Rwanda

Country Operational Plan

(COP/ROP) 2022

Strategic Direction Summary

April 6, 2022

Contents

*__Military PSNU data are non-public__

A portion of PEPFAR data relates to foreign military sites, such as bases, barracks, or military hospitals. Data originating at these sites are aggregated to each respective OU's Military PSNU and are non-public. When developing graphics for the SDS, do not include the Military PSNU, which you can find in PSNU dropdowns in Panorama. These services may be funded through a variety of implementing agencies or mechanisms, so the Military PSNU designation is not equivalent to DOD as an implementing agency.

1.0 Vision and 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 2022/Fiscal Year 2023 (COP22). PEPFAR minimum program requirements which are "in-process" will continue to be prioritized in COP22.

In COP22, the PEPFAR Rwanda Program will maintain the paradigm shift from COP19 to sustain epidemic control. The updates to the 2022 EPP Spectrum model suggest Rwanda is on track to achieve epidemic control in 2023.COP22 builds on the results of the Rwanda Population Based HIV Impact Assessment (RPHIA) and programmatic data from COP20 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, COP22 maintains the highest yield testing strategies from COP21, including a shift to targeted 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 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, social network testing of high-risk groups, 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, continued care, and drug adherence to support (1) completion of Tuberculosis Preventive Therapy (TPT) to all people living with HIV (PLHIV) and focus on those newly diagnosed, (2) transition of all eligible PLHIV to tenofovir/lamivudine/dolutegravir (TLD), including for women of child bearing age and children, (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. The program will continue to focus on retention to care of all children living with HIV (CLHIV) and transition CLHIV to DTG10.

COP22 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 and Unique Patient Identifier (UPID), a high-performing index testing system, an enhanced Laboratory Information System (LIS) and 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 COP22 PEPFAR will continue to support long-term financial sustainability objectives by increasingly procuring commodities through with the commercial parastatal organization, the Rwanda Medical Supply, Ltd. (RMS); in COP22, RMS will procure with 100% supply of all PEPFAR-funded antiretrovirals (ARVs) and lab commodities with PEPFAR providing budgetary support.

In COP22, PEPFAR will continue to increase its funding to local and indigenous organizations in Rwanda, reaching to 91% of the total budget. For the first time, this calculation includes investments in commodity procurement (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[1] Projection from the 2012 census estimates the 2022 population at 13,252,274.[2] HIV prevalence in 2022 is at 1.67% and there are estimated 227,134 people living with HIV (PLHIV) in Rwanda. 4 According to 2018/19 RPHIA, for adults 15-64 years old, prevalence among women is 3.7% as compared to 2.2% among men. Prevalence of HIV among adolescents 10-14 years was 0.4%, corresponding to approximately 5,900 young adolescents living with HIV in Rwanda. The estimated annual incidence of HIV among adults 15-64 in Rwanda is 0.03%, representing approximately 4,009 new cases of HIV among adults 15-64 year.

As of December 2021, Rwanda had 210,344 PLHIV on ART nationally, an increase from 203,016 PLHIV on ART in 2020. At the end of 2021, ART coverage for all estimated PLHIV nationally was 93%.5 Loss to follow-up has historically been very low, at approximately 0.2% in PEPFAR-supported sites and 0.4% nationally according to data from the national reporting system, Rwanda Health Management Information System (RHMIS).6

Prevalence of community viral load suppression (VLS) among all HIV-positive adults 15-64 years old was 76% according to 2018/19 RPHIA, with 79% VLS among women and 71% VLS among men. Among women living with HIV, the prevalence of viral load suppression was found to be highest among women 35-44 (85.2%) and lowest among women aged 15-24 years (62.3%). Among men living with HIV, the prevalence of viral load suppression was found to be highest among men aged 55-64 (84.9%) and lowest in men aged 25-34 (45.9%).7

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.

According to Demographic and Health Survey 2019-20, across the country, the self-reported prevalence of medical male circumcision (MMC) among men aged 15-64 was 56%, ranging from 41% in the South to 72.4% in the City of Kigali[3]. Prevalence of self-reported MMC was highest among men aged 20-24 (74.56%) and lowest among older men aged 40 -49 years (29.5%).18

Donor funding to the national HIV program has decreased in the past years, a five-year trend that is expected to continue. Rwanda's gross national income is $780 per capita.9 Rwanda ranks 157 according to UNDP's Human Development Index in 2018.10 Significant financial barriers remain to achieve a sustained domestically funded HIV response in the near future. However, the GOR has committed (through MOH and the Ministry of Economics and Finance) to work together with the U.S. Government (through PEPFAR agencies and Treasury) to increase domestic investment in the national HIV/AIDS response to ensure long-term sustainability of the HIV program, which is a priority in the current COP and will continue into COP 2020.

Rwanda's HIV epidemic is generalized, with higher key population (KP) infection rates, and an urban prevalence of 4.8%, compared to a 2.5% rural prevalence.11 Women have a higher HIV prevalence than men in general (2.04% vs. 1.29% nationally). For men and women aged 20-24, HIV prevalence is 2.2 times higher among women (1.2%) than men in the same age group (0.54%).12 Sixty-five percent of transmission is estimated to be in stable heterosexual relationships, while 20% of new infections are attributed to sex workers, their clients and their partners.13 FSWs have an estimated HIV prevalence of 45.8% from a national survey conducted in 2018/19, while MSM are estimated to have a 6.97% from a national survey conducted in 2020/21. An earlier study conducted in 2019 estimated HIV prevalence of 9.2% in Kigali.

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1 [1] 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] National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF. 2021. *Rwanda Demographic and Health Survey 2019-20 Final Report*. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF

Standard Table 2.1.1.

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	13,252,274	100 %	2,407,002	18.2%	2,428,555	18.3 %	1,384,830	10.4%	1,351,956	10.2 %	3,008,104	22.7 %	2,671,827	20.2 %	NISR Census Projections 2022
HIV Prevalence (%)		1.71 %		0.18%		0.18 %		0.86%		0.47 %		4.15 %		2.82 %	EPPS 2022*
AIDS Deaths (per year)	2,620		173		176		173		169		950		979		EPPS 2022*
# PLHIV	227,134		4,369		4,403		11,884		6,351		124,689		75,438		EPPS 2022*
Incidence Rate /1,000 (Year)		0.33		-		-		0.7		0.2		0.6		0.3	EPPS 2022*
New Infections /(Year)	4,290		330		339		867		218		1,497		1,038		EPPS 2022*
Annual births	360,858	2.7 %													NISR census Projections 2022
% of Pregnant Women with at least one ANC visit		97.7%		-				-				-			DHS2020 Table 9.1
Pregnant women needing ARVs	7,972														EPPS 2022*
Orphans (maternal, paternal, double)	392,644		126,218		126,446		70,397*		69,583*		-		-		NISR x DHS 2020 Table 2.9 (<15, 15-17)*
Notified TB cases (Year)	5,470	100 %	165	3.02%	183	3.35 %	251	4.59%	485	8.87 %	1,114	20.37%	3,272	59.82 %	HMIS, 2021 (TB & ORD Division RBC)
% of TB cases that are HIV infected	985	18.01 %	6	0.61%	15	1.52 %	Females 15+ = 336 (34.8%) Males 15+ =628 (65.1%)								HMIS, 2021 (TB & ORD Division RBC) <15, 15+
% of Males 15-59 years Circumcised		52.5%				N/A				73.3 %				43.1%	DHS2020 Table 13.9
Estimated Population Size of MSM*	18,141	100 %													MSM IBSS 2021
MSM HIV Prevalence							6.5% (5.3 – 8.1)								MSM IBBS-PSE 2021
Estimated Population Size of FSW	13,714 (8,853-23,495)	100 %													FSW PSE 2018
FSW HIV Prevalence	1,741	35.5%						19.0%				39.9 %			FSW IBBS 2019

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													
	EPP Spectrum as of February 2022														

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*

	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate	HIV Prevalence	Estimated Total PLHIV		On ART	ART Coverage (%)	Viral Suppression (%)*	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	PLHIV diagnosed (#)	(#)			(#)	(#)	(#)
Total population	13,598,122	1.67%	227,134	223,244	210,344	93%	96%	1,876,165	10,582	9,959
Population <15 years	5,345,007	0.16%	8,772	5,540	5841	67%	92%	99,827	432	364
Men 15-24 years	1,314,430	0.48%	6,351	6,326	5,192	82%	95%	247,853	471	292
Men 25+ years	2,683,866	2.8%	75,438	75,325	69,884	93%	96%	453,167	3,437	3,250
Women 15-24 years	1,333,719	0.89%	11,884	11,781	10,860	91%	93%	389,943	1,760	1,612
Women 25+ years	2,921,100	4.27%	124,689	124,272	118567	95%	96%	685,375	4,482	4,441
MSM	18,141	6.5%	739	NA	NA	NA	NA	NA	NA	NA
FSW	23,495	45.80%	8935	NA	NA	NA	NA	NA	NA	NA

* Viral Suppression data from PEPFAR FY22Q1 Report. Please note that this is not population viral suppression, rather viral suppression among those on ART and get tested. PEPFAR cover 60% of the Total ART patient cohort.

Estimates for testing, treatment, ART continuity, and suppression for key and priority population groups (below grey line) should only be included if reliable data exists.

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

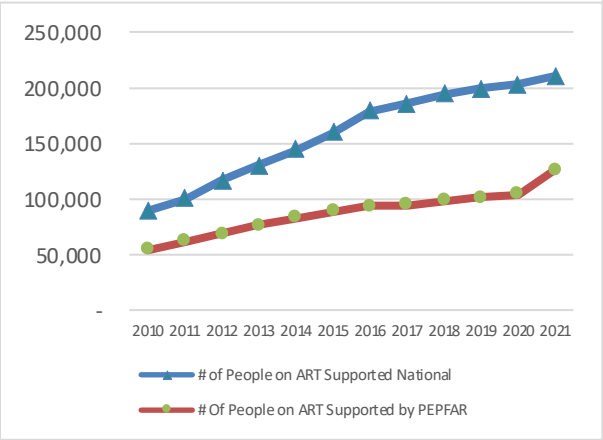


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

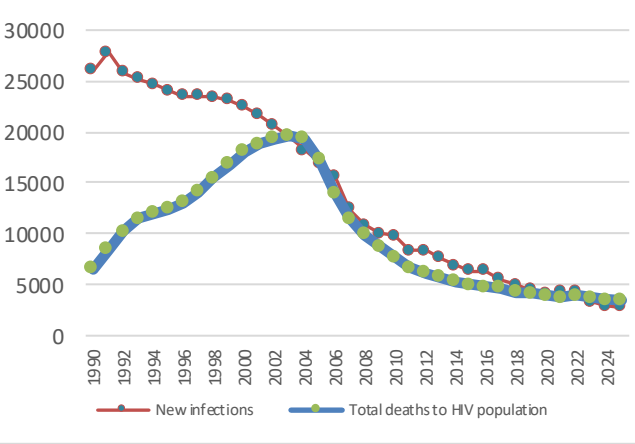


Figure 2.1.5 Assessment of ART program growth in FY21

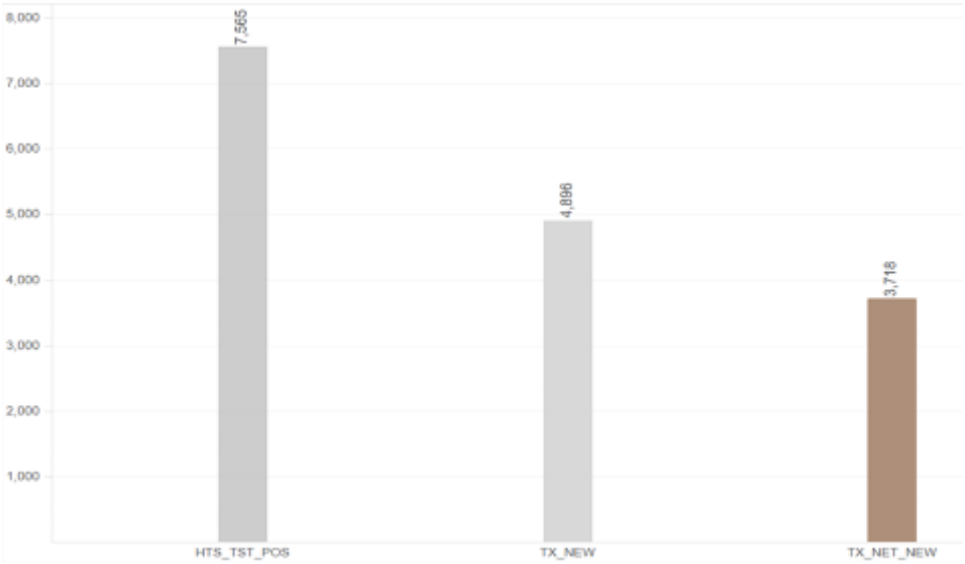
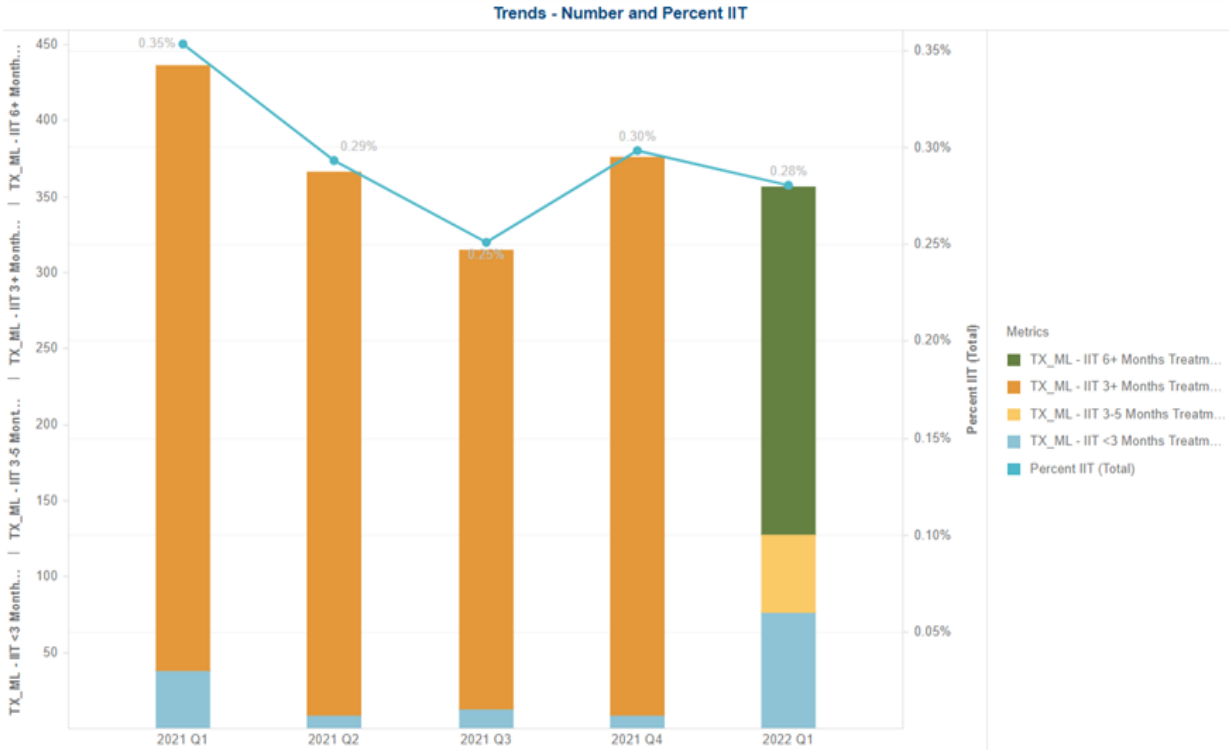


Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4



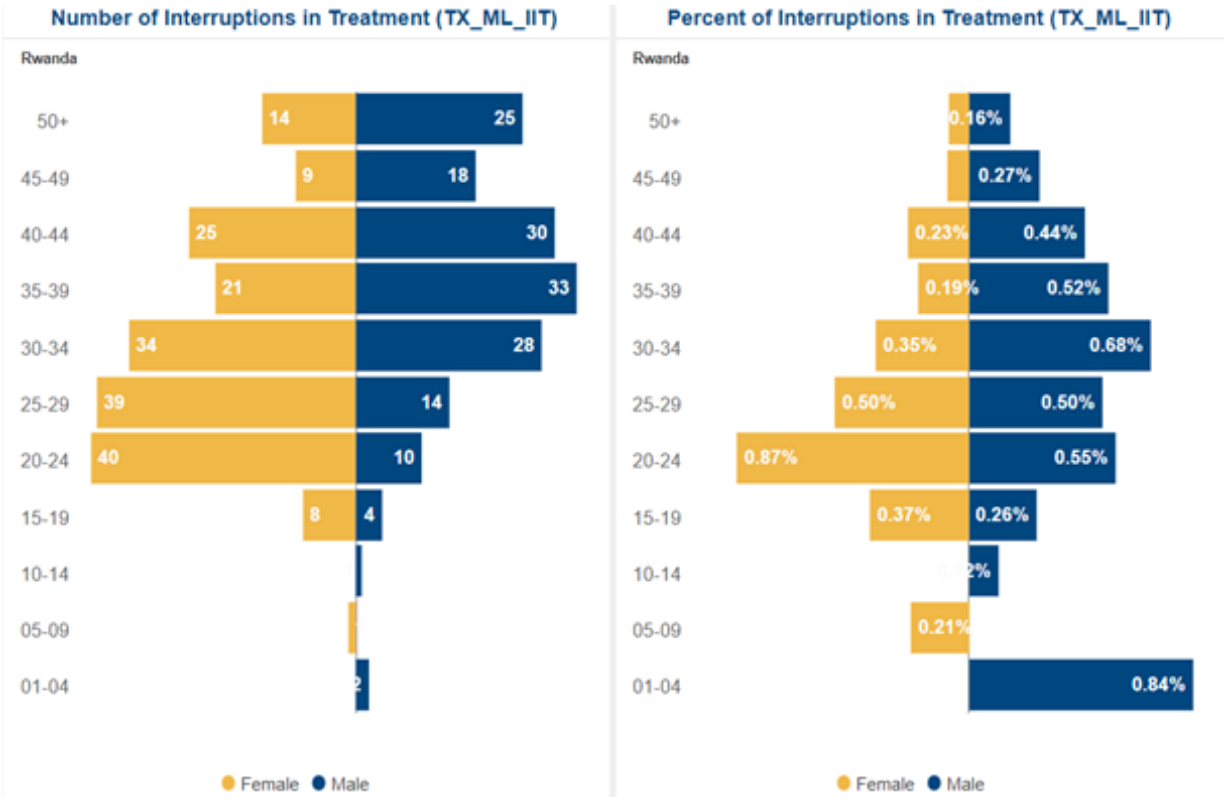


Figure 2.1.7 Epidemiologic Trends and Program Response Rwanda

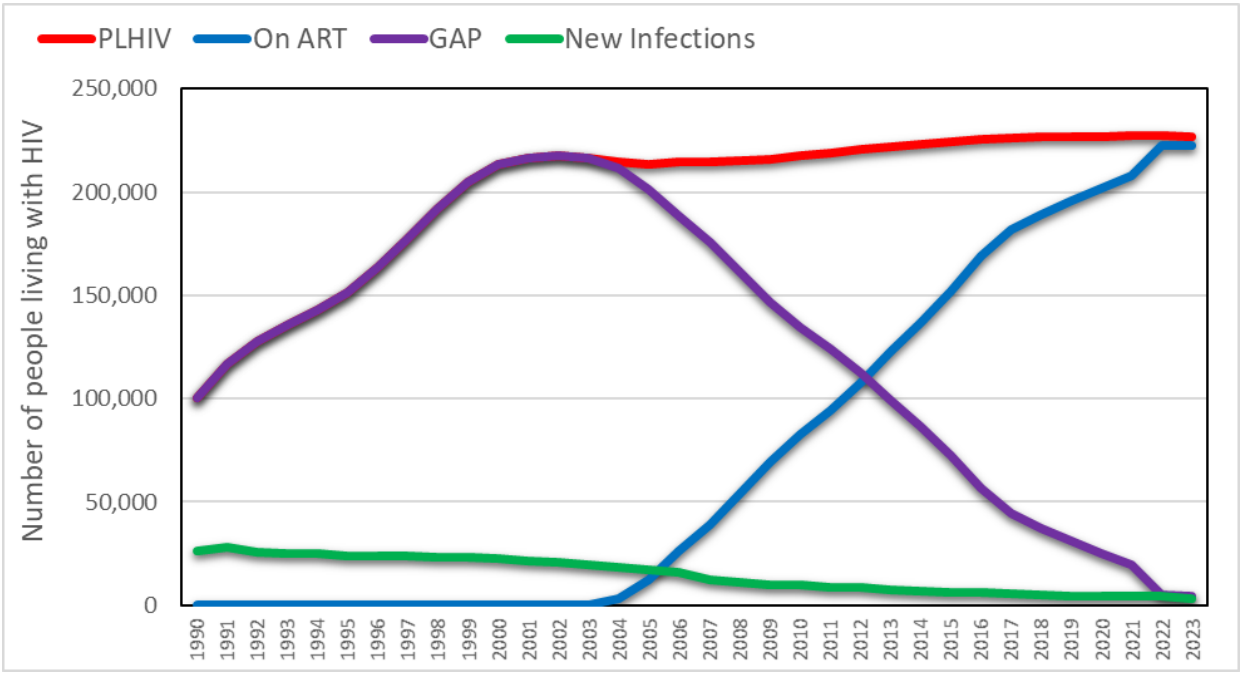
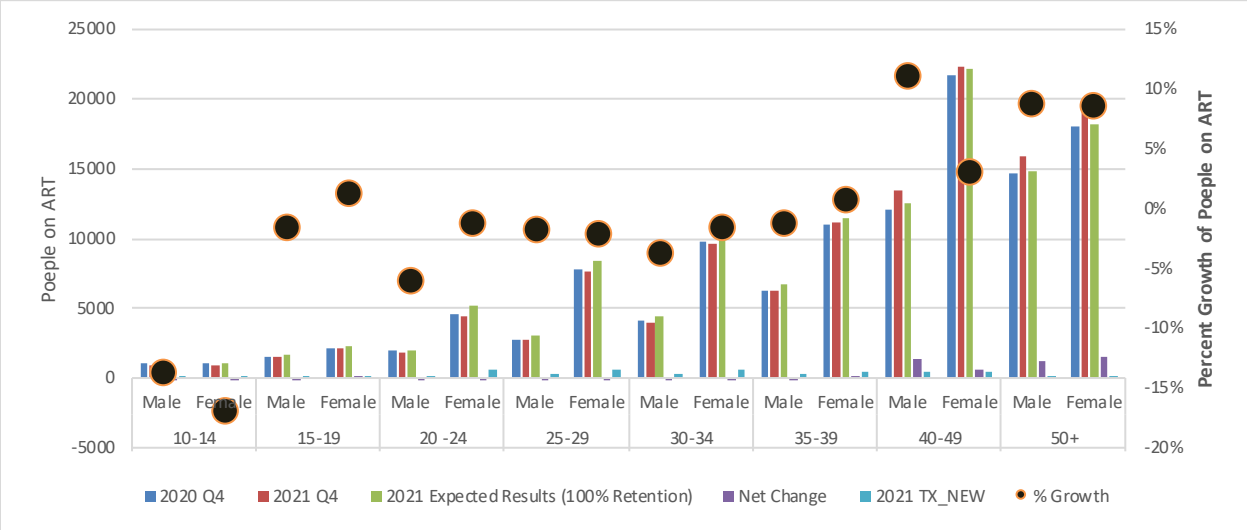


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4



2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

The PEPFAR Rwanda program continues to see great success in the second and third 95 for all PLHIV. However, the program will focus on those small numbers not successfully linking to care and challenges with viral load coverage and suppression. The two main areas of concern are children living with HIV (CLHIV) and men aged 15 to 34 years old. These two populations of concern were highlighted in the 2022 EPP Spectrum data and a focus for programming in COP22. More details are covered in section 4.2.

2.3 Investment Profile

In FY22, Rwanda's HIV response was funded primarily by three sources: PEPFAR (50%), the Global Fund (GF) (34%), and the GOR (15%).[2] Overall donor funding for Rwanda's HIV program continues to decrease. 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. Currently, the 2021-2024 funding cycle allocates 47 million per year (not including above allocation funding). PEPFAR total funding (base and central funds) has decreased from $70.3 million in FY2022 to $67 million in FY2023.[3] The GOR's investment of $22 million for FY21 accounted for 15% of the contribution to

[2] 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.

[3] PEPFAR COP21 and COP22 planning level letters.

HIV response, similar to previous investments. The numbers above reflect the budgeted dollars for the HIV response in Rwanda.

Total expenditures for FY21 do not reflect overall expenditures for the HIV response in Rwanda due to differences in fiscal cycles (PEPFAR's FY21 was October 1, 2020 to September 30, 2021; GF and GOR's FY20/21 was July 1, 2020 to June 30, 2021) and expenditure reporting. MOH reports GF and GOR expenditures not by program area, HIV National Strategic Plan (NSP) cost categories. 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 impact 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, or the gains made in certain technical areas.

PEPFAR and 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 future.

