



Rwanda

Country Operational Plan

COP2021

Strategic Direction Summary

May 10, 2021

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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), stakeholders, and representatives from civil society organizations to develop Rwanda's Country Operational Plan for 2021/Fiscal Year 2022 (COP21). All PEPFAR minimum program requirements and policies will be fully achieved prior to the end of COP20.

In COP21, the PEPFAR Rwanda Program will maintain the paradigm shift from COP19 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 by reaching the second and third pillars of the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 goals nationally.¹ COP21 builds on the results of the RPHIA and programmatic data from COP19 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, COP21 maintains the testing strategies from COP20, including strategic shift to limited case finding focused on at-risk 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. With respect to prevention, PEPFAR will support Early Infant Diagnosis (EID) and community testing of key populations, which include female sex workers (FSWs), their clients, and men who have sex with men (MSM). The program will also support prevention services targeting at-risk and under-served populations of adolescents and young adults through the Orphans and Vulnerable Children (OVC) and the Determined Resilient Empowered AIDS-Free Mentored and Safe (DREAMS) program, as well as expanded Voluntary Medical Male Circumcision (VMMC) services.

PEPFAR will also invest in improved HIV treatment, retention, and drug adherence to support (1) continued implementation 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.

COP21 investments reflect support to direct service delivery and central and site-level systems to bolster the MOH's public health capacity to sustain HIV epidemic control. This includes investments in active CBS with the development of a national Unique Patient Identifier (UPID), a high-performing index testing system, an enhanced Laboratory Information System (LIS) and

¹ RPHIA, 2019

Supply Chain Logistic Management Information System (e-LMIS), the human resources for health (HRH) e-Learning System, and a continuous quality improvement (CQI) system. All central level systems investments will support improvements in site-level patient diagnosis and treatment and enhance monitoring of the performance of the national HIV program.

In addition, moving forward in COP21 PEPFAR will continue to support long-term financial sustainability objectives by transitioning commodities procurement to the commercial parastatal organization, the Rwanda Medical Supply, Ltd. (RMS), with 100% of all antiretrovirals (ARVs) going to RMS with PEPFAR providing budgetary support.

In COP21, PEPFAR will continue to increase its funding to local and indigenous organizations in Rwanda, which increased from 73% in COP2019 to 84% in COP20 (not inclusive of the cost of doing business). PEPFAR is committed to supporting local and indigenous organization management 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 an estimated 227,904 people living with HIV (PLHIV) in Rwanda.⁴ According to the RPHIA, among adults 15-64 years old, prevalence among women is 3.7% as compared to 2.2% among men. 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. The prevalence of HIV among adolescents 10-14 years was 0.4%, indicating that there are approximately 5,900 young adolescents living with HIV in Rwanda.

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

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

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 aged 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 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 (MMC) among men aged 15-64 was 39.9%, ranging from 30.2% in the South to 62.1% in Kigali City. 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 achieving a sustained domestically funded HIV response in the near future. However, the GOR has committed (through the 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 COP2021.

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 occur 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

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

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	12,955,763	100%	2,574,985	22.3%	2,569,113	22.3%	1,310,758	11.4%	1,262,509	10.9%	2,799,052	24.3%	2,439,343	21.2%	NISR Census Projections 2021
HIV Prevalence (%)		1.7%		0.2%		0.2%		1.0%		0.7%		4.2%		2.9%	EPPS 2021*
AIDS Deaths (per year)	2,264		152		154		171		166		802		822		EPPS 2021*
# PLHIV	222,617		5,030		5,053		13,753		8,783		118,485		71,488		EPPS 2021*
Incidence Rate /1000 (Year)		0.42		-		-		0.9		0.3		0.6		0.5	EPPS 2021*
New Infections /(Year)	4,024		218		224		1055		259		1376		891		EPPS 2021*
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	7,542														EPPS 2021*
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)

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															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 IBBS 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														
<i>*Draft data of EPP Spectrum as of February 2020</i>																

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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		
Source(s)	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 2021	Spectrum 2021 RHMIS 2020	RHMIS 2021	Spectrum 2021; RHMIS 2020	RPHIA 2019*; NRL 2020; RHMIS 2020; DATIM 2020	RHMIS 2020	RHMIS 2020	RHMIS 2020
Total population	12,955,763	1.7	222,617	93.6	204,016	91.6%	70.0	3,471,333	17,116	18,579
Population <15 years	5,144,098	0.2	10,083	63.8	6,472	64.2%	50.0	255,007	797	635
Men 15-24 years	2,569,113	0.7	8,783	84.4	5,433	61.9%	(55.9)	568,755	1,256	544
Men 15-49 years	3,111,028	1.7	54,021	93.1	44,990	83.3%	65.7	1,152,446	5,153	5,767
Men 50+	705,737	3.7	28,250	96.1	28,202	100.0%	70.3	127,310	592	1,409
Women 15-24 years	1,310,758	1.0	13,753	89.4	11,077	80.5%	62.3	493,222 [†]	2,364 [†]	2,731
Women 15-49 years	3,330,297	3.1	102,799	85.0	89,006	86.6%	78.6	1,287,478 [†]	6,759 [†]	9,359
Women 50+	915,157	3.2	29,439	95.1	35,346	100.0%	77.2	137,533 [†]	2,325 [†]	1,409
Source(s)	2018 FSW PSE; 2018 MSM PSE &	2018 MSM PSE & BSS	-	-	-	-	-	-	-	-

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	BSS Kigali; 2015 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

