

# Rwanda

## Country Operational Plan (COP) 2019

### Strategic Direction Summary



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## 1.0 Goal Statement

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The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) worked closely with the Government of Rwanda (GOR), including senior leadership at the Ministry of Health (MOH), to develop Rwanda's Country Operational Plan for 2019/Fiscal Year 2020 (COP 2019). All PEPFAR minimum program requirements and policies will be fully achieved prior to the end of COP 2019.

In COP 2019, the PEPFAR Rwanda Program will make a paradigm shift to sustaining epidemic control. The results of the Rwanda Population Based HIV Impact Assessment (RPHIA) are anticipated to show that Rwanda is close to achieving HIV epidemic control in reaching the second and third pillars of the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 goals nationally.<sup>1</sup> COP 2019 takes this assumption; while looking at gaps in viral load (VL) suppression among all age bands, sexes, and geographic units; and incorporates a strategy of maintaining epidemic control within all interventions and initiatives.

At the site-level, COP 2019 transitions all traditional, facility-based case finding to GOR/MOH ownership. PEPFAR will support enhanced active case finding through improved index testing services, including partner notification and family testing for all PLHIV, with strategic use of point-of-care (POC) recency testing and case-based surveillance (CBS) to identify pockets of active transmission. PEPFAR will also support Early Infant Diagnosis (EID) and community testing of key populations (female sex workers [FSWs], their clients, and men who have sex with men [MSM]), with additional prevention services targeting at-risk and under-reached populations of adolescents and young adults through the Orphans and Vulnerable Children (OVC) and Determined Resilient Empowered AIDS-Free Mentored and Safe (DREAMS) programs, and expanded Voluntary Medical Male Circumcision (VMMC) services. This strategic policy shift in case finding and enhanced prevention is central to PEPFAR Rwanda's COP 2019 strategy.

PEPFAR will also invest in improved HIV treatment, retention, and drug adherence to support 1) provision of Tuberculosis Preventive Therapy (TPT) to all people living with HIV (PLHIV), 2) transition of all eligible PLHIV to tenofovir/lamivudine/dolutegravir (TLD), including opt-in for women of child bearing age, 3) transition from three-month to six-months multi-month prescribing and dispensing depending on beneficiaries assessment results, and 4) interventions to improve VL coverage and VL suppression with a focus on adolescents and young adults.

COP 2019 investments reflect a shift from direct service delivery to central and site-level systems investments to support MOH's public health capacity to sustain HIV epidemic control. This includes increased investments in active CBS with the development of a national Unique Patient Identifier (UPID), a high-performing index testing system, and enhanced Laboratory Information System (LIS) and Supply Chain Information System (e-LMS), the human resources for health (HRH) e-Learning System and a Continuous Quality Improvement system (CQI). All central level systems investments will support improvements in site-level patient diagnosis and treatment and enhance monitoring of the performance of the national HIV program.

In addition, PEPFAR is moving forward in COP 2019 to support long-term financial sustainability objectives by supporting the GOR's transformation of the MOH Medical Products Procurement

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<sup>1</sup> Final, published results from RPHIA are expected in mid-to-late 2019.

Division (MPPD) to a parastatal organization, the Rwanda Medical Services, Ltd. (RMS). COP 2019 incorporates a plan to move procurement of 40-50% of all antiretrovirals (ARVs) to RMS with PEPFAR providing budgetary support.

In COP 2019, PEPFAR will significantly increase its funding to local and indigenous organizations in Rwanda from 43% in COP 2018 to 73% in COP 2019, not inclusive of the cost of doing business. PEPFAR is committed to supporting local and indigenous organization control of the HIV/AIDS response in Rwanda.

## 2.0 Epidemic, Response, and Program Context

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### 2.1 Summary statistics, disease burden and country profile

Rwanda's 2012 Census reported a population of 10,482,641, with 41% under the age of 15 and an annual population growth rate of 2.6%.<sup>2</sup> Projection from the 2012 census estimates the 2018 population at 12,089,721.<sup>3</sup> HIV prevalence has remained stable at 3% for adults and in FY18 there were an estimated 229,245 people living with HIV (PLHIV) which is projected to increase to 229,305 by the end of FY 2019.<sup>4</sup> The 2010 Demographic and Health Survey (DHS) stated that 77% of women and 73% of men reported having ever had an HIV test, which increased to 86% of women and 81% of men in the 2015 DHS, although the proportion of PLHIV who knew their current positive status at that time is unknown.<sup>5</sup> The estimated HIV incidence rate for 2019 from the most recent UNAIDS EPP Spectrum model is .035 per 100 adults.<sup>6</sup>

By the end of FY18, Rwanda had 190,477 PLHIV on antiretroviral therapy (ART), an increase from the 183,507 on ART the previous year. At the end of FY18, ART coverage for all estimated PLHIV nationally was 83%.<sup>7</sup>

With the expansion of Treat All, measuring viral suppression became increasingly important in Rwanda's efforts to control the epidemic by ensuring that clients are less likely to experience HIV-related morbidity or mortality and are less likely to infect others with the virus. Two studies conducted in 2009 and 2013 assessed the proportion of those on ART with an undetectable VL (VL) (less than 40 copies/ml) at 83% and 82% respectively, and these results did not vary by time on ART.<sup>8</sup> These studies were prior to the full rollout of routine VL testing.<sup>9</sup> PEPFAR monitoring and evaluation data from all supported Rwandan health facilities in FY18 showed viral suppression

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<sup>2</sup> National Institute of Statistics of Rwanda. *Fourth Population and Housing Census – 2012*. Kigali, Rwanda: January 2014. <http://www.statistics.gov.rw/publication/rphc4-population-projections>

<sup>3</sup> Ibid.

<sup>4</sup> HIV prevalence was 3.0% for the 2005, 2010 and 2015 Demographic and Health Surveys (DHS). National PLHIV estimates are from the 2019 EPP Spectrum estimates; 85% of all estimated PLHIV were on ART at the end of 2018.

<sup>5</sup> RPHIA results are expected to provide a more definitive understanding of the HIV epidemic in Rwanda.

<sup>6</sup> EPP-Spectrum v.5.752, 2019

<sup>7</sup> RHMIS 2017-18; EPP-Spectrum Estimates, 2019

<sup>8</sup> Elul B et al. High 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-sectional analysis of the national programme. *Lancet HIV* Mar 2015.

<sup>9</sup> Rwanda currently has nine VL testing hubs, including the National Reference Laboratory

to be 92%, compared to 91% in FY18 among those tested, with 81% of all eligible ART patients having a recorded annual result.<sup>10</sup> It is anticipated that results from RPHIA will provide additional information; those data, along with regularly monitored program data, will be used to target interventions and further improve viral suppression in districts and facilities that are lagging.

Donor funding to the national HIV program has decreased in the past years, a five-year trend that is expected to continue. Rwanda's gross national income is \$720 per capita.<sup>11</sup> Rwanda ranks 158 according to UNDP's Human Development Index in 2018.<sup>12</sup> Significant financial barriers remain to achieve a sustained domestically funded HIV response in the near future. However, the GOR has committed (through MOH and the Ministry of Economics and Finance) to work together with the U.S. Government (through PEPFAR agencies and Treasury) to increase domestic investment in the national HIV/AIDS response, which is a priority in COP 2018 and will continue into COP 2019.

Rwanda's HIV epidemic is generalized, with higher key population (KP) infection rates, and an urban prevalence of 6.2%, compared to a 2.2% rural prevalence.<sup>13</sup> Women have a higher HIV prevalence than men (3.6% vs. 2.2% nationally, 8.0% vs. 4.4% in Kigali) and young women aged 20-24 years old have nearly twice the rate of infection males the same age (1.8% vs. 1.0%).<sup>14</sup> 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.<sup>15</sup> FSWs have an estimated HIV prevalence of 45.8%,<sup>16</sup> while MSM are estimated to have a 9.2% prevalence in Kigali.<sup>17</sup>

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<sup>10</sup> PEPFAR Program Data, 2018

<sup>11</sup> 2017, World Bank.

<sup>12</sup> United National Development Programme, Human Development Indices and Indicators: 2018 Statistical Update, 2018.

<sup>13</sup> Rwanda DHS 2015.

<sup>14</sup> Ibid.

<sup>15</sup> UNAIDS Modes of Transmission Study (MOT) 2013.

<sup>16</sup> Female Sex Worker Behavioral Sentinel Survey (BSS) 2015. Preliminary findings from the BSS report ~51% FSW national HIV prevalence.

<sup>17</sup> MSM Behavior Surveillance Survey 2018. Previous MSM BSS (2015) estimated prevalence is 4%.

**Table 2.1.1 Government of Rwanda Results**

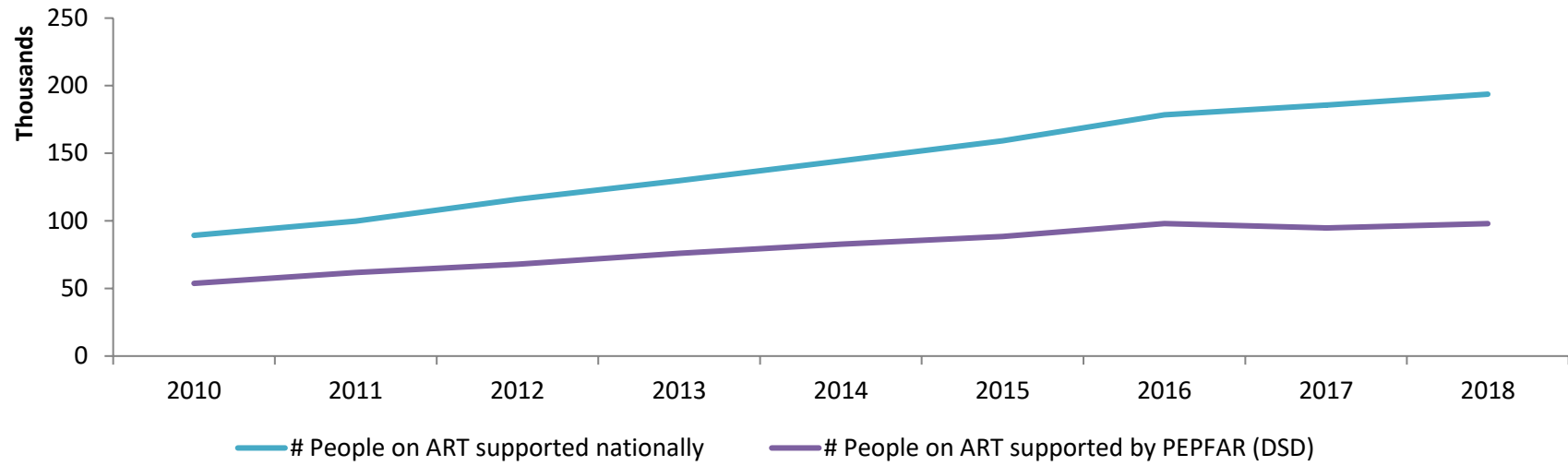
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	12,089,721	100%	2,337,888	19.3%	2,342,868	19.4%	1,228,424	10.2%	1,189,186	9.8%	2,659,121	22.0%	2,332,234	19.3%	NISR Census Projections 2018
HIV Prevalence (%)		1.9%		0.2%		0.2%		0.9%		0.5%		4.7%		3.3%	EPPS 2019*
AIDS Deaths (per year)	2,939		161		170		132		127		1247		1102		EPPS 2019*
# PLHIV	229,305		5,602		5,654		11,177		6,521		123,841		76,512		EPPS 2019*
Incidence Rate /1000 (Year)		0.35		-		-		0.9		0.3		0.6		0.5	EPPS 2019*
New Infections /(Year)	4,409														EPPS 2019*
Annual births	362,692	3.0%													NISR census Projections 2018
% of Pregnant Women with at least one ANC visit		99.2%		-				-				-			DHS2015 Table 9.2
Pregnant women needing ARVs	7,820														EPPS 2019*
Orphans (maternal, paternal, double)	674,556		75,728		75,157		262,810*		260,861*		-		-		NISR x DHS 2010 Table 2.12 (<15, 15+)*
Notified TB cases (Year)	5,960	100%	190	3.2%	201	3.4%	371	6.2%	559	9.4%	1,340	22.5%	3,299	55.4%	HMIS, 2018 (TB & ORD Division RBC)
% of TB cases that are HIV infected	1,235	20.7%	16	8.4%	26	12.9%	Females 15+ = 431 (25.2%) Males 15+ =762 (19.8%)							HMIS, 2018 (TB & ORD Division RBC) <15, 15+	
% of Males Circumcised		N/A				N/A				59.2%				38.7%	RPHIA
Estimated Population Size of MSM*	N/A	N/A													MSM IBSS 2015
MSM HIV Prevalence							4.0%							MSM IBSS 2015	
Estimated Population Size of FSW	13,714 (8,853-23,495)	100%													FSW PSE 2018
FSW HIV Prevalence	1,967	45.8%						33.6%				53.9%			FSW IBSS 2014/15
Estimated Population Size of PWID	-	-													
PWID HIV Prevalence	-	-													
Estimated Size of Priority Populations (specify)	N/A	N/A													
Estimated Size of Priority Populations Prevalence (specify)	N/A	N/A													
*Draft data of EPP Spectrum as of February 2019															

<b>Epidemiologic Data</b>					<b>HIV Treatment and Viral Suppression</b>			<b>HIV Testing and Linkage to ART Within the Last Year</b>		
	<b>Total Population Size Estimate (#)</b>	<b>HIV Prevalence (%)</b>	<b>Estimated Total PLHIV (#)</b>	<b>PLHIV diagnosed (#)</b>	<b>On ART (#)</b>	<b>ART Coverage (%)</b>	<b>Viral Suppression (%)</b>	<b>Tested for HIV (#)†</b>	<b>HIV Positive Tests† (#)</b>	<b>Initiated on ART (#)</b>
Total population	12,432,365	1.9%	229,305	205,534	190,477	83.1%	92.2%	2,670,906	16,343	13,617
Population <15 years	4,781,447	0.2%	11,256	9,159	7,490	66.5%	83.0%	277,606	748	591
Population 15+	7,650,918	2.8%	218,049	196,375	182,987	83.9%	92.5%	2,393,300	15,595	13,026
Men 15-24 years	1,228,270	0.5%	6,521	6,220	6,304	96.7%	84.7%	432,694	1,408	452
Men 25+ years	2,414,632	3.2%	76,511	66,259	60,522	79.1%	92.3%	632,286	5,281	4,786
Women 15-24 years	1,265,637	0.9%	11,177	10,881	10,898	97.5%	85.8%	491,889	2,672	2,050
Women 25+ years	2,742,379	4.5%	123,840	112,818	105,263	85.0%	93.7%	836,431	6,234	5,738
SOURCE	NISR Population Projection for 2019 [2012 Census]	2019 EPP-Spectrum Estimates for 2019	2019 EPP-Spectrum Estimates for 2019	Midpoint of DHS2015 'ever tested' and HMIS # on ART	RHMIS 2018	RHMIS 2018 & 2019 EPP-Spectrum Estimates	PEPFAR APR2018	RHMIS 2018	RHMIS 2018	RHMIS 2018

\*Data Estimated based on PEPFAR on treatment data age breakdowns

†Lack of unique identifiers allows reporting only on positive tests, not newly identified positive individuals

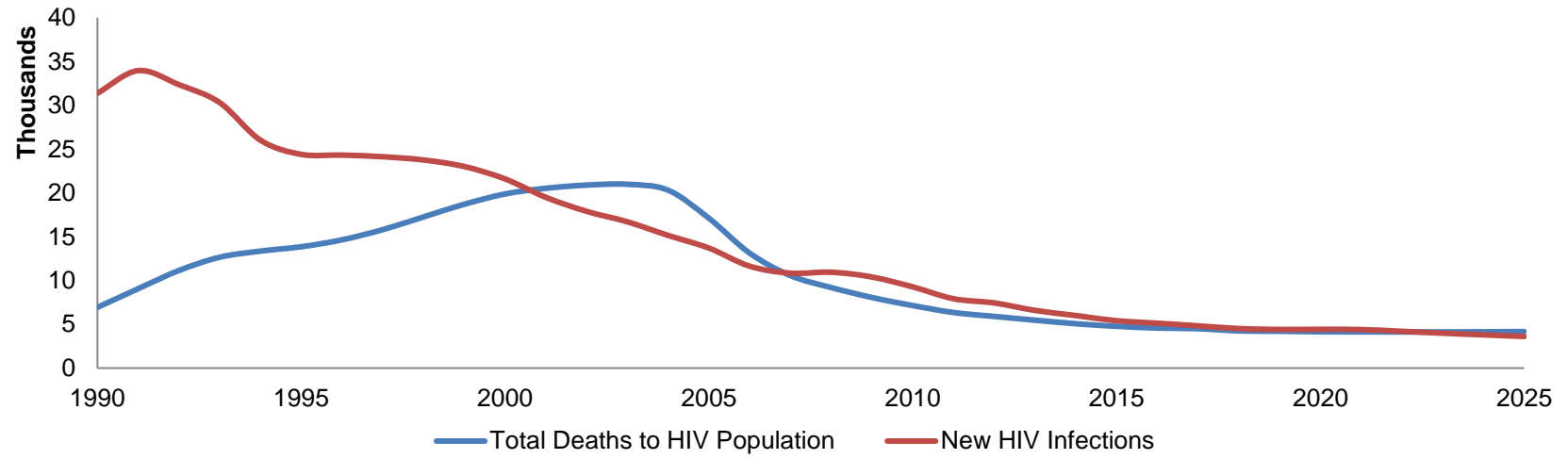
Figure 2.1.3 Trend of National and PEPFAR PLHIV on Treatment



Data source: 2019 EPP-Spectrum Estimates for the period of 1990 to 2025.



Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV



## 2.2 Investment Profile

In FY 18, Rwanda's HIV response was funded primarily by three sources – PEPFAR (42%), the Global Fund (GF) (43%) and the GOR (14%).<sup>18</sup> Overall donor funding for Rwanda's HIV program continues to decrease. In FY16, GF allocated \$59 million for HIV, down from \$100 million annually in FY13 and FY14.<sup>19</sup> For the 2018-2020 GF funding cycle, Rwanda has been allocated \$154 million for HIV, which represents an average of \$51.3 million per year. PEPFAR total funding (base and central funds) has fluctuated from \$78.5 million in FY17 to \$80.9 million in FY18, \$76 million in FY 2019 to \$70 million in FY 2020.<sup>20</sup> While GOR contribution to total HIV expenditures increased from 10% to 13% from FY15 to FY16<sup>21</sup> and remained at 13% in FY17, the GOR's budget allocation to HIV decreased from \$24.3 million<sup>22</sup> to \$21 million<sup>23</sup> in FY18. Anticipated decreases in GF and PEPFAR funding will create particular challenges for Rwanda's HIV program and will place pressure on Rwanda's health system, especially in light of limited domestic resources to fill the donor-funding gap.

Total expenditures for FY18 do not reflect overall expenditures for the HIV response in Rwanda due to differences in fiscal cycles (PEPFAR's FY18 was October 1, 2017 to September 30, 2018; GF's FY18 was January 1, 2018 to December 31, 2018; and GOR's FY18 was July 1, 2017 to June 30, 2018) and expenditure reporting. MOH reports GF and GOR expenditures not by program area as shown in Table 2.2.1 but by HIV National Strategic Plan (NSP) cost categories: human resources, technical assistance, training, health products and equipment, medicines and pharmaceuticals, procurement and supply management, infrastructure and equipment, communication materials, monitoring and evaluation, living support to clients, planning and administration, and overhead. Therefore, examination of expenditures toward the national HIV response in Rwanda by program area may not represent an accurate account of the proportion of support from PEPFAR, GF, and GOR for these areas.

Assessments are ongoing on MOH's ability to reduce inefficiencies to realize cost savings, secure additional domestic funding for human resources and other system costs no longer donor funded. Significant financial barriers remain to achieve a sustained domestically funded HIV response in the near future.

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<sup>18</sup> PEPFAR 2018 Expenditure Analysis; Rwanda HIV Consolidated Operational Plan, 2013-2015; National HIV Annual Report, 2017-2018. Note that various sources with non-aligned time frames are used for the investment profile analysis.

<sup>19</sup> GOR fiscal year 2015/16, July 2015 to June 2016.

<sup>20</sup> PEPFAR COP16, COP17, COP 2018 and COP19 planning level letters.

<sup>21</sup> COP16 SDS Table 1.2.1 compared to COP17 SDS Table 2.2.1.

<sup>22</sup> Rwanda HIV Annual Report 2015-2016.

<sup>23</sup> Rwanda Biomedical Center Corporate Services Division.

PEPFAR and GF are coordinating with GOR to maximize donor investments and strategically align with domestic and other available resources to achieve epidemic control. The MOH established a working group, within the Health Sector Working Group (HSWG), to prioritize areas for collaboration and develop an implementation road map for health financing reform. The Ministry of Economics and Finance agreed to the proposal and confirmed its participation. The co-chairs of the HSWG will ensure follow-through to advance steps on sustainability planning.

Rwanda is the first country to participate in GF's Results-Based Financing (RBF) model and is the largest non-commodities PEPFAR implementing partner through the USG's MOH cooperative agreement (CoAg), providing direct services to 98% of PEPFAR-supported patients on ART. Furthermore, in COP 2019, PEPFAR will significantly increase its funding to local and indigenous organizations in Rwanda to an overall 62% in COP 2019 up from 37% in COP 2018.

<b>Table 2.2.1 Annual Investment Profile by Program Area<sup>24</sup></b>				
<b>Program Area</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% Host Country</b>
Clinical care, treatment and support	\$76,684,710	45%	43%	12%
Community-based care, treatment, and support	\$9,409,490	12%	47%	41%
PMTCT	\$4,153,980	8%	92%	-
HTS	\$2,266,057	80%	20%	-
VMMC	\$7,839,258	92%	8%	-
Priority population prevention (AGYW)	\$3,095,210	75%	17%	8%
Key population prevention	\$2,045,003	55%	45%	-
OVC	\$6,748,519	85%	17%	8%
Laboratory	\$3,113,715	51%	46%	3%
SI, Surveys and Surveillance	\$4,515,671	82%	11%	7%
HSS	\$23,568,435	2%	63%	34%
<b>Total</b>	<b>\$143,440,049</b>	<b>42%</b>	<b>46%</b>	<b>15%</b>

<sup>24</sup> (GRP, National AIDS Spending Assessment , 2012), all amounts in 2018 USD.

**Table 2.2.2 Annual Procurement Profile for Key Commodities**

Commodity Category	Total Expenditure	% PEPFAR	% GF	Host Country (\$)	Other (\$)	Comments
ARVs	\$ 23,786,794	46%	54%	\$ -	\$ -	
Rapid test kits	\$ 6,845,800	7%	93%	\$ -	\$ -	
Other drugs	\$ 173,720	49%	51%	\$ -	\$ -	
Lab reagents	\$ 4,645,944	0%	100%	\$ -	\$ -	
Condoms	\$ 850,374	73%	0%	\$	27%	USAID & UNFPA
VL commodities	\$ 5,438,613	67%	33%	\$	\$ -	
VMMC kits	\$ 5,158,114	2%	98%	\$	\$ -	
MAT						
Other commodities						
<b>Total</b>	<b>\$ 46,899,359</b>	<b>34%</b>	<b>65.5%</b>		<b>0.5%</b>	

+ Total projected national costs are taken from the national quantification (revised December 2019). Percentage of PEPFAR contribution is the dollar amount from the FAST as a percentage of the total national quantification dollar amount, not a percentage of national quantity.

\* In COP 2019, PEPFAR will provide 11,412,000 unbranded condoms and 13,314,330 branded condoms for social marketing of condoms program through the central USAID Condom Fund and COP 2019 25% matching condom funds.

^ Government of Rwanda does not contribute to the budget categories listed; however, it procures general commodities for the HIV program and the latest available total spending on drugs and medical supplies is reported in the 2014-2015 budget execution report at 19.9 billion Rwandan Francs, approximately \$27.5 million at the 2015 exchange rate. [http://www.minecofin.gov.rw/fileadmin/templates/documents/Budget\\_Unit/Budget\\_Execution\\_Reports/2014-2015\\_Annual\\_Budget\\_Execution\\_Report.pdf](http://www.minecofin.gov.rw/fileadmin/templates/documents/Budget_Unit/Budget_Execution_Reports/2014-2015_Annual_Budget_Execution_Report.pdf)

<b>Funding Source</b>	<b>Total USG Non-PEPFAR Resources</b>	<b>Non-PEPFAR Resources Co-Funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
USAID Non-HIV	\$44,675,000	\$12,477,587	7	\$29,479,884	USAID non-PEPFAR resources are focused on MCH, Malaria, Nutrition, WASH, family planning and Health Systems Strengthening. When combined with PEPFAR funds, the focus is on improving access to service delivery in Nutrition, Water, MCH, FP activities and commodities availability.
CDC (International Ebola)		\$10,000			To support the EBOLA response in Rwanda
CDC Influenza		\$144,780			Sustaining influenza surveillance networks and response to seasonal and pandemic influenza by national health authorities.
<b>Total</b>	<b>\$44,675,000</b>	<b>\$12,632,367</b>		<b>\$29,479,884</b>	

<b>Funding Source</b>	<b>Total PEPFAR Non-COP Resources</b>	<b>Total Non-PEPFAR Resources</b>	<b>Total Non-COP Co-funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
Other PEPFAR Central Initiatives	\$914,874			1	\$239,200	Value of condom procurement planned to use the Central Commodity Fund
Other Public Private Partnership	\$500,000			1	\$100,000	SFI Central Funds
<b>Total</b>	<b>\$1,414,874</b>				<b>\$339,200</b>	

## 2.3 National Sustainability Profile Update

COP 2019 planning furthers the systems investments highlighted in the results of the Sustainability Index and Dashboard (SID) 3.0.<sup>25</sup> These systems investments are outlined in Section 6.0 (*see below*).

Rwanda has made remarkable progress in reaching the UNAIDS Fast Track 95-95-95 Goals following the 1994 genocide. The GOR has demonstrated strong leadership and vision in crafting a national HIV/AIDS strategy and coordinating the response. However, Rwanda still remains highly dependent on donors to fund its HIV response, particularly PEPFAR and GF. Those donor contributions are declining, which poses a significant risk to the long-term sustainability of the national HIV program and to the great successes Rwanda has achieved. The GOR is taking strides to find and treat remaining positives through targeted outreach and testing models, focusing on key and priority populations and key geographic areas, and to provide immediate treatment for PLHIV under the fully implemented Treat All program. The GOR is optimizing their service delivery models and identifying ways to absorb the costs of administering the national HIV program, even though Rwanda is a low-income country.

To address the SID 3.0 vulnerability on “domestic resource mobilization” (score 8.25), the systems investments outlined in Section 6 focus on building systems investments for eventual transition to the GOR, even in light of limited domestic budget to fund the HIV program. When donor funding is reduced dramatically, the goal is to have these systems in place with minimal implementation costs so that domestic resources are used with maximal efficiency and only for the maintenance of these systems. The lack of domestic resources continues to be the biggest challenge in Rwanda, although PEPFAR and the GOR are working to strengthen and develop systems while donor funding exists.

In COP 2019, PEPFAR significantly increased its funding to local and indigenous organizations in Rwanda – to an overall 62% in COP 2019 from 37% in COP 2018. When cost-of-doing-business (CODB) is removed from the overall totals, the percentage of funding to local and indigenous organizations in Rwanda is 73% (compared to 43% in COP 2018).

In addition, strengths identified in SID 3.0 continue to be of high quality in Rwanda, including quality management (QM), which is integrated in the national health budget and showcases the strong quality management system in Rwanda. In addition, a recent data quality assessment by the PEPFAR team compared site-level TX\_CURR data at ten HIV clinics (a mix of PEPFAR-supported and Global Fund-supported) with reported data in the national system (RHMIS) and PEPFAR’s DATIM system. The results showed an overall discrepancy between the site-level data review and the electronic system (RHMIS) of less than 1% (where the absolute difference of the number of TX\_CURR from the site-level data was 60 fewer than reported in RHMIS).

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<sup>25</sup> <https://www.pepfar.gov/countries/cop/sids/2018/index.htm>

## 2.4 Alignment of PEPFAR investments geographically to disease burden

HIV care is widely available, predominantly delivered through the public system network of District Hospitals and Health Centers. In FY18, 51% of ART patients received treatment in PEPFAR-supported facilities, with the proportion of facilities and patients on ART, as well as HIV services supported by PEPFAR, varying widely by district and province. In addition to direct clinical support, PEPFAR funds other programs, such as OVC as well as key and priority population prevention services that do not correlate with the proportion of funded clinical support. PEPFAR expenditures may not reflect overall spending per PLHIV in the province because higher proportional expenditures can be due to PEPFAR supporting the majority of facilities or patients in the province, and lower expenditure per PLHIV may indicate that few or no facilities are supported by PEPFAR. Therefore, examination of PEPFAR expenditures alone does not account for the full picture of support for PLHIV in Rwanda.

PEPFAR spent on average \$410 per PLHIV in Rwanda in FY18.<sup>26</sup> For estimated ART coverage, the Western province is an outlier, which may be due to cross-border movements. The weighting of the UNAIDS EPP Spectrum estimates to distribute them to the provinces involves both the population estimates and prevalence for the province. In particular, the population estimates will not have taken into account recent migration and, therefore, may over or underestimate the number of PLHIV in the province, depending on the direction of the migration. Given the very high rate of urbanization in Rwanda, COP 2018 concentrates additional resources in Kigali province to address its 6.3% prevalence and to fund the intensive index/family testing and scale-up of prevention activities among key and priority populations.

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<sup>26</sup> Based on PEPFAR FY18 Expenditure Reporting data. This amount includes PEPFAR expenditures for commodities and the military.



Figure 2.4.1 Percent PLHIV by SNU, Total PLHIV by SNU, Coverage of total PLHIV with ART, and VL Coverage by SNU

Rwanda: PLHIV, ART coverage, and viral load coverage



**PLHIV, Spectrum2019**

- 30,341
- 45,320
- 47,602
- 51,455
- 54,527

**National ART coverage**

- 71%
- 75%
- 84%
- 87%
- 90%

**VL Coverage Pepfar, 2018**

- 91%
- 92%
- 94%
- 95%

## 2.5 Stakeholder Engagement

As in prior years, COP development is a layered process, with stakeholder involvement in all aspects, including data/epidemiology analysis programmatic priorities. The GOR/MOH – from the technical working group (TWG) level to the senior leadership level within MOH (including the Minister, Minister of State and PS) – plays a key leadership role in COP development.

Civil society, private sector, PEPFAR Implementing Partners (IPs) and other stakeholders provided input for the COP 2019 working groups through participation in a strategic planning retreat held at the U.S. Embassy in Kigali in January 2019. The meeting engaged numerous community partners and their constituencies, including UNAIDS, civil society organization (CSO) umbrella groups working in HIV, the GF Country Coordinating Mechanism (CCM) Secretariat, IP representatives, and GOR/MOH representation. Stakeholder representatives from GOR/MOH, UNAIDS, the World Health Organization, and Global Fund headquarters in Geneva, Switzerland also took part in the COP 2019 planning meetings for Group 1, held in Johannesburg, South Africa March 4-8, 2019, and will continue to be engaged through the COP 2019 planning and implementation process, including having an opportunity to comment on the SDS for COP 2019.

## 3.0 Geographic and Population Prioritization

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The PEPFAR and MOH teams are focused on reaching and surpassing the UNAIDS 90-90-90 targets with sights on attaining 95-95-95 and epidemic control in Rwanda. According to current UNAIDS Spectrum models and estimates, Rwanda is close to achieving the first 90, but has met the second and third, with 88% of all PLHIV identified, 96% of those identified on treatment, and 92% of those on treatment virally suppressed.<sup>27</sup> Epidemiological estimations and program performance data suggest that with more focused planning and resource allocation, reaching these goals in all provinces is possible. RPHIA data, available in FY19, will confirm Rwanda's achievement towards the 90-90-90 targets.

The PEPFAR and MOH planning teams jointly set geographic priority areas during COP15 development, which remained in effect for COP16. 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. Districts are relatively small geographically, with an average of 844 square kilometers and a range of 134-1937 square kilometers, having an average population of 350,532. Given the small size and inter-district movement of people within Rwanda, as the country moved toward saturation, many districts showed ART coverage greater than 100%. Additionally, the DHS prevalence estimates are only to the provincial level, and no accurate district prevalence figures are available. Given the limitations with the accuracy of the estimations, the district coverage greater than 100%, the small geographic areas and the mobility of the population, for COP17 the sub-national unit (SNU) of prioritization for Rwanda was changed to the provincial (between national and district) level. This change allows a more accurate regional assessment of where additional resources are needed to ensure that all PLHIV have access to ART, as well as the flexibility to target hotspots, facilities or other sub-SNU regions where improvements are needed. COP 2018 continued with the provincial level as the SNU of prioritization, with programming targeting specific populations based on their presence and risk for HIV. In COP 2019 PEPFAR will continue similar geographic support with major adjustments to the overall country testing strategy.

Provincial ART coverage at the end of 2018 was 90% for Kigali, 85% for the East, 75% for the South, 90% for the West and 70% for the North.<sup>28</sup> FY 2020 targets have adult ART coverage above 80% for the total population. Pediatric PLHIV estimations have varied greatly from year to year in the Spectrum models, and current pediatric ART coverage is estimated at 63% according to the most recent Spectrum estimates and targeted to reach 85% in COP 2019.

While the level of prioritization is the province, targets are set at the site and sector levels. In particular for key and priority populations, planning began at sector-level hotspots and community, based on the location and need of the identified populations. Size estimations for some KPs are available in hotspots, and this data was used to inform prioritization decisions for targets, resources and service-delivery package planning.

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<sup>27</sup> EPP-Spectrum Estimates, 2019

<sup>28</sup> Ibid.

