



PEPFAR Rwanda

U.S. President's Emergency Plan for AIDS Relief

Country Operational Plan

COP 2020

Strategic Direction Summary

March 23, 2020

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1.0 Goal Statement

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 2020/Fiscal Year 2021 (COP 2020). All PEPFAR minimum program requirements and policies will be fully achieved prior to the end of COP 2019.

In COP20, the PEPFAR Rwanda Program will maintain the paradigm shift from COP 2019 to sustain epidemic control. The results of the Rwanda Population Based HIV Impact Assessment (RPHIA) 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.¹ COP20 builds on the results of the RPHIA; 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, COP20 slightly expands case finding strategies from COP2019, PEPFAR will support case finding in key modalities including ANC, index testing, key and priority populations. PEPFAR will continue to 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. COP20 will continue to support the strategic shift implemented in COP2019 to limited case finding focused on at risk populations.

PEPFAR will also invest in improved HIV treatment, retention, and drug adherence to support 1) continued implementation of catch up plan into COP20 to achieve targets for 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) continued rollout 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.

COP20 investments reflect support to direct service delivery and central and site-level systems investments to support MOH's public health capacity to sustain HIV epidemic control. This includes maintenance 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.

¹ RPHIA, 2019

In addition, moving forward in COP20 PEPFAR continues to support long-term financial sustainability objectives by supporting the GOR's transformation of the MOH Medical Products Procurement Division (MPPD) to a parastatal organization, the Rwanda Medical Services, Ltd. (RMS). COP20 continues to support RMS with 40-50% of all antiretrovirals (ARVs) going to RMS with PEPFAR providing budgetary support.

In COP20, PEPFAR continues to increase its funding to local and indigenous organizations in Rwanda from 73% in COP 2019 to 84% in COP20, 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

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%.² Projection from the 2012 census estimates the 2020 population at 12,663,117.³ HIV prevalence has remained stable at 3% for adults since 2005 and in 2020 there are estimated 227,904 people living with HIV (PLHIV) in Rwanda.⁴ According to RPHIA, for adults 15-64 years old, prevalence among women is 3.7% as compared to 2.2% among men. Prevalence of HIV among adolescents 10-14 years was 0.4%, corresponding to approximately 5,900 young adolescents living with HIV in Rwanda. The estimated annual incidence of HIV among adults 15-64 in Rwanda is 0.08%, representing approximately 5,400 new cases of HIV among adults per year.

As of December 2019, Rwanda had 198,658 PLHIV on ART nationally, an increase from 190,477 PLHIV on ART in 2018. At the end of 2019, ART coverage for all estimated PLHIV nationally was 87.2%.⁵ Loss to follow-up has historically been very low, at approximately 0.2% in PEPFAR-supported sites and 0.6% nationally according to data from the national reporting system, Rwanda Health Management Information System (RHMIS).⁶

Prevalence of community viral load suppression (VLS) among all HIV-positive adults 15-64 years old was 76% according to RPHIA, with 79% VLS among women and 71% VLS among men. Among women living with HIV, the prevalence of viral load suppression was found to be highest among women 35-44 (85.2%) and lowest among women aged 15-24 years (62.3%). Among men living with HIV, the prevalence of viral load suppression was found to be highest among men aged 55-64 (84.9%) and lowest in men aged 25-34 (45.9%).⁷

² 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>

³ Ibid.

⁴ HIV prevalence was 3.0% for the 2005, 2010 and 2015 Demographic and Health Surveys (DHS), as well as RPHIA 2019; National PLHIV estimates are from the 2020 EPP Spectrum estimates

⁵ RHMIS 2020; EPP-Spectrum Estimates, 2020

⁶ DATIM 2019; RHMIS 2019

⁷ RPHIA 2019; Note that estimates of prevalence of VLS among men were based on a small number of observations and should be interpreted with caution

The data from RPHIA, along with regularly monitored program data, are being used to actively target interventions and further improve viral suppression in geographic regions and facilities that are encountering challenges.

Across the country, the self-reported prevalence of medical male circumcision among men aged 15-64 was 39.9%, ranging from 30.2% in the South to 62.1% in the City of Kigali. Prevalence of self-reported MMC was highest among men aged 20-24 (56.6%) and lowest among older men aged 60-64 years (10.2%).⁸

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 \$780 per capita.⁹ Rwanda ranks 157 according to UNDP's Human Development Index in 2018.¹⁰ 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 the current COP and will continue into COP 2020.

Rwanda's HIV epidemic is generalized, with higher key population (KP) infection rates, and an urban prevalence of 4.8%, compared to a 2.5% rural prevalence.¹¹ Women have a higher HIV prevalence than men in general (3.7% vs. 2.2% nationally). For men and women aged 20-24, HIV prevalence is three times higher among women (1.8%) than men in the same age group (0.6%).¹² 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.¹³ FSWs have an estimated HIV prevalence of 45.8%,¹⁴ while MSM are estimated to have a 9.2% prevalence in Kigali.¹⁵

⁸ RPHIA, 2019

⁹ 2018, World Bank.

¹⁰ United National Development Programme, 2019 Human Development Index Ranking

¹¹ RPHIA, 2019

¹² Ibid.

¹³ UNAIDS Modes of Transmission Study (MOT) 2013.

¹⁴ Female Sex Worker Behavioral Sentinel Survey (BSS) 2015.

¹⁵ 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	12,663,117	100%	2,389,239	18.4%	2,406,678	18.6%	1,346,230	10.4%	1,311,550	10.1%	2,917,870	22.5%	2,584,200	19.9%	NISR Census Projections 2021
HIV Prevalence (%)		1.8%		0.2%		0.2%		0.9%		0.6%		4.1%		3.0%	EPPS 2020*
AIDS Deaths (per year)	2,695		166		174		142		141		1076		996		EPPS 2020*
# PLHIV	227,904		5,546		5,590		12,404		7,632		120,460		76,271		EPPS 2020*
Incidence Rate /1000 (Year)		0.42		-		-		0.9		0.3		0.6		0.5	EPPS 2020*
New Infections /(Year)	5013		231		236		1084		391		1633		1528		EPPS 2020*
Annual births	362,692	3.0%													NISR census Projections 2021
% of Pregnant Women with at least one ANC visit		99.2%		-				-				-			DHS2015 Table 9.2
Pregnant women needing ARVs	7,739														EPPS 2020*
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)	5,949	100%	226	3.8%	229	3.8%	335	5.6%	532	8.9%	1,304	21.9%	3,323	55.9%	HMIS, 2019 (TB & ORD Division RBC)
% of TB cases that are HIV infected	1,245	21.0%	18	1.4%	20	1.6%	Females 15+ = 405 (32.5%) Males 15+ =802 (64.4%)						HMIS, 2019 (TB & ORD Division RBC) <15, 15+		
% of Males Circumcised		N/A				N/A				59.2%				38.7%	RPHIA 2018
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													

*Estimates based on observations with a denominator <50 from RPHIA are included in parentheses and should be interpreted with caution.
 †Value does not include tests at ANC1 or labor/delivery (age disaggregation not available)

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression (2020)

Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (%)	On ART (#)	ART Coverage – all PLHIV (%)	Community VLS (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Source(s)	NISR 2012	RPHIA 2019; Spectrum 2020; NISR 2012	Spectrum 2020	RPHIA 2019*; Spectrum 2020	RHMIS 2020	Spectrum 2020; RHMIS 2020	RPHIA 2019*; NRL 2020; RHMIS 2020; DATIM 2020	RHMIS 2020	RHMIS 2020	RHMIS 2020
Total population	12,663,117	1.8	227,904	90.9	198,658	87.2	70.0	3,471,333	17,116	18,579
Population <15 years	4,758,933	0.2	11,135	62.1	6,914	62.1	50.0	255,007	797	635
Men 15-24 years	1,269,694	0.5	7,632	(67.5)	5,497	72.0	(55.9)	568,755	1,256	544
Men 15-49 years	3,164,780	1.8	56,868	76.6	46,621	82.0	65.7	1,152,446	5,153	5,767
Men 50+	603,467	4.5	27,036	-	24,580	90.9	70.3	127,310	592	1,409
Women 15-24 years	1,305,927	1.2	12,404	70.0	10,291	83.0	62.3	493,222 [†]	2,364 [†]	2,731
Women 15-49 years	3,353,960	3.3	103,085	85.0	90,981	88.3	78.6	1,287,478 [†]	6,759 [†]	9,359
Women 50+	781,977	3.8	29,779	-	29,562	99.3	77.2	137,533 [†]	2,325 [†]	1,409
Source(s)	2018 FSW PSE; 2018 MSM PSE & BSS Kigali; 2015 BSS	2018 MSM PSE & BSS Kigali; FSW BSS 2015	-	-	-	-	-	-	-	-
MSM (Kigali City)	8,411	9.2	-	-	-	-	-	-	-	-
FSW	13,138	45.8	-	-	-	-	-	-	-	-

*Estimates based on observations with a denominator <50 from RPHIA are included in parentheses and should be interpreted with caution.

[†]Value does not include tests at ANC1 or labor/delivery (age disaggregation not available)

Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment

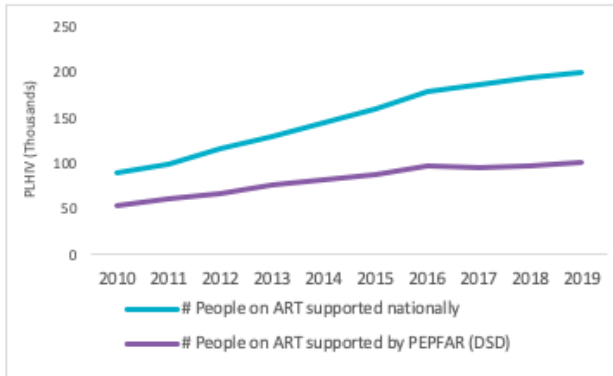


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

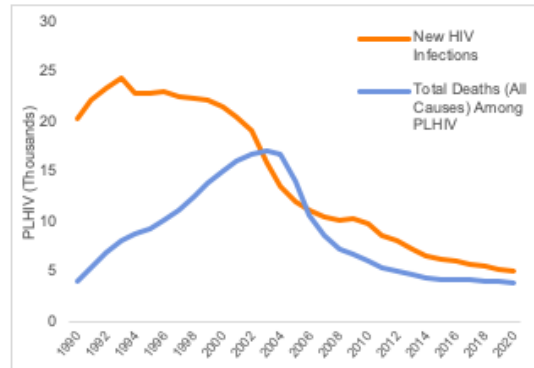


Figure 2.1.5 Progress retaining individuals in lifelong ART in FY19

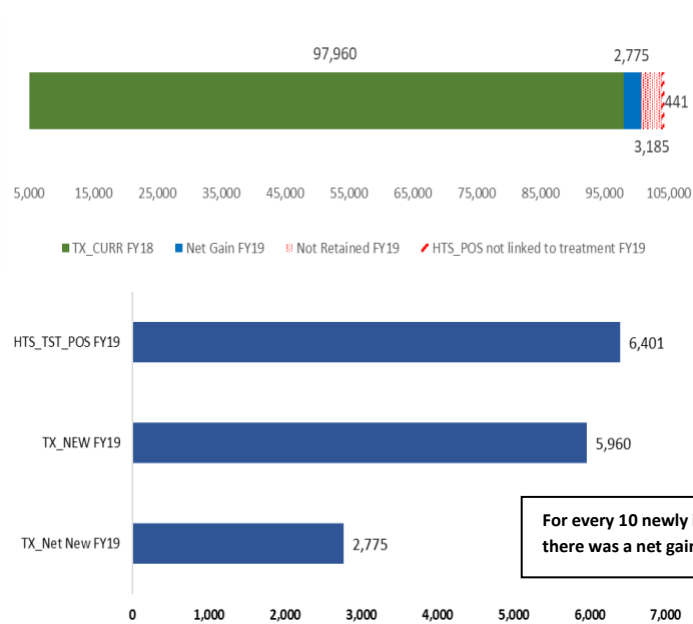


Figure 2.1.6 Proportion of clients lost from ART 2018 Q4 to 2019 Q4

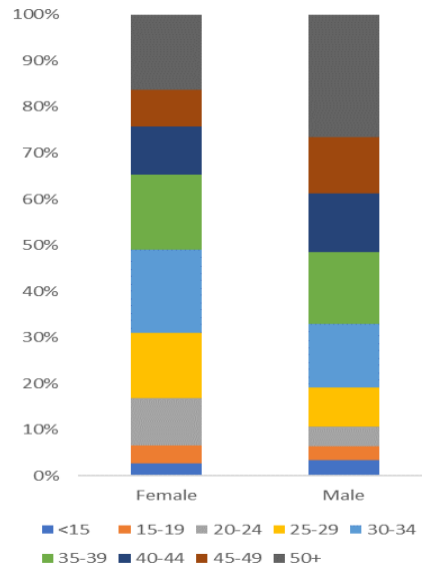


Figure 2.1.7 Epidemiologic Trends and Program Response for Rwanda

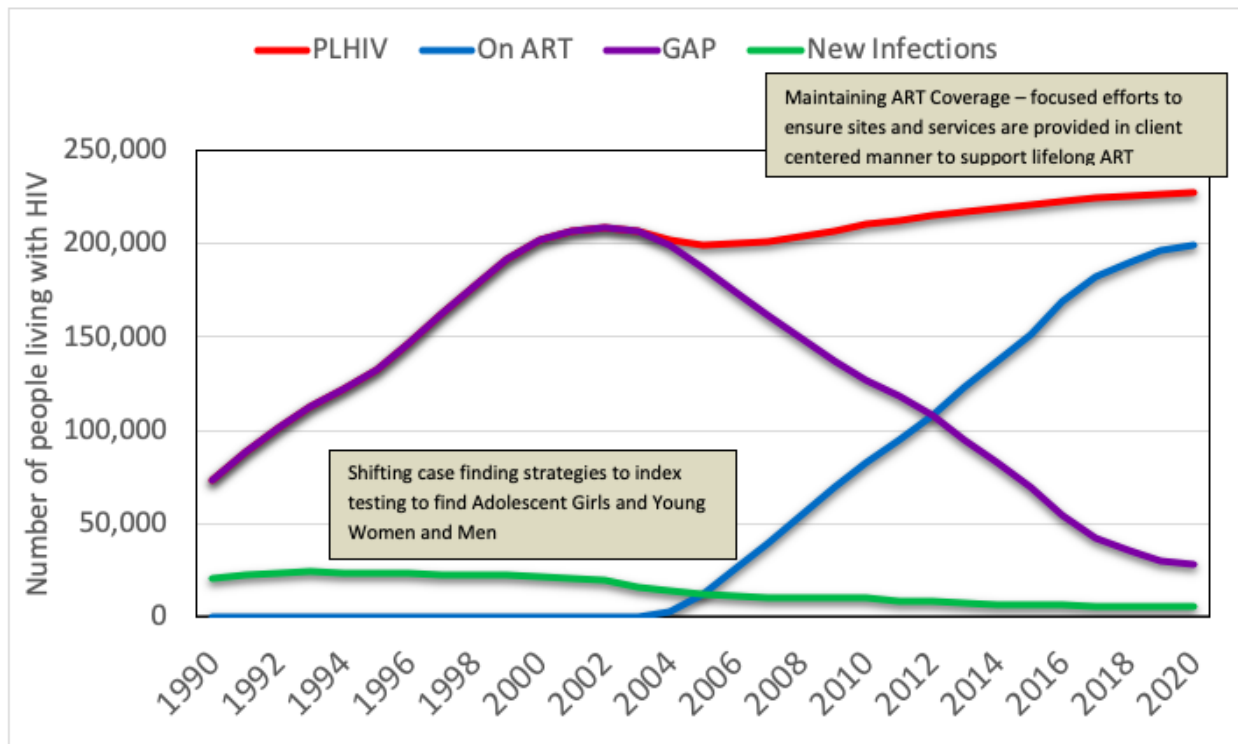
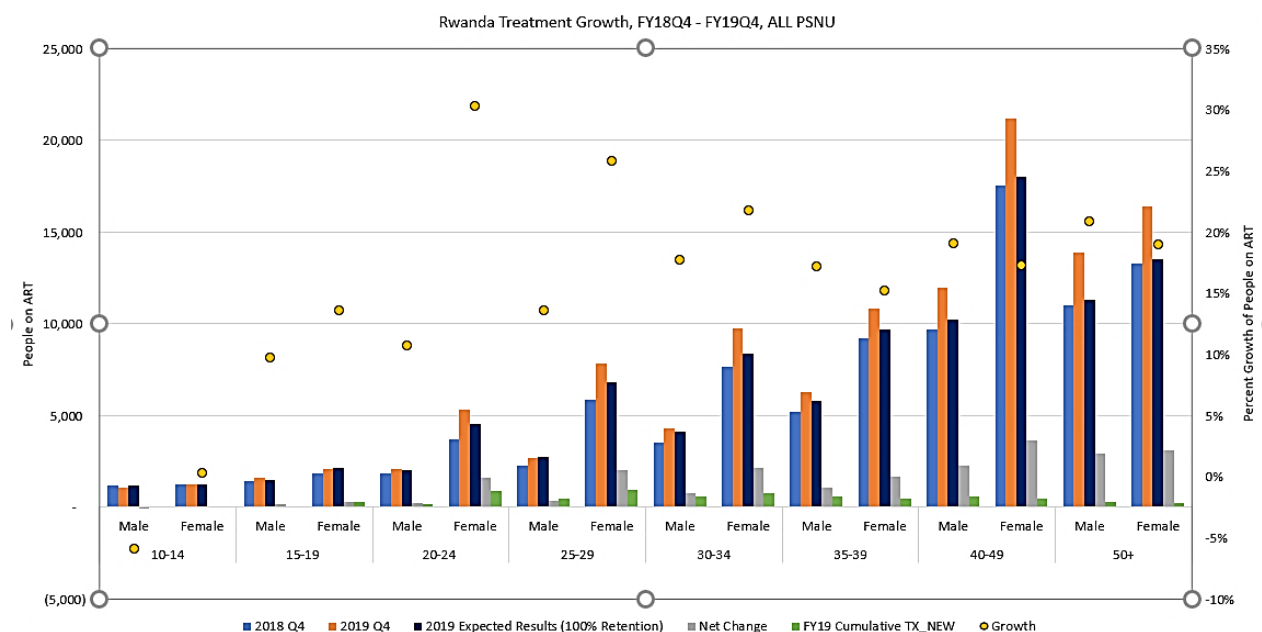


Figure 2.1.8 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

Figure 2.1.8 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4



2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

In COP20, PEPFAR will build on the achievement made in previous implementation years to ensure client centered services. Much focus will be put on patient retention as the program target to achieve 2nd and 3rd 95 in all populations and location by COP20. Until APR 18 when retention indicator was phased out, retention of PLHIV on treatment in PEPAFR supported sites had always been high to 95% compared to 92% nationally. In APR 19, the overall lost to follow up (LTFU) was 0.2% in PEPFAR supported sites and 0.6% nationally. The new TX_ML indicator shows gaps in retention with a total of 2,270 PLHIV had no clinical contact after 28 days of ART initiation. Majority of these 1,451 64% were transferred out and 619 (19%) were LTFUP/refused to come back. Nevertheless, 44% of all lost to follow up returned to treatment in the same reporting period. As a contribution to reducing national gap to 2nd 95 by COP 20, PEPFAR targets to initiate up 5,094 new PLHIV on treatment and a cumulative target of 127,581 currently on ART including TX_CURR TA in COP 20. PEPFAR DSD targets alone account for 50% of all PLHIV on treatment at national level in FY 21.

Given the PEPFAR commitment to achieve all three 95s, strategies will be implemented targeting sites with retention and viral load gaps by age, sex and geography. These strategies include; Introduction of specific group support of mothers/ caregivers/ guardians of non-suppressing children and young adolescents; Scale up of HIV Adolescent Model, targeted mentorship on age/sex and timely counselling and disclosure through child/adolescent friendly support groups, schools' involvement and linkage to OVC services. For men, PEPFAR will support male-only space/corners in clinic that ensures privacy and time, introduction of male champion clients who

provide tailored adherence and retention support to clients, dedicated non suppressing clinic days and support groups for men and enhancing a tracking and tracing missed appointments system for men and conducting quarterly review of retention and PVLS data with IPs to inform targeted site level mentorship for non-suppressing sites.

2.3 Investment Profile

In FY 19, Rwanda's HIV response was funded primarily by three sources – PEPFAR (42%), the Global Fund (GF) (43%) and the GOR (14%).¹⁶ 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 FY14.¹⁷ 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, projected investment for FY2021 is \$79.9 million.¹⁸ While GOR contribution to total HIV expenditures increased from 10% to 13% from FY15 to FY16,¹⁹ and remained at 13% in FY17, the GOR's budget allocation to HIV decreased from \$24.3 million²⁰ to \$21 million²¹ in FY18. In December 2019, Global Fund announced a 21% decrease in HIV funding for the next allocation cycle beginning in July 2021. 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 FY19 do not reflect overall expenditures for the HIV response in Rwanda due to differences in fiscal cycles (PEPFAR's FY19 was October 1, 2018 to September 30, 2019; GF's FY19 was January 1, 2019 to December 31, 2019; and GOR's FY19 was July 1, 2018 to June 30, 2019) 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.

PEPFAR and GF are working with MOH's to reduce inefficiencies to realize cost savings, secure additional domestic funding for human resources and other system costs no longer donor funded.

¹⁶ PEPFAR 2018 Expenditure reporting; Rwanda HIV Consolidated Operational Plan, 2018-2020; National HIV Annual Report, 2018-2019. Note that various sources with non-aligned time frames are used for the investment profile analysis.

¹⁷ GOR fiscal year 2015/16, July 2015 to June 2016.

¹⁸ PEPFAR COP16, COP17, COP 18, COP19 and COP20 planning level letters.

¹⁹ COP16 SDS Table 1.2.1 compared to COP17 SDS Table 2.2.1.

²⁰ Rwanda HIV Annual Report 2015-2016.

²¹ Rwanda Biomedical Center Corporate Services Division.

Significant financial barriers to achieving a sustained domestically funded HIV response in the near future remain.

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 COP20, PEPFAR will continue to increase its funding to local and indigenous organizations in Rwanda, from 73% in COP 2019 to 84% in COP20, not inclusive of the cost of doing business.

Table 2.3.1 Annual Investment Profile by Program Area²²

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country
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	\$1,500,000	80%	12%	8%
AGYW Prevention	\$8,095,210	90%	6%	4%
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%
Total	\$148,776,640	51%	36%	13%

Standard Table 2.3.2 is required; however, columns should be added to reflect other significant funders in country.

Table 2.3.2 Annual Procurement Profile for Key Commodities – COP19					
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$16,177,242	56.75%	43.25%	0%	0%
Rapid test kits	\$6,181,934	7.5%	92.49%	0%	0%
Other drugs*	\$271,063	67.8%	32.22%	0%	0%
Lab reagents	\$2,134,602	0.0%	100.00%	0%	0%
Condoms	\$186,042	98.1%	1.85%	0%	0%
Viral Load commodities**	\$5,258,888	70.1%	29.89%	0%	0%
VMMC kits***	\$82,802	100.0%	0.00%	0%	0%
MAT					
Other commodities****	\$491,604	70.95%			
Total	\$30,784,176	45.41%	54.36%	0.00%	0.00%

*Opportunistic Infections (OIs)

** Viral load & EID reagents and consumables

*** VMMC kits were procured in FY19 funds by both PEPFAR & GFATM

**** GeneXpert cartridges and TPT for HIV/TB coinfecting patients

Table 2.3.2 Annual Procurement Profile for Key Commodities – COP20						
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other	TBD
ARVs	\$34,282,645	28.92%	20.14%	TBD		50.93%
Rapid test kits	\$3,290,011	15.86%	84.14%	TBD		0.00%
Other drugs*	\$729,206	31.16%	30.39%	TBD		38.45%
Lab reagents	\$4,635,256	0.00%	67.62%	TBD		32.38%
Condoms	\$674,521	25.28%	0.00%	TBD		74.72%
Viral Load commodities**	\$2,885,340	66.15%	1.20%	TBD		32.66%
VMMC kits	\$2,108,743	52.16%	0.00%	TBD		47.84%
MAT				TBD		
Other commodities***	\$4,776,957	18.85%	0.00%	TBD		81.15%
Total	\$53,382,679	27.62%	24.47%			47.91%

*OIs

** Viral load & EID reagents and consumables

*** GeneXpert cartridge and TPT medicines for HIV/TB coinfecting patients

Note: The current Global fund grant covers up to December 2020. The total ARV budget needed is high because of the introduction of TLD90 which suggests an additional 3 months to the

national need and considering it is also a new product, based on the Government of Rwanda guidelines, stock in country to cover at minimum 9 months to a maximum of 14 months.

Per the Dec 2019 national quantification report, the FY21 HIV program commodities have an estimated shortfall of 47.91% of the national forecasted needs, see in table 2.3.2 for the selected category of commodities in the details. In addition, there is also a forecasted gap of \$1,869,842 for ready-to-use therapeutics foods (RUTF).

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID Non-HIV	\$ 46,000,000	\$ 15,642,242	5	\$34,832,277	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.
USAID MCH	\$ 10,000,000				
USAID Malaria	\$ 18,000,000				
USAID Family Planning	\$ 10,000,000				
USAID Water	\$ 5,500,000				
USAID Nutrition	\$ 3,500,000				
CDC (Influenza)		\$ 315,060			To support the Ebola response in Rwanda
CDC (Global Health Security)		\$ 115,959			Sustaining influenza surveillance networks and response to seasonal pandemic influenza by national health authorities
Total	\$ 47,000,000	\$ 16,073,261	5	\$ 34,832,277	

2.4 National Sustainability Profile Update

2019 HIV/AIDS SUSTAINABILITY INDEX AND DASHBOARD: RWANDA

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 125 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Dark Green Score (8.50-10 points) (sustainable and requires no additional investment at this time)
Light Green Score (7.00-8.49 points) (approaching sustainability and requires little or no investment)
Yellow Score (3.50-6.99 points) (emerging sustainability and needs some investment)
Red Score (<3.50 points) (unsustainable and requires significant investment)

Rwanda Overview: Rwanda has made significant and remarkable progress in reaching the UNAIDS Fast Track 90-90-90 Goals over the last 25 years. The Government of Rwanda (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 the Global Fund. 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 Government of Rwanda 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, to provide immediate treatment for PLHIV under the fully implemented Treat All program, to optimize service delivery models, and to find ways to absorb the costs of administering the national HIV program even though Rwanda is a low income country.

SID Process: The fourth of Rwanda’s SID day-long workshop was co-convened with UNAIDS Rwanda and organized jointly with GOR and the Ministry of Health (MOH) in September 2019 and was attended by more than 30 participants from more than 10 organizations working in the national HIV program. Participants included representatives from the MOH, Rwanda Biomedical Center (RBC), UNAIDS, WHO, as well as local civil society organizations and PEPFAR implementing partners’ staff. After opening remarks by PEPFAR Coordinator and the UNAIDS Country Representative for Rwanda, the participants broke into four groups around each of the domains and jointly answered the questions and provided source data and notes for the final 2019 SID. After the day-long meeting, the 2019 SID was circulated among participants and further feedback was incorporated into the final 2019 SID.

Sustainability Strengths: All 2019 SID domains were identified as sustainable, approaching, or emerging sustainability with notable strength in the domain “Governance, Leadership, and Accountability.”

- **Public Access to Information (8.33, light green):** This score reduced from 9.00 to 8.33 from SID 3.0 to 2019 SID due clarifications in the reporting schedule. The GOR widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges toward achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, etc.) related to HIV/AIDS. Information is readily available on GOR websites. GOR reports internally on a quarterly basis but the reports are made public on an annual basis (one later than one month following the close of the fiscal year).
- **Quality Management (7.76, light green):** Because quality improvement (QI) and quality management (QM) is integrated in the national health budget and significant improvements in QI/QM has occurred since SID 2.0, SID 3.0 shows a much stronger quality management system in Rwanda.
- **Financial/Expenditure Data (9.17, dark green):** Rwanda maintained the Financial/Expenditure score from SID 3.0 to 2019 SID. Rwanda continues to provide consistent quality expenditure

reporting data through upward reporting from MOH's decentralized structure, and through the Ministry's Health Resource Tracking System

Sustainability Vulnerabilities:

- **Technical and Allocative Effectiveness (5.56, yellow):** Technical and allocative effectiveness remains a vulnerability to the sustainability of the Rwandan HIV response. There is limited domestic budget to fund the HIV program, and donor funding, including PEPFAR funding, is reducing. Both PEPFAR and Global Fund have invested substantially in Rwanda's HIV response, and both funding sources are reducing at a significant pace and rate. Nearly 50% of PEPFAR funding and all GF support are delivered through the government, which demonstrates the high capacity of the GOR and MOH systems. However, the lack of domestic resources continues to pose a challenge to the long-term sustainability of the national HIV response when donor funding has reduced.
- **Epidemiological and Health Data (6.18, yellow)** Epidemiological and health data are collected, analyzed, and made available to the public in some cases, including size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, limited data on viral load and AIDS-related mortality rates. Surveys and surveillance activities are conducted to measure both general population and key populations, but the Government provided minimal funding for these activities.
- **Data for Decision-Making Eco-system (6.33, yellow)** The Government of Rwanda has demonstrated commitment to advancing the use of data to inform government decisions and cultivate an informed, engaged civil society. The capacity and use of existing and nascent systems are still in varied stages of development. The main reason that this score is not higher is the lack of a nationally rolled out unique identification system in Rwanda, though the system is in development and is planned for full implementation by September 2020