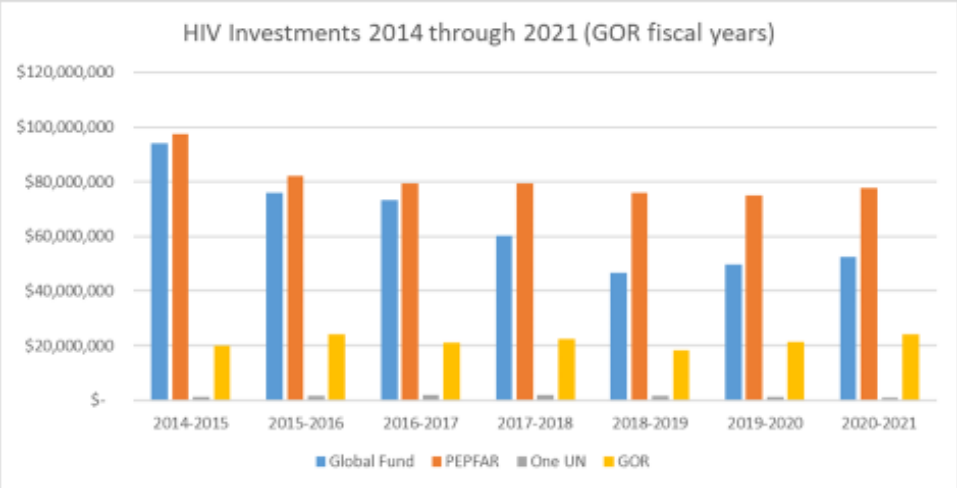
PEPFAR and the GF are coordinating with the GOR to maximize donor investments and strategically align with domestic and other available resources to achieve epidemic control. The MOH established a working group, within the Health Sector Working Group (HSWG), to prioritize areas for collaboration and 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 COP22, PEPFAR will continue to increase its funding to local and indigenous organizations in Rwanda, from 87% in COP21 to 91% in COP22, not inclusive of the cost of doing business.

2.3.1a HIV Expenditures by Government and Donor Partner[4]

Program Area	Total	Domestic Government %	Global Fund %	PEPFAR %
Care and Treatment	$71,046,115	18%	39%	43%
HIV Testing Services	$5,618,450	0%	75%	25%
Prevention	$13,877,669	0%	32%	68%
Orphans and Vulnerable Children	$8,233,986	0%	5%	95%
Above Site Programs	$14,660,849	29%	33%	38%
Program Management	$35,325,265	20%	30%	50%
Total (incl. Commodities)	$113,437,069	15%	37%	64%

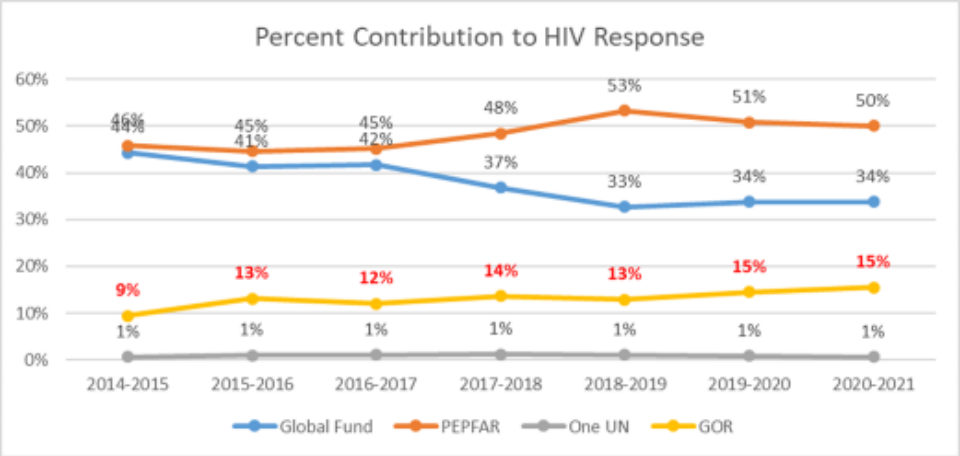
2.3.1b Rwanda HIV Investments 2014 through 2021 (GOR fiscal Years)[5]



2.3.1c Percent Contribution to the HIV Response (GOR Fiscal Years) [4]

[4] SGAC Resource Alignment Tool and Rwanda HIV annual report 2020-2021

[5] Rwanda HIV Annual Reports 2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021



2.3.2 Investment Profile for HIV Commodities

Table 2.3.2. Investment Profile (Funding Landscape) for HIV Commodities						
	Total	Domestic Government	Global Fund	PEPFAR	Other Funders	Trend
	current Year	%	%	%	%	2018-2021
Antiretroviral Drugs	**$19,286,534**	**NA**	**48%**	**52%**	**0%**	
Condoms and Lubricants	**$2,155,359**	**NA**	**0%**	**14%**	**9%**	
Female Condoms	$0	**NA**	**0%**	**0%**	**0%**	
Male condoms	$2,155,359	**NA**	**0%**	**14%**	**9%**	
Other Condoms and Lubricants	$0	**NA**	0%	0%	0%	
Rapid Test Kits	**$4,066,454**	**NA**	**44%**	**12%**	**0%**	
Laboratory Supplies and reagents	**$7,250,236**	**NA**	65%	16%	0%	
CD4	$154,153	**NA**	100%	0%	0%	
Viral Load	$2,244,562	**NA**	47%	51%	0%	
Other laboratory supplies	$4,851,521	**NA**	72%	1%	0%	
Medicines	**$1,199,369**	**NA**	57%	23%	0%	
Essential medicines	$117,886	**NA**	100%	0%	0%	
Tuberculosis Medicines	$1,081,482	**NA**	53%	25%	0%	
Other medicines	$0	**NA**	0%	0%	0%	
Consumables	**$3,921,899**	**NA**	0%	0%	0%	
VMMC kits and supplies	$3,921,899	**NA**		0%	0%	
Other Consumables	$0	**NA**	0%	0%	0%	
Health Equipment						
Health Equipment						
Service maintenance						
PSM Costs	$3,993,562.49	NA	37%	46%	0%	
Total commodity cost only	**$37,879,849.91**	NA	43%	32%	1%	
Commodity and PSM cost	**$41,873,412.40**		**43%**	**34%**		

Data Sources

The sources are (1) National Quantification Draft Report, (2) COP22 FAST, and (3) COP21 period implementation budget alignments.

The COP15 to COP21 trends are shown in the below table (data source: National CPDS data)

Year	PEPFAR	GFATM	Total	PEPFAR	GF	Remark
COP15	$21,058,361	$16,672,585	$37,730,947	56%	44%	National forecasted need was 100% covered
COP16	$18,250,134	$13,219,686	$31,469,820	58%	42%	
COP17	$18,781,138	$18,783,286	$37,564,424	50%	50%	
COP18	$16,157,985	$17,013,828	$33,171,813	49%	51%	
COP19	$13,465,985	$13,426,712	$26,892,697	50%	50%	
COP20	$15,005,205	$15,272,097	$43,061,453	35%	35%	30% gaps
COP21	$10,758,085	$19,599,090	$39,199,776	27%	50%	Estimated 20% gaps

Standard Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
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	**$49,200,000**	**$9,580,908**	**3**	**$32,272,343**	USAID non-PEPFAR resources are focused on MCH, Malaria, Nutrition, WASH, family planning and Health Systems Strengthening. When combined with PEPFAR funds, the focus is on improving access to service delivery in Nutrition, Water, MCH, FP activities and commodities availability.
Family *Planning*					
NIH					
CDC (Global Health Security)	$4,470,523	$4,470,523	2	$1,288,000	Procurement of lab equipment, strengthen data systems, public health emergency management, CODB costs
Peace Corps					
DOD Ebola					
MCC					

Other (specify)					
Total	**$53,670,523**	**$14,051,431**		**$33,560,343**	

2.4 National Sustainability Profile Update

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

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

Rwanda Overview: Rwanda has made significant and remarkable progress in reaching the UNAIDS Fast Track 90-90-90 Goals following the genocide of 1994. The Government of Rwanda (GOR) has demonstrated strong leadership and vision in crafting a national HIV/AIDS strategy and coordinating the response. However, Rwanda remains highly dependent on donors to fund its HIV response, particularly PEPFAR and the Global Fund. Those donor contributions are declining, which poses a significant risk to the long-term sustainability of the national HIV program, and to the great successes Rwanda has achieved. The Government of Rwanda is taking strides to find and treat remaining positives through targeted outreach and testing models focusing on key and priority populations and key geographic areas, to provide immediate treatment for PLHIV under the fully implemented Treat All program, to optimize service delivery models, and to find ways to absorb the costs of administering the national HIV program even though Rwanda is a low-income country.

By September 2021, PEPFAR leveraged over $5 million to assist in Covid-19 response. Covid-19 and resulting country lockdowns negatively affected the HIV response activities where different movement restrictions affected activities that involve community outreach and those that would bring together individuals which were severely delayed in implementation. The team has used several mechanisms to make sure prevention, care and clinical services reach beneficiaries. Such mechanisms include the 3 and 6 months dispensing of ARVs people who are on HIV treatment.

SID Process: The 2021 SID was adjusted to accommodate COVID-19 restrictions. Domain leads reviewed and updated the SID in small virtual meetings. The PEPFAR Coordination Office compiled the results and shared the updated document with partners and stakeholders. A review and validation meeting was held in late October 2021.

Sustainability Strengths: All 2021 SID domains were identified as sustainable, approaching, or emerging sustainability with notable strength in the domain "Governance, Leadership, and Accountability."

- **Policies and Governance** (8.04, light green) The score for policies and governance reduced from 8.50 in 2019 (SID4.0) to 8.04 in 2021 SID. The MOH follows the national guidelines which mandates high quality services.
- **Private sector engagement (9.67 Dark green):** This score increased from 9.50 in 2019 (SID4.0) to 10.0 in 2021 SID. The GoR gave opportunities for the private sector to engage in services related to HIV prevention, health worker training, and delivery of products and in clinical care. In Rwanda private entities participate and contribute to strategic planning of activities related to HIV care and management. Both public and private institutions that provide HIV care work hand in hand under the same referral system. Private institutions are allowed to use public supply channels of HIV commodities.
- **Quality Management (8.05, light green):** The country has seen continuous growth in quality improvement (QI) and quality management (QM). Despite the pressure of Covid-19, that require the health system to allocate significant effort to Covid-19 management, Rwanda preserved a strong quality management system.

Sustainability Vulnerabilities:

- **Technical and Allocative Effectiveness (6.60, yellow):** Technical and allocative effectiveness remains a vulnerability to the sustainability of the Rwandan HIV response. There is a limited domestic budget to fund the HIV program, and donor funding, including PEPFAR funding, is reducing. Nearly 50% of PEPFAR funding and all GF support are delivered through the government, which demonstrates the high capacity of the GOR and MOH systems. However, the lack of domestic resources continues to pose a challenge to the long-term sustainability of the national HIV response when donor funding has reduced.
- **Epidemiological and Health Data (6.18, yellow)** Epidemiological and health data are collected, analyzed, and used to inform programs. Surveys and surveillance activities are conducted to measure both general population and key populations, but the Government provided minimal funding for these activities.

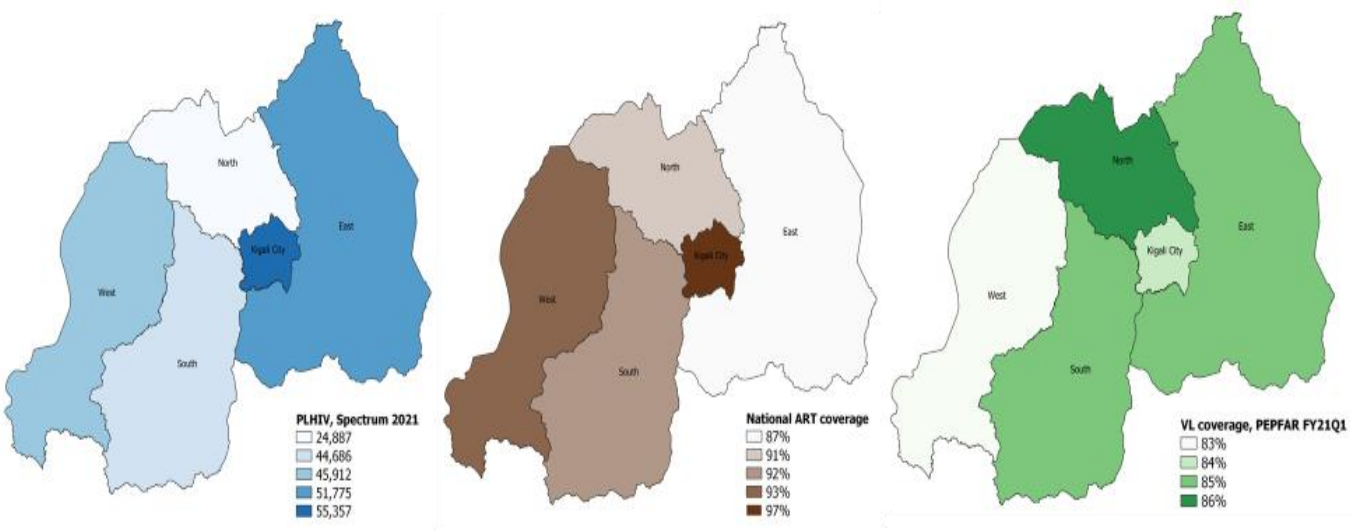
- **Data for Decision-Making Eco-system (5.14, yellow)** The Government of Rwanda has demonstrated commitment to advancing the use of data to inform government decisions and cultivate an informed, engaged civil society. The capacity and use of existing and nascent systems are still in varied stages of development. The main reason that this score is not higher is the lack of a nationally rolled out unique identification system in Rwanda, though the system is in development and the team is committed to have it fully up.

2.5 Alignment of PEPFAR investments geographically to disease burden

HIV care is widely available, predominantly delivered through the public system network of District Hospitals and Health Centers. In FY21, 59% 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 Eastern 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, COP22 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.

Figure 2.5.1. This figure demonstrates the total PLHIV, Spectrum 2021, national ART coverage and viral load coverage by SNU.



2.6 Stakeholder Engagement

As in prior years, COP development is an iterative 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), multilateral partners, and other stakeholders provided input for the COP22 working groups through participation in virtual strategic planning retreat held online in February 2022. 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.

The PEPFAR Coordination Office and Technical Working Groups facilitated multiple civil society engagements throughout the COP planning process.

- Civil Society COP22 kick-off meeting
- Key and vulnerable population listening session, participants included representatives from Rwanda Biomedical Center, civil society, and beneficiaries
- PLHIV feedback meeting hosted by Rwanda's Network of PLHIV (RRP+)
- CPM Civil Society Representative Coffee hosted by the Chargé d'Affaires (CDA), a pre-CPM meeting to brief the CDA on issues facing the community in Rwanda
- Post-CPM readout to CSO representative organizations

Representatives from the GOR/MOH, WHO, UNAIDS, Global Fund, and civil society also took part in the COP22 virtual planning meeting March 8-10th, 2022 and will join the approval meeting call on April 27. 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 COP2022; these stakeholders will continue to be engaged throughout COP22 implementation. Additionally, the PEPFAR Rwanda team will work with the MOH to ensure the GF application is in alignment with PEPFAR initiatives and programming.

2.7 Stigma and Discrimination

PEPFAR and Government of Rwanda continue to work together to achieve the universal access and utilization of HIV prevention, care, and treatment services for all targeted populations without any HIV related stigma and discrimination. COP22 will focus on innovative strategies that address both public and self-stigma as well as discrimination at all points in the HIV service delivery cascade. Strategies include expansion of KP Friendly services to ensure the safety and security for KPs at health facilities, updating, distribution and mentorship on facility-based stigma and discriminations tools, KP's specific hours and days, HCP's refresher training and onsite mentorship on KP friendly services and Youth friendly clinical services for AGYW including stigma reduction, reinforce education among MSM and AGYWs using peer navigators/educators while openly identifying their own experiences. In addition, strengthen GBV and stigma discrimination services implementation at facility level by training all HCPs on LIVES approach for GBV response.

3.0 Geographic and Population Prioritization

The PEPFAR and MOH teams are focused on maintaining epidemic control in Rwanda during COP22. According to results from RPHIA 2019, in Rwanda, 84% of HIV-positive adults between 15-64 years were aware of their HIV-positive status, 98% of those PLHIV were on ART, and among adults currently on ART, 90% had achieved viral load suppression.

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

In Rwanda, districts are relatively small geographically, with an average of 844 square kilometers and a range of 134-1937 square kilometers, having an average population of 350,532. Given the small size and inter-district movement of people within Rwanda, as the country moved toward saturation, many districts showed ART coverage greater than 100%. Given the limitations with the accuracy of the estimations, the district coverage greater than 100%, the small geographic areas and the mobility of the population, for COP17 the sub-national unit (SNU) of prioritization for

Rwanda was changed to the provincial (between national and district) level. This change allowed a more accurate regional assessment of where additional resources are needed to ensure that all PLHIV have access to ART, as well as the flexibility to target hotspots, facilities or other sub-SNU regions where improvements are needed. COP 2018, 2019, 2020 and 2021 continued with the provincial level as the SNU of prioritization, with programming targeting specific populations based on their presence and risk for HIV. In COP22, PEPFAR will continue to target resources at the provincial level, focusing on the gaps identified by RPHIA. Resources will target the identification and linkage of PLHIV to treatment in the East, where gaps were found in diagnosis and viral suppression of PLHIV, particularly among men.

Provincial ART coverage at the end of 2021 was 88.9% for the East, 96.1% for Kigali City, 89 .3% for the North, 93.1% for the South, 93.9% for the West and 92.6% overall. COP22 targets have population viral load suppression (popVLS) target at 92% for the total population, considering where the provinces are, estimated at 90% in the East, 95% in Kigali City, 89% in the North, 91% in the South, and 92% in the west. Pediatric PLHIV estimations have varied greatly from year to year in the Spectrum models, and popVLS for pediatrics at 54% (with estimated pediatric ART of 82% in COP 2020).

Analysis of population viral load suppression and ART coverage by age and sex was used to determine where the gaps were greatest. Through this analysis, in combination with the current understanding of modes of transmission in Rwanda, the city of Kigali was identified as a focus area due to its relatively high HIV prevalence and its young and growing population, due largely to the fact that Rwanda is one of the fastest urbanizing countries in the world.[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 epidemic control in Rwanda and achieving an AIDS-free generation.

Table 3.1 Current Status of ART saturation

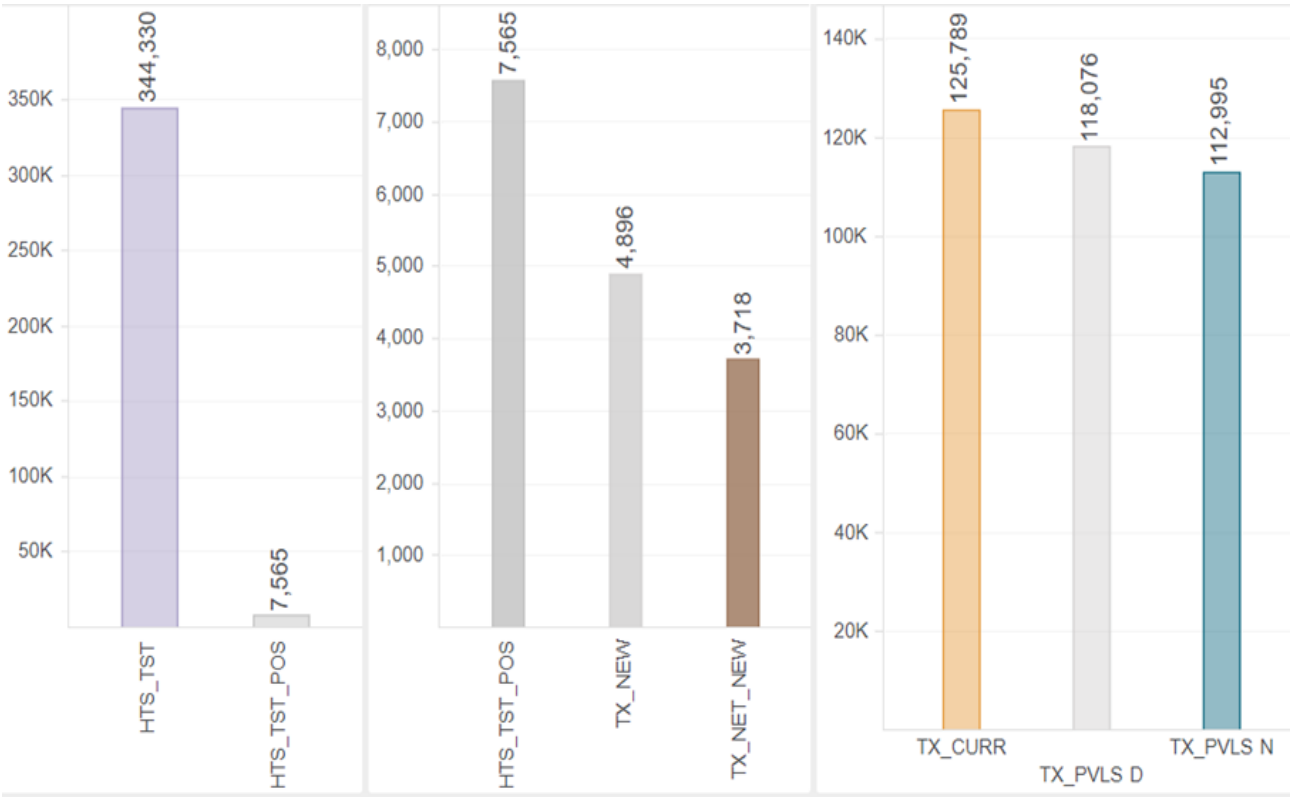
SNU1	Total PLHIV/% of all PLHIV for COP22	# Current on ART (December 2021)	Estimated ART Coverage	VL Testing Coverage*(FY22Q1)	VL Suppression *(FY22Q1)	# of SNU COP21 (FY22)	# of SNU COP22 (FY23)
National	**227,134**	**210,344**	**92.6%**	**93.5%**	**97.6%**	**5**	**5**
Kigali City	57,424	55,174	96.1%	93.1%	97.1%	1	1
East	52,744	46,901	88.9%	96.2%	98.7%	1	1
South	45,236	42,110	93.1%	93.1%	98.2%	1	1
West	46,059	43,245	93.9%	93.0%	97.0%	1	1

North	25,671	22,914	89.3%	88.1%	98.5%	1	1

**PEPFAR Data for FY22Q1 is used.

4.0 Client-Centered Program Activities for Epidemic Control

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



This visual comes from the clinical cascade, single OU dossier, overall cascade page.

4.1 Finding people with undiagnosed HIV and getting them started on treatment

Rwanda's most significant challenge in reaching HIV epidemic control is finding new HIV positive individuals. In APR 21 (FY21), PEPFAR Rwanda diagnosed 4,965 individuals with HIV positives, representing 150% of the annual target. In FY 22 Quarter 1 (Q1), PEPFAR supported sites identified 1,152 new HIV positives through index testing, 28% of the annual target. According to the 2022 EPP Spectrum estimates, the challenges in reaching the first 95 were around finding children both males and females below 15 years and linking them to treatment (with an estimated gap of 2,613 PLHIV not yet identified based on FY22Q1 data). During COP22, PEPFAR aims to identify 3,824 new HIV positives of which 2,363 (62%) will come from index testing. PLHIV with unknown status will be reached using targeted case finding strategies. Through facility-based testing modalities, PEPFAR will focus its support of facility-based testing modalities of case identification through HIV testing for pregnant and lactating women seeking ANC/PMTCT services and index testing of their sexual partner as well as children born to HIV positive women and case finding through retesting PrEP beneficiaries. PEPFAR will support community-based testing targeting KP (Female sex workers and MSM), and Priority Populations (clients of Female Sex Workers (FSWs), truck drivers, mobile populations and adolescents and young women (AGYW) through DREAMS).

All 195 of the PEPFAR supported testing sites across Rwanda are currently supporting index testing services. In FY22 Quarter 1, 11,608 index clients were offered index testing. Of those offered index PNS and family testing, 57% provided partner contacts. Overall test yields through index services remains low at 4.8% overall, with a 0.9% yield for those under 15 years of age, and a 5.6% yield for those 15 years or older.

In COP22, Index testing/Partners notification services and family testing will continue to be administered to all persons testing HIV positive at all sites, with a priority to those newly identified and PLHIV on ART with unsuppressed VL, to further identify HIV positive adults and children. Family Index testing will help the program close the gap among children as data shows there is an average of 45% index testing contribution to total positives. PEPFAR team and IPs will continue to ensure that for Index testing services provision, an identified HIV+ person receives individualized counselling following the required WHO 5 Cs standard for HIV testing services: Consent, confidentiality, Counselling, correct results and connection to other services including care and treatment. The services are voluntary with the index client having an option to opt in or out. Services are provided by trained health care providers. Safe and ethical index assessment is being conducted along with SIMS, and remediation action plan are developed after each assessment.

During COP22 implementation period, closing the gap on reaching missing children will be achieved through intensive site-level monitoring and mentorship identifying and mitigating challenges in effective service delivery and program management, with near-POC recency testing offered at all district hospitals for health centers in its catchment area and the roll out of the active HIV Case-Based Surveillance (CBS) system with an integrated national unique patient identifier (UPID). Increased numbers of PLHIV found through case finding strategies is being achieved by: 1) Conducting monthly USG/IPs technical meetings to review PEPFAR HTS results to inform the testing strategy, 2) Conducting quarterly MOH/PEPFAR technical meetings to review MOH/PEPFAR HTS results and inform testing strategies including index testing, recency testing and cluster investigations, 3) Enhancing site level monitoring and mentorship, and 4) conducting regular CQI activities to improve case finding.

Improved PNS testing yields is being achieved by 1) increasing the proportion of high-risk individuals as index cases, 2) Improved reporting of index case test results of primary sexual partners with a higher risk of exposure through ANC couples testing and 3) Increasing the proportion of index cases which are newly diagnosed as the facilities complete index PNS of those currently on treatment.

In COP22, while the Government of Rwanda continues supporting HIV testing in all testing modalities, PEPFAR will focus on supporting index testing for the children and sexual partners of

the HIV positive individuals identified through PMTCT ANC and post ANC, DREAMS, PrEP and KP testing services.