Given the strength of Rwanda’s screening program for HIV through couples testing for marriage and pregnancy,<sup>29</sup> COP 2019 focuses on strategies that would reach PLHIV with unknown status who were less likely to be or have been reached through antenatal care (ANC) or marriage testing. This strategy focuses on a community based approach for reaching and testing KPs (FSW and MSM) and priority populations (PPs), FSW clients, individuals with symptoms of sexually transmitted infections (STI), out-of-school youth and adolescent girls and young women (AGYW), with a strong emphasis on index testing at the facility level.<sup>30</sup> Index, recency and family testing will be offered to all newly identified positives in all PEPFAR-supported health facilities. In addition, medical records for all PLHIV enrolled in PEPFAR-supported facilities will be reviewed, and index/family testing will be offered to those whose records do not indicate this has been done previously.

Analysis of ART coverage by age and sex was used to determine where the gaps were greatest. Through this analysis, in combination with the current understanding of modes of transmission in Rwanda, the city of Kigali was identified as a focus area due to its relatively high HIV prevalence and its young and growing population, due largely to the fact that Rwanda is one of the fastest urbanizing countries in the world.<sup>31</sup> Allocation of resources to maximally identify and treat PLHIV in Kigali will effectively interrupt transmission at an accelerated pace and is critical to epidemic control in Rwanda and achieving an AIDS-free generation. Additionally, HIV testing data from the national antenatal care program was used to identify where there may be gaps in case identification. Observation over time of positive pregnant women shows a decline in the number of pregnancies and the number of new HIV ST diagnosed for the first-time during ANC.

<b>Prioritization Area</b>	<b>Total PLHIV/% of all PLHIV for COP 2019</b>	<b># Current on ART (FY18)</b>	<b># of SNU COP 2018 (FY 2019)</b>	<b># of SNU COP 2019 (FY 2020)</b>
Attained	--	--	--	--
Scale-up Saturation	100%	190,477	5	5
Scale-up Aggressive	--	--	--	--
Sustained	--	--	--	--
Central Support	--	--	--	--

<sup>29</sup> Rwanda DHS 2015

<sup>30</sup> A 2010 census of Persons with Disabilities (PWD) in Rwanda found 522,856 PWDs (263,928 female and 258,928 male). A 2014 study in Rwanda (“Prevalence of HIV among People with Physical Disabilities in Rwanda,” <https://www.ncbi.nlm.nih.gov/pubmed/26867257>) found that HIV prevalence among PWDs to be 5.73%. The national HIV response works to include PWDs in prevention programming and in the quality of services provided to PWDs.

<sup>31</sup> ‘2014 Revision of World Urbanization Prospects’ United Nations, Department of Economic and Social Affairs, Population Division.

## 4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

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### COP 2019 Programmatic Priorities for Epidemic Control

#### 4.1 Finding the missing, getting them on treatment, and retaining them to ensure viral suppression.

##### 4.1.1 Finding the missing PLHIV

Rwanda's most significant challenge in reaching HIV epidemic control is identifying new HIV positive individuals. Overall, the testing gap for the first 95 (diagnosed HIV positives) reaches across genders, age groups, and SNU. In APR 18 (FY18), PEPFAR Rwanda identified 16,151 new HIV positives, 53% of the annual target. In FY 2019 Quarter 1 (Q1), PEPFAR supported sites identified 2,176 new HIV positive individuals. While this represented a 15% increase compared to FY18Q4, the overall testing yield remained low at 0.8%. Based on the current rates of diagnosis and linkage to treatment and the RPHIA preliminary data there will be an estimated 6,000 PLHIV nationally left to link to treatment by the end of FY 2019, half of which will be through PEPFAR supported sites. With an assumed 95% rate of linkage, in COP 2019, PEPFAR supported sites will identify 3,170 new HIV positive individuals of which 1,606 or 51% will come from index testing.

As part of the transition to maintenance of sustained epidemic control, MOH-supported HIV facility-based testing shall continue where necessary; however, PEPFAR support will focus on index-facility based testing, including reduction of unnecessary testing through broad use of an HIV testing tool. PEPFAR will improve the index testing system of partner notification services (PNS) and family testing, with effective national scale up through PEPFAR sites and central level TA to MOH for non-PEPFAR sites. This will be achieved through intensive site-level monitoring and mentorship identifying and mitigating challenges in effective service delivery and program management, with POC recency testing and the roll out of the active (CBS) with an integrated national unique patient identifier (UPID).

All 172 of the PEPFAR supported testing sites across Rwanda are currently supporting index testing services, though with varying degrees of success. Seventy-five percent of all newly diagnosed HIV positive individuals and 35% of those currently on treatment in all PEPFAR sites have been offered index PNS. Of those offered index PNS, only 24% agreed to participate in providing partner contacts, with newly diagnosed individuals participating at higher rates than those currently on treatment and men participating at higher rates than women. Overall test yields through index services remains low at 4.2%, with a 2% yield for those under 15 years of age, and a 5.3% yield for those 15 years or older. However, test yields of sexual partners from newly diagnosed index cases was 13%, compared to 4% from those currently on treatment. By the end of FY 2019, it is expected that 85% of all patients on treatment will have been offered index PNS. As the proportion of index cases who have been on treatment for more than 12 months decreases, and the proportion of newly diagnosed increases, the overall PNS testing yield is expected to increase.

The PEPFAR strategy for increasing index testing case finding and yield in COP 2019 consists of three main aspects: 1) increasing the absolute number of PLHIV offered index testing, 2) increasing index case participation rates from 24% to 80%, and 3) increasing index PNS testing yields from 10% to 20%.

Increased numbers of PLHIV offered index services will be achieved by; 1) enhanced site-level monitoring and mentorship with monthly data reporting on coverage through HMIS and through the expanded CBS program to achieve 95% coverage of all PLHIV eligible for index PNS and family testing; 2) the use of recency test results and A-CBS to identify social networks of recently infected individuals; 3) index case referral and use of self-testing kits to promote testing of among social networks of those recently infected; 4) an increased partner-to-case ratios by expanding partner elicitation to include *any* sexual partners versus, especially prior to VL suppression in the last 12 months and inclusion of individuals with multiple sexual partners such as FSW in facility testing and index testing and 5) improved reporting by IPs of other sexual partner testing as Index (e.g. ANC couples testing and client testing of HIV positive FSW).

Improved index case participation in PNS will be achieved by 1) amending the CBS protocol to allow for verbal consent; 2) holding focus group discussions to better understand concerns shared by those asked to disclose partners; 3) offering alternative and more acceptable ways for anonymously reaching partners, such as drop boxes, anonymous e-platforms, self-test kits with tracking referral coupons and referral coupons or messaging inviting partners to come for broad STI testing (inclusive of HIV) as opposed to HIV testing; 4) improving counseling messages tailored specifically to elicit older and non-spousal partners; 5) deploying POC recency testing and disclosure of results; 6) re-purposing facility based testing staff into index testing counselors and partner follow up; 7) expanding peer educator support for the differentiated service delivery model (DSDM) to include index testing; 8) adding joint partner counseling to the list of partner notification options and 9) allowing flexible testing options (e.g., during weekends, after work hours and outreach/home-testing).

Improved PNS testing yields will be achieved by 1) increasing the proportion of high risk individuals as index cases, such as FSWs or MSM; 2) improved reporting of index case test results of primary sexual partners with a higher risk of exposure through ANC couples testing and 3) increasing the proportion of index cases which are newly diagnosed as the facilities complete index PNS of those currently on treatment.

Recency testing will measure frequency of new infections and provide information on how to focus testing strategies by identifying transmission networks and social networks. With the scale up of CBS and an integrated national unique patient identifier (UPID) in COP 2018/FY 2019, clinical, demographic, and risk behavior indicators will be collected for all individuals who test positive for HIV, as well as recency test results. This will allow a detailed analysis of both geographic clusters of recent infections and the identification of transmission and social networks correlated with recent infections to inform specific strategies to reach others who may be positive and maximally interrupt transmission network.

PEPFAR will support more focused active case finding of key populations (KP), including FSWs and MSM, and their social networks through community-based initiatives focused in high impact geographic areas. PEPFAR will revise community KP index testing and social/sexual network testing focusing on high yield venue testing in conjunction with the use of validated screening

tools and in high impact geographic areas. Through MOUs with MOH facilities, prevention IPs will bring KPs to MOH facilities for HIV testing, and HIV positive individuals will be offered recency testing, index PNS and family testing and linkage to treatment. In COP 2019, PEPFAR will identify 742 new HIV positive FSWs and MSM in high burden areas.

In addition, case finding will be supported by a more focused distribution of HIV self-test kits to index cases who may not wish to disclose partner contacts and/or sexual partners/contacts unwilling to come to health facilities for HIV testing. Furthermore, HIV self-test kits will be distributed to KPs at hotspots during outreach testing for KPs to distribute within their sexual networks, as well as to bars and locals frequented by young men at risk for HIV who may be unwilling to come to facilities for testing. PEPFAR will work with MOH to develop a self-test kit coupon referral system which could link HIV test results back to self-test kit distribution platforms and index cases where appropriate to measure the efficacy of this strategy.

In COP 2018, PEPFAR laboratory activities will support MOH to transition from carrying out recency testing at VL testing hubs to POC testing. The reduction in turn-around time of test results from a minimum of 2 weeks to several hours will optimize the impact of recency data promoting Index PNS test outcomes as well as rapid identification of infection clusters and networks.

In COP 2019, building on achievements in the implementation of Rapid Testing Continuous Quality Improvement (RTCQI), laboratory activities will focus on the implementation of strategies that ensure prompt and accurate identification of PLHIV who come to test at various HIV testing entry points. To date 100% of PEPFAR-supported HIV testing and counseling (HTS) have their HTS health care workers trained on RTCQI; 77% of whom received PT panels in the last three rounds and passed at 98% achievement. An auditing and certification program will be instituted to reinforce these achievements. In COP 2019 PEPFAR will expand the CQI program to include recency proficiency testing.

These aspects of active case finding will help Rwanda develop a comprehensive public health approach to sustain epidemic control by promoting effective case identification and maximally interrupting HIV transmission with rapid linkage and retention of clients on treatment.

#### 4.1.2 Getting PLHIV on Treatment

In FY18, PEPFAR put 7,727 new individuals on treatment, reaching 55% of FY18 targets for a total of 98,018 patients on treatment. At the end of FY18, ART coverage for all estimated PLHIV nationally was 84%. December 2018, Rwanda had 193,726 PLHIV on anti-retroviral therapy (ART), of which 98,881 (51%) was PEPFAR contribution and an increase from the 183,507 on ART the previous year. In FY 2019 Q1, PEPFAR saw an increase in TX\_NEW (TX\_NEW DSD and TX\_NEW TA) by 6.5%, as a result of increases in HTS\_POS, which only represents a 55% achievement of the quarterly FY 2019 target. While PEPFAR supported-sites initiated 1,637 new individuals on treatment in FY18 Q4, 987 (1.0% of FY18 Q4 TX\_CURR) of patients in care transferred out to GF-supported sites and 1,273 transferred in reflecting a high rate of movement by patients between different health facilities. Additional analysis indicated that between FY18 Q4 and FY 2019 Q1, there was a loss of 222 patients due to death (0.2% mortality of patients in care in FY18 Q4) and 212 individuals (0.2%) were lost to follow up. However, during that same period, 285 (0.3%) of patients previously lost to follow up were brought back to treatment. Previous site level monthly

data analysis indicated an average of 70% of patients lost to follow up return to treatment through facility outreach activities.

In spite of the increase in TX\_NEW in FY 2019 Q1, PEPFAR achieved 55% of the FY 2019 Q1 target with the largest gaps for males and females in Kigali. Given the reported high linkage rate of more than 90% in FY18 and FY 2019 Q1, this under-achievement is largely driven by challenges in finding positives, as opposed to loss to follow up between testing positive and linkage to treatment for the general population. In addition, data for the recent MSM BSS 2018 indicates that linkage to treatment in this sub population is high (98%) with gaps remaining largely identifying new positives and maintaining them to achieve VL suppression.

The 2019 EPP Spectrum model – anticipated to be confirmed through preliminary RPHIA data – indicates that, by the end of FY 2019, there will be approximately 6,000 individuals left to put on treatment to achieve 90% ART coverage of all PLHIV (UNAIDS Goal of 95-95-95). In COP 2019, PEPFAR is targeting to initiate 50% of these new PLHIV on treatment by the end of FY 2020. To achieve this treatment target, PEPFAR will continue to support Treat All and implementation of the Multi-Month Prescription (MMP). Review of the Differentiated Service Delivery Model (DSDM) monitoring and evaluation (M&E) data indicates that VL suppression rates have remained constant following the transition from monthly clinical visits and drug pickups to quarterly visits and drug pickups. MOH, together with RRP+, is planning an assessment among beneficiaries to assist the transition of stable patients to semi-annual visits and drug pick-ups, to roll out in COP 2019. In addition, PEPFAR will support site level CQI and mentorship activities to improve TLD implementation and ART optimization including phasing out of NVP and AZT to improve VL suppression.

To optimize linkage, COP 19 will support numerous strategies at site level including site-level monitoring to ensure effective implementation of same day enrollment, same-day ART initiation, use of linkage register, effective Pre-ART counselling, flexible hours for adolescent and youth for ART initiation and enhanced follow-up (phone, home visits, Peer educator support). Linkage improvements will also be support within PMTCT and community levels to enhance EID cascade linkage to ART initiation and link OVC case-finding to ART services.

The above strategies will be supported by PEPFAR supported above site level services including mentorship, targeted trainings, updated tools/and supportive supervision. Site-level monitoring will strengthen the use of linkage registers to follow up with patients who do not initiate ART within the recommended seven-day period, including the use of phone calls and home visits, coupled with KP, age and gender-specific peer educator support groups. PEPFAR will also ensure that facilities have child and adolescent friendly services to promote knowledge of HIV and same day initiation with flexible hours for ART initiation. Linkage referral and counter referral systems will be strengthened to ensure children, OVC, FSW and MSM link to ART services. KP networks and KP associations will be used to help MSM and FSW effectively link to treatment.

PEPFAR recognizes challenges in linking PLHIV especially KPs identified in the community to the treatment centers. In COP 2019, PEPFAR will mentor prevention IPs to improve linkage to treatment for KPs tested in the community using following approaches: enhancing the linkage between community and nearby health facility by assigning a counselor who will act as client navigator to ensure same day enrollment and ART initiation and ensure active follow-up of KPs identified in community and not enrolled the same day. The counselor will serve as the liaison



between the health facility and the community and collaborate with ART nurses to ensure same day ART initiation. In this regard, KPs will also benefit from support structures at the facility level, including home visits and flexible schedules that meet their needs. At the community level, newly HIV positive KPs will be linked to the existing KP peer support group for easy follow up, tracking and linkage to facility for ART initiation.

#### 4.1.3 Retaining PLHIV on Treatment

In FY18, PEPFAR had a national average of 92% of patients enrolled in the last 12 months retained on treatment. Trend analysis over the last four fiscal years shows a steady increase in retention of individuals under 15 years old from 93% in FY15 to 99.8% in FY18. This improvement was a result of site level analysis of poor retention, which also reflected poor VL suppression. This analysis identified that adults with poor adherence, such as FSWs and their children, were at high risk of failing HIV services. These women and their children were brought back into HIV services through site-level initiatives using FSW peer support groups. In addition, HIV positive orphaned children living in the community and children in boarding schools were at high risk of failing treatment. Treatment and adherence improved through site-level outreach programs, such as home visits and greater on-site support by parents of children in boarding schools.

While PEPFAR has maintained strong retention of PLHIV 15 years and older for the last three fiscal years (females at 93%, males at 91%), age and sex analysis of FY18 data identified a gap in retention of young men 20-24 years old in Kigali, the Eastern, and the Northern provinces with rates of 84%, 72%, and 83%, respectively. In FY 2019 Q1, retention in men 20-24 years old improved in Kigali to 89%, with the Eastern Province at 75%, and the Northern Province at 71%, but decreased below 90% in the Southern Province (79%) and the Western (85%) Province. This indicates that this continues to be a priority group at risk of failing retention for focus in COP 2019. Strategies to address this include rapid patient level monitoring through CBS with detailed analysis of risk factors and demographic, clinical and behavior correlates of risk, and gender specific site level support and follow up combined with optimization of ART drug regimes.

Finally, retention in breastfeeding women in PEPFAR supported sites has steadily increased from 86% in FY16 to 97% in FY18. While this indicator was retired after FY18, PEPFAR will continue to support retention strategies in COP 2019, focusing on 20-24 year old males Kigali, the Eastern Province, and the Northern Province. PEPFAR will perform site level and patient record level data analysis to improve patient level and program outcomes. In addition, active CBS will be used to flag lost to follow up (LTFU) at the patient and program levels and will allow detailed analysis of correlates of dropout to inform strategies both to prevent LTFU and to maximally bring back patient who have left treatment.