Table 2.4.1: Summary of Sustainability Index and Dashboard results

		2015 (SID 2.0)		2017 (SID 3.0)		2019		2021			
SUSTAINABILITY DOMAINS and ELEMENTS		Sustainability Analysis for Epidemic Control:		Rwanda							
		Epidemic Type: Generalized									
		Income Level: Low income									
		PEPFAR Categorization: Long-term Strategy									
		PEPFAR COP 19 Planning Level: <u>\$ 74,505,066</u>									
		Governance, Leadership, and Accountability									
		1. Planning and Coordination		9.50	10.00	10.00	10.00				
		2. Policies and Governance		8.63	9.19	8.50					
		3. Civil Society Engagement		7.67	8.33	8.33					
		4. Private Sector Engagement		6.11	9.22	9.50					
		5. Public Access to Information		10.00	9.00	8.33					
		National Health System and Service Delivery									
		6. Service Delivery		6.67	6.67	7.06					
		7. Human Resources for Health		8.50	8.24	8.13					
		8. Commodity Security and Supply Chain		7.30	6.06	7.36					
		9. Quality Management		7.38	8.05	8.05					
		10. Laboratory		7.36	6.67	7.22					
Strategic Financing and Market Openness											
11. Domestic Resource Mobilization		6.94	8.25	8.25							
12. Technical and Allocative Efficiencies		6.43	5.56	6.56							
13. Market Openness		N/A	N/A	9.75							
Strategic Information											
14. Epidemiological and Health Data		6.27	6.56	6.18							
15. Financial/Expenditure Data		7.50	9.17	9.17							
16. Performance Data		7.94	8.11	8.00							
17. Data for Decision-Making Ecosystem		N/A	N/A	6.33							

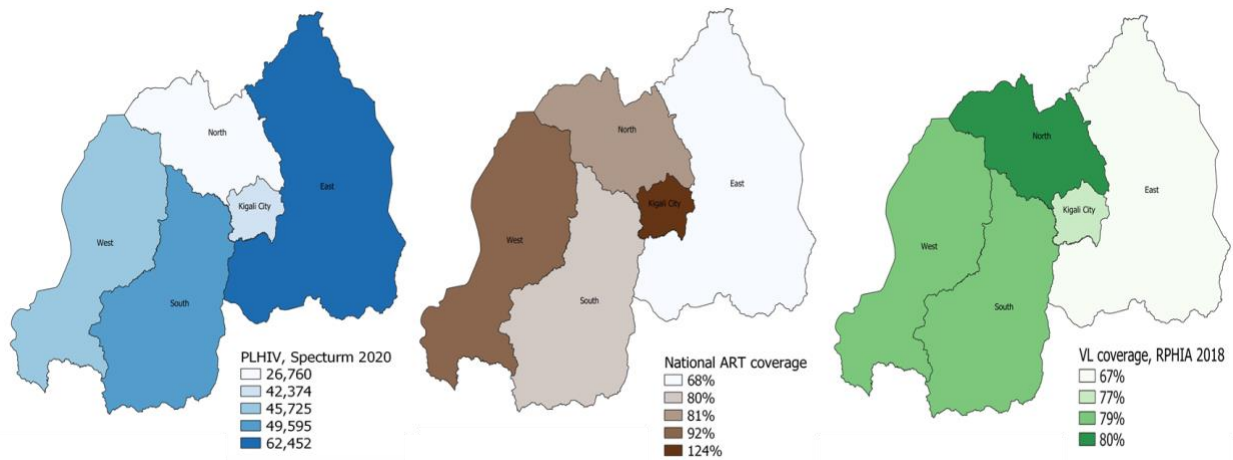
2.5 Alignment of PEPFAR investments geographically to disease burden

HIV care is widely available, predominantly delivered through the public system network of District Hospitals and Health Centers. In FY19, 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.

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.

Figure 2.5.1 PLHIV, Treatment Coverage and Viral Load Coverage (Map)



2.6 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 Permanent Secretary) – plays a key leadership role in COP development.

Civil society, private sector, PEPFAR Implementing Partners (IPs) and other stakeholders provided input for the COP20 working groups through participation in a strategic planning retreat held at the U.S. Embassy in Kigali in January 2020. 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 COP20 planning meetings for Group 3, held in Johannesburg, South Africa March 2-6, 2020, and will continue to be engaged through the COP20 planning and implementation process, including having an opportunity to comment on the SDS for COP 2020. Additionally, the PEPFAR Rwanda teams will work with MOH to ensure the Global Fund application is in alignment with PEPFAR initiatives and programming.

3.0 Geographic and Population Prioritization

The PEPFAR and MOH teams are focused maintaining epidemic control in Rwanda during COP20. According to results from RPHIA 2019, in Rwanda, 84% of HIV-positive adults between 15-64 years were aware of their HIV-positive status, 98% of those PLHIV were on ART, and among adults currently on ART, 90% had achieved viral load suppression.

Program performance data suggest that with focused planning and resource allocation, increasing the number of PLHIV who are aware of their status, linked to ART and achieve VLS will be possible in all provinces.

In Rwanda, 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%. 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 and 2019 continued with the provincial level as the SNU of prioritization, with programming targeting specific populations based on their presence and risk for HIV. In COP20, PEPFAR will continue to target resources at the provincial level, focusing on the gaps identified by RPHIA. Resources will target the identification and linkage of PLHIV to treatment in the East, where gaps were found in diagnosis and viral suppression of PLHIV, particularly among men.

Provincial ART coverage at the end of 2019 was 80% for the East, 94% for Kigali City, 86% for the North, 87% for the South, 88% for the West and 87% overall. COP20 targets have ART coverage above 95% for the total population, estimated at 92% in the East, 100% in Kigali City (taking into account patients who travel into Kigali from outside the city), 92% in the North, 95% in the South, and 93% in the west. Pediatric PLHIV estimations have varied greatly from year to year in the Spectrum models, and current pediatric ART coverage is estimated at 59% according to the most recent Spectrum estimates and targeted to reach 68% in COP 2020.

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.²² In addition, owing to results from RPHIA, targets will focus on reaching men in the Eastern province, where gaps in diagnosis and viral suppression were identified. Allocation of resources to maximally identify and treat PLHIV in Kigali and the Eastern province will effectively interrupt transmission at an accelerated pace and is critical to epidemic control in Rwanda and achieving an AIDS-free generation.

Table 3.1: Current Status of ART Saturation

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP20	# Current on ART (FY19) [RH MIS 2020]	# of SNU COP19 (FY20)	# of SNU COP20 (FY21)
Attained	100%	198,658	-	5
Scale-up Saturation	-	-	5	-
Scale-up Aggressive	-	-	-	-
Sustained	-	-	-	-
Central Support	-	-	-	-

4.0 Client Centered Program Activities for Epidemic Control

4. Client Centered Program activities for sustaining epidemic control

4.1 Finding the missing and getting them on treatment

Rwanda's most significant challenge in reaching HIV epidemic control is finding new HIV positive individuals. In APR 19 (FY19), PEPFAR Rwanda identified 7,635 new HIV positives, 47% of the annual target. In FY 20 Quarter 1 (Q1), PEPFAR supported sites

²² '2014 Revision of World Urbanization Prospects' United Nations, Department of Economic and Social Affairs, Population Division.

identified 722 new HIV positives through index testing, 19% of the annual target. According to the 2018 RPHIA results, the challenges in reaching the first 95 were finding men in all provinces especially men between 15-34 years and finding women between 15-24 and linking them to treatment (with an estimated gap of 4,500 PLHIV not yet identified based on FY20Q1 data). During COP20, PEPFAR aims to identify 3,305 new HIV positives of which 1,443 (44%) will come from index testing. PLHIV with unknown status will be reached using targeted case finding strategies. Through facility-based testing modalities, PEPFAR will focus its support of facility-based testing modalities of case identification through HIV testing for pregnant and lactating women seeking ANC/PMTCT services and index testing of their sexual partner as well as children born to HIV positive women and case finding through retesting PrEP beneficiaries. PEPFAR will support community-based testing targeting Key populations (Female sex workers, clients of female sex workers, and MSM), and priority populations (clients of FSWs and adolescents and young women (AGYW) through DREAMS).

All 196 of the PEPFAR supported testing sites across Rwanda are currently supporting index testing services, with varying degrees of success. In FY20 Quarter 1, 18,501 index clients (including 91% of all newly diagnosed HIV positive individuals) were offered index PNS. Of those offered index PNS, 49% provided partner contacts, with newly diagnosed individuals participating at higher rates than those currently on treatment (70% vs 43%) and men participating at higher rates than women. Overall test yields through index services remains low at 3.9% overall, with a 1.3% yield for those under 15 years of age, and a 4.4% yield for those 15 years or older. However, test yields of sexual partners from newly diagnosed index cases was 16.4%, compared to 3.5% from those currently on treatment.

In COP19, Index Cases /Partners notification services and family testing is being administered to all HIV positive, with a priority to those recently infected, to further identify HIV positive adults and children. Index testing will help the program close the gap among men as data shows there is an average of 40% index testing contribution to total positives among men aged 30-49. This will be achieved through intensive site-level monitoring and mentorship identifying and mitigating challenges in effective service delivery and program management, with near-POC recency testing offered at all district hospitals for health centers in its catchment area and the roll out of the active HIV Case-Based Surveillance (CBS) system with an integrated national unique patient identifier (UPID). Increased numbers of PLHIV found through case finding strategies is being achieved by: 1) Conducting monthly USG/IPs technical meetings to review PEPFAR HTS results to inform the testing strategy, 2) Conducting quarterly MOH/PEPFAR technical meetings to review MOH/PEPFAR HTS results and inform testing strategies, 3) Enhancing site level monitoring and mentorship, and 4) conducting regular CQI activities to improve case finding.

Improved PNS testing yields is being achieved by 1) increasing the proportion of high risk individuals as index cases, 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.

In COP20, while the Government of Rwanda continues supporting index testing for all HIV positive, PEPFAR will focus on supporting index testing for the children and sexual partners of the HIV positive individuals identified through PMTCT, DREAMS, PrEP and KP testing services.

Recency testing will measure the frequency of recent infections among newly diagnosed HIV positives and provide information on how to focus testing and prevention strategies by identifying transmission networks and social networks. With the scale up of CBS and an integrated national unique patient identifier (UPID) in COP 2019/FY 20, clinical, demographic, and risk behavior indicators, and recency test results are being collected for all individuals who test positive for HIV and those already on treatment with a higher risk of transmitting the virus (e.g. patients with unsuppressed viral load and KPs). This will allow a detailed analysis to identify the geographic focus 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.

During COP20, PEPFAR will continue supporting recency testing at all PEPFAR supported health facilities for all newly identified HIV positive clients regardless of the testing entry point. In addition, COP20 PEPFAR will focus on improving the recency results turnaround time with rollout of the laboratory recency data system to healthcare providers and enhance the use of recency data in the EMR/CBS to identify areas with recent infections and intensify prevention and testing strategies in those areas.

COP20 strategies to increase case finding for men include: Offering index testing to HIV positive women, particularly among AGYW, partners of unsuppressed women and to partners of FSWs, targeted KP testing focusing on MSM in high prevalence locations, particularly areas with low social network testing for MSM.

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 including the hot spots surrounding military bases. PEPFAR will revise community KP social/sexual network testing focusing on high yield venue testing in conjunction with the use of validated screening tools in high impact geographic areas. In line with the DREAMS guidance to link the high risk AGYW to HTS services, the DREAMS beneficiaries will be sensitized on HIV testing and provided with HIV testing in the safe spaces or actively linked to a facility. Through MOUs with MOH and MOD facilities, prevention and DREAMS IPs will bring KPs and AGYW to MOH facilities for HIV testing, and HIV positive individuals will be offered recency testing, PNS and family testing and linkage to treatment. DOD prevention IPs will ensure identified HIV positive KPs are linked to either DOD or MOH facilities according to their choice. In COP 20, PEPFAR will identify 1,015 new HIV positive FSWs, MSM and clients of sex workers in high burden areas. OVCs at high risk for HIV, identified using an HIV risk screening tool, will be referred to testing partners for HIV testing and follow up. In COP20, the OVC program will help to find children living with HIV who have not yet been diagnosed. In fact, it will contribute to finding 'well children' by facilitating index testing of biological children of mothers living with HIV. They will do it by assessing HIV+ adults in care in consultation with health facilities and conducting home visits to facilitate testing uptake of their children.

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 other locations frequented by young men at risk for HIV who may be unwilling to come to facilities for testing. Self-testing kits will also be distributed through the DREAMS program. PEPFAR will work with the MOH to develop a self-test kit coupon referral system which would link HIV test results back to self-test kit distribution platforms and index cases, where appropriate, to measure the efficacy of this strategy.

In COP20, PEPFAR laboratory activities will support MOH to transition from carrying out recency testing at VL testing hubs to near-POC testing at all district hospitals for health centers in their catchment area. 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 recent infections and transmission networks. 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.

In COP20, building on achievements in the implementation of Rapid Testing Continuous Quality Improvement (RTCQI) for HIV diagnostic and recency testing, 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. Testing site auditing using standardized CQI checklists (SPI-RT), participation in external quality assessment through performing proficiency testing (PT) and enhanced reporting and feedback to testers using electronic PT and certification program will be instituted to reinforce these achievements. In COP20, PEPFAR aims at improving the laboratory-clinical interface to improve quality of testing services and result documentation through onsite DQA and the use of standardized HTS logbooks. In the same vein, NRL is enhancing the use of quality corps and clinical mentors to implement HIV rapid testing CQI activities including quarterly distribution of proficiency testing panels to testers and facilitating return of PT feedback between the NRL and HIV testers at the health facilities. In COP20 PEPFAR is expanding the CQI program to include recency proficiency testing.

In COP20, scale-up of the Active Case-Based Surveillance (CBS) digital platform in all PEPFAR-supported facilities (with the exception of military and mental health sites), will facilitate enhanced monitoring of index and recency testing using longitudinal patient level data. Information exchange between EMR, laboratory systems, and national unique ID database will facilitate electronic return of results to the health facility and deduplication of client records across facilities. CBS data will be used to monitor and inform key testing strategies including index and recency testing among new positives and patients currently on ART, characterization of index contacts to support targeting of partner and family testing to address gaps in the First 95, and analysis of risk behaviors associated with recent infection to inform KP and prevention programming. Further, the CBS will provide data on treatment outcomes (including viral suppression, co-morbidities and mortality) at individual client and population levels.

4.1.1 Getting PLHIV on Treatment

The 2019 EPP Spectrum model, confirmed through RPHIA data, indicated that, by the end of FY 2019, there were approximately 6,000 individuals left to put on treatment to achieve 90% ART coverage of all PLHIV (UNAIDS Goal of 95-95-95). To optimize linkage, COP20 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 a linkage register, effective Pre-ART counselling, flexible hours for adolescent, youth and men for ART initiation and enhanced follow-up (phone, home visits, peer educator support). Linkage improvements will also be supported within PMTCT and community levels to enhance EID cascade linkage to ART initiation and link OVC and DREAMS case-finding to ART services. In COP20, PEPFAR will continue offering the TLD to all PLHIV weighing >30 kg including adolescents and women of childbearing potential.

The above strategies will be supported by PEPFAR supported above site level services including CQI 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, DREAMS beneficiaries, FSW and MSM link to ART services. The KP, DREAMS/OVC platform and other PLHIV networks will be used to facilitate effective linkage to treatment.