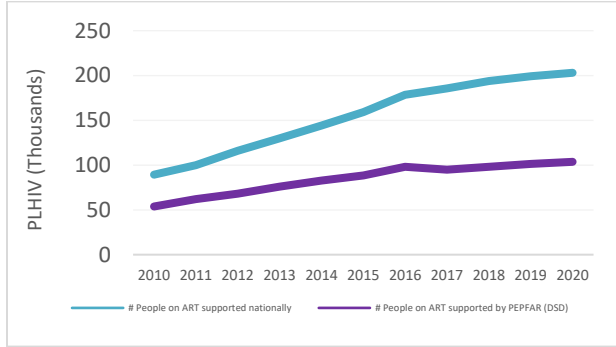


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

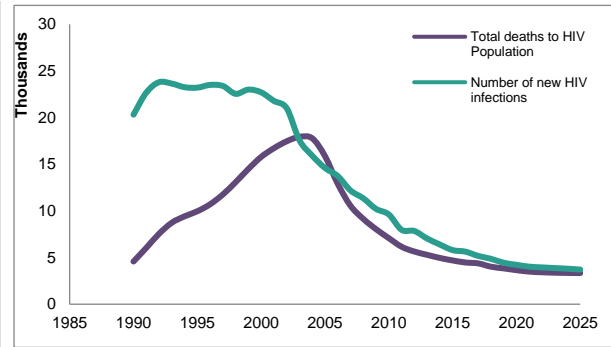


Figure 2.1.5 Progress retaining individuals in lifelong ART in FY20

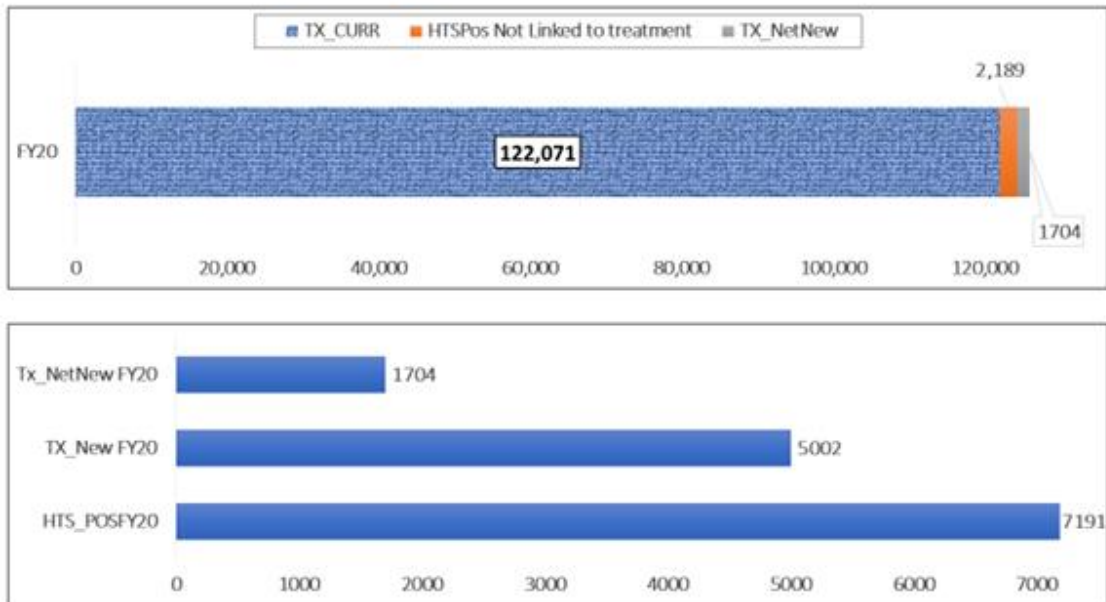


Figure 2.1.6 Proportion of clients lost from ART 2019 Q4 to 2020 Q4

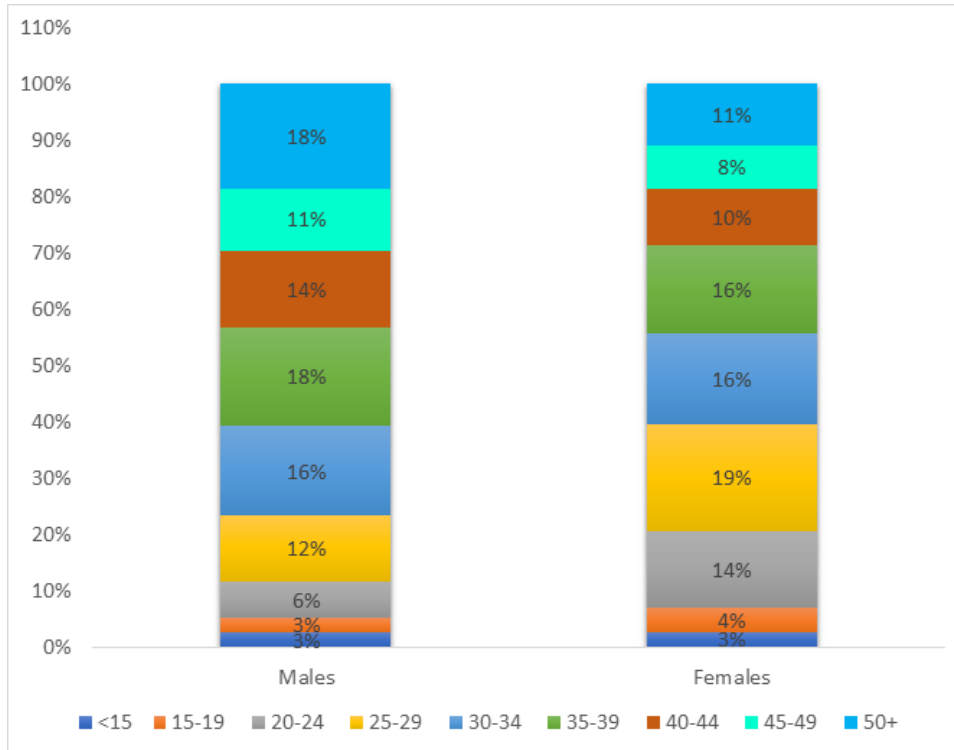


Figure 2.1.7 Epidemiologic Trends and Program Response for Rwanda

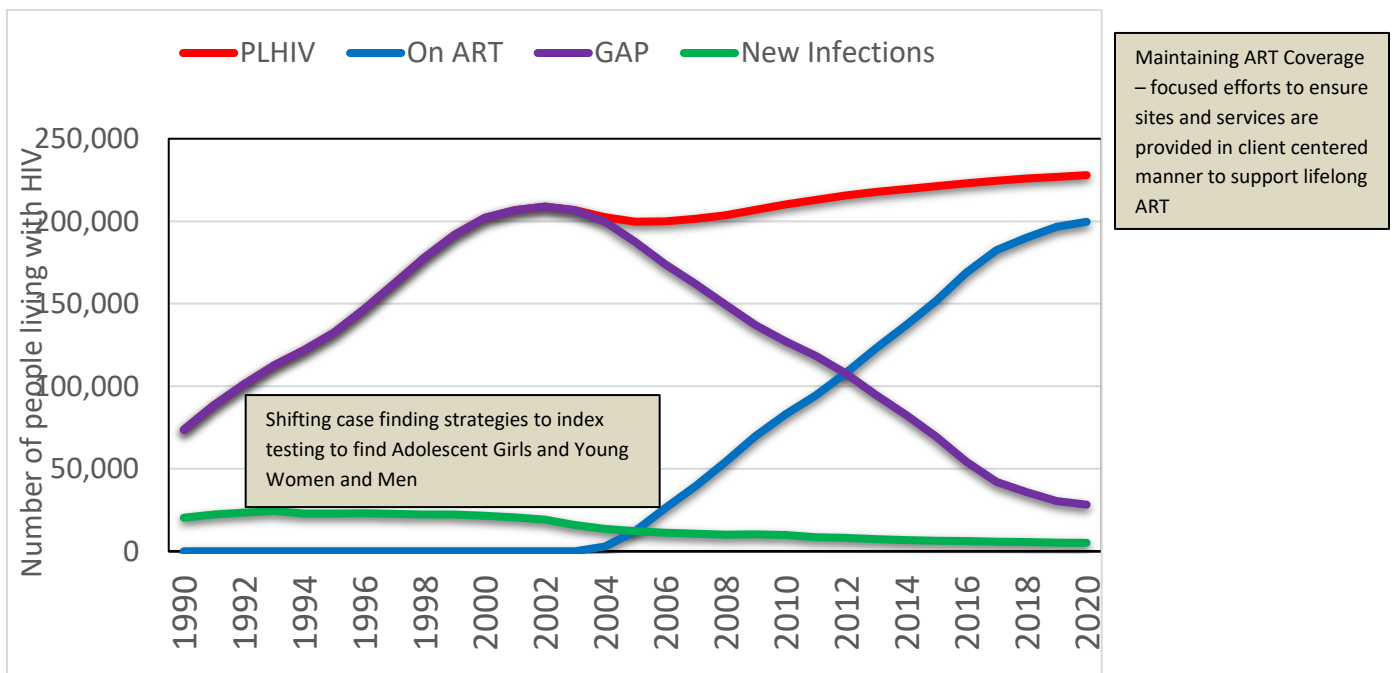
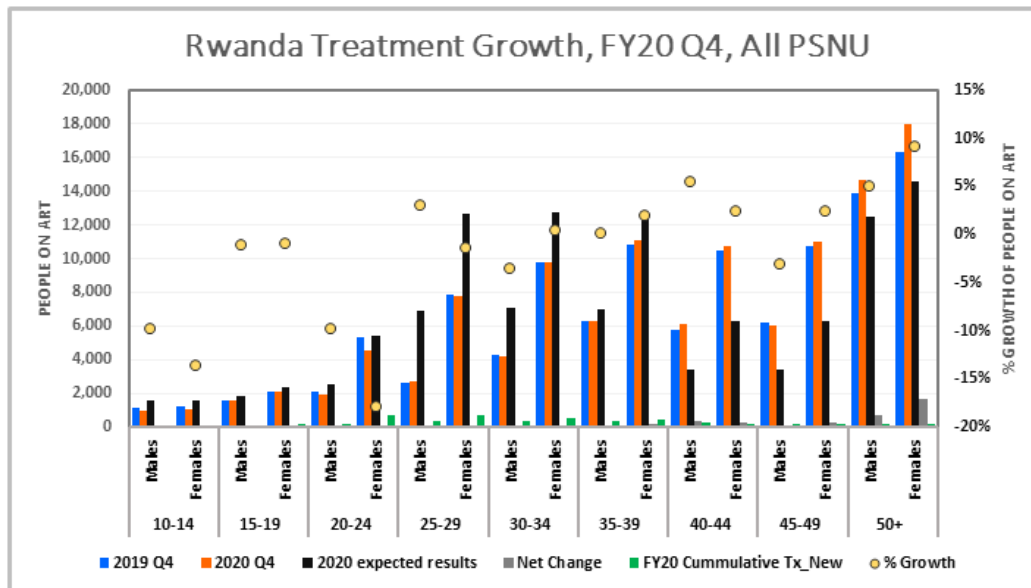


Figure 2.1.8 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

Figure 2.1.8 Net change in HIV treatment by sex and age bands 2019 Q4 to 2020 Q4



2.2 New Activities and Areas of Focus for COP21, Including Focus on Client Retention

In COP21, PEPFAR will build on the achievements made in previous implementation years to ensure client-centered services. An emphasis will be put on patient retention, as the program aims to achieve the 2nd and 3rd 95 in all populations and locations by the end of COP20. Until APR 18, when the retention indicator was phased out, retention of PLHIV on treatment in PEPFAR-supported sites had always been high at 95% compared to 92% nationally. In APR 20, the overall loss 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 2,087 PLHIV who had no clinical contact after 28 days of ART initiation. Of these, 1,342 (64%) were transferred out, and 530 (25%) were LTFU/refused to come back. Nevertheless, 32% of all lost to follow up returned to treatment in the same reporting period. As a contribution to reducing the national gap to the 2nd 95 by COP21, PEPFAR Rwanda will initiated 5,301 new PLHIV on treatment to achieve a cumulative target of 133,152 currently on ART, including TX_CURR TA, in COP21. PEPFAR DSD targets alone account for 50% of all PLHIV on treatment at the national level in FY 22.

Given PEPFAR’s commitment to achieve all three 95s, strategies will be implemented targeting any sites with retention and viral load gaps by age, sex, and geography. These strategies include (1) introduction of specific group support of mothers/ caregivers/ guardians of non-suppressed children and young adolescents; (2) scale up of HIV Adolescent Model, (3) targeted mentorship on age/sex and timely counselling and disclosure through child/adolescent friendly support groups, schools’ involvement and linkage to OVC services. To close gaps among men, PEPFAR will support male-only spaces/corners in clinics that ensure privacy and time, introduction of

male champion clients to provide tailored adherence and retention support to clients, dedicated clinic days for unsuppressed men, support groups for men, an enhanced system for tracking and tracing missed appointments by men, and quarterly review of retention and PVLS data with IPs to inform targeted site-level mentorship for sites with low viral suppression.

2.3 Investment Profile

In FY21, Rwanda's HIV response was funded primarily by three sources: PEPFAR (46%), the Global Fund (GF) (40%), and the GOR (14%).¹⁶ Overall donor funding for Rwanda's HIV program continues to decrease. In FY16, the 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 decreased from \$79.9 million in FY2021 to \$70.3 million in FY2022.¹⁸ The GOR's investment of \$22 million for FY2019-2020 accounted for 14% of the contribution to HIV response, similar to previous investments. In December 2019, the GF 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 the 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 2.3.1, 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, the GF, and the GOR for these areas.

Additional funding streams were made available through COP19 and COP20 in response to the impacts of COVID-19 on health systems. Development Partners in Rwanda provided financial support, donations of necessary medical equipment, and additional technical assistance. It is unclear what the long-term impacts of COVID-19 will be on the health system in Rwanda. PEPFAR, through American Rescue Plan Act (ARPA) funding, is proposing activities and interventions to minimize the impact of COVID-19 on PEPFAR programming (see section 7).

¹⁶ PEPFAR 2020 Expenditure reporting; Rwanda HIV Consolidated Operational Plan, 2018-2020; National HIV Annual Report, 2019-2020. 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 COP20 and COP21 planning level letters.

PEPFAR and the GF are working with the MOH to reduce inefficiencies and realize cost savings, as well as to secure additional domestic funding for human resources and other system costs no longer funded by donors. Significant financial barriers remain to achieving a sustained domestically funded HIV response in the near future.

PEPFAR and the GF are coordinating with the 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 in the working group. The co-chairs of the HSWG will ensure follow-through to advance steps on sustainability planning.

Rwanda is the first country to participate in the 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 COP21, PEPFAR will continue to increase its funding to local and indigenous organizations in Rwanda, from 84% in COP20 to 87% in COP21, not inclusive of the cost of doing business and commodities.

Table 2.3.1 Annual Investment Profile by Program Area¹⁹				
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%

¹⁹ (GRP, National AIDS Spending Assessment, 2019), all amounts in 2019 USD

Table 2.3.2 Annual Procurement Profile for Key Commodities – COP21						
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other	Gap
ARVs	\$20,903,469	48%	50%	0%	0%	2%
Rapid test kits	\$4,059,108	14.70%	49.81%	0%	0%	35.48%
Other drugs*	\$80,518	0%	60%	0%	0%	40%
Lab reagents	\$2,764,262	0%	100%	0%	0%	0%
Condoms	\$1,011,301	30%	0%	0%	0%	70%
Viral load commodities**	\$ 3,774,446.08	37%	19%	0%	0%	44%
VMMC kits	\$3,823,665	12%	63%	0%	0%	24%
MAT				0%	0%	
Other commodities***	\$2,997,512	16%	0%	0%	0%	84%
Total	\$39,414,281	34%	47%	0%	0%	20%

Note: The total required ARV budget is high due to 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.

*Opportunistic Infections (OIs)

** Viral load & EID reagents and consumables

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

Per the December 2019 national quantification report, there is an estimated shortfall of 47.91% in FY21 HIV program commodities as compared to the national forecasted needs (see Table 2.3.2 for details on gaps by commodity). In addition, there is also a forecasted gap of \$1,869,842 for ready-to-use therapeutics foods (RUTF).

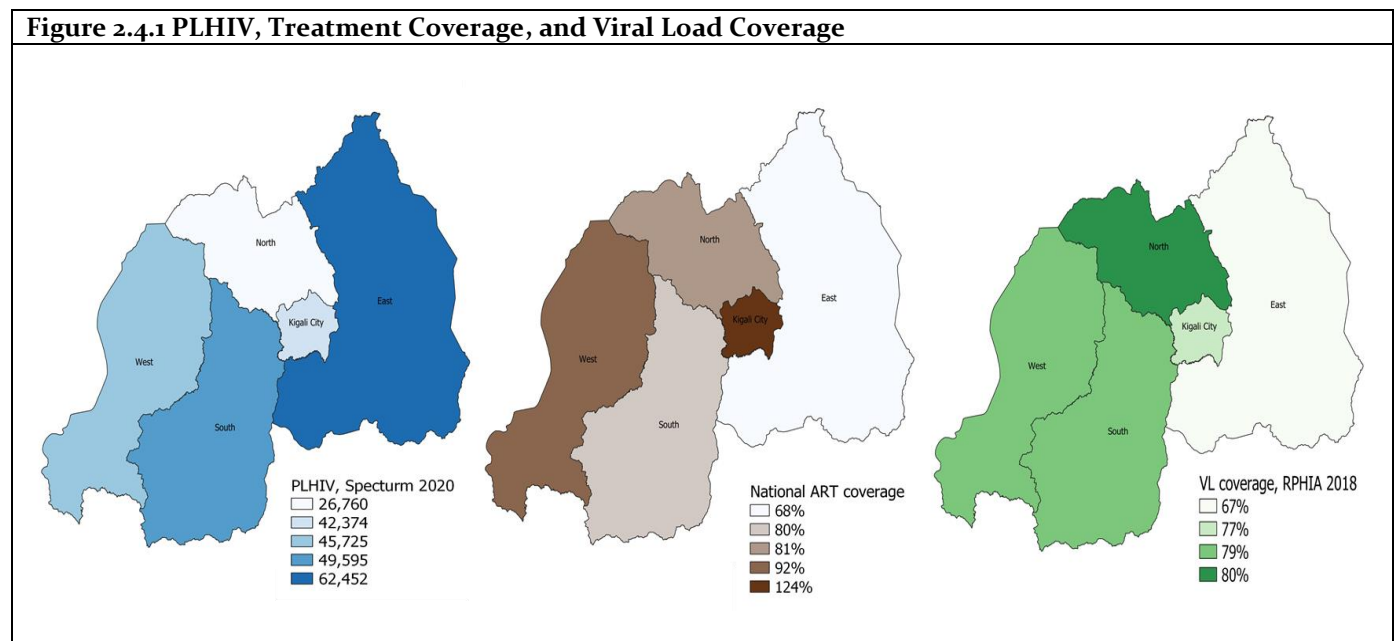
Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration – (not updated in COP21)					
Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID Non-HIV	\$ 46,000,000	\$ 15,642,242	5	\$34,832,277	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, and 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 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 Orphans and Vulnerable Children (OVC) and 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 result from PEPFAR supporting the majority of facilities or patients within a province, and lower expenditure per PLHIV may indicate that few or no facilities in a province 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, COP21 continues to concentrate 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.



2.5 Stakeholder Engagement

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

Civil society, the private sector, PEPFAR implementing partners (IPs), and other stakeholders provided input for the COP21 working groups through participation in a virtual 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 organizations (CSO), umbrella groups working in HIV, the GF Country Coordinating Mechanism (CCM) Secretariat, and the GOR/MOH. Representatives from the GOR/MOH and civil society also took part in the COP21 virtual planning meeting on April 26-27, 2021 and approval meeting on May 17. They were also provided with drafts of budget and target planning documents for their review and were given an opportunity to comment on the SDS for COP2021; these stakeholders will continue to be engaged throughout COP21 implementation. Additionally, the PEPFAR Rwanda team will work with the MOH to ensure the GF application is in alignment with PEPFAR initiatives and programming.

3.0 Geographic and Population Prioritization

The PEPFAR and MOH teams are focused on maintaining epidemic control in Rwanda in COP21. According to results from the 2019 RPHIA, 84% of HIV-positive adults in Rwanda between 15-64 years old were aware of their HIV-positive status; of those, 98% 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 virally suppressed will be possible in all provinces.