In FY 2019, a new indicator, Treatment Mortality (TX-ML) was introduced measuring the absolute number of patients, of all patients currently enrolled, who are LTFU or dead. That indicator identifies clients as LTFU four weeks after they miss a scheduled appointment, which will trigger efforts to bring the client back into care at an earlier point. In FY 2019 Q1, PEPFAR supported sites reported 212 patients (0.2%) lost due to death and 222 (0.2%) LTFU, similar to what was reported in FY18. During this same period, however, sites also reported 285 (0.3%) patients previously LTFU being brought back into treatment due to focused site level outreach. The continued roll out of active CBS will further support site-level efforts to identify LTFU and understand reasons to inform strategies to prevent and more effectively bring patients back to

treatment. During this same timeframe, sites reported that while 1,637 new clients were put on treatment, 1,273 currently in treatment transferred to other sites, and 987 patients transferred in from other sites illustrating the high degree of patient mobility between sites.

Rwanda has adequate capacity and quality of testing to meet the VL assessment requirements for monitoring treatment. Program data indicates that VL suppression rates among PEPFAR-supported patients remain high with an overall 92%, with four provinces and the military program attaining more than 90% and Kigali at 89%.

While VL coverage in FY18 remained or improved ranging from 80% -85% across four provinces, including Kigali, coverage decreased significantly in Eastern Province from 79% in FY17 Q4 to 72% in FY 2019 Q1. Site level analysis identified 47 sites in FY17 Q4 were below 90% VL coverage. Intensive support to these sites resulted in 66% of these improving with VL coverage above 90% in FY 2019Q1. However, in FY 2019Q1, there were an additional 17% of sites which had been above 90% VL coverage in FY17 which had dropped below this in FY 2019Q1. This dynamic illustrates the need for strong partner management to constantly monitor performance and provide support to sites to maintain 90% or better VL coverage.

Given the widespread issues of VL coverage, Rwanda Biomedical Centre (RBC) led site visits in January 2019 to all VL hubs countrywide to understand the issues and gaps. Results of this exercise will inform strategies to address the gaps identified. To complement information from the VL hubs, PEPFAR is planning to do site level analysis and visit the most affected sites to understand the gaps and bridge them at the point of care. Results of this exercise indicated gaps in sample transportation (inadequate means of transport, sample processing, and overload at VL hubs) and poor documentation (improperly or omitting recording patient's results in the patient charts) at the clinics. Steps to address these gaps are already underway. National Reference Lab (NRL) will be sharing bi-weekly reports on the status of sample processing and results return to the sites, and site level mentorship through clinical mentors and lab quality corps to improve documentation prioritizing low performing sites. CDC is reviewing RBC and MOH IP work plans to support additional testing hubs and sample transportation in low coverage areas of South, East, and Kigali provinces to reduce workload. A standing subcommittee of partners in HIV response chaired by RBC has been created and will be meeting monthly to monitor the progress.

Site-level analyses for FY 19 Q1 indicate that 152 PEPFAR supported sites (79%) had VL suppression rates greater than 90%, with 39 sites at less than 90%. Age, sex, and specific population analyses indicate that children under 15 (male and female) have an overall VL suppression rate of 85%.

Comparative analyses of sites below 90% suppression in FY18 and FY 2019 indicate that 46% and 40% of sites had VL suppression of <90% in FY18 and FY 2019. It should be noted that these are not the same sites and deeper analysis indicated that 32 out of previous 44 sites in FY18 improved to >90% suppression, 11 sites remained the same while 26 dropped back from those originally with >90 suppression. This indicates the dynamic nature at the sites level influenced by many factors in spite of strong site-level mentorship. The team has developed a package of interventions to introduce at sites with low-level VL suppression.

In FY 2019 Q1, PEPFAR supported site-level visits and an adolescent symposium to identify weaknesses contributing to low VL suppression. Results from this works show that the lack of

age-specific support groups to enhance adherence, inadequate monitoring for support groups activities, and the absence of flexible hours that suit age and gender specific categories all contribute to low VL suppression. In addition, students in boarding schools and children with no parents or born to non-adhering parents, including FSWs, have low VL suppression.

PEPFAR will support strategies that address these gaps, including improved documentation/ electronic transfer of lab results to patient records within EMR, using computers in facilities to facilitate use of digital systems, including the LIS by site staff, tracking patient appointments using electronic medical records (EMR) and analysis within the active CBS system and appointment registers for ART and VL scheduling. In COP 19, more attention will be put on non-suppressing PLHIV to improve retention and limit new HIV transmission. Supplement to the strategies highlighted above for all PLHIV (phone calls, peer educators, home visits), supportive strategies to track and retain non suppressing PLHIV will include community peer support being implemented under DSDM where PE will conduct home visit to group of PLHIV assigned to them, specific clinic and support group sessions where by all non-suppressing PLHIV will be hosted by a social worker and discuss issues and find solutions pertaining to non-suppression. PEPFAR IPs will focus on recovery of PLHIV lost to follow-up through phone calls, peer educators, home visits, and enhanced adherence support for those who are not virally suppressed. In addition, PEPFAR will support the capacity building of health care providers in tracking samples and results for all eligible patients. Finally, the clinical monitoring and mentorship program will strengthen site-level use of HIV patient level and laboratory paper and electronic information systems, for recovery of loss to follow up and will provide training on intensive adherence support for patients with low VL suppression rates.

#### **4.2 Prevention, specifically detailing programs for priority programming**

##### **4.2.1 HIV prevention and risk avoidance for Adolescent Girls and Young Women and Orphans and Vulnerable Children**

In Rwanda, the policies related to the wellbeing of OVC are captured in two national documents: the Integrated Child Rights Policy (ICRP) and the National Strategic Plan for HIV/AIDS (NSP). The ICRP serves as the comprehensive child policy framework that addresses the rights and needs of children in the country.<sup>32</sup> This document also ensures coordination and consistency in interventions across various thematic areas and ministerial mandates. The NSP outlines social mitigation objectives that are important to OVC and their families: 1) ensure economic opportunity and security of PLHIV, 2) protect OVC targeting school attendance greater than 85% in the 10–14 year old age group, and 3) reduce stigma and discrimination.

The OVC program in Rwanda is implemented by four partners: one international non-governmental organization (NGO), Global Communities (implementing Twiyubake), and three local civil society organizations (CSOs), Francois-Xavier Bagnoud (FXB) (implementing Turengere Abana), African Evangelistic Enterprise (AEE) (a faith-based organization implementing Ubaka Ejo), and Caritas Rwanda (a faith-based organization implementing Gimbuka). In FY18, the IPs

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<sup>32</sup> The policy aims to strengthen families, provide a family environment for all children and ensure universal access to education and health services. It emphasizes children's participation; protection from abuse, violence and exploitation; priority for children without discrimination; and accountability of GOR and non-State actors to ensure the respect and human rights of children.

met their targets, serving a total of 121,237 OVC against the target of 121,229 (100%). In FY18, the OVC program reached 72,587 OVC under the OVC\_HIVSTAT indicator, including 54,580 self-reported negative (75%), 16,825 unknown (23%), and 1,182 positive (2%). Out of the 16,825 unknown, a total of 7,804 were OVC with test not needed (i.e, they were not at risk and no HIV test was required) and 9,021 with other reasons (54%). For the latter category, the IPs encouraged parents/guardians to have their children tested and the students take an HIV test during school vacations. The IPs with lower performance on this indicator learn from the more successful IPs. The IPs hold regular learning/exchange sessions to ensure the HIV risk assessment is conducted, to ensure HIV testing is targeted by OVC, and to strengthen the referral/linkage system. OVC found HIV positive and not on ART were immediately linked to treatment.

In COP 2019, the OVC program in Rwanda will continue its implementation in all five provinces in the 13 districts that were identified as having the highest HIV prevalence and highest number of Most Vulnerable Children (MVC). IPs will be more engaged with the structures of the National Council of Persons with Disability (NCPD) to ensure that enrollment of new beneficiaries includes vulnerable children and adolescents with disabilities.

In COP 2018, the OVC program is reaching 92,600 OVC beneficiaries in all five provinces, 13 districts, and 123 sectors. In COP 2019, the program will continue implementing in those districts, targeting 98,878 OVC beneficiaries, including 33,284 females [54%] and 45,107 males [46%]. This also constitutes a total of 63,105 OVC under 18 [64%] and 35,773 OVC aged 18 and above [36%]. In COP 2019, there will be an increase in OVC targets for local IPs (AEE, Caritas, and FXB) in their existing districts; while Global Communities, the international NGO IP will have decreased targets. This means that Global Communities will not enroll any new OVC beneficiaries in their program in order to facilitate the transition of OVC programming to local partners. In addition to the OVC\_SERV indicator, the OVC program in COP 2019 is targeting 100% coverage of all OVC\_SERV under 18 (84,814) for OVC\_HIVSTAT and aims to reach 100% linkage to treatment for those self-reporting positive.

Continuing in COP 2019, OVC partners will track and monitor findings under the OVC\_HIVSTAT indicator. Beneficiaries who self-report “unknown” status for “other reasons” will be followed-up to ensure the HIV status of all beneficiaries is known among those potentially at risk for HIV. Seroconversion among OVC beneficiaries under age 18 will be monitored by observing the number of beneficiaries moving from a negative or unknown status to a positive self-reported status.

The OVC program will continue to implement an integrated case management approach and the services provided will continue to include access to health services, child protection, HIV and violence prevention and response, household economic strengthening, food security and nutrition, water sanitation and hygiene (WASH), education support, parenting support, and psychosocial support. In COP 2019, the OVC program will have an intensified focus on sexual Violence against Children and Youth Survey (VACYS) findings, the OVC program will integrate comprehensive sexual violence and HIV prevention programming into the existing curriculum, with a special focus on 9-17 year olds and sexually active boys and young men. Learning from the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program, the OVC program will emphasize on the benefits of delaying sexual debut and addressing consent issues. It will also mobilize communities and families on prevention of other forms of violence.

The strategic approaches in COP 2019 will be 1) focusing on prevention of HIV and sexual violence among 9-17 year olds; 2) targeting most vulnerable children by including specific OVC subpopulations that are at risk of HIV (including children living with and/or exposed to HIV, children living with an HIV-positive adult, children at heightened risk of HIV infection, children at risk of or who have experienced sexual violence or other forms of violence, children with disabilities, children especially adolescent females at risk of transactional sex, children who have lost a parent due to AIDS, and children of key populations); 3) enhancing systematic linkage/referrals through MOUs between IPs and health facilities and by continuing to use community volunteers to better link with clinical services, support adherence and facilitate access to services for hard to reach populations; 4) continuing to conduct HIV risk assessment among children and adolescents under 18; 5) coordinating DREAMS and OVC interventions to ensure comprehensive HIV and sexual violence prevention programming; 6) increasing coordination with government local initiatives/home grown solutions such as *Friends of the Family/Inshuti z'Umuryango*, *Parents' evening fora/Umugoroba w'Ababyeyi* in the implementation of some program components.

#### 4.2.2 DREAMS Programming

In COP 2019, Rwanda will continue to implement a DREAMS-like program integrated into its OVC platform. The aim of the DREAMS integration is to prevent HIV transmission among AGYW by empowering them to make informed decisions about their sexual health and wellbeing through a holistic and layering of services approach. The DREAMS-like program will target 32,269 AGYW in five districts, including the three districts of Kigali (Gasabo, Kicukiro and Nyarugenge), Nyanza in the Southern province and Rwamagana in the Eastern province. The geographic prioritization is based upon districts with the highest HIV prevalence among young women, highest teen pregnancy and sexual violence rates and the highest number of Most Vulnerable Children (MVC).

In COP 2019, the DREAMS Implementing Partners (IPs) will continue conducting joint work planning, harmonizing approaches and tools, and holding regular reviews of implementation for quality work and efficiencies. While COP 2018 funding did not allow for full district coverage, the DREAMS-like program will see both target increases and geographic coverage expanded at the sector level. COP 2019 DREAMS services will cover the entire districts of Nyanza, Rwamagana and Gasabo, all of which are served by local partners. Global Communities (the international NGO) will add three sectors in each district of Kicukiro and Nyarugenge. This will bring the coverage to 17 sectors out of 20. In Kicukiro, Twiyubake will implement DREAMS in 8 sectors (out of 10), whereas in Nyarugenge they will implement in 9 sectors (out of 10). Kicukiro and Nyarugenge are not at complete geographic coverage because of COP 19 budget constraints as well as the program's efforts to meet the target of routing 70 percent of funding to indigenous partners. As a result of this expansion, the DREAMS IPs will cover a total of 54 sectors (out of 57 sectors in those five districts). However, for adolescent girls and young women who are FSWs or children of FSWs, the geographic coverage will be open to the entire district to account for the mobility of FSWs. As in COP 18, the DREAMS-like program will target 1,000 male sexual partners of AGYW in COP 2019. The male partners will be identified through different community platforms and referred for HTS services and VMMC.

In COP 2018, IPs are planning to collect data for the new indicator, AGYW\_PREV. In COP 2019, there are no targets for AGYW\_PREV, however the partners will continue to collect data on this

indicator to show service layering in DREAMS using unique identifiers tracked through DHIS2. This will count AGYW if they are enrolled in DREAMS and have completed the full DREAMS primary package of services/interventions or have completed the full DREAMS primary pack of services/interventions and at least one secondary service/intervention. The roll out of this system is well underway in COP 2018, and the team will be able to collect data for the AGYW\_PREV during SAPR 2019.

In COP 2019, implementing partners will continue strengthening their partnership with Disabled Persons' Organizations (DPOs) to ensure that DREAMS outreach workers are educated on Persons with Disabilities (PWDs), and that necessary modifications are made (disability-sensitive programming) to ensure that layered services are accessible to AGYW with disabilities.

A growing body of evidence suggests that people with disabilities are more likely to experience factors that put them at higher risk of HIV infection than people who are not disabled. In addition, there is a misconception that people with disabilities are sexually inactive or unlikely to use drugs or alcohol, which has resulted in them being left out of HIV programming.<sup>33</sup> The evidence clearly demonstrates that adolescent girls and young girls with disabilities face greater discrimination, have less access to education and health services, experience a lower degree of independence and have less developed communication skills and lower self-esteem.<sup>34</sup> These factors combine to make them significantly more vulnerable to the risk of HIV infection. Living with a disability is one of the criteria for enrollment in the Rwanda DREAMS program.

The total number of DREAMS-like program beneficiaries will include 910 eligible adolescents that will be drawn from the OVC program in the four DREAMS districts. These, plus 31,359 AGYW from outside the OVC program, will receive an enhanced needs-based and age-appropriate package of services consistent with the DREAMS program. The package of services will be tailored to three AGYW age bands (10-14, 15-19 and 20-24) and include violence prevention and post-violence care, HIV and STI prevention, youth-friendly sexual and reproductive health care, household economic strengthening, social asset building, community mobilization/norms change and retention of girls in school. The majority of the DREAMS beneficiaries (85.5%) will be adolescents aged 10-19. The Rwanda Violence Against Children and Youth Survey (VACYS) 2014 results showed that 25.9% of females aged 13-24 had experienced sexual violence in the last 12 months. We also know that sexual violence and HIV prevalence are highest among young women aged 20-24. Targeting adolescent girls under 20 years old, therefore, is intended to provide them with the necessary support and equip them with knowledge and skills before they reach the most vulnerable stage of their life. The program will also continue to support AGYW who have survived sexual and gender-based violence. Using the VACYS findings, the OVC/DREAMS partners will move to include other forms of violence. This will require strengthening the referral/linkage system to ensure the AGYW are protected and closely followed up. The mentors at safe spaces and other community volunteers will need to be more empowered on the prevention and response of violence; this will be a focus in COP 2019.

In COP 2019 implementation, the OVC and DREAMS programs will co-plan to ensure the tools, approaches, and services are well coordinated. The OVC/DREAMS partners will make sure that they are reaching and enrolling the most at risk AGYW within DREAMS districts. Learning from the two years of DREAMS implementation, the refinement of the selection criteria will be based on AGYW's concrete needs and risk factors. In COP 17 and 18, the IPs used selection criteria such

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<sup>33</sup> UNAIDS 2014, "The Gap Report: People with Disabilities."

<sup>34</sup> United Nations, 2011, "The State of the World's Children."

as school dropouts, gender-based violence cases, and teen motherhood. These criteria are well aligned with the subpopulations outlined in the COP 19 guidance.

In COP 2019, the DREAMS-like program will continue to address AGYW's HIV risk by layering evidence-based interventions implemented by the four OVC/DREAMS IPs. The four IPs will carry out the same set of interventions except condom distribution, which will be done by FXB and Global Communities (its local partners DUHAMIC ADRI and YWCA). In sites where faith-based organizations are unable to distribute condoms, a local social marketing organization, Society for Family Health (SFH), will coordinate with them in order to ensure the availability of free condoms to AGYW.

As previously mentioned, the DREAMS program will not expand geographically in terms of districts but will increase the number of sectors within the existing districts. At this time, there are no plans to cease any specific interventions within the DREAMS core package; but IPs will manage shifts in terms of age to ensure the age appropriate package of services is consistently provided to AGYW.