PEPFAR recognizes challenges in linking PLHIV especially KPs identified in the community to the treatment centers. In COP 20, PEPFAR will continue to support 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, 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.

4.2 Retaining clients on treatment and ensuring viral suppression

In FY19, the national retention rate of patients enrolled in the last 12 months on treatment was 92% with retention in 15-34 at 88%, far below the national average of 92%. In PEPFAR, 12 months retention was 94% before this indicator was phased out in 2018. In children,

trend analysis of PEPFAR data showed a steady increase in retention of individuals under 15 years old from 90% in FY15 to 95% in FY18, and national data showed that retention in children under 15 reached 97% in FY19. This improvement was a result of intensive mentorship of health facilities with poor retention, which also reflected poor VL suppression: Ongoing site mentorship 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.

In FY 2019, a new retention indicator, Treatment Mortality (TX-ML) and Loss-to-Follow-Up (LTFU) was introduced measuring the absolute number of ART patients who had no clinical contact since their last expected clinical contact, disaggregated by transfers out, refused or stopped ART, 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. Overall, there was 0.2% LTFU in COP 18. In FY20, Q1, site level TX_ML analysis indicates that 82% of LTFU are in 40 sites (20%) located mainly in Kigali and western provinces, while 93 sites (48%) had zero LTFU. During this same period, however, sites also reported 275 (44%) patients previously LTFU or refused/stopped ART being brought back into treatment (measured by TX_RTT) due to focused site level outreach approaches.

Following sites to uncover the reasons for lost to follow-up, retention strategies included; enhanced continuous adherence counselling throughout continuum of care, verification of PLHIV address at every visit, use of a standardized tracking and tracing appointments register, recovery of lost to follow-up through phone calls, peer educators and home visits, and targeted site level monitoring and mentorship were designed and implemented.

Rwanda has adequate capacity and quality of testing to meet the VL assessment requirements for monitoring treatment. Rwanda Population-Based HIV Impact Assessment (RPHIA) indicates a relatively low proportions of VLS in the Eastern province and in men particularly those in the younger age groups 15-34. Site level analysis for FY 20 Q1, indicates that 104 PEPFAR supported sites had VLS less than 95% among men aged 15-34 years old and 128 PEPFAR supported sites had VLS less than 95% among adolescents aged 10-19 years old. In addition, 33 sites had both VLC and VLS below 95%.

In FY 2019 Q4, PEPFAR supported a one-day PLHIV consultative meeting including men to identify weaknesses contributing to low VL suppression among men. Results from focus group discussions (FGDs) show that the lack of male champion support program, ideal corners, inconvenient hours and long waiting times for HIV service provision are perceived as not male friendly service delivery for men. In addition, targeted mentorship of the sites with low VLs showed that the inadequate use of a standardized tracking appointment system contributes to missed appointment with no follow up leading to low VL suppression.

In COP20, PEPFAR will support strategies that address these gaps, including identifying male only space /corners in the clinic that ensures privacy and confidentiality, flexible hours for men to shorten wait times and introduction of male champion clients who provide tailored adherence and retention support to clients, adherence counseling, with men specific messages, and dedicated non-suppressing clinic days and support groups for men.

Moreover, in COP20 PEPFAR will focus its strategies on non-suppressing adolescent PLHIV to improve retention, adherence and VLS. Strategies to improve VLS among adolescents include scale up HIV Adolescent Model, training of focal person/ counselors at schools, involvement of teaching staff in school-based HIV programs, flexible hours for drug pick up and close coordination with schools to allow adolescents to easily access HIV services, health care provider awareness and capacity building on child/adolescent friendly communication skills to ensure well prepared transition to adult HIV program, enhanced linkage to OVC services, specific clinic and support group of mothers/ caregivers/ guardians of non-suppressing children and young adolescents, learn and implement best practices through experience sharing meetings among health facilities involving children and young adolescents.

FY19 PEPFAR partner data showed a low VLS among FSW and MSM respectively, 81% and 75 % thus in COP20 PEPFAR will support retention and adherence among FSW and MSM through effective use of KP specific peer groups and engagement of FSW and MSM specific networks, home visits for scheduling appointments and providing adherence support.

Other supportive strategies to track and retain non-suppressing PLHIV will include community peer support being implemented under DSDM where peer educators will conduct home visits to groups 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. With routine review of data with the MOH, the CQI will be targeted to those sites that have high LTFU and non-VL suppression rates. With a focus on those sites, 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 test results using 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.

In addition, in COP20, PEPFAR will improve the documentation of VL results in the patients' medical record, through electronic transfer of lab results from Laboratory Information Systems(LIS) at the NRL and the VL hubs testing networks to patient Electronic Medical Records (EMR) through the health information exchange, using computers in facilities to facilitate the use of digital systems, including the LIS by site staff, tracking patient appointments using EMR and analysis within the CBS system and appointment registers for ART and VL scheduling.

Following countywide visits by RBC to evaluate issues of VL coverage in the south, it was evident that the catchment area served by this hub attracted high workload and need for extra laboratory capacity to cope with demand as well as use of the laboratory information system to help in sample tracking and timely return of results to health facilities. Among other strategies by RBC was to expand on the

existing 9 VL hubs with new catchment area, optimize the sample referral network and implement a decentralized transportation system within hub catchment areas. In COP20, an optimized VL hubs network and designated catchment areas will be operationalized with an adequate number of VL hubs per province. The new VL hubs will be interfaced with laboratory information systems to ease test requests, return of results and shorten turnaround time (TAT) of results to boost VL coverage and retention. In COP20, the national reference laboratory (NRL) will implement options to improve efficiency of sample referrals, such as decentralizing sample referral to district hospitals to manage samples in their catchment area without relying on the NRL for weekly pickup and drop off. NRL will remain the role of oversight and monitoring of the quality of the decentralized sample referral system. In COP20, the laboratory information system will be maintained to facilitate ART nurses and clinical mentors have access and track lab test requests and access VL patient results.

TPT is an important aspect of routine HIV care and treatment in Rwanda, implementation started in the last quarter of COP 2018 under a phased approach with only new PLHIV initiated on ART at five district hospitals and 80 health centers in phase one. Phase one implementation will guide the program on the best public health approach to TB screening and TB disease exclusion prior to initiation of TPT. Given the current GoR requirement for chest X-Ray in the screening algorithm, phase one implementation is accompanied by close supervision and mentorship on quality symptom-based TB screening to improve TB detection. The GoR will be reviewing data from both screening approaches to determine that quality symptom screening may provide reliable results and alleviate need for chest X-Rays. Removing the requirement of a chest X-Ray before starting TPT is critical to successful implementation of TPT. After a successful phase 1 in May 2020, TPT implementation will be aggressively scaled up to all PLHIV on monthly ART pick up in July 2020. Wide scale-up of TPT services to all PLHIV is scheduled to start in January 2021 with the goal of providing TPT to all eligible PLHIV in care by the end of COP 2020.

In COP20, PEPFAR will continue supporting the implementation of the Differentiated Service Delivery Model (DSDM) and with focus of transitioning from three months prescription to six Multi-Months Prescription (MMP) at all sites as soon as possible. In FY2019, the National Technical Working Group (TWG) has set up eligibility criteria for six MMP, these include; viral load suppression for 12 months, good adherence and patient willingness. The national guideline is currently being amended to include six MMP and implementation will be accelerated to maximize the impact so that by end of FY 20, 50% of sites will be implementing six MMP. By the end of COP20 all sites will be implementing six MMP. To support the adherence and retention of patients enrolled in six MMP, PEPFAR will continue supporting the community group support led by the PLHIV peer educators.

In COP 20, Rwanda's Active Case-Based Surveillance (CBS) system digital platform will be scaled in PEPFAR-supported sites. Achieving scale of CBS will enable use of the system for monitoring longitudinal patient outcomes such VL suppression, ART regimen changes, treatment adherence, OIs and TPT outcomes by patient characteristics such as time on ART, recent infection and risk behaviors. Information exchange between the EMR, laboratory information systems, and national unique ID database will facilitate timely electronic return of lab test results to the health facility, as well as linkage and deduplication of patient records across health facilities for improved patient level monitoring and clinical care.

4.3 Prevention, specifically detailing programs for priority programming:

4.3.1 HIV prevention and risk avoidance for AGYW and OVC

In Rwanda, the policies and objectives related to the wellbeing of OVC are mainly captured in two national documents: The Integrated Child Rights Policy (ICRP) and National Strategic Plan (NSP) for HIV/AIDS. The ICRP²³ serves as the comprehensive child policy framework that addresses the rights and needs of children in the country. This document also ensures coordination and consistency in interventions across various thematic areas and ministerial mandates. Rwanda's HIV 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.

Within the framework of aligning with the PEPFAR COP20 Guidance on the use of standard vulnerability criteria for OVC enrollment, the OVC program will prioritize districts with a high number of ART clients under 18 years old as well as districts with high HIV prevalence rates. In total, the OVC program will be implemented in 16 districts: 3 districts from Kigali City (Kicukiro, Gasabo and Nyarugenge); 5 districts from Western Province (Rusizi, Nyamasheke, Karongi, Rutsiro, Rubavu); 3 districts from Southern Province (Huye, Muhanga, Kamonyi); 2 from Eastern province (Rwamagana and Kayonza); and 3 from Northern Province (Burera, Musanze, Gicumbi). A two-year transition plan for four COP20 non-priority districts (Burera, Musanze, Gicumbi and Kamonyi) will ensure that existing beneficiaries are served until their planned graduation and no new enrollment of OVC takes place in those districts. Active enrollment in the remaining twelve districts will take place in COP20, including nine existing (Nyamasheke, Karongi, Rutsiro, Kicukiro, Nyarugenge, Gasabo, Huye, Rwamagana and Kayonza) and three new districts (Muhanga, Rusizi and Rubavu).

In COP 20, the OVC program in Rwanda will be implemented by four partners: one international NGO, (Pact implementing ACHIEVE), and three local CSOs: Francois-Xavier Bagnoud (FXB) (implementing Turengere Abana), African Evangelistic Enterprise (AEE) (a faith-based organization, implementing Ubaka Ejo), and Caritas Rwanda (FBO implementing Gimbuka). USAID/Rwanda will utilize the ACHIEVE central mechanism to replace Global Communities, which is ending in September 2020. The implementation under ACHIEVE will be done by the same local CSOs currently implementing under Global Communities, which are YWCA and DUHAMIC ADRI; and these organizations will maintain their current districts (Kayonza and Huye). In addition to supporting implementation, ACHIEVE will have an M&E and capacity development component that will support each of the local CSOs.

²³The 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.

There will be a substantial increase in the OVC_SERV targets from 131,147 in COP 19 to 247,553 in COP 20. This target of 247,553 includes 192,972 OVC beneficiaries and 54,581 AGYW under 18 years old from the DREAMS program. The COP20 OVC_SERV includes 166,512 females [67%] and 81,041 males [33%]. This also constitutes a total of 225,756 OVC under 18 [91%] and 21,797 OVC aged 18 and above [9%]. The main reasons for the increase in targets are the following: i) Anticipated efficiencies from shifting more resources to local partners; ii) Low level of effort required for serving existing OVC awaiting graduation; iii) ability to cover additional CLHIV given the tremendous support provided by the Rwanda Network of People Living with HIV (RRP+), who provides support to PLHIV, including children; and iv) OVC Preventive program will include only a single intervention; and most importantly v) there will likely be a significant over achievement of COP19 targets representing an under-reporting resulting from reaching the siblings of beneficiaries enrolled in the OVC program who may have received a service but who were not counted for three of four IPs.

Overall, the target for the OVC_SERV indicator includes 118,272 OVC comprehensive [48%], 74,700 OVC preventive [30%], and 54,581 DREAMS only under 18 [22%] beneficiaries. While more efforts and resources will need to be invested for CLHIV, given the overall number in the proposed districts (6,339 under 19 as of January 2020 (Rwanda HMIS)), it is anticipated that these beneficiaries will be a small proportion of the overall targets. Since most families in Rwanda have more than 1 child (average of 4.3), non-HIV-positive siblings enrolled in the program may receive a single intervention and not a comprehensive package of services that will be offered to the index beneficiary.

The PEPFAR Rwanda OVC program will continue to evolve as the country nears epidemic control. In COP 20, the OVC program will be characterized by two approaches: OVC Comprehensive and OVC Preventive. There is an evolving emphasis on priority subpopulations within OVC Comprehensive: HIV+ children under 18, children of PLHIV, HIV-exposed infants under 2, children of female sex workers (FSW) and sexual violence survivors. The OVC Comprehensive approach is family-based and is comprised of integrated case management and graduation benchmarks. The illustrative services 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; and parenting and psychosocial support. The OVC program will continue its focus on sexual violence and HIV prevention in 9-17-year-old beneficiaries. Following S/GAC guidance and the Violence Against Children and Youth Survey (VACYS) findings, the OVC program will integrate 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 DREAMS programming, the OVC program will emphasize the benefits of delaying sexual debut and consent issues. It will also mobilize communities and families on prevention of other forms of violence.

The OVC Preventive approach is individually based and focused on primary HIV and sexual violence prevention targeting boys and girls aged 9-14. As there will be no case management for OVC preventive beneficiaries, there will be no reporting of their HIV status and no use of the standard vulnerability criteria for eligibility. Rwanda will use the following curricula: 1) *Sexual and Reproductive Health (SRH) Curriculum* which is approved by GoR and accepted by S/GAC with the addition of the S/GAC module on sexual consent; 2) *Families Matter Program (FMP)* which is already in use under DREAMS and being piloted in the OVC program in COP19; and 3) *Coaching Boys into Men* which will need to be adapted to the Rwandan context.

To achieve results toward epidemic control and HIV impact mitigation, the strategic approaches in COP20 will be 1) supporting retention of children and adolescents in treatment and care; 2) helping to find children living with HIV who have not yet been diagnosed; 3) facilitating index testing of biological children of mothers living with HIV; and 4) providing primary prevention of HIV and sexual violence interventions for children aged 9-14 years. The OVC program will continue to conduct HIV risk assessments among children and adolescents under 18, and to coordinate with the DREAMS program to ensure comprehensive HIV and sexual violence prevention programming. Additionally the OVC program will strategically coordinate 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, to continue the country-owned response, and shift support from direct service delivery to non-service delivery for a long term vision of the OVC program. The OVC program will enhance 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. The MOUs will be reviewed to include the following: geographic coverage area; OVC IP staff in the community and at clinics and community volunteers; shared confidentiality; testing, especially index testing; LTFU and tracing; adherence & home monitoring; and socio-economic assessment and support. To support these efforts, Linkage Facilitators will be placed at health facilities and will play a key role in ensuring the OVC program is well aligned with Care and Treatment services ensuring that those CLHIV found at clinics are offered enrollment into the OVC program and will also follow up on HIV-positive OVC beneficiaries to ensure they are adhering to treatment and are virally suppressed.