Recency testing will measure the frequency of recent infections among newly diagnosed HIV positives and provide information on how to focus testing and prevention strategies by identifying transmission networks and social networks. With the scale up of CBS and an integrated national unique patient identifier (UPID) in COP 2020/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 COP22, 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 COP22 PEPFAR will focus on improving the recency results turnaround time with rollout of the laboratory recency data system to healthcare providers and maintain the use of recency data in the Open MRS/CBS to identify areas with recent infections and intensify prevention and testing strategies in those areas.

In COP22 PEPFAR will continue to build on COP 21 strategies to increase case finding for men including: Offering index testing to HIV positive women, particularly among AGYW, partners of unsuppressed women and to partners of FSWs, targeted KP testing focusing on MSMs in locations with high prevalence and low awareness on HIV+ status (first 95), as per preliminary MSM PSE/IBBS study, 2021.

PEPFAR will continue to support more focused active case finding of KP, including FSWs and MSM, and their social networks through community-based initiatives focused in high impact geographic areas including the hot spots surrounding military bases. PEPFAR will implement social network testing on high yield venue testing.

The Social Network strategy will be enhanced to find hidden KP, especially MSM using the identified influencers and key informants MSM. Through the strengthened CBS program, new hotspots will be mapped and prioritized for testing. In line with the DREAMS guidance to link high risk AGYW to HTS services, in all 404 safe spaces, DREAMS beneficiaries will be sensitized about HIV testing and actively linked to a facility. Through MOUs with MOH and MOD facilities, prevention and DREAM IPs will bring KPs and AGYW to MOH facilities for HIV testing, and HIV positive individuals will be offered recency testing, PNS and family testing and linkage to ART treatment. In FY23, PEPFAR will improve screening and linkage or referrals of HIV negative individuals to other prevention services at health facilities, including PrEP, VMMC and others as

well as in community for prevention services such as the DREAMS program. DOD prevention IPs will ensure identified HIV positive KPs are linked to either DOD or MOH facilities according to their choice. In COP 22, PEPFAR will diagnose 876 FSWs, MSM and clients of sex workers with HIV 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 COP22, the OVC program will aim to find children living with HIV who have not yet been diagnosed. In fact, it will contribute to finding 'well children' by facilitating index testing of biological children of mothers living with HIV while improving collaboration with health facilities for easy referrals to OVC program at community level. 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 would not ordinarily seek out a facility or mobile 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/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. PEPFAR will work with the MOH to develop a self-test kit coupon referral system which would link HIV test results back to self-test kit distribution platforms and index cases, where appropriate, to measure the efficacy of this strategy.

In COP22, PEPFAR laboratory activities will strengthen MOH 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 2 weeks to several hours will optimize the impact of recency data promoting Index PNS test outcomes as well as rapid identification of recent infections and transmission networks. These aspects of active case finding will help Rwanda develop a comprehensive public health approach to sustain epidemic control by promoting effective case identification and maximally interrupting HIV transmission with rapid linkage and retention of clients on treatment.

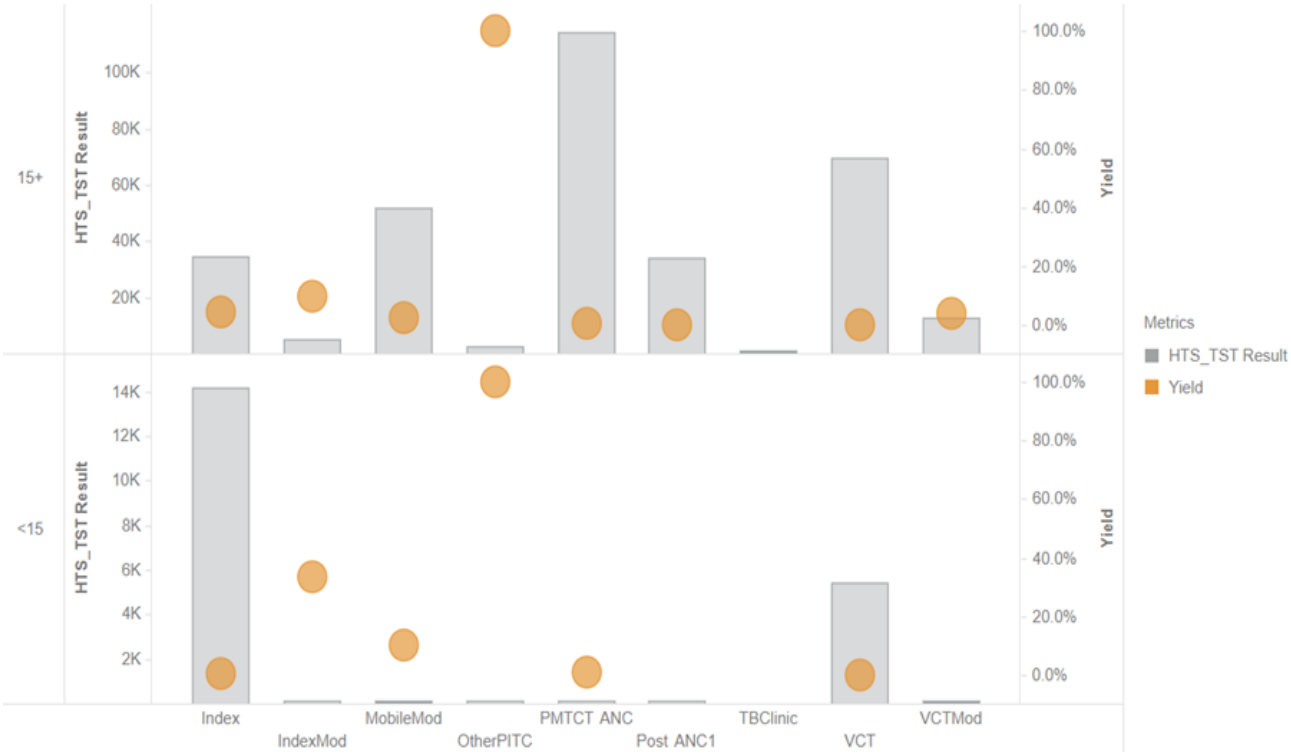
Building on achievements in the implementation of Rapid Testing Continuous Quality Improvement (RTCQI) for HIV diagnostic and recency testing, COP22 laboratory activities will focus on the implementation of strategies that ensure accurate and prompt return of HIV test results while realigning efforts to address challenges created by COVID-19. PEPFAR continues its support to the National Reference Laboratory (NRL)'s efforts to restore the distribution of proficiency testing (PT) 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 establishment of five new HIV-Viral testing hubs in COP20, efforts will be continued towards improving and maintaining

the quality of HIV recency and VL testing at both the old and new testing sites in COP22.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 COP22, efforts will continue to resume HIV testing sites audit (using standardized CQI checklists (SPI-RT)) due to COVID-19 related travel restrictions and remedial action(s) implemented at the sites as needed. Participation in external quality assessments through PT programs and enhanced reporting and relay of feedback to testers using electronic PT will be reinforced. 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 (HTS) 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 (NRL) 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 COP22, PEPFAR will continue to improve laboratory-clinical interface to improve quality of testing services and result documentation through onsite DQA. In the same vein, NRL will continue enhancing the use of quality corps and clinical mentors to implement HIV rapid testing CQI activities including quarterly distribution of proficiency testing panels to testers and facilitating return of PT feedback between the NRL and HIV testers at the health facilities.

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

Figure 4.1.1 Testing Volume and Yield by Modality, FY21



This visual comes from: testing single OU dossier; testing and yield: modalities by age/sex/modality page, all 4 quarters, coarse age bands.

4.2 Ensuring viral suppression and ART continuity

In FY21, the national retention rate of patients enrolled in the last 12 months on treatment was 92%. In PEPFAR supported sites, 12 months retention was 94% before this indicator was phased out in 2018 and replaced by TX-ML.

In FY 22, Q1, among 1,853 PLHIV with no clinical contacts, 356 (19%) PLHIV were reported to have interrupted ART within the overall Treatment Mortality (TX-ML) and Interruption in Treatment (IIT). This 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, IIT or dead. IIT indicator identifies clients four weeks after they miss a scheduled appointment, which will trigger efforts to bring them back into care at an earlier point. Overall, PLHIV with no clinical contacts accounted for 2% in FY22 Q1, which is in line with COP18, COP19 and COP20. In FY22 Q1, site level TX_ML analysis indicates that 73 % of PLHIV who interrupted treatment are in 39 sites (20%) located mainly in Kigali and southern provinces, while 112 sites (58%) had zero IIT. During this same period, however, sites also reported 207 (57%) patients previously interrupted ART or refused/stopped ART being brought back into treatment (measured by TX_RTT) due to focused site level outreach approaches.

Following site level analysis to uncover the reasons for the interruption in treatment, strategies to enhance continuity of treatment include; enhanced continuous adherence counselling throughout continuum of care, flexibility in schedule to meet adolescent and men living with HIV, age and sex appropriate adherence support group, adherence support group for parents/guardians of CLHIV and ALHIV, enhanced disclosure of HIV status to children, recovery of PLHIV with no clinical contacts through phone calls, community peer educators and home visits, enhanced referral and counter referral mechanism and targeted site level monitoring and mentorship were designed and implemented.

Rwanda has adequate capacity and quality of testing to meet the VL assessment requirements for monitoring treatment. The RPHIA indicates a relatively low proportion of VLS in the Eastern province and in men particularly those in the younger age groups 15-34. While there is no updated RPHIA data, PEPFAR COP22 data pack maintains low VL suppression rate among children, adolescents, and men (20-29), at 71%, 79%, and 87% respectively.

In COP22, PEPFAR will support strategies that address these gaps, including full transition to optimized ART and monitor DTG10mg implementation for CLHIV 4 <20kg, flexible schedule to meet Adolescent Living with HIV (ALHIV) and Men Living with HIV (MLHIV) needs, leverage DREAMS and OVC platforms to improve clinical services access for adolescent girls and social support. PEPFAR will also continue to support use of Recency data to enhance CD4 testing for the long-term to detect and manage Advance HIV Disease, using CBS data to improve VL outcome, detection and management of adverse drug reaction as well as ensuring optimized ART and Multi-Months Dispensing.

FY 19 FSW Integrated Biological and Behavioral Surveillance (IBBS) report indicated a low VLS among FSWs (71%) thus in COP22 PEPFAR will support adherence, retention, and optimized ART among FSWs through effective use of KP specific peer groups and engagement of FSW 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 Differentiated Service Delivery Model (DSDM) where peer educators will conduct home visits to groups of PLHIV assigned to them, specific clinic, and support group sessions whereby 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 with ITT 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 interruption to ART 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 PLHIV who

interrupted ART and will provide training on intensive adherence support for patients with low VL suppression rates.

In addition, in COP22, PEPFAR will continue efforts to enhance the documentation of VL results in the patients' medical records, 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 use of LIS by site staff, tracking patient appointments using EMR and analysis within the CBS system and appointment registers for ART and VL scheduling. The MOH continues countywide led efforts to COVID-19 pandemic response in collaboration with partners and HIV program implementing strategies towards mitigation of impact of COVID-19 on the laboratory network for VL monitoring. At the close of FY20, the VL coverage reported from PEPFAR supported sites had declined and gradually improving from 83% to over 90% in FY21 during COVID-19. Additional resources from PEPFAR/ARPA support for laboratory surge testing capacity at the VL hubs and availability of rapid COVID-19 antigen test over PCR based testing in public and private health facilities as well as flattening the wave of new COVID cases enabled VL testing services and improved testing coverage patients at health facilities.

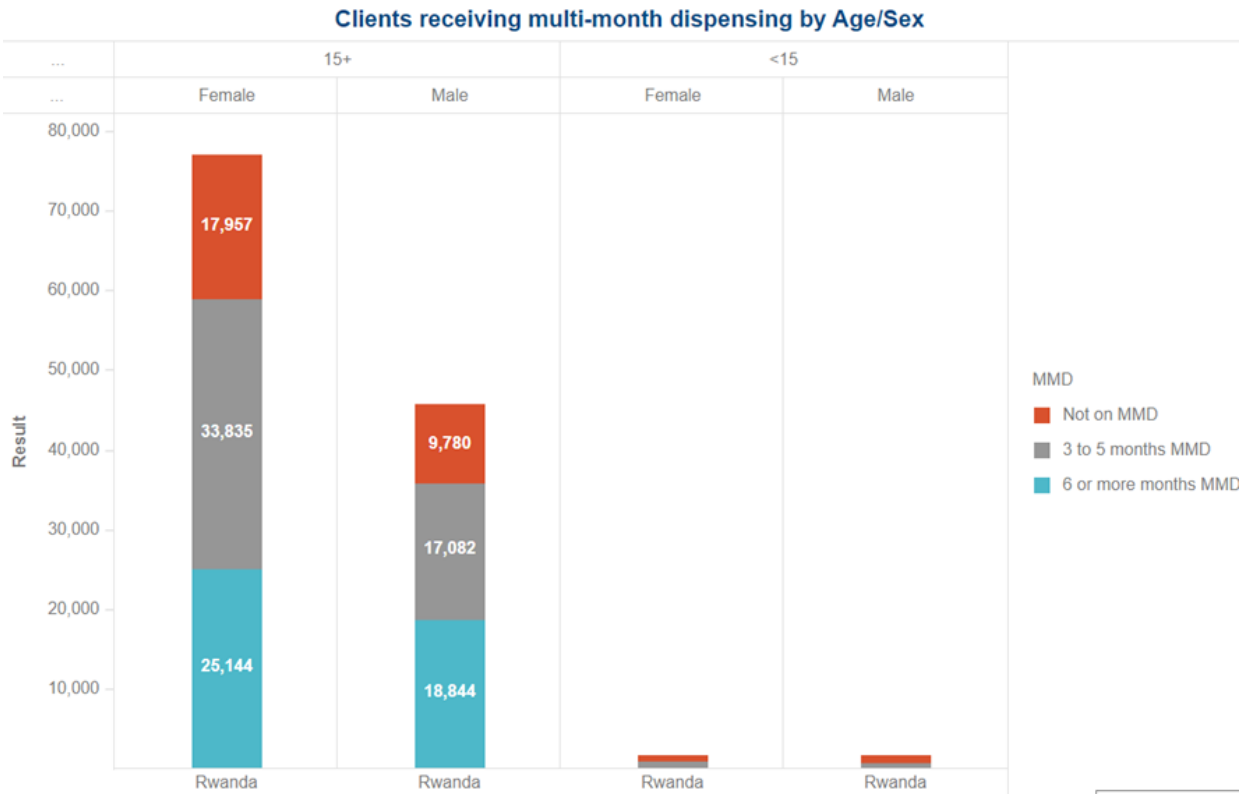
TPT as an important aspect of routine HIV care and treatment in Rwanda started in the last quarter of COP18 under a phased approach with only new PLHIV initiated on ART at five district hospitals and 80 health centers in phase one. Phase one implementation guided the program on the best public health approach to TB screening and TB disease exclusion prior to initiation of TPT. In FY20, GoR approved policy change and removed chest X-Ray requirement prior to TPT initiation resulting in high uptake of TPT services. Yet, TPT scale up pace has been limited due to low stock levels. In addition, TPT services are implemented along Multi-Month Dispensing (MMD) for ART resulting in passive enrollment on TPT due to spaced ART appointment. TPT enrollment has been aligned to ART schedules to minimize multiple facility visits. National data as of January 2022 showed 127,330 PLHIV initiated on TPT in 17 administrative districts, representing 64% of the total target of 198,500 eligible clients and a 94% TPT completion rate. TPT scale up beyond the 17 districts will resume in March 2022 following in country stock level replenishment. TPT enrollment at all health facilities is expected by June 2022 which will allow enrollment of all eligible PLHIV. To improve TB screening among specific groups (children, PLHIV with <200 CD4 and non-suppressing patients), PEPFAR will support quality improvement approaches through mentorship and supervision on TB Lipoaribomannan Assay (TB LAM) implementation.

In COP22, PEPFAR will continue supporting the implementation of the DSDM with a focus on monitoring of three and 6 MMD implementation at all sites. In FY22, Q1, PEPFAR enrolled 44,067 PLHIV on 6 MMD (42% coverage of TX-CURR DSD). There is an increase in 6 MMD enrollment overtime with decrease in other categories (<3 MMD and 3-5 MMD). 6 MMD is

implemented in 23 districts representing 77 % national coverage. A scale up plan for 6 MMD is ongoing and expected to cover all districts countrywide by the end of April 2022. To support the adherence and retention of patients enrolled in 6 MMD, PEPFAR will continue supporting the community group support led by the PLHIV peer educators.

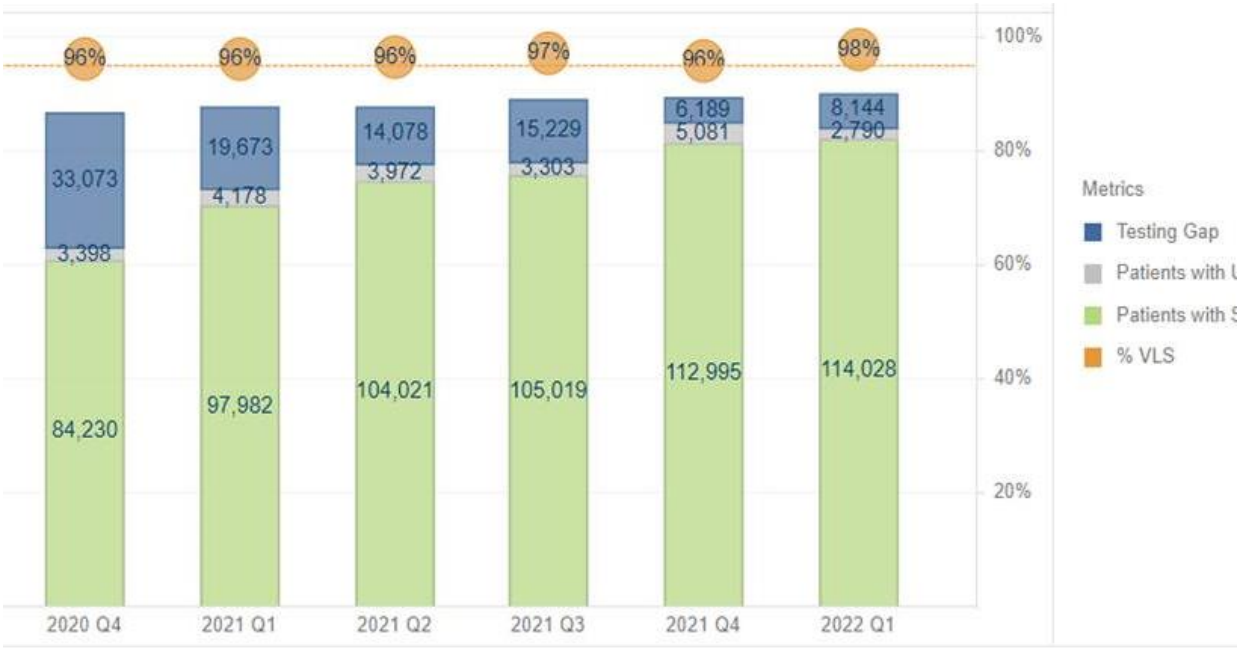
In COP 22, Recency and CBS data will be used to adjust the care and treatment program. This includes enhancing linkage approaches (same day ART initiation) and retention to minimize IIT, improving early re-engagement in ART (PLHIV< 6months on ART), conducting data triangulation for targeted interventions by sub population and geography to orient program focus, routine screening of OIs (TB, cryptococcus Meningitis), and enhanced CD4 testing for the long-term to detect and manage Advanced HIV Disease. In addition, 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.

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY22_Q1



This visual comes from: Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex

Figure 4.2.2 Viral Load Outcomes, FY21 and FY22



This visual comes from: Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex

4.3 Prevention, specifically detailing programs for priority programming:

a. HTS

In COP22, PEPFAR Rwanda will continue to support HIV testing targeting high risk populations through community-based testing with mobile outreach for KP and PP and referral to health facility for HIV test confirmation, linking those identified HIV positive to ART and linking individuals with HIV negative results to essential prevention services which include VMMC. VMMC services are provided to clients with their consent and it is voluntary. Individuals who are HIV negative and at risk of acquiring HIV will be linked to other prevention services including condoms, and PrEP services if eligible. This will be monitored by strengthening the referral system within health facilities and community health services by enhancing documentation of linkage from testing services to other prevention services.

The 2021 MSM Population size estimates (PSE) and integrated Behavior and Biological Surveillance (PSE/IBBS), not yet published, showed that HIV prevalence is high in Eastern province. only 43,4% of HIV + MSM know their HIV status and most of newly identified HIV positive MSM who were unaware of their HIV are from Kigali city (38,7% and from western province (33, %). Therefore, PEPFAR will enhance HIV case finding among MSM focusing on Eastern, Kigali and western

provinces. This will be achieved through moving beyond LGBTIQ associations to identify influencers and key informants to support identification of MSM through social network testing strategy for both HIV+ and high-risk HIV- MSM, enhance the implementation of community index testing among MSM, flexible hours and days for MSM HIV testing services at Health facility. Additional PEPFAR will use experience of FSW program to reinforce the MSM mobilization through Peer Navigators/key informants among MSM. Facility based testing will continue to focus on index testing including Partner Notification and family testing services and HIV testing of pregnant women through ANC and labor & delivery. A Social Network testing strategy will also be implemented among Index negative partners.

Testing for PrEP enrollment and retesting for PrEP beneficiaries follow the National HTS guideline to ensure that individuals have HIV negative status. Once enrolled in the PrEP program, clients are tested every three months for HIV following the WHO requirements.
Recency testing after consent will continue to be provided to all newly identified HIV positive linking them in the case base surveillance system as per the national HIV guidelines.
Self-test kits are distributed both at health facilities and community targeting partners of index cases not willing to reach health facility for HIV testing.
The referral system will also be improved across prevention programs both at community and facility levels to ensure beneficiaries are accessing all available services.

During FY22, Safe and Ethical index assessment has identified weaknesses in index testing adverse events monitoring and response, therefore in FY23 implementation period, PEPFAR will reinforce documentation on Adverse Events Monitoring and response. This includes LIVES Trainings to clinical mentors and health care providers

b. DREAMS

In COP22, Rwanda's DREAMS program will focus on the reduction of HIV incidence among adolescent girls and young women (AGYW) by delivering a multi-sectoral, comprehensive package of evidence-based interventions. DREAMS 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 high burden 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 a combination of risk factors that drive HIV acquisition in AGYW based on epidemiological data, findings from the Violence Against Children and Youth Survey (VACYS), Rwanda Demographic and Health Survey (DHS) and RPHIA. A combination of risk factor data from the DHS, VACYS and RPHIA combined with census data population projections was used to calculate the AGYW size estimate used in COP22. For 10–14-year-olds, risk factors include orphanhood and experience of violence; for 15–19-year-olds, risk factors include inconsistent condom use, experience of violence, and teen pregnancy. For 20–24-year-olds, inconsistent condom use, and experience of violence were included. The AGYW Vulnerable Size Estimate in the five DREAMS districts is 229,092. The goal of DREAMS is

to reach a saturation of 75%, which translates to 171,819 vulnerable AGYW beneficiaries completing the DREAMS program.

In COP20, DREAMS services expanded to cover all administrative sectors in all 5 districts. In addition to the full geographic footprint realized in COP20, the DREAMS program has continued to increase the number of targeted beneficiaries from 73,838 in COP20 to 82,500 in COP21, and in COP22, the AGYW_PREV target is planned at 90,386, a 9 percent increase. Eighty-four percent of these, or 76,828 AGYW, are expected to complete at least the primary package in FY23. These targets align with the goal to reach 44% program saturation by the end of FY23. With all four DREAMS implementing mechanisms (IMs) coming to an end in September 2022, DREAMS targets have been allocated by district to ensure the follow-on DREAMS IMs will continue to be implemented with no interruption of services for enrolled beneficiaries. These targets have been set in consideration of the updated size estimate. In COP22, the program will reach male sexual partners of AGYW with HIV prevention messaging and refer them for voluntary HIV testing and voluntary medical male circumcision (VMMC) services.

The DREAMS partners will reach and enroll the most at-risk AGYW by using COP22 standard vulnerability criteria. These criteria include high number of sex partners, sexually transmitted infection (STI), no or irregular condom use, transactional sex, experiences of violence, out of school/never schooled, and alcohol misuse and orphanhood among 10–17-year-olds. By closely working with other PEPFAR supported clinical service providers, DREAMS will actively consult with other PEPFAR programs in identification and mapping of entry points for most vulnerable AGYW. Through established MOUs with health facilities, DREAMS will collaborate with PMTCT platforms, ANC clinics and GBV service delivery points, as well as HTS, STI and FP settings, to create strong referral networks and enroll AGYW who meet the DREAMS eligibility criteria. DREAMS will also target new and emerging hotspots where highly vulnerable AGYW sub-groups may be convening as informed by program data.

Enrolled 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). The services will be delivered through the safe space model. This model uses age cohorts (10-14, 15-19, 20-24) and similar homogeneous characteristics (schooling status, marital status, childbearing status, etc.) to designate participants in safe space groups. These safe spaces provide a platform where AGYW are able to share their experiences, make friends and be mentored. Safe space groups have been proven to be effective in building AGYW social capital and have been shown to increase agency and empowerment among AGYW. The safe spaces enable AGYW to build social assets including friends, trusting relationships and self-efficacy. Through the safe space group model, AGYW will be supported to access existing resources in their communities. As part of the safe space model, a mentor is assigned to a group of enrolled AGYW to provide services including referrals and linkages, and journey with them as the first responders. In alignment with the COP22 guidance, DREAMS will cascade the first-line

support training (LIVES training) to the mentors. All other DREAMS program staff received LIVES training in COP21. Mentors will also continue to receive supportive supervision coupled with refresher training that includes technical information, curriculum facilitation, and delivery and mentorship skills to strengthen mentors' capacity to respond to disclosures of violence. DREAMS IPs will continue to address AGYWs' HIV risk by layering evidence-based interventions implemented by the four TBD OVC/DREAMS IPs. The IPs will implement a combination of services that includes behavioral interventions including social asset building, HIV and GBV prevention interventions, sexual health education, financial literacy interventions, condom education and distribution, information, education and communication (IEC) on contraception, IEC on PrEP (15 -24), social protection interventions, and combination economic approaches. Bio-medical interventions delivered through referral and linkage to health facility-based services will include post-violence care, HIV testing services (HTS), provision of contraceptive method mix, screening services for STIs and treatment as necessary, and voluntary medical male circumcision (VMMC) for male sexual partners. Structural interventions will include community mobilization and norms change using SASA, and the parent/caregiver program using Families Matter! Program (FMP) for parents of AGYW (10-17).