Rwanda plans to increase programming for preventing sexual violence and HIV transmission through avoiding risk among 9-14 and 15-17 year olds. Since preventing sexual violence is already a focus, PEPFAR will work within the established channels to coordinate services and avoid duplication. Through the provision of sexual and reproductive health and rights (SRHR) and life skills education, IPs respond to sexual violence prevention and response using the GOR approved curriculum and training manuals. Also, the GOR has made progress to include oral PrEP in the national guidelines for specific populations. Since AGYW are not one of those specific populations, the DREAMS-like program plans to advocate further with the GOR to include specific AGYW in the national policy and operational guidelines going forward. Initial conversations around expanding populations eligible for PrEP will start within the national prevention TWG and progress to the MOH.

Overall, between the OVC and DREAMS programs, Rwanda will reach 130,237 beneficiaries, including 98,878 who will receive OVC services and 31,359 DREAMS-like services across 14 districts (overlapping in four districts of Rwamagana, Nyarugenge, Gasabo and Kicukiro). Both programs will continue to coordinate with PEPFAR counterparts and other partners in order to ensure the availability of age appropriate and youth-friendly services.

Finally, for sustainability purposes, the OVC/DREAMS program is well underway in moving investments to indigenous partners. In COP 2019, 70% of PEPFAR/Rwanda's OVC/DREAMS budget will go to local partners SFH, Caritas, FXB, and AEE. Global Communities will continue to build the capacity of the three local partners in terms of Monitoring Information System (MIS) in order to ensure successful tracking and reporting. PEPFAR Rwanda plans for further transition to local partners in COP20 and beyond in order to facilitate country ownership and achieve sustained epidemic control.

#### 4.2.3 Children

Improved early infant diagnosis (EID) turn-around time from greater than 60 days to less than 14 days coupled with the introduction of POC testing and testing through PMTCT services, as well as

improved index family testing, will increase HIV testing coverage for children. In addition, children will be reached through DREAMS and OVC linked testing services. High-risk youth will be identified through DREAMS and KP testing strategies. Voluntary medical male circumcision (VMMC) testing will reach sexually active young males ages 15 and above. The potential for improving access to HIV testing services for “street children” with reportedly higher HIV, STI and tuberculous (TB) prevalence, 8%, 7% and 9%, respectively, will be explored with MOH and the National Commission for Children (NCC).

#### 4.2.4 Key Populations

Key populations (KPs) in Rwanda include FSWs and MSM. Results from recent studies have informed KP and priority population (PP) strategies.<sup>35</sup> Preliminary results from the population size estimates (PSE) among FSW in Rwanda in 2018 indicate that the FSWs median estimate is at 13,138 with a confidence interval of 8,277 – 22,919. The 2015 FSW IBBS show FSWs have a 46% national HIV prevalence (55% in Kigali) compared to a national adult prevalence of 3%. While more than 90% of FSWs report having been tested for HIV, only 78% report being on ART. Only 47% of FSWs reported using condoms consistently with both paying and non-paying sexual partners. The preliminary results of the 2018 MSM PSE and BSS in Kigali indicate that the MSM population size is estimated to be 8,411 (6,760 – 11,151) in Kigali and the HIV prevalence was estimated at 9.2% (95% CI: 6.28 – 12.11). This contrasts with the results from the 2015 MSM BSS in Rwanda that reported MSM having a prevalence of 4%, not statistically significantly different from that of the general age matched male population. However, 42% of MSM reported transactional sex, and those engaged in commercial sex for more than two years had prevalence almost three times greater than those engaging in commercial sex for less than two years (4.4% vs. 1.4%, respectively). Multiple factors such as stigma, high mobility, and limited sources of stable income provide challenges to effective prevention and treatment interventions.

Incidental information indicates there may be a significant population of older MSM who are challenging to reach as they may be married and do not self-identify as MSM. This was suggested by the 2018 MSM BSS preliminary results which indicate that 14% of the recruited MSM were of 30 years and above. In FY 2019, efforts are being made to reach this group through MSM networks and associations, in addition to partner notification services. In addition, efforts will be made during COP 2019 to reach additional KPs, such as “VIP” FSWs, older MSM, and male sex workers.

The package of services for KPs includes community voluntary counseling and testing (VCT) and mobile HIV testing, home based testing (self-testing), index/partner and family testing, risk reduction counselling (retesting every 12 months or following any risk of exposure), linkage to peer education services, linkage to care and treatment services, STI education, screening and treatment, VMMC, condom and lubricant distribution and promotion, family planning counselling, TB screening and treatment and referral for hepatitis screening and vaccination. Health care providers will continue to gain skills through the capacity building and mentorship on provision of KP friendly services to reduce KP barriers to HIV prevention and treatment services.

PEPFAR will align COP 2019 activities with both MER 3.0 indicators and Rwanda’s NSP to support the GOR goal of a three-fold reduction in new infections and achieve epidemic control. During

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<sup>35</sup> FSW PSE 2018, FSW IBBS 2015, MSM PSE & IBBS 2018, DHS 2015 and RAIHIS 2014.



COP 2019, to maximally interrupt HIV transmission, PEPFAR will reach 19,701 KPs, including 17,973 FSWs and 1,728 MSM with testing, prevention, retention, and adherence services, reflecting a reduction from semi-annual to annual provision of services to known clients. To achieve this, PEPFAR will scale up proven methods of high yield community VCT and mobile testing strategies targeting KPs in hotspots of high burden areas, combined with increased efficiency of linking HIV positive KPs to treatment in health facilities, as well as military locations. Testing strategies include 1) index/partner and family testing, 2) recency testing, 3) self-testing, 4) community VCT and mobile testing in hotspots, 5) referrals from active and retired KP peer educators, and 6) referrals by private and public health facility serving hotspots. Furthermore, case finding among KPs in COP 2019 will be done through annual testing of KPs, focused active case finding using social and sexual networks, high risk and KP youth referred for testing through DREAMS and OVC, and data use for quality improvement through monthly KP implementing partner coordination meetings to find program efficiencies and best practices. PEPFAR prevention partners will be required to develop MOUs with local health facilities to strengthen linkage of HIV positives to treatment, as well as to coordinate increased support and follow up for retention and drug adherence.

With the support of PEPFAR, in COP 2018 a phase one PrEP program started in Kigali targeting 1,450 FSWs and 350 sero-discordant couples of which the HIV positive partner is not virally suppressed. However, the arrival of PrEP drugs in country was delayed to December 2018, and the preliminary results of the initial phase will be available in FY 2019 Q4. A training of trainers and healthcare providers was also conducted in November 2018 with PEPFAR support. In COP 2019, PEPFAR will continue to implement a PrEP program through all three PEPFAR prevention IPs in 10 selected health facilities in high burden areas of Kigali targeting 1,250 FSWs and 200 MSM at high risk of HIV acquisition, and 350 sero-discordant couples of which the HIV positive partner is not virally suppressed. High risk FSWs and MSM will be identified using a standardized screening tool measuring partner numbers and condom use. Eligible FSWs will be recruited through all the PEPFAR partners working with KPs, as well as through DREAMS and OVC partners. Eligible MSM will be recruited through one PEPFAR partner working with MSM. Eligible partners of discordant couples will be recruited by PEPFAR-supported MOH clinics in Kigali through ANC and ART services. PrEP will be administered to KP beneficiaries and followed up by non-MOH PEPFAR KP partners and by MOH for discordant couples. KP prevention partners will work closely with health facilities to make sure that the clients initiating PrEP adhere to treatment and are re-tested every three months.

With MOH coordinating all HIV program partners working with KPs, MOH central level prevention data will be tracked through monthly, joint prevention/treatment data review meetings identifying challenges, and best practices to inform program strategies, in line with the national KP strategy addendum to the national HIV strategic plan. National program implementation will be measured through monthly and quarterly data review and coordination meetings with MOH, Ministry of Defense (MOD), and all PEPFAR and GF prevention and treatment partners involved in KP services. New hotspot identification will be crucial to continue informing the program directions. In COP 2018 and COP 2019, results from the 2018 MSM and FSW size estimates, IBBS, and the 2018 RPHIA will be essential to refine and strengthen program strategies. Current international partners will continue to provide capacity building to local entities, including MOH to ensure transition of KP program activities and facilitate the transfer of effective prevention methodologies. PEPFAR partners as well as other IPs will use a UPID code with the KP booklet in order to reduce data duplication and match patients across sites and

systems, thereby maximizing standardized data collection procedures while ensuring the quality of the data collected.

PEPFAR will strengthen partner management through monthly data reporting and partner meetings to review achievements, identify challenges, and problem solve. Quarterly partner meetings will be held to review projected and actual expenditures against program achievements reflected in approved work plans. Semi-annual data quality assessments (DQAs) and site visits will be carried out for all PEPFAR- partners supporting KP services to ensure quality of services and data collection and reporting. Corrective action plans will be developed as needed.

#### 4.2.5 VMMC

During FY18 PEPFAR-supported 156,377 VMMC procedures which is 160% of the FY18 annual target at PEPFAR-supported sites. Even with this over achievement in FY18, the NSP objective of 66% national coverage of males aged 15-59 was not achieved by the end of 2018. However, with the PEPFAR investment for VMMC in COP 2019, PEPFAR will prioritize investments in VMMC by focusing the 200,000 VMMC service targets on males aged 15-29 and contribute to achieving 67% national coverage by end of FY 2020 in the priority age bands 15-29.

VMMC targets for COP 2019 were developed using new data on geographic distribution of unmet need as well as consideration of the anticipated unmet need within the “youth bulge.” Various strategies will be used to help achieve COP 2019 targets, including targeting high HIV prevalence and low circumcision coverage areas, targeting high-risk individuals, continuing VMMC service delivery in Kigali due to high HIV prevalence, shifting services to 80% for surgical versus 20% for PrePex, and strengthening VMMC demand creation (specifically for surgical circumcision) for ages 15-29. Strategies to reach older men with VMMC services include adopting flexible hours and offering VMMC services and/or demand creation at sporting events, Car-Free days (where large groups of Rwandan men gather for health-related sports activities), and monthly community work (*Umuganda*). VMMC IPs will improve privacy, use interpersonal communication to improve service uptake, assure linkage and referral from other PEPFAR services, and strengthen linkage of PLHIV to care and treatment.

There is growing evidence that people with disabilities are at increased risk of HIV infection. Working with disabled people’s organizations (DPOs), DOD, in partnership with MOD and MOH, will increase demand creation for VMMC targeting PWDs aged 15-29 years of age through focused radio campaigns and outreach campaigns during the MOD’s “Army Week” program. In collaboration with PEPFAR prevention and OVC partners, HIV negative persons with disabilities will be actively linked to VMMC services.

To limit high numbers of young boys between 10 – 14 years of age coming for VMMC services, demand creation for VMMC carried out through focused radio campaigns and sensitization targeting primary school aged boys has been discontinued and currently focuses on young men aged 15-29. The VMMC program will use both PrePex and surgical devices, target military populations and new recruits, and reach men aged 15-29 at highest risk, including those linked from DREAMS programming, clients of FSWs, males in discordant relationships with HIV-positive partners, and males attending STI clinics.

Partners will reach beneficiaries leveraging youth centers, existing community meetings such as, *Umuganda*, and other community activities. MOD will carry out enhanced VMMC programs through its health outreach program, “Army Week,” in collaboration with MOH and through intensified national radio campaigns. All PEPFAR prevention and OVC partners will link HIV negative male beneficiaries with VMMC services.

The GOR has prioritized early infant male circumcision (EIMC) as a long-term HIV prevention strategy, and, since 2010, has been receiving funding from UNICEF to implement the national EIMC program. EIMC is included in the national Strategic Plan for VMMC. Cross-training with PEPFAR IPs in VMMC occurred from 2015 to 2018; to date, the program is implemented in 11 health facilities and approximately 3,000 EIMC procedures have been completed. MOH plans to scale up EIMC, focusing first on district hospitals.

#### **4.3 Additional country-specific priorities listed in the planning level letter**

Prior to COP 2019 implementation, a number of key policy and/or guideline changes will be put into effect by the GOR, which will support the smooth implementation of COP 2019. To assist all PLHIV in Rwanda (including KPs and PPs as well as PWD who might face barriers in accessing HIV services), GOR integrated same-day ART initiation into national HIV guidelines and will offer same-day ART implementation at the site-level. Further support at the site-level to ART providers will continue to ensure that no incidental barriers to the provision of same-day ART occur due to providers’ misunderstanding of the guideline.

In COP 2019, GOR agreed to take full financial and management responsibility of all facility-based HIV testing with the exception of index testing, recency testing, and early infant diagnosis.

Further aiding all PLHIV in Rwanda to expand access to the differentiated service delivery model (DSDM) and multi-month prescribing/dispensing (MMP), the MOH has revised the definition of “stable patient” to include those patients who have a VL at 200 copies/ml (rather than the higher threshold of 20 copies/ml) and will now include children under two years old in this definition. With the definition change in “stable patient,” Rwanda will work to move toward six month clinical visits (rather than quarterly) and six month ART pick-ups (rather than monthly) to a greater number of “stable patients.” from three months to six months, contingent on a positive outcome from a patient satisfaction assessment being carried out in FY 2019. DSDM and MMP is useful to persons with disabilities who might have physical barriers in reaching a facility.

In addition, GOR agreed in COP 2019 to implement the integration of HIV services into routine outpatient services, starting first in the low volume sites to assess impact on quality of services before scaling nationally. GOR also agreed to transition from carrying out recency testing at the nine VL laboratory regional hubs to POC recency testing to provide same day test results to health care providers and clients in COP 2019.

During COP 2018 implementation, Rwanda will move toward full TLD transition, which was agreed to by GOR at the COP 2018 Regional Planning Meeting (RPM) in Kigali, Rwanda (February 27 – March 3). This includes offering TLD to women of child-bearing age. Changes in procurements and revisions to the national supply plan will ensure that the TLD transition occurs during COP 2018/FY 2019 and will begin before COP 2019/FY 2020 implementation. MOH has

agreed to destroy all remaining stocks of Lamivudine/Nevirapine/Zidovudine (LNZ) by September 2019. In addition, MOH has agreed to support an optimized anti-retroviral treatment plan with the following transitions in COP 2019:

<b>NRTIs</b>	<b>Current Proportion</b>	<b>After transition</b>
TDF based	73.91%	83.07%
AZT based	11.85%	0%
ABC based	14.23%	5.93%
<b>NNRTI/INSTI</b>	<b>Current proportion</b>	<b>After transition</b>
NVP based	38.51%	0%
EFV based	61.41%	53%
DTG based	0.08%	46%

National scale up of key programs to support epidemic control in Rwanda will continue in COP 2018/FY 2019 implementation to support the full, national scale up of self-testing, recency testing, and index testing, including partner notification services and family testing.

In FY 2019, COP 2018/FY 2019 phase 1 for training and provision of TPT for clients who are new on ART will be launched in July 2019 with a full implementation for all new ART clients by January 2020. PEPFAR is working with the MOH to ensure that those most at risk, such as those with known low CD4 cell counts or patients who were hospitalized for HIV-related conditions, are prioritized rather than limiting TPT to new PLHIV on ART. By mid-COP 2019, TPT provision will be expanded to those high-risk cases (based on historical data) who are already on ART. Rwanda projects to have offered TPT to all eligible clients by January 2021.

Implementing partners are managed and informed of key programmatic directives and quarterly data through monthly meetings where the PEPFAR team reviews strategies and approaches and shows challenges through data. During quarterly IP meetings, budget execution rates are reviewed against work plan objectives and MER indicators. Throughout the year, SIMS visits occur to ensure successful remediation of any low performing SIMS scores. Annually, IPs review their programmatic and financial progress reports and revise work plans to ensure alignment with COP priorities.

Rwanda is currently developing a new health financing strategy, offering a timely opportunity to codify the roadmap in a national document. The Rwanda PEPFAR country team has also begun discussions with the US Treasury and USAID headquarters economists to provide technical assistance. The Rwanda team has requested that the US Treasury support the flow and monitoring of donor resources through country financial systems and advise GOR on revenue generating taxes and that USAID headquarters economists provide support to cost HIV services at the health post level. The latter could result in adding HIV services to a public-private partnership and non-HIV USG investments in sustainable health posts that increase Rwandans'

geographic access to care. In COP 2019/FY 2020, the Sustainable Financing Institute (SFI) will support the development of a roadmap for domestic resource mobilization for HIV services in Rwanda (see Section 6, *below*).

## 4.4 Commodities

PEPFAR, in collaboration with the GOR and GF, has identified four critical priorities for PEPFAR commodity procurement and management in COP 2019: (1) accelerate national ART optimization for both adult and pediatrics (inclusive of the TLD transition), (2) finalize and refine the roll-out of multi-month prescribing/dispensing (MMP/D), (3) provide commodity support to case finding, and (4) facilitate patient data triangulation.