In COP 20, the OVC partners will continue tracking and monitoring findings under the OVC_HIVSTAT indicator. The COP20 target for OVC_HIVSTAT is 151,048, which includes 96,467 OVC from the OVC program²⁴ and 54,581 AGYW from DREAMS. Beneficiaries who self-report an "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. While OVC_HIVSTAT is self-reported, through the strengthened relationships and enhanced MOUs with the health facilities, IPs will be tracking actual HIV status and viral load. Seroconversion among OVC beneficiaries under 18 years will be monitored by observing the number of beneficiaries moving from a negative or unknown status to a positive self-reported status in SAPR20 and APR20. The implementing partners (IPs) will continue to encourage parents/guardians to have their children tested and to have students in boarding schools take an HIV test during school vacations, if deemed necessary by the screening. After quarter 1, USAID will facilitate a meeting with OVC partners so that IPs with lower performance on this indicator can learn from the more successful partners. IPs will continue to hold regular learning/exchange sessions to ensure the HIV risk assessment is conducted, that HIV testing is done for the right OVC, and the referral/linkage system is strengthened. OVCs found HIV positive and not on ART will immediately be linked to treatment.

DREAMS Programming

In COP 20, Rwanda's DREAMS program aims 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. Rwanda will continue to implement

²⁴Only those enrolled in the OVC comprehensive program will report OVC_HIVSTAT. This indicator will not be reported for those in the OVC preventive program.

the DREAMS program in five districts, including three districts of Kigali (Gasabo, Kicukiro and Nyarugenge), Nyanza in the Southern province and Rwamagana in the Eastern province. The DREAMS geographic prioritization was based upon districts with the highest HIV prevalence among young women, specifically those 15-24, and highest teen pregnancy and sexual violence rates. In COP 19, DREAMS services covered all administrative sectors of Nyanza, Rwamagana and Gasabo. For Kicukiro and Nyarugenge, there were three sectors that were not covered. In COP 20, all 57 sectors of the five districts will be covered, which will ensure a full geographic footprint. In addition to the full geographic footprint coverage in COP 20, the DREAMS program will also increase the number of beneficiaries targeted from 32,269 in COP 19 to 73,838 in COP 20. This means that the Rwanda DREAMS program will be reaching 77% of AGYW towards saturation; with a gap of 23% to reach full saturation.

In COP 20, the DREAMS program will be implemented by three partners, including two local Rwandan civil society organizations, African Evangelistic Enterprise (AEE) and Francois-Xavier Bagnoud (FXB), and one international NGO (Pact). FXB will begin implementation in the district of Rwamagana, formerly covered by Caritas, and Pact will implement in Nyarugenge and Kicukiro districts, replacing Global Communities/Twiyubake, which is ending in September 2020. For continuity purposes, Pact will continue working with the local sub-partners that were implementing Twiyubake in the same locations (YWCA in Kicukiro and DUHAMIC ADRI in Nyarugenge). AEE (a faith-based organization) will reach 27,118 AGYW out of 73,838 at risk AGYW (37%), Pact will reach 24,972 (34%) and FXB will reach 21,748 (29%). In COP 20, the program will also target 3,000 male sexual partners of AGYW and males who fit the profile of sexual partners distributed as follows: 840 under Pact, 1,410 under FXB and 750 under AEE.

The DREAMS partners will reach and enroll the most at risk AGYW by using COP20 standard vulnerability criteria. These criteria include, high number of sex partners; sexually transmitted infection (STI); no or irregular condom use; transactional sex; experiences of violence; out of school/never schooled; alcohol misuse and orphanhood 10-17. The total number of OVC eligible for DREAMS will include 694 from the OVC program in the four districts where the OVC and DREAMS programs overlap (Nyarugenge, Kicukiro, Gasabo and Rwamagana). These, plus 73,144 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 (91%) will be adolescents aged 10-19. The Rwanda VACYS 2014 results showed that 25.9% of females aged 13-24 had experienced sexual violence in the last 12 months. Additionally, 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, for the 10-14 year old age cohort, the OVC/DREAMS partners will move to include support for survivors of other forms of violence. This will require strengthening the referral/linkage system to ensure the AGYW are protected and closely followed up.

DREAMS IPs will continue to address AGYWs' HIV risk by layering evidence-based interventions implemented by the three OVC/DREAMS IPs. The IPs will carry out the same set of interventions including condom distribution. Through the provision of sexual and reproductive health and rights (SRHR) and life skills education, IPs will incorporate sexual violence prevention and response using the GOR and S/GAC approved curriculum and training manuals. Also, the GOR has made progress to include oral PrEP in the national guidelines for specific populations. Currently in Rwanda, HIV-negative AGYW 18 and older who engage in transactional sex without consistent use of condoms, are part of a sero-discordant couple with a virally unsuppressed partner not consistently using condoms and/or who are an FSW who do not consistently use condoms are eligible for HIV Pre exposure prophylaxis (PrEP). In COP 20, PrEP will be expanded from Kigali to all five DREAMS districts, and eligibility criteria will be expanded to include AGYW engaged in transactional sex, and those without consistent use of condoms. Therefore, DREAMS implementing partners will expand PrEP activities to include demand creation, training of AGYW PrEP champions and HCWs, active linkage of eligible AGYW to MOH facilities for PrEP initiation, and ongoing follow-up of AGYW enrolled in PrEP. The IPs will also work on a joint condom distribution plan to ensure the availability of free condoms to AGYW.

In line with the DREAMS guidance to link all AGYW to HTS services, the DREAMS beneficiaries will be sensitized on HIV testing and provided with HIV testing in the safe spaces or actively linked to a facility. All 10-14 year olds enrolled will receive HIV screening and, if deemed high-risk, will be tested for HIV. It is estimated that approximately 7,181 10-14-year olds will be tested. All 15-24-year-olds (45,121) enrolled in DREAMS are already deemed to be high-risk and will receive HIV testing once a year if they don't know their status or are HIV-negative. Any beneficiary found to be positive will be immediately linked to recency testing and treatment services, with DREAMS mentors providing follow-up to ensure adherence and viral load suppression. As mentors have established trust with beneficiaries, they will continue providing HIV prevention messaging at safe spaces and in the communities. HTS will be conducted jointly with health facilities and with the support of local government authorities. The program will maintain strong partnerships with the health facilities, formalized through MOUs. Wherever possible, health facility staff will come to safe spaces to ease the burden of AGYW having to reach the health facility. There will also be an option of active linkages for testing at facilities or other partner sites. On a voluntary basis, community volunteers will ensure those cases are accompanied to the health facilities or HIV testing sites. In addition, DREAMS will reach male sexual partners as well as males who fit the profile of sexual partners and link them to VMMC and HTS services. The Program will continue to build on strong coordination with other prevention partners to ensure AGYW receive a comprehensive package of services through an improved referral/linkage system.

Also, in COP20 implementation, the OVC and DREAMS programs will continue co-planning to ensure all tools, approaches, and services are well coordinated. The IPs will continue conducting joint work planning, data review, harmonizing approaches and tools, and holding regular reviews of implementation for quality work and efficiencies. IPs will utilize innovative approaches and improve on the economic strengthening intervention through: conducting labor market survey; strengthening linkages to employment post-TVET including non-traditional trades; strengthening saving groups through performance based incentives; strengthening linkages with financial institutions and government structures, and continuing to provide soft skills and financial literacy through the life skills curriculum.

In COP 20, the DREAMS program will collect and report on the following indicators: AGYW_PREV, PP_PREV, OVC_SERV, OVC_HIVSTAT, HTS_RECENT, HTS_TST, HTS_TST_POS, PREP_CURR, PREP_NEW and HRH_CURR. Reporting on testing and PrEP

will be new and will require more collaboration with health facilities and clinical testing and PrEP partners. To ensure smooth implementation, the procedures for carrying out testing and PrEP referrals will be clarified in the revised MOUs with those partners. The DREAMS partners will continue to share learning from service layering in DREAMS, especially on the use of unique identifiers tracked through DHIS2. In COP 19, the fully operational DHIS2 layering tracking system was hosted by Global Communities; in COP 20, it will transition to Pact. Pact will also have the mandate to build the capacity of the 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 and GoR beyond COP20 in order to facilitate country ownership and achieve sustained epidemic control.

For more effective coordination and implementation, the PEPFAR/COP20 Guidance recommended the introduction of a DREAMS Coordinator and DREAMS Ambassadors. USAID will hire the DREAMS Coordinator, who will serve as the AGYW point person in the coordination of all DREAMS activities and programming across the entire USG PEPFAR portfolio. S/he will work closely with the proposed AGYW focal point within the Government of Rwanda to enhance coordination across all stakeholders and programs, including the Global Fund's HER activities. The DREAMS program will introduce DREAMS Ambassadors in each district to support the advocacy related to AGYW support and the DREAMS coordination and oversight. They will fill in the gaps in program implementation and will be hired by the relevant IP in each district. DREAMS Ambassadors will have to meet the following basic criteria: age 18-24, exhibit leadership qualities and a high level of self-efficacy, live in the target DREAMS districts, and have been a DREAMS Program beneficiary. They will be responsible for generating public awareness of DREAMS and issues affecting the lives of AGYW in public events, and leverage existing structures such as *'Umuganda/community work'*, *'Umugoroba w'ababyeyi/parents' evening fora'* and *'Inteko z' abaturage/Citizens Assemblies'* to serve as positive role models and provide mentorship to others. They will receive training on HIV, PrEP and GBV and will be supported with DREAMS materials for their advocacy work.

4.3.2 Children / PMTCT

The government of Rwanda adopted and implemented the strategy of Elimination of Mother to Child Transmission (EMTCT) of HIV with the goal of attaining a mother to child transmission rate of < 2% across all geographic locations. PEPFAR FY19 program data indicates a mother to child transmission (MTCT) rate of 1.56% lower than the national MTCT rate of 1.69%. Since 2015, following elaboration of the national level EMTCT strategy, district level EMTCT plans have been designed and implemented. EMTCT is implemented along the four pillars of PMTCT (primary prevention, prevention of unintended pregnancies, ART treatment for positive women and linkage to treatment and retention). In COP 20, PEPFAR will support national level processes for EMTCT attainment including the establishment of a validation committee, pre-assessment and submission of validation request to the regional committee. COP20 PEPFAR will support HIV testing to all pregnant and lactating women following the national guideline and all HIV positive women will be immediately linked to treatment. At all PEPFAR sites, infants born to HIV positive mothers will be offered ARV prophylaxis based on the national PMTCT guideline. Infants born to HIV negative mother in discordant couple relationship are assumed to be at high risk of HIV infection and will be offered extended ARV prophylaxis as recommended by the national guidelines.

In COP 19 the focus at facility level is the provision of PrEP to negative partners in sero-discordant couples whose partner is not on ART or on ART but not virally suppressed. In COP 20, PEPFAR will expand PrEP to also target young women, pregnant and lactating women at high-risk of HIV infection identified through ANC and OPD/STI settings. In addition, high-risk young women will be identified through DREAMS and KP testing strategies and referred to PrEP programs.

In COP 19, improvement in the early infant diagnosis (EID) turn-around time from 14 days to between 1 and 10 days was observed following introduction of POC testing in 18 sites. With improved HEI testing coverage in COP20 mentorship and supervision will be reinforced at PMTCT facilities to achieve testing coverage of 95% at six weeks post-partum HIE testing.

In COP 20, PEPFAR will continue to support enhanced viral load monitoring for pregnant and breast-feeding women in accordance with national algorithm to minimize risk for MTCT and contribute to the overall goal for reducing new HIV infection among the general population.

In COP 20, Sexual and Reproductive Health (SRH) Education including HIV/STI Prevention, and PrEP for AGYW will be delivered through referrals to health facilities.

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.

4.3.3 Key Populations

Key populations (KPs) in Rwanda include FSWs and MSM. Results from recent studies have informed KP and priority population (PP) strategies.²⁵ 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 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

²⁵ FSW PSE 2018, FSW IBBS 2015, MSM PSE & IBBS 2018, DHS 2015 and RAIHIS 2014.

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.

Information from the MSM community indicates there is 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 results which indicate that 14% of the recruited MSM were of 30 years and above. Furthermore, CBS has provided further data to inform strategies to help focus the outreach and geographic focus of HIV prevention services to MSM. In COP20, efforts will be made to reach this group through MSM networks and associations.

The package of services for KPs includes targeted community voluntary counseling and testing (VCT) and mobile HIV testing, self-testing, pre exposure prophylaxis, risk reduction counseling (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 capacity building and mentorship on provision of KP friendly services to reduce KP barriers to HIV prevention and treatment services.

PEPFAR will align COP20 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 COP20, to maximally interrupt HIV transmission, PEPFAR will reach 19,701 KPs, including 19,853 FSWs and 2,500 MSM with testing, prevention, retention and adherence services. To achieve this, PEPFAR will scale up proven methods of high yield mobile testing and community VCT 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) Community VCT and mobile testing in hotspots, 2) recency testing, 3) self-testing, 4) referrals from active and retired KP peer educators, and 5) referrals by private and public health facility serving hotspots. Furthermore, case finding among KPs in COP20 will be done through annual testing of KPs, focused active case finding using social network strategy, 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. Through MOUs with local health facilities, PEPFAR prevention partners will be required to strengthen linkage of HIV positives to treatment, as well as to coordinate increased support and follow up for retention and drug adherence.

In COP 20, PEPFAR will expand its PrEP support from 10 selected health facilities in high burden areas of Kigali targeting FSWs and MSM at high risk of HIV acquisition, and sero-discordant couples of which the HIV positive partner is not virally suppressed as well as AGYW at high risk for HIV. This expansion of PrEP will include all Kigali PEPFAR supported facilities targeting 683 MSM and expand to all sites in Kigali and other high burden area targeting 5,481 FSW. PEPFAR will expand the PrEP program of sero-discordant couples to all PEPFAR supported health facilities sites in Rwanda and initiate DREAMS AGYW in all DREAMS supported districts. AGYW at high risk for HIV will be targeted in all PEPFAR supported sites for PrEP programming through the ANC/PMTCT entry modalities. High risk FSWs, MSM and AGYW will be identified using a standardized screening tool measuring risk factors identified from the RPHIA data analysis on HIV among AGYW 15-24 and condom use. Eligible FSWs and AGYW 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 and other AGYW at high risk will be recruited by PEPFAR-supported clinics through ANC services. PrEP will be administered to beneficiaries and followed up by all PEPFAR clinical partners KP partners and DREAMS partners. All community 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, the 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 guidelines. 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 20, results from the 2018 MSM and FSW size estimates, IBBS, and the 2018 RPHIA will be essential to refine and strengthen program strategies. 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. 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.

4.3.4 VMMC

During FY19 PEPFAR-supported 135,395 VMMC procedures which is 126% of the FY19 annual target (135,395 out of 107,234) at PEPFAR-supported sites. Even with this over achievement in FY19, the NSP objective of 66% national coverage of males aged 15-59 was not achieved by the end of 2019. However, with the PEPFAR investment for VMMC in COP20, PEPFAR will prioritize investments in VMMC by prioritizing the 203,000 VMMC service targets on males aged 15-29 and contribute to achieving 85% at 90% saturation nationally by end of FY 2021 in the priority age bands 15-29. In FY21, no under 15 years of age males will be circumcised.