DREAMS 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 aged 18 and older who engage in transactional sex with and/or without consistent use of condoms, sero-discordant couples with virally unsuppressed partners not consistently using condoms, and/or who are female sex workers (FSW) 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 not consistently using condoms. COP22 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 involvement of young people will be vital. It is critical to promote PrEP champions and links with peer educators to provide outreach and education, including young women using oral PrEP successfully. In order to combat stigma and self-stigma around AGYW use of PrEP, 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. Priorities will include training of healthcare providers in the provision of AGYW friendly services and identifying safe spaces and specific days and hours for AGYW PrEP enrollment and follow-up. Approaches will include setting joint strategies to strengthen adherence such as using peer navigators/motivators, phone alarms, and counseling about the side effects. In July 2021, WHO updated guidance on creatinine testing to be optional for individuals less than 30 years of age with no kidney-related comorbidities. Through the prevention TWG,

PEPFAR will continue to collaborate with RBC to review and update creatinine testing requirements for PrEP initiation, update training modules and data reporting tools and to develop AGYW and community information and education tools to address PrEP uptake barriers such as knowledge and awareness of PrEP; social stigma; provider bias and distrust of healthcare providers and systems. In COP22, DREAMS will enroll 3,365 AGYW on PrEP for the first time, a 95% increase from COP21 targets.

In line with the DREAMS guidance to link all AGYW to HTS services, the DREAMS beneficiaries will be provided with education and information on HIV prevention and testing services and actively linked to a facility for voluntary testing as per the national testing guidelines. All 10-14 year olds enrolled will receive HIV screening and, if deemed high-risk, will be tested for HIV. All 15-24-year-olds enrolled in DREAMS are already deemed to be high-risk and will receive HIV testing once a year as per the national policy if they don't know their status or are HIV-negative. Any beneficiary found to be positive will be immediately linked to recency testing and treatment services with DREAMS mentors providing follow-up to ensure adherence and viral load suppression. As mentors have established trust with beneficiaries, they will continue providing HIV prevention messaging at safe spaces and in the communities. HTS will be conducted jointly with health facilities and with the support of local government authorities. The program will maintain strong partnerships with the health facilities, formalized through MOUs. As needed, DREAMS mentors 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. In COP22, DREAMS will link 75,407 AGYW and their male sexual partners for HIV testing services.

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 such as mental health and psychosocial support. This will require strengthening the referral/linkage system to ensure the AGYW are protected and closely followed up. In doing so, they will also facilitate referrals to external post-violence care as appropriate.

In COP21, Rwanda acquired its own three in-country Trainer of Trainers (ToT) in the FMP. This is a big added value to the DREAMS program, which will help in improving efficiency in the implementation of FMP, an evidence-based parent-focused intervention, designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction, including risk for child sexual abuse and gender-based violence for parents or caregivers of 10–14-year-olds. The TOTs will in turn train facilitators, increasing the pool of parents trained on FMP, both in the DREAMS and OVC programs.

In COP22 implementation, the OVC and DREAMS programs will continue co-planning to ensure harmonization and coordination of all tools, approaches, and services, as appropriate. The IPs will continue conducting joint work planning, data reviews, harmonizing approaches and tools, and holding regular implementation reviews for quality work and efficiencies. IPs will utilize innovative approaches and improve on the economic strengthening intervention by 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. During COP21, the adaptation of the curriculum and TOT were conducted. In COP22, the scale up of the ELA model will continue through training of AGYW and linking them to employment.

In COP22, DREAMS will closely monitor implementation quality through a number of custom indicators in addition to MER indicators. The DREAMS program will collect and report on the following indicators: AGYW_PREV, PP_PREV, HTS_TST, HTS_TST_POS, PREP_CT PREP_NEW and HRH_CURR. IPs will closely track AGYW to assess their secondary package needs and when they are approaching program completion. USAID will conduct routine DQA exercises on select MER and custom indicators that have been identified to have performance issues. Among the custom indicators to be monitored are contraceptive uptake and gender norms. PrEP_NEW and PrEP_CT, which is a new indicator, will be monitored too. 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). In COP21, Pact will ensure that IPs are fully able to utilize the RDTS for all program tracking, monitoring and reporting purposes. PEPFAR Rwanda plans a further transition of this system to local partners beyond COP22 in order to facilitate country ownership.

PEPFAR, through the DREAMS Coordinator who serves as the AGYW point person, will continue to coordinate AGYW programming across the USG PEPFAR portfolio while working closely to strengthen linkages and collaboration with the GOR across all stakeholders and programs, including the Global Fund's HER activities. Among COP22 priorities will be provision of technical assistance to RBC to establish key program indicators and AGYW national program resources for HIV prevention including training modules and monitoring and evaluation tools. Across the DREAMS program, DREAMS Ambassadors will continue to provide advocacy related to AGYW support and provide active AGYW voices in program planning, design, and implementation of interventions. In COP21, USAID started convening quarterly meetings with all DREAMS Ambassadors to directly learn how to best incorporate field experience and inputs to improve AGYW program interventions. The DREAMS Ambassadors are responsible for generating public awareness of DREAMS and the issues affecting the lives of AGYW 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.

The COP22 preliminary analysis on DREAMS saturation indicates saturation will be reached in both Kicukiro and Nyarugenge districts or 10–19-year-olds by the end of the COP year. Saturation in DREAMS is achieved when at least 75% of AGYW most vulnerable to HIV in a DREAMS SNU have completed the appropriate package of DREAMS interventions for their age group. Further analysis to include consultation with GOR and other stakeholders to inform a maintenance program will be conducted.

C. OVC Programming

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 ICRP 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 the following 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. Building on 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: three districts in Kigali City (Kicukiro, Gasabo and Nyarugenge); five districts in Western Province (Rusizi, Nyamasheke, Karongi, Rutsiro, and Rubavu); two districts in Southern Province (Huye and Muhanga); and two in Eastern province (Rwamagana and Kayonza).

In COP22, the OVC program in Rwanda will be implemented by five local partners, with an international partner providing technical assistance across both OVC and DREAMS programs. In fact, the end of COP21 marks the end of all three implementing mechanisms implemented by local CSOs: Turengere Abana implemented by Francois-Xavier Bagnoud (FXB), Ubaka Ejo implemented by African Evangelistic Enterprise (AEE), and Gimbuka implemented by Caritas Rwanda, with a smooth transition planned with the new COP22 partners.

Overall, the COP22 target for the OVC_SERV indicator will be 186,349, which is a slight reduction of eight percent since the COP21 target was 202,009. These include 112,791 under OVC Comprehensive [61%], 24,442 under OVC Preventive [13%], and 49,116 [26%] adolescent girls under 18 years from the DREAMS program. The reduction is mainly coming from the DREAMS target under 18 which was reduced from 59,233 in COP21 to 49,116 in COP22 [a decrease of 17%]. The decrease also comes from the OVC Comprehensive, which was reduced from 117,575 to 112,791

[a decrease of four percent]. As far as the OVC Preventive is concerned, its target of 24,442 children aged 10-14 was maintained. The main reason for reducing the DREAMS AGYW under 18 (comparing COP21 and COP22) is that the DREAMS program is enrolling more AGYW above 18 than those below 18 to better respond to the high gap found in the age band 18-24, as revealed by the saturation analysis. As far as the main reasons for the reduction in OVC Comprehensive target is concerned, the first is affordability as the OVC program will not manage to enroll new OVC at the same level as those graduating by September 2022. By September 2022, a total of 36,243 OVC are projected to graduate and a total of 31,460 new OVC are projected to be enrolled. Given that the cost of the OVC Comprehensive package for new beneficiaries is more costly than the one for existing beneficiaries, the OVC program will not enroll the same number of new beneficiaries as those graduating. A second reason is that all the current OVC/DREAMS implementing mechanisms end by September 2022. In COP22, we are accommodating the shifts between partners to align OVC and DREAMS by IP and by district. Once completed, this alignment will enable better preventive programming and efficiencies in the future. While more efforts and resources will need to be invested for C/ALHIV, it will be equally important to improve the OVC Preventive intervention. 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 COP22 target includes 137,233 OVC beneficiaries [74%], and 49,116 AGYW under 18 from the DREAMS program [26%]. The COP22 OVC_SERV includes 128,819 females [69%] and 57,530 males [31%]. The target of 186,349 also constitutes a total of 160,190 beneficiaries under 18 [86%], 8,989 aged 18 - 20 years who will still benefit from education subsidies and economic strengthening services [5%], and 17,170 adults aged above 18 [9%]. Though there is a slight reduction in the OVC comprehensive target, the Rwanda program will ensure that the COP21 beneficiaries eligible for graduation follow the standard graduation benchmarks. During the COP22 implementation, the OVC graduation rate is projected at 20%. Although this may appear low, OVC beneficiaries carried over to COP22 were affected by COVID-19, and one third of the OVC program beneficiaries will be new. In COP22, priority OVC subpopulations, especially the C/ALHIV, HIV-exposed infants, and survivors of violence, will 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. The OVC preventive interventions program will prioritize Kigali districts as they have the highest HIV prevalence rate. For districts outside Kigali, the focus of interventions will be around hot spots and areas around business centers.

The PEPFAR Rwanda OVC program will continue to evolve as the country nears epidemic control. In COP22, the OVC program will continue to support two approaches: OVC Comprehensive and OVC Preventive. With new beneficiaries planned to be enrolled in COP22, the OVC program will

prioritize specific priority subpopulations within OVC Comprehensive, specifically, HIV+ children under 18, HIV-exposed infants under two, and sexual violence survivors. If space remains in the cohort, children of PLHIV and children of FSW will be enrolled. The OVC Comprehensive approach is family-based and consists of integrated case management and graduation benchmarks. The illustrative services include access to health services, child protection, HIV and violence prevention and response, household economic strengthening, food security and nutrition, water sanitation and hygiene (WASH), education support, and parenting. Within the framework of the case management approach, the OVC program is planning to integrate mental health and psychosocial support (MHPSS), since MHPSS is seen as an issue globally. COP22 guidance includes an expanded section on mental health disorders which differentiates mental health from psychosocial support and provides an opportunity for programs to invest in programming that can be impactful on the HIV continuum, beginning with prevention and across the three 95s. Integration of Violence Against Children (VAC) and LIVES will also be prioritized, ensuring that all the community cadres are trained and closely monitored. The OVC program will also ensure that IMs have the most updated Child Safeguarding policies. For a smooth tracking of these interventions, electronic case management for OVC will be fully implemented.

To achieve results toward epidemic control and HIV impact mitigation, the strategic approaches in COP22 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 10-14 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 to coordinate with the DREAMS program to ensure comprehensive HIV and sexual violence prevention programming. Additionally, the OVC program will continue to coordinate with government local initiatives/home grown 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. The OVC IPs will also continue collaborating with RRP+ to ensure the C/ALHIV and their families are properly followed up. OVC and clinical partners will jointly monitor the implementation of clauses in these MOUs. Through case conferencing or other methods, both parties will re-assess key topics, such as shared confidentiality and testing, especially index testing; LTFU and tracing; adherence & home monitoring; and socio-economic assessment and support. After identifying the gaps and needs, they will work together on developing plans for improvement. Training will be one of the opportunities to address these gaps. It is expected that the focus for COP22 will be the strengthening of systems and processes to build on the relationships formed through the MOUs. To support these efforts, Linkage

Facilitators in coordination with case management volunteers will be expected to play a key role in ensuring the OVC program is well aligned with Care and Treatment services to ensure that C/ALHIV found at clinics are offered enrollment into the OVC program (with a target of at least 90% of C/ALHIV (<age 19). They will also ensure follow up on HIV-positive OVC beneficiaries to ensure they are adhering to treatment and are virally suppressed.

In COP22, the OVC partners will continue tracking and monitoring findings under the OVC_HIVSTAT indicator. The COP22 target for OVC_HIVSTAT is 86,632, decreasing from 92,236 in COP21 (a decrease of six percent). The slight reduction resulted from a decrease in OVC-SERV under 18 under OVC Comprehensive, since the OVC_HIVSTAT indicator constitutes the number of OVC (<18 years old) enrolled in the OVC Comprehensive program with HIV status reported and 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 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 SAPR22 and APR22. 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 COP22, the OVC partners will build on COVID-19 lessons learned from previous COPs to adapt their programming and implementation. For example, they will continue to find efficiencies in training and meetings by holding training and meetings in available infrastructure 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), especially for the DQAs which are internal to IPs. In case of any emerging pandemics, they will resume implementing remote case management – especially using phone calls and SMS to remain in touch with the field staff, community volunteers and beneficiaries. In that case, they will also use standardized messaging, scripted voice recording and digital posters as relevant. Since the COVID-19 outbreak in Rwanda, there have been limited site visits. Now that COVID-19 restrictions have been loosened, the team will plan more site visits, including Site Improvement through Monitoring Services (SIMS) to assess progress of activity implementation, propose areas of improvement and improve quality. In the same regard, it will be a good opportunity to interact

with the field officers and community volunteers to get more insights on the relatively new HRH inventory, as well as the graduation of OVC beneficiaries. For the latter, the visiting teams may also have an opportunity to meet OVC who graduated and hear success stories.

d. HIV Prevention and Sexual Violence

In COP22, the USAID/PEPFAR Rwanda OVC and DREAMS programs will continue to prioritize the HIV prevention and sexual violence, especially among beneficiaries aged 10-14 years of age. The OVC program will continue providing HIV prevention and sexual violence services among 10–17-year-old beneficiaries, with a focus on 10–14-year-old boys and girls. Following S/GAC guidance and the VACYS findings, the OVC program will continue integrating sexual violence and HIV prevention programming into the existing curriculum, with a special focus on 10–17-year-olds and sexually active boys and young men. Learning from DREAMS programming, the OVC program will emphasize the benefits of delaying sexual debut and address consent issues. It will also mobilize communities and families to prevent other forms of violence.

Using a mentoring model, the DREAMS program will also continue to focus on HIV prevention and sexual violence among AGYW, with an emphasis of AGYW aged 10-14. HIV and violence prevention messaging reaches parents of the AGYW aged 10-14 through the provision of positive parenting using the Families Matter! Program. It also targets the AGYW themselves through the provision of sexual and reproductive health (SRH) curriculum. Also, through different sessions with mentors, the AGYW are empowered and acquire knowledge and skills about HIV prevention and sexual violence. Both OVC and DREAMS programs also provide education subsidies to keep children in school, which also contributes to HIV and sexual violence prevention. At school, the beneficiaries are also encouraged to join different clubs, especially anti-AIDS clubs and the child protection related clubs dealing with violence issues.

The OVC preventive approach is individual based and focused on primary HIV and sexual violence prevention targeting boys and girls aged 10-14. 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 continue to 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 (FMP) which is in use by DREAMS and OVC; and 3) Coaching Boys into Men which was adapted to the Rwandan context during COP20. A total of 73,972 beneficiaries from the OVC and DREAMS programs will benefit from the evidence-based primary HIV prevention and violence curriculum. On top of these targets, the knowledge and skills will also reach their parents and their siblings, noting that the messaging goes beyond the prevention of sexual violence and includes other forms of violence. Finally, the OVC and DREAMS IPs will continue to coordinate and strengthen linkages with other stakeholders, including other HIV prevention partners, the police, and Isange One-Stop Centers, to ensure beneficiaries get their services in a more friendly manner. With help of the abovementioned structures and fora, the feedback from beneficiaries on child and youth

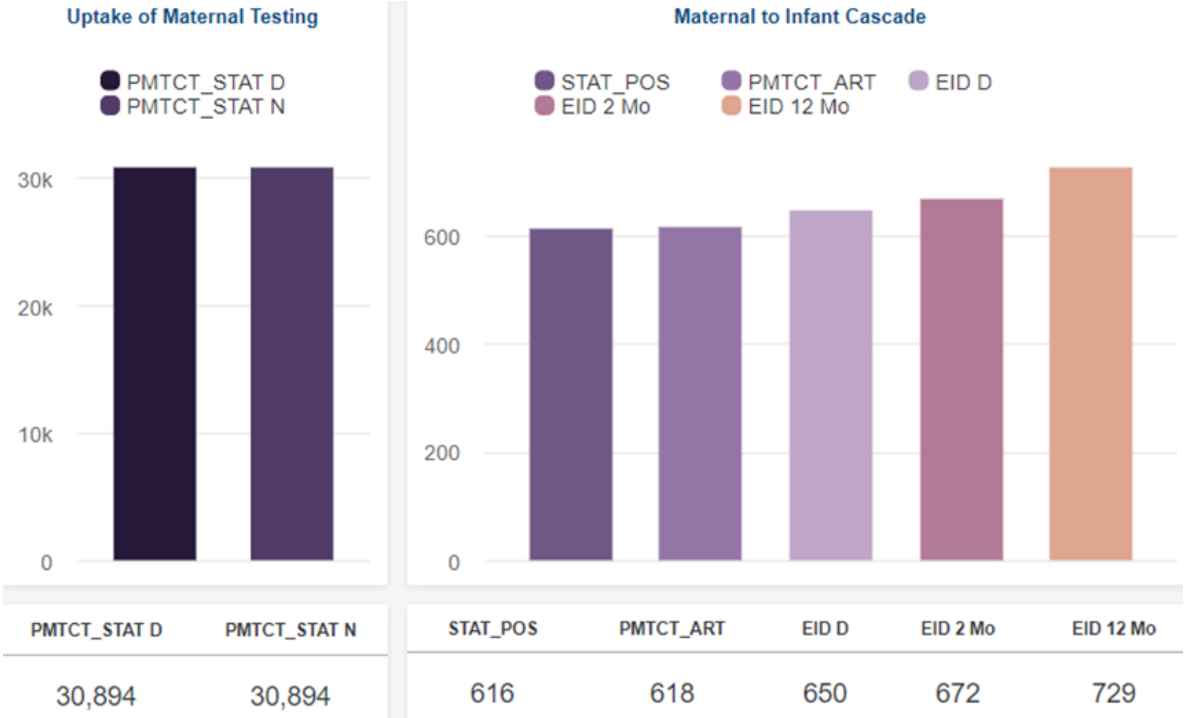
friendly services will be key in providing a safe space to have a conversation on HIV prevention and sexual violence.

e. 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 FY22 Q1 program data indicates a mother to child transmission (MTCT) rate of 0.4% lower than the national MTCT rate of 1.5%. 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 COP22, PEPFAR will continue to support national level processes for EMTCT attainment including the establishment of a subcommittee to lead EMTCT processes such as review and validation of ongoing data collection to inform EMTCT strategy, support validation committee, pre-assessment, and submission of validation request to the regional committee. COP22 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 COP22 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 COP22, improvement in the early infant diagnosis (EID) turn-around time from 14 days to between 1 and 10 days was observed following the introduction of POC testing in 18 sites. With improved HEI testing coverage, in COP22 mentorship and supervision will be reinforced at PMTCT facilities to achieve testing coverage of 95% at six weeks post-partum HIE testing.
In COP 22, 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 22, 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

Figure 4.3.1 PMTCT Cascade_FY22_Q1



This visual comes from: PMTCT-HEI: Single OU dossier; Overview page; PMTCT and HEI Cascade page for PEPFAR Q1 reporting.

f. Key Populations

Key populations (KPs) in Rwanda include female sex workers (FSWs) and men who have sex with men (MSM). Results from recent studies have informed KP and priority population (PP) strategies. Results of the 2019 Integrated Behavior and Biological Surveillance Survey (IBSS) among Female Sex Workers (FSW) indicate that the 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. Only 47% of FSWs reported using condoms consistently with both paying and non-paying sexual partners. The preliminary results of the 2021 MSM PSE/IBBS indicates that the MSM population size is estimated to be 18,141 [11,265 – 29,708] and the HIV prevalence was estimated at 6.5%. The PEPFAR team is still analyzing behavioral data to inform prevention program. However, IBBS MSM 2020 showed that 18.4% MSM reported transactional sex (ever have 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 higher prevalence than those who did not sell in the 3 months prior the survey

(8.4% vs. 6.6%, respectively). Multiple factors such as stigma, high mobility, and limited sources of stable income provide challenges to effective prevention and treatment interventions.

In FY22, efforts are being made to reach MSM groups through MSM networks and association in addition to partner notification services. In COP22, efforts will continue to focus on reaching both young and older MSM and male sex workers through social network strategy (SNS) for both HIV positive and high-risk HIV negative, this includes influencers and key informants, associations, and use of social media platforms. Preliminary results from the 2021 MSM PSE IBBSS o but not yet published will further inform program on the geographic coverage and risk characteristics for targeted HIV prevention interventions in COP22.

The package of services for KPs includes targeted community voluntary counseling and testing (VCT) and mobile HIV testing, self-testing, social network testing, PrEP, 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, and DREAMS services, condom and lubricant distribution and promotion, family planning counselling GBV services, 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, ensure the safety and security for Key Populations and Strengthen GBV and stigma discrimination services implementation at the health facilities.

PEPFAR will align COP22 activities with both MER 2.6 indicators and Rwanda's NSP to support the GOR goal of a three-fold reduction in new infections to achieve epidemic control. During COP22, to maximally interrupt HIV transmission, PEPFAR will reach 27,090 KPs, including 25,082 FSWs and 2,008 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) enhance implementation of community index 3) recency testing and CBS to identify new hotspots, 4) self-testing, 5) referrals from active and retired KP peer educators, 6) referrals by private and public health facility serving hotspots and 7) referral to other prevention services such as VMMC. Furthermore, case finding among KPs in COP22 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. For the MSM program implementation, PEPFAR IP will enhance MSM program by monitoring ongoing MSM program expansion, reinforcing mobilization/education among MSM through peer navigators, providing information on PrEP services availability, scheduling MSM appointment at HF in flexible hours and separate days for HIV positive and high-risk HIV negative KP mainly targeting

old MSM and Priority populations. 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.

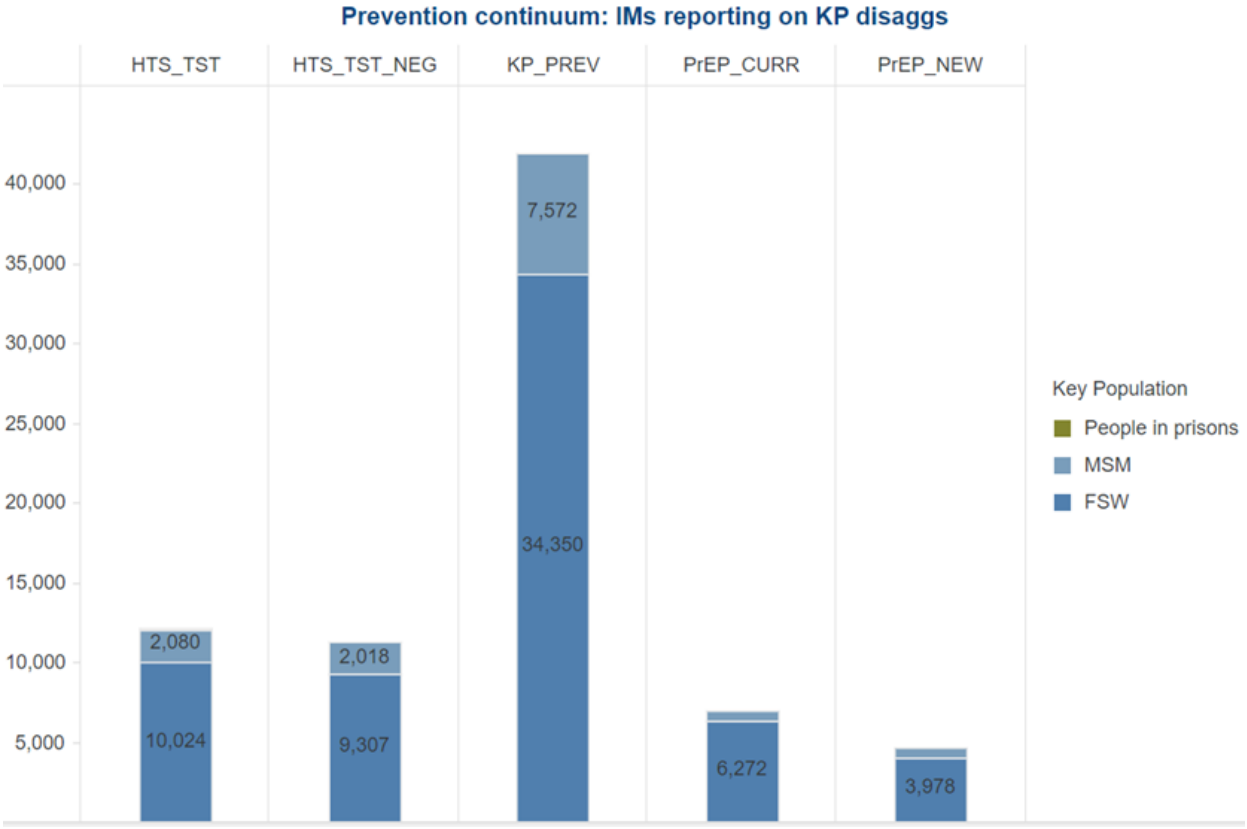
In COP22, PEPFAR will continue to build on best practices and lesson learned to expand PrEP services to eligible KPs in supported health facilities in high burden areas targeting FSWs and MSM at high risk of HIV acquisition, and sero-discordant couples of which the HIV positive partner is not virally suppressed, AGYW at high risk for HIV as well as sexual partners of index cases through partner notification services. This expansion of PrEP will include all KP PEPFAR supported facilities targeting 1,205 MSM and 3,377FSW in high burden area. The PEPFAR PrEP program for sero-discordant couples in all PEPFAR supported health facility sites in Rwanda will continue to be implemented. Eligible AGYW in all DREAMS supported districts and AGYW from KP networks will be supported and enrolled on PrEP. HIV negative sexual partners of index cases are targeted for PrEP in all PEPFAR supported index testing facilities. In addition, HIV negative partners identified through the ANC/PMTCT entry modalities are screened for PrEP eligibility and offered services. Eligible FSW and AGYW are recruited through all the PEPFAR partners working with KPs, as well as through DREAMS and OVC partners. Eligible MSM are recruited through one PEPFAR partner working with MSM. Eligible partners of discordant couples and index partners at high risk will continue to 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 followed up for PrEP adherence, risk evaluation 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 directions. In COP22, results from the ongoing hotspots mapping conducted by RBC will be used to inform the KP program. The 2021 MSM and 2018 FSW size estimates, 2019 FSW BSS, 2020 MSM IBBS, and the 2018 RPHIA will be essential to refine and strengthen program strategies. PEPFAR partners as well as other IPs will use an UPID code with the KP booklet in order to reduce data duplication and match patients across sites and systems, thereby maximizing standardized data collection procedures while ensuring the quality of the data collected.