In COP 2019, PEPFAR's commodity planning strategy reflects the changes needed to support sustained epidemic control. The program will continue to supply ARVs to maintain and excel the gain in the second and third 95s, reagents and consumables for HIV testing including Rapid Test Kits (RTKs), for VL and early infant diagnosis, TPT medicines and diagnostics, and condoms. Additionally, PEPFAR will continue to support national priorities for commodity data collection, analysis, and use through existing platforms such as the Rwanda Coordinated Procurement and Distribution System (CPDS), the Procurement Planning and Monitoring Report for HIV (PPMR-HIV), as well as regular stock status reviews between the GOR, PEPFAR, and other donors.

In COP 2019, PEPFAR will procure the following prevention commodities: condoms (branded and generic), ARVs for PrEP, and VMMC kits. There will also be procurement of RTKs, self-testing kits, and recency kits. RTK procurement will be significantly reduced to accommodate the new strategy for targeted case finding and index testing. Recency testing commodities procured with funds during COP 2018 will be sufficient to cover recency test kit needs in COP 2019. Additionally, PEPFAR will procure and provide an estimated 24,726,330 male condoms to Rwanda's national program through the Central Condom Fund with 25% bilateral COP 2019 matching funds.

In FY18, Rwanda did not experience any delivery delays or stock-outs that resulted in or caused patients to stop treatment. As a result, the stockout rates for tracer HIV commodities was on average less than 2%. PEPFAR's procurement agent in Rwanda has made valuable improvements in on time deliveries (OTD) over time. The OTD FY 2019 Q1 was 90%. In COP 2019, the PEPFAR procurement agent will continue to ensure a high rate of OTD and prevent stock outs from occurring and will maintain the current minimal stock out level of less than 2%.

### 4.4.1 Accelerate National ART Optimization

To accelerate the introduction of better, less expensive ART for HIV patients in Rwanda, the GOR is leading a national transition to the fixed-dose combination of tenofovir 300mg/lamivudine 300mg/dolutegravir 50mg (TLD). The transition is expected to be completed by August 2019, and details will be finalized through 2019 based on discussions among national TWGs. As a result, the proportion of patients – both new and those on legacy ARVs using a dolutegravir (DTG) based regimen – will be 95% and the remaining 5% will be on efavirenz (EFV) plus two other ARVs. Eligible PLHIV are all adults male and boys including those weighing >20kg, women of childbearing age who choose DTG based regimen after being informed of available ART options and associated risks. TLD/DTG containing regimen started in August 2018 for drug naïve eligible (newly enrolling) patients. March to May 2019 will be the biggest push in the TLD transition; all eligible patients will be transitioned from their current regimen to TLD. The current drawdown of lamivudine-nevirapine-zudovudine (LNZ) lasts until March 2020; however, a disposal plan was developed to end LNZ and nevirapine (NVP) by September 2019. PEPFAR has ordered

replacement TLD for those patients transitioning off the NVP-based regimens earlier than originally planned.

Planning for the TLD transition has included a comprehensive review of consumption trends for ARVs and laboratory supplies, current national stock status, supply plans, quantities currently on order, and ART regimen mix and proportions. The review used Rwanda's national program minimum and maximum stock levels and the COP 2019 timeline to determine resources required. The national program inventory maximum for ARVs (and other HIV medicines) is 14 months, while the minimum is 9 months. The supply plan and quantities on order for both the Rwandan Medical Products Procurement Division (MPPD) (supported with GF funding) and the PEPFAR IP were also reviewed.

To support the management of the TLD transition in Rwanda, a comprehensive forecasting tool has been developed for the monitoring and tracking of ARV inventory levels and service demand. This tool is considered a "dynamic document" and will be continuously edited and updated. The tool will allow USG to provide regular monthly updates of the transition progress; monitor the drawdown of legacy stock; and identify when, how, and why a new procurement of TLE400 would be needed (between the transition start and the point at which TLD is fully available for Rwanda). In COP 2019, a report will be developed to summarize the transition process.

#### 4.4.2 Finalize/Refine Roll-Out of Multi-Month Prescribing/Dispensing (MMP/D)

In COP 2018, PEPFAR Rwanda supported the roll-out of MMP/D. Initially, the eligibility criteria were <20 RNA copies/mm<sup>3</sup> which resulted in slow patient enrolment, where only 45% of eligible patients enrolled. In July of 2018, the enrollment criteria were revised to <200 RNA copies/mm<sup>3</sup> which resulted in the achievement of 60% of eligible patients enrolled by the end of year 2018. In COP 2019, PEPFAR will support the GOR to achievement their target of 85% enrollment of eligible patients.

#### 4.4.3 Commodity Support for the COP 2019 Revised Case Finding Strategy

In COP 2019, the budget for procuring RTKs will be reduced to align with the index testing strategy to achieve more targeted yields and program efficiency. PEPFAR will collaborate with the GOR to review historical RTK forecasts as compared to consumption rates in order to improve the regular and consistent availability of RTKs within the national program and site level implementation. PEPFAR will also work with GOR to review clinical testing protocols and RTK consumption versus targets to ensure targeted testing is adequate to implement the national testing strategy and meet RTK needs.

#### 4.4.4 Utilization of Commodities Data for Patient Data Triangulation

In COP 2019, PEPFAR will continue to work to better integrate commodity procurement, inventory, and distribution data into program planning. The sharing of national inventory data – particularly that of product consumption rates – and planned shipments of product across the relevant stakeholders is a key to program effectiveness and long-term sustainability. Reviewing data both within the supply chain planning forums, as well as within the national care and treatment forum, will provide another view of the program to ensure positive patient outcomes.

This is particularly important for COP 2019 and the TLD transition as all patients within the national program will be directly impacted.

#### **4.5 Collaboration, Integration and Monitoring**

COP 2019 is building on the achievements to date and the vision of Rwanda's NSP. It is expected that the Rwanda Population HIV Impact Assessment (RPHIA) results will support the recent EPP Spectrum to show that Rwanda has reached HIV epidemic control. PEPFAR's COP 2019 priority is maintain epidemic control and continue to strengthen the HIV cascade of care in Rwanda with a focus on all three pillars of the UNAIDS's 95-95-95 goals. Age and sex disaggregations along the HIV cascade indicate challenges in community VL suppression among 15-24-year olds, predominantly in male populations (<60%), and great variation across provinces with the Eastern province as low as 57% and 73% for males and females, respectively. Development and implementation of strategies to address case finding and VL suppression and coverage will be coordinated through the national prevention technical working group (TWG).

The national TWGs will coordinate and standardize implementation guidelines and reporting tools for all partners working in the national HIV response. In addition, MOH will coordinate joint partner and reporting and data review through monthly and quarterly partner/stakeholder workshops to review results, identify challenges, and share best practices. Emphasis will be placed on existing gaps to identify how implemented strategies are addressing them. The MOH clinical mentorship program supported by PEPFAR at both the central-and site-levels will be a critical cornerstone to effective implementation, monitoring, and continuous improvement of initiatives throughout the country based on the lessons learned in FY 2019.

In COP 2019, all USG agencies will continue to strengthen partner management, building on COP 2018 processes. As part of Continuous Quality Improvement (CQI) plans agencies will have regular monthly meetings with IPs to ensure continued alignment of implementation strategies with COP 2019 strategic objectives, review achievements against work plans, and identify challenges and best practices. CQI activities for index testing as a priority case finding intervention is already underway implemented by MOH and CDC with TA from a CDC IP in five Kigali sites. The CQI framework and integrated clinical mentorship model based on index testing initiatives will be strengthened to a broader platform for other HIV service delivery initiatives and scaled up to all PEPFAR supported sites in FY 2020. Partners implementing new or improved initiatives will receive monthly site-level monitoring and mentorship with monthly data reporting. All agencies will carry out quarterly partner meetings reviewing achievements against projected work plan achievements and program targets. Achievements will be measured against projected and actual expenditures as both a measure of progress and to prevent potential over-spending. In addition, partner progress will be tracked through SIMS visits, integrated USG and MOH site visits, and quarterly PEPFAR data result reviews.

CDC, USAID, and DOD IPs will continue to collaborate closely to ensure strong referral linkages between partners to ensure all key and priority populations, such as FSWs, MSM, AGYW, and OVC receive a comprehensive package of prevention and treatment services across the cascade of prevention, testing, treatment, retention, drug adherence, and VL suppression services. In addition, CDC and DOD prevention partners will continue to collaborate with MOD and MOH to achieve VMMC targets.



The prevention and care and treatment TWGs will coordinate with partners to improve identification, linkage, and retention to ensure VL suppression of all positives to treatment, with a focus on those most vulnerable to loss to follow up, such as FSW and MSM, through stronger coordination of MOH facilities with referring partners to strengthen referral/counter referral processes, stronger group specific peer/support groups, and stronger follow-up for those lost to treatment. The implementation of active CBS for active case finding coupled with the national UPID will strengthen linkages between testing and treatment and to provide the data necessary to continuously track the HIV epidemic from case finding to viral suppression. COP 2019 will support implementation of these strategies to improve linkage to treatment and close the current national ART coverage gap of 13,957 to reach the second 95. Finally, PEPFAR will initiate semi-annual prevention data quality assessment across the seven PEPFAR-supported prevention (KP/PP/OVC/DREAMS) IPs.

In COP 2019, PEPFAR will support policy and guideline modifications to support the implementation of minimum HIV treatment priority interventions including TLD transition, TPT, and six-month prescribing/dispensing. The TLD transition for COP 2019 focuses on transitioning all eligible PLHIV including women of child-bearing age based on the opt in/opt out strategy grounded in a women-centered approach. The national TWG has met and submitted technical recommendations for approval in which all women of childbearing will be informed of and supported to make an informed choice. Scale up of TLD will increase the number of patients virally suppressed, “stable,” and eligible for MMP under DSDM.

TPT is an important aspect of routine HIV care and treatment but has not been scaled widely for PLHIV in Rwanda. After multiple discussion in COP 2017, implementation will start in the last quarter of COP 2018 under a phased approach with only new PLHIV initiated at five district hospitals and 85 health clinics. PEPFAR is working with the MOH to prioritize the provision of TPT to those most at risk rather than only new PLHIV. Wide scale up is scheduled to start in January 2020; by the end of COP 2019 implementation, TPT services will begin expansion to all PLHIV, with the goal of providing TPT to all eligible PLHIV in care by the end of COP 2020.

PEPFAR will support ART optimization and support MOH to review and address specific gaps identified in retention among adolescents and young adult (15-24 years old) males and females, as well as low VL suppression rates among the same age group, with particular attention to male non-adherence. Strategies to address gaps in the above sex and age brackets are already underway in COP 18. For example, PEPFAR supported adolescent symposium in February 2019 to understand concerns specific to this age group. Age appropriate strategies were developed to address concerns identified in this symposium including stigma and discrimination (common in boarding schools), providers attitudes, inadequate patient education, delayed ART transition that complies with change in age and lack of adolescent friendly services. Strategies to address these concerns that are underway are: development of HIV adolescent model/program that defines adolescent friendly services, multisectoral involvement, site level staff mentorship and age and sex appropriate support groups to enhance retention. Implementation of CBS and a national UPID will greatly facilitate site-level and individual patient-level analyses of retention, drug adherence, and viral suppression.

Leveraging previous PEPFAR investments in information technology, the CBS system is integrating a previously developed electronic health record systems (EMR), health information exchange systems, and routine data collection systems (RHMIS) to help to develop an effective

HIV active case finding and longitudinal case surveillance system. Human Resources for Health (HRH) initiatives continue to support central HRH cost-effective training systems for continuous HIV in-service training and leverage the PEPFAR above-site e-learning platform. In addition, PEPFAR will continue to support the MOH centrally managed site-level monitoring and mentoring program to improve HIV clinical, laboratory, and strategic information service delivery.

COP 2019 supports continued improvements in laboratory quality and turn-around-time, with a focus on rapid test continuous quality improvement and reduced early infant diagnosis (EID) and VL suppression turn-around time including VL/EID optimization and enhanced monitoring with more 80% access to annual VL testing and reporting to ensure reductions in morbidity and mortality across age, sex, and risk groups.

PEPFAR will continue to collaborate with the GOR and the World Health Organization in Rwanda, which is assisting in the accreditation of the National Reference Laboratory (NRL) to ensure adequate laboratory quality management and continuous quality improvement systems are in place for sustained quality of testing in the national laboratory network for HIV and TB Programs. The systems will also enable NRL to inform national policy and implementation strategies for new laboratory technologies such as POC testing initiatives. In addition, PEPFAR is coordinating with the GOR to provide technical assistance on the feasibility of public private partnerships (PPP). For example, Abbott Diagnostics is conducting a feasibility study on a cost recovery business model focused on long-term sustainability of laboratory services, and Labs for Life is looking into a PPP with Becton Dickinson to support a step-wise approach of laboratory CQI in the laboratory network toward meeting national and international quality standards.

To ensure sustainable quality HIV care in light of anticipated declining donor resources, in COP 2019 will support the fully integration of HIV services into routine outpatient services to improve efficient use of clinic space, reduce stigma among patients living with HIV, and reduce unnecessary and redundant steps in the patient process. In COP 2019, the integration model will be developed and implemented in the low volume selected sites. PEPFAR in collaboration with GOR will monitor the impact of integrated model to inform its national scale up.

#### 4.6 Targets for scale-up locations and populations

<b>Entry Streams for ART Enrollment</b>	<b>Tested for HIV (APR FY 2020) <i>HTS_TST</i></b>	<b>Newly Identified Positive (APR FY 2020) <i>HTS_TST_POS</i></b>	<b>Newly Initiated on ART (APR FY 20) <i>TX_NEW</i></b>
Total Men (15+)	20,436	1,928	1,218
Total Women (15+)	25,574	2,418	1,338
Total Children (<15)	11,983	446	444
Total from Index Testing	34,693	2,358	-
<b>Adults</b>			

Key populations	24,270	1,578	7
<b><u>Pediatrics (&lt;15)</u></b>			
HIV Exposed Infants	2,189	-	-

**Table 4.6.2 VMMC Coverage at 100% saturation based on DHS (2015) and Targets by Age Bracket in men 15-29 years by province**

SNU	Target Populations (15-29 age band focus)	Population Size Estimate (SNUs)	Current Coverage (FY18)	VMMC_CI RC* (in FY 2020)	Expected* Coverage (in FY 2020)
Kigali	22,000	200,342	130,117	154,085	77%
East	57,000	430,027	222,286	286,707	67%
South	49,000	421,708	213,981	257,514	61%
North	37,000	279,756	137,264	190,749	68%
West	35,000	399,385	235,800	278,273	70%
<b>Total</b>	<b>200,000</b>	<b>1,670,086</b>	<b>939,448</b>	<b>1,167,328</b>	<b>Average: 70%</b>

\*Assuming targets for FY 2019 and FY 2020 are met

\*\* Expected coverage in percentage are at 100% saturation level of the 2019 projected population size estimate in men 15-29 years

**Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY 2020)	FY 2020 Target
FSW (KP_PREV)	13,714 (8,853 - 23,495)	78%	17,973
MSM (KP_PREV)	8,411 (6,760 - 11,151)	26%	1,728
AGYW 15-24 (PP_PREV)			21,149
<b>TOTAL</b>			<b>40,850</b>

**Table 4.6.4 Targets for OVC/DREAMS and Linkages to HIV Services (FY 2020)**

SNU	Estimated # of Orphans and Vulnerable Children	Target # of Active OVC (FY 2020) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known (OVC_HIVSTAT)
			<18
Kigali City	44,336	41,180	26,515
Eastern	131,300	23,681	16,749
Southern	233,917	22,059	14,042
Northern	133,641	21,845	13,612
Western	177,425	21,472	13,896
<b>Total</b>	<b>720,619</b>	<b>130,237</b>	<b>84,814</b>

- Estimated number of OVC is from National Commission for Children (NCC)/Most Vulnerable Children Database, 2014, mostly based on economic vulnerability.
- Total OVC/DREAMS - OVC\_SERV include 31,359 DREAMS and 98,878 OVC.
- OVC\_HIVSTAT includes 21, 709 DREAMS and 63,105 OVC <18.

**Table 4.6.4.a COP 2018 DREAMS-like Expected Results**

Implementing Partner	Province	Outside OVC	From OVC	Total DREAMS
AEE & Global Communities	Kigali	16,081	493	<b>16,574</b>
Caritas	Eastern	6,009	417	<b>6,426</b>
FXB	Southern	5,000	-	<b>5,000</b>
<b>Total</b>		<b>27,090</b>	<b>910</b>	<b>28,000</b>

**Table 4.6.4.b DREAMS-like Program Targets by Age Band (COP 2019/FY 2020)**

IP/Mechanism	Province	District(s)	10-14 Yrs	15-19 Yrs	20-24 Yrs	Total targets
AEE/Ubaka Ejo	Kigali	Gasabo	2,203	2,515	1,433	6,151
Caritas/Gimbuka	Eastern	Rwamagana	2,691	3,885	230	6,806
FXB/Turengere Abana	Southern	Nyanza	1,957	3,010	690	5,657
GC/Twiubake	Kigali	Kicukiro; Nyarugenge	4,150	7,123	2,382	13,655

#### 4.7 Cervical Cancer Program Plans

PEPFAR does not currently implement cervical cancer activities in Rwanda.