VMMC targets for COP20 were developed using RPHIA, 2021 census projections from the National Institute of Statistics of Rwanda (NISR), 2019 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 COP20 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 100% for surgical method and strengthening VMMC demand creation (specifically for surgical circumcision) for ages 15-29. No under 15 years of age males will be circumcised during COP20. 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.

As per COP20 PEPFAR Guidance to discontinue/stop circumcising boys below 15 years of age, demand creation for VMMC for young boys between 10 – 14 years of age 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 surgical method, target military populations and new recruits, and reach men aged 15-29 at highest risk, including those linked from DREAMS programming, clients of FSWs, men who have sex with men, 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 3,500 EIMC procedures have been completed. MOH plans to scale up EIMC, focusing first on district hospitals.

4.4 Commodities

COP20 is building on the achievements to date and the vision of Rwanda's NSP of universal access to ART and achievement of global UNAIDS targets. The Rwanda Population HIV Impact Assessment (RPHIA) results released last year showed that Rwanda is on track to reach HIV epidemic control. PEPFAR's COP20 priority is maintaining epidemic control and to 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 by geographic location, gender and sex and age. Age and sex disaggregation along the HIV cascade indicates challenges in community VL suppression among 15-34-year olds, predominantly in men with great variation across provinces with the Eastern province as low as 54% for males and 73% for females (RPHIA). Development and implementation of strategies to address case finding and VL suppression and coverage will be coordinated through the national prevention and Care & Treatment technical working groups (TWG).

Recently, the national TWGs coordinated and standardized implementation guidelines for all partners working in the national HIV response. In addition, MOH will coordinate joint partner reporting and data review through monthly and quarterly partner/stakeholder workshops to review results, identify challenges, and share best practices. Emphasis on Continuous Quality Improvement based on site level analysis will identify poor performing sites and gaps and lay out strategies to address those gaps. 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 2020.

In COP20, all USG agencies will continue to strengthen partner management, building on COP 2019 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 COP20 strategic objectives, review achievements against work plans, and identify challenges and best practices. The CQI framework and integrated clinical mentorship model based on index testing initiatives is being strengthened to a broader platform for other HIV service delivery initiatives and will be 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.

In COP20 PEPFAR will continue to support HIV data quality improvement by strengthening the HIV component of the national data quality assessments (DQAs) and conducting routine DQA of key PEPFAR indicators. Building on past PEPFAR Data Alignment efforts, COP20 will support implementation of improved data quality checks within RHMIS and the SI TWG will conduct quarterly site level data validation of key indicators in DATIM and RHMIS to ensure high quality and sustainable national program data.

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 USG team will coordinate with the MOH to ensure availability of ARV and HIV tests to avoid any interruption of HIV services.

4.4.1 Accelerate National ART Optimization

To accelerate the introduction of better, less costly 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, or TLD. Phase I of transition was 98.5% completed by January 2020. Phase II of the transition started in January 2020 for women of childbearing age, and it is expected to be completed by July/August 2020. TLD 90 will be available in the country in June 2020 to support six-month MMP. About 95% of patients will use a dolutegravir (DTG) based regimen and the remaining 5% will be on efavirenz (EFV) plus two other ARVs. TLD/DTG containing regimens started in August 2018 for naïve eligible patients per the STG. The GOR started reverse logistics and quarantining all remaining legacy ARVs (nevirapine 200mg (NVP), and Lamivudine 300mg/Nevirapine 200mg/Zidovudine 300mg (LNZ)) for disposal starting February 2020 and initiated the phase II transition of TLD with minimal or no wastage of TLE600. All women of childbearing potential currently on LNZ or NVP based ARVs were transitioned to TLD in January and February 2020. The disposal plan for the legacy ARVs was developed and shared with all relevant stakeholders.

Planning for the Phase II TLD transition included a comprehensive review of consumption trends for ARVs and laboratory supplies, current national stock status (of TLE600 in particular), 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 COP19 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 (TLE600) in stock and in pipeline from all sources were also reviewed. As a result, there won't be additional orders of TLE600; and the majority of first line adults will be TLD.

To support the management of the TLD transition in Rwanda, a comprehensive forecasting and supply plan tool was developed for the monitoring and tracking of ARV inventory levels and service demand. This tool will be continually edited and updated moving forward. The supply plan tool will allow USG & GoR to provide regular monthly updates of the transition progress and of the drawdown of legacy stock (TLE600), as well as identify when, how and why a new procurement of TLE400 would be needed (between the transition start and the point at which TLD 90 is fully available for Rwanda). In Q1 of COP20, a report will be developed to summarize how the transition processes of Phase II went.

4.4.2 Finalize/Refine roll-out of Multi-Month Prescribing/Dispensing (MMP/D)

Since COP16, PEPFAR Rwanda supported the GoR's roll-out of MMP/D. Initially, one of the eligibility criteria was <20 RNA copies/mm³ which resulted in slow patient enrollment - 49% of eligible patients enrolled by end of FY18. In July of 2018, the enrollment criteria were revised to <200 RNA copies/mm³, which resulted in the achievement of 60% of eligible patients enrolled by the end of year 2019. In the new ART STG, the MMP enrollment criteria changed from 18 months to 12 months on ART. In COP20, PEPFAR will continue to support the GoR in achievement of their target of 85% enrollment of eligible patients. PEPFAR will also be supporting the GoR's transitioning from a three-month, 30-count bottle standard for MMP/D to a six-month, 90-count two bottle standard (not 180-count bottles after the beneficiaries' survey and consultative meetings).

4.4.3 Commodity Support for Revised Case Finding Strategy

In COP19, the budget for procuring RTKs was significantly reduced to align with the index testing strategy to achieve more targeted yields and program efficiency. However, in COP20, there is a slight increase to finding the remaining cases as identified in Rwanda PHIA 2019. PEPFAR will collaborate with the GOR to review historical RTK forecasts as compared to consumption rates to improve the regular and consistent availability of RTKs within the national program. PEPFAR will also work with GOR to review clinical testing protocols and RTK consumption compared to targets to ensure targeted testing is adequate to meet the Rwandan national RTK needs.

4.4.4 Utilization of Commodities Data for Patient Data Triangulation

PEPFAR has been supporting and improving data quality to facilitate triangulating patient and supply chain data since FY19. Moreover, in COP20, PEPFAR will continue to work to improve integration of commodity procurement, inventory and distribution data within 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 forums will provide another view of the program to ensure positive patient outcomes. This is particularly important for COP20 as Rwanda is completely transitioning to ART optimization for both adults and pediatrics as well as introducing new TLD pack sizes which will impact all patients within the national program.

4.5 Collaboration, Integration and Monitoring

COP20 is building on the achievements to date and the vision of Rwanda's NSP of universal access to ART and achievement of global UNAIDS targets. The Rwanda Population HIV Impact Assessment (RPHIA) results released last year showed that Rwanda is on track to reach HIV epidemic control. PEPFAR's COP20 priority is maintaining epidemic control and to 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 by geographic location, gender and sex and age. Age and sex disaggregation along the HIV cascade indicates challenges in community VL suppression among 15-34-year olds, predominantly in men with great variation across provinces with the Eastern province as low as 54% for males and 73% for females (RPHIA). Development and implementation of strategies to address case finding and VL suppression and coverage will be coordinated through the national prevention and Care & Treatment technical working groups (TWG).

Recently, the national TWGs coordinated and standardized implementation guidelines for all partners working in the national HIV response. In addition, MOH will coordinate joint partner reporting and data review through monthly and quarterly partner/stakeholder workshops to review results, identify challenges, and share best practices. Emphasis on Continuous Quality Improvement based on site level analysis will identify poor performing sites and gaps and lay out strategies to address those gaps. 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 2020.

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The prevention and care and treatment TWGs will coordinate with partners to improve identification, linkage, and retention to ensure VL suppression of all positives on treatment, with a focus on those most vulnerable to loss to follow up, such as FSW and MSM. This will be done through stronger coordination of MOH facilities by referring partners to strengthen the referral/counter referral processes, stronger group specific peer/support groups, and stronger follow-up for those lost to treatment. Much focus will be put on interventions targeting men and adolescent groups to improve identification, enrollment on treatment, retention and viral load suppression through implementation of PEPFAR supported HIV adolescent model and defined strategies to reach men. The implementation of active CBS for active case finding coupled with the national UPID will strengthen linkages between testing and treatment to provide the data necessary to continuously track the HIV epidemic from case finding to viral suppression. COP20 will support implementation of these strategies to improve linkage to treatment and close the current national ART coverage gap of 18,128 to reach 95% of the estimated PLHIV in Rwanda.

In COP20, PEPFAR will continue to support the implementation of updated policy and guidelines including modifications to support the implementation of TLD transition including women of reproductive age, TPT, and six-month prescribing/dispensing. Scale up of TLD will increase the number of patients virally suppressed, “stable,” and eligible for MMP under DSDM.

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 attention to male non-adherence and suppression. 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 develop an effective HIV active case finding and longitudinal case surveillance system. In COP20, the CBS digital platform will be implemented and maintained in PEPFAR-supported facilities, along with the health information exchange, enabling critical data sharing of EMR, laboratory and national unique ID systems for improved patient-centered care and program monitoring. COP20 investments will also focus on institutionalizing routine analysis and use of CBS data to inform case finding strategies, monitor treatment outcomes and inform the public health response to recent infections.

PEPFAR will continue to build capacity of health care providers 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.

COP20 supports continued improvements in laboratory testing quality and turn-around-time, with a focus on integration of continuous quality improvement (CQI) of testing and improved VL coverage including VL/EID optimization and enhanced monitoring with more 90% access to annual VL testing and reporting to ensure reductions in morbidity and mortality across age, sex, and risk groups.

PEPFAR continues to collaborate with the GOR and other partners including World Health Organization in Rwanda, to achieve and maintain ISO accreditation of the National Reference Laboratory (NRL) for sustained quality monitoring and improvement of testing in the national laboratory network for HIV and TB Programs. The program is implementing laboratory informatics solutions for laboratory service delivery and monitoring quality of testing as well as leveraged for informing diagnostic network optimization and integration

strategies for new laboratory technologies. In addition, PEPFAR is coordinating with the GOR to provide technical assistance on the feasibility of Public Private Partnerships (PPP).

To ensure sustainable quality HIV care considering anticipated declining donor resources, PEPFAR in collaboration with GOR will monitor the impact of integrated model to inform its national scale up. To control the HIV epidemic is crucial to understand the level stigma and discrimination, in COP20 PEPFAR will coordinate with Rwanda civil societies including network PLHIV, non- governmental organization and faith based organization, to establish a community led monitoring system to identify and report an potential stigma issues and approaches to address them.

4.6 Targets by population

In COP20, PEPAR will continue to focus its program activities in five provinces of Rwanda (Kigali, Northern, Southern, Eastern, and Western) with each of these designated as having attained epidemic control.

Table 4.6.1: ART Targets by Prioritization for Epidemic Control

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Prioritization Area	Total PLHIV	Expected current on ART (PEPFAR APR FY20)	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) TX_CURR	Newly initiated (APR FY21) TX_NEW	ART Coverage (APR 21)
Attained	227,904	127,581	0	130,690	5,383	95%
Scale-Up Saturation	-	-	-	-	-	-
Scale-Up Aggressive	-	-	-	-	-	-
Sustained	-	-	-	-	-	-
Central Support	-	-	-	-	-	-
Commodities (if not included in previous categories)	-	-	-	-	-	-
Total	227,904	127,581	0	130,690	5,383	95%

Table 4.6.2 VMMC 90% Coverage and Targets in FY21 Age Bracket (15 – 29 years) in Scale-up Districts						
SNU	Target Population at 90% in FY21 (15-29 age band focus)	Population Size Estimate 15 – 29 Years in FY21	Current Coverage (End COP19)	VMMC_CIRC (in FY21)	Expected Coverage (in FY21)	
EAST	409,406	454,896	283,305	50,803	82%	
KIGALI	190,735	211,928	166,812	23,767	100%	
NORTH	266,342	295,935	202,875	39,843	91%	
SOUTH	401,487	446,097	252,278	55,155	77%	
WEST	380,234	422,482	284,900	33,632	84%	
Total	1,648,204	1,831,338	1,190,170	203,200	85%	

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 2021)	FY 2021 Target
FSW (KP_PREV)	13,714 (8,853 – 23,495)	85%	19,853
MSM (KP_PREV)	8,411 (6,760 – 11,151)	37%	2,500
Clients of FSW (PP_PREV)			28,500
AGYW 15-24 (PP_PREV)			73,840
Male Partners of AGYW 15-24			3,000
TOTAL			127,693

Table 4.6.3a Target Populations for Prevention Interventions to Facilitate Epidemic Control - AGYW			
Target Populations	Population Size Estimate (SNUs) and disease burden	Coverage Goal (in FY21)	FY21 Target
Kigali	101,818	64,279 (63%)	52,090
Eastern	26,899	14,877 (55%)	11,949
Southern	27,877	12,161 (44%)	9,799
Northern			
Western			
TOTAL	156,594	91,317 (58%)	73,838

Table 4.6.3b Target Populations for Prevention Interventions to Facilitate Epidemic Control – DREAMS PP Prev			
Target Populations	Population Size Estimate (SNUs) and disease burden	Coverage Goal (in FY21)	FY21 Target
Kigali			53,680
Eastern			12,659
Southern			10,499
Northern			-
Western			-
TOTAL			76,838

Table 4.7.4 Targets for OVC and Linkages to HIV Services			
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY21Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC*
Kigali	44,336	84,063	63,088
Eastern	131,300	36,337	24,101
Southern	233,917	37,428	22,140
Northern	133,641	10,444	6,395
Western	177,425	79,281	35,324
TOTAL	720,619	247,553	151,048

Notes: 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 54,581 DREAMS and 192,972 OVC. OVC_HIVSTAT includes 54,581 DREAMS and 96,467 OVC <18. Note: OVC_HIVSTAT does not include the OVC preventive 9-14 years old.

4.7 Viral Load and Early Infant Diagnosis Optimization

PEPFAR is working to ensure efficient use of VL and EID testing instruments to provide more than 90% 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; improved testing for timely return of results and documentation for VL/EID results into patient records at the site level. Currently viral load and early infant diagnosis (EID) testing is performed in a spoke and hub approach using high throughput conventional PCR and near point of care (POC) instruments at high volume EID testing sites. In COP20 PEPFAR will continue to provide technical assistance to ensure that the equipment is optimally utilized to ease sample referral and ensure return of results to achieve optimal testing coverage and where possible integration of diagnostics platforms to eliminate underutilization of VL testing capacity. Currently, MOH is conducting a data collection and network optimization exercise of existing testing platforms for a comprehensive program needs assessment for HIV, Hepatitis and Human papillomavirus testing. The result will be to make recommendations of required changes to the laboratory testing network as well as fully implement the decentralized sample transportation system in finite laboratory catchment areas closer healthcare facilities.

COP20 PEPFAR 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. Since 2018, all VL testing hubs operate a functional LIS which is accessed through the internet at all health facilities to track patient samples and retrieve test result information. Integration of VL testing into a dashboard supports monitoring and tracking of sample registrations, rejected specimens, viral load suppression by age and reduces the turnaround time of testing at VL Hubs and printing results at health facilities.