PEPFAR will strengthen partner management though 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.

Figure 4.3.2 Prevention Continuum by Key Population Group, FY21



This visual comes from: Prevention: Singe OU dossier; All Prevention chapter; Prevention Continuum by KP page

g. VMMC

During FY21 PEPFAR-supported 269,441 VMMC procedures which is 133% of the FY21 annual target (269,441 out of 203,203) at PEPFAR-supported sites. Even with this over achievement in FY21, the NSP objective of 66% national coverage of males aged 15-59 was not achieved by the end of 2021. DHS 2019/2020 showed national circumcision coverage of 52.5% of males aged 15-59. However, with the PEPFAR investment for VMMC in COP22, PEPFAR will prioritize investments in VMMC by prioritizing the 160,000 VMMC service targets on males aged 15-29 and contribute to achieving 90% saturation nationally by end of FY 2023 in the priority age bands 15-29. In FY23, no under 15 years of age males will be circumcised.

VMMC targets for COP 22 were developed using RPHIA 2018/2019, DHS 2019/2020, 2022 census projections from the National Institute of Statistics of Rwanda (NISR), 2021 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 COP22 targets, including targeting high HIV prevalence and low circumcision coverage areas, targeting high-risk individuals, continuing VMMC service delivery in Kigali due to high HIV prevalence, shifting services to 100% for surgical method and strengthening VMMC demand creation (specifically for surgical circumcision) for ages 15-29. No males under 15 years of age will be circumcised during COP22. 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.

Demand creation for VMMC among People with Disabilities will be enhanced in COP22. 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.

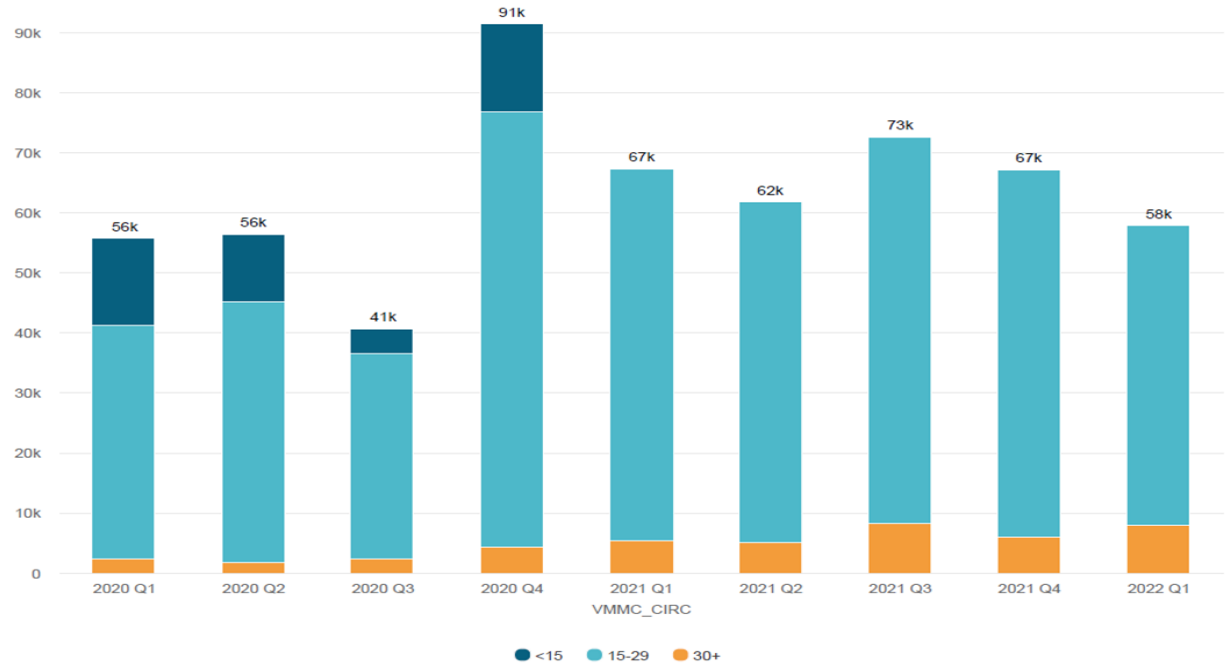
As per PEPFAR Guidance to discontinue/stop circumcising boys below 15 years of age, demand creation for VMMC for young boys between 10 – 14 years of age through focused radio campaigns and sensitization targeting primary school aged boys has been discontinued and currently focuses on young men aged 15-29. The VMMC program will use surgical method, target military populations and new recruits, and reach men aged 15-29 at highest risk, including those linked from DREAMS programming, clients of FSWs, men who have sex with men, males in discordant relationships with HIV-positive partners, and males attending STI clinics.

With few cases of COVID-19 reported in Rwanda (positivity rate of 0.27% on March 24, 2022) 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.

Figure 4.3.3 VMMC Quarterly Trends by Age



This visual comes from: Prevention: Singe OU dossier; VMMC chapter; Results by Age Trends page; expand Trends by Priority Age Bands figure

4.4 Additional country-specific priorities listed in the planning level letter

All country specific priorities are highlighted in detail in the sections above and below.

4.5 Additional Program Priorities

Community Led Monitoring remains a priority for Rwanda. The PEPFAR team has experienced delays in rollout due to staffing shortages and limitations of the SGAC mandated mechanism for fund disbursement. PEPFAR is working with UNAIDS to overcome these challenges and implement CLM.

PEPFAR, UNAIDS and Global Fund, in collaboration with civil society, are working towards a harmonized CLM rollout. UNAIDS will host a CLM framework workshop in May 2022 to establish the goals of CLM. Participants in the workshop will include civil society organizations representing PLHIV, key populations, people living with disabilities, faith-based organizations, and the private sector.

4.6 Commodities

PEPFAR, in collaboration with the GoR and GFATM, has identified four critical priorities for PEPFAR commodity procurement and management in COP22: (1) accelerate national ART optimization for both adult and pediatric populations (inclusive of the tenofovir-lamivudine-dolutegravir (TLD) transition and scale up of pediatrics dolutegravir (DTG)); (2) scale up the multi-month dispensing (both 3 MMD and 6 MMD); (3) support commodity procurement for case finding strategy; and (4) facilitate patient data triangulation.

In COP22, PEPFAR Rwanda's commodity planning strategy reflects the changes needed to support sustained epidemic control and continued progress towards 95-95-95. The program will continue the supply of ARVs to maintain and accelerate progress towards excel the gain in the 2nd and 3rd 95s, reagents and consumables for viral load and early infant diagnosis, medicines for PrEP, TPT medicines, and condoms, and test kits. Additionally, PEPFAR will continue to support national priorities for commodity data collection, analysis and use through existing MOH platforms such as the Rwanda Coordinated Procurement and Distribution System (CPDS) and the Procurement Planning and Monitoring Report for HIV (PPMR-HIV); and conduct regular stock status reviews between the GoR, USG, and other donors.

In COP22, PEPFAR will procure the following prevention commodities: ARVs for PrEP, and Rifapentine/Isoniazid 300/300 mg for TPT. There will also be procurement of rapid test kits (RTKs), and recency kits. The RTKs procured will be for targeted and index and other targeted testing. Additionally, PEPFAR will procure and provide an estimated 7,329,000 male condoms through the Central Condom Fund to support Rwanda's national program through the Central Condom Fund for the public sector and social marketing program. The COP21 and COP22 COP22 RTK funding has been kept constant from COP21 are kept at the same levels. PEPFAR will collaborate with the MOH to review the RTK forecasts as compared to consumption rates to improve the regular and consistent availability of RTKs within the national program. Moreover, PEPFAR will continue to procure the Rapid Recency Assay in COP22 to align with the need to increase recency testing coverage.

In FY20, and 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 at about 1.5%. However, there were (1) funding gaps for TLD90 in FY2021 Q3 for the scale up of 6 MMD which was later filled by PEPFAR/ARPA funds, and (2) delivery delays of EID supplies in Q1 and Q2 of FY22 which led to an interruption of services. PEPFAR/Rwanda's international procurement agent, GHSC-PSM, has made valuable improvements in on time deliveries (OTD) over time; the OTD FY2020 and FY2021 was an average 90% and 93% respectively. The local procurement agent, Rwanda Medical Supply Limited (RMS) had an OTD rate of 100%. In COP22, RMS and GHSC-RTK will continue to ensure a high rate of OTD and prevent stock outs from occurring and keep the current minimal stock out level of less than 2%. GHSC-PSM will share its expertise with the RMS so that it can continue delivery on time for the remaining COP21 commodities and COP22 procurement. PEPFAR will transition all

procurement services of HIV/AIDS commodities except condoms from GHSC-PSM to TRMS in COP22 implementation. This transition is in line with the USG plan to successfully transition procurement services from an international partner to a local partner. The USG team will coordinate with the MOH to ensure availability of all HIV/AIDS program commodities to avoid any interruption of HIV services. Moreover, the PEPFAR American Rescue Plan Act (ARPA) funds and treatment scale up core funds helped to meet Rwanda's HIV commodity security specifically for ARVs and medicines for TPT in FY20 and FY21.

It is not anticipated that commodities such as: ARV (TLD and DTG), viral load, EID, PrEP, and RTKs will have any commodity security challenges in COP22. However, there are some commodity security concerns for condoms, laboratory consumables and supplies, medicines for TPT, medicines for opportunistic infections, and VMMC commodities and supplies. PEPFAR is working with the MOH Coordinated Procurement and Distribution System (CPDS) team to conduct a commodity alignment and prioritization exercise to minimize shortages. In addition, in COP 22, to find cost savings and efficiencies, VMMC supplies will be procured by Global Fund. The procurement of self-test kits will also fall to the Global Fund. However, the shortage of condoms may be significant. In COP20 PEPFAR received over $600,000 to purchase condoms, many of which covered the need in COP21. With 2 years of flatlined in COP21 and COP22, there is concerned Rwanda will see a condom shortage. Currently, there are alternative funding sources identified yet by the MOH.

Rwanda has started the implementation of lab bundling and diagnostic network optimization activities whereby an all-inclusive price model for VL and EID is being implemented. The procurement of VL and EID commodities using the all-inclusive pricing model has been implemented through both PEPFAR and GFATM funding.

MOH, PEPFAR, GFATM, and partners should plan commodity supply of needs for 12-18 months, coordinate and share data on supply plans, and order in advance to reduce the potential COVID-19 effects on suppliers, transportations, and demand variability challenges.

4.7 Collaboration, Integration and Monitoring

In COP22 CDC will continue to enhance partner management through regular technical monthly meetings with IPs to ensure continued alignment of implementation strategies with COP22 strategic objectives, review achievements against work plans, and identify challenges and best practices. Partners with poor performance will receive monthly site-level monitoring and mentorship with monthly data reporting. CDC will carry out quarterly partner meetings reviewing achievements against projected work plan achievements, program targets, budget execution and the program data to inform the program adjustment as appropriate. 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.

DOD will continue to strengthen partner management, building on COP 21 processes. As part of Continuous Quality Improvement (CQI) plans, DOD will have regular monthly meetings with Alliance for Healthy Communities (AHC) to ensure continued alignment of implementation strategies with COP21 strategic objectives, review achievements against work plans, and identify challenges and best practices. DOD 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, and quarterly PEPFAR data result reviews.

DOD, CDC, and USAID 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. DOD will coordinate with USG team and MOH to ensure availability of ARV and HIV tests to avoid any interruption of HIV services.

COP22 PEPFAR will continue to strengthen the Rwandan national health systems through planning, implementation, and monitoring of integrated health services, and provision of high-quality HIV/AIDS prevention, care, and treatment services, as well as working towards epidemic control and reaching the 95-95-95 goals. PEPFAR Rwanda will emphasis on continuous Quality Improvement based on program data including CBS and recency as well as the site level analysis to identify poor performing sites and gaps and lay out strategies to address those gaps. The prevention, care and treatment and strategic information 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 with relatively low VL suppression including children and adolescent. To ensure good linkages to all services, USG will strengthen the bidirectional referral system between community and health facility as well as across all HIV services such as HTS, care and treatment, VMMC, DREAMS, KP, OVC and nutrition centers. This will be done through stronger coordination of community and clinical partners to strengthen the referral/counter referral processes, stronger group specific peer/support groups, and stronger follow-up for those lost to treatment. 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.

PEPFAR will continue supporting HIV case finding strategies to reach the remaining unknown HIV positive, including the index testing and social network testing strategy targeting KPs and newly identified index cases. PEPFAR will continue to support implementation of children and adolescent models at all PEPFAR supported sites to enhance HIV pediatric case finding, linkage,

retention and VL suppression, with focus on family testing, age-appropriate counselling and disclosure, community adolescent treatment groups. Moreover, PEPFAR will also support strategies to reduce stigma and discrimination for AGYW and KPs through training of health care providers on AGYW and KP friendly service delivery, flexible hours, integration of AGYW HIV services into existing reproductive health services at health facility.

In COP22, PEPFAR will continue to build capacity of health care providers for continuous HIV in-service training and find efficiencies by strengthening and leveraging online platforms to train and mentor the health care providers to enhance the quality of services including 6MMD, Pediatric optimization, and TPT completion. Moreover, PEPFAR will continue to support the community models the roll out of differentiated care services. In addition, PEPFAR will find efficiencies by enhancing the integration of mentorship and supportive supervision.

In COP22, the optimized hub and spoke network of VL testing sites supported with a decentralized transportation system for sample referral within designated hub catchment areas will be maintained and enhance monitoring of the cornerstones of diagnostic network optimization implementations plan for adequate stakeholder and sustainability of VL hubs to provide timely and uninterrupted VL testing services. The entire VL hub network operates testing equipment that are interfaced with laboratory information systems (LIS) to ease test requests, return of results, and shorten turnaround time (TAT) of testing to boost VL coverage and retention. In COP22, the NRL will provide above-site support for implementation and monitoring of the quality of the decentralized sample referral, integrated LIS with other e-health systems and continuous quality improvement of VL testing hubs. In COP22, the laboratory information system will be maintained to facilitate access and tracking of lab test requests by ART nurses and clinical mentors as well as enhanced monitoring and reporting of VL testing coverage to achieve more than 95% of all patients on ART have timely documented VL test results and virally suppressed for sustained 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 maintain ISO accreditation of the NRL for sustained quality monitoring and improvement of testing in the national laboratory network for HIV and TB Programs. In COP21, one additional VL testing hub has achieved ISO accreditation and NRL has extended its competent support to improve quality management systems at six (6) additional hubs. 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 COP21, PEPFAR is coordinating its implementing partner to consolidate a data driven strategy for prioritizing of above site support for targeted continuous quality improvement activities at site level informed by use of digitized CQI tools for data collection, and triangulation with LIS and electronic proficiency testing (ePT) system for scaled up implementation in COP22.

In COP22, DOD will continue to provide technical assistance to the Rwanda Defense Forces (RDF) health providers to improve coverage and monitor VL suppression at Rwanda Military Hospital (RMH) and at Brigade clinics. Efforts will be made to improve VL testing capacity and implementation of an optimized diagnostic network that provides timely services and closes gaps of testing coverage among PLHIV during COVID-19. DOD will continue supporting VL testing CQI through supervision mentorship and ensure uninterrupted provision of VL testing; enhance Brigade clinics sample referral and return of results from RMH VL testing facility and Brigade clinics for cost effective and sustainable sample transportation while maintaining high quality VL results and short TAT. It is anticipated that VLS level of DOD Program currently at 97.3%as (FY22Q1) will be maintained in COP22 indicating quality of service provided to PLHIV.
In Cop22, PEPFAR will continue to support the development and revision of national guidelines, standard operating practices, and implementation to reflect key program adjustment. The program will also work to improve national guidelines that will encompass a client centered approach to service, national coordination of AGYW and KP programming, integration of NCD screening and management of PLHIV. In addition, PEPFAR will leverage the MOH e-learning platform to support health care workers' continuous learning on HIV and mentorship practices to improve PEPFAR COP22 implementation of the different program initiatives throughout the country. As Rwanda further targets programming around case finding, the program will use CBS/recency and programmatic data to further refine testing strategies

In COP21, PEPFAR continues to implement strategies to mitigate impact of COVID-19 on the laboratory services and strengthening laboratory systems to 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 monitoring management, enhance use of the laboratory information system with adequate skilled human resources at the central and district levels and integration/ interoperability with other national e-health systems to improve turnaround times of VL test results, digitization of continuous quality improvement tools to improve monitoring of quality of testing service delivery in the laboratory network, revamping proficiency testing and continuous quality improvement (PTCQI) activities of HIV core affected by stringent COVID-19 prevention measures, support specimen referral for specialized HIV/TB tests including near point of care testing (POCT) technologies from PEPFAR supported healthcare facilities with limited testing infrastructure and equipment to designated laboratories in the network for continued patient care and treatment.

COP22 continues maintenance and closing gaps in laboratory systems for an integrated laboratory diagnostics network and increased efforts of the MOH/NRL in stakeholder engagement to optimize and sustain the diagnostic and sample referral network for improved quality of the viral load testing infrastructure, adequate skilled laboratory workforces for quality testing service provision and use of the laboratory information system interoperated with other e-health systems, and continuous laboratory quality improvement activities such as mentorships to reduce turn-around-time and improved test results management for care and treatment of PLHIV as well as

leveraged for surveillance and public health response of HIV and preparedness for other pandemic threats such as COVID-19.

Using COP 20 and 21 resources, with PEPFAR support, RBC initiated work on establishing a nationally unique patient identifier (UPID) that is based on the Rwanda National Identification Agency (NIDA) issued IDs. A client registry acts as a repository for the UPIDs. So far, UPID has been used for patient registration in an EMR in a test environment, Additional tests, including record matching and linkage across systems are in process. In COP22, PEPFAR will support RBC to implement the UPID at selected health facilities that are representative of various levels of service provision (such as district hospitals, health centers, etc). This will ensure integration of services across programs (HTS and ART, TB, ANC), systems (EMR, LIS, CBS) and health facilities over time. The client registry which generates and stores UPIDs is a central component of the Rwanda Health Information Exchange architecture.

4.8 Targets by population

The targets for the following four tables are generated using data from COP22 Data Pack:

Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY22)	Additional patients required for 80% ART coverage	Target current on ART (APR FY23) *TX_CURR*	Newly initiated (APR FY23) *TX_NEW*	ART Coverage (APR 23)
Attained	227,134	133,152	-	136,612	6277	98%
Scale-Up Saturation						
Scale-Up Aggressive						
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	227,134	133,152	-	136,824	5,073	98%

Standard Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	Target Populations*	Population Size Estimate (SNUs)	Current Coverage (date)	*VMMC_CIRC* (in FY23)	Expected Coverage (in FY23)
	15-59	15-59			
Total/Average	2,263,456	3,256,608	52.5%	160,000	69.5%
Kigali City	299,612	344,419	72.4%	20,313	87.0%
East	529,095	826,434	41.4%	43,128	64.0%
North	398,547	527,043	62.6%	27,525	75.6%
South	509,406	821,112	49.8%	36,946	62.0%
West	563,429	737,600	56.3%	32,088	76.4%

Based on DHS2020 VMMC estimates, 52.5% in 2020, 60.8% in 2021, 64.6% in 2022, and 69.5% in 2023

* Included targets for COP20, COP21 and COP22 (FY21+FY22+FY23) = (268,737+125,000+160,000) since DHS survey was conducted in FY20

Table 4.8.3: Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Population	Population Size Estimate* (SNUs)	Disease Burden* (in FY 2023)	FY 2023 Target
FSW (KP_PREV)	13,714 (8,853 – 23,495)	35.5%	24,064
MSM (KP_PREV)	12,268 (11,826 – 12,757)	6.8%	3,028
Clients of FSW (PP_PREV)			28,502
AGYW 15-24 (PP_PREV)			80,590
Male Partners of AGYW 15-24			3,000
TOTAL			**139,184**

Standard Table 4.8.4 is required, except for countries with no OVC investments or targets.

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	Estimated # of Orphans and Vulnerable Children (Source EPP Spectrum 2022)	Target # of active OVC (FY23 Target)	Target # of OVC (FY23 Target)	Target # of active OVC (FY23 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target)
		OVC_SERV Comprehensive	OVC_SERV Preventative	OVC_SERV DREAMS	OVC*
East		18,614	2,250	12,953	11,809
Kigali City		27,839	17,942	27,212	22,476
North		-	-	-	-
South		15,592	2,250	8,951	10,463
West		50,747	2,000	-	41,884
TOTAL	392,644	112,792	24,442	49,116	86,632

4.9 Viral Load and Early Infant Diagnosis Optimization

The Rwanda MOH through NRL with support from the Clinton Health Access Initiative (CHAI) and its partners conducted a molecular diagnostic network optimization (DNO) exercise and specimen referral system (SRS) design in 2020. Since COP20, USG agencies have been engaged by NRL and

CHAI along with other partners to develop integrated strategies for national laboratory testing network and implementation plans for sustainable and efficient use of existing molecular testing instruments and other laboratory support systems for HIV VL/EID, TB, Hepatitis, and other infectious diseases including COVID-19. In COP21, PEPFAR has aligned its resources to contribute to this initiative through technical assistance and strategic investments to provide more than 95% access for all eligible PLHIV to annual VL testing while using its reporting mechanism 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 hub and spoke approach using high throughput conventional PCR and near point of care (POC) instruments at high volume EID testing sites.

In COP22, PEPFAR will continue to provide technical assistance to establish a routine monitoring and evaluation framework with key performance indicators for operation of the optimized scenarios of the integrated laboratory testing network and sample referral system to ensure return of results to achieve optimal testing coverage and, where possible, integration of near point of care testing (POCT) platforms to eliminate redundancies and contingency testing capacity including decentralized sample transportation system in a finite laboratory catchment areas closer healthcare facilities. 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 is ongoing into a dashboard to support 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 COP22, PEPFAR will continue site-level support to maintain and integrate access of the LIS with the national patient level e-health systems such CBS and OpenMRS to monitor site-level VL coverage, suppression events, and continuous laboratory quality improvement for optimum specimen referral management and timely return of results as well as data visibility for the national coordinated procurement and distribution system (CPDS) for supply chain forecast planning, inventory, and distribution of public health commodities including laboratory commodities. 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 and initiate the use of this platform for all EID testing services with full transition from the conventional PCR to near POCT platform that accommodates decreasing volume of testing. In COP22, 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 in addition for integrated diagnostic testing for HIV EID to promote strategies for EMTCT, timely diagnosis and rapid ART initiation of HIV exposed infants.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The goals in the above site investments are to strengthen and institutionalize systems within MOH to better improve planning, boost efficiencies and increase ownership of the HIV program as funding declines over time. The outcome of these time-bound approaches is to establish policies and mechanisms within MOH that are implemented, evaluated, and refined to support evolving HIV initiatives; build the capacity of health care workers to identify, treat and manage HIV care; and promptly respond to challenges in HIV service delivery through evidence-based data collection. PEPFAR Rwanda invested in digital health in Rwanda through support for EMR and LIS which store individual patient level clinic and lab data that are critical for HIV care and quality improvement of program services delivery. The EMR is installed at 195 PEPFAR-supported health facilities across the country while the VL LIS is installed at all VL testing sites labs. These systems generate routine program data used for performance monitoring and reporting, surveillance and clinical care. PEPFAR has also invested in the Rwanda HMIS which has aggregate patient data for program monitoring and the Rwanda's Health Information Exchange (RHIES) platform which facilitates data sharing between systems, programs and health facilities to support service delivery, program monitoring and HIV surveillance. Key components of the RHIES have been developed and tested and it is expected that RHIES will lead to automated information exchange resulting in efficiencies and enhanced data quality. As the Rwanda works on sustained epidemic control, the support and maintenance of these systems is critical in ensuring that the remaining undiagnosed individuals are identified and linked to care, and all those on treatment are tracked and long-term outcomes (such as viral suppression, treatment failure or death) monitored through case-based surveillance system supported by robust digital health systems. PEPFAR supported e-health systems will also be used to support services for key and priority populations in a secure and confidential way that reduces stigma among these populations.

