Rwanda

Country Operational Plan

(COP/ROP) 2023

Strategic Direction Summary

05/31/2023

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Acronyms and Abbreviations

Acronym	Definition
AGYW	Adolescent Girls Young Women
AHC	Alliance for Healthy Communities
AHD	Advanced HIV Disease
AMA	African Medicine Agency
AP3	Accelerating Progress in Pediatric HIV and PMTCT
CAD	Computer-Aided Detection
CALHIV	Children Adolescents Living with HIV
CBIM	Coaching Boys into Men
CBS	Case Based Surveillance
CDC	US Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CLM	Community Led Monitoring
CoAg	Cooperative Agreement
CODB	Cost of Doing Business
COP	Country Operational Plan
CPDS	coordinated procurement and distribution system
CPM	COP Planning Meeting
CQI	Continuous Quality Improvement
CRP	C-Reactive Protein
CRVS	Civil Registration and Vital Statistics
CSCS	Capital Security Cost Share
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DH	District Hospital
DHS	Demographic Health Survey
DNO	Diagnostic Network Optimization
DQA	Data Quality Assessment
DREAMS	Determined Resilient Empowered AIDS-Free Mentored and Safe
DSD	Differentiated service delivery
DTG	Dolutegravir
ECD	Early Childhood Development
ECHO	Extension for Community Healthcare Outcome

eCMS	electronic Case Management System
EID	Early Infant Diagnosis
eLMIS	electronic Logistic Management System
EMR	Electronic Medical Record
ERP	Enterprise Resource Planning
FETP	Field Epidemiology Training Program
FMP	Families Matter Program
FP	Family Planning
FSW	Female Sex Workers
G2G	Government to Government
GBV	Gender Based Violence
GF	Global Fund
GOR	Government of Rwanda
HCP	Health Care Providers
HCW	Health Care Workers
HIE	Health Information Exchange
HIS	Health Information System
HMIS	Health management Information System
HPV	Human Papilloma Virus
HR	Human Resources
HRH	Human Resources for Health
HTS	HIV Testing Services
IBBS	Integrated Biological-Behavioral Surveys
ICAP	International Center for AIDS Care and Treatment Program
ICRP	Integrated Child Rights Policy
IEC	Information Education Communication
IP	Implementing Partner
IPV	Intimate Partner Violence
ITT	Interagency Technical Team
KP	Key Population
KPI	Key Performance Indicator
LF-LAM	Lateral Flow Urine Lipoarabinomannan
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer
LMIS	Laboratory Management Information System
LOE	Level of Effort
MER	Monitoring And Evaluation Report

MFI	Microfinance Institution
MIGEPROF	Ministry of Gender and Family Promotion
MINEDUC	Ministry of Education
MIS	Management Information System
MMD	Multi Month Dispensing
MOD	Ministry of Defense
MOH	Ministry of Health
MOU	Memorandum of Understanding
MPR	Minimum Program Requirements
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
mWRD	Molecular WHO-recommended Rapid Diagnostic tests
NAPHS	National Action Plans for Health Security
NCD	Non Communicable Diseases
NCDA	National Child Development Agency
NIDA	National ID Agency
NPC	National Product Catalog
NPHI	National Public Health Institute
NRL	National Reference Laboratory
NSP	National Strategic Plan
NTP	National TB Program
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAW	PEPFAR Analytics Workspaces
PBFW	Prevention for Breastfeeding Women
PCO	PEPFAR Coordinating Office
PE	Peer Educator
PMTCT	Prevention of Mother To Child Transmission
POC	Point of Care
PP	Priority Population
PrEP	Pre Exposure Prophylaxis
PSE	Population Size Estimates
PT	Proficiency Testing
QA	Quality Assessment / Assurance
QAT	Quantification and Analytics Tool
QC	Quality Control

QI	Quality Improvement
QM	Quality Management
QMIA	Quality Management Improvement Approach
RCE-VIHSCM	Regional Centre of Excellence for Vaccines, Immunization and Health Supply Chain Management
RDF	Rwanda Defense Force
RDTS	Rwanda DREAMS Tracking System
RFDA	Rwanda Food and Drugs Authority
RHIES	Rwanda Health Information Exchange System
RHMIS	Rwanda Health Management Information Systems
RMS	Rwanda Medical Supply
RPHIA	Rwanda Population-Based HIV Impact Assessment
RRP+	Rwanda Network of People Living with HIV
SDC	Sero Discordant Couples
SDS	Strategic Direction Summary
SFH	Society for Family Health
SI	Strategic Information
SID	Sustainable Index Dashboard
SIMS	Site Improvement Through Monitoring System
SNS	Social Network Strategy
SNU	Sub National Unit
SOP	Standard Of Practice
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRS	Specimen Referral System
STI	Sexually Transmitted Infections
TAP	Technical Assistance Platform
TAT	Turn-Around Time
TG	Transgender
TLD	Tenofovir/Lamivudine/Dolutegravir
TLE	tenofovir/lamivudine/efavirenz
TPT	TB Preventive Therapy
TRACE	Tracking with Recency Assays to Control the Epidemic
TVET	Technical and Vocational Education and Training
UNMHSC	University of New Mexico Health Sciences Center
UPID	Unique Patient Identifier

USDH	U.S. Direct Hire
USG	United States Government
VAC	Violence Against Children
VCT	Voluntary Counseling Testing
VHF	Viral Hemorrhagic Fevers
VL	Viral Load
VMI	Vendor-Managed Inventory models
VMMC	Voluntary Male Medical Circumcision
WASH	Water, Sanitation, and Hygiene

Vision, Goal Statement and Executive Summary of PEPFAR's Investments and Activities in Support of the COP/ROP Plan

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 (COP) for 2023 (FY23/24). This year's COP has been set for 2 fiscal year targets; the second year will follow the review of year 1 achievements. PEPFAR's 5-year strategic plan to end HIV as a global health threat by 2030 was used as direction in the development of this year's country operation plan.

In COP23, the PEPFAR Rwanda Program will work alongside the Rwandan government, CSOs to keep the momentum and sustain epidemic control. The updates to the 2023 EPP Spectrum model suggest Rwanda is on track to achieve epidemic control in 2023. COP23 focuses on achieving health equity for adolescent girls and young women (AGYW), children, and key populations, on building robust public health and security systems, and on laying the groundwork for a country-led, sustainable HIV response. Teams used programmatic data, national data, the Rwanda 2022 census data and 2023 EPP spectrum estimates to build COP23 targets and areas of focus.

The PEPFAR Rwanda program aligns with the 5x3 PEPFAR strategic plan by maintaining the highest yield strategies and by initiating new activities that sustain gains in the HIV response. PEPFAR priorities in COP23 include improving the cascade for Key Populations (KP) building capacity for appropriate and friendly person-centered services, enhancing case finding among KPs and children, and expanding prevention for AGYW and KPs. PEPFAR will continue to support prevention services targeting at-risk and under-served populations of adolescent girls and young women through the Determined Resilient Empowered AIDS-Free Mentored and Safe (DREAMS) and the Orphans and Vulnerable Children (OVC) platforms. Advances in prevention will also be made by increasing voluntary medical male circumcision (VMMC) coverage, scaling up pre-exposure prophylaxis (PrEP) services for AGYW and KPs, and by closing remaining gaps in Prevention of Mother to Child Transmission (PMTCT). PEPFAR will also invest in improved HIV treatment, drug adherence, enhanced retention, and in re-engaging in care those most likely t to have challenges such as C/ALHIV, KPs. PEPFAR will also continue to invest in improving TB screening, diagnosis and treatment completion among PLHIV and TB; leveraging OVC platforms to provide socio-economic support services for most vulnerable children and adolescents including hard to reach and supporting OVC enrollment and retention in school. PEPFAR will

work with MoH and RBC to incorporate NCDs into the standard of care for PLHIV. In alignment with the fourth pillar, the program will also engage multi-sectoral collaboration (line Ministries) to improve C/ALHIV access and utilization of HIV services at school, and to ensure person-centered quality services through differentiated care models.

PEPFAR Rwanda will continue to focus on strategic investment which build the capacity of local entities and continues to focus on sustainability. Over 90% of PEPFAR investments, including commodities, are with local and indigenous organizations. Laboratory and supply chain investments are essential elements to reinforcing health systems and ensuring health security. The program will implement quality improvement and management systems of laboratory network, support biosafety, biosecurity, and laboratory waste management, enhance and integrate Laboratory Information Management System (LIMS). To support supply chain initiatives, PEPFAR will work to transform and capacitate national supply chains, Rwanda Medical Supply (RMS), as part of sustainability inputs PEPFAR will collaborate with development partners to align & leverage resources on warehouse improvement and Enterprise Resource Planning (ERP) tool for RMS and to address the commodity needs mainly for prevention and laboratory matters.

In addition to laboratory and supply chain information systems, PEPFAR investments in COP23 reflect support to direct service delivery, central and site-level systems to bolster the MOH's public health system and workforce capacity to sustain HIV epidemic control. These include patient level data systems (Electronic Medical Record [EMR] and Health Information Exchange [HIE]), integration of community and facility information systems, improving quality of data for increased availability and use (KP, PP, backlog of data entry); development of standardized tools, Data Quality Assessments (DQAs) and indicators. In addition, PEPFAR will align the OVC electronic Case Management System (eCMS) with the National Child Development Agency (NCDA) and Child Protection Management Information System (MIS). 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. See Table 1.

Table 1 95-95-95 Cascade

Table 1.1 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression*										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to Antiretroviral Therapy (ART) Within the Last Year**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV Diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	13,487,218	1.76%	235,272	218,981	215,246	91%	97%	1,547,185	11,768	10,403
Population <15 years	5,143,346	0.17%	7,851	5,250	5,298	67%	96%	44,140	385	361
Men 15-24 years	1,376,051	0.50%	6,716	5,532	5,455	81%	96%	118,109	374	340
Men 25+ years	2,624,748	2.95%	76,826	72,710	71,094	93%	97%	281,350	3,750	3,473
Women 15-24 years	1,383,528	0.82%	10,667	9,190	10,002	94%	96%	266,009	1,886	1,687
Women 25+ years	2,959,545	4.48%	133,212	126,299	123,397	93%	97%	837,577	5,373	4,542
MSM	18,100	6.87%	1,243	NA	NA	NA	NA	NA	NA	*NA*
FSW	37,646	35.50%	13,364	NA	NA	NA	NA	NA	NA	*NA*

*Data from Rwanda Health Information Management System, December 2022, used for HIV testing and Linkage to ART part of the table. All other data are from EPP/Spectrum and Naomi Model Outputs used in COP2023 Target Setting Tool.

Estimates for testing, treatment, ART continuity, and viral suppression for key and priority population groups (below grey line) should only be included if reliable data exists (cite source). This table can be found in the SDS chapter of the COP23 Target Setting Tool dossier in PEPFAR Analytics Workspaces (PAW) using estimates derived from the target setting tool. This table should be updated with national data where available. See Figure 1.1 and Table 1.2.

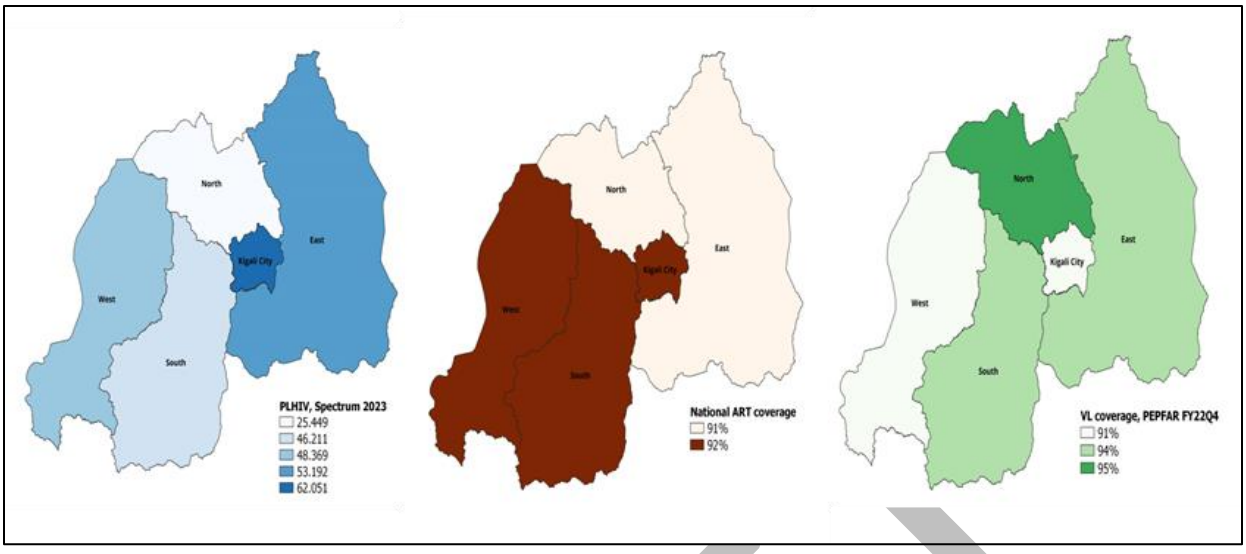


Figure 1 People Living with HIV (PLHIV), Treatment Coverage, and Viral Load Monitoring Coverage, Rwanda, December 2022.

Table 2 Current Status of ART Saturation

Table 1.2 Current Status of ART Saturation				
Prioritization Area /SNU1	**Estimated Total Number of PLHIV by Province for COP23**	**# Current on ART (December 2022)**	**# of SNU COP22 (FY23)**	**# of SNU COP23 (FY24)**
Attained	**235,272**	**215,246**	**5**	**5**
Kigali City	**62,051**	56,809	1	1
East	**53,192**	48,430	1	1
South	**46,211**	42,443	1	1
West	**48,369**	44,396	1	1
North	**25,449**	23,168	1	1
Total National	**235,272**	**215,246**	**5**	**5**

Pillar 1: Health Equity for Priority Populations

This section addresses the United States Government (USG) plan for COP23 including strategic direction, program shifts, and alignment of resources for PEPFAR within the context of the national HIV response as it relates to Pillar 1 for Rwanda.

Plan to Close Gaps in the Pediatric Cascade

Rwanda has made tremendous achievements in the HIV response and is on a strong trajectory to achieve UNAIDS 2030 milestone of achieving the three 95's. Despite high ART coverage for adults, gaps persist for children. Both program data and spectrum estimates indicate that Rwanda has achieved the 2nd and 3rd 95 for all populations with a remaining gap in the first 95 for children less than age 15. UNAIDS 2023 spectrum estimates that 7,851 children less than age15 are living with HIV in Rwanda of whom only 5,296 are on ART. Program data indicates high linkage to ART rates of 98% for all children and adults, but disparities are observed in VL coverage and suppression for children. PEPFAR FY23 Q1 results show an overall 98% VL suppression for adults (age 15+) in all provinces compared to 94% VLS for children. This is an improvement from 90% in the last three years which likely is attributable to optimized ART regimens (about 97% CLHIV are on Dolutegravir [DGT] based regimens) which are improving treatment adherence and reducing treatment failure. VL coverage results follow the same trends with significant variation observed in FY23 Q1 of 88% for children and 92% for adults. Nevertheless, gaps remain in HIV awareness among children and adolescents requiring stronger case findings to bridge the gap and ensure linkage, and maintenance, to treatment.

In COP23, PEPFAR will support enhanced case finding approaches in all districts while targeting districts and communities with high reported new HIV positive cases. This new case finding approach aligns with priorities under pillars 1 and 2 and leads with data to review and address program gaps. Based on recency data, Eastern and Western provinces will be prioritized while Kigali will continue to be monitored as an epicenter of HIV infections. Targeted case finding activities will include: 1) active family testing at all facilities including inventory of all parents whose children <15 do not know their status and will be counselled for HIV testing, 2) index testing where partners and children will be reached and tested, 3) enhance post-partum testing to timely detect HIV sero-conversion and linkage to treatment, 4) testing offered to all children with unknown HIV status born from HIV positive female sex workers, and, 5) using case-based surveillance (CBS) and recency data to orient testing among clusters of new infection including children and adolescents. The active case finding component of the HIV case surveillance system will be used to enhance family testing by ensuring that all mothers with biological children <15 years have their children tested. This will be one of the strategies to reach undiagnosed children. The above strategies will be complemented by Lift Up funds warded to

Rwanda to re-enforce HIV case finding among living with HIV and link them to treatment as described bottom of this section.

Equity for HIV service provision in COP23 will be a priority for the PEPFAR team. While Rwanda is not an AP3 focused country - Accelerating Progress in Pediatric HIV and PMTCT (AP3), PEPFAR will support a multifaceted approach for pediatrics and adolescents along the HIV cascade targeting multiple pillars including skills development of the healthcare providers, strengthening monitoring and evaluation for pediatric and PMTCT services. This will be accomplished through regular routine data analysis to identify and address the gaps from Monitoring and Evaluation Report (MER) indicators and Site Improvement through Monitoring System (SIMS) results. PEPFAR will also provide technical assistance to the government and implementing partners to define custom indicators such as tracking pediatric optimization, TB prevention, enrollment in multi-month dispensing (MMD) and turnaround time for lab diagnostic and follow up test results including access to early infant diagnostics (EID) service, review quality of VL monitoring for barriers contributing to lower VL testing coverage as well as working with CSO involved in pediatrics and adolescent HIV response. PEPFAR will also leverage OVC resources to support socio-economic needs of subpopulations among children and adolescents such as those failing treatment and adolescent mothers and their HIV exposed infants while exploring practical approaches to mobilize, test and treat those hard to reach including street children. While younger children face challenges across all three 95's, older adolescents aged 15-19 face challenges regarding VLS. In COP23 implementation, PEPFAR will closely work with Rwanda Biomedical Center (RBC)/ MoH and implementing partners (IPs) to develop and harmonize HIV services for adolescents reflecting proven models of care including "Operation Triple Zero" with zero missed ARVs, zero missed appointments, and zero VL – an asset-based model that identifies strengths among adolescents and sees them as ingredients to the solution of their problems and co-producers as opposed to passive recipients while supporting the treatment cascade for all 95s. With this strategy, adolescents will gain more involvement, feel empowered and motivated and participate in activities meant for them led through adolescent peers/champions thereby creating a friendly environment for C/ALHIV and promotes sense of positive living including U=U. The strategy also embraces active participation of care givers promoting treatment literacy and improving adherence, and VL suppression.

Lift Up Funds: Closing Gaps Among CLHIV

Rwanda has successfully been awarded 1 million dollars onetime Lift Up equity funding to support new initiatives and surge HIV case finding to close CLHIV gap in targeted high burden areas in Kigali, Eastern and Western provinces of Rwanda. This activity aligns to pillar one PEPFAR strategy and leads with data and community engagement to close HIV case finding gaps among CLHIV and will be employed through two main components, A and B.

Component A will focus on identifying undiagnosed CLHIV 5-14 years born to PLHIV enrolled in the HIV care & treatment program at the Health Facility (HF) level and will implement the following strategies to improve case finding among CLHIV; 1) intensively engage HCPs to conduct chart reviews of PLHIV enrolled between 2009-2018 and generate an inventory of all biological and non-biological children listed by PLHIV accessing care mainly through care and treatment; 2) the HCPs will update the chart for those PLHIV who had children after enrollment in care; and 3) use PEs to track and bring to health facilities (HFs) all children identified through the inventory for HIV testing and linkage to treatment as found appropriate.

Component-B will focus on identifying undiagnosed CLHIV 5-14 years born to parents with unknown HIV status or undiagnosed Orphans and Vulnerable Children (OVC) at the community level utilizing CHW who are already engaged in implementing Maternal Child Health (MCH) and malaria activities at the community level, as well as linkage facilitators who work with the OVC and DREAMS program and civil society organizations working with FSW at the community level. Component B will employ the following strategies; 1) Utilizing CHW and linkage facilitators in high burden areas to identify high risk households with a) Children missing immunization clinics, b) Pregnant women not attending ANC clinics, c) undiagnosed OVC and malnourished children, d) Teen/AGYW mothers, e) Children looked after by their grandparent(s), f) offspring of FSW, and g) families who do not use the HFs at all, and to mobilize children in these households to get tested for HIV, and interviewing parents/guardians at HFs. 2) The CHW will coordinate with HFs to arrange the testing for children identified in community. By conducting testing at the HFs, linkage to treatment will be strengthened and same day ART initiation will be ensured.

This activity will have a positive programmatic impact by profiling the unmet need by person-place-time, closing the HIV testing, awareness, and case finding gaps and in turn mitigate morbidity and mortality in children. This activity will expand case-finding among CLHIV in the selected areas-populations and linkage to care will be facilitated for all newly identified CLHIV

Plan for Services for Pregnant and Breast-Feeding Women

Since 2004, Rwanda initiated PMTCT services including primary prevention (HIV prevention messaging), HIV testing for pregnant women at antenatal, labor and delivery, family planning (FP), lifelong optimized ART, ARV prophylaxis for HIV-exposed infants, and post-natal follow-up of mother-infant pairs until 24 months after delivery. With support of partners, the national PMTCT coverage has increased over time with 98% of health facilities currently offering PMTCT services. National data indicates that 99% of all pregnant women attending ANC get tested for HIV and all of them get test results with a positivity rate of 0.4%. The majority (98%) of HIV positive women in PMTCT are already on optimized ART and 99% of those newly diagnosed women are initiated on ART minimize risks of MTCT. The national HIV prevalence among

pregnant and breastfeeding women presenting at health facilities has decreased overtime from 2.78% in 2016 to 2.08% in 2021 owing to the reduction of new HIV infections.

High testing and ART coverage for PMTCT is also reported in PEPFAR support health facilities with 100% (testing and results received) and 99% ART for HIV positives respectively for FY23 Q1. 82% of all HIV positives pregnancies are already on ART treatment.

Despite high coverage for PMTCT at health facilities, population based PMTCT service gaps remain mostly among women not attending ANC at all, or who report at later stages of pregnancy posing the greatest risk of HIV transmission to their infants. Analysis of Health Management Information Systems (HMIS) data and spectrum estimates indicate the following are the main contributors of risk for MTCT during pregnancy and breastfeeding period: 1) women not receiving ART during pregnancy, or breastfeeding period, 2) women infected during breastfeeding, and 3) women dropping off ART during breastfeeding.

In COP23, PEPFAR will support the national program to close these gaps in line with PEPFAR strategy pillars1 and 2 and engaging community to ensure continuity of treatment and VL suppression through routine data reviews to identify subpopulations at risk along the PMTCT cascade, providing education focusing on pregnancy planning (HIV testing and timely ART initiation prior to conception) and ensuring VL suppression during pregnancy and breastfeeding periods. PEPFAR will continue to emphasize enhanced VL monitoring along the PMTCT cascade and implement strategies relevant to different populations especially young and newly diagnosed HIV positive women who may face HIV related challenges including stigma and discrimination and Intimate Partner Violence (IPV).

A one stop shop approach will be enhanced at all health facilities to facilitate integrated services delivery model and allowing pregnant and breastfeeding women and their infants to access services they need including maternal and newborn care. As much as possible, ANC and postnatal visits will be aligned with the ART pick-up schedule to minimize frequent and unnecessary clinical appointments. PEPFAR's support will also include community-based strategies and partners (civil society, Faith Based Organizations) and local leadership to reinforce knowledge on pregnancy intentions, safer pregnancy and benefits for early ANC attendance, facility deliveries, and PMTCT benefits.

Plan for Adolescents Girls and Young Women (AGYW) Services

AGYW aged 10–24 years remain highly susceptible to HIV acquisition. In Rwanda, AGYW are three times more likely to acquire HIV than adolescent boys and young men of the same age group. PEPFAR Rwanda is committed to a gender-equitable approach for HIV prevention targeting AGYW in meeting their unique needs through DREAMS. In COP23, through Rwanda's DREAMS program, PEPFAR will focus on the reduction of HIV incidence among AGYW with the

highest rates of new HIV infections according to national data. DREAMS will deliver a multi-sectoral, comprehensive package of evidence-based interventions to AGYW ages 10 - 24 at elevated risk of HIV infection. 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 districts, including three districts of Kigali (Gasabo, Kicukiro and Nyarugenge), Nyanza in the Southern province and Rwamagana in the Eastern province. These five districts were the top five high burden districts according to the Demographic Health Survey (DHS) 2015. Nyanza district has since dropped off the top ten high burden districts according to spectrum estimates with Bugesera district rising to a top five high burden district. For this COP, DREAMS will work to develop a maintenance plan for Nyanza and work closely with GOR on an expansion plan into Bugesera district which is currently not a Global Fund (GF) supported AGYW district.

Like previous years, in COP23, DREAMS will target and enroll the most at-risk AGYW with an increased focus in the age band 20-24 representing 48% of COP 23 targets. These targets are based on higher new HIV infections in this age band. Since COP20, DREAMS planned to cover the entire district's geographic footprint and has continued to increase the number of targeted beneficiaries from 73,838 in COP20 to 82,500 in COP21, 90,386 in COP22, and 91,388 is planned for COP23. Eighty-eight percent of these, or 80,855 AGYW, are expected to complete at least the primary package in FY24, noting that 72% of these are not new enrollees. During this planning cycle, DREAMS program saturation was calculated using the new SGAC R Shiny App in combination with partner management data on annual program completion which has revised saturation estimates downward from previously used internal estimates. With the new estimates the program will not be attaining saturation in any age band in COP23.

DREAMS will assess AGYW at elevated risk of HIV infection using 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, history of pregnancy, out of school, never schooled, alcohol misuse and orphanhood. By actively coordinating with other PEPFAR supported clinical service providers, DREAMS will utilize these entry points to identify the most vulnerable AGYW. Through established Memorandum of Understanding (MOUs) with health facilities, DREAMS will collaborate with PMTCT platforms, ANC clinics and gender-based violence (GBV) service delivery points, as well as HIV Testing Services (HTS), STI and FP settings, to create strong cross-referral networks and enroll AGYW who meet DREAMS eligibility criteria. DREAMS will also target new and emerging hotspots by working in close collaboration with the local communities to identify and enroll highly vulnerable AGYW sub-groups as informed by program data.

The DREAMS package of services is tailored to three AGYW age-bands (10-14, 15-19 and 20-24). Services are delivered through AGYW-only safe spaces where AGYW are grouped in age cohorts with homogeneous characteristics (schooling status, marital status, childbearing status, etc.). The safe spaces enable AGYW to build social assets including friendships, trusting relationships, and self-efficacy. 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. In FY23, DREAMS Mentors were trained in first-line support (LIVES training) to improve their capacity to respond effectively and responsibly to disclosure of violence. Mentors will also continue to receive supportive supervision coupled with refresher training that includes key soft and technical information, curriculum facilitation, and delivery and mentorship skills.

Enrolled AGYW will receive layered evidence-based interventions intended to reduce AGYW's HIV risks at individual, societal and structural levels of influence. Individual need-based interventions are meant to empower AGYW and reduce their risk of HIV, unintended pregnancy and violence. Interventions targeting the AGYW directly will include comprehensive sexual and reproductive (SRH) education, condom distribution, demand creation, provision and adherence support. Bio-medical interventions delivered through referral and linkage to health facility-based services include post-violence care, HTS, provision of contraceptive method mix, screening services for STIs and treatment as necessary, and PrEP services. The program will continue to build on successes of PrEP scale-up to eligible AGYW through PrEP demand creation, training of AGYW PrEP champions and health care workers, active linkage of eligible AGYW to health facilities for PrEP initiation, and ongoing follow-ups). AGYW will be sensitized on HTS and provided with HTS in the safe spaces or actively linked to a facility as indicated. 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 algorithm if they are unaware of their status or are HIV-negative. Any beneficiary found to be positive will be immediately linked to care and treatment and continue to receive the DREAMS package of services and support. The program will continue to support AGYW who have survived GBV by strengthening the referral/linkage system to ensure the AGYW are provided services, protected and closely followed up.

To respond to individual AGYW economic disparity related to gender inequalities, DREAMS will implement combined social economic empowerment interventions aimed at decreasing AGYW's reliance on transactional sex and strengthen AGYW's self-efficacy and decision-making power in relationships. These interventions will utilize innovative approaches informed by labor market surveys to strengthen linkages, technical and vocational education, and training (TVET), employment and 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 curriculums.

To strengthen vulnerable AGYW families, DREAMS will implement the Families Matter! Program (FMP) for parents of AGYW (10 -17). This intervention increases parent's/caregiver's knowledge, skills, and comfort with talking to their children about sexual health, HIV, GBV, violence prevention and response, as well as guiding parents on how best to monitor AGYW activities and increase positive parenting practices. Furthermore, the DREAMS program will continue to closely work with the local government to ensure that all out-of-school enrolled AGYW are re-enrolled in school and are provided with required education subsidies and material support to ensure that they remain and complete their education.

Structural interventions aimed at building skills and community-level awareness and ownership of HIV risk reduction will engage community members with a focus on men and opinion leaders in community conversations about HIV, gender norms, sexuality, relationships, violence prevention and response and joint decision-making. These interventions will be implemented following the approved evidence based SASA! curriculum. To reduce the risk of AGYW sexual male partners, DREAMS will continue to conduct potential male sexual partner's characterization and provide linkage to biomedical services including HTS and voluntary medical male circumcision in DREAMS districts.

The OVC/DREAMS programs will continue co-planning to ensure harmonization and coordination of tools, approaches, and services, as appropriate. The IPs will continue conducting joint data reviews and hold regular quality implementation reviews for efficiencies. DREAMS will closely monitor implementation quality through 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 completion benchmarks. USAID will conduct routine DQA on select MER and custom indicators for quality monitoring. The DREAMS IPs will continue to share learning from service layering, especially on the use of unique identifiers tracked through the Rwanda DREAMS Tracking System (RDTS). In COP23, through Pact, an International TA mechanism, USAID 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 link/align it to GOR reporting systems at MOH and NCDA under Ministry of Gender and Family Promotion (MIGEPROF) to facilitate country ownership.

To secure DREAMS's gains and expand its impact for AGYW beyond DREAMS implementation districts, under the stewardship of the RBC, the national program, PEPFAR through USAID has led in providing technical assistance to RBC to establish a national AGYW minimum package of services guidelines based on DREAMS and GF AGYW service delivery models. The minimum package will be provided by GF supported CSOs in 18 supported districts that do not implement PEPFAR-supported DREAMS. This will increase access for AGYW across the country. In COP23, PEPFAR will also continue to provide support to RBC to establish an AGYW led multi-sectoral

advisory council that will provide leadership in AGYW national programming and support to establish an AGYW-Ambassadors led advisory group that will be part of the National Prevention Technical Working Group. This AGYW advisory group will consist of the DREAMS Ambassadors who have already received training and mentorship through the PEPFAR/UN women partnership, actively participated in the COP planning meetings, and helped to define the national AGYW minimum package. Additionally, the DREAMS ambassadors fully participated in the co-creation and design of the current IP awards. To ascertain that the voices and leadership of the DREAMS ambassadors are integrated and inform decision making, USAID convenes quarterly meetings with all 5 DREAMS Ambassadors to directly learn how to best incorporate field experience and inputs to improve AGYW program interventions. In addition, the DREAMS Ambassadors are leading the development and implementation of cross-sector roundtables on Teenage Pregnancy which bring together communities affected by the issue, policy makers, and key stakeholders to discuss, determine, and advocate for national policy change to improve the status of teenage mothers and strengthen prevention of unwanted pregnancies in youth.

Plan for OVC Services

In COP23/24, the OVC program in Rwanda will be directly implemented by five local partners, with international partner Pact implementing a global mechanism known as ACHIEVE to provide technical assistance across both OVC and DREAMS programs. All the five OVC and DREAMS mechanisms are referred to as 'IGIRE', a Kinyarwanda word meaning 'Be resilient/self-reliant'; and this '*Igire*' is deep in meaning in community members' minds and reinforces the outcomes and sustainability that the OVC programs want to achieve. The five implementing mechanisms include Igire-Ubaka Ejo implemented by African Evangelistic Enterprise (AEE), Igire-Turengere Abana implemented by Francois-Xavier Bagnoud (FXB) Rwanda, Igire-Gimbuka implemented by Caritas Rwanda, Igire-Jyambere implemented by DUHAMIC ADRI and Igire-Wiyubake implemented by Young Women Christian Association (YWCA) Rwanda.

Overall, the COP23 target for the OVC_SERV indicator will be 170,818, which is a decrease of 15.5 percent from the COP22 target of 186,349. The 170,818 includes 112,992 OVC under OVC Comprehensive [66%], 20,000 beneficiaries under OVC Preventive [12%], and 37,825 adolescent girls under 18 years from the DREAMS program [22%]. The reduction is mainly due to the DREAMS target for adolescent girls under 18, which was reduced from 49,116 in COP22 to 37,825 in COP23 [a decrease of 23%]. The main reason for reducing the DREAMS AGYW under 18 (comparing COP22 and COP23) is that the DREAMS program is enrolling more AGYW above 18 than those below 18 to better respond to the unmet need for HIV prevention services found in the age band 18-24, as revealed by the saturation calculation analysis. The decrease also comes from the OVC Preventive program, which was reduced from 24,442 children aged 10-14 to 20,000 [a decrease of 18 percent], as the program continues to work towards

transitioning this to the government. The OVC comprehensive target was maintained (112,791 OVC in COP 22 and 112,992 OVC in COP 23). Though there will be maintenance of the comprehensive target in absolute numbers, the OVC program will still increase coverage as it will reach 22,341 new OVC. The total of 112,992 will include 90,652 continuing OVC and 22,341 new OVC to replace the 22,139 OVC projected to graduate by September 2023. The COP23 OVC_SERV target of 170,818 includes 111,451 females [65%] and 59,367 males [35%]. The target of 170,818 also constitutes a total of 140,248 beneficiaries under 18 (90,929 female & 49,319 male) [82%], 7,024 OVC aged 18-20 (3,713 female & 3,311 male) [4%] still getting education subsidies and economic strengthening, and 23,546 adults above 18 (16,809 female & 6,737 male) [14%]. In COP 23, there is a 27% increase in beneficiaries above 18, to reinforce the strategy of sustaining the response, especially ensuring economic stability of families.

In response to the PEPFAR Strategy Pillar One of the Health Equity for PP, the PEPFAR Rwanda OVC program will continue to evolve as the country sustains epidemic control. In COP23/24 the OVC program will continue to target OVC priority subpopulations, specifically, children and adolescents <18 living with HIV, HIV-exposed infants under two, sexual violence survivors, and children of PLHIV. The latter will be accommodated if space remains in the cohort. The OVC program will also offer enrolment to children of FSW. This subpopulation was already part of the OVC programming, but the COP Planning Meeting (CPM) recommended greater prioritization and intentionality through strengthening linkages with key population programs. The CPM also recommended considering other PP, namely street children, children/adolescents with mental health issues, teen mothers and children with disabilities.

The CPM also included discussion of several priorities, including implementing OVC comprehensive case management and strengthening linkages/referral systems between community-health facilities. The interventions under this priority will support improved health outcomes for program beneficiaries. The illustrative interventions include case management - enrolment, establishment/review of OVC care plans, implementing graduation benchmarks, strengthening referral systems, including MOU reviews & bi-directional referral protocols; systematic referrals/linkages to targeted HIV testing of OVC (at risk children/adolescents & at-risk caregivers), follow up and tracking of HIV testing of beneficiaries; HIV risk assessment; knowing one's HIV status; and education and referrals to other needed services: PMTCT, treatment, childhood illnesses, nutrition, legal support. The second priority identified is enhancing economic resilience of beneficiaries to enable beneficiaries to become more financially stable. The interventions include household economic strengthening (for parents /guardians of OVC), namely saving groups, technical and vocational and education training - TVET and apprenticeships, access to livestock, financial literacy/education. Other services will include increased linkages with microfinance institutions (MFIs) and banks for mature saving groups, business groups and cooperatives; linkage to nutrition and food security, and water, sanitation, and hygiene (WASH) programs; and provision of social protection services, including

household grants for selected most vulnerable households. To stabilize the beneficiaries, the CPM also identified as a priority improving psychosocial support (with mental health integration). This will require the mapping of available resources (materials, capacities, human resource); development/reviews of tools and training at different levels. To help OVC to be schooled, the CPM recommended continuing to support OVC enrolment and retention in school. Beyond the provision of education subsidies in primary and secondary schools, the OVC program will also continue to monitor school attendance and performance of OVC, integrate life skills education and support OVC to access Early Childhood Development (ECD) services. Based on guidance from the Ministry of Education (MINEDUC) to regulate the school fees payment, the OVC/DREAMS IPs will align with it and continue to monitor costs for education subsidies. In case of cost savings, IPs will put them toward economic strengthening of households to sustain the response.

The CPM also highlighted the importance of community leadership for the safety of beneficiaries, families, and communities, by recommending a priority around strengthening violence prevention of and response mechanisms for abuse, exploitation, and violence against children. This will include strategies for reducing stigma and discrimination through community mobilization for behaviors and norms change, improving child safeguarding, and enhancing positive parenting, child protection and SRH. Under the enabler of community leadership, the OVC program will also enhance identification, retention, and viral load suppression of C/ALHIV and PLHIV. It will put an emphasis on improvement in serving C/AHIV in boarding schools to reduce stigma and discrimination, which will require a transformative partnership with the MINEDUC, districts, and schools. In COP 23/24, the OVC program will integrate mental health with psychosocial support, which 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 the LIVES/LIVESCC approach will also be prioritized, ensuring that all the community cadres are trained and closely monitored. The OVC program will also ensure that IPs implement the most updated Child Safeguarding policies. For a smooth tracking of these interventions, electronic case management for OVC will be fully implemented.

For OVC Preventive, the OVC program will continue to implement primary prevention for HIV and sexual prevention among 10-14 boys and girls using the following curricula: 1) *SRH,* which is approved by GoR and accepted by S/GAC with the addition of the S/GAC module on sexual consent; 2) *FMP* which is largely in use in DREAMS programming; and 3) *Coaching Boys into Men* (CBIM) which was adapted to the Rwandan context. With COP 23/24, the locations within the 12 OVC districts will be further targeted by prioritizing schools and communities situated around hot spots and business centers. During the 2023 CPM discussion, this intervention was proposed to be one of the interventions that is likely to be transitioned to the GOR, especially the MINEDUC, districts, and schools. The OVC IPs will work on the transition plan to ensure that

the GoR sustains the intervention. Comparing the COP 23 and COP 24 targets, the OVC program will have a gradual target reduction, from 20,000 beneficiaries in COP 23 to 14,000 beneficiaries in COP 24, with a full transition to GoR in COP 25. OVC Comprehensive will also continue to incorporate HIV and violence prevention, reaching all household members (children, siblings, parents) with knowledge, skills and messaging on preventing all forms of violence. Additionally, the OVC program will continue to coordinate with the DREAMS program 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 an age-appropriate and child-friendly manner. With help of the above-mentioned structures and fora, 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 violence against children.

In COP23/24, the OVC IPs will continue tracking and reporting on the OVC_HIVSTAT indicator. The COP23 target for OVC_HIVSTAT is 82,423, decreasing from 86,632 in COP22 (a decrease of five percent). The reduction resulted from the 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 be able to track clinic-confirmed HIV status and VL. 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 SAPR23 and APR23. 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 and processes are functioning effectively. OVC found HIV positive and not on ART will immediately be linked to treatment; and accompaniment will be provided as appropriate. To be successful in reaching most vulnerable priority subpopulations, the OVC program will continue fostering linkages with the Rwanda Network of People Living with HIV (RRP+) and other KP partners, as appropriate. The MOUs between health facilities and OVC IPs will be reviewed to identify gaps and needed updates. 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 on the PEPFAR 5x3 Strategy will be a good opportunity for strengthening systems and processes by building on the relationships formed through the mentioned MOUs. To support these efforts, linking 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 (<19). They will also ensure follow up on HIV-positive OVC beneficiaries to ensure they are adhering to treatment and are virally suppressed.

Plan for KP Services

KPs in Rwanda include female sex workers (FSWs), men who have sex with men (MSM) and transgender (TG). Results from recently conducted Integrated Biological-Behavioral Surveys (IBBS) and population size estimate (PSE) studies have informed KP and priority population (PP) strategies. The population size of FSW in Rwanda from the FSW PSE 2022 is estimated to be 37,647 [31,873 –43,354]. Results of the 2019 IBBSS among FSW indicate that FSWs have a national HIV prevalence of 35.5% (39.6% in Kigali) compared to a national adult (15-64 years) prevalence of 3.0%. A high proportion of FSWs (98.6%) reported to have ever been tested for HIV, and among HIV positive FSW, 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 indicate that the MSM population size is estimated to be 18,141 [11,265 – 29,708] and the HIV prevalence was estimated to be 6.5%. MSM IBBS 2021 showed that 18.4% MSM reported transactional sex (ever have anal or oral sex with a man in exchange of money, goods, or services). MSM who engaged in commercial sex for more than two years had higher prevalence than those who did not sell sex in the 3 months prior the survey (8.4% vs. 6.6%, respectively). IBBSS results indicated that multiple factors such as stigma, high mobility, and limited sources of stable income provide challenges to effective prevention and treatment interventions.

In FY24, efforts are being made to reach KP groups through KP networks and associations, in addition to partner notification services. The PEPFAR team has identified key gaps in KP services delivery that will be addressed during COP23 in FY24 to close gaps and promote equity among KP populations. Key gaps include low first 95 among MSM (43%) and FSW (73%), low third 95 among MSM (76%) and FSW (71%). Feedback from the recently conducted MSM listening sessions, learned that male sex workers are not being targeted for prevention services, that there is low coverage of health facilities offering appropriate services, and that educational materials are not comprehensive regarding KP information.

In COP23, efforts will continue to improve the case finding among KP networks and will focus on FSW, MSM, TG, male sex workers, and clients of FSW. Strategies will include targeting MSM through key informants, event driven outreach, social network strategy (SNS), improved case finding among children of HIV positive FSW, improved VL suppression among KP, scaled up KP appropriate services at all PEPFAR supported sites, enhanced community index testing at all PEPFAR supported sites, PrEP provision and accessibility to all eligible KPs through SNS for both

HIV positive and high-risk HIV negative. Strategies will include utilization of key informants, associations, and social media platforms.

Results from the 2021 MSM PSE IBBSS informed program on the geographic coverage and risk characteristics for targeted HIV prevention interventions. In COP23, KP interventions will focus in three provinces mainly Kigali City, Eastern and Western Provinces which have a high HIV prevalence (7%; 10% and 5.4%) respectively; the two remaining provinces (Northern and Southern) with a prevalence of 5.3% and 4.5% will be supported focusing on high burden catchment area. PEPFAR IPs will continue enhancing MSM program by monitoring ongoing MSM program expansion, reinforcing mobilization/education through peer navigators, providing information on PrEP services, scheduling MSM appointments at health facilities using flexible hours and separate days for HIV positives and high-risk HIV negative KP, mainly targeting older MSM and priority populations. Male sex workers will be targeted in Kigali through their social network.

The package of services for KPs includes targeted community voluntary counseling and testing (VCT), mobile HIV testing, self-testing distribution, SNS, 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, STIs education, screening and treatment, referral for VMMC and DREAMS services, condoms and lubricants distribution and promotion, FP counselling, GBV services, TB screening and treatment and referral for hepatitis screening and vaccination. Health care providers (HCP) 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 KP and strengthen GBV and stigma discrimination services implementation at the health facilities.

In COP23, PEPFAR will implement new initiatives to close gaps among KP. These initiatives include: Piloting MSM led outreach testing in Kigali and using event driven outreach testing to target hard to reach KPs (mainly MSM); scaling up the SNS at all PEPFAR supported sites; supporting Provider initiated risk-based provision of services at health facility (KP classification based on the risk behavior); piloting an intervention targeting male sex workers in Kigali to inform the scale up; establishing one to two health facilities in Kigali to become MSM centers of excellence; and collaborating with Kigali private clinics to provide KP appropriate services, as one of the recommendations from the listening session.

To sustain the response, PEPFAR will maintain stigma reduction interventions at all PEPFAR supported sites, capacity building of HCP working in the HIV services to provide KP appropriate services, ensure availability of commodities (lubricants) for MSM and harmonization of KP package of services across all IPs. PEPFAR will continue to conduct listening sessions for program adjustment and align COP23 activities with both MER 2.6 indicators and Rwanda's

National Strategic Plan (NSP) to support the GOR goal of a three-fold reduction in new infections to achieve epidemic control. As new initiatives/changes are introduced in the direction to close gaps, PEPFAR will conduct frequent meetings between stakeholders and beneficiaries to hear their feedback on the program implementation in COP23.

During COP23, to maximally interrupt HIV transmission, PEPFAR will reach 42,819 KPs, including 32,819 FSWs and 10,000 MSM with testing, prevention, retention, and adherence services. To achieve this, PEPFAR will implement proven methods of high yield mobile testing and targeted KP facility VCT strategies that will target KPs in hotspots of high burden areas and refer them to the nearest health facility. This will be combined with increased efficiency of linking HIV positive KPs to treatment in health facilities, as well as military locations. Testing strategies include 1) facility VCT and mobile testing in hotspots, 2) enhance implementation of community index testing, 3) recency testing and CBS to identify new hotspots, 4) self-testing, 5) referrals from active and KP peer educators, 6) referrals by private and public health facility serving hotspots, and 7) referral to other prevention services such as VMMC and PrEP. Furthermore, strategies to improve case finding among KPs in COP23 will include using KP classification based on the risk behavior, annual testing of KPs, focused active case finding using social network strategy (SNS), high risk and KP youth referrals 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 IPs will enhance MSM programming by monitoring ongoing MSM program expansion, reinforcing mobilization/education among MSM through peer navigators, providing information on PrEP services availability, scheduling MSM appointments at health facilities during flexible hours and separate days for HIV positive and high-risk HIV negative KP, mainly targeting older MSM and male sex workers. 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 COP23, PEPFAR will continue to build on best practices and lessons learned to expand PrEP services to eligible KPs in supported health facilities in high burden areas targeting FSWs and MSM at high risk of HIV acquisition. This expansion of PrEP will include all KP PEPFAR supported facilities targeting 1,360 MSM and 4,190 FSW in high burden area. AGYW from KP networks will be supported and enrolled in PrEP. Eligible FSWs will be recruited through all PEPFAR IPs working with KPs. Eligible MSM will be recruited through one PEPFAR partner working with MSM. PrEP will be administered to KPs and followed up by all PEPFAR clinical partners and KP partners. All KP community partners will work closely with health facilities to ensure that the clients initiating PrEP are followed up for PrEP adherence, risk evaluation and are re-tested for HIV every three months (more details on the Rwanda PrEP program can be found on page 23).

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. Results from the hotspots mapping conducted by RBC will be used to inform the KP program. The 2021 MSM and 2022 FSW size estimates, 2019 FSW BSS, 2021 MSM IBBS, and the 2018 Rwanda Population Based HIV Impact Assessment (RPHIA) will be essential to refine and strengthen program strategies. PEPFAR partners as well as other IPs will use a Unique Patient Identifier (UPID) code with the KP booklet to reduce data duplication and match patients across sites and systems, thereby maximizing standardized data collection procedures while ensuring the quality of the data collected.

PEPFAR will strengthen partner management though monthly data reporting and partner meetings to review achievements, identify challenges, solve problems, and review and update the KP hotspot mapping. 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.

To ensure that KP data are kept up to date to monitor programmatic coverage and impact, identify gaps in service delivery, and to locate new transmission hotspots, PEPFAR-Rwanda, in partnership with the MOH/RBC, GF and other partners, will support PSEs and IBBSs every 3 years as recommended in the WHO guidelines for surveillance among KPs. While PEPFAR funded the PSE for FSW in 2022, GF is supporting the ongoing (2023) IBBS for FSW. PEPFAR-Rwanda proposes to leverage resources from partners for the implementation of the MSM PSE and IBBS in FY25.

Plan to Address Stigma, Discrimination, Human Rights, and Structural Barriers

The Rwanda Stigma Index 2.0, completed in July 2020, showed that HIV related stigma and discrimination has generally reduced. Most PLHIV interviewed noted a positive change in terms of decrease in HIV related stigma and discrimination compared to 10 years back. However, HIV related stigma and discrimination continues to be a problem to some categories of PLHIV, including young people, women and KPs (FSW and MSM). It was also observed that knowledge of the laws and policies that protect PLHIV needs to be increased. The PLHIV still need to be aware of policies and laws that protect their rights so that they know their rights and responsibilities and can act as necessary.

In COP22, PEPFAR and GoR continued to work together to achieve universal access and utilization of HIV prevention, care, and treatment services for all KPs and PPs without any HIV related stigma and discrimination. The proposed interventions to address stigma and discrimination interventions directly support the priorities outlined in Pillar 1, 2 and will lean heavily on community leadership and leading with data enablers.

In COP23, there will be a focus on strategies that address both public and self-stigma, through the raising awareness of stigma and its harmful consequences through media campaigns, KP led group support and sensitization of community leaders as well as discrimination, at all points in the HIV service delivery cascade. Strategies include expansion of KP appropriate services to all PEPFAR supported sites to ensure the safety and security for KPs and PPs at health facilities, updating Information, Education and Communication (IEC) materials to include MSM specific prevention messages, implementing KP specific hours and days, training of all health workers involved in HIV services and onsite mentorship on KP appropriate services and youth friendly clinical services so that HCP can effectively serve key and priority population and offer non-judgmental health services, and reinforcement of education among MSM and AGYWs using peer navigators/educators while openly identifying their own experiences.

To control the HIV epidemic, it is crucial to understand the level of stigma and discrimination that hinder uptake of HIV prevention and treatment. In COP23, PEPFAR will continue coordinating with Rwanda civil societies including networks of PLHIV, non-governmental organizations and faith-based organizations, to monitor stigma- and discrimination-related indicators through the community led monitoring (CLM) system and will identify and report potential stigma issues and approaches to address them. Moreover, in COP23 PEPFAR will collaborate with the MSM associations and MSM social network to conduct regular KP listening sessions as one form of community engagement platform for beneficiaries to share their opinions, ideas, and experiences to help improve the quality of appropriate MSM services. In addition, GBV and stigma discrimination services implementation at facility level will be strengthened by continuing training all HCPs on LIVES approach for GBV response.

To support the adherence and continuity of treatment for patients enrolled in MMD, as well as address misinformation, stigma, and discrimination issues, PEPFAR will continue supporting community group support led by the PLHIV peer educators. The support groups consist of PLHIV with similar KP background, age, and gender, in which peer educators conduct home visits to the groups of PLHIV assigned to them.

During COP23 implementation, USAID/OVC and DREAMS programs will contribute to the prevention and reduction of stigma and discrimination among CALHIV, adults living with HIV and HIV affected people. OVC/DREAMS programs will operate in thirteen districts out of thirty districts of Rwanda. There are more than 400 mentors, more than 2,000 case management

volunteers, and more than 100 linkage facilitators working closely with peer educators – this workforce supports implementation of strategies to reduce stigma and discrimination. Building on an MOU between OVC/DREAMS IMs/ IPs (Igire-Gimbuka/Caritas Rwanda, Igire-Turengere Abana/FXB Rwanda, Igire-Wiyubake/YWCA Rwanda, Igire-Ubaka Ejo/AEE, Igire-Jyambere/DUHAMIC ADRI and ACHIEVE/Pact), and the Rwanda Network of PLHIV, known as RRP+, there will be discussions on concrete actions to reduce stigma and discrimination. The MOUs between OVC/DREAMS IPs and health facilities also constitute a good entry point for engaging the health facilities on stigma and discrimination. The OVC/DREAMS IPs will also benefit from good relationships with schools, including boarding schools, to increase engagement of school administration and teachers on stigma and discrimination for C/ALHIV. Throughout this exercise, the beneficiary engagement as well as stakeholder engagement will be useful in having plans and actions that respond to real needs.

Furthermore, the OVC/DREAMS IPs will also engage local government structures especially the Friends of the Family known as Inshuti z'Umuryango/IZUs, CHWs, and local leaders to increase education and awareness of rights of the PLHIV. As the OVC/DREAMS community cadres (especially case management volunteers, linkage facilitators, DREAMS mentors, saving group leaders and members) attend social gatherings and family activities, they will challenge negative social norms including HIV related stigma and discrimination. The engagement of community leadership will happen at all levels. For example, the engagement of faith-based leaders will be key in reducing discriminatory gossip among those who join religious activities. With the provision of economic strengthening services to PLHIV, the OVC/DREAMS IPs will contribute to the reduction of stigma and discrimination as the PLHIV engage in economic sustainable programs to enable them to meet their basic needs.

HIV Testing Plan: Close Gaps, Promote Equity, Prioritize Public Health Approaches, and Assure Appropriate Linkage to Treatment and Prevention Services

Rwanda's most significant challenge in reaching HIV epidemic control is finding new HIV positive individuals. According to the 2023 published 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 3971 CLHIV not yet identified. Another challenge was identified by the MSM PSE/IBBS 2021 that only 43% of MSM were aware of their HIV status.

In FY23 Q1, PEPFAR supported sites identified 879 new HIV positives or 23% of the annual target. All 172 PEPFAR supported testing sites across Rwanda are currently supporting index testing services. In FY23 Q1, 10,249 index clients were offered index testing, overall test yields through index services remains low at 4.4% overall, with a 2.2% yield for those under 15 years of age, and a 4.6% yield for those 15 years or older.

During COP22, PEPFAR aims to identify 3530 new HIV positives of which 1684 will come from index testing. PLHIV with unknown status are being reached through facility-based testing modalities, PEPFAR is focusing 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 supports community-based testing targeting KP (FSWs and MSM), and PPs (clients of FSWs, mobile populations and AGYW through DREAMS). Moreover, PEPFAR is implementing the SNS targeting KP and high-risk populations.

In COP23, to close the gap in the first 95, while the GoR continues supporting HIV testing and quality assurance processes in all testing modalities, PEPFAR will focus on supporting index testing for all persons testing HIV positive at all PEPFAR supported 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. In COP23 PEPFAR will enhance family testing and counselling to target children born from HIV positive FSWs and positive women during ANC/PMTCT. The OVC program will aim to find CLHIV 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. Closing the gap on reaching missing children will be achieved also through intensive site-level monitoring and mentorship identifying and mitigating challenges in effective service delivery and program management.

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 use of appropriate national HIV testing algorithm, linkage, and retention to care and treatment. The services are voluntary with the index client having an option to opt in or out. Services are provided by trained HCP. Safe and ethical index assessment is being conducted along with SIMS, and remediation action plans are developed after each assessment. In addition to case finding testing strategies, PEPFAR will support PMTCT/ANC and post ANC, DREAMS and KP testing services. PEPFAR will continue to support the retesting for PrEP beneficiaries at follow up visit according to the national HTS guidelines to ensure that individuals have HIV test results and appropriate counselling. Once enrolled in the PrEP program, clients are tested every three months for HIV.

To close the gap among the KP, in COP23, PEPFAR Rwanda will continue to support HIV testing targeting KP and PP, including FSWs, MSM, TG and their social networks through community-

based testing in high impact geographic areas including the hot spots surrounding military bases and referral to a health facility for HIV test confirmation, linking identified HIV positive individuals 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 continue to be linked to other prevention services including condoms, lubricants, 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. To promote health equity for PP, PEPFAR will continue to support more focused active case finding of KP and PP. The SNS will be enhanced to find hidden KP, especially MSM. New hotspots will be mapped and prioritized for testing.

The 2021 PSE and IBBS indicated that HIV prevalence is high in the Eastern province with 10.4%. Only 43,4% of HIV positive 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 the Western Province (33,0%). Therefore, PEPFAR Rwanda will enhance HIV case finding among MSM focusing on Eastern, Kigali and Western Provinces. Northern and Southern provinces will be supported focusing on high burden catchment areas. This will be achieved through collaboration with the identified MSM influencers and key informants for mobilization of their peer for testing services, PEPFAR team and IP will work closely with MSM associations and key informants to support identification of MSM through SNS for both HIV + and high-risk HIV negative MSM, enhance the implementation of community index testing among MSM, and making flexible hours and days for MSM testing at health facilities. Additionally, PEPFAR will use the experience of FSW program to reinforce the MSM mobilization through MSM Peer Navigators. Moreover, PEPFAR will collaborate with two private clinics in Kigali to offer HTS for those who are not will seek HTS at Public health facility. Facility based testing will continue to focus on index testing including Partner Notification services to reach KP partners who are not willing to come into health facilities to seek routine HIV testing services.

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 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.

To sustain the response, PEPFAR will maintain HTS among AGYW with HIV status baseline, screen high risk ANC/PMTC (pre- and post-postpartum), case finding by targeting priority populations (Clients of FSWs and AGYW at high risk of acquiring HIV), inclusion of HTS among all categories of people with disabilities, HTS for sexual partners of index clients, self-test kit distribution at health facilities and by community targeting partners of index cases who are not willing to reach health facilities for routine HIV testing services. The existing referral system will also be enhanced across prevention programs both at community and facility. Systematic recency testing of newly diagnosed HIV positive clients will be maintained, and CBS will scale up including in private clinics.

To address public health systems and security, PEPFAR Rwanda will continue building capacity of HCP and peer educators through training, supervision, and mentorship. PEPFAR will ensure the use of program data to inform testing program through 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 and quality assurance of HTS.

During COP23, 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 COP23 PEPFAR will maintain the use of recency data together with the CBS data captured in the OpenMRS digital platform to identify areas with recent infections and intensify prevention and testing strategies in those areas.

With the scaled-up CBS and an integrated national UPID to be implemented in COP 2023, clinical, demographic, and risk behavior indicators, and recency test results are being collected for all newly diagnosed individuals who test HIV positive aged from 15 years and above with verbal consent and those already on treatment with a higher risk of transmitting the virus (e.g., patients with unsuppressed VL and KPs). Additional information on screening for KPs and risk factors for HIV infection will be collected using the revised CBS forms. This will allow a detailed analysis to reach KPs who don't self-report as well as identifying the geographic (clusters) of recent infections and the identification of transmission and social networks correlated with recent infections to inform specific strategies to reach others who may be positive and maximally interrupt transmission network. Moreover, PEPFAR Rwanda will merge and simplify paper-based data collection tools (CBS file and patient file) as a new initiative and conduct an evaluation of family testing into care and treatment to determine number of children who need to be tested. CBS tools (both paper based and electronic system) will be revised by adding group categories and a PMTCT component to allow for longitudinal follow up of those groups.

Through transformative partnerships, PEPFAR Rwanda will maintain collaboration with CSOs and harmonize PEPFAR and national data systems.

Prevention Plan: Promote Equity, Especially Advancing Access to PrEP

In Rwanda, PrEP is a key combination HIV preventive intervention geared towards HIV epidemic control. Implementation of PrEP complements other HIV preventive interventions that have been scaled up to reach Rwanda's current success in combating the HIV epidemic. To ensure effective PrEP service delivery, MoH instituted the national PrEP policy in the National HIV guidelines in 2020. This culminated in a successful PEPFAR-led pilot phase of PrEP implementation in 2021 PEPFAR-supported health facilities serving KPs.

PEPFAR first implemented the PrEP as part of programming beyond the pilot phase in Rwanda in COP 18, with an initial target of 1,800 FSW and to negative partners of virally unsuppressed discordant couples (SDC) in 21 selected facilities in Kigali. In COP 19, the target population was expanded to include MSM. Starting in COP 20, PrEP for AGYW was added targeting five DREAMS Districts. In the same year, the PrEP program was scaled-up to provide services to FSW and discordant couples in 18 PEPFAR-supported KP districts. In COP 22, the PEPFAR PrEP strategy, informed by data on new recent infections captured by the national CBS and recency testing, further expanded the PrEP target population to include HIV negative sexual partners in all Index-testing platforms.

In COP23, PEPFAR will continue to support PrEP services in PEPFAR-supported health facilities targeting FSWs and MSM, SDC with a non-virally suppressed HIV positive partner, and AGYW at high risk for HIV infection. KP and high-risk young women will be identified through both facility and community entry points and will be recruited through PEPFAR community partners working with KPs and DREAMS. PrEP will be administered to beneficiaries and followed up by PEPFAR clinical implementing partners working closely with community partners for follow-up and adherence support services. Moreover, PEPFAR will enhance the PrEP services provision for HIV negative sexual partners of index cases identified through facility-based partner notification services. The PEPFAR PrEP program for SDC in all PEPFAR supported health facility sites in Rwanda will continue to be implemented. Eligible partners of discordant couples and index partners at high risk will continue to be recruited by PEPFAR-supported health facilities through ANC/PMTCT, Index testing, and care and treatment services. In the DREAMS program, as a part of the primary package for AGYW 15 - 24, PrEP information and education is provided at safe spaces by trained mentors and, as a secondary intervention, AGYW 18 -24 years are provided counseling and screening using an MOH-approved community screening tool. Those found at substantial risk will be referred to and or directly accompanied by a mentor to a health facility.

In COP23, six PEPFAR supported IPs will facilitate uptake of PrEP services through promotion, screening and referral for specific populations to ensure equity and quality services; these are

DREAMS program community partners: FXB, AEE, YWCA, and DUHAMIC ADRI. All four partners focus on AGYW; the Society for Family Health (SFH) focuses on KP (FSW, and MSM) including PP, Alliance of Health Communities (AHC) focuses on Rwanda Defense Forces including surrounding populations, and the MOH clinical services CoAG provides PrEP to all eligible populations in all PEPFAR-supported health facilities across the country.

In Rwanda, PrEP services are integrated with other health services both at community and facility levels for sustainability purposes. In that line, demand creation and awareness messaging training and mentorship are key for the quality of PrEP service delivery which creates an enabling environment for service uptake. This integrated approach with community mobilization and engagement from various key players within the community helps improve knowledge and awareness and eliminates stigma around PrEP. At the health facility, PEPFAR's MOH-CoAg or GF supported sites offer all facility-based services including, among others, screening for substantial risk, HIV testing, counseling, linkage to care for those who are HIV positive, counseling around risk reduction, and PrEP, for those who are HIV negative, further laboratory investigations, PrEP initiation, and follow up, in collaboration with community IPs. Follow-up utilizes telephone calls and home visits to ensure adherence. Community and facility-based IPs have collaborated with the health facilities to provide training for HCP to ensure they are trained on friendly and stigma-free PrEP service provision. This will continue to improve the quality of services.

In COP23, the national strategic information (SI) TWG led for the first time an exercise to establish the national PrEP estimate need using two SGAC recommended approaches; a) Estimating the number of individuals at substantial HIV RISK among KPs/PPs needing PrEP using (a). A USAID funded UNAIDS PrEP estimates tool called PrEP-it and (b). Using a 2018 UNAIDS Excel PrEP-target Estimation tool. This exercise is key to guiding the PrEP national scale-up roadmap and has better informed and refined target setting and geographic coverage. PEPFAR will strategically support the national program to monitor the impact of PrEP services to identify program gaps, new cases, safeguard rights, and protect vulnerable populations, triangulating from available data sources (country, program, MER, custom data) for precision intervention to close the need/ gap by investing in above site technical support and capacity building of HCPs in non-PEPFAR supported health facilities to increase access of quality and population friendly services nationally. Additionally, PEPFAR will continue to invest in multi-partner data quality assessment (DQA) activities and continuous quality improvement (CQI) to strengthen the PrEP program. At the USG level, SI and Prevention Interagency Technical Teams (ITTs) will continue to monitor implementing partners for better non-duplicative reporting in DATIM and at HMIS level.

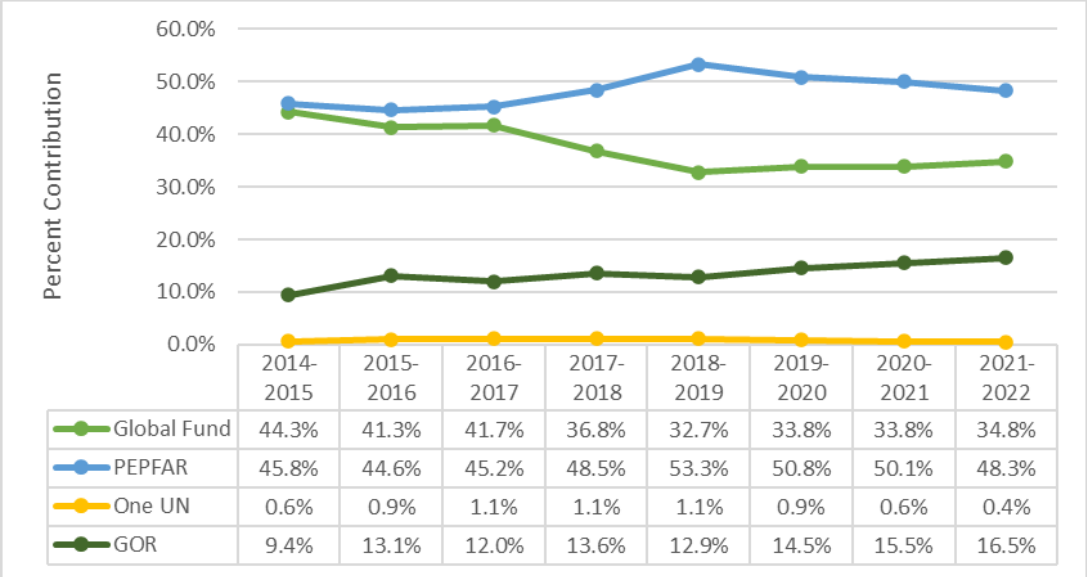
Pillar 2: Sustaining the Response

PEPFAR and the GoR work hand in hand in the HIV response. The MOH 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. Though the domestic resources have been increased overtime, the government investment in HIV response was at 16% in FY22; Hence, government ownership to lead the HIV response does not equate to domestic resources available to support all aspects of the current HIV program.

Over 90% of PEPFAR Rwanda's funding supports local and indigenous organizations. Through CDC, PEPFAR funding directly supports the MOH and RBC to provide and oversee clinical service delivery, laboratory services, and data systems. PEPFAR funding through USAID supports five local CSOs implementing OVC/DREAMS programming and RMS, a local parastatal for procurement of commodities. The Government to Government (G2G) support and RMS commercial parastatal contract accounts for 49.5% of PEPFAR Rwanda funding.

Funding the HIV Response

The HIV response in Rwanda is primarily donor funded, in GOR fiscal year 2021 to 2022 the total budget for HIV was $152,778,691. PEPFAR and GF are the largest contributors, accounting for 83% of the response according to the 2021-2022 National HIV Annual Report (Figure 2).



	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Global Fund	44.3%	41.3%	41.7%	36.8%	32.7%	33.8%	33.8%	34.8%
PEPFAR	45.8%	44.6%	45.2%	48.5%	53.3%	50.8%	50.1%	48.3%
One UN	0.6%	0.9%	1.1%	1.1%	1.1%	0.9%	0.6%	0.4%
GOR	9.4%	13.1%	12.0%	13.6%	12.9%	14.5%	15.5%	16.5%

Figure 2 Percent Contribution to the HIV Response in Rwanda

Domestic contributions to the HIV response have marginally increased over time. In GOR fiscal year 2021-2022 domestic resources accounted for 16.5% of the total response ($25,151,444).

Most of these resources were spent on human resources. GOR does not purchase any HIV related commodities, procurement is 100% supported through PEPFAR and GF resources.

Assess and Address Health Systems Gaps in Alignment with National Priorities

Progress towards epidemic control is being successfully measured, in part, through an effective strategic information framework that not only monitors program outputs, but also key outcomes and programmatic impact. The UNAIDS data shows that Rwanda is one of the PEPFAR countries that have successfully reduced HIV incidence and are at or near epidemic control. PEPFAR-Rwanda will assess and address the health systems gaps in alignment with national priorities to generate high quality data to support routine program monitoring and identify gaps in performance, PEPFAR has invested in strengthening the GoR's health information systems (HIS), monitoring & evaluation (M&E) and surveillance systems at the community and facility levels. Key gaps identified in COP22 were on data quality, on-going capacity building around new indicators and tools (this challenge was also made worse by high staff turnover), and limited data use to inform program improvement.

Given the progress over the past decade, PEPFAR Rwanda has been planning, monitoring, and evaluating the programs at the subnational, facility and community levels to achieve the greatest impact. PEPFAR-Rwanda believes that the collection and use of disaggregated data that characterize the populations (e.g., age, sex, key, or priority populations, etc.) are important in understanding the program performance and planning for future interventions.

Health Information Systems

The in-country team uses granular aggregate data as a powerful tool to monitor and manage the progress of programs in reaching epidemic control in the country. As Rwanda reaches and works on sustaining epidemic control, there is a need for systems for individual level data to address the remaining gaps among specific populations (e.g., 15–25-year-olds, key populations). Discussions with PEPFAR, MOH and other external stakeholders highlight the need for electronic based individual-level data systems. Individual-level data can track clients across the clinical cascade and is nimble to evolving programmatic questions. The PEPFAR Rwanda in collaboration with government of Rwanda will continue to develop EMR, laboratory, surveillance systems, and other data systems that can monitor patient outcomes.

The GoR has developed an ambitious digital transformation roadmap aimed at digitizing all government services including the health sector. Rwanda doesn't have well-integrated and interoperable electronic health information electronic systems to generate individual patient level data to support HIV clinical care, case surveillance and other routine program monitoring. PEPFAR-Rwanda continues to support the rollout and implementation of OpenMRS EMR system to generate patient level information for HIV care and serves as the CBS digital platform. In COP

22, efforts are in place to ensure data completeness in the EMR at health facilities which were identified through the DQA as having a backlog of data entry for better outcome monitoring.

To facilitate data exchange between health facilities for continuity of care when patients move from one facility to another, improved program monitoring through de-duplicated data, and for enhanced data availability for surveillance, PEPFAR supports the implementation of the Rwanda Health Information Exchange System (RHIES). RHIES facilitates interoperability between EMR, laboratory information system, client registry (with unique identifiers for patients), facility registry, RHMIS/DHIS-2 and other key systems that are critical in supporting HIV care. The data exchange has been piloted at three sites in Kigali (Kibagabaga District Hospital, We-Act Clinic and Cor-Unum Health Center). The experience gained by addressing the challenges encountered during this pilot will inform the national scale-up that will start in COP 22 and continue in COP 23. The unique identification process and format is well aligned and linked with the GoR owned National ID Agency (NIDA) database and can be used to uniquely identify children and adults, citizens, and non-citizens. The unique ID has also been piloted in the three sites mentioned above and the MoH plans to roll it out more broadly at selected districts in COP 23.

Various HIS assessments have shown that the National digital health budget line items are limited and do not allow for full functionality of the National HIS. The Investment Plan for Building a Resilient Health System (2011-2024) calls for the design and development of a sustainable health financing system and allocation of substantial funds to HIS and communications. Currently, development partners including PEPFAR provide most of the funding for HIS activities in Rwanda. Any significant reduction of this support would negatively affect the implementation of this Plan. To ensure sustainability of the investments in digital health systems, PEPFAR-Rwanda continues to support capacity building of teams at RBC and MOH to implement and maintain the systems. As part of the capacity building strategy, PEPFAR Rwanda secured the support of the centrally funded, CDC-HQ led Technical Assistance Platform (TAP) to promote the use of digital public goods that are re-usable to accelerate the implementation of the RHIES. The MOH software development team continues to receive hands-on training (hackathons) where they solve real-life problems associated with the implementation of the national digital health systems – especially the RHIES and EMR. Although Rwanda will not be buying into the TAP mechanism in COP 23, the country will continue to benefit from the software products, policies and other artifacts that have been developed and tested under TAP.

The successful implementation of the HIS strategy is measured by the capability of the HIS to supply adequate data to address core health sector indicators. Further, to ensure sustainability of the monitoring system, PEPFAR will continue supporting the Rwanda Health Management Information Systems (RHMIS) based on the DHIS-2 platform. The RHMIS captures routine

aggregate MER indicators that are reported from the health facilities to the national level, and subsequently into DATIM. Data Quality Assessment (DQA) has been carried out at points of data collection, collation, and analysis by technical staff of the respective sectors/ institutions; the RHMIS is often used as a reference point while cleaning data. The MOH/PEPFAR Data Alignment Activity has showed progressive improvement in the quality of data on key indicators for the HIV program hosted on the RHMIS. Rwanda is one of the countries with the highest rate of consistency of data between the data reported using Government and PEPFAR systems.

Human Resources for Health (HRH)

Staff turnover of HIV trained personnel remain a system gap within HRH system, especially in facilities located in remote areas, building an institutionalized in-service training system including tracking and monitoring of trained HCPs to ensure continuity of quality service provision remain a gap.

HRH capacity building is a key area to strengthen Rwanda's health systems. Although the Rwanda MoH has developed Rwanda E-learning platform, a tele-mentorship program, continuous quality Control (CQI) strategic plan and digital CQI, there are challenges in sustaining the capacity building system.

There is inadequate number of public health workforce, thus more capacity building for effective public health response is needed to foster public health responses including conducting continuous data analysis to inform data-driven decision making and conduct cluster/outbreak identification, investigation, and response to allow real time understanding of programmatic coverage gaps leveraging PEPFAR resource.

Laboratory Information Management Systems

There is a low stakeholder's engagement in Diagnostic Network Optimization (DNO) implementation and monitoring and inadequate infrastructure for laboratory information system (LIS), limited skills for system users and low capacity for in country developers.

In COP23 RBC, MOH and other stakeholders will leverage eLearning and Tele-mentorship to continuously build capacity for LIS users and use HIS infrastructure to host laboratory information systems.

Sustainability Roadmap

Following the leadership of MOH and RBC, PEPFAR will support the development of a sustainability vision and roadmap. GoR will lead the planning of the roadmap and include consultations from funders, implementing partners and civil society to ensure all voices are at the table.

Pillar 3: Public Health Systems and Security

PEPFAR Rwanda has a long track record of partnering with Rwandan health institutions to achieve strategic system's improvements. The laboratory, commodities and data platforms used in the country are a direct result of PEPFAR's investments and longstanding partnerships with local entities. PEPFAR Rwanda will continue to build on these successful investments and fruitful partnerships to ensure the strength and resilience of Rwanda's public health system. PEPFAR and Global Fund investments are used to strengthen systems.

Strengthen Regional and National Public Health Institutions

Strengthening National Public Health Institutes (NPHI) forms PEPFAR's COP23 strategic vision of ending HIV/AIDS as a public health threat by 2023 and sustainably strengthening public health systems. The GoR does not have a separate NPHI entity. However, functions executed by these institutes in other countries are implemented by the RBC which is a local entity supported by CDC through Technical and Science Support Services (TSSS) mechanism. Established in 2011, it primarily provides coordination, oversight, and provision of technical expertise to decentralized health entities regarding disease prevention and control. PEPFAR supports strengthening of other national public health and supply chain entities including 1) Rwanda Food and Drugs Authority (RFDA) that focuses on regulation of the safety of medical products and supplies and 2) RMS responsible for supply chain functions.

Through the TSSS mechanism, PEPFAR supports above site activities mainly policy and guidelines review, strategic information, and laboratory network. Support for laboratories focuses on institutional and policies implementation in the laboratory networks and service delivery towards sustainable person-centered health outcomes including diagnostic network optimization (DNO), appropriate use of Point Of Care (POC) testing platforms, continuous quality improvement and management systems, integrated diagnostics and multi-disease testing, laboratory commodities security and supply chain with all-inclusive pricing and vendor managed inventory approaches, and biosafety and waste management. PEPFAR partners with WHO, GF, UNITAID, UNICEF, the Clinton Health Access Initiative to strengthen and ensure sufficient capacity for downstream support of other laboratories and aligns resources and approaches particularly regarding outbreak investigation, pandemic preparedness, and response.

PEPFAR's Five Year Strategy promotes regional manufacturing activities in Sub-Saharan Africa that are aligned with HIV and global health security goals. The establishment of the Africa Medicine Agency (AMA), which will be headquartered in Rwanda, will provide opportunities to actualize this vision. PEPFAR's support for the placement of an in-country expert from the US FDA to provide technical assistance to the new agency will help advance regional regulatory

harmonization, will enable faster adoption of new HIV innovations and regionally manufactured HIV commodities, and will ultimately result in strengthening Rwanda's regulatory capacity.

PEPFAR will further build regulatory capacity of the RFDA to achieve and sustain the WHO maturity level-3 which is a key requirement for increasing the quality assurance and market authorizations of health commodities manufactured in country. In COP23 PEPFAR will continue to procure antiretrovirals (ARV) approved by US FDA or tentatively approved by US FDA in the region or in other regions. PEPFAR will also leverage and build regulatory capacity toward the medium and long-term goals of regionalizing the sourcing of ARVs and other health commodities. This will help build an environment favorable to regional manufacturers, help create jobs and foster trading opportunities within the region. Moreover, in COP23, PEPFAR will continue to support the RFDA integrated regulatory information systems, pharmacovigilance systems, and the strengthening of the registration and quality control/assurance systems.

PEPFAR will also support workforce development though training and mentorship activities to equip health professionals with skills and knowledge to provide high-quality services that reduce morbidity, mortality, and improve the overall quality of life of PLHIV in Rwanda. Recognizing the importance of a skillful workforce for sustainable program implementation, PEPFAR supports competency training of health cadres through the Field Epidemiology Training Program (FETP) within the School of Public Health. The Rwanda FETP strengthens capacity within MoH/RBC to mount an effective HIV public health response by leveraging FETP residents and graduates to improve surveillance systems, conduct continuous data analysis to inform data-driven decision making, and conduct cluster/outbreak identification, investigation, and response to allow real time understanding of programmatic coverage gaps.

Quality Management Approach and Plan

In the past 20 years, the public health sector in Rwanda has seen continuous growth in quality improvement (QI) and quality management (QM). The 2021 Sustainability Index and Dashboard (SID) results scored the QM domain light green (8.05). Despite the pressure of Covid-19, which required the health system to allocate significant effort to Covid-19 management, Rwanda preserved a strong quality management system.

In COP22 PEPFAR Rwanda supported Rwanda MoH, IPs, HCP, and the recipients of care to enhance quality of HIV services at all levels. This was achieved through training of HCPs and peer educators (PEs) on QM to ensure compliance with the national guidelines which mandate high quality services. In addition, PEPFAR provided technical assistance to MOH through RBC in developing the NSP and other SOPs that provide technical guidance on implementation of CQI activities. Moreover, with PEPFAR support, RBC initiated CQI activities in 27 selected health facilities starting with capacity building of personnel on necessary knowledge, skills, and

abilities to identify and define QM gaps, and design a CQI project that will address the identified gaps.

The QM is essential to achieve and sustain high-quality comprehensive HIV services delivery, improved health outcomes, and to the provision of person-centered care. Therefore, in COP23, PEPFAR will continue supporting the scale-up of CQI activities at all PEPFAR supported sites. In FY23, the trained district mentors will scale-up the CQI activities to all PEPFAR supported sites under their catchment areas. This includes establishing CQI committees at site level, conducting regular program reviews, data analysis and review of CQI indicators, identifying the gaps, developing the CQI projects to address the identified gaps, and monitoring the implementation of strategies laid out.

In FY23, a CQI core team made up of RBC and various stakeholders involved in HIV program implementation was established. In COP23, PEPFAR will continue supporting the CQI core team to meet on quarterly basis, conduct quarterly data analysis, review, and draw recommendations to inform the CQI projects at site level.

In FY23, RBC with CQI stakeholders through the CQI technical working group, will conduct in depth monitoring of CQI projects progress, analyze CQI performance indicators using CQI digital dashboards, conduct experience sharing sessions to share best practices and lessons learned throughout the implementation of CQI projects among all key stakeholders including at central and decentralized level.

Quality of services requires policies, guidelines, and Standard Operating Procedures (SOPs). In this context, in COP23 the PEPFAR team in collaboration with other stakeholders and CSOs, through the national technical working group, will support MOH to update the national guidelines, SOPs, and tools to integrate the new initiatives. This will include policy and core standards of services for Non-Communicable Diseases (NCD) and HIV integration, advanced HIV disease, new TB screening and diagnosis algorithm and HIV Adolescent Model. The revised tools will be printed and distributed to all PEPFAR supported sites and HCPs will be trained in the new guidelines and SOPs.

The PEPFAR team will strengthen partner management to ensure that all IPs work plans include QM and QI activities to support quality services, and all IPs will continue harmonizing the package of services, strengthening QM, and holding regular implementation reviews for quality work and efficiencies. This will be done through regular partner meetings to review achievements, identify challenges, and problem solving.

To ensure that HCPs are following GOR and PEPFAR policies and guidelines, the PEPFAR team in collaboration with MOH and IPs will conduct targeted supportive supervision and mentorship

focusing on poor performing sites with gaps in testing, linkage and viral suppression, by population and regions.

In COP23, PEPFAR will continue supporting MOH and RBC to ensure quality, client-centered services for optimal health outcomes at all PEPFAR-supported sites. The QM systems that will be implemented in COP23 year 1 include SIMS, CLM, and listening sessions targeting KP. PEPFAR will continue verifying that core standards) are being met at the sites, including infection prevention and control (IPC) which is the new core standard for COP23. SIMS and MER metrics are the tools that will be used for QA and QI. The prioritization of sites will be based on both program needs and program gaps. To address program needs, PEPFAR will prioritize sites that are implementing the full package of the HIV program including prevention activities (HTS, HIV Self testing, PrEP, PEP, PMTCT, and VMMC) and care and treatment activities (ART, TPT). Using MER data from the FY22 annual report, PEPFAR will give priority to sites that have low performance against targets for some selected indicators and/or sites that have challenges for meeting the core standards implementation. The SIMS plan will be continuously updated considering the quarterly MER results, prioritizing sites that show low performance and those that have challenges meeting core standards, including IPC. PEPFAR will also give priority to PEPFAR supported district hospitals to continue assessing their QA/QI integration in the management and delivery of HIV care services so that they are able to support QA/QI in the health centers under their catchment area.

PEPFAR will conduct regular KP listening sessions as one form of community engagement platform for beneficiaries to share their opinions, ideas, and experiences to help improve the quality of appropriate KP services.

CLM has been delayed in Rwanda due to staffing shortages in the PEPFAR coordination office and grant requirements/restrictions. In COP22, CLM funds were shifted to UNAIDS to begin implementation of CLM and in subsequent years the funding will be implemented through a USAID central mechanism to fund UNAIDS. Despite the delays, UNAIDS and CSOs convened a meeting in the summer of 2022 to begin development of a CLM framework outlining priorities with CLM activities. The roadmap outlines the priorities for CSOs to initiate CLM. Key needs of CSOs include capacity building of CSOs, strengthening the collaboration amongst CSOs working in HIV and health sector, harmonization and validation of HIV community interventions and indicators, and develop a community information system in line with national HMIS. Although not currently funded by PEPFAR, CSOs routinely provide feedback to the MoH and RBC on service provision. Notably, the Rwanda Network of People Living with HIV (RRP+), actively follows up on reports or issues with service provision from their constituencies. CLM will strengthen these reporting channels and help quantify issues faced by the community.

Building on COP22 achievements in the implementation of laboratory quality assurance (QA) and quality control (QC) programs, COP23 laboratory QA/QC activities will focus on the implementation of strategies that ensure accurate and prompt return of HIV test results, while realigning efforts to address challenges encountered in COP22. Efforts will be made to improve the frequency and coverage of HIV rapid testing and related proficiency testing (PT) panels targeting testers at PEPFAR supported sites by improving consistency in the distribution of PT panels (both locally produced and outsourced) to testers and facilitating return of PT feedback between the NRL and HIV testers. PEPFAR will support promoting QA while maximizing efficiency by conducting HIV testing site audits, mentorship, and supervision visits that will provide capacity building of staff to improve/sustain QMS at NRL and District Hospitals (DHs) and support the upgrade/enhancement of EQA/PT tools. In COP23, NRL is exploring acquisition of automated PT machines to ease PT production, pipetting, labeling, and capping.

To consolidate and sustain gains made over the past years in the face of decreasing funding, in COP23, PEPFAR will continue to support MoH and RBC to adopt and enhance the use of e-learning platforms to facilitate online mentorships. CDC laboratory staff will provide Technical Assistance (TA) in the development of online modules and, with NRL staff, conduct online classes on laboratory QA and QC. With the digitization of laboratory tools and deployment of LIS applications, PEPFAR will support MoH and RBC to enhance the use of digital tools and laboratory electronic applications to promote the use of laboratory data for program planning and visibility.

Using electronic HTS (eHTS) logbook and other data capture tools, PEPFAR will continue to support NRL to compile and analyze HIV rapid testing data to track tester adherence to the national HIV testing algorithm, routine use of quality control specimens and concordance/discordance rates between HIV test kits that are currently used and those procured. PEPFAR will continue to support NRL to adopt a national laboratory quality management system and accreditation roadmaps for laboratories in the periphery network. Efforts will be made to have the national tester certification guidelines approved to pave way for certification of the first cohort of testers. In COP23, PEPFAR will continue to improve laboratory-clinical interface to strengthen the quality of testing services and result documentation through onsite DQA by supporting quality corps to implement HIV rapid testing CQI activities.

In COP23 PEPFAR team in collaboration with MOH and RBC will continue assessing the implementation of index testing to ensure that all PEPFAR supported sites providing index testing services meet the following minimum standards for safe and ethical index testing: 1) Adherence to 5C's (consent, confidentiality, counseling, correct test results, and connection to prevention/treatment), 2) IPV risk assessment and provision of "first line" response, including safety check and referrals to clinical and non-clinical services (if not provided on site), 3) A site

level adverse event monitoring and reporting system, 4) Providers trained and supervised on index testing procedures and 4) ethics (respect for the rights of clients, informed consent and 'do no harm'). The assessment will be conducted using PEPFAR standard assessment tools. Site staff will always be provided with same-day feedback and a remediation plan that is actionable and time bound will be developed to address any minimum standards that are not achieved.

Effective supply chain management is pivotal to minimizing the stockouts of essential commodities that prevent, diagnose, and treat HIV. A high performing supply chain, a foundation for HIV commodity security can also boost health system resilience, excel program success, and increase patient satisfaction. The uninterrupted supply of ARV medicines, VL supplies, condoms, and HIV test kits help patients live healthier and longer, HIV programs succeed, and keep the general population safe from HIV.

PEPFAR and USAID's health programs use a Quality Management Improvement Approach (QMIA) to help countries monitor the performance of supply chain professionals and enhance their skills in supply chain operations. The approach has two components: supervisory site visits to assess performance and discussion sessions for experience-sharing and skill-building. The PEPFAR's QMIA support for supply chain focuses on subnational levels i.e., district warehouses where commodities are distributed to service delivery levels, and the health facilities where the commodities are needed. The QMIA activities have contributed to the percentage of sites that use the electronic logistic management information system (eLMIS) increasing from 55 percent (2017) to 96 percent (2022). Use of the eLMIS is essential for the effective procurement, tracking, and distribution of HIV commodities. As a result, the stock out rate of ARVs at the last mile (health facility) was very consistently low, below 2% from FY 17 to FY 22. Assessments also showed that data accuracy at last mile levels increased from 25% to 71% during the same period. PEPFAR has a target to increase eLMIS use from 96% in 2022 to 98% in FY24 and 99% in FY25, and to increase data accuracy to a minimum of 80% in FY24 and to 85% in FY25. In COP23 and COP24, the tracer HIV commodities stock out rates are also targeted to be minimal, less than 2%. All QM approaches are in line with Pillars 1 and 2 and will lean heavily on leading with data as an enabler.

Person-Centered Care that Addresses Comorbidities Posing a Public Health Threat for People with HIV (Advanced Disease, TB, Hypertension) Plus Mental Health Services

Advancing integrated health service delivery is PEPFAR's COP23 strategy for a sustainable and stronger health system aimed at ending HIV/AIDS as a public health threat by 2030. To achieve this strategy, PEPFAR aims at supporting NPHIs and partnership with regional agencies to build capacity of the public and private healthcare staff for quality health services. Along this line, PEPFAR intends to support public health workforce development, supply chain and laboratory strengthening as well as surveillance systems that achieve delivery targets and desired HIV

outcomes. These investments are coordinated with GoR to support integrated health service delivery systems that address the needs of the beneficiaries. Recognizing the long-term benefit of integrating HIV and other health services (Maternal Child Health, NCD, Advanced HIV Diseases, and Mental Health), Rwanda's strategy in COP23 aligns to the government's vision and views integrated services delivery as a strategic shift towards person-centered care that addresses patients' needs.

Rwanda has made significant strides in integrating health services particularly in HIV/AIDS and TB screening among PLHIV. Recent annual reports for HIV and TB indicate good coverage for TB screening among PLHIV to >95% and 100% of HIV patients in the TB program initiated on ARV drugs. TB positivity on symptom-based TB screening among PLHIV on ART treatment was 3% and those screening TB negative are initiated on TB preventive Therapy (TPT). By January 2023, 80% of all PLHIV who screened negative had received TPT to prevent HIV and TB co-infection and reduce morbidity and mortality among PLHIV. Mental health and NCDs services are available at health facilities but integration within HIV program is less optimal. Gaps remain in systematic screening for mental health and NCDs although ART patient level chart capture this information at the time of enrollment. Besides tools, there is need for capacity of HCPs for quality mental health screening to avoid missed diagnosis and delayed referral for management. Advanced HIV Disease has been included in the revised HIV guideline and implementation with tools (screening algorithm and M and E) and training yet to be done. Cervical cancer screening services are provided in 16 districts targeting the general population and provided in dedicated rooms. Cardiovascular and hypertensive diseases management are currently entrenched in ordinary healthcare and not integrated in HIV program.

In COP23, PEPFAR will support HIV and co-morbidities integration including development and/ or updating tools including M&E, capacity building of HCPs, alignment of patient clinical visits for HIV and comorbidities, quantification of commodities, enhanced referral mechanisms for higher level care and ensuring minimum package of health care tailored to PLHIV sub populations (adults >50 y/o, children under 5 years and women of reproductive age). Quality of service provision will be ensured through mentorship, supportive supervision, and continuous quality improvement.

Supply Chain Modernization and Adequate Forecasting

PEPFAR has been a pioneer in modernizing supply chain throughout the supply chain cycle to build local capacity, find efficiencies, ensure sustainability, intentionally strengthen and implement localization, and collaborate to strengthen national ownership. PEPFAR, in collaboration with GFATM, MOH and USAID has supported warehouse improvements, training of supply chain cadres, improvements to the supply chain information systems, and development of tools and SOPs. The PEPFAR investment positively impacted the national supply

chain system and has contributed to strengthening of the Rwanda supply chain system for all health programs including the integration of critical supply chain operations, forecasting and supply planning, warehousing and distributions. As a result, effectiveness and efficiencies are gained, and resources are saved over the Rwanda supply chain systems.

In COP23, the focus will be continuing the partnership with MOH, GFATM, RMS, and RFDA toward:

1. Improving the supply chain and regulatory information systems for increased end-to-end visibility and enhanced decision making. PEPFAR will continue to support the implementation of the national digital supply chain strategy, implementing the national product registry i.e., national product catalog (NPC), scaling the barcoding and adoption of GS1 for traceability, ensure interoperability between Supply Chain and regulatory information system. GS1 (also called Global Standard One) is an independent, not-for-profit organization that works to standardized business information globally to improve efficiency and communication for companies across the world. GS1 maintains global standards for barcodes and radio frequency identification tags to ensure electronic data interchange throughout the supply chains to authenticate the product (s) with the originator and avoid falsified products to protect public health and business.
2. Improving the use of tools and systems for improved data quality and real-time data for decision making. PEPFAR will continue to strengthen the implementations of the Rwanda supply chain information systems (eLMIS), and Quantification and Analytics Tool (QAT) for the national forecasting and supply planning.
3. Coordinating and collaborating between key supply chain plans with public, private and faith-based organizations.

PEPFAR supported the development of the Rwanda Private Sector Engagement Plans 2022 - 2027 for greater private sector engagement within the public health supply chain which will result in improving availability and access to essential medicines and will improve the performance outcomes of the national supply chain. PEPFAR will continue to contribute to the implementation of the strategy to greatly diversify private sector engagement within the public health supply chain for better performance outcomes. Moreover, to improve availability and increase efficiency of laboratory reagents and supplies for VL and EID, PEPFAR will support the modernization of the supply of VL and EID toward Vendor-Managed Inventory models (VMI). In COP23, VMI will be piloted, and lessons learned will be documented for scale-up in COP24.

Laboratory Systems (VL, EID, DNO, etc.)

Past PEPFAR laboratory systems investments in collaboration and support from the GoR and other stakeholders such as GF, World Bank, WHO and other partners, have had a fundamental and substantial impact on overall clinical laboratory capacity for HIV epidemic response across

the entire healthcare system. These investments have permitted the provision of essential high quality clinical diagnostics and a network of satellite laboratories to respond to outbreaks and pandemics that are located along borders and other points of entry. This was demonstrated in the global COVID-19 pandemic during which existing PEPFAR supported VL testing hubs (10 out of 14 VL hubs) in Rwanda were leveraged to support provision of molecular diagnostic services. These services remain integrated and provide a platform for additional diagnostic approaches to support global health security. However, the pandemic exposed vulnerabilities and challenges in the laboratory network to sustain the national integrated laboratory diagnostic systems and meet multi-diseases testing demand for outbreak response, surveillance and other essential public health functions required to sustain response and end HIV epidemic as a public health threat. Strong laboratory systems are needed to support patient-centered care, enhance the clinical-laboratory interface, maintain effective HIV response, prepare for outbreak response, and facilitate other public health practices.

During COP23 implementation, PEPFAR will work with GoR to support the strengthening of decentralized specimen referral systems, interoperability of the laboratory and health information system, and DNO. Efforts will be made to maintain access and increase coverage to HIV related testing, timely return of results, quality monitoring and quality improvement of testing services to reach underserved populations and reach HIV and TB program targets. PEPFAR will support country led stakeholders' engagements through national technical working groups to address overall systemic challenges within supply chain, data collection and utilization, human resources (HR) capacity building, low testing coverage and long turn-around time (TAT).

In COP23, PEPFAR will continue to support diagnostic networks and other support systems through data-driven performance monitoring CQI activities. PEPFAR will also support overall systems strengthening efforts including biosafety and waste management for safe work environment and compliance to good clinical laboratory practices. Through country coordination with laboratory stakeholders, resources and approaches will be aligned, particularly in staff capacity building, use of routine lab data for evaluations, placement of testing platforms, transition from outright instrument procurement to all-inclusive pricing, and joint execution of diagnostic network implementation and monitoring.

The laboratory serves as an essential source of data being used for programmatic decision making, including disease surveillance, health management and information, and data driven decision-making for HIV/AIDS, comorbidities, and other emerging disease threats. Data quality and systems that are secure, accessible, user-friendly, exchangeable with other systems and integrated with other diseases are core to achieving these goals. In COP23, PEPFAR will support enhancements of CQI initiatives using integrated data management system for data visibility and use to ensure the quality of all laboratory results entering the LIMS and improve efficiency

and impact of CQI activities. In addition, PEPFAR will work closely with MOH/RBC and other partners to enhance functionality of integrated LIS for laboratory workflow management and real-time results reporting into patient electronic medical record at all healthcare facilities through support in upgrades and maintenance of the LIS infrastructure and staff capabilities at the National Reference Laboratory (NRL) and focal persons in the laboratory network. Building a central data repository to view lab data both at site and at national level. Linked analytics platforms such as dashboards will be considered to monitor the implementation of CQI activities. System generated data will be analyzed on reporting progress and sustainability of quality management systems at site level. PEPFAR will continue to work with partners to capacitate NRL workforce to upgrade and maintain these systems and to analyze the information routinely for data-driven program improvement and laboratory policy and decision making. The plan will ensure the transition of the fully operational digital tools, technology, and maintenance of the systems to local Rwandan entities including MOH digital team. For program sustainability, PEPFAR will promote country led partnerships with, but not limited to, GF, WHO, UNICEF, CHAI, Africa CDC, and Private sector. These partnerships will permit strengthening of local and regional public health laboratories to acquire capacities and capabilities that in turn, provide quality assurance support to lower tier laboratories for services delivery and long-term leadership, resource mobilization and program oversight of the laboratory services and systems strengthening.

HRH (Priorities, National Capacity to Manage Workforce, Aligning to Government Planning, Pay and Cadres, etc.)

PEPFAR supports HRH in 192 HIV Clinical Services sites in Rwanda through a government to government (G2G) agreement with the aim of building ownership and capacity to manage the public health workforce in the long term. The G2G consists of staff salaries & benefits, and capacity building and mentorship aligned with the government of Rwanda HRH system (cadres, pay scale and qualifications).

PEPFAR will continue support to build capacity of HCP through the institutionalization of in-service training through the eLearning platform targeting clinical HCPs (Nurses, Medical Doctors), ancillary and lay workers to continue sustaining the HIV/AIDS response gains. Moreover, in COP23, PEPFAR will enhance and scale the use of eLearning platform and tele mentorship to build a sustainable, cost-effective in-service program across all health sectors including HIV/AIDS service and other diseases management.

Since 2010, the Rwanda FETP has built capacity among the nation's health care workers to strengthen multi-disease surveillance systems, data-driven public health decision making, and detection, prevention and response to public health emergencies and outbreaks– objectives that are aligned with Strategic Pillar 3.

As Rwanda nears epidemic control of