In COP20, PEPFAR will provide technical assistance to the Rwanda Biomedical Center (RBC) to improve coverage and monitor VL suppression in geographic areas that have historically lagged, particularly the South and East provinces. Efforts will be made to streamline national VL testing capacity and needs to meet acceptable threshold of 50-80% to make sure that there is neither deficiency nor redundancy in VL testing capacity to monitor suppression trends among PLHIV. PEPFAR will continue supporting VL testing CQI through training and commodity forecasting at national and decentralized laboratories to ensure the quality of VL testing; enhance decentralized sample referral and result return systems between VL testing hubs and health facilities in the catchment area to minimize the cost of sample transportation while maintaining high quality VL results and short TAT.

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 diagnostics testing from clinically suspected patients. In COP20 TB GeneXpert CQI will be continued to ensure quality assurance of TB GeneXpert testing for diagnosis of TB to support rollout of TPT among TB negative PLHIV and an opportunity for integrated diagnostic testing for HIV VL and/or EID under the diagnostic network optimization.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

5.0 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). As Rwanda's Population-Based HIV Impact Assessment (RPHIA) data demonstrated that Rwanda has reached epidemic control, PEPFAR will now focus on building the systems necessary to 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. The country's full PHIA results and program data analysis suggests that systems support is critical to continue to expand case finding, reach children and adolescents (including adolescent and young women), and men. This includes linking these targeted groups to treatment, retain in care, and keep them virally suppressed. Systems support continues to be an important investment as Rwanda shifts from achieving epidemic control to building a sustained national 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 treatment and care. COP 20's systems investments will focus on targeted approaches in commodity security and supply chain, service delivery, health information systems, strengthened quality management and laboratory to support HIV case finding, reduce the incidence of new infections and sustain epidemic control.

In COP20, PEPFAR will continue to maintain investment priorities from COP19 as the program sustains 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 identify remaining gaps in the 95-95-95 cascade, measure impact of PEPFAR investments, support data-driven decisions to achieve epidemic control and strengthen continuous quality improvement of programs
5. Enhance laboratory testing network, CQI for improved quality of service delivery and monitoring systems for specimen referral, testing and timely return of test results from laboratory to healthcare providers for high quality patient centered care and improved health outcomes

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

5.1 Improve Systems to Ensure Supply Chain Management Capacity and Commodities Security

In COP 20, PEPFAR's supply chain systems strengthening strategy will focus on (1) the transition of USG commodity procurement and delivery to Rwanda Medical Service, Ltd (RMS); (2) leveraging USG pharmaceutical services and Rwanda Food and Drugs Authority (FDA) investments & implement pharmacovigilance; (3) improving the electronic logistics management information system for better decision-making; and (4) ensuring the proper implementation of ART optimization including the scale up of TLD and MMP/D.

During COP19 and COP20 implementation, PEPFAR will support the transformation of the GoR's Medical Production and Procurement Division (MPPD) to a parastatal organization, RMS. Historically, as a GoR MPPD presented various challenges such as being cumbersome and inflexible with regards to the sourcing and procurement system, fractured distribution networks, gaps in oversight and tracking availability of commodities, and burdensome administrative process to manage stock shortages. Rwanda is in the final stages of establishing RMS. Currently, RMS is registered as a company and a law separating MPPD from RBC has been amended. An inventory of assets is being conducted, which will result in a transfer of assets from MPPD to RMS. The key decision required from GOR is the appointment of RMS Senior Leadership and the Board of Directors. PEPFAR supported the development of a comprehensive business plan for RMS and conducted an activity-based costing (ABC) exercise of the in-country supply chain. In COP19/COP20, PEPFAR will provide TA to revise procedure manuals in order to smoothly transition from MPPD to RMS.

The establishment of RMS will improve the national supply chain system by ensuring availability of essential medicines through streamlined procurement and distribution processes, increased inventory oversight and traceability of commodities from central level to the customer and improve consumption data capturing. In COP20, PEPFAR will be directly funding RMS Ltd. for in-country logistics and 40% of ARV procurement, with an initial focus on TLD. As soon as the RMS Senior Leadership and Board of Directors are appointed by the cabinet, USAID will start negotiations with RMS on contracting and will begin direct funding to RMS Ltd. The plan is to complete the transition of commodity procurement from GHSC-PSM and GHSC-RTK to RMS within the next 24-36 months. During this transition process, PEPFAR Rwanda will rethink and revamp the internal management of commodities oversight to ensure efficiency and sustainability.

Like COP 19, in COP 20, PEPFAR will leverage resources from USAID's wider health portfolio to work with the Medicine Technology and Pharmaceuticals Services (MTaPS) project. The MTaPS activities in Rwanda will be focused on product registration (TLD 90, pediatrics DTG, and other new molecules), adverse event reporting/pharmacovigilance, poor-quality medicine notifications, medicine safety and quality, medication error mitigation, product recall, rational use and related regulatory and safety matters. MTaPS will provide support to Rwanda's newly formed regulatory authority, RFDA, to ensure evaluation, registration and market authorization of new products and/or formulations (TLD90, DTG5mg, DTG10mg, TLE400). These activities will facilitate the institutionalization of an internal system for pharmacovigilance through monitoring the safety of medicines, rolling out of regulatory related ART optimization plans, ART medication error mitigation, advocating for inclusion of patient level ART regimen data in the reporting systems, and establishing drug and therapeutic committees to promote appropriate use of medicines, and to contain antimicrobial resistance.

In COP 20, PEPFAR will continue working to improve logistics data for decision-making by institutionalizing and upgrading the eLMIS, exploring the Global Standards One (GS1) standard for tracing commodities, and increasing capacity of high-volume ART sites supply

chain oversight through Quality Management Improvement Approach (QMIA). PEPFAR will additionally continue to implement the laboratory bundling and strengthen network capacity to manage laboratory stock, ensure proper national transition of TLD- and DTG-based regimens, and support the national integrated Coordinated Procurement and Distribution Systems budgeting and supply planning exercises.

5.2 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 COP20, PEPFAR's above-site service delivery efforts will strengthen existing systems within Ministry of Health (MOH) to maintain quality HIV service provision and HIV prevention through PMTCT, PrEP, and VMMC. As Rwanda further targets programming around case finding, recency testing, self-testing, PrEP, MMP, TPT, and TLD the program will use programmatic data from MOH's developed policies to further refine strategies from COP19's implementation of these initiatives.

PEPFAR and MOH will improve guidelines, standard operating practices, and implementation to reflect key program directives for the national HIV program. The program will also work to improve national guidelines that will encompass a client centered approach to service, national coordination of AGYW programming, and integration of NCD screening and management of PLHIV. PEPFAR will also continue support to 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 leverage MOH development of a central learning platform to support health care workers' continuous learning on HIV and mentorship practices to improve PEPFAR COP20 implementation of the different program initiatives throughout the country.

In COP20, PEPFAR will also continue to support Rwanda's National Reference Laboratory (NRL) to improve capacities of healthcare providers and other laboratory cadres to enhanced use of the electronic Lab Information (eLab) Systems for patient centered service delivery, quality improvement monitoring and improved lab-clinical interface. Recency testing sites will be expanded to near POC recency testing established at district hospitals to conduct the rapid test for recent HIV infection (RTRI) for all health centers in their catchment to increase geographical access of recency testing to all newly diagnosed HIV-positive including site staff training, proficiency testing and onsite mentorships. PEPFAR will continue to provide technical assistance and financial support for robust laboratory quality management and continuous quality improvement systems for accurate and timely return of test results and monitoring of specimen referral and transportation for integrated diagnostics and optimized VL, EID and TB laboratory 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.

5.3 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 with a focus on data use. 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; 4) risk behaviors associated with recent and long-term infection, and 5) 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 scale-up to remaining CBS site and maintenance of the digital platform for case finding and patient management through surveillance in COP20. 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 use of the national UPID enables the deduplication of data and improves the quality of aggregate reports. The extraction of the MER indicator data from the EMR to the Rwanda Health Management Information System (RHMIS) 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.

5.4 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 maintained 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 service delivery for client centered care and monitoring of epidemic control. In COP 20, PEPFAR will focus on completing the scale-up and maintenance of systems developed in the previous years and to ensure they continue to support client level monitoring for sustained 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 reviews and data quality improvement activities, data analysis and use data to make decisions regarding the HIV epidemic in Rwanda remains a key component of sustaining epidemic control. In COP20, PEPFAR will continue to support health care providers to expand their capacities in HIV surveillance, data

collection and data use. PEPFAR will continue to support and leverage on the Field Epidemiology Training Program (FETP) to strengthen and institutionalize capabilities to synthesize and use HIV data to inform public health response at national and sub-national levels. FETP will also play a key role in supporting investigations of foci of recent infections reported through the CBS/recency testing alert systems.

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.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

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 minimal increases CODB have been included in COP20 to achieve PEPFAR directives.

CDC currently has six vacant positions of which all are in various stages of the recruitment process and expected to be filled by or during COP20 implementation. All positions were vacated starting in June 2019. Filling these vacancies is critical to carrying out CDC's 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 19, CDC will repurpose a contracted communications position to a locally employed position resulting in substantial cost savings and increased meaningful engagement with local partners. CDC will also request one new position to support laboratory-based surveillance including detection of outbreaks, provide technical assistance to increase laboratory capacity and strengthen a national laboratory referral and testing network and conduct necessary SIMS visits. CDC will not request any new positions in the next fiscal year.

USAID is requesting one new position for COP20, while maintaining its currently filled positions. The position is a dedicated DREAMS Coordinator to support Rwanda's DREAMS portfolio who will serve as the AGYW point person in the coordination of all DREAMS activities and programming across the entire USG PEPFAR portfolio. The DREAMS Coordinator will also work closely with the proposed AGYW focal point within the Government of Rwanda. The DREAMS Coordinator will work across all USG agencies and report to the USAID Health Office Director for programmatic, administrative and personnel matters. The plan is for a local hire to fill the new DREAMS coordinator position and to prepare the pre-solicitation documents now. However, an offer cannot be made until COP20 funds are available. The anticipated hire date is 1-3 months after receiving COP20 funds.

The two new positions requested in COP 19, were a Commodities Specialist and a Contracting Specialist. The Commodities Specialist is currently under recruitment (closing date for solicitation was February 21, 2020). The Contracting Specialist position will support the transition from the Medical Procurement and Production Division (the government-run central medical store in Rwanda) to the RMS, a commercial parastatal entity that has been formed to take on supply chain functions. The Contracting Specialist position will be a consultant hired through a USAID central mechanism, Boost, implemented by Jefferson Consulting Group, which provides acquisition and assistance support services. The consultant will likely be hired in mid-2020 as the transition to RMS has progressed with the Cabinet of Ministers expected to form the Board in early 2020.

In order to ensure adequate staffing and proper alignment of the staff needed for the DOD portion of the PEPFAR programming, DOD filled the vacant DOD Clinical Services Specialist position, which was fully funded in COP16 and position hired in year of 2017. DOD has now right sized its staffing footprint to its PEPFAR workload (no change from COP19) and will be able to carry out the necessary SIMS visits and provide TA on clinical services activities. Requested funding for CODB for COP20 is \$220,000.

The PEPFAR Coordination office is currently staffed by a PEPFAR Coordinator and a Strategic Information Liaison, both positions are hired using a USAID USPSC mechanism and costs are captured under USAID's CODB. In COP 20, PCO will add a program assistant/grants manager position. This person will be responsible for managing the Community Led Monitoring program being introduced in COP 20. In COP19, PCO abolished the Deputy PEPFAR Coordinator position.

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
Kigali City	COP17	Scale-Up: Saturation	APR18	48%	48%	73%	76%	97%	89%	90%
	COP18	Scale-Up: Saturation	APR19	54%	55%	76%	77%	99%	91%	92%
	COP19	Scale-Up: Saturation	APR20	67%	67%	79%	79%	98%	92%	93%
	COP20	Attained	APR21	68%	74%	116%	80%	92%	91%	92%
East	COP17	Scale-Up: Saturation	APR18	67%	67%	68%	70%	90%	83%	85%
	COP18	Scale-Up: Saturation	APR19	75%	76%	70%	72%	91%	85%	87%
	COP19	Scale-Up: Saturation	APR20	88%	88%	73%	73%	91%	85%	88%
	COP20	Attained	APR21	56%	51%	117%	112%	111%	98%	103%
South	COP17	Scale-Up: Saturation	APR18	64%	64%	60%	62%	79%	73%	75%
	COP18	Scale-Up: Saturation	APR19	72%	73%	62%	63%	80%	74%	77%
	COP19	Scale-Up: Saturation	APR20	85%	85%	66%	66%	81%	76%	78%
	COP20	Attained	APR21	55%	65%	117%	112%	91%	93%	92%
West	COP17	Scale-Up: Saturation	APR18	82%	83%	71%	74%	95%	87%	90%
	COP18	Scale-Up: Saturation	APR19	93%	94%	74%	76%	96%	89%	92%
	COP19	Scale-Up: Saturation	APR20	108%	108%	78%	78%	96%	90%	93%
	COP20	Attained	APR21	80%	84%	120%	109%	98%	86%	95%
North	COP17	Scale-Up: Saturation	APR18	54%	54%	56%	59%	75%	69%	70%
	COP18	Scale-Up: Saturation	APR19	61%	62%	59%	60%	76%	70%	72%
	COP19	Scale-Up: Saturation	APR20	69%	69%	59%	59%	75%	70%	72%
	COP20	Attained	APR21	75%	77%	97%	106%	96%	90%	93%
TOTAL	COP17	Scale-Up: Saturation	APR18	63%	63%	66%	69%	88%	81%	83%
	COP18	Scale-Up: Saturation	APR19	67%	67%	68%	70%	90%	83%	85%
	COP19	Scale-Up: Saturation	APR20	83%	83%	72%	72%	89%	84%	86%
	COP20	Attained	APR21	67%	70%	113%	103%	98%	92%	96%

APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP20 Budget by Program Area