#### 4.8 Viral Load and Early Infant Diagnosis Optimization

PEPFAR is working to ensure efficient use of VL and EID testing instruments to provide more than 80% access for all eligible PLHIV to annual VL testing. PEPFAR also continues to use the reporting structure to reduce morbidity and mortality across age, sex, and risk groups; improve documentation of VL/EID results into patient records; and increase IT infrastructure and personnel computer skills at the site level. In COP 2018, RBC and MOH increased the number of VL testing hubs in the Southern, Eastern, and Kigali provinces to optimize VL testing coverage. MOH also decentralized the sample transportation system and monitored patients at the site level to ensure that those patients who were eligible for VL testing had a documented result in their medical records.

COP 2019 will continue site level support to maintain and improve access to the LIS and enhance patient tracking using CBS and EMR to monitor site level VL coverage, suppression events, and continuous laboratory quality improvement for optimum specimen management and timely return of results. In COP 2018, all VL testing hubs included a functional LIS that manages patient sample and test results information which is then connected to a web-interface application that provides remote access to healthcare providers at the site level. Integration of LIS data on VL testing is incorporated in a dashboard at the site level to support monitoring and tracking of sample registrations, testing, and the return of results to sites.

Review of FY 2019 Q1 data indicated a significant decrease in VL coverage in the Southern Province from 76% in FY18 Q4 to 72% in FY 2019 Q1. Joint analysis with the MOH National Reference Laboratory identified challenges at both the Eastern Province regional testing hub and

site level utilization of VL test results received through the LIS, where results were not being transferred from the laboratory registers to patient records at sites. COP 2019 aims to increase VL coverage in the Eastern Province and across all sites through improved district level management, improved laboratory/clinical interface at site levels, and enhanced site and district level trainings to improve LIS end-user capacity.

Currently, early infant diagnosis (EID) testing performed using the spoke and hub approach for timely service provision. In 2017, EGPAF, with support from UNITAID, piloted POC EID with the placement of 22 instruments (AlereQ) at high ANC volume sites. EGPAF will transition this project to the Ministry of Health in 2019. In COP 2019, the EID testing network will be optimized and fully integrated to ensure there is no deficiency in EID testing capacity and to ensure reduced conventional testing at VL testing hubs in order to facilitate same day testing and linkage to treatment of HIV-infected infants under the ANC program tested through POC.

GeneXpert instrument capacity for TB testing among PLHIV is well established at high volume sites including hospitals and selected health centers in PEPFAR supported sites to support confirmatory TB testing. TB Xpert CQI started in COP 2018 and will be continued in COP 2019 to ensure quality assurance of TB Xpert testing. However, GeneXpert CQI is not currently considered for use in POC testing for EID testing.

## 5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

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**In COP 2019, PEPAR will focus its program activities in five provinces of Rwanda (Kigali, Northern, Southern, Eastern, and Western) with each of these designated for scale-up to saturation, implementing scale-up activities as described in Section 4 of the SDS (see above).**

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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### 6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Rwanda has made considerable progress in finding, diagnosing, treating, and achieving viral suppression among people living with HIV (PLHIV). Assuming that Rwanda Population-Based HIV Impact Assessment (RPHIA) data will show that Rwanda has reached epidemic control, PEPFAR will now focus on building the systems necessary to reach and sustain epidemic control in Rwanda.

Rwanda has enjoyed progress in its HIV program and management of the country's HIV and AIDS response; however, challenges remain. Preliminary PHIA results and program data analysis are expected to suggest that systems support is critical to expand case finding and reaching the gap of

unmet need. Systems support is important as Rwanda shifts from achieving epidemic control to building a sustained public health response to HIV/AIDS.

PEPFAR's above-service delivery investments continue to align with strategies designed to improve site-level programmatic challenges – particularly to identify new sources of infections, link them to treatment and bring the remaining undiagnosed PLHIV into the cascade of care and treatment. COP 2019's systems investments will focus on targeted approaches in commodity security and supply chain, service delivery, health care worker capacity improvement, health information systems, quality management and laboratory to support HIV case finding, reduce the incidence of new infections and sustain epidemic control.

In COP 2019, PEPFAR will build on intensified efforts in COP 2018 that work to close programmatic gaps to sustain epidemic control:

1. Improve systems to ensure supply chain management capacity and commodities security
2. Continue investments in the existing HIV workforce, quality improvement for service delivery, improve resource efficiencies as Rwanda focuses on reaching new positives through case finding, linking them to treatment, retain adherence to retention, and increase the number PLHIV with suppressed VL
3. Enhance patient and population-level systems to emphasize HIV prevention activities, promote HIV case finding, index testing, improve linkage to treatment, increase viral suppression and ensure efficient and effective public health response
4. Evolve monitoring systems to measure impact of PEPFAR investments, support data-driven decisions to achieve epidemic control and strengthen continuous quality improvement of programs
5. Continue to improve laboratory infrastructure, CQI, monitoring systems for transportation, specimen referral and test results between lab and sites

The following sub-sections will describe targeted approaches to address programmatic gaps, outline benchmarks and outcomes and discuss leveraging systems by MOH where applicable.

### **6.1.1 Improve Systems to Ensure Supply Chain Management Capacity and Commodities Security**

In COP 2019, PEPFAR's supply chain systems strengthening strategy will focus on four key areas. First, the transition of USG-led commodity procurement and delivery to Rwanda Medical Service Ltd (RMS). Second, leveraging USG pharmaceutical services and Rwanda FDA investments. Third, improving the electronic logistics management information system for better decision-making. Fourth, ensuring the proper implementation of ART optimization and continue the scale up of TLD and multi-month prescribing/distribution (MMP/D).

During COP 2018 and COP 2019 implementation, PEPFAR will support the transformation of the Rwanda Medical Products Procurement Division (MPPD) to a parastatal organization – Rwanda Medical Supply, Ltd (RMS). Currently, Rwanda is in the final stages of establishing, funding, and operating the commercial parastatal entity, RMS.

The establishment of RMS will improve the national supply chain system by ensuring availability of essential medicines through a streamlined procurement and distribution process, increasing



inventory oversight and traceability of commodities from central level to the customer, and improving consumption data capturing. USAID will be directly funding RMS Ltd. for in-country logistics and 40-50% of ARV procurement, with an initial focus on TLD. USAID is currently in negotiations with Rwanda Biomedical Center (RBC) and finalizing the new MPPD/RMS procedure manual, as well as developing the RMS Detail Costed Business Plan to align with the GOR's vision. USAID will begin direct funding to RMS Ltd. during COP 2019 implementation, with an aggressive plan to transition all commodity procurement from GHSC-PSM and GHSC-RTK to RMS within the implementation of COP20. During this transition process, PEPFAR Rwanda will rethink and revamp the internal management of commodities oversight to ensure efficiency and sustainability.

In COP 2019, PEPFAR will leverage resources from USAID's wider health portfolio to work with the Medicine Technology and Pharmaceuticals Services (MTaPS) project. MTaPS activities in Rwanda are an evolution of GHSC-PSM's work on Rwanda FDA and will be focused on product registration; adverse event reporting/pharmacovigilance and poor-quality medicine notifications; medicine safety and quality; medication error mitigation; and product recall, rational use, and related regulatory and safety matters. MTaPS will provide support to the Rwanda's newly formed food and drug regulatory authority (RFDA) to ensure evaluation, registration, and market authorization of new products or formulations (eg., TLD90, TLD180, TLE400). These activities will facilitate the institutionalization of an internal system in the following critical areas:

1. Pharmacovigilance and monitoring the safety of medicines
2. Roll out of regulatory related ART optimization plans
3. ART medication error mitigation
4. Advocacy for inclusion of patient level ART regimen data in the reporting systems
5. Establishment of drug and therapeutic committees to promote appropriate use of medicines and to contain antimicrobial resistance.

In COP 2019, PEPFAR will continue working to improve logistics data for decision-making by institutionalizing and upgrading the eLMIS, exploring the GS1 standard for tracing commodities, and increasing capacity of high-volume ART sites supply chain oversight through Quality Management Improvement Approach (QMIA). Additionally, PEPFAR will continue to implement the laboratory bundling and strengthen network capacity to manage laboratory stock, ensure proper national transition of TLD- and DTG-based regimens, provide technical assistance for complete NVP and AZT phase out, and support the national integrated Coordinated Procurement and Distribution Systems budgeting and supply planning exercises.

### **6.1.2 Continue Investments in the Existing HIV Workforce and Service Delivery Systems and Improve Resource Efficiencies as Rwanda Adopts Innovative Approaches to Find New Sources of HIV Infections, Reach New Positives, Link Positives to Treatment, Maintain Retention and Adherence while in Care and Increase PLHIV with Viral Load Suppression.**

In COP 2019, PEPFAR's above-site service delivery efforts will continue to improve systems within Ministry of Health (MOH) to maintain quality HIV service provision, identify new positives through case finding and link them to care and treatment. As Rwanda intensifies index testing, recency testing, targeted self-testing, implements PrEP and TPT, and develops policies around MMP and TLD transition, PEPFAR will support MOH to develop policies, design programmatic approaches, train health care workers and standardize systems necessary to sustain HIV services,

as well as revise existing guidelines and tools as needed based on the experience from Phase I implementation of these initiatives.

PEPFAR and MOH will revise guidelines, standard operating practices, and implementation to reflect key program directives for the national HIV program. These policies and guidelines will be focused on MMP, TLD transition and ARV optimization, and implementation of preventive TB therapy among people living with HIV (PLHIV). Guideline and tool revisions will focus on intensifying case finding, enforcing standardized national KP clinical and reporting tools, highly targeted testing through HIV risk screening, and other strategies to improve HIV diagnosis, retention and VL suppression. PEPFAR will also support and finalize the Ministry's integrated national clinical mentorship program and continuous quality improvement strategies to strengthen health care workers' ability to monitor and improve implementation processes as the Ministry's national programs are formalized. PEPFAR will continue to support cost-effective and sustainable systems to train health care worker in clinical, lab and SI to ensure quality of HIV services, especially as new modalities are implemented. PEPFAR will leverage MOH development of a central learning platform to support HIV training content through distance and remote learning so that health care workers can have timely resources to keep themselves abreast of nuances in HIV service delivery, perform clinical mentorship and evaluate implementation of COP 2019 program directives at PEPFAR-supported sites.

In COP 2019, PEPFAR will also continue to support Rwanda's National Reference Laboratory (NRL) to improve capacities of healthcare providers and other laboratory cadres to utilize electronic Lab Information (eLab) Systems (VL sample management systems, recency, ePT and SPI-RT) to ensure quality management of the lab-clinical interface. This investment is critical to establish and maintain a functional specimen referral and LIS for timely return of HIV test results for patient care and to establish human resource capacity for systems use and monitoring of laboratory services in the HIV testing network.

The goals in the investments listed above are to institutionalize systems within MOH to better improve planning, boost efficiencies and increase ownership of the HIV program as funding declines over time. The outcome of these time-bound approaches is to establish policies and mechanisms within MOH that are implemented, evaluated and refined to support evolving HIV initiatives; build the capacity of health care workers to identify, treat and manage HIV care; and promptly respond to challenges in HIV service delivery through evidence-based data collection.

### **6.1.3 Enhance Patient and Population-level Systems to Promote HIV Prevention Activities, Emphasize HIV Case Finding, Improve Linkage, Increase Viral Suppression and Ensure Efficient and Effective Public Health Response.**

PEPFAR's strategic information investments will continue to enhance site- and central-level monitoring of the epidemic. The CBS system focuses on patient-level data to inform practitioners, health facilities and the ministry. For example, information on patients' VL suppression can trigger a change in patient management at the practitioner level, can support the use of case follow-up at the facility level and the aggregate of the VL data at the central-level can inform the ministry of possible changes in the epidemic. Active CBS and Routine CBS system use a national unique patient identifier (UPID) to link patient-level data from HIV testing and treatment services, which provides more immediate access to the data needed to understand important trends for newly diagnosed PLHIV. Active CBS data can inform practitioners of: 1) who

are acquiring infections (characteristics); 2) when the new infections were acquired (recency); 3) where new diagnoses are concentrated; and 4) how new diagnoses were found on an aggregate level. Routine CBS data can inform practitioners of: 1) linkage to treatment; 2) disease progression; 3) patient adherence, and; 4) VL suppression.

PEPFAR will continue to support the development of the digital platform for case finding and patient management through surveillance in COP 2019. This initiative leverages previous investments by PEPFAR and the GOR through the adoption, adaption and application of electronic health information systems, such as the electronic medical record (EMR), currently used to support HIV treatment. The fundamental ability of electronic health information systems to exchange data increases the focus on the individual patient's health, regardless of which system has their health-related data. The joining of health-related data provides a more accurate view of the epidemic from an individual-level to national-level when the data are aggregated and analyzed. The extraction of the MER indicator data from the EMR to the Rwanda Health Management Information System (RHMS) improves data quality and timeliness of the data collected. This allows for more detailed, rigorous and timely examination of the PEPFAR indicators to monitor the national HIV program address challenges to sustaining epidemic control.

#### **6.1.4 Evolve Monitoring Systems to Measure Impact of PEPFAR Investments, Support Data-driven Decisions to Achieve Epidemic Control and Strengthen Continuous Quality Improvement of Programs.**

In COP 2018, the focus was on strengthening monitoring and surveillance activities with an emphasis on expanding key foundational systems to support case finding through active and routine public health surveillance. In COP 2019, PEPFAR will maintain Ministry's support to develop the integrated digital platform of health information systems to provide the data for monitoring programmatic activities. The focus is the development of a digital platform to identify and report health-related attributes of new and existing HIV cases; understand impact of acquired ARV drug resistance among PLHIV; and enhance Rwanda's health information exchange to improve data sharing for EMR, Lab Information System (LIS), and other systems to support monitoring of epidemic control. The capacity to conduct vital data analysis and synthesis required for HIV programmatic decisions at the central, district and facility levels continues to be strengthened.

Building human capacity to conduct data quality assessments, continuous data quality improvement activities, data analysis and use data to make decisions regarding the HIV epidemic in Rwanda continues to be a key component of sustaining epidemic control. In COP 2019, PEPFAR will continue to support health care providers to expand their epidemiological capacities in HIV surveillance and data collection. As the Field Epidemiology Training Program (FETP) is transitioning to MOH, PEPFAR will continue to provide support to train HIV epidemiologists as strategies for epidemic control require epidemiologic analysis and HIV case finding. FETP will continue to play a key role in data analysis and synthesis (at national and subnational levels) to inform timely adjustments to programmatic implementation in order to help enhance testing yields and improve quality of care and associated morbidity indicators.

To monitor the continual progress of data quality, health information systems, surveys, surveillance and capacity-building initiatives, periodic milestones continues to be strengthened to

more accurately measure progress towards achieving above service delivery investments. Interim milestones have been incorporated into project and work plans and monitored using project-tracking software as part of PEPFAR's partner management, performance and financial monitoring.

## **6.2 Improve Financial Sustainability Systems**

Rwanda has a heavy reliance on donor funding for its HIV response. While domestic contributions have been increasing, in FY 202019, the government contributed only 15% of the overall HIV response. Meanwhile, donor funding has been steadily declining, and Global Fund is likely to begin transition planning once Rwanda hits lower-middle income status. This threatens to leave a resource gap, unless Rwanda is able to increase contributions through domestic funding or private investment.

Recent successes in the PEPFAR program have transitioned Rwanda into the “Evolve to Sustain” group. For COP 2019, PEPFAR Rwanda is focused on honing the program to find efficiencies, maintain epidemic control, shift implementation towards local partners, and increase the GOR's ability to fund the response. Domestic resource mobilization (DRM) was included as a minimum requirement for COP 2019 and the PEPFAR program is expected to demonstrate annual increases in domestic funding for the HIV response moving forward.

The Rwanda Health Financing Strategic Plan (HFSP), due to be finalized in April 2019, lays out strategies to improve financing of the health sector overall. The strategy highlights the need for instituting revenue raising strategies and mentions specific innovative financing mechanisms as a way to do this but does not evaluate the impact and feasibility of these mechanisms in depth, prioritize them, or identify which have implications for HIV. The mechanisms mentioned in the strategy include health bonds, diaspora bonds, impact bonds, sin taxes (soda, tobacco, alcohol), and other earmarked taxes (on vehicles, roads, research, clinical trials). Other revenue-raising mechanisms not mentioned in the HFSP also might have potential for the country, such as earmarked taxes on infrastructure or increasing tax revenue through auditing, improved compliance or broadening the tax base.

In order to begin to operationalize the HFSP, the Sustainable Financing Initiative (SFI), working with GOR/Ministry of Finance and Economic Planning, will do the following in Rwanda:

- Development of a roadmap for Domestic Resource Mobilization for HIV for Rwanda: evaluating and prioritizing potential domestic revenue raising strategies based on their feasibility and potential for impact, including innovative financing; and defining key steps, responsible parties and a timeline for action.
- Further implementation of select elements of the Roadmap, such as thorough evidence generation/feasibility analysis/political economy analysis of one high-priority DRM mechanism; design of how to operationalize the mechanism; advocacy/TA to the GOR to launch mechanism.