In COP 22, PEPFAR's above-service delivery investments continue to align with strategies designed to address the key system barriers that were determined through review of progress made in implementation of activities against set benchmarks and required above site investments needed to achieve and sustain HIV epidemic control. These include policy, quality assurance epidemiological competencies for continuous data analysis, functional health information systems, and continuous quality improvement, supply chain and ensuring technical competencies to achieve public health response and adequate health and laboratory systems. Two SID elements under Strategic Information that scored the lowest in 2021 were "Epidemiological and Health Data" and "Data for Decision-Making Ecosystem". This highlighted the need to continue prioritizing investments in generating and using quality epidemiologic and program data to inform targeted interventions. Functional underlying HIS such as EMR, LIS, routine HMIS and others are critical in the generation of critical program data. Performance enhancement and maintenance of the HIS ensure timely availability of the data. Ongoing capacity building on HIV case-based and recent infection surveillance is contributing to the country's efforts towards sustained epidemic control.

In addition to above program quality systems investments, Rwanda implements SIMS and conducts supervision to identify program gaps and orient strategic approaches to address them. In FY21, PEPFAR conducted limited SIMS assessment due COVID-19 pandemic. Program gaps identified during these assessments include knowledge gaps among health care providers at decentralized levels mainly due to staff turnover thus affecting implementation of the new initiatives including PrEP, Self-test Pediatrics ART optimization and MSM program implementation. Additional gaps include adherence and retention for children and adolescents, as well as service referral and linkage system of beneficiaries to other high-impact HIV services including community based social support services. System gaps identified in laboratory include a fully integrated laboratory diagnostics network and weak coordination of the stakeholder engagement to sustainable model of the diagnostic and sample referral network for improved quality of the viral load testing infrastructure, adequate skilled laboratory workforce for quality testing service provision and use of the laboratory information system interoperated with other e-health systems, and continuous laboratory quality improvement activities such as mentorships to reduce turn-around-time and improved test results management for care and treatment of PLHIV as well as leveraging for surveillance and public health response of HIV and preparedness for other pandemic threats such as COVID-19.

In COP22, through PEPFAR's above site support, RBC will continue to implement sustainable capacity building approaches through e-learning platforms and on job training including quality improvement approaches through mentorship and regular site level data analysis to identify and address site specific challenges. In additional, PEPFAR investments in the specimen referral and testing infrastructure and other laboratory systems will strengthen the laboratory network to become more efficient and sustainable, improve timely delivery of test results for optimal patient care. The laboratory network will operate with defined and continuously monitored performance metrics to promote evidence based diagnostic network optimization and foster reliable and timely laboratory results. Laboratory equipment well maintained to consistently meet expectations of their intended use and international standards enabling a high level of laboratory results reliability and timely delivery of laboratory service. Laboratory data-driven continuous quality improvement and systems leveraged for public health surveillance with skilled human resources and infrastructure capacity at NRL to implement tester-based proficiency testing (PT) program for HIV serology, VL/EID testing, CD4, Recency testing and TB diagnostics and monitoring the quality of HIV testing at all health facilities. Improved technical capacity at NRL and peripheral Laboratories to collect, report and analyze HIV testing related data and systematic reporting from testing sites and data visibility of the national continuous quality improvement and structured external quality assurance/ proficiency testing program activities. NRL will also continue implementing external quality assurance programs to enhance the technical and managerial competencies of the quality of management system of HIV and related testing at decentralized laboratories. To ensure high quality MER data are used to improve programs from national to site level, quarterly data reviews and data quality assessments, which were disrupted by the Covid-19

pandemic, will resume. Poor performing health facilities or those submitting poor quality data will be identified and prioritized for support including supervision and mentorship.

PEPFAR supports a greater proportion of the national level needs for above site activities and commodities leveraging national and other stakeholders' investments to close the gap. PEPFAR contributes to common basket fund for commodities procurement under Commodity Procurement and Distribution System (CPDS) as well as quality improvement initiatives for clinical and laboratory programs while ensuring reliable health information systems that are supported through domestic and other partners' funding. These activities are routinely monitored through evidence-based data collection tools and collected information is utilized during quarterly above site meetings with implementing partners for review and refocusing of the program to maximize patient level outcomes.

5.1.1 National ART Optimization

Since 2019, Rwanda has been transitioning to an optimized ARV - the tenofovir 300mg/lamivudine 300mg/dolutegravir 50mg (TLD) with a corresponding drawdown of legacy ARVs. The TLD users increased from 60,879 (FY19) to 104,582 (FY20) to 162,497 (FY21). The transition was done in phases starting with Phase I, which included adult males and adolescents, and women over 50. The Phase I transition to TLD (98.5%) was completed by January 2020. Phase II, which included women of childbearing age started in February 2020. The consumption trends of TLE600 have been reduced significantly with complete transition progressing in FY22. The plan is that in FY23, 97% of adult patients will use dolutegravir and the remaining 3% of patients will continue on EFV and other medicines. The current proportion of the transition between the two Nucleoside Reverse Transcriptase Inhibitors (NRTIs) for adults are Tenofovir (90%) and of Abacavir (10%). The target is to reach TDF (93%) and ABC (7%) by the end of June 2023.

ART optimization for pediatrics started and Rwanda has achieved 74% of children on DTG. The target is to reach 98% by the end of June 2023. To support this, PEPFAR has procured DTG 10mg (16,000 bottles) in FY21. In FY22, PEPFAR will procure 16,713 bottles of DTG 10 mg to continue to support the full transition. The national program, including the care and treatment and supply chain working groups, are working hand in hand to minimize the wastage of legacy pediatric ARVs.

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 will allow USG and GoR to provide regular monthly updates of the transition progress, of the drawdown of legacy ARV stock both for adults and pediatrics, scale up of TLD90, proper introductions of pediatrics DTG, and optimizing ARVs for optimal care of patients on ART.

5.1.2 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 –only 49% of eligible patients were enrolled by the 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 FY2019. In the new ART STG, the MMP enrollment criteria changed from 18 months to 12 months on ART. By end of Q1 FY22, over 88% of the eligible patients are receiving MMD (3 MMD or 6MMD) but only about 52,234 patients are on 6MMD (or about 42%). In COP22, PEPFAR will continue to support the GoR in achieving their target of 80% enrollment of PLHIV on ART.

PEPFAR will also continue to support the GoR's transitioning from a three-month, 30-count bottle standard for MMP/D to six-month, 90-count two-bottle standard (not 180-count bottle based on the beneficiaries' survey and consultative meetings). It is assumed that 80% of adult and pediatric patients on TLD and DTG will be stable patients and will need to consume TLD 90 tabs and DTG 90 tabs in support of Multi-Month Dispensing. TLD 30 tabs and DTG 30 tabs will be reserved for 20% of patients on regimens including these molecules.

5.1.3. Utilization of Commodities Data for Patient Data Triangulation

PEPFAR has been supporting and improving data quality to facilitate triangulation of patient and supply chain data since FY19. That information was used to plan and implement a proper transition of legacy ARVs, scale up of TLD, and the startup of 6MMD. Moreover, in COP22, 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 products 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 COP22 implementation as Rwanda is completely transitioning to ART optimization for both adults and pediatrics as well as scaling up pediatrics DTG from the current 74% to 98%.

5.1.4. Improve Systems to Ensure Supply Chain Management Capacity and Commodities Security

In COP22, PEPFAR's supply chain systems strengthening strategy will focus on (1) full transition of USG ARVs, VL, EID, and TPT medicines procurement and delivery to RMS; (2) Capacitating RMS's quality control/quality assurance systems towards the World Health Organization's Model Quality Assurance System for procurement agencies (WHO/MQAS); (3) leveraging USG pharmaceutical services and Rwanda Food and Drugs Authority (RFDA) investments to implement pharmacovigilance and be a matured regulator; (4) improving the electronic logistics management information system (eLMIS) for better decision-making; and (5) ensuring the proper

implementation of ART optimization by shifting all remaining PLHIV to TLD, transitioning all children to a DTG based regimen, and scaling up of MMD, especially 6 MMD.

From COP17 till COP21 implementation, PEPFAR supported the transformation of the GoR's central and district level supply chain organization into a commercial parastatal organization, RMS ltd. This governance and structural change were to resolve the various challenges such as cumbersome and inflexible procurement system, fractured distribution networks, delayed supplier payments, gaps in oversight and tracking availability of commodities, and burdensome administrative processes to manage stock shortages. In FY21, USAID has contracted RMS using PEPFAR funds to conduct procurement services for COP20 and future COPs. This USAID contract also supports the development of a five-year comprehensive business plan for RMS, development and updating of the procurement and financial management manuals, and updating of standard operating procedures. In COP22, PEPFAR will continue to provide TA to RMS to help RMS practice industry standard tools and procedures and to continue to perform its USG procurement services including building a long-term financing strategy, strengthening the ABC costing and operational efficiencies, and providing certificate supply chain training to selected RMS staff.

The establishment of RMS was a significant decision of the GoR to improve the public health supply chain in multiple ways including sector governance, management structures, performance management, procurement processes, and sustainability of the supply chain. As a result, improvements have been observed in streamlining the supply chain management structures and alleviating the piecemeal and lengthy procurement processes. Furthermore, RMS is partnering with other local suppliers to improve availability of essential medicines, streamline the procurement and distribution processes, increase inventory oversight and traceability of commodities from central level to the customer, and improve consumption data. The USAID Transforming Rwanda Medical Supply Chain (TRMS) Activity is a five-year activity with a scope that includes multiple program commodity procurement services. The procurement services started with ARV, and then expanded to include VMMC, VL, EID and TPT medicines and supplies. In COP22, RMS/TRMS will be the major procurement agent for PEPFAR/Rwanda. The plan is to complete the transition of commodity procurement from GHSC-PSM and other mechanisms to TRMS within the next 24-36 months. During this transition process, PEPFAR Rwanda will rethink and revamp the internal management of commodities oversight to ensure efficiency and sustainability.

Like previous COPs, especially COP19, in COP22 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, 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 RFDA, to ensure evaluation, registration, and market authorization of new products and/or formulations. These activities will facilitate the

institutionalization of an internal system for pharmacovigilance by monitoring the safety of medicines, rolling out regulatory related ART optimization plans, mitigating ART medication errors, advocating for the 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 containment of antimicrobial resistance.

In COP22, PEPFAR will continue working to improve logistics data for decision-making by institutionalizing and upgrading the eLMIS, implementing the Global Standards One (GS1) 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 complete diagnostic network optimization for VL/EID/TB, ensure proper national transition of TLD and DTG-based regimens for both adult and pediatrics, and support the national integrated CPDS budgeting and supply planning exercises.

Moreover, in COP22, PEPFAR will support RMS through FHI360 (implementer of the Global Health Supply Chain - Quality Assurance Program (GHSC-QA) to capacitate RMS to meet the World Health Organization's Model Quality Assurance System for procurement agencies (WHO/MQAS) and USAID's quality assurance requirements (ADS312). PEPFAR will support a third-party monitoring partner to ensure that PEPFAR funded health commodities reach the beneficiaries and end users and cross check the quality of data reported. PEPFAR will also support RMS' strategic financing and sustainability.

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 COP22 to achieve PEPFAR directives.

USAID currently has three (3) vacant positions funded by PEPFAR. Two positions, the Community Health Specialist and the Development Outreach Communications Specialist, only just became vacant in late March 2022. The position descriptions will be reviewed and the positions will be re-advertised. The final vacant position is a new position and is for an Acquisition and Assistance Specialist (A&A) to support the award management of multiple local partners, including RMS. This new position has been discussed and approved by both USAID/Rwanda Mission leadership as well as USAID/W. Also, O/GAC provided funding outside of the COP budget envelope to fund this critical position.

CDC currently has three vacant positions, all of which are in various stages of the recruitment process and expected to be filled by or during COP22 implementation. All three positions have been within the recruitment process for the last seven months. 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 COP22, CDC will abolish one locally employed staff position and will not request any new positions.

In order to ensure adequate staffing and proper alignment of the staff needed for the DOD portion of the PEPFAR programming, DOD has right sized its staffing footprint (2 staff) to its PEPFAR workload needed to carry out the necessary SIMS visits and provide TA on clinical services activities. DOD Program Manager will retire in COP22 and the requested COP22 CODB increase from COP21 will cover his retirement benefits and cover the cost of hiring a new Program Manager (his replacement). Requested funding for CODB for COP2022 is $280,000.

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 added a program assistant.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach and Sustain Epidemic Control

Attained: 90-90-90 (81%) by Age/Sex Band to reach 95-95-95 (90%) Overall										
SNU	**COP**	**Prioritization**	**Results Reported**	**<15 (F)**	**<15 (M)**	**15-24 (F)**	**15-24 (M)**	**25+ (F)**	**25+ (M)**	**Overall TX Coverage**
Kigali City	COP17	Scale-Up: Saturation	APR18	48%	48%	73%	76%	97%	89%	**90%**
	COP18	Scale-Up: Saturation	APR19	54%	55%	76%	77%	99%	91%	**92%**
	COP19	Scale-Up: Saturation	APR20	67%	67%	79%	79%	98%	92%	**93%**
	COP20	Attained	APR21	68%	74%	116%	80%	92%	91%	**92%**
	COP21	Attained	APR22	50%	49.4%	102.2%	101.9%	102.5%	101.8%	100.1%
East	COP17	Scale-Up: Saturation	APR18	67%	67%	68%	70%	90%	83%	**85%**
	COP18	Scale-Up: Saturation	APR19	75%	76%	70%	72%	91%	85%	**87%**
	COP19	Scale-Up: Saturation	APR20	88%	88%	73%	73%	91%	85%	88%
	COP20	Attained	APR21	56%	51%	117%	112%	111%	98%	103%
	COP21	Attained	APR22	64%	63.6%	97.6%	98.1%	97.5%	98.7%	96.6%
South	COP17	Scale-Up: Saturation	APR18	64%	64%	60%	62%	79%	73%	**75%**
	COP18	Scale-Up: Saturation	APR19	72%	73%	62%	63%	80%	74%	**77%**
	COP19	Scale-Up: Saturation	APR20	85%	85%	66%	66%	81%	76%	**78%**
	COP20	Attained	APR21	55%	65%	117%	112%	91%	93%	**92%**
	COP21	Attained	APR22	70%	69.9%	98.7%	98.5%	98.7%	98.9%	97.7%
West	COP17	Scale-Up: Saturation	APR18	82%	83%	71%	74%	95%	87%	**90%**
	COP18	Scale-Up: Saturation	APR19	93%	94%	74%	76%	96%	89%	**92%**
	COP19	Scale-Up: Saturation	APR20	108%	108%	78%	78%	96%	90%	**93%**
	COP20	Attained	APR21	80%	84%	120%	109%	98%	86%	95%
	COP21	Attained	APR21	74%	73.7%	98.9%	99.0%	98.9%	99.6%	98.2%
North	COP17	Scale-Up: Saturation	APR18	54%	54%	56%	59%	75%	69%	**70%**
	COP18	Scale-Up: Saturation	APR19	61%	62%	59%	60%	76%	70%	**72%**
	COP19	Scale-Up: Saturation	APR20	69%	69%	59%	59%	75%	70%	**72%**
	COP20	Attained	APR21	75%	77%	97%	106%	96%	90%	93%
	COP21	Attained	APR22	59%	58.8%	96.6%	96.4%	96.4%	96.7%	95.1%
TOTAL	COP17	Scale-Up: Saturation	APR18	63%	63%	66%	69%	88%	81%	**83%**
	COP18	Scale-Up: Saturation	APR19	67%	67%	68%	70%	90%	83%	**85%**
	COP19	Scale-Up: Saturation	APR20	83%	83%	72%	72%	89%	84%	**86%**
	COP20	Attained	APR21	67%	70%	113%	103%	98%	92%	**96%**
	COP21	Attained	APR22	63%	62.8%	99.2%	99.1%	99.1%	99.5%	97.9%

** According to the recent Spectrum estimate the PLHIV number increased to 227.127 I Rwanda

APPENDIX B – Budget Profile and Resource Projections

B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

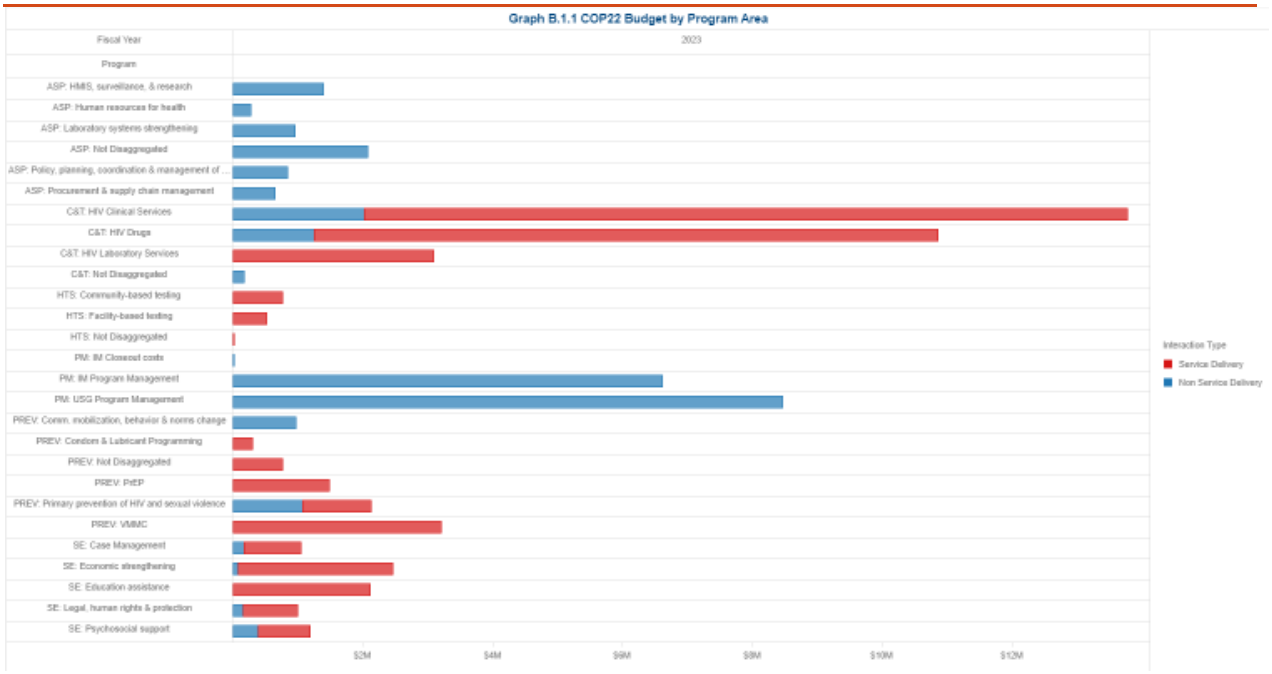


Table B.1.2 COP22 Budget by Program Area

Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		$27,326,793	$39,552,267	$67,879,908	41%	59%	100%
C&T	Total	$3,441,673	$24,459,831	$27,906,503	12%	88%	100%
	HIV Clinical Services	$2,022,716	$11,756,671	$13,779,387	15%	85%	100%
	HIV Drugs	$1,254,166	$9,810,282	$10,954,442	12%	88%	100%
	HIV Laboratory Services		$3,892,478	$3,892,478		100%	100%
	Not Disaggregated	$164,196		$164,196	100%		100%
HTS	Total		$1,207,701	$1,207,701		100%	100%
	Community-based testing		$706,534	$745,534		100%	100%
	Facility-based testing		$808,382	$808,382		100%	100%
	Not Disaggregated		$12,845	$12,845		100%	100%
PREV	Total	$2,026,438	$6,787,729	$8,814,168	23%	77%	100%
	Comm. mobilization, behavior & norms change	$960,703		$960,703	100%		100%
	Condom & Lubricant Programming		$308,000	$308,000		100%	100%
	Not Disaggregated		$761,348	$761,348		100%	100%
	PrEP		$1,475,002	$1,475,002		100%	100%
	Primary prevention of HIV and sexual violence	$1,065,727	$1,051,389	$2,117,116	50%	50%	100%
	VMMC		$3,208,000	$3,208,000		100%	100%
SE	Total	$794,576	$7,017,276	$7,811,852	10%	90%	100%
	Case Management	$170,108	$978,172	$1,148,281	15%	85%	100%
	Economic strengthening	$76,156	$2,387,900	$2,463,662	3%	97%	100%
	Education assistance		$2,118,017	$2,118,017		100%	100%
	Legal, human rights & protection	$148,848	$844,519	$993,364	15%	85%	100%
	Psychosocial support	$389,803	$787,869	$1,187,728	33%	67%	100%
ASP	Total	$6,179,238		$6,179,238	100%		100%
	HMIS, surveillance, & research	$1,390,107		$1,390,107	100%		100%
	Human resources for health	$276,714		$276,714	100%		100%
	Laboratory systems strengthening	$957,541		$957,541	100%		100%
	Not Disaggregated	$2,696,176		$2,696,176	100%		100%
	Policy, planning, coordination & management of disease control programs	$838,872		$838,872	100%		100%
	Procurement & supply chain management	$645,629		$645,629	100%		100%
PM	Total	$10,895,477		$10,895,477	100%		100%
	IM Closeout costs	$3,908		$3,908	100%		100%
	IM Program Management	$6,419,916		$6,419,916	100%		100%
	USG Program Management	$4,471,651		$4,471,651	100%		100%

Budget by Program & Sub

Metrics	Amount			Percent to Total By Rows (Amount)		
Program and Sub	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total	$1,975,138,514	$2,834,744,354	$4,809,882,868	41.06%	58.94%	100.00%
C&T: HIV Clinical Services	$320,255,301	$850,022,760	$1,170,278,061	27.37%	72.63%	100.00%
PM: IM Program Management	$571,014,001		$571,014,001	100.00%		100.00%
C&T: HIV Drugs	$7,973,952	$464,102,163	$472,076,115	1.69%	98.31%	100.00%
C&T: Not Disaggregated	$167,049,032	$185,552,061	$352,601,093	47.38%	52.62%	100.00%
C&T: HIV Laboratory Services	$37,135,737	$305,376,923	$342,512,660	10.84%	89.16%	100.00%
	$188,386,289		$188,386,289	100.00%		100.00%
PREV: VMMC	$12,104,265	$157,930,855	$170,035,120	7.12%	92.88%	100.00%
ASP: HMIS, surveillance, & research	$145,754,294		$145,754,294	100.00%		100.00%
PREV: Not Disaggregated	$35,668,957	$104,414,121	$140,083,078	25.46%	74.54%	100.00%
HTS: Facility	$33,998,558	$99,924,893	$133,923,451	25.39%	74.61%	100.00%
PM: USG Program Management	$120,574,504		$120,574,504	100.00%		100.00%
PREV: Comm. mobilization, behavior & norms change	$16,455,050	$101,063,890	$117,518,940	14.00%	86.00%	100.00%
PREV: PrEP	$10,624,347	$89,175,929	$99,800,276	10.65%	89.35%	100.00%
HTS: Community	$15,262,387	$74,030,345	$89,292,732	17.09%	82.91%	100.00%
SE: Case Management	$8,918,899	$79,718,989	$88,637,888	10.06%	89.94%	100.00%
SE: Economic strengthening	$4,690,612	$82,775,194	$87,465,806	5.36%	94.64%	100.00%
HTS: Not Disaggregated	$16,670,505	$48,176,080	$64,846,585	25.71%	74.29%	100.00%

Table B.1.3 COP22 Total Planning Level

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	$3,506,208	$63,572,792	$67,079,000
Rwanda	$3,506,208	$63,572,792	$67,079,000

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

This visualization can be generated from the COP22 FAST Dossier in PAW.

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Rwanda	Total	$27,900,503	$1,287,761	$8,814,169	$7,801,852	$6,179,238	$15,095,477	$67,079,000	100%	100%	100%	100%	100%	100%	100%
	Females	$129,247	$384,727	$2,621,287	$4,474,335	$744,836		$8,364,432	0%	31%	30%	57%	12%		12%
	Key Pops	$46,022	$304,585	$1,860,239		$75,000		$2,285,846	0%	24%	21%		1%		3%
	Males	$129,247		$1,600,000				$1,729,247	0%		18%				3%
	Non-Targeted Pop	$25,725,579	$476,835	$301,060		$4,687,102	$10,669,066	$42,859,642	92%	37%	3%		79%	71%	63%
	Not Specified					$472,300	$3,872,883	$4,345,183					8%	26%	6%
	OVC			$831,583	$3,327,517			$4,159,100			9%	43%			6%
	Pregnant & Breastfeeding Women	$1,415,212						$1,415,212	5%						2%
	Priority Pops	$455,196	$111,614	$1,600,000			$553,528	$2,720,338	2%	9%	18%			4%	4%

B.2 Resource Projections

PEPFAR Rwanda continues to balance investments between direct service delivery and above site investments. For direct service delivery, the Ministry of Health has divided facilities between PEPFAR and Global Fund. Due the PEPFAR's in country presence and oversight, PEPFAR manages the majority of the high-volume sites. Above site investments are aligned with Global fund to ensure no funding is duplicative.

APPENDIX C – Tables and Systems Investments for Section 5.0

The Key Systems Barriers-E, Table 6-E tab, and SRE Tool-E tab of the Table 6 and SRE Excel workbook should be saved as a PDF and attached here in Appendix C.