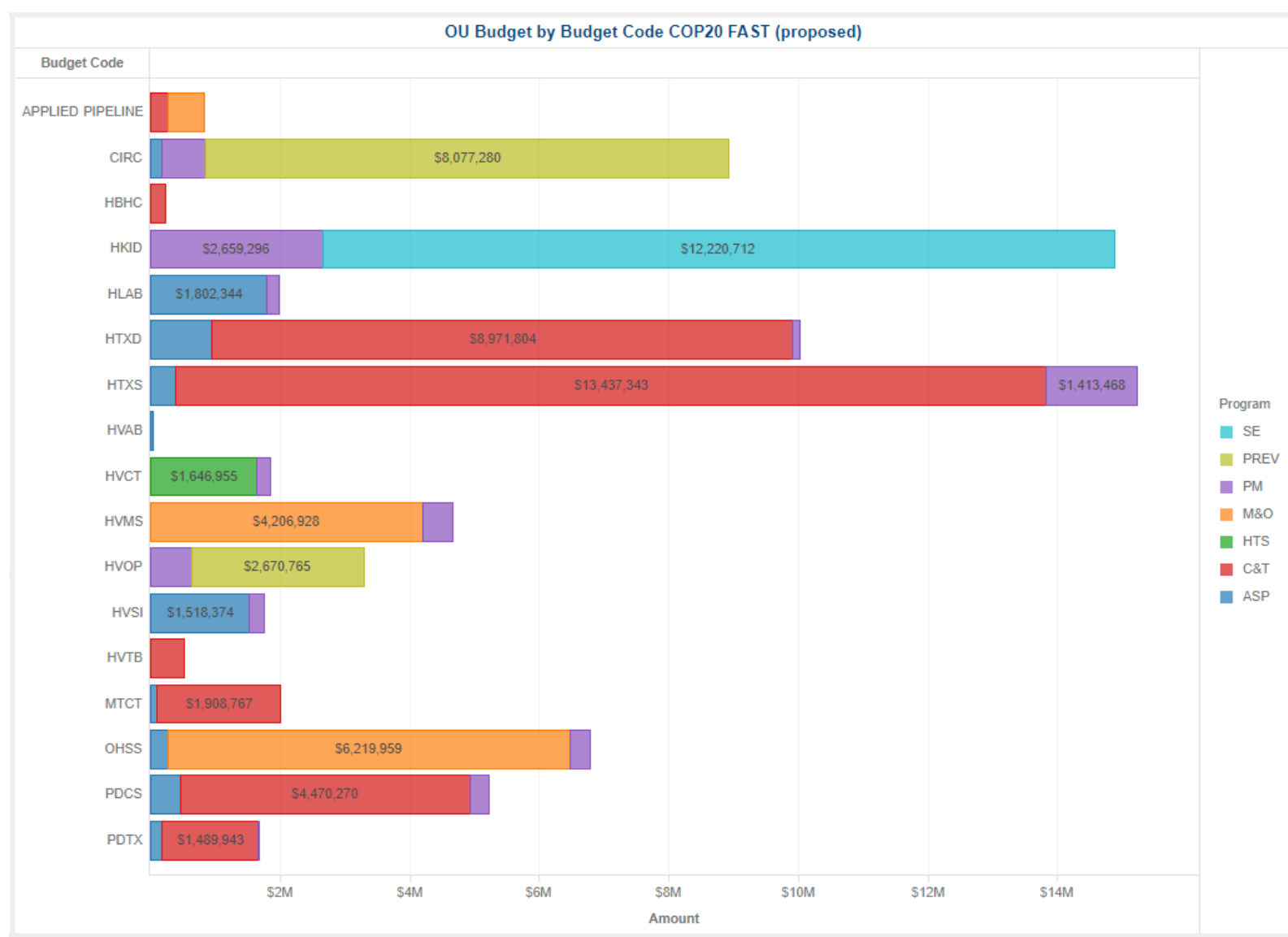


Table B.1.2 COP20 Total Planning Level

Applied Pipeline	New Funding	Total Spend
\$837,050 US	\$79,106,953 US	\$79,944,000 US

*Data included in Table B.1.2 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$ 2,012,461
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$ 44,443
HVOP	Other Sexual Prevention	\$ 3,305,669
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	\$ 8,932,420
HVCT	Counseling and Testing	\$ 1,842,898
HBHC	Adult Care and Support	\$ 226,769
PDCS	Pediatric Care and Support	\$ 5,216,889
HKID	Orphans and Vulnerable Children	\$ 14,880,008
HTXS	Adult Treatment	\$ 15,228,556
HTXD	ARV Drugs	\$ 10,033,000
PDTX	Pediatric Treatment	\$ 1,685,785
HVTB	TB/HIV Care	\$ 514,081
HLAB	Lab	\$ 1,978,279
HVSI	Strategic Information	\$ 1,750,008
OHSS	Health Systems Strengthening	\$ 6,794,477
HVMS	Management and Operations	\$ 4,661,210
TOTAL		\$ 79,106,953

*Data included in Table B.2.2 should match FACTS Info records.

B.2 Resource Projections

COP20 planning focused on program-based, incremental budgeting to determine the required resources to sustain program activities and focus on a client centered approach to service delivery. 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 – Tables and Systems Investments for Section 6.o

Table 6:

Table 6-E (Entry of Above Site Programs Activities)								
Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
HHS/CDC	Trustees Of Colum	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Inadequate epidemiological competencies required for continuous data analysis and synthesis for HIV programmatic decision making	COP19	COP21	[COP21 Benchmark] RBC independently conducting data management, analysis and public health response
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Inadequate IT infrastructure and human resources to improve sample referral, timely return of test results and insufficient mechanisms to monitor turnaround times (TAT) of VL/EID and recency results to ensure that patients are documented and effectively utilized	COP18	COP21	[COP21 Benchmark] NRL operating an optimized sample referral and transport systems in the lab network for VL/EID testing. Over 95% of health facilities have access to LIS for requesting and return of results within acceptable established turnaround time
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Inadequate IT infrastructure and human resources to improve sample referral, timely return of test results and insufficient mechanisms to monitor turnaround times (TAT) of VL/EID and recency results to ensure that patients are documented and effectively utilized	COP18	COP21	[COP21 Benchmark] 100% of health facilities have access to LIS for requesting and return of results within acceptable established turnaround time
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Inadequate monitoring of specimen referral, rejections and return of laboratory results for clinical and remedial action. Insufficient systems in place for post market surveillance of HIV self-testing kits	COP18	COP21	[COP21 Benchmark] 100% maintained, certified/ calibrated and functional equipment at all specialized testing facilities including VL hubs
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate IT infrastructure and human resources to improve sample referral, timely return of test results and insufficient mechanisms to monitor turnaround times (TAT) of VL/EID and recency results to ensure that patients are documented and effectively utilized	COP19	COP21	[COP21 Benchmark] NRL maintains international accreditation status and 95% intermediate lab level engaged in CQI activities meet national/international quality and biosafety standards. 100% of HIV/RT use standard HTS logbook, and 100% certification of HIV testers
HHS/CDC	GOVERNMENT OF RWANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	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	[COP21 Benchmark] Functional EMR supporting clinical care and case-based surveillance transitioning to MOH/RBC
HHS/CDC	GOVERNMENT OF RWANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	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	COP16	COP20	[COP21 Benchmark] Components of RHIES supporting HIV care (including EMR, LIS, DHIS-2/RHMS) implemented.
HHS/CDC	GOVERNMENT OF RWANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	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	COP18	COP20	[COP21 Benchmark] RHIES infrastructure in place to support data sharing between HIV systems, partially maintained using local resources as part of national eHealth architecture
HHS/CDC	GOVERNMENT OF RWANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	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	COP20	[COP21 Benchmark] Enhanced use of CBS data to identify sources of new/recent infections, risk factors for new infections, loss to follow-up, morbidity and mortality at national, district and facility levels.
HHS/CDC	GOVERNMENT OF RWANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	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	[COP21 Benchmark] Core MER indicators are routinely exchange from EMR to RHMS to high-volume PEPFAR sites able to exchange electronic data
HHS/CDC	GOVERNMENT OF RWANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	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	COP16	COP20	[COP21 Benchmark] Client registry is functional and the primary source of UIDs supporting client-centered care, CBS and program data de-duplication through appropriate record linkage

HHS/CDC	GOVERNMENT OF RWANDA	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Pre-service training	Institutionalize systems within MOH to better improve planning, efficiencies, and increased ownership of the HIV program in light of funding reductions	COP18	COP21	[COP21 Benchmark] 100% of training for 10 residents completed
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	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	COP18	COP21	[COP21 Benchmark] 100% eligible PLHIV initiated complete TPPT
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	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	COP21	[COP21 Benchmark] 100% all facilities able to conduct their own gap analysis, report them on time and implement remedial strategies to address program gaps
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	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	COP20	
HHS/CDC	UNIVERSITY OF RWANDA	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	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	COP20	[COP21 Benchmark] Program data indicating improvement of case finding, adherence, and VLS by site, location, age, and sex as a result of targeted CQI practices
HHS/CDC	UNIVERSITY OF RWANDA	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate IT infrastructure and human resources	COP18	COP21	[COP21 Benchmark] eLab systems are handed over to NRL team to fully support upgrades of functionalities, integration and administration for testing and QA service delivery

HHS/CDC	GOVERNMENT OF RWANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Inadequate epidemiological competencies required for continuous data analysis and synthesis for HIV programmatic decision making	COP20	COP21	[COP21 Benchmark] National programs routinely use the PSE data to
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	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	COP21	[COP21 Benchmark] 100% of all eligible MMP will be on 6-months MMP
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	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	COP18	COP20	
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Training in laboratory	Inadequate CQI systems for HIV Recency, HIV	COP20	COP21	[COP21 Benchmark] Reach 95% coverage of HTS-POS offered Recency
HHS/CDC	GOVERNMENT OF RWANDA	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate CQI systems for HIV Recency, HIV	COP19	COP21	[COP21 Benchmark] 95% intermediate lab level participating and successfully passing EQA/PT and performing QC

USAID	Chemonics Interna	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	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	COP16	COP22	1) Optimized ART (TLD90) implemented for both adult and pediatrics 2) Availability of medicines for PrEP and TPT 3) 85% of TX-CURR on MMP/D
USAID	Chemonics Interna	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	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	COP17	COP22	1) Laboratory bundling manual and tools used by SDPs 2) All procurement, storage units and SPPs implement lab bundling 3) Lab reagent/supplies availability improved to 95% or above
USAID	Chemonics Interna	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	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	COP16	COP22	1) 90% of facilities with accurate logistics data 2) 98% of facilities using eLMIS replenishment engine to estimate their needs 3) Full interoperability of all relevant MIS systems achieved. 5) PPMR-HIV reporting
USAID	Chemonics Interna	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Product selection, registration, and quality	Inadequate continuous quality improvement of HIV core and specialized tests to support epidemic control Lack of local accrediting body	COP17	COP22	Continued Tracer commodity stock out rate decreased to less than 2%
USAID	Chemonics Interna	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Product selection, registration, and quality monitoring	Inefficiencies in the country supply chain management including inflexible procurement policies and guidelines in the supply chain operations at various levels and insufficient capacity for procurement of HIV commodities	COP18	COP22	1) 75% reduction in supplier lead time for ABC products 2) 80% On Time in Full Delivery (OTFD)

SRE:

SRE Tool-E (Entry of Surveillance, Surveys, Research and Evaluation Activities)						
Funding Agency	Mech Name	Prime Partner	Project Title	Project Lead	Primary evaluation or study questions	COP or HOP Funded?
HHS/CDC	Recency HQ Mechanism-ICAP	Trustees Of Columbia University In The City Of New York	Support RBC to oversee data management, quality assurance, data analysis and use of TRACE and CBS data for public health response before transitioning to ICAP	ICAP	The primary scope of work is for ICAP to support RB	COP
HHS/CDC	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	GOVERNMENT OF RWANDA	Integrated management, analysis and use of CBS and MER data to inform public health response and program improvement: Institutionalize data management, analytics and use of the active case-based surveillance system at national, district and facility levels. Use data for public health response at national, district and facility level. Examples are: identifying sources of new/recent infections, risk factors for new infections, co-morbidity, viral suppression and mortality.	Rwanda Biomedical Center	To increase understanding of HIV transmission modes through network analysis and recency test results	COP
HHS/CDC	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	GOVERNMENT OF RWANDA	Population size estimation of men who have sex with men in Rwanda, 2021	Society for Family Health	To estimate the population size of MSM in Rwanda, 2021	

Funding Agency	Mech Name	Prime Partner	Work ID	COP/Program Area	COP/Pop. Category	COP/Pop. Disaggregation	Budget	Activity Description	Filter Here - Select Surveillance, Research and Evaluation	Activity Type	Project Title	Project Lead
HHS/CDC	Recency HQ Mechanism-ICAP	Trustees Of Columbia University In The City Of New York	81871	ASP: HIVMS, surveillance, & research-NSD	Non-Targeted Pop: Not Disaggregated		\$ 280,000	Support RBC to oversee data management, quality assurance, data analysis and use of TRACE and CBS data for public health response before transitioning to ICAP/NSD	Surveillance	Other	Support RBC to oversee data management, quality assurance, data analysis and use of TRACE and CBS data for public health response before transitioning to ICAP/NSD	ICAP
HHS/CDC	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	GOVERNMENT OF RWANDA	81872	ASP: HIVMS, surveillance, & research-NSD	Non-Targeted Pop: Not Disaggregated		\$ 287,795	1. Institutionalize data management, analytics and use of the active case-based surveillance system at national, district and facility levels. Use data for public health response at national, district and facility level. Examples are: identifying sources of new/recent infections, risk factors for new infections, co-morbidity, viral suppression and mortality. [11.7/700] 2. MER data from all 5 regions will be used to identify facilities with gaps in testing and viral suppression by monitoring data use at district and facility level through monthly data reviews, targeting poor performing facilities. [11.00] 3. Review and update policies for data security and data sharing policies, formal engagement of the Government of Rwanda's key agencies (by RBC) that develop policies and legislation on data protection. [05]	Surveillance	Case surveillance	Institutionalize data management, analytics and use of the active case-based surveillance system at national, district and facility levels. Use data for public health response at national, district and facility level. Examples are: identifying sources of new/recent infections, risk factors for new infections, co-morbidity, viral suppression and mortality. Data needed for CBS within this activity - 11.7.700 Table 8 Activity	Rwanda Biomedical Center
HHS/CDC	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	GOVERNMENT OF RWANDA	81873	ASP: HIVMS, surveillance, & research-NSD	Non-Targeted Pop: Not Disaggregated		\$ 100,000	Conduct a population size estimation (PSE) for MSM nationally. Data from PSE will inform the RBC support strategy (RST) to inform targeted programming for MSM.	Surveillance	Population estimation	Population size estimation of men who have sex with men in Rwanda, 2021	Society for Family Health

REGISTRY REF: UNCLAS/NOFORN

APPENDIX D– Minimum Program Requirements

The minimum requirements for continued PEPFAR support include:

Program Area	Minimum Program Requirement	Rwanda Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Achieved
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing >20kg, and removal of all nevirapine-based regimens.[2]	In Progress - TLD now offered to all, including women of childbearing age
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	On Track to achieve by COP20
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Catch up plan in place for COP19, Ministry of Health confident to meet targets set forth in COP20
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Achieved
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Achieved
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	In Progress - PrEP guidelines to be updated by COP20 implementation
	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Achieved
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	Achieved

2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Achieved
3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	In Progress
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Achieved
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	In Progress
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Achieved
7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	In Progress

Site level MPRs related to linkage and retention: During FY 2020 (COP19 implementation), all OUs are expected to fully implement retention-related PEPFAR Minimum Program Requirements at every PEPFAR-supported site, as these have a known impact on continuity of ART. Site level implementation of these 4 elements must be assessed to inform COP20 planning. In addition, an effective tracking and tracing system must be in place at each site.

Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. – Achieved in Rwanda
Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥ 20kg, and removal of all nevirapine-based regimens. – molecules for children are not available in country
Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services. – Achieved in Rwanda
Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits. – to be achieved by the close of COP19