## 7.0 Staffing Plan

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The PEPFAR team is comprised of staff from the PEPFAR Coordination Office (PCO) through the State Department, the Centers for Disease Control and Prevention (CDC), the U.S. Agency for International Development (USAID) and the Department of Defense (DOD). The PEPFAR team reviewed and assessed staff-to-program alignment within the context of sustained epidemic control.

PEPFAR agencies that are managing site-level data have staff skills to conduct necessary data analysis and interpretation, as well as data application for program improvement. Overall, the estimated cost of doing business (CODB), focusing on PEPFAR implementing agency-level management and operations considers a variety of factors. Agencies have anticipated increased ICASS and Capital Sharing-Cost Sharing (CSCS) rates, as well as Mission-required staff salary increases. Agencies have found efficiencies to keep the overall CODB down to accommodate lower future PEPFAR planning levels and no increases to CODB have been included in COP 2019.

The PCO will hire a new PEPFAR Country Coordinator to fill the vacancy expected during COP 2018 implementation using a US Personal Services Contracting mechanism through USAID. The position will sit in the PCO and will report directly to the Deputy Chief of Mission.

CDC currently has seven vacant positions of which five are in various stages of the recruitment process and expected to be filled by COP 2019 implementation. One position will be abolished in COP 2019 and the remaining position will be filled during COP 2019 implementation. All positions were vacated from June 2017. Filling these vacancies is critical to carrying out CDC's expanded portfolio. CDC will continue to reduce its staffing profile by eliminating positions and repurposing current staff to align with PEPFAR program priorities and maximize efficiencies. In COP 2018, CDC will abolish one existing position and three of the five positions currently under recruitment were repurposed to align with program priorities. CDC will not request any new positions in FY 2020.

USAID is requesting three new positions for COP 2019, while maintaining its currently filled positions. The first position will be a Community Health Specialist to support Rwanda's DREAMS portfolio. This position is currently under recruitment and expected to be filled before the start of COP 2019. The other two positions are a Commodities Specialist and a Contracting Specialist which will directly support the transition of procurement of commodities from the Medical Procurement and Production Division (the government-run central medical stores in Rwanda) to Rwanda Medical Supply, Ltd (a commercial parastatal entity that has been formed to take on the supply chain functions).

In order to ensure adequate staffing and proper alignment of the DOD PEPFAR portfolio, DOD has reviewed its staffing footprint to its PEPFAR workload and has no plan in increasing its staffing level (no change from COP 2018/FY 2019). DOD will still be able to carry out the necessary SIMS visits and achieve COP 2019/FY 2020 priorities.

## APPENDIX A -- PRIORITIZATION

Table A.1 Continuous Nature of SNU Prioritization to Reach Epidemic Control

Attained: 90 90 90 (81%) by Age/Sex Band to reach 95 95 95 (90%) Overall										
SNU	COP	Prioritization	Results Reported	<15 (F)	<15 (M)	15-24 (F)	15-24 (M)	25+ (F)	25+ (M)	Overall TX Coverage
<b>Kigali City</b>	COP17	Scale-Up: Saturation	APR18	48%	48%	73%	76%	97%	89%	<b>90%</b>
	COP 2018	Scale-Up: Saturation	APR19	54%	55%	76%	77%	99%	91%	<b>92%</b>
	COP 2019	Scale-Up: Saturation	APR20	67%	67%	79%	79%	98%	92%	<b>93%</b>
<b>East</b>	COP17	Scale-Up: Saturation	APR18	67%	67%	68%	70%	90%	83%	<b>85%</b>
	COP 2018	Scale-Up: Saturation	APR19	75%	76%	70%	72%	91%	85%	<b>87%</b>
	COP 2019	Scale-Up: Saturation	APR20	88%	88%	73%	73%	91%	85%	<b>88%</b>
<b>South</b>	COP17	Scale-Up: Saturation	APR18	64%	64%	60%	62%	79%	73%	<b>75%</b>
	COP 2018	Scale-Up: Saturation	APR19	72%	73%	62%	63%	80%	74%	<b>77%</b>
	COP 2019	Scale-Up: Saturation	APR20	85%	85%	66%	66%	81%	76%	<b>78%</b>
<b>West</b>	COP17	Scale-Up: Saturation	APR18	82%	83%	71%	74%	95%	87%	<b>90%</b>
	COP 2018	Scale-Up: Saturation	APR19	93%	94%	74%	76%	96%	89%	<b>92%</b>
	COP 2019	Scale-Up: Saturation	APR20	108%	108%	78%	78%	96%	90%	<b>93%</b>
<b>North</b>	COP17	Scale-Up: Saturation	APR18	54%	54%	56%	59%	75%	69%	<b>70%</b>

COP	2018	Scale-Up: Saturation	APR19	61%	62%	59%	60%	76%	70%	<b>72%</b>
COP	2019	Scale-Up: Saturation	APR20	69%	69%	59%	59%	75%	70%	<b>72%</b>
COP17	2018	Scale-Up: Saturation	APR18	63%	63%	66%	69%	88%	81%	<b>83%</b>
COP	2018	Scale-Up: Saturation	APR19	67%	67%	68%	70%	90%	83%	<b>85%</b>
<b>TOTAL</b>	2019	Scale-Up: Saturation	APR20	83%	83%	72%	72%	89%	84%	<b>86%</b>

Prioritization Area	Total PLHIV	Expected current on ART (APR FY 2019)	Additional patients required for 80% ART coverage	Target current on ART (APR FY 2020) <i>TX_CURR</i>	Newly initiated (APR FY 2020) <i>TX_NEW</i>	ART Coverage (APR 20)
Attained	--	--	--	--	--	--
Scale-Up Saturation	229,245	126,620	--	122,936	3,000	100%
Scale-Up Aggressive	--	--	--	--	--	--
Sustained	--	--	--	--	--	--
Central Support	--	--	--	--	--	--
<b>Total</b>	229,245	126,620		122,936	3,000	100%

**APPENDIX B – Budget Profile and Resource Projections**

**Table B.1.1 COP 2019 Total Planning Level**

Table B.1.2 COP 2019 Total Planning Level		
Applied Pipeline	New Funding	Total Spend
\$11,204,266	\$63,301,700	\$74,505,966

**Table B.1.2 COP 2019 Budget by Program Area**

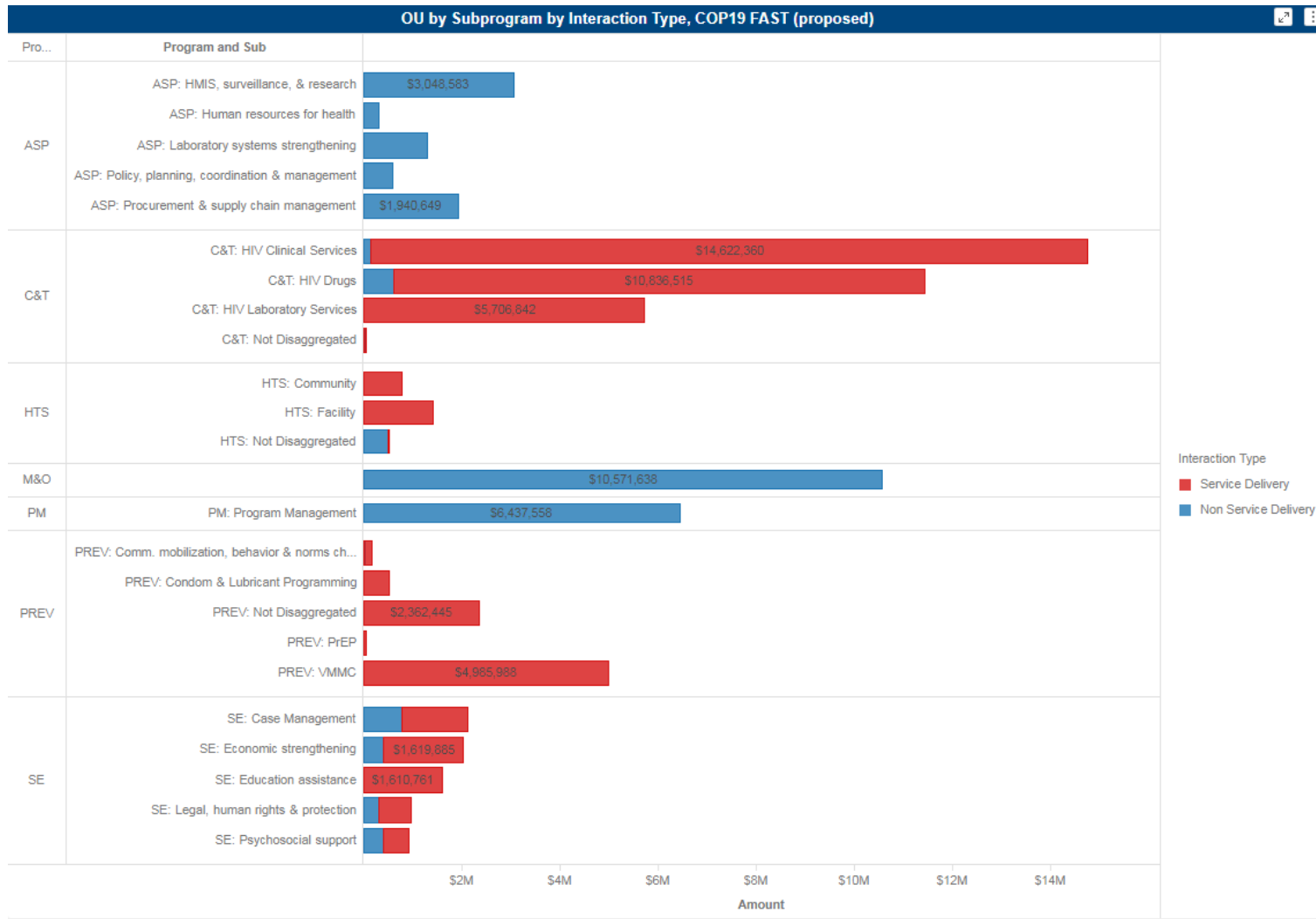
Budget by Agency	
	Budgeted in FAST Total
<b>Total budgeted in FAST</b>	\$ 74,505,966
<i>DOD</i>	\$ 4,532,074
<i>HHS/CDC</i>	\$ 36,685,778
<i>State</i>	\$ 185,394
<i>USAID</i>	\$ 33,102,719



**Table B.1.3 COP 2019 Budget by Budget Code**

Initiative Type	Fiscal Year	2020
	Budget Code	Amount
Planning Level	Applied Pipeline	\$11,204,266
	CIRC	\$7,174,308
	HBHC	\$1,402,678
	HKID	\$5,810,920
	HLAB	\$1,613,766
	HTXD	\$12,335,615
	HTXS	\$19,268,323
	HVAB	\$1,213,459
	HVCT	\$2,162,998
	HVMS	\$3,330,774
	HVOP	\$2,436,618
	HVSI	\$959,493
	HVTB	\$947,642
	IDUP	\$0
	MTCT	\$52,262
	OHSS	\$242,634
PDCS	\$1,259,777	
PDTX	\$2,890,434	

**Table B.1.2 COP 2019 Budget by Subprogram by Interaction Type**



## **B.2 Resource Projections**

COP 2019 planning focused on program-based, incremental budgeting to determine the required resources to sustain program activities. PEPFAR Implementing Agencies used prior year budgeting as a starting point and highlighted year-over-year changes to programming to determine incremental increases or decreases to budgets. Implementing Agencies provided work plans and categorized their strategic objectives into approaches to analyze if current funding and strategy were aligned and to allow for reallocation when not aligned.

## APPENDIX C– Minimum Program Requirements

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MINIMUM REQUIREMENTS	STATUS
1) TEST AND START	Complete
2) DIFFERENTIATED DSD (MMP)	Transition to 80% for COP 2019
3) TLD TRANSITION	Complete by May, 2019
4) INDEX AND SELF TESTING	Scaled up in COP 2018 and COP 2019
5) TPT	Initiate by July, 2019
6) 95% LINKAGE	Currently 92%; achievement by COP 2019
7) USER FEES ELIMINATION	N/A
8) VL/EID OPTIMIZATION	VL Coverage currently 92%
9) MORBIDITY MONITORING AND REPORTING	Incorporated into CBS plan
10) OVC SERVICE PACKAGE ALIGNMENT	Aligned
11) HOST COUNTRY COMMITMENT	Developing DRM options
12) LOCAL AND INDIGENOUS FUNDING	70% OU level funding by end of COP 2019
13) UNIQUE IDENTIFIER SCALE UP	Scaled across PEPFAR sites by end of COP 2019

## Tables and Systems Investments for Table 6

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Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 74,800	Training in laboratory systems strengthening	Inadequate epidemiological competencies required for continuous data analysis and synthesis for HIV programmatic decision making	COP18	COP19	Healthcare providers utilizing e-lab systems for patients lab testing results with support from UMB in at least 90% of PEPFAR supported sites NRL/MOH documenting 90% of patients on ART have documented VL results using VLSM and dashboard for monitoring TAT and VL suppression rates
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 81,600	Institutionalization of in-service training	Insufficient MOH systems to improve planning and increase resource efficiencies as PEPFAR support decreases and as Rwanda adopts innovative approaches to find new sources of HIV infections, reach new positives, link, treat, adhere, and maintain VLS	COP19	COP19	HIV clinical mentorship model in place for priority HIV initiatives HIV clinical mentorship tracking tool developed

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 224,400	Service organization and management systems	Institutionalize systems within MOH to better improve planning, efficiencies, and increased ownership of the HIV program in light of funding decreases	COP19	COP19	Integrated HIV service delivery model feasibility assessment complete; Phase 1 implementation in selected low volume sites
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 136,000	Clinical guidelines, policies for service delivery	Institutionalize systems within MOH to better improve planning, efficiencies, and increased ownership of the HIV program in light of funding reductions	COP19	COP19	Policies in place (developed, implemented, and revised) for MOH to plan the national HIV program and in line with PEPFAR-supported priorities

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 95,000	Forecasting, supply chain plan, budget, and implementation	Inadequate infrastructure and human resources to improve return of test results between lab and sites, and insufficient mechanisms to monitor turnaround times (TAT) of VL/EID results to ensure that patients promptly receive test results	COP18	COP20	<ul style="list-style-type: none"> <li>1) Full scale up of TLD/DTG</li> <li>2) Complete transition of NVP from both adult and pedi</li> <li>3) phaseout of LNZ from 1st line adult</li> </ul>
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 45,000.00	Training in supply chain systems	Inadequate infrastructure and human resources to improve return of test results between lab and sites, and insufficient mechanisms to monitor turnaround times (TAT) of VL/EID results to ensure that patients promptly receive test results	COP18	COP20	Implementation of lab bundling at central medical stores, in ART lab sites, and national reference lab
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 120,000.00	Product selection, registration, and quality monitoring	<p>Insufficient mechanisms to:</p> <ul style="list-style-type: none"> <li>1) Efficiently measure impact of PEPFAR investments on Treat All and new service delivery and testing models,</li> <li>2) Focus on identification of key populations, &amp;</li> <li>3) Support data-driven decisions for achieving epidemic control</li> </ul>	COP16	COP21	<ul style="list-style-type: none"> <li>1) 95% of facilities with accurate data</li> <li>2) 98% of facilities using eLMIS replenishment engine to estimate their needs</li> <li>3) Number of decisions taken by senior leadership based on dashboard analytics</li> <li>4) National product Registry in place</li> <li>5) PPMR-HIV reporting improved</li> </ul>
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 55,000.00	Forecasting, supply chain plan, budget, and implementation	Insufficient MOH systems to improve planning and increase resource efficiencies as PEPFAR support decreases and as Rwanda adopts innovative approaches to find new sources of HIV infections, reach new positives, link, treat, adhere, and maintain VLS	COP17	COP20	<ul style="list-style-type: none"> <li>1) Implementation of GS1 standards</li> <li>2) Use of barcode for track and trace of pharmaceutical products</li> </ul>



Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Chemionics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 115,000.00	Training in supply chain systems	Inadequate continuous quality improvement of HIV core and specialized tests to support epidemic control Lack of local accrediting body	COP17	COP20	1) Supply chain performance at DPs and SDP improved 2) Scale up of TLD, MMP and, phaseout of NVP 3) Improved availability of tracer commodities to over 97%
USAID	Chemionics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 55,000.00	Product selection, registration, and quality monitoring	Insufficient mechanisms to: 1) Efficiently measure impact of PEPFAR investments on Treat All and new service delivery and testing models, 2) Focus on identification of key populations, & 3) Support data-driven decisions for achieving epidemic control	COP18	COP20	1) List of MPPD prequalified suppliers with framework contract 2) Drug registration SOPs and tools implemented
USAID	Chemionics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 45,000.00	Training in supply chain systems	Insufficient mechanisms to: 1) Efficiently measure impact of PEPFAR investments on Treat All and new service delivery and testing models, 2) Focus on identification of key populations, & 3) Support data-driven decisions for achieving epidemic control	COP18	COP19	1) Track supply chain cost per functional area,2) Improved supply chain operational efficiency 3)Cost per functional area as % of total supply chain available.