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)

Step 1: Select SID element	SID score (autopopulated)	Step 2 - What is the outcome expected from investing in this element? (may duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?
1. Planning and Coordination	0	Improved quality of service delivery through implementation of updated standards and guidelines	Lack of Financial Resources
9. Quality Management	0	Improved quality of of life	Lack of technical capacity
7. Human Resources for Health	0	improverd competences in implementation and management of national health services	Lack of technical capacity
10. Laboratory	0	The national referral system and testing becomes more efficient and sustainable, improve timely delivery of test results for optimal patient care	Legal, policy or regulatory constraint
10. Laboratory	0	Defined and continually monitored performance metrics to promote evidence based diagnostic network optimization and foster reliable and timely laboratory results	Lack of information on costs and program requir
10. Laboratory	0	Laboratory equipment that consistently meet expectations of their intended use and international standards enabling a high level of laboratory results reliability	Lack of Financial Resources
10. Laboratory	0	Timely lab service delivery, data-driven continuous quality improvement and leveraged to public health surveillance systems	Lack of technical capacity
10. Laboratory	0	Timely lab service delivery, data-driven continuous quality improvement and leveraged to public health surveillance systems	Lack of Financial Resources
10. Laboratory	0	Improved HR and infrastructure capacity at NRL to implement PT program for all HIV related testings and monitor the quality of HIV testing at all HFs	Physical infrastructure not complete/further inve
10. Laboratory	0	Improved technical capacity at NRL and peripheral Laboratories to collect, report and analyse HIV testing related data	Lack of technical capacity
6. Service Delivery	0	hospitals to improve on appropriate	Legal, policy or regulatory constraint

6. Service Delivery	0	Increase in spontaneous reporting of ADRs/ADEs on HIV and other medicines by healthcare providers, public health programs, industry, and the public through the national PV system and feedback to reporters	Legal, policy or regulatory constraint

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6. Service Delivery	0	Improved clinical management of DTGbased regimens in Rwanda to enhance treatment outcomes for HIV/AIDS patients	Legal, policy or regulatory constraint
8. Commodity Security and Supply Chain	0	Meet internal and international requirements of ensuring that regulatory documents are up-to-date	Legal, policy or regulatory constraint
8. Commodity Security and Supply Chain	0	Increased the assessors' competencies in areas such as BE studies evaluation, and evaluation of APIs	Legal, policy or regulatory constraint
8. Commodity Security and Supply Chain	0	Increased number of medical products registered on the domestic market	Legal, policy or regulatory constraint
8. Commodity Security and Supply Chain	0	Scale up of 6 MMD and TPT to all eligible clients in 30 districts and Transitioning to pediatric DTG 10mg for all eligible chlidren	Lack of Financial Resources
8. Commodity Security and Supply Chain	0	Improvement of supply chain data quality to 90%	Lack of technical capacity
Laboratory		Full implementation of lab bundling and Diagnostic network optiomazation to reduce expiries and wastage of lab commodities and avoid interruption of HIV related lab testing	Lack of technical capacity
6. Service Delivery	0	Improved capacity of RMS to perform procurement functions for PEPFAR funded commodities	Lack of technical capacity
1. Planning and Coordination	0	Establish longterm RMS financial strategy	Lack of Financial Resources

Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed
Guidelines and Tools exist but needs updating to include changes in prevention and care and treatment including Pediatrics ART optimization, updated TB screening and management and management of advanced HIV disease to support implememtation of quality HIV services	1 year
Need for evidence based HIV treatment and biomedical intervations to improve management of HIV services along the continuum of care including oversight of prevention and treatment	2-3 years
Limited MoH/RBC capabilities to implement effective public health tresponse and adequately manage integrated HIV programs	2-3 years
The current system of specimen referral lacks financial and temporal efficiency, specimens transport more centralized and referral and testing network unoptimized	2-3 years
Lack of robust and ongoing mechanism to track and measure the performance of diagnostic network to continually explore avenues for optimization	2-3 years
The diagnostic network still faces disproportionate funding from the government and other non-PEPFAR partners for equipment maintenance and calibration	4-5 years
Inadequate skilled human resources and complex labclinical interfacing between LIS and diverse e-medical record systems for tracking patient samples, test request, return and documentation of test results to ensure timely clinical evaluation of lab diagnostic and monitoring of patient treatment outcomes	4-5 years
Inadequate resources for integrated lab data management of routine performance evaluation and continual quality improvement of lab testing services in the healthcare delivery system and sustained epidemic control	4-5 years
Insufficient infrastructure and capacity at NRL to produce, distribute PT panels and implement site level quality monitoring of HIV Recency, HIV rapid diagnostics, CD4, VL, EID and TB Xpert testing services	2-3 years

Irregular collection, reporting and analysis of HIV testing related data to inform and adapt HIV programs quickly to address gaps in HIV testing and quality assurance	2-3 years
doesn't know when and where to report once get	2-3 years
insufficient patient and medicines safety monitoring and reporting system at all levels mostly at health facility to allow health care providers, public health programs and patients to report any medicines adverse events to PV center for evidence based dicision making	2-3 years
insufficient ARVs regimens has put on hold transitioning of HIV eligble clients from being transitioned to avoid any expires	2-3 years
Lack of adequate regulation and guidlines to guide the authority clients. Rwanda FDA's internal policy requires it to have their regulations, guidelines and SOPs to be updated to guide the daily operations of agency to their clients.	2-3 years
Limltted compentencies in most of the dossier evaluations areas. Rwanda FDA newly recruited staff without regulatory background, have limtted compentencies in most of the dossier evaluations areas	4-5 years
Registration of medical products is requirement for it to be on Rwandan market and application for registration has to undergo assessment before approval if not done will lead to lack of quality medicines on the market	4-5 years
ART optimization with focus on pediatric DTG 10mg transition for all eligible chlidren,scale up of 6MMD and TPT will contribute to achieving epidemic control to achieve the desired HIV treatment outcome	2-3 years
The supply chain data accuracy has declined to 53% from 70% with inadequate continuous quality improvement due to the impact of COVID-19 with the increased workload of the Health workers at the health facilities. Continous data quality improvement with mentorship, supervision and site visits will improve the availability of reliable logistics data for informed decision making	2-3 years
continous implementation of laboratory bundling and labratory diagnostics network optimization will reduce stock out,improve the availability of lab commodities, improve the lab results (EID/VL) turnaround time, and reduce expires	2-3 years
As new PEPFAR subrecipient,strengthening RMS capacity to manage PEPFAR commodity management, will improve efficiencies to ensure continuous availability of HIV commodities to achieve epidemic control	4-5 years

establishing RMS longterm financial strategy will help to allevaiate RMS's short term finacial gaps due to delayed recovery and payment from the health facilities and help strengthen its long term financial position and sustainability as an independent firm.	2-3 years

Table 6:

Table 6-E (Entry of Above Site Programs Activities)
Please note that for this tab to function properly, data must have already been pasted in the FAST-P tab.

Funding Agency	MechName	PrimePartner	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	7.06
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.06
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionalization of in-service training	7. Human Resources for Health	8.13
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.06
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.18
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.18
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.18
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.18
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.00
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.18
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.18
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.18

HHS/CDC	Trustees Of Columbia University In The City Of New York	Recency HQ Mechanism - ICAP	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.18
HHS/CDC	Trustees Of Columbia University In The City Of New York	Enhancing Sustainable and Integrated Health, Strategic Information and Lab Systems for Quality Comprehensive HIV Services through Technical Assistance to	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.18
HHS/CDC	JEMBI HEALTH SYSTEMS	JEMBI HQ	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.18
USAID	Pact, Inc.	RCAY Reaching Pregnant Breasfeeding Women Children, and Youth	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.06
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	10. Laboratory	7.22
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and strategic plans	10. Laboratory	7.22
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	7.22
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	10. Laboratory	7.22
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	7.22
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	7.22
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	7.22
HHS/CDC	Trustees Of Columbia University In The City Of New York	Enhancing Sustainable and Integrated Health, Strategic Information and Lab Systems for Quality Comprehensive HIV Services through Technical Assistance to	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Training in laboratory systems strengthening	10. Laboratory	7.22
HHS/CDC	Trustees Of Columbia University In The City Of New York	Recency HQ Mechanism - ICAP	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.18
HHS/CDC	Trustees Of Columbia University In The City Of New York	Enhancing Sustainable and Integrated Health, Strategic Information and Lab Systems for Quality Comprehensive HIV Services through Technical Assistance to	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionalization of in-service training	7. Human Resources for Health	8.13
HHS/CDC	Trustees Of Columbia University In The City Of New York	Enhancing Sustainable and Integrated Health, Strategic Information and Lab Systems for Quality Comprehensive HIV Services through Technical Assistance to	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	7.06
USAID	Management Sciences For Health, Inc.	Medicines, Technologies, and Pharmaceutical Services (MTaPS)	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.06

USAID	Management Sciences For Health, Inc.	Medicines, Technologies, and Pharmaceutical Services (MTaPS)	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.06
USAID/WCF	Chemonics International, Inc.	GHSC-PSM	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	7.36
USAID/WCF	Chemonics International, Inc.	GHSC-PSM	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	7.36
USAID/WCF	Chemonics International, Inc.	GHSC-PSM	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	7.22
USAID/WCF	Chemonics International, Inc.	GHSC-PSM	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	7.36
USAID	TBD	[Placeholder - 160565 Rwanda USAID]	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Administrative and financial systems	15. Financial/Expenditure Data	9.17

SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End
7.38	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	standardized policies andguidelines and improved quality of life of PLHIV	Lack of technical capacity	Lack of Financial Resources	Lack of Financial Resources	This activity will update exiting HIV national guideline to align to international standards and allow provision of quality integrated HIV services	COP18	COP25
7.38	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	Improvement in HIV case finding, optimal linkage and adherence, optimized ART despensing and achieving max viral load suppression resulting in improved quality of life of PLHIV	Lack of technical capacity	Lack of Financial Resources	Lack of Financial Resources	Enhancing routing HIV program approaches to improve quality of service delivery and patient level outcome as the country mounts capabilities to achieve and maintain HIV epidemic control. Ensuring adherence and retention , optimized treatment to achieve viral load suppression and enhancing continous quality improvement are cornerstone to achieve epidemic control.	COP18	COP25
8.13	7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (If exact o	Institutionalized in-service training and e-learning services available and used to respond to technical capacity needs of the program . compitent health care cadres to adequately respond to public health needs	Lack of sufficient HRH	Lack of technical capacity	Lack of sufficient HRH	Supporting implementation of e-learning and competent trainings of health care caderes in field epidemiology to enhance their skills in active case finding, outbreak investigations and routine data analysis to inform public health response.	COP18	COP25
7.38	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	Optimal coverage of quality circumcission services reduces HIV infection transition among targeted age groups	Lack of technical capacity	Lack of Financial Resources		Maintaining support to VMMC services at decentralized levels through routine mentorship and supportive supervision	COP19	COP24
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	Functional EMR at 192 PEPFAR sites providing critical, quality HIV care data and Case based surveillance digital platform	Lack of technical capacity			Maintaining the digital platform on OpenMRS ver. 2.3 - including a helpdesk support - for all 192 PEPFAR supported sites. Future systems enhancements to include any new clinical care	COP18	Post COP25
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	Functional and maintained health information exchange linking EMR, LIS, DHIS-2, Client Registry, Facility Registry and a	Lack of technical capacity			Maintain functional components of the Rwanda Health Information Exchange (RHIE) to support critical data sharing between systems in PEPFAR supported sites. Includes maintaining interfaces with RHMIS, EMR, LIS and the registries	COP18	COP25
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	ICT infrastructure to host the systems supporting data management for crital delivery of HIV services. Updated client	Lack of technical capacity			Maintain the infrastructure to support the RHIE including cloud-based hosting (renting space from RISA) + Internet connectivity recurrent cost	COP18	COP25
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	HIV recency and CBS data analysed and used for public health response and program improvement.	Lack of technical capacity			Support data management, analytics, visualization and use of the HIV recency and case-based surveillance data for program improvement and public health response.	COP18	Post COP25
8.33	16.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic	High quality data used to inform HIV at all levels (national, regional, district and facility).	It is not included in local HIV response plans			Routine review of MER data from all 5 regions to identify facilities with gaps in testing and viral suppression by population through enhanced use of MER data at district and facility level through monthly data reviews, targeting poor performing facilities.	COP18	Post COP25
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	Efficient data availability of data from EMR, LIS and DHIS facilitated by automated information exchange.	Lack of technical capacity			Maintain automated exchange of MER indicators from EMR/LIS to RHMIS to align PEPFAR/DATIM and MOH indicators	COP20	COP22
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	HIV drug resitance data to inform treatment program routinely	Lack of technical capacity			Integrate and use routine VL data for HIV-DR surveillance per CADRE approach	COP21	COP25
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	Up to date data from intergrated bio-behavioral survey (IBBS) for female sex workers (FSW)	It is not included in local HIV response plans			Protocol development for FSW/IBBS	COP22	COP22

6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	RBC capacitated to conduct HIV recency and case based surveillance	Lack of technical capacity			Provide technical assistance and capacity building to RBC/MOH on HIV CBS and Recency data management, analysis, visualization and use for program improvement and public health response	COP18	COP24
6.18	2.8 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of	Data on structural barriers to access KP services in Rwanda	Lack of USG-Government integration planning			Conduct a facility assessment to identify structural barriers to access to KP services.	COP22	COP22
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	Functional health infromation exchange through skills transfer from global partners	Lack of technical capacity			Adaptation of software artifcacts to facilitate health information exchange based on global open standards.	COP21	COP22
7.38	6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all	1)The improved organizational capacity of local CSOs 2) Functional Electronic data systems	Lack of technical capacity			Provide technical capacity building to local CSOs implementing DREAMS /OVC programs including: 1) Financial Management 2) Quality service delivery	COP22	COP24
6.96	10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	The national referral system and testing becomes more efficient and sustainable, improve timely delivery of test	Legal, policy or regulatory constraint	Lack of Financial Resources		Maintain a decentralized national specimen referral and transportation system for optimized geographical access, cost-effective and sustainable lab testing services that responds to demand of timely laboratory results for patient care	COP18	Post COP25
6.96	10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	Defined and continually monitored performance metrics to promote evidence based diagnostic network	Lack of information on costs and program requirements			Establish a monitoring and evaluation framework to inform stakeholder engagements in the implementation of the Diagnostic network optimization (DNO) and Sample referral system (SRS) towards a sustainable lab testing network for HIV	COP22	COP25
6.96	10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	Laboratory equipment that consistently meet expectations of their intended use and international standards	Lack of Financial Resources			Maintain NRL and laboratory network's equipment inventory, preventive maintenance and certification for biosafety cabinets and ancillary equipments	COP18	Post COP25
6.96	10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	Timely lab service delivery, data-driven continuous quality improvement and leveraged to public health surveillance	Lack of technical capacity	Lack of Financial Resources		Upgrades and maintenance of existing lab information systems (LIS) supporting interoperability between LIS in use within the lab network and the OpenMRS/OpenHIM (DHIS2) at health facilities or national data repository for public health	COP18	Post COP25
6.96	N/A	Timely lab service delivery, data-driven continuous quality improvement and leveraged to public health surveillance	Lack of technical capacity	Lack of managerial capacity		Integrated laboratory data management system to link delivered testing services and continual improvement activities for data visibility used to inform and improve HIV and TB testing services in the lab network	COP22	Post COP25
6.96	10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor	Improved HR and infrastructure capacity at NRL to implement PT program for all HIV related testings and monitor the quality	Lack of managerial capacity	Lack of Financial Resources		Produce, distribute PT panels to all testers and implement site level quality monitoring for HIV Recency, HIV rapid diagnostics, CD4, VL, EID and TB Xpert testing services in Rwanda	COP19	COP25
6.96	10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor	Improved technical capacity at NRL and peripheral Laboratories to collect, report and analyse HIV testing related	Lack of technical capacity	Lack of Financial Resources		Conduct site monitoring and mentorship activities to identify and address quality gaps in HIV Rapid testing, EID, VL, CD4 and TB testing at all PEPFAR supported sites	COP19	COP25
6.96	10.4 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to	Improved systematic reporting from testing sites and data visibility of the national continuous quality	Lack of technical capacity	Lack of managerial capacity		Provide technical assistance and capacity building to RBC/NRL on integrated laboratory data management system to link delivered testing services and continual improvement activities for data visibility used to inform and improve HIV and TB testing services	COP22	COP25
6.18	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance	RBC capacitated to conduct HIV recency and case based surveillance	Lack of technical capacity			Provide technical assistance and capacity building to RBC/MOH on HIV CBS and Recency data management, analysis, visualization and use for program improvement and public health response	COP18	COP24
8.13	7.1 Health workforce Supply: To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic	Fully functional, flexible and nationally used e-learning platform	Lack of sufficient HRH	Lack of technical capacity		TA support to enhance tele-health, e-mentorship, monitoring and improvement of eLearning delivery and uptake. Community of practice for e-health will be established, and monthly webinar series initiated and a digital platform to promote community	COP21	COP25
7.38	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	Improvement in HIV case finding, optimal linkage and adherance, optimized ART despensing and achieving max	Lack of technical capacity	Lack of sufficient HRH		Support institutionalization, maintenance and effective use of the digitalized CQI framework. An effectively utilized digital CQI framework will help improve the implementation for priority interventions like Index testing, self-testing, PreP, 6MMD, and	COP21	COP23
7.38	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	public hospitals to improve on appropriate use of medicines including ARVs & medicines safety reporting	Legal, policy or regulatory constraint	Lack of technical capacity	Lack of Financial Resources	HIV commodities, to improve HIV/AIDS patient safety and therapeutic effectiveness with: 1)Training 40 members of the Medicines Therapeutic Committees (MTC) at the health facilities	COP19	COP23

7.38	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	both internal and international requirements of ensuring that regulatory documents are up-to-date with improved	Legal, policy or regulatory constraint	Lack of Financial Resources	Lack of technical capacity	marketing authorization processes for HIV/AIDS health products including: 1) Supporting advanced capacity development training of Rwanda FDA medicines registration dossiers evaluation assessors and	COP18	COP23
6.39	Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities	Increased confidence in 6-month MMD and TPT uptake to all eligible clients	Lack of Financial Resources	Lack of technical capacity		Support ART regimens optimization with focus on pediatric DTG transition, scale-up of MMD, TPT, and Prep including: 1) Continued scale-up of TLD for adults and adolescents with a focus on transitioning eligible CLHIV to DTG 10 mg with minimal	COP18	COP23
6.39	Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities	Improvement of supply chain data quality to 90% to ensure informed decision making	Lack of Financial Resources	Lack of technical capacity		through: 1) eLMIS enhancement to ensure proper end to end visibility of supply chain data with interoperability of Supply Chain Management systems through the implementation of NPC/PCMT	COP18	COP23
6.96	10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	and Diagnostic network optimization to reduce expiries and wastage of lab commodities and avoid	Lack of technical capacity	Lack of Financial Resources	Other	bundling for HIV lab commodities required to perform HIV related tests and laboratory diagnostics network optimization to ensure availability of laboratory supplies at the facility level to avoid disruptions of laboratory testing	COP19	COP23
6.39	Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities	Improved capacity of RMS to perform procurement functions for PEPFAR funded commodities	Lack of technical capacity	Lack of Financial Resources		improve its technical capabilities for efficient supply chain system for medicines by: 1) Strengthening RMS procurement capacity for HIV Commodities to include more PEPFAR supported commodities including TPT	COP20	COP23
9.17	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	Established Rwanda Medical Supplies Financial Strategy	Lack of Financial Resources	Lack of technical capacity		Develop longterm financial strategy for RMS to trengthen its long term financial position and sustainability as an independent firm.	COP22	COP25

If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued once all benchmarks have been achieved?
Revision of the existing guidelines will allow inclusion of new scientific evidences and program service delivery changes for the benefit of patient level outcomes including recency , pediatrics optimization and testing algorithms.	Ensuring availability of supplemental guidance for new initiatives	Yes	Non updated existing HIV national guidelines and tools and used for HIV management	National HIV guideline and tools update completed, approved and used	Updated guideline approved and in place	Yes
Ensuring quality implementation of ART optimized regimen, PrEP , enhancing CBS platform to improve patient level outcome and TB prevention and treatment are important pillars of direct service delivery to PLHIV and will be maintained in following implementation years to achieve quality of life of PLHIV. Scale up to some of the program elements (TPT, 6 MMD) is underoing but will	Scaling up of 6MMD, TPT at national level . enhancing utilization of CBS data to improve retetion and viral load suppression	Partial	Prevention and treatment (program minimum requirements,HIV case finding ,PMTCT) implemented	Completion of scale up of program minimum requirement interventions and ensuring program (prevention and treatment) maintenance through CQI	National level coverage for 6 MMD, TPT and Peds optimization. performance of cascade indicators. CBS longtudinal data is utilized to inform the program performance and improvement.	Yes
There is still need for technical capacity building to support and oversee HIV and other disease out breaks to enhance diease control at national and sub-regional levels	supporting existing cohort of students and enrollment of other cadres	Yes	Competency training continues	Cohort of COP 21 graduates and New enrolles in FETP supported to complete competency training	Students graduate and presents end of course theses for certification	Yes
VMMC is a proven biomedical prevention intervention for HIV and will be continues to limit new infection in the targeted age group	Training of TOTs, Mentorship at district hospitals to equip mentors with knowledge to support health centres in implementation	Yes	Continue program implentation	Prepare policy environment for shang-ring intervention methods for VMMC	Tools including surveillance platform to support shang-ring implementation in place	Yes
Supports routine clinical care, program monitoring and HIV case based surveillance	Enhanced system functionality, including MMD, index testing, adverse event tracking	Partial	A functional CBS digital platform implemented on OpenMRS ver. 2.3 deployed at all PEPFAR sites.	Software maintenance of the CBS digital platform and ongoing support at all PEPFAR sites.	Fully functional CBS digital platform at all 192 PEPFAR supported sites. Functional EMR with up to date	
Supports routine clinical care, program monitoring and HIV case based surveillance	Development and testing of the health information platform for HIV case based surveillance	Partial	Key components of the RHIE critical for HIV care and case based surveillance developed, tested and are functional.	Ongoing maintenance of the RHIE components, including the middleware (OpenHIM) and key components to optimize	Number of functional components (EMR, LIS, DHIS-2/RHMIS and registries) functional.	
Supports routine clinical care, program monitoring and HIV case based surveillance	Infrasrtucture improvement and rental of cloud space. client registry has been developed and has been tested for patient registration.	Partial	Ongoing recurring maintenance costs for renting cloud space through RISA and Internet connectivity to support data hosting for HIV care. Replacement and maintenance of	Continue providing infrastructure support for data management (clinical care, surveillance and reporting).	Functional infrastructure (including computers, connectivity and cloud space) to support HIV data management.	
As Rwanda has reached epidemic control, recency and CBS data are critical in understanding the sources of recent infections through cluster investigation. Other prevention programs are also	Collection, analysis and use of recency and CBS data to inform prevention and treatment programs.	Yes	Ongoing support for collection, analysis and use of recency and CBS data to inform prevention and treatment programs.	Ongoing support for collection, analysis and use of recency and CBS data to inform prevention and treatment programs at provincial,	Number of PEPFAR sites using CBS/Recency data to inform their programs.	
A few facilities still fail to achieve their targets or submit poor quality data. Data use at facility and district levels need enhancement to improve target achievement and quality of programs.	Collection, processing and use of M&E data at national level. Inconsistent data quality assessment	Partial	Ongoing support for collection, processing and use of M&E data at national level, including routine DQA and data reviews at provincial and district levels	Sustained epidemic control through ongoing support for collection, processing and use of M&E data at national level, including routine DQA	Number DQA and data reviews conducted. Data quality metrics such as data	
Need to maintain the the systems that support information exchange between the EMR, LIS and DHIS	health information exchange system developed and tested.	Partial	Functional automated exchange of MER indicators from EMR/LIS to DHIS-2/RHMIS.	Maintained infrastructure and software for MER data exchange between EMR/LIS and DHIS-2/RHMIS and DATIM	Proportion of MER indicators exchanged between EMR/LIS and DHIS-2/RHMIS.	
This is a more cost-effective and sustainable approach to HIV drug resistance monitoring, including DTG	Protocol has been developed and should be implemented in FY22	Partial	Data collection continued	HIVDR data collcted and data made available for program use		Yes
N/A	This is a new activity and will be conducted based on an amended protocol.	Not applicable	Planning, protocol drafting	IBBSS among FSWs completed and data made available	Findings of the IBBS among FSWs available and is used to inform programs.	No

Skills transfer has been slowed down by staff changes at the RBC. Capacity building ongoing for new staff. Training and mentorship also cascaded to regional and district levels	Analysis and use of recency and cbs data. Intuitive dashboard developed and used routinely.	Partial	Ongoing data management for HIV CBS and recency	CBS implementation continued and data made available for HIV surveillance and program planning	Proportion of PEPFAR sites using HIV CBS and recency data for program improment	Yes
N/A	This is a new activity.	Not applicable	Lack of data on barriers to KP services	Protocol clearance, data collected	Assessment completed and results disseminated and are used to inform KP services	No
TA to local partners had a late start but the skills transfer to local partners should phase out gradually.	Initial stages of adaptation of software artifacts and application of open standards in health information exchange.	Partial	Standardized software artifacts developed by global partners partially adapted for Rwanda to support HIE (including customization and testing).	Complete adaptation of software artifacts to support health information exchange for HIV care and case based surveillance.	Functional health information exchange which implements global standards applied across PEPFAR countries.	No
new activity	N/A	Not applicable	Two local CSOs will be receiving USAID direct funding for the first time starting COP22	IPs able to report program indicators using the electronic systems	Monthly, quarterly, and annual reports on the activities	Yes
The optimization of specimen referral and sample transportation system involves among others, establishment of tools to capture and help monitor performance of sample transportation	NRL operating an optimized sample referral and transport systems in the lab network for VL/EID testing. Over 95% of health facilities have access	Partial	The national sample referral network still operating through a centralized sample transportation system, revision of the system underway although COVID-19 has impacted to	The national sample referral network operates through a decentralized sample transportation and equitably accessible system resulting into	1. The turnaround time for: HIV VL: Less than a week EID, TB and CD4: Less than a day 3. HIV VL coverage: >95%	Yes
New activity	None	Not applicable	There is no established framework to monitor and evaluate current diagnostic network to continually identify opportunities for optimization	Define, collect, analyze and regularly act on performance indicators for the optimized diagnostic network and sample referral system	Increased number of stakeholders/ resources supporting the lab infrastructure; Length of testing downtime reduced; Increased HIV VL	Yes
The maintenance and certification of biosafety cabinets and ancillary equipments is a life-long activity. There is no alternative funding for this critical activity that is meant to protect personnel,	100% maintained, certified/ calibrated and functional equipment at all specialized testing facilities including VL hubs	Yes	100% maintained, certified/ calibrated and functional equipment at all specialized testing facilities including VL hubs	100% maintained, certified/ calibrated and functional equipment at all specialized testing facilities including VL hubs	Proportion of timely maintained and certified/ calibrated lab equipment	Yes
To maintain/ upgrades of the integrated LIS and its interoperability with other e-health systems for delivery of lab services and monitor patient care and treatment, national HIV surveillance and	Functional integrated LIS interconnected with OpenMRS/ OpenHIM (DHIS2) utilized by all health facilities for high quality HIV	Partial	Integrated LIS assessment ongoing in COP21 and human resource capacity building efforts in place, LIS interfaced with high throughput testing instuments for HIV/TB tetsing and	Integrated LIS assessment completed with skilled team of human resources at the MOH/NRL and use cases of LIS interconnected with	Functional eLab systems installed at NRL and utilized by Health facilities for VL and Recency testing service delivery and HIV quality assurance	Yes
To maintain the integrated data management system and visibility for monitoring performance quality of lab service delivery and bring efficiences in implementation of HIV/TB testing continuous	Data visibility on the quality of lab service delivery performance and results of CQI interventions conducted at testing sites in the lab	Not applicable	Siloed databases for lab testing and CQI application data with no existing national repository and key performance/ quality indicators	NRL and other testing sites with access to functional national lab data repository and integrated data management system for visibility of	Established national lab data repository for integrated data management and visibity of key performance and quality indicators	Yes
The NRL is still building their financial and technical capacity to implement national PT programs	0.6	Partial	60% (testers and sites) reached per annum	80% (testers) and 100% (sites) reached by PTCQI programs supported by the national lab level	NRL is able to produce, distribute and provide feedback to 80% testers and monitor the quality of HIV testing at all (100%) PEPFAR	Yes
Routine site monitoring and mentorship activities are important to help identify and adress gaps in quality of HIV,VL, EID, CD4 and TB testing	60%	Partial	60% sites have structured quality improvement and quality management system in place	100% (sites) assessed for quality of testing and quality improvement and management mechanism in place supported by national and sub-	NRL collects and analyses HIV/RT, CD4, VL, EID, TB quality testing data from all (100%) PEPFAR supported HFs using standard tools on annual	Yes
To maintain the integrated data management system and visibility for monitoring performance quality of lab service delivery and bring efficiences in implementation of HIV/TB testing continuous	Data visibility on the quality of lab service delivery performance and results of CQI interventions conducted at testing sites in the lab	Not applicable	Siloed databases for lab testing and CQI application data with no existing national repository and key performance/ quality indicators	NRL and other testing sites with access to functional national lab data repository and integrated data management system for visibility of	Established national lab data repository for integrated data management and visibity of key performance and quality indicators	No
Skills transfer has been slowed down by staff changes at the RBC. Capacity building ongoing for new staff. Training and mentorship also cascaded to regional and district levels	Analysis and use of recency and cbs data. Intuitive dashboard developed and used routinely.	Partial	Ongoing data management for HIV CBS and recency	CBS implementation continued and data made available for HIV surveillance and program planning	Proportion of PEPFAR sites using HIV CBS and recency data for program improment	Yes
Maintenance, continued insitutionalizatio, develope	eLearning and telementorship infrast	Partial	eLearning and eMentorship system established	eLearning modules and telementorship structures established	Maintenance and new modules developed, uploaded and uptake tracked.	Yes
Maintenance and continued insitutionalization of d	Digital CQI and clinical mentorship str	Yes	Digital CQI and clinical mentorship not integrated and effectively insitutionalized	Digital CQI and clinical mentorship not integrated and effectively insitutionalized	Digital CQI institutionalized and integrated with clinical mentorship structures	Yes
supporting Rwanda FDA to strengthen pharmacovigilance and patient safety monitoring with developed PV implementation plan, customized an online Pharmacovigilance	In PVIMS 2) Started the enrollemnets of clients in the DTG based regimen active surveillance	Partial	Manual (MTC) manual and SOP 2) Started the enrollemnets of clients in the DTG based regimen active surveillance 3) Completed Theurapeutic Committees	committees (MTC) at districts hospitals with trained members 2) Report on the findings for DTG -	or Event (ADR/E) reported to Rwanda FDA 2) Number of MTCs members trained	No

supporting Rwanda FDA to strengthen products registration and market authorization with capacity building of Rwanda FDA dossiers assessors in medicines registration and evaluation,	Building training on medicines registration dossiers evaluation and assessment 2) Created E-Learning platform and	Partial	fully operational Integrated regulatory Management information system (IRIMS) up and running 2)Reduced registration period of Medicines	2) Trained at least 50 IRIMS internal users from RFDA and 100 external users registration and evaluation	12 Months 2) 10 IRIMS modules up and running 3) number of External stakeholders training on the use of IRIMS	Yes
From 2019 to 2021, GHSC-PSM has been providing technical assistance to supporting Rwanda in the implementation of ART optimization with increased transition uptake of TLD, Transitioning	2) Continue Scale-up of TPT to all eligible clients 3) Scale-up of PrEP to all eligible clients in need	Partial	2) Increased cale-up of TPT to all eligible clients 3) Inceased Scale-up of PrEP to all eligible clients in need	legacy ARVs 2) 75% of eligible CLHIV on Pediatric DTG 3) 3MMD and 6MMD to the target	HIV patients on TLD 2) Proportion of eligible patients on 6 MMD 3)Number of districts scaled up TPT	Yes
of Rwanda to strengthen the supply data quality across all levels with improved accuracy in reporting and increased utilization of eLMIS. Despite the efforts, in COP20, supply chain data	(reporting) rate is 96% across the key functions of the system 2) Validation of Supply chain digital	No	approved 2) The NPC implemented and integrated with other systems 3)Increase level of ELMIS utilization to all	strategy and architecture 2) Integrate National Product Catalog products identifications (product description, GTINs, country	logistics data for program decision making, 2) Availability and use of dashboard for logistics management	Yes
historically, been quantified and delivered separately, even though a set of commodities at health facilities is required to perform tests, therefore putting the other commodities at the	technician across the country 2) Lab bundlings applied from procurement to distribution at RMS Leve	Partial	commodities from the central medical stores to service delivery points with 70% of laboratory supplies distributed to the health facilities in bundles	of lab commodities from the central medical stores to service delivery points with 80% of laboratory supplies distributed to the health	tools used by SDPs 2) All procurement, storage units and SDPs implement lab bundling 3) Lab reagent/supplies availability	Yes
capacity to manage PEPFAR Funds with efficiency. GHSC-PSM has been providing TA to RMS Ltd to strengthen their capacity to manage PEPFAR funds and conduct procurement, warehousing, and	developed and validated, 2) Procurement manual, Capacity building plan was developed and approved.	Partial	professional certification training 2) RMS QA and Procurement manuals and SOPs developed and validated 3) started the activity-based costing to track	monitoring metrics 2) Developed key supply chain performance indicators 3)Implementation of Global	1) % of PEPFAR supported commodities delivered on time 2) Number RMS Staff trained and received Professional certificate	Yes
N/A	N/A			RMS financial strategy document developed	Developed RMS Financial strategic plan	

SRE:

SRE Tool-SoSR (Entry of Surveillance, Surveys, and Research Activities)

Users need to complete this table for all surveillance, surveys, and research activities that will be either partially or fully funded (outlays projected) during the COP22 implementation period. All above-site activities should be generated in columns A-I below, and users can surveillance and research activities. Only these activities need information supplied in columns J-AJ. If an ongoing SRE activity does not appear in this list, please make sure that it has been entered in the FAST and in Tab 2 Table 6-E before continuing.

Funding Agency	Mech Name	Prime Partner	Mech ID	COP22 Program Area	COP22 Beneficiary	COP22 Activity Budget	Activity Description	Filter Here - Select Surveillance and Research	Activity Type
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	81872	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	$ 131,168	Support data management, analytics, visualization and use of the HIV recency and case-based surveillance data for program improvement and public health response.	Surveillance	HIV case surveillance
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	81872	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	$ 71,434	Integrate and use routine VL data for HIV-DR surveillance per CADRE approach	Surveillance	HIV drug resistance surveillance
HHS/CDC	GOVERNMENT OF RWANDA	Implementing Technical and Science Support Services (TSSS) in the Republic of Rwanda under PEPFAR	81872	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	$ 3,000	Protocol development for FSW/IBBS	Surveillance	Bio-behavioral survey (BBS)
HHS/CDC	Trustees Of Columbia University In The City Of New York	Recency HQ Mechanism - ICAP	81871	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	$ 232,400	Provide technical assistance and capacity building to RBC/MOH on HIV CBS and Recency data management, analysis, visualization and use for program improvement and public health response	Surveillance	HIV case surveillance
HHS/CDC	Trustees Of Columbia University In The City Of New York	Enhancing Sustainable and Integrated Health, Strategic Information and Lab Systems for Quality Comprehensive HIV Services through Technical Assistance to GoR under PEPFAR	160552	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	$ 75,000	Conduct a facility assessment to identify structural barriers to access to KP services.	Surveillance	Other

filter using column I for

Country	Activity Title	Primary evaluation or study questions	Activity objectives	Activity's primary study population	Additional populations studied
Rwanda	Support Data management, analytics, visualization and use of HIV recency and Case based surveillance data for program impovement and public health respsonce	Implementation of an operational HIV surveillance system that can help identify index cases and generate routine surveillance data	• Develop and implement ACF strategy for HIV, and assess its effectiveness to identify PLHIV who do not know their HIV status in Rwanda • Identify and track sexual partner networks in the context of Rwanda , Develop and implement a HIV RCBS, with a deduplication system using unique patient identifier • To longitudinally track outcomes of newly diagnosed and existing PLHIV, from their 1st HIV positive result, linkage to and retention until death • Identify and track treatment outcomes of PLHIV including the following: VL, recency test results, Initial CD4 count, retention, ART adherence, OIs, VL suppression and death	PLHIV: Adults and children	
Rwanda	Cyclical Acquired HIV-Drug Resistance (CADRE) Surveillance in Rwanda	Estimate the prevalence of ADR among individuals who are not virally suppressed (VL ≥1000 copies/mL), overall and by age sub-groups.	• Estimate prevalence and describe the pattern of acquired HIVDR among patients with more than one high viral load (HVL) (two or more VL results showing VL ≥1000 copies/mL), • Estimate the prevalence of acquired HIVDR among patients failing second line ART, Identify risk factors for acquired HIVDR among patients who are not virally suppressed, • Identify the common HIVDR mutations among patient with unsuppressed VL (VL ≥1000 copies/mL)	PLHIV: Adults and children	None
Rwanda	Integrated Bihavioural and Biological surveillance among FSWs in rwanda 2023	To estimate the prevalence of HIV, STIs and Viral Hepatitis B & C (HBV &HCV) among FSWs in Rwanda	• Evaluate the evolution of sexual behavioral among FSW in Rwanda, • Assess risk factors associated with HIV, STIs and HBV & HCV among FSWs,	Kep pop: FSW	None
Rwanda	Provide technical support to RBC for recency, CBS implementation			PLGIV:All	None
Rwanda	Conduct a facility assesment to identify structural barriers to KP services	TBD	TBD	Key POP: All	None

Planned activity sample size	Planned sampling methodology	HIV biomarkers to be assessed as part of protocol	COP or HOP funded?	Activity Start COP/FY Year	Activity End COP/FY Year	Current Stage of activity (as of COP22)	COP22 Baseline Status (major)	COP22 Baseline Status (detail)
	N/A	N/A	COP	COP22/FY23	COP25/FY26	Ongoing	Data_collection	In progress
TBD	PPS- probability Proportion to Size	HIVDR testing (Genotyping), HIV VL	COP	COP21/FY22	COP24/FY25	Ongoing	Protocol_Scope	Under development
TBD	PPS- probability Proportion to Size		COP	COP22/FY23	COP22/FY23	Proposed in COP	Protocol_Scope	Under development
NA	NA		COP	COP22/FY23	COP24/FY25	Ongoing	Data_collection	In progress
TBD	TBD		COP	COP22/FY23	COP22/FY23	Proposed in COP	Protocol_Scope	Not started

The final Excel workbook should be considered a part of the SDS and submitted at the same time.

APPENDIX D– Minimum Program Requirements

This should be addressed in narrative in the sections above however in this section succinctly note if the program is meeting or not meeting the minimum program requirement. Address assessment of MPRs by SNU and by proportion of sites meeting standards, as applicable. The minimum requirements for continued PEPFAR support include:

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	Completed
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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	In-process
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	In-process
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	In-process
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.	Completed
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 should be offered testing for HIV.	Completed
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)	In-process
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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Completed
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	In-process
10) 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	Completed

and routine clinical services affecting access to HIV testing and treatment and prevention.	
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	Completed at all PEPFAR supported sites
12) Evidence of treatment literacy 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.	Completed
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	Completed
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	In-process
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Completed
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	In-process

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

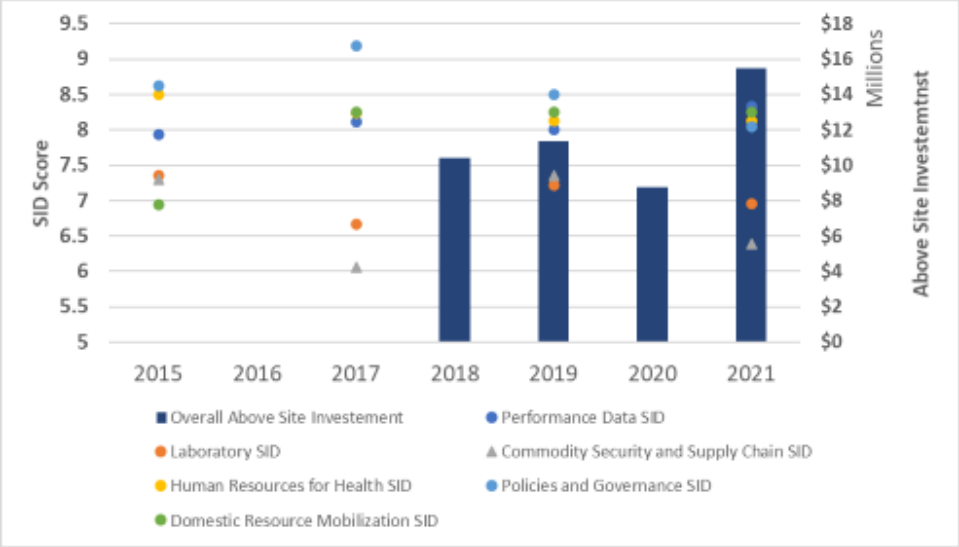
PEPFAR and the Government of Rwanda work hand in hand in the HIV response. The Ministry of Health provides guidance and leadership to all partners working in the HIV space. With strategic investments and systems support, Rwanda will further strengthen its position as a leader in the HIV space. However, government ownership to lead the HIV response does not equate to domestic resources available to support all aspects of the current HIV program.

1. Misalignments between Investments and Outcomes

PEPFAR Rwanda continues to balance investments between direct service delivery and above site investments. For direct service delivery, the Ministry of Health has divided facilities between PEPFAR and Global Fund. Due the PEPFAR's in country presence and oversight, PEPFAR manages the majority of the high-volume sites. Above site investments are aligned with Global fund to ensure no funding is duplicative.

- ***Program Expenditures vs. SID Score Trends and Responsibility Ratings:***
  Trends in systems-related (above site programs) expenditures will be compared with changes in relevant SID scores to demonstrate where cumulative investments in these areas may have contributed to improvements in SID scores over time.

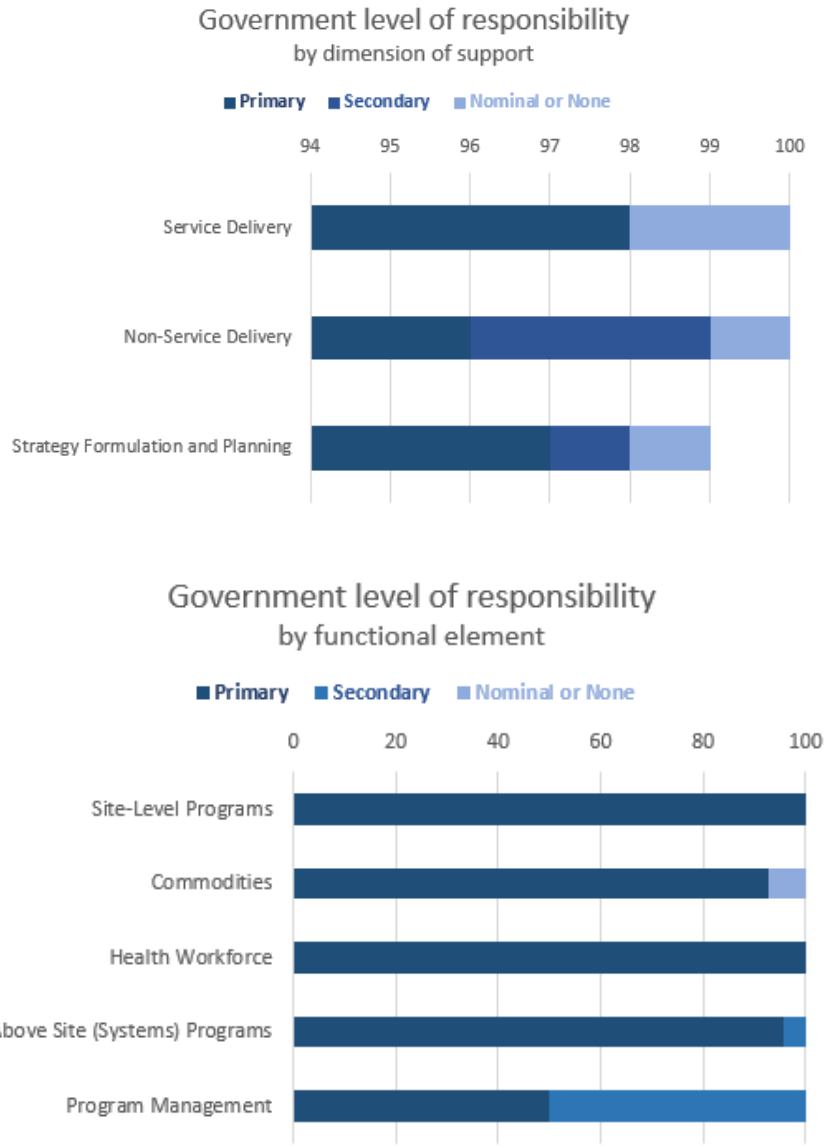
Figure E.1.1. Trends in Investments and SID Scores for System-Related Elements



Responsibility Matrix ratings will also be presented to show the degree of functional responsibility that each major funder (i.e., Partner Government, Private Sector, PEPFAR, or Global Fund) has for

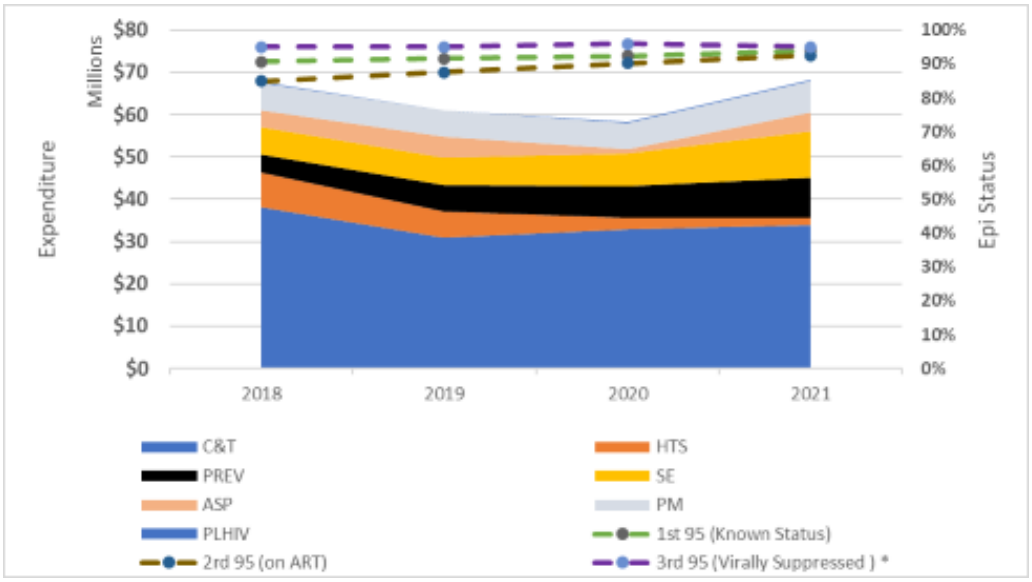
each investment area, and where there may be opportunities to transition to greater domestic responsibility.

Figure E.1.2. Percent Primary Responsibility Ratings from Responsibility Matrix



- ***Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:***

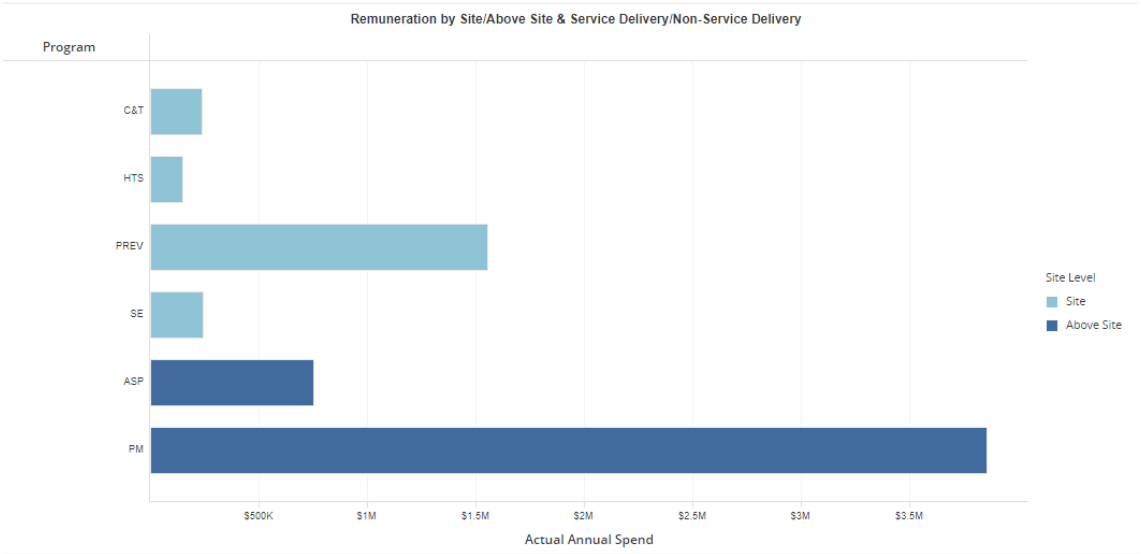
Figure E.1.3. Assessing Country X's PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status



*Viral Suppression data from PEPFAR program covering 60% of ART Cohort in Rwanda. VS Rate computed from those tested for viral load, not represent of the PLHIV Population

- ***HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:***

Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



Note – PEPFAR Rwanda's two largest implementing partners were unable to upload their HRH data, therefore not reflected in the above table

2. Areas for Transition

The PEPFAR country team and Ministry of Health will work to prioritize areas of transition. Rwanda will use the time between the close of COP22 planning and COP23 PLL to prioritize areas of investment for PEPFAR and transitions. Currently, over 90% of PEPFAR Rwanda's implementing partners are local and indigenous organizations, this includes the commodities

partner Rwanda Medical Supply, Ltd. PEPFAR Rwanda is interested in learning from the six evolve countries and adapting innovative ideas to the Rwanda context.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

The Ministry of Health is not only leading the HIV response in Rwanda but is PEPFAR Rwanda's largest implementing partner. Through CDC, the Ministry of Health and Rwanda Biomedical Center account for 30% of the OU budget. PEPFAR engages at the leadership level and co-chairs the national technical working groups.

Beyond government engagement, agency leads take active roles in coordinating with partners and civil society. The USAID Health Office Director is the chair of the Health Development Partners Working Group and chairs monthly meetings with partners across the health space. The PEPFAR Coordinator serves as the USG representative on the Global Fund Country Coordinating Mechanism. In addition, the coordinator serves on the oversight committee.

PEPFAR and UNAIDS meet regularly to ensure an open line of communications between the institutions and host quarterly meetings with civil society.

Agencies meet regularly with their partners to review performance and provide feedback. PEPFAR hosts meetings to orient partners on new initiatives, COP planning and achievements throughout the year.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

PEPFAR Rwanda is supporting the Ministry of Health and Rwandan Biomedical Center in generating, analyzing, and using high-quality public health data. As Rwanda reached epidemic control, robust public health data are needed to sustain the epidemic control. Robust data in terms of the variety (surveillance, survey/research, and routine health service) and depth (patient-level or aggregate). A very good example is the emerging need to explore HIV recent infection surveillance for picking hotspots and responding with appropriate public health intervention.

The team is generating key population integrated bio-behavioral data. The team has also implemented HIV recent infection surveillance, generating critical data on recent infections and other variables. The routine health information data is continuously monitored to evaluate the performance of the program.

To help facilitate proper handling of all public health data and ensure its timely use for the intended public health actions, PEPFAR Rwanda and the Ministry of Health have agreed on a set

of procedures and rules in data sharing and use. This agreement was signed in 2019, and covers procedures in data request and acquisitions, identifying and ensuring data quality, and ensuring data security and integrity. The Data Sharing agreement covers the smooth exchange of data from all sites, irrespective of status of PEPFAR support to the sites.

Rwanda has contextually used the central support reporting option to collect and report non-PEPFAR supported HIV test positive data from PEPFAR supported sites. This approach is appropriate as the team triangulates and uses routine data with Recent HIV infection surveillance data.