In Rwanda, districts are relatively small geographically, with an average of 844 square kilometers and ranging from 134-1937 square kilometers, with 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 in the accuracy of the estimations, the small geographic areas, and the mobility of the population, in COP17 the sub-national unit (SNU) of prioritization for Rwanda was changed to the provincial (between national and district) level. This change allowed for a more accurate regional assessment of where additional resources were 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 might be needed. COP18-COP20 continued with the provincial level as the SNU of prioritization, with programming targeting specific populations based on their presence and risk for HIV. In COP21, PEPFAR will continue to target resources at the provincial level, focusing on

the gaps identified by RPHIA, RHMIS, EPP/Spectrum and other data sources. 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 2020 was 81% for the East, 94% for Kigali City, 86% for the North, 87% for the South, 88% for the West, and 87% overall. COP21 targets have ART coverage as 96% for the total population, estimated at 90% in the East, greater than 100% in Kigali City (taking into account patients who travel into Kigali from outside the city), 94% in the North, 94% in the South, and 95% 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 65.8% according to the most recent EPP Spectrum and program data and targeted to reach 90% in COP2021.

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, Kigali City is a focus area due to its relatively high HIV prevalence and its young and growing population, reflecting the fact that Rwanda is one of the fastest urbanizing countries in the world.²⁰ 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 achieving an AIDS-free generation in Rwanda.

Table 3.1.1: Current Status of ART Saturation

Province	Adult HIV Prevalence (15-64)	Estimated total PLHIV 2019	National PLHIV on ART (Dec 2019)	Estimated ART coverage	VL Testing Coverage (PEPFAR)	VL Suppression (PEPFAR)
Source	RPHIA 2018	Spectrum 2020	RHMIS 2020	-	DATIM FY20Q1	DATIM FY20Q1
NATIONAL	3.0%	226,906	198,658	88%	85%	95%
Kigali City	4.3%	42,374	52,393	124%	82%	94%
East	2.9%	62,452	42,652	68%	85%	96%

²⁰ '2014 Revision of World Urbanization Prospects' United Nations, Department of Economic and Social Affairs, Population Division.

South	2.9%	49,595	39,887	80%	82%	96%
West	3.0%	45,725	41,937	92%	86%	94%
North	2.2%	26,760	21,789	81%	89%	97%

4.0 Client-Centered Program Activities for Epidemic Control

4.1 Finding the missing

Rwanda's most significant challenge in reaching HIV epidemic control is finding new HIV-positive individuals. In APR 20 (FY20), PEPFAR Rwanda identified 3,165 new HIV-positives, 81% of the annual target. In FY 21 Quarter 1 (Q1), PEPFAR-supported sites identified 1210 new HIV-positives through index testing, 37% of the annual target. According to the 2019 RPHIA results, the challenges in reaching the first 95 were finding men in all provinces, especially men between 15-34 years old, and finding women between 15-24 and linking them to treatment (with an estimated gap of 4,219 PLHIV not yet identified based on FY21 Q1 data). During COP21, PEPFAR aims to identify 3,494 new HIV-positives, of which 2,085 (61%) 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 index-facility based testing modalities of case identification through enhancement of partner notification services (PNS) and testing of children born to HIV-positive women. In addition, PEPFAR will support HIV testing for pregnant and lactating women seeking ANC/PMTCT services and retesting PrEP beneficiaries according to the national guideline. PEPFAR will support community-based testing targeting key populations (Female sex workers, clients of female sex workers, and MSM), and priority populations, i.e., clients of FSW and adolescents and young women (AGYW) through DREAMS. In COP21 PEPFAR will introduce the social networking testing strategy in KP program

All 196 of the PEPFAR-supported testing sites across Rwanda are currently supporting index testing services. In FY21 Q1, 15,689 index clients (including 91% of all eligible newly diagnosed HIV-positive individuals) were offered index testing. Of those offered index PNS, 46% provided partner contacts, with newly diagnosed individuals participating at higher rates than those currently on treatment (70% vs 43%), and women participating at higher rates than men. Overall testing yields through index services remains low at 4% overall, with a 0.8% yield for those under 15 years of age and a 5% yield for those 15 years or older. However, test yields of sexual partners from newly diagnosed index cases was 8.3%, compared to 3.9% from those currently on treatment.

In COP20, index testing/partners notification services and family testing will be administered to all HIV-positive individuals, with a priority given 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 that, on average, index testing accounts for 43% of the number of total positives identified among men aged 30-49. Closing this gap will be achieved through intensive site-level monitoring and mentorship and 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 their catchment area and the rollout 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 will be 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 including recency testing and cluster investigations, (3) enhancing site-level monitoring and mentorship, and (4) conducting regular CQI activities to improve case finding.

While the GOR continues supporting HIV testing in all testing modalities, in COP₂₁ 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. Improved PNS testing yields are 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.

Recency testing will measure the frequency of recent infections among newly diagnosed HIV-positives and inform focused testing and prevention strategies by identifying transmission networks and social networks. With the scale-up of CBS and an integrated national unique patient identifier in COP₂₀₂₀/FY 21, clinical, demographic, and risk behavior indicators, and recency test results are being collected for all new individuals who test HIV-positive 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 COP₂₁, 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, in COP₂₁ PEPFAR will focus on improving the recency results turnaround time with rollout of the laboratory recency data system to healthcare providers and enhanced use of recency data in the OpenMRS/CBS to identify areas with recent infections and subsequently intensify prevention and testing strategies in those areas.

In COP₂₁, PEPFAR will continue to build on COP₂₀ strategies to increase case finding for men, including offering index testing to HIV-positive women (particularly AGYW), partners of

unsuppressed women, and to partners of FSWs as well as targeting KP testing to MSM in high prevalence locations, particularly areas with low social network testing for MSM.

PEPFAR will continue to support more focused active case finding of KPs, including FSW and MSM, as well as other emerging KPs such as people who inject drugs (PWID) and transgender persons (TG) and their social networks through community-based initiatives focused in high impact geographic areas, including the hotspots surrounding military bases. PEPFAR will implement social network testing on high yield venue testing in conjunction with the use of validated screening tools in high impact geographic areas. Through the strengthened CBS program, new hotspots will be mapped and prioritized for testing. 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 services in 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 will be linked to treatment. DOD prevention IPs will ensure identified HIV-positive KPs are linked to either DOD or MOH facilities according to their preference. In COP21, PEPFAR will identify 798 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 COP21, the OVC program will identify undiagnosed children living with HIV. 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 in the communities through KP peer navigators targeting high risks groups who will not ordinarily attend a facility or mobile unit to access an HIV test. In addition, HIV self-test kits will continue to be distributed to index cases who may not wish to disclose partner contacts and/or sexual partners or 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 GOR 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 COP21, PEPFAR laboratory activities will strengthen the MOH's capacity to conduct recency testing at near-POC testing at all district hospitals for health centers in their catchment area and referral of samples for viral load testing at VL hubs. The reduction in turn-around time of test results from a minimum of two 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.

Building on achievements in the implementation of Rapid Testing Continuous Quality Improvement (RTCQI) for HIV diagnostic and recency testing, COP21 laboratory activities will focus on the implementation of strategies that ensure accurate and prompt return of HIV test results while realigning efforts to address challenges created by COVID-19. PEPFAR will continue support the National Reference Laboratory (NRL)'s efforts to restore the distribution of proficiency testing panels that were affected by COVID-19, particularly those that are outsourced. These include HIV/Viral load, EID and GeneXpert for TB diagnosis.

With the scale-up of recency testing to all PEPFAR-supported district hospitals and the establishment of five new HIV viral testing hubs in COP20, efforts will be geared towards enhancing the quality of HIV recency and VL testing at both the old and new testing sites in COP21. These efforts will include scale-up of proficiency testing panel distribution and use of laboratory information systems at all sites to facilitate return and documentation of patient test results. In COP21, efforts will be made to resume HIV testing site audits (using standardized CQI checklists) that were not conducted due to COVID-19 related travel restrictions. Participation in external quality assessments through proficiency testing (PT) programs and enhanced reporting and relay of feedback to testers using electronic PT will be reinforced. An HIV tester certification program will be rolled out to cover at least 50% of testers in PEPFAR-supported sites. With all PEPFAR-supported HIV testing and counseling sites using a standardized HTS logbook, PEPFAR will support establishment of an electronic tool/system to ease data capture, consolidation, and reporting.

Aggregated data received at NRL will help it track tester adherence to the national HIV testing algorithm, implementation of quality assurance programs, and review of concordance/disagreement rates between HIV test kits used. In COP21, PEPFAR will continue to improve the laboratory-clinical interface to enhance the quality of testing services and of result documentation through onsite DQA. In the same vein, NRL will continue to enhance the use of quality corps (i.e., a group of trained lab and nurse mentors based at district hospitals through PEPFAR) 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 supported the 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), which will continue to facilitate enhanced monitoring of index and recency testing using longitudinal patient-level data. Information exchange between the EMR, laboratory systems, and the national unique ID database will facilitate electronic return of results to the health facility and

deduplication of client records across facilities. In COP21, CBS data will continue being 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.

4.2 Getting PLHIV on Treatment

The 2021 EPP Spectrum model, indicated that, by Q1 of FY21, Rwanda has surpassed 2nd and 3rd 95 by 98% and 96% respectively for all PLHIV age groups and attained 92% of the national ART coverage. To optimize linkage, COP21 will support numerous strategies at site level including site-level monitoring to ensure effective implementation of same day enrollment, same-day ART initiation, proper use of a linkage/enrollment 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 COP21, PEPFAR will continue offering the TLD to all PLHIV and including transition of all eligible children weighing < 20 Kg from legacy ARVs to optimized DTG 10mg. The above strategies will be supported by PEPFAR supported above site level services including CQI, mentorship, supportive supervision targeted trainings and updated tools. Site-level monitoring will strengthen the use of linkage / enrollment 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 implement 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 are linked 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 21, 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 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

4.3 Retaining clients on treatment and ensuring viral suppression

In FY20, the national retention rate of patients enrolled in the last 12 months on treatment was 96.8% with retention in 15-34 in the same range at 96%. In PEPFAR, 12 months retention was 94% before this indicator was phased out in 2018. Nevertheless, retention to treatment is currently measured through a proxy indicator does not suggest significant gaps in program retention or treatment interruption and aligns to the national data showing that retention in children under 15 reached 98% in FY20. This improvement was a result of good collaboration between MoH/RBC and USG partners providing virtual mentorship of selected health facilities with poor retention, which also reflected poor VL suppression. Through routine data analysis and site mentorship, specific groups of PLHIV including FSWs and their children were identified for poor adherence and, 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 continued to improve through site-level outreach programs, such as home visits by healthcare providers and facility-based mentorships services provided by clinical mentors.

The current TX-ML indicator measures 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. This indicator identifies clients as LTFU - currently renamed Interruption To Treatment (ITT) 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 19. In FY21, Q1, site level TX_ML analysis indicates that ITT accounted for 22% (442) of patient missing appointment with the higher percentage 1410 (69%) being transfers out. During this same period, however, sites also reported 312 (71%) patients that previously reported ITT or refused/stopped ART being brought back into treatment due to focused site level outreach approaches.

Following sites to uncover the reasons for Interruption In Treatment, 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. Through routine sites level data analysis, these strategies will continue to be implemented with much focus on the health facilities identified to have retention gaps.

Rwanda has adequate capacity and quality of testing to meet the VL assessment requirements for monitoring treatment. PEPFAR FY21 Q1 program data results showed PEPFAR supported services has maintained higher proportions of Viral Load Suppression (VLS) of 96% among all PLHIV on treatment against 90% national VLS indicated by recent Rwanda Population-Based HIV Impact

Assessment (RPHIA) with relatively low viral load suppression among men particularly those in the younger age groups 15-34. Nevertheless, FY21Q1 program data also indicated lower VLS among children and adolescents living with HIV at 86% and gaps in viral load coverage in all provinces averaging to 84%. PEPFAR has engaged with IPs and Initial findings pointed to possible contributing factors including dual use of viral load testing platforms for both VL and COVID-19, equipment breakdown, COVID-19 response measures (lockdowns and restricted movement). Through this engagement, numerous strategies to address VLC challenges were identified for implementation including 1) implementing a contingency plan to ensure an uninterrupted VL testing procedure, 2) Improved tracking and impact management of interrupted VL testing and 3) enhanced patient monitoring to timely assess and report on VL gaps at health facilities. PEPFAR will continue partner engagement and collaboration to uncover other contributing factors, find and implement targeted remedies

In COP 21, PEPFAR will continue and initiate other innovative solutions to address challenges highlighted by male during consultative meeting supported by PEPFAR in FY 19 ending. 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 COP21, PEPFAR will continue to support strategies that address these gaps, including identifying male environment 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. While some of these strategies are already in progress, they have not been fully implemented as planned in COP20 due to COVID19 pandemic mitigation measures.

Moreover, in COP21 PEPFAR will still 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. Most of these strategies are being implemented and planned to be scaled up to all sites in Cop 20 and COP 21 funding will support maintenance, program review and change implementation.

FY20 PEPFAR partner data showed an increased VLS among KP at 97% subsequent to retention and adherence strategies supported during COP19 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 Interruption In Treatment and will provide training on intensive adherence support for patients with low VL suppression rates.

In addition, in COP21, PEPFAR will continue to 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.

