	592	4,914	706	4,405
Rwamagana	45,146	269	2,407	408	2,169
Other_ Rwanda	35,000	120	2,424	141	2,026
Total	**1,682,443**	**11,359**	**106,863**	**11,518**	**93,623**

Rwanda COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Bugesera	-	-	2,295
Burera	121	482	12,370
Gakenke	-	-	-
Gasabo	215	446	13,864
Gatsibo	2,424	-	3,395
Gicumbi	2,518	370	5,838
Gisagara	-	-	-
Huye	149	354	7,023
Kamonyi	200	442	7,456
Karongi	2,824	448	7,388
Kayonza	203	494	7,350
Kicukiro	951	1,321	3,846
Kirehe	-	-	-
Muhanga	28	-	1,210
Musanze	28	-	6,008
Ngoma	27	-	870
Ngororero	-	-	2,100
Nyabihu	-	-	1,535
Nyagatare	-	-	1,500
Nyamagabe	-	-	4,435
Nyamasheke	121	480	6,000
Nyanza	-	-	740
Nyarugenge	672	1,254	12,014
Nyaruguru	-	-	2,146
Rubavu	470	79	2,156
Ruhango	-	-	2,500
Rulindo	-	-	-
Rusizi	625	261	856
Rutsiro	121	446	10,497
Rwamagana	121	535	4,150
Other_ Rwanda	10,430	-	-
Total	**22,248**	**7,412**	**129,542**

Rwanda COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Bugesera	4,220	119
Burera	948	12
Gakenke	787	14
Gasabo	4,597	259
Gatsibo	11,382	191
Gicumbi	9,738	210
Gisagara	-	-
Huye	565	23
Kamonyi	8,777	298
Karongi	7,138	213
Kayonza	1,173	35
Kicukiro	5,961	251
Kirehe	-	-
Muhanga	11,059	278
Musanze	1,310	27
Ngoma	4,679	100
Ngororero	3,412	51
Nyabihu	3,354	72
Nyagatare	9,611	164
Nyamagabe	7,416	116
Nyamasheke	12,078	335
Nyanza	1,155	37
Nyarugenge	7,522	390
Nyaruguru	6,908	114
Rubavu	5,105	128
Ruhango	8,601	211
Rulindo	6,387	142
Rusizi	-	-
Rutsiro	8,100	186
Rwamagana	5,323	175
Other_ Rwanda	1,229	43
Total	**158,535**	**4,194**

Rwanda COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Bugesera	64	14
Burera	1	2
Gakenke	10	-
Gasabo	139	33
Gatsibo	240	53
Gicumbi	129	25
Gisagara	-	-
Huye	97	7
Kamonyi	140	26
Karongi	164	32
Kayonza	50	11
Kicukiro	231	52
Kirehe	-	-
Muhanga	201	43
Musanze	6	1
Ngoma	119	29
Ngororero	62	12
Nyabihu	27	7
Nyagatare	136	32
Nyamagabe	90	19
Nyamasheke	93	21
Nyanza	16	4
Nyarugenge	593	111
Nyaruguru	32	5
Rubavu	188	42
Ruhango	127	36
Rulindo	57	13
Rusizi	-	-
Rutsiro	69	15
Rwamagana	78	17
Other_ Rwanda	60	21
Total	**3,219**	**683**

Rwanda COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Bugesera	-
Burera	-
Gakenke	-
Gasabo	-
Gatsibo	-
Gicumbi	-
Gisagara	-
Huye	-
Kamonyi	-
Karongi	-
Kayonza	-
Kicukiro	-
Kirehe	-
Muhanga	-
Musanze	-
Ngoma	-
Ngororero	-
Nyabihu	-
Nyagatare	-
Nyamagabe	-
Nyamasheke	-
Nyanza	-
Nyarugenge	-
Nyaruguru	-
Rubavu	-
Ruhango	-
Rulindo	-
Rusizi	-
Rutsiro	-
Rwamagana	-
Other_ Rwanda	38,094
Total	**38,094**