In COP 19, and 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 have been operationalized with an adequate number of VL hubs per province. The new VL hubs are being 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. Yet, together with other operational challenges, these initiatives have been largely affected by COVID-19 pandemic with the testing platform left to process both viral load and CoVID-19 samples. In COP21, the national reference laboratory (NRL) will continue to 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, and implementation of a contingency plans to minimize testing interruption. NRL will remain the role of oversight and

monitoring of the quality of the decentralized sample referral system. In addition, the laboratory information system will continue to 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. Eight months into phase one implementation punctuated by review of Phase one site level data, and as informed by international evidence based recommendations including World Health Organization, the GoR supported by development partners revised TPT policy and chest X-Ray requirement before being initiation to TPT was removed in July 2019, leading to a successful and rapid scale up of TPT implementation. TPT scaleup has been guided by TPT medication availability. However, with emergency of COVID-19, that affected commodity procurement processes, delivery lead time and movement restrictions, scale up process slowed down that initially anticipated. With easing of restriction, TPT implementation has been aggressively scaled up to all PLHIV in eight out of total thirty districts and over 27,000 PLHIV initiated on TPT with the goal of achieving annual target by the end of COP20. In COP 20, PEPFAR through national TWG supported review of TPT monthly refill for PLHIV to align it to the ART differentiated/ Multi-Months Dispensing care model. This review was done to minimize unnecessary visits, reduce facility congestion thereby averting COVID-19 risk of infection with the guidance shared with implementing health facilities. Under this guidance, TPT is initially dispensed for one month to allow for review and management of any possible immediate drug side effects, and then the rest of the TPT medication package is dispensed according patients' monthly or MMD ART schedule. In Cop 21, PEPFAR will continue to support further enrollment largely for newly initiated on ARV and site level mentorship and review of reporting tools based on the field experience and reporting requirements.

In COP21, PEPFAR will continue supporting the implementation of the Differentiated Service Delivery Model (DSDM) with focus of transitioning from three months prescription to six Multi-Months Description (MMD) 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. In FY 20, The national TWG amended and refined 3 MMD tools and algorithm to address 6 MMD requirement. The national guideline has too been amended to include six MMD and implementation accelerated to maximize the impact so that by end of FY 21, all sites will be implementing six MMP. To support the adherence and continuity of treatment for patients enrolled in six MMD, PEPFAR will continue supporting the community group support led by the PLHIV peer educators. In cop21 emphasis will put on supporting central and decentralized health levels to implement pediatrics ART optimization TLD transition – transitioning eligible children living with HIV from legacy medications to DTG 10 mg.

In COP20, Rwanda's active case based surveillance (CBS) was scaled in all PEPFAR-supported sites and the CBS/recency data is now used for public health response and to inform prevention

programs. The implementation of the CBS digital platform was delayed in COP 19 but RBC has provided a catch-up plan that projects completion by the end of COP 20. The CBS data sub-committee led by RBC has finalized the indicators for longitudinal monitoring of outcomes. Achieving scale of CBS will enable use of the system for monitoring longitudinal patient outcomes such as 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. In COP 21, the country team will focus on providing above-site TA for the scale-up of CBS in non-PEPFAR sites for a complete national data on HIV treatment outcomes.

4.4 Prevention, specifically detailing programs for priority programming

4.4.1 OVC Portfolio

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 the National Strategic Plan (NSP) for HIV/AIDS. The ICRP²¹ 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 COP21 Guidance on the use of standard vulnerability criteria for OVC enrollment, the OVC program will continue to 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 12 districts: 3 districts from Kigali City (Kicukiro, Gasabo and Nyarugenge); 5 districts from Western Province (Rusizi, Nyamasheke, Karongi, Rutsiro, Rubavu); 2 districts from Southern Province (Huye, Muhanga); and 2 from Eastern province (Rwamagana and Kayonza). COP21 marks the completion of a two-year transition away from four non-priority districts (Burera, Musanze, Gicumbi and Kamonyi) that started during COP 19 implementation. The plan ensured that existing beneficiaries were served until their planned graduation and no new enrollment of OVC took place in those districts. During COP20, the OVC program added three new districts (Muhanga, Rusizi, and Rubavu).

²¹The 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.

In COP21, 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, an FBO implementing Gimbuka. ACHIEVE replaced Global Communities, which ended in September 2020. Implementation under the ACHIEVE program is conducted by YWCA and DUHAMIC ADRI, two of the local CSOs that were implementers under Global Communities, and these organizations have maintained their districts (Kayonza and Huye). In addition to supporting implementation, ACHIEVE has an M&E and capacity development component to support each of the local CSOs in alignment with PEPFAR and USAID's local capacity objectives.

During COP21, the OVC comprehensive target and program will be maintained from COP20, but the OVC Preventive target will reduce, leading to a reduction in the overall OVC_SERV targets from 247,553 in COP20 to 202,009 in COP21. The COP21 target includes 142,776 OVC beneficiaries and 59,233 AGYW under 18 years old from the DREAMS program. The COP21 OVC_SERV includes 139,757 females [69%] and 62,252 males [31%]. This also constitutes a total of 175,911 beneficiaries under 18 [87%], 8,354 aged 18-20 years who will still benefit from education subsidies and economic strengthening services [4%] and 17,744 adults aged above 18 [9%]. By maintaining the OVC comprehensive target, the Rwanda program will ensure that in COP21, priority OVC subpopulations—especially the C/ALHIV, HIV-exposed infants, and survivors of violence—continue to receive a comprehensive package of services. The OVC program will also strengthen systems and processes by fostering health facility and community linkages, as well as linkages with the Rwanda Network of People Living with HIV (RRP+) and other KP partners, as appropriate. With a reduced OVC preventive target, the OVC program will strategically prioritize Kigali districts as they have the highest HIV prevalence rate. For districts outside Kigali, the focus of interventions will be around hotspots and areas around business centers.

Overall, the COP21 target for the OVC_SERV indicator includes 118,332 OVC comprehensive [59%], 24,442 OVC preventive [12%], and 59,233 DREAMS only under 18 [29%] 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), it is anticipated that these beneficiaries will be a small proportion of the overall targets. Since most families in Rwanda have more than one child (average of 4.1), 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 COP21, the OVC program will continue to support two approaches: OVC comprehensive and OVC preventive. With a small number of new beneficiaries planned to be enrolled in COP21, the OVC program will prioritize specific priority subpopulations within OVC Comprehensive: HIV+ children under 18, HIV-exposed infants under 2, and sexual violence survivors. If space remains in the cohort, children of PLHIV and children of female sex workers (FSW) will be enrolled.

The OVC comprehensive approach is family-based and is comprised of integrated case management and graduation benchmarks. Illustrative elements 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 is integrating 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. Drawing up lessons learned through 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 individual-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)*, 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* which is in use by DREAMS and OVC; and (3) *Coaching Boys into Men* which was adapted to the Rwandan context during COP20.

To achieve results toward epidemic control and HIV impact mitigation, the strategic approaches in COP21 will be (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; and (3) reducing risk for adolescent girls in high HIV-burden areas in addition to 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. The OVC program will continue to conduct HIV risk assessments among children and adolescents under 18 and 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/homegrown solutions such as *Friends of the Family/Inshuti z'Umuryango* and *Parents' evening fora/Umugoroba w'Ababyeyi* in the implementation of some program components to strengthen 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 strengthen relationships between IPs and health facilities through MOUs, and by continuing to use community volunteers and linkage facilitators to better link with clinical services, support adherence, and facilitate access to services for hard-to-reach populations. Roles and responsibilities included in the MOUs developed and signed during COP20 will be maintained in COP21. OVC and clinical partners will jointly monitor the implementation of

clauses in these MOUs. Through case conferencing or any other methods, both parties will reassess key topics, such as shared confidentiality, LTFU and tracing, adherence and home monitoring, socio-economic assessment and support testing, especially index testing. After identifying the gaps and needs, they will work together on developing plans for improvement. Training presents an opportunity to address those gaps. It is expected that the focus for COP₂₁ will be the strengthening of systems and processes to build on the relationships formed through the MOUs. To support these efforts, linkage facilitators will be expected to play a key role in ensuring the OVC program is well aligned with care and treatment services to ensure that CLHIV found at clinics are offered enrollment into the OVC program and HIV-positive OVC beneficiaries are tracked to ensure they are adhering to treatment and are virally suppressed.

In COP₂₁, OVC partners will continue tracking and monitoring findings under the OVC_HIVSTAT indicator. The COP₂₁ target for OVC_HIVSTAT is 92,235, which constitutes the number of OVC (<18 years old) enrolled in the OVC comprehensive program with HIV status reported, disaggregated by HIV status. 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 track 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 SAPR₂₁ and APR₂₁. The 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 through screening. 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, and accompaniment will be provided as appropriate.

During COP₂₁, the OVC partners will adapt their programming and implementation based on COVID-19 lessons observed during COP₂₀ implementation. For example, they will continue implementing small group sessions to help ensure the training and meetings are effective while also ensuring physical distancing as a COVID-19 preventive measure. They will find by holding trainings and meetings in communities closer to beneficiaries, using available schools, health facilities, and churches. This engagement with local actors will be essential in reinforcing ownership and sustainability of the OVC program. Such an approach to training also helps to reduce field staff in-person meetings. OVC partners will integrate virtual coordination and follow up in activity monitoring and implementation. They will use a blended approach for data quality assurance (DQAs). With virtual DQAs internal to IPs, it is possible to hold more frequent monthly DQAs, as opposed to quarterly in-person DQAs. They will continue implementing remote case management – especially using phone calls and SMS to remain in touch with the field staff, community volunteers, and beneficiaries. They will also use standardized messaging, scripted voice recording, and digital posters as relevant.

COP21 marks the end of all four OVC implementing mechanisms (IMs), as they will all end in September 2022. In the same way that Global Communities/Twiyubake transitioned activities to Pact/ACHIEVE, USAID will ensure there are no gaps in service delivery when these four activities end. The design of the OVC follow-on IMs will be prioritized and some COP21 funds will be set aside for the startup of the new IMs to ensure a smooth transition.

DREAMS Programming

In COP21, 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 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 COP20, DREAMS services covered all administrative sectors of Nyanza, Rwamagana and Gasabo, Kicukiro and Nyarugenge. In addition to the full geographic footprint realized in COP20, the DREAMS program will also increase the number of beneficiaries targeted from 73,838 in COP20 to 82,500 in COP21, of which 63,774 (77.3%) will be continuing in the program from FY21 while 18,726 (22.7 %) will be newly enrolled. The outbreak of the COVID-19 pandemic in March 2020 led to an interruption in the provision of DREAMS primary and required secondary package of services. The interventions that were most impacted were those related to school subsidies, as schools were closed from March to December 2020. Other interventions affected were those that involved gathering in groups, such as in safe spaces and training. This led to a high number of beneficiaries not completing the primary and secondary packages of services.

In COP21, 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 continue to implement in the districts of Rwamagana and Nyanza, and Pact will implement in Nyarugenge and Kicukiro districts. Pact will continue working with the local sub-partners (YWCA in Kicukiro and DUHAMIC ADRI in Nyarugenge). Of the targeted 82,500 at-risk AGYW, AEE (a faith-based organization) will reach 29,288 (35.5%), Pact will reach 27,584 (33.4%), and FXB will reach 25,628 (31.1%). In COP21, the program will also target 5,427 male sexual partners of AGYW and males who fit the profile of sexual partners distributed as follows: 1,894 under Pact, 1,464 under FXB, and 2,069 under AEE.

The DREAMS partners will reach and enroll the most at-risk AGYW by using COP21 standard vulnerability criteria. These criteria include a high number of sex partners, having a 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. In the DREAMS program, there are also 427 girls from the OVC program who are receiving additional DREAMS

interventions in Kigali (Nyarugenge, Kicukiro, and Gasabo). These AGYW 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 DREAMS beneficiaries (74%) will be adolescents aged 10-18.

The Rwanda VACYS 2015-2016 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 tracked. In doing so, they will also facilitate referrals to external post-violence care as appropriate.

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 pre-exposure prophylaxis (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 in a sero-discordant couple with a virally unsuppressed partner not consistently using condoms, and/or who are FSWs who do not consistently use condoms are eligible for HIV PrEP. In COP20, PrEP was expanded from Kigali to all five DREAMS districts, and eligibility criteria were expanded to include AGYW engaged in transactional sex, and those without consistent use of condoms.

In COP21, DREAMS implementing partners will continue to expand PrEP activities to include demand creation, training of AGYW PrEP champions and HCWs, active linkage of eligible AGYW to health 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. The involvement of young people will be vital: promote PrEP champions and linking with peer educators to provide outreach and education, including young women using oral PrEP successfully. The USAID-supported partners will collaborate with RBC to increase community education through development and distribution of IEC materials on PrEP such as leaflets, posters, and social media. There will also be increased relationships between USAID-supported partners and health facilities in addressing barriers to PrEP uptake and setting joint strategies to

strengthen adherence, such as using peer navigators/motivators, phone alarms, pocket doses when away from home, as well as counselling about the side effects.

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 205 10-14 year-olds will be tested. All 15-24 year-olds (5,1616) enrolled in DREAMS are already deemed to be high-risk and will receive HIV testing once a year if they do not 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 provide HTS services at safe spaces to ease the burden of AGYW who reside far from health facilities. There will also be an option of active linkages for testing at facilities or other partner sites. As needed, community volunteers will accompany AGYW 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. DREAMS will continue to build on strong coordination with other prevention partners to ensure AGYW access to a comprehensive package of services through an improved referral/linkage system.

Also, in COP21 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 and data reviews, harmonizing approaches and tools, and holding regular implementation reviews to ensure quality work and to find efficiencies. IPs will utilize innovative approaches and improve on the economic strengthening intervention through conducting labor market surveys; 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 COP20, the evidence-based Empowerment and Livelihood for Adolescents (ELA) economic strengthening model was adopted. The adaptation of the curriculum and training of trainers of trainers were conducted. In COP21, the implementation of the ELA model will continue through training of AGYW and linking them to employment.

In COP21, the DREAMS program will collect and report on the following indicators: AGYW_PREV, PP_PREV, OVC_SERV, OVC_HIVSTAT, HTS_TST, HTS_TST_POS, PREP_CURR, PREP_NEW, and HRH_CURR. To ensure smooth implementation, the procedures for carrying out testing and PrEP referrals were clarified in the revised MOUs with IPs. The DREAMS partners will continue to share learning from service layering, especially on the use of unique identifiers

tracked through the Rwanda DREAMS Tracking System (RDTS), a DHIS2 web-based system. In COP20, the RDTS was fully transitioned from Global Communities to Pact, another INGO which has the mandate to build the capacity of the local partners in terms of a management information system (MIS) in order to ensure successful tracking and reporting. PEPFAR Rwanda plans a further transition of this system to local partners beyond COP21 to facilitate country ownership and achieve sustained epidemic control.

In COP20, USAID hired a DREAMS Coordinator who will serve as the AGYW point person coordinating all DREAMS activities and programming across the entire USG PEPFAR portfolio. She will work closely with the proposed AGYW focal point within the GOR to enhance coordination across all stakeholders and programs, including the Global Fund's HER activities. The DREAMS program introduced DREAMS Ambassadors in all DREAMS districts and hired by IPs to support the advocacy related to AGYW support and the DREAMS coordination and oversight. They will fill any gaps in program implementation. To be eligible, the DREAMS Ambassadors had 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 are 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 receive training on HIV, PrEP, and GBV and are supported with DREAMS materials for their advocacy work.

4.4.2 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 FY21 Q1 program data indicates a mother to child transmission (MTCT) rate of 1% lower than the national MTCT rate of 1.65%. 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 continuity of ART). In COP 21, PEPFAR will continue to support national level processes for EMTCT to achieve national validation. COP21 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 21 PrEP will continue to be offered to negative partners in sero-discordant couples whose partner is not on ART or on ART but not virally suppressed as well as young women, pregnant

and lactating women at high-risk of HIV acquisition identified through ANC and Partner Notification Services. In addition, high-risk young women will be identified through DREAMS and KP community testing strategies and referred to facility for PrEP initiation.

In COP 20, 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 COP21 mentorship and supervision will be reinforced at PMTCT facilities to achieve testing coverage of 95% at six weeks post-partum HIE testing.

In COP 21, 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 21, 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.

4.4.3 Key Populations

Key population (KP) programming in Rwanda focuses on services for FSW and MSM. Results from recent studies have informed KP and priority population (PP) strategies. Preliminary results of the 2019 FSW IBBS show FSWs have a 35.5% national HIV prevalence (39.6% in Kigali) compared to a national adult prevalence of 3%. A high proportion of FSWs (98.6%) report ever been tested for HIV of whom 99% report being on ART. The results of the 2018 MSM integrated population size estimation (PSE) and integrated bio-behavioral survey (IBBS) in Kigali indicate that the MSM population size is estimated to be 5937 [95% Confidence Interval: 4784 – 7835] in Kigali and the HIV prevalence was estimated at 9.2%. This is higher than the results from the 2015 MSM BSS in Rwanda that reported MSM having a prevalence of 4%, i.e., not statistically significantly different from that of the general age matched male population. However, 17.9% MSM reported transactional sex (ever having had anal or oral sex with a man in exchange of money, goods, or services), and those engaged in commercial sex for more than two years had a prevalence almost six times greater than those engaging in commercial sex for less than two years (7.77% vs. 1.26%, 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 hard to reach because they may be married and do not self-identify as MSM. This was suggested by the 2018 MSM BSS results which indicate that just 14% of the recruited MSM were 30 or older. Furthermore, CBS has provided further data to inform strategies to help focus the

outreach and geographic focus of HIV prevention services to MSM. In COP21, efforts will be made to reach this group through MSM networks and associations. A population size estimate (PSE) for MSM will be conducted in COP20 will further inform program on the size and geographic coverage and risk characteristics for better HIV prevention interventions in COP21. In addition, program data has pointed to new and emerging KPs not previously identified, including persons who inject drugs (PWID) and transgender persons. In COP21 the program will include services to ensure that these emerging population are targeted for HIV prevention.

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, referral for VMMC services, 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 COP21 activities with both MER 3.0 indicators and Rwanda's NSP to support the GOR goal of a three-fold reduction in new infections to achieve epidemic control. During COP21, to maximally interrupt HIV transmission, PEPFAR will reach 25,689 KPs, including 23,745 FSWs and 1,953 MSM with testing, prevention, retention, and adherence services. To achieve this, PEPFAR will implement proven methods of high-yield mobile testing and targeted KP 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 facilities serving hotspots. Furthermore, case finding among KPs in COP21 will be done through annual testing of KPs, focused active case finding using social network strategy (SNS), 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 COP21, PEPFAR will continue to build on best practices and lessons learned to expand PrEP services to eligible KPs in supported health facilities in high-burden geographic area targeting FSWs and MSM at high risk of HIV acquisition, sero-discordant couples in which the HIV-positive partner is not virally suppressed, and AGYW at high risk for HIV. This expansion of PrEP will include all KP PEPFAR supported facilities targeting 498 MSM in high burden areas and targeting 3,300 FSW. The PEPFAR PrEP program for sero-discordant couples in all PEPFAR supported health facilities sites in Rwanda will continue to be implemented. Eligible AGYW in all DREAMS districts will be supported to enroll on PrEP starting in COP21. HIV-negative sexual

partners of index cases will be targeted for PrEP in all PEPFAR supported index testing facilities. In addition, HIV-negative partners identified through the ANC/PMTCT entry modalities will be screened for PrEP eligibility and offered services. PEPFAR will collaborate with the national program to harmonize and standardize a screening tool measuring risk factors. Eligible FSW 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 a PEPFAR partner working with MSM. Eligible partners in sero-discordant relationships and index partners at high risk will be recruited by PEPFAR-supported health facilities through ANC and index testing 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 are monitored for PrEP adherence, assessment of risk of acquiring HIV after initiating on PrEP and are re-tested for HIV 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 and mapping will be crucial to continue informing the program direction. In COP21, 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 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.

4.4.4 VMMC

During FY20 PEPFAR supported 243,998 VMMC procedures, or 123% of the FY19 annual target (243,998 out of 198,440), at PEPFAR-supported sites. Even with this overachievement in FY20, the NSP objective of 66% national coverage of males aged 15-59 was not achieved by the end of 2020. However, with the PEPFAR investment for VMMC in COP21, PEPFAR will prioritize investments in VMMC by prioritizing the 125,000 VMMC service targets on males aged 15-29 and contribute to

achieving 90% saturation nationally by end of FY 2022 in the priority age bands 15-29. In FY22, no males under 15 years of age will be circumcised.

VMMC targets for COP21 were developed using the 2019 RPHIA, 2021 census projections from the National Institute of Statistics of Rwanda (NISR), 2020 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 COP21 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% surgical circumcision and strengthening VMMC demand creation (specifically for surgical circumcision) for ages 15-29. Strategies to reach older men with VMMC services include adopting flexible hours while observing COVID-19 regulations and offering VMMC services and/or demand creation once restrictions are lifted due to COVID-19 pandemic 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 while following GOR guidelines on COVID-19 prevention control measures.

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 new innovations like WhatsApp groups and SMS messages, focused radio campaigns, and outreach campaigns following MOH guidelines on COVID-19 prevention measures 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 PEPFAR guidance to discontinue circumcisions of 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 halted and demand creation efforts currently target young men aged 15-29. The VMMC program will use the 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 sero-discordant relationships with HIV-positive partners, and males attending STI clinics.

Once the COVID-19 pandemic is under control and following MOH guidelines, 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.

4.5 Commodities

PEPFAR, in collaboration with the GOR and GFATM, has identified four critical priorities for PEPFAR commodity procurement and management in COP21: (1) accelerate national ART optimization for both adult and pediatrics (inclusive of the tenofovir-lamivudine-dolutegravir (TLD) transition and scale up of pediatrics dolutegravir (DTG)); (2) scale up multi-month dispensing (both 3 MMD and 6 MMD); (3) commodity support to Rwanda's case finding strategy; and (4) facilitate patient data triangulation.

In COP21, PEPFAR Rwanda's commodity planning strategy reflects the changes needed to support sustained epidemic control. The program will continue to procure ARVs to maintain and accelerate gains in the 2nd and 3rd 90s, reagents and consumables for viral load and early infant diagnosis, and condoms. PEPFAR will procure Tuberculosis preventive therapy (TPT) medicines and diagnostics for all PLHIV including children and will integrate Cotrimoxazole into the HIV clinical care package. Additionally, PEPFAR will continue to support national priorities for commodity data collection, analysis, and use through existing platforms such as the Rwanda Coordinated Procurement and Distribution System (CPDS), the Procurement Planning and Monitoring Report for HIV (PPMR-HIV), as well as regular stock status reviews between the GOR, USG, and other donors.

In COP21, PEPFAR will procure the following prevention commodities: ARVs for PrEP and VMMC kits. There will also be procurement of rapid test kits, self-testing kits, and recency kits. The rapid test kit quantity will mainly support the targeted and index testing strategy and OVC/DREAMS programs. Additionally, PEPFAR will procure and provide an estimated 10,365,000 male condoms to Rwanda's national program through the Central Condom Fund for the public sector and social marketing program.

In FY20 and in the 1st and 2nd quarter of FY21, Rwanda did not experience significant delays in delivery of commodities or stock-outs that resulted in or caused patients to stop treatment. As a result, the stockout rates for tracer HIV commodities were kept on average about 1.5%. PEPFAR/Rwanda's procurement agent, GHSC-PSM, has made valuable improvements in on-time deliveries (OTD) over time; the OTD FY2020 was average 90%. In COP21, GHSC-PSM will continue to ensure a high rate of OTD and prevent stock outs from occurring, keeping the current minimal stock out level of less than 2%. Moreover, GHSC-PSM will share its expertise with its planned new local procurement partner, the Rwanda Medical Supply Ltd (RMS), so that it

can deliver on time. The USG team will coordinate with the MOH to ensure availability of all HIV/AIDS program commodities to avoid any interruption of HIV services.

4.5.1 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 included adult men, adolescent boys, and women over 50 and the transition to TLD was 98.5% completed by January 2020. Phase II included women of childbearing age, and the transition started in February 2020. 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. As a result, the projected completion of the remaining patients on TLE600 to TLD will be completed by June 2021. By the end of FY21, about 97.6% of adult patients will use a dolutegravir (DTG) based regimen and the remaining 2.4% will be on efavirenz (EFV) plus two other ARVs. The planned proportion between the two Nucleoside Reverse Transcriptase Inhibitors (NRTIs) for adults are Tenofovir (93%) and that of abacavir (7%). TLD/DTG containing regimens started in August 2018 for naïve eligible patients per the STG. The national program inventory maximum for ARVs (and other HIV medicines) is 14 months, while the minimum is 9 months.

Similarly, ART optimization for pediatrics is on track. In COP21 implementation, the national program has a plan to scale up pediatric DTG from the current 47% to 96.4%. To support that, PEPFAR has procured DTG 10mg (16,000 bottles) which is expected to be delivered in the beginning of July 2021. In FY20 and Q2 FY21, the GOR had disposed the remaining stocks of nevirapine 200mg (NVP), and Lamivudine 300mg/Nevirapine 200mg/Zidovudine 300mg (LNZ)) to facilitate the phase II transition of TLD. The national program (care and treatment and supply chain working groups) are working hand in hand to minimize or ensure no wastage of tenofovir-lamivudine-efavirenz (TLE600) and tenofovir-lamivudine (TL).

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 the USG and GOR to provide regular monthly updates of the transition progress and of the drawdown of legacy stock (TLE600), scale of TLD90, proper introductions of pediatrics DTG, and optimizing ARVs for optimal care of patients on ART. In Q4 of COP20, a report will summarize the transition processes of Phase II and pediatrics DTG.

4.5.2 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 - with only 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 2019. In the new ART STG, the MMP enrollment criteria changed from 18 months to 12 months on ART. Currently, over 68% of patients on ART are receiving MMD (3 MMD or 6MMD). In COP₂₁, PEPFAR will continue to support the GOR in achievement of their target of 80% 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). TLD 90 was available in the country in June 2020 to support 6MMD which started in early August 2020.

4.5.3 Commodity Support for Revised Case Finding Strategy

Since 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 was a slight increase to support finding the remaining cases as identified in Rwanda PHIA 2019. Now in COP₂₁, there is a reduction of funds and a proportional adjustment was made to reduce RTKs. PEPFAR will collaborate with the GOR to review the RTK forecasts as compared to consumption rates to improve the regular and consistent availability of RTKs within the national program. 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 the 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.

4.5.4 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. The available data was used to plan and implement a proper transition of legacy ARVs and the startup of 6MMD. Moreover, in COP₂₁, 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 COP₂₁ as Rwanda is completely transitioning to ART optimization for both adults and pediatrics as well as introducing pediatrics DTG and the utilization of the TLD90 pack sizes which will impact all patients within the national program.

4.6 Collaboration, Integration, and Monitoring

COP21 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 two years ago showed that Rwanda is on track to reach HIV epidemic control. PEPFAR's COP21 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 indicate challenges in community VL suppression among 15-34-year old, 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 have been coordinated through the national prevention and Care & Treatment technical working groups (TWG).

The national TWGs coordinated and standardized implementation guidelines for all partners working in the national HIV response. In addition, MOH /RBC has coordinated with implementing partners to review through virtual monthly and quarterly partner technical meetings to identify challenges and propose strategies to address them. Emphasis of the meetings was on Continuous Quality Improvement based on site level analysis to 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 have been critical cornerstone to effective implementation, monitoring, and continuous improvement of initiatives throughout the country based on the lessons learned in FY 2020. Furthermore, University of Maryland at Baltimore (UMB) has supported national program's CQI effort through technical support to health facilities in Kigali to implement small taste of change approach which employs identifying and implementing small innovation to effect a positive outcome.

In COP 21, all USG agencies will continue to strengthen partner management, building on COP 20 processes. 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 is being scaled up to all PEPFAR supported sites. 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 COP21 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, COP21 will continue to 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.

The prevention and care and treatment TWGs will continue to 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 COP21, PEPFAR will continue to support the implementation of updated policy and guidelines including implementation of TLD and ART optimization for children, 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 continue to 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 in HIV mainstreaming, 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 (RH MIS) to help develop an effective HIV active case finding and longitudinal case surveillance system. In COP₂₁, 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 HIV integrated model to inform its national scale up. To control the HIV epidemic is crucial to understand the level stigma and discrimination that hinder uptake of HIV prevention and treatment. In COP₂₁ 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 a potential stigma issues and approaches to address them.

4.7 Targets by population

In COP20, PEPFAR 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 4.7.1 ART Targets by Prioritization for Epidemic Control

Table 4.7.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (PEPFAR APR FY21)	Additional patients required for 80% ART coverage	Target current on ART (APR FY22) <i>TX_CURR</i>	Newly initiated (APR FY22) <i>TX_NEW</i>	ART Coverage (APR 22)
Attained	222,617	130,690	0	133,152	5,301	95%
Scale-Up Saturation	-	-	-	-	-	-
Scale-Up Aggressive	-	-	-	-	-	-
Sustained	-	-	-	-	-	-
Central Support	-	-	-	-	-	-
Commodities (if not included in previous categories)	-	-	-	-	-	-
Total	222,617	128,984	0	130,107	5,022	95%

Table 4.7.2 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_C IRC (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 4.7.3: 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

No new data on Key Populations

Table 4.7.3a Target Populations for Prevention Interventions to Facilitate Epidemic Control - AGYW

Target Populations	Population Size Estimate (SNUs) and disease burden	Coverage Goal (in FY21)	FY22 Target
Kigali	141,962	52,090 (37%)	56,872
Eastern	34,209	11,949 (35%)	14,314
Southern	34,097	9,799 (29%)	11,314
Northern			
Western			
TOTAL	210,268	73,838 (35%)	82,500

Table 4.7.3b Target Populations for Prevention Interventions to Facilitate Epidemic Control – DREAMS PP_Prev

Target Populations	Population Size Estimate (SNUs) and disease burden	Coverage Goal (in FY22)	FY22 Target*
Kigali	141,962		60,900
Eastern	34,209		14,900
Southern	34,097		12,182
Northern			-
Western			-
TOTAL	210,268		87,982

*Targets include male partners of AGYW

Table 4.7.4 Targets for OVC and Linkages to HIV Services			
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY22 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target) OVC*
Kigali	44,336	86,187	22,912
Eastern	131,300	34,793	14,800
Southern	233,917	28,462	12,646
Northern	133,641	0	0
Western	177,425	52,566	41,877
TOTAL	720,619	202,008	92,235

Notes: Estimated number of OVC is from the National Commission for Children (NCC)/Most Vulnerable Children Database, 2014, mostly based on economic vulnerability. Total OVC/DREAMS: OVC_SERV include 59,233 DREAMS and 142,776 OVC. OVC_HIVSTAT includes

92,236 OVC Comprehensive <18. Note: OVC_HIVSTAT does not include DREAMS and OVC preventive 9-14 years old.

4.8 Viral Load and Early Infant Diagnosis Optimization

PEPFAR is working to ensure efficient use of VL and EID testing instruments to provide more than 90% access for all eligible PLHIV to annual VL testing. PEPFAR will continue to use the reporting structure to monitor VL coverage across age, sex, populations and geography towards improved testing for timely return of results and documentation for VL/EID results into patient records at the site level. Currently, VL and 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 COP21, 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. The MOH completed a data collection and network optimization exercise for existing testing platforms for a comprehensive program needs assessment for HIV, hepatitis, TB and HPV testing. The results were used to make recommendations of required changes to the laboratory testing network and develop an implementation plan, including decentralized sample transportation system in finite laboratory catchment areas closer healthcare facilities.

COP21 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, and viral load suppression by age and reduces the turnaround time of testing at VL hubs and printing results at health facilities.

In COP21, PEPFAR will provide technical assistance to the Rwanda Biomedical Center (RBC) to improve coverage and monitor VL suppression in sites or geographic areas manifesting below the average of the national coverage across all provinces. Efforts will be made to streamline national VL testing capacity and implement an optimized diagnostic network that provides timely services and closes gaps of testing coverage among PLHIV during COVID-19. PEPFAR will continue supporting VL testing CQI through supervision mentorship and forecasting of commodities at national and decentralized laboratories to ensure uninterrupted provision of VL testing and enhance decentralized sample referral and return of results systems between VL testing hubs and health facilities in the catchment area for cost effective and sustainable 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 COP21 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 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 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 RPHIA results and program data analysis suggests that systems support is critical to continue to expand case finding and to reach children, adolescents (including adolescent and young women), and men. This includes linking these targeted groups to treatment, retaining them in care, and keeping 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 HIV-positive individuals and link them to treatment and bring the remaining undiagnosed PLHIV into the cascade of treatment and care. COP2020's systems investments will focus on targeted approaches in commodity security and supply chain, service delivery, health information systems, and strengthened quality management, sample referral and transportation and laboratory information systems to support HIV case finding, and patient follow up on treatment for viral suppression to reduce the incidence of new infections, and sustain epidemic control.

In COP21, PEPFAR will continue to maintain investment priorities from COP20 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, support quality improvement for service delivery, and improve resource efficiencies;

3. Enhance patient and population-level systems to emphasize HIV prevention activities, promote HIV case finding and index testing, improve linkage to treatment, increase viral suppression, and ensure an efficient and effective public health response;
4. Evolve monitoring systems to identify remaining gaps in the 95-95-95 cascade, measure the impact of PEPFAR investments, support data-driven decisions to achieve epidemic control, and strengthen continuous quality improvement of programs;
5. Enhance the laboratory testing network and PTCQI 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 COP21, PEPFAR's supply chain systems strengthening strategy will focus on (1) the transition of USG ARVs and VMMC procurement and delivery to Rwanda Medical Supply, Ltd (RMS); (2) strengthening RMS's quality control/quality assurance systems towards to the World Health Organization Model Quality Assurance System for procurement agencies (WHO/MQAS); (3) leveraging USG pharmaceutical services and Rwanda Food and Drugs Authority (FDA) investments and implement pharmacovigilance; (4) improving the electronic logistics management information system for better decision-making; and (5) ensuring the proper implementation of ART optimization by shifting all PLHIV to TLD, DTG based regimens, transitioning all children to DTG based regimens, and scaling up MMD, especially 6MMD.

During COP19 and COP20 implementation, PEPFAR supported the transformation of the GOR's Medical Production and Procurement Division (MPPD) to a commercial parastatal organization, RMS Ltd. Historically, MPPD experienced 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 processes to manage stock shortages. To address these systemic challenges, PEPFAR supported the GOR to transition its central medical store and 30 district pharmacies to a commercial parastatal. PEPFAR also supported the development of a comprehensive business plan for RMS to update standard operating procedures and conducted an activity-based costing (ABC) exercise of the in-country supply chain. The GOR officially established RMS in August 2020, appointing the Board of Directors, Chief Executive Officer, and senior leadership of the company. In COP21, PEPFAR will provide TA to RMS to revise procedure manuals and procurement manuals to help RMS establish industry standard tools and procedures and to smoothly complete the 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 the central level to the customer, and improve consumption data capturing. USAID expects to begin direct funding to RMS Ltd in June 2021. In COP20, RMS will procure a portion of PEPFAR-funded ARVs, and in COP21 RMS will procure all PEPFAR-funded ARVs and VMMC kits. The plan is to complete the transition of commodity procurement from GHSC-PSM to RMS within the next 24-36 months. During this transition process, PEPFAR Rwanda will reevaluate the internal management of commodities oversight to ensure efficiency and sustainability.

As in previous COPs, especially COP 19 and COP20, in COP21 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, 3HP, and 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 COP21, PEPFAR will continue working to improve logistics data for decision-making by institutionalizing and upgrading the eLMIS, exploring the Global Standards One standard for tracing commodities with proper implementation of the national product catalog, 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.

Moreover, in COP21, PEPFAR will support RMS through FHI360, the implementer of the Global Health Supply Chain-Quality Assurance Program (GHSC-QA) activity, to help ensure that RMS can meet the World Health Organization Model Quality Assurance System for procurement agencies and USAID's quality assurance requirements (ADS312). PEPFAR will also support a third-party monitoring partner to ensure that PEPFAR funded health commodities reach the beneficiaries and end users and to cross check the quality of data reported.

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 Viral Load Suppression.

In COP21, PEPFAR's above-site service delivery efforts will strengthen existing systems within the 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, 6 MMP, TPT, and effective and efficient transition to DTG 10mg for CLHIV, the program will use programmatic data from MOH's developed policies to further refine strategies from COP20's implementation of these initiatives.

PEPFAR and the 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 KP and 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 continue leveraging the MOH central learning platform to support health care workers' continuous learning on HIV and mentorship practices to improve PEPFAR COP21 implementation of the different program initiatives throughout the country. PEPFAR will also continue to support and leverage the Field Epidemiology Training Program to strengthen and institutionalize capabilities to synthesize and use HIV data (including CBS) to inform public health response at national and sub-national levels.

In COP21, PEPFAR will also continue to support Rwanda's National Reference Laboratory to improve capacities of healthcare providers and other laboratory cadres to enhance use of the electronic Lab Information (eLab) Systems for patient centered service delivery, quality improvement monitoring, and improved lab-clinical interface. In COP20, 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 and in COP21, strengthen quality of testing services at these sites to increase geographical access of recency testing to all newly diagnosed HIV-positive individuals, including continuous quality improvement using test kit quality control monitoring, tester performance of proficiency testing, and onsite mentorships of laboratory staff for corrective/ preventive actions. 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 the 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 the 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, and can inform the ministry of possible changes in the epidemic. Active CBS and Routine CBS systems use a national unique patient identifier 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 and recency data are informing practitioners in Rwanda of (1) the characteristics of those who are acquiring infections, (2) how recently new infections were acquired (recency), (3) where new diagnoses and recent infections are concentrated, (4) which risk behaviors are associated with recent and long-term infection, and (5) how new diagnoses were identified on an aggregate level. Routine CBS data can track linkage to treatment, disease progression, patient adherence, VL suppression, and drug toxicity, including those on DTG. Cluster investigation following identification of two or more recent infections per month per facility is informing public health response, while the CBS data has also been used to identify AGYW and sero-discordant couples eligible for PrEP.

PEPFAR will maintain support for the 192 sites currently participating in the CBS and will continue to provide TA for scale-up to remaining CBS non-PEPFAR sites. Support for the maintenance of the digital platform for case finding and analysis of longitudinal patient data will continue in COP21 at PEPFAR sites. This initiative leverages previous investments by PEPFAR and the GOR through the adoption, adaptation, and application of electronic health information systems, such as the electronic medical record (EMR) system 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 integration 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 record linkage and 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 PEPFAR indicators to monitor the national HIV program and address challenges to sustaining epidemic control. Additionally, enhanced EMR and the CBS digital platform enable efficient individual patient

monitoring for toxicity and facilitate identification of stable patients for multi-month scripting and those at risk of acquired drug resistance.

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

In COP2019, 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 COP2019 and 2020, PEPFAR maintained the Ministry's support to develop the integrated digital platform of health information systems through the Rwanda Health Information Exchange System (RHIES) to provide the data for surveillance and monitoring programmatic activities. The focus was to develop and maintain a digital platform to identify and report health-related attributes of new and existing HIV cases; understand the 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), RHMIS, and other systems to support service delivery for client-centered care and monitoring of epidemic control. In COP21, PEPFAR will focus on maintenance and enhancement of the systems developed in previous years and ensuring they continue to support client-level monitoring for sustained epidemic control. The capacity to conduct the vital data analysis and synthesis required for HIV programmatic decisions and public health response at the central, district, and facility levels continues to be strengthened.

Building human capacity to conduct data quality assessments, conducting continuous data reviews and data quality improvement activities, and analyzing and using data to make decisions regarding the HIV epidemic in Rwanda remains key components of sustaining epidemic control. In COP21, PEPFAR will continue to support health care providers to expand their capacities in HIV surveillance, program monitoring, data collection, and data use. PEPFAR will continue to support and leverage the Field Epidemiology Training Program (FETP) to strengthen and institutionalize capabilities to synthesize and use HIV data to inform public health response at the 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 data quality, health information systems, survey, surveillance, and capacity-building initiatives, periodic milestones continue to be strengthened to better assess progress towards achieving above-site 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.

5.5 Enhance the laboratory testing network and PTCQI 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.

As Rwanda further implements targeted testing, Treat All and 3-6 MMD, the country must continue its efforts to strengthen scaled up laboratory systems to promptly identify and link all newly diagnosed and existing PLHIV to effective HIV treatment. These systems remain critically important for sustaining reduction in new HIV infections, maintain a high rate of linkage to treatment and improve viral load suppression.

In COP20, PEPFAR supported the maintenance and enhancements of an integrated laboratory diagnostics network and support systems built on established and newly implemented initiatives to provide timely, reliable and accurate test results for care and treatment of PLHIV whereas leveraged to respond to the unprecedented COVID-19 pandemic; more precisely – dual use of molecular (PCR) testing platforms for VL and COVID-19, efforts to optimize the diagnostic and sample referral network with improved quality of the infrastructure, skilled human resources for health on the use of the laboratory information system, and continuous laboratory quality improvement activities such as mentorships to reduce turn-around-time and improved test results management.

COP21 continues to build on COP20 achievements through strengthening laboratory systems to capably provide timely, complete, and accurate results for HIV case finding, surveillance of recent HIV infections, test to treatment and monitoring of VL suppression. These include improving laboratory quality management, enhance the laboratory information system, adequate skilled human resources and above-site support mechanisms to improve turnaround times of VL/EID results, enhanced monitoring to improve quality of testing service delivery in the laboratory network during COVID-19, implement proficiency testing and continuous quality improvement (PTCQI) of HIV core and specialized tests to ensure accurate and reliable test results for patient care and program outcomes.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

The PEPFAR team is comprised of staff from the PEPFAR Coordination Office (PCO), 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 in CODB have been included in COP₂₁ to achieve PEPFAR directives.

CDC currently has eight vacant positions, all of which are in various stages of the recruitment process and expected to be filled by or during COP₂₁ implementation. Seven of the positions were vacated starting in September 2020, and one was vacated in May 2021. 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 COP₂₀, CDC will abolish two positions (one USDH and one locally employed position) and repurpose one locally employed position to assume the duties of the abolished USDH position, resulting in substantial cost savings and increased meaningful engagement with local partners. CDC will also request one new non-PEPFAR position that provides technical expertise and guidance needed to effectively and efficiently implement Rwanda Field Epidemiology Training Program (FETP) and strengthen public health preparedness and response. CDC will not request any new positions in the next fiscal year.

USAID is not requesting any new positions for COP₂₁. In COP₂₀, the DREAMS Coordinator position was hired and onboarded.

The two new positions requested in COP 19, were a Commodities Specialist and a Contracting Specialist. The Commodities Specialist was virtually on boarded in 2020. The Contracting Specialist position, contracted through a USAID central mechanism, is providing support to the transition to RMS.

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 filled in 2017. DOD has now right-sized its staffing footprint to its PEPFAR workload (no change from COP₂₀) and will be able to carry out the necessary SIMS visits and provide TA on clinical services activities. Requested funding for CODB for COP₂₁ is \$220,000.

The PEPFAR Coordination office is comprised of 3 positions, PEPFAR Coordinator, Strategic Information Liaison and a program assistant. The coordinator and SI positions are maintained under a USAID USPSC mechanism and costs are captured under USAID's CODB. In COP₂₁, PCO will add a program assistant/grants manager position. This person will be responsible for managing the community led monitoring program being introduced in COP₂₀. In COP₁₉, PCO abolished the Deputy PEPFAR Coordinator position.

7.0 American Rescue Plan Act Funding Request

In March 2021, President Biden signed the American Rescue Plan Act (ARPA), which designated funds to PEPFAR to mitigate the impact on COVID-19 on PEPFAR programs. Rwanda was eligible

to apply for 5% of the COP21 Planning Level Letter. Below is the proposal submitted by the PEPFAR Rwanda team.

PEPFAR Rwanda proposal for APRA funds to respond to programmatic needs and protect PEPFAR investments in the context of COVID-19. The overall request of \$3,511,690, 5% of the planning level letter for Rwanda (\$70,300,000).

The majority of the interventions below address issues at PEPFAR sites, no other partners are providing support in PEPFAR supported sites or to PEPFAR beneficiaries. The commodities purchase will be aligned with Global Fund C19RM support once proposal development is underway. All proposed activities below fall under key pillars outlined in the Rwanda COVID-19 National Response Plan.

Interventions proposed above will only support PEPFAR sites with needs which have not been met by Ministry of Health COVID-19 interventions to date. Coordination between Global Fund C19RM interventions and PEPFAR interventions will be coordinated at the CCM level. All interventions below are anticipated for COP20 unless otherwise noted. Proposed interventions will assist partners mitigate COVID-19 challenges and achieve COP targets, no targets are associated with the proposed activities below. Please refer to the FAST COVID-E table for additional information.

Prevention

IPC: Rwanda COVID-19 National Response Plan – IPC Pillar

Funding Agency	Partner	Brief Description of Activity	Brief Description of Gap or Need and proposed implementation year
USAID	Pact, Inc.	Tippy taps (hand washing stations), soap and thermometers at safe spaces with inadequate hand washing stations	70 Pact-supported DREAMS safe spaces lack handwashing stations. This funding will ensure and accelerate the delivery of safer group-based curricula activities which were impacted during COVID lockdowns. COP20
USAID	FXB Rwanda	Tippy taps (hand washing stations), soap and thermometers at safe spaces with inadequate handwashing stations	141 FXB-supported DREAMS safe spaces lack handwashing stations. This funding will ensure and accelerate the delivery of safer group-based curricula activities which were impacted during COVID lockdowns. COP20
USAID	AEE	Tippy taps (hand washing stations), soap and thermometers at safe spaces with inadequate handwashing stations	141 AEE-supported DREAMS safe spaces lack handwashing stations. This funding will ensure and accelerate the delivery of safer group-based curricula activities which were impacted during COVID lockdowns. COP20

HHS/CDC	Rwanda Biomedical Center	Procure biohazard waste bins and PPE materials to ensure proper laboratory waste management and personnel safety to implement infection prevention and control at the VL testing hubs and selected GeneXpert sites	Due to enhanced lab biosafety and increased lab testing related to COVID-19, VL/EID testing sites generates lots of biohazard waste and increased usage of PPE from prolonged operation hours of staff in the lab COP21
DOD	Alliance for Family Health	Procurement of social/physical distance barriers. Improving conditions of current hand washing stations at health facilities offering prevention services. Procurement of face mask/ shields for clients, providers.	These funds would support the addition of hand washing stations our health facilities prior to receiving mandatory temperature checks, improving water systems to allow for handwashing through health facilities, and face mask/shields. - Hands washing : \$7,625.96 - Provider masks: \$1,906.49 - Client masks: \$39,763.96 - Provider face shields: \$3,812.98 - Support staff to enforce COVID precautions at HF entry: \$6,536.61 COP21

Clinical Management: Rwanda COVID-19 National Response Plan – Infection Prevention Control Pillar

Funding Agency	Partner	Brief description of Activity	Brief Description of Gap or Need and proposed implementation year
HHS/CDC	Rwanda Ministry of Health	This activity will support enhancement of essential hygiene infrastructures existing at health facilities by ensuring washing stations are adequately spread out to various locations to allow for frequent handwashing and avoid overcrowding at fewer existing stations. In addition, this activity will support the procurement of additional patient screening structures to support covid-19 preventive efforts among healthcare providers and PLHIV clients in selected PEPFAR supported health facilities. Activities will include improving the COV-19 infection control in facilities to support hand washing for healthcare workers and clients and improving screening structures that allow social distancing.	Hand washing, temperature screening while maintaining physical distancing remains critical pillars of covid-19 preventive measures in all areas where people congregate. Healthcare facilities are places where people including PLHIV clients frequently come to seek health care services and there is increased risk of covid-19 infection and transmission if proper hygienic, temperature screening and social distancing measure are not well implemented COP21

DOD	Alliance for Health Communities	Funds will be used to ensure COVID-19 prevention measures including social distancing, physical barriers as well as improving water systems and washing stations meet the increased demand at C&T facilities. Funds will also support COVID-19 preventive efforts established in hard-to-reach sites where military personnel are stationed	There is a need to ensure COVID-19 prevention measures including social distancing, physical barriers as well as improving water systems to meet the additional demand from increased hand hygiene via a one-time investment. Many of the sites do have existing hand hygiene stations but COVID has increased the demand for additional stations. COP21
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Other: Rwanda COVID-19 National Response Plan – Infection Prevention Control

Funding Agency	Partner	Brief description of Activity	Brief Description of Gap or Need and proposed implementation year
DOD	Alliance for Healthy Communities	Funds will be used to cover additional mobile clinic C&T and VMMC travel cost to observe social distancing during COVID-19 pandemic as per national travel requirement. Weekly COVID-19 testing will be implemented among VMMC and C&T health care providers at sites where military personnel are stationed. Funds will also cover new innovation of better communicating with clients (VMMC clients & PLHIV) to avoid congestion at sites.	National travel requirement necessitates fewer people travelling in a vehicle. There is a need for extra vehicle to transport health providers to conduct mobile activities (Rental vehicles). There is a need to test health providers weekly for COVID-19. To avoid congestion at sites, there is need for new innovations for demand creation e.g. use of a hotline to call VMMC clients, send reminders and for setting appointments COP21

Mitigation and Repair

Laboratory: Rwanda COVID-19 National Response Plan – Laboratory Pillar

Funding Agency	Partner	Brief description of Activity	Brief Description of Gap or Need
USAID	Chemonics International	To implement lab bundling and support the quantification of lab commodities and consumables	COVID affected the implementation of the lab bundling activities and resulted in frequent stock fluctuations of lab consumables as multiple tests (HIV, TB and COVID19) use similar consumables. Hence, this funding will help to mitigate and repair the impact of COVID and rebuild the lab supply chain. COP20
HHS/CDC	Rwanda Biomedical Center	Procure ancillary lab equipment to enhance testing capacity, safe specimen handling, and processing	Due to dual use of testing equipment for COVID-19 and HIV at 9 VL hubs, with inadequate ancillary and biosafety equipment for VL testing capacity and

		within acceptable testing turnaround time (TAT)	accumulating sample backlogs, delayed testing, and TAT of VL test results COP ₂₁
HHS/CDC	ICAP	Provide surge lab staff capacity at VL hubs to optimize testing capacity and ensure timely return of test results	Due to high demand of COVID-19 and HIV related testing at VL hubs, unanticipated workload and sub-optimal testing leading to delayed testing and return/ TAT of VL test results COP ₂₁

Logistics: Rwanda COVID-19 National Response Plan – Data Management and Continuity of Essential Health Services

Funding Agency	Partner	Brief description of Activity	Brief Description of Gap or Need
USAID	Chemonics International	To strengthen eLMIS at all ART sites, improve data quality for commodity security, and manage the patients on 6MMD	Logistics data quality sharply reduced from 79% in FY19 to 71% in FY20. This reduction was due to limitations for site level technical assistance during the COVID travel restrictions. The requested funding would strengthen the data management systems and would support increased data requirements for TLD transition, 6MMD scale up (accelerated during COVID) and implementation of TPT. COP ₂₁
USAID	MTaPS	Enhance the DTG scale up for pediatrics through registration, looks for options to adjust the monthly dispensing programs to bimonthly for those not on MMD, and improve the pharmacovigilance systems	Site level training for the PViMS wasn't conducted due to COVID, and Rwanda wasn't able to sustain the bimonthly dispensing options which was initiated during the early COVID ₁₉ pandemic for non-stable patients. Hence, this request would provide training on PViMS and assess the possibility of regular bimonthly dispensing instead of monthly to help protect clients from COVID ₁₉ . COP ₂₀

Repair to Program: Rwanda COVID-19 National Response Plan – Data Management Pillar

Funding Agency	Partner	Brief description of Activity	Brief Description of Gap or Need
HHS/CDC	TBD	To establish a platform that will facilitate innovative tele-mentoring and will allow enhanced virtual	Mentorship, close supervision and knowledge sharing are critical elements in supporting effective implementation of

		support, strengthened mentorship and efficient knowledge sharing among health workers (especially those in remote facilities) in order to mitigate programmatic implementation challenges. This project will leverage on the Extension for Community Healthcare Outcomes (ECHO) “hub” and “spokes” model. A central hub will be established in Kigali and then 30 spokes established in 30 districts. The one- off start-up costs will provide the foundation for cost-effective knowledge exchange opportunities in future. Subsequence – ECHO- years cost will be minimum and will be integrated into routine HIV program	HIV programs across the continuum of care. Unfortunately, the COVID-19 disrupted these efforts due to challenges associated with travel. The setting up of the infrastructure needed to initiate virtual mentoring through the ECHO model will expand opportunities for more cost-effective virtual peer collaboration, mentorship and knowledge exchange among health workers and further lessen the need for travel for physical meetings and trainings. COP21
HHS/CDC	ICAP	Better documentation and support for clinical decisions on HIV patients with Covid-19 infection, enhancements will be made to the case management components of the Rwanda EMR to document Covid-19 infection among HIV+ patients.	Lack of seamless linkage between Covid-19 case management and HIV care in one EMR to enable delivery of comprehensive services COP21
HHS/CDC	ICAP	Complete the data entry and cleaning backlog for routine HIV program and Case Based Surveillance (CBS)/recency data and update the analysis and visualization platforms to ensure immediate use.	Due to Covid-19 disruptions, nurses and data managers who routinely abstract and enter data into systems at health facilities were unavailable and their absence created data entry and cleaning backlogs. COP21

Other: Rwanda COVID-19 National Response Plan – Continuity of Essential Health Services Pillar

Funding Agency	Partner	Brief description of Activity	Brief Description of Gap or Need
USAID	Chemonics International	Procurement of one month consumptions of TLD 90 (a) to continue the scale of 6MMD and (b) to smoothly transition the ARV procurements from PSM to RMS (c) to avert stock outs of ARVs especially TLD	Currently only 18% of the eligible TX_CURR for 6MMD (92,971) are accessing 6MMD. One main reason is unavailability of enough TLD90. The 6MMD scale up plan (accelerated by GOR over the past year due to COVID 19) requires additional stocks in order to (1) avoid stock outs of TLD for 3MMD and monthly dispensing patients (2) to continue scaling up 6MMD to all eligible TX_CURR, and (3) to smoothly transition commodity procurement from one COP to the next COP during the transition of

			procurement between an international and local partner. COP20
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PEPFAR and Global Fund to coordinate buffer stock replenishment funding at the CCM level.

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	COP 17	Scale-Up: Saturation	APR18	48%	48%	73%	76%	97%	89%	90%
	COP 18	Scale-Up: Saturation	APR19	54%	55%	76%	77%	99%	91%	92%
	COP 19	Scale-Up: Saturation	APR20	67%	67%	79%	79%	98%	92%	93%
	COP 20	Attained	APR21	68%	74%	116%	80%	92%	91%	92%
	COP 17	Scale-Up: Saturation	APR18	67%	67%	68%	70%	90%	83%	85%
East	COP 18	Scale-Up: Saturation	APR19	75%	76%	70%	72%	91%	85%	87%
	COP 19	Scale-Up: Saturation	APR20	88%	88%	73%	73%	91%	85%	88%
	COP 20	Attained	APR21	56%	51%	117%	112%	111%	98%	103%
	COP 17	Scale-Up: Saturation	APR18	64%	64%	60%	62%	79%	73%	75%
	COP 18	Scale-Up: Saturation	APR19	72%	73%	62%	63%	80%	74%	77%
South	COP 19	Scale-Up: Saturation	APR20	85%	85%	66%	66%	81%	76%	78%
	COP 20	Attained	APR21	55%	65%	117%	112%	91%	93%	92%
	COP 17	Scale-Up: Saturation	APR18	82%	83%	71%	74%	95%	87%	90%
	COP 18	Scale-Up: Saturation	APR19	93%	94%	74%	76%	96%	89%	92%
	COP 19	Scale-Up: Saturation	APR20	108%	108%	78%	78%	96%	90%	93%
West	COP 20	Attained	APR21	80%	84%	120%	109%	98%	86%	95%
	COP 17	Scale-Up: Saturation	APR18	54%	54%	56%	59%	75%	69%	70%
North	COP 18	Scale-Up: Saturation	APR19	61%	62%	59%	60%	76%	70%	72%
	COP 19	Scale-Up: Saturation	APR20	69%	69%	59%	59%	75%	70%	72%

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	COP	Attained	APR21	75%	77%	97%	106%	96%	90%	93%
	COP	Scale-Up:								
	17	Saturation	APR18	63%	63%	66%	69%	88%	81%	83%
	COP	Scale-Up:								
	18	Saturation	APR19	67%	67%	68%	70%	90%	83%	85%
	COP	Scale-Up:								
	19	Saturation	APR20	83%	83%	72%	72%	89%	84%	86%
TOT	COP									
AL	20	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

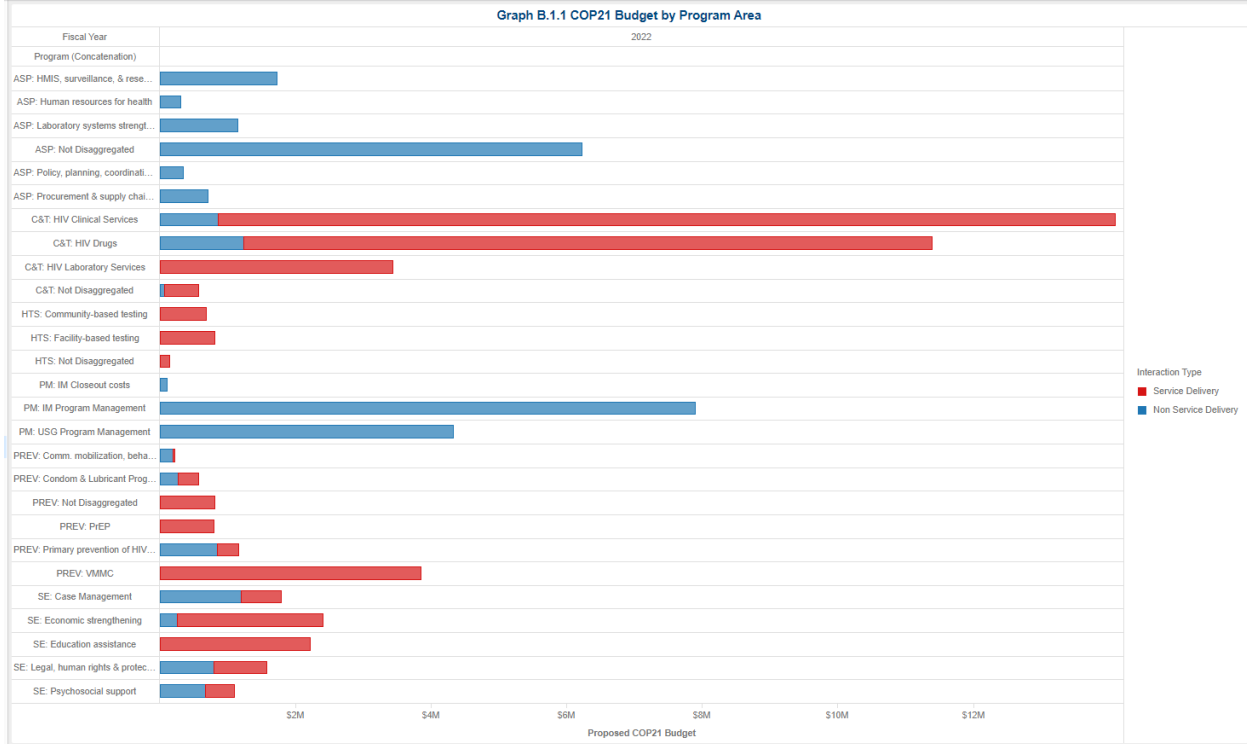


Table B.1.2 COP20 Total Planning Level

Applied Pipeline	New Funding	Total Spend
\$1,301,353 US	\$68,698,647 US	\$70,300,000 US

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

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

Table B.1.3 COP21 Budget by Program Area

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$29,111,321	\$41,188,678	\$70,299,999	41.41%	58.59%	100.00%

C&T	Total	\$2,147,963	\$27,323,684	\$29,471,647	7.29%	92.71%	100.00%
	HIV Clinical Services	\$855,756	\$13,237,177	\$14,092,933	6.07%	93.93%	100.00%
	HIV Drugs	\$1,230,011	\$10,155,000	\$11,385,011	10.80%	89.20%	100.00%
	HIV Laboratory Services		\$3,431,622	\$3,431,622		100.00%	100.00%
	Not Disaggregated	\$62,196	\$499,885	\$562,081	11.07%	88.93%	100.00%
HTS	Total		\$1,626,858	\$1,626,858		100.00%	100.00%
	Community-based testing		\$682,528	\$682,528		100.00%	100.00%
	Facility-based testing		\$810,333	\$810,333		100.00%	100.00%
	Not Disaggregated		\$133,997	\$133,997		100.00%	100.00%
PREV	Total	\$1,295,801	\$6,074,169	\$7,369,970	17.58%	82.42%	100.00%
	Comm. mobilization, behavior & norms change	\$193,464	\$20,915	\$214,379	90.24%	9.76%	100.00%
	Condom & Lubricant Programming	\$262,500	\$300,000	\$562,500	46.67%	53.33%	100.00%
	Not Disaggregated		\$798,764	\$798,764		100.00%	100.00%
	PrEP		\$786,766	\$786,766		100.00%	100.00%
	Primary prevention of HIV and sexual violence	\$839,837	\$316,093	\$1,155,930	72.65%	27.35%	100.00%
	VMMC		\$3,851,631	\$3,851,631		100.00%	100.00%
SE	Total	\$2,900,931	\$6,163,967	\$9,064,898	32.00%	68.00%	100.00%
	Case Management	\$1,190,393	\$597,161	\$1,787,554	66.59%	33.41%	100.00%
	Economic strengthening	\$245,475	\$2,161,810	\$2,407,285	10.20%	89.80%	100.00%

UNCLASSIFIED

	Education assistance		\$2,213,282	\$2,213,282		100.00%	100.00%
	Legal, human rights & protection	\$797,863	\$770,243	\$1,568,106	50.88%	49.12%	100.00%
	Psychosocial support	\$667,200	\$421,471	\$1,088,671	61.29%	38.71%	100.00%
ASP	Total	\$10,440,001		\$10,440,001	100.00%		100.00%
	HMIS, surveillance, & research	\$1,724,036		\$1,724,036	100.00%		100.00%
	Human resources for health	\$297,394		\$297,394	100.00%		100.00%
	Laboratory systems strengthening	\$1,146,042		\$1,146,042	100.00%		100.00%
	Not Disaggregated	\$6,228,171		\$6,228,171	100.00%		100.00%
	Policy, planning, coordination & management of disease control programs	\$345,000		\$345,000	100.00%		100.00%
	Procurement & supply chain management	\$699,358		\$699,358	100.00%		100.00%
PM	Total	\$12,326,625		\$12,326,625	100.00%		100.00%
	IM Closeout costs	\$97,754		\$97,754	100.00%		100.00%
	IM Program Management	\$7,899,798		\$7,899,798	100.00%		100.00%
	USG Program Management	\$4,329,073		\$4,329,073	100.00%		100.00%

Fiscal Year	2022														
Program	C&T		HTS		PREV		SE		ASP		PM		Total		
Beneficiary	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	
Total	\$29,471,647	100%	\$1,626,858	100%	\$7,369,970	100%	\$9,064,898	100%	\$10,440,001	100%	\$12,326,625	100%		\$70,299,999	100%
Females	\$138,000	0%	\$370,039	23%	\$676,013	9%	\$5,458,733	60%						\$6,642,785	9%
Key Pops	\$46,022	0%	\$243,001	15%	\$1,204,147	16%								\$1,493,170	2%
Males	\$138,000	0%			\$2,051,631	28%								\$2,189,631	3%
Non-Targeted Pop	\$27,279,422	93%	\$755,873	46%	\$949,635	13%			\$10,440,001	100%	\$12,326,625	100%		\$51,751,556	74%
OVC					\$671,722	9%	\$3,606,165	40%						\$4,277,887	6%
Pregnant & Breastfeeding Women	\$1,485,007	5%												\$1,485,007	2%
Priority Pops	\$385,196	1%	\$257,945	16%	\$1,816,822	25%								\$2,459,963	3%

B.2 Resource Projections

COP21 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

Not updated in COP21

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]	On Schedule
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	3MMD is fully implemented, 6MMD rollout in progress. Delayed due to COVID-19. Expect to achieve targets 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 COP20, 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	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV-positive biological parent must be tested for HIV.[5]	Achieved

Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	In Progress - PrEP guidelines expanded to include negative partners of index cases in COP21
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) 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	9. 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
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	In progress, limited due to COVID-19 movement restrictions
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	In Progress
	12. Clear evidence of agency progress toward local, indigenous partner direct funding.	Achieved
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	In Progress
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Achieved
	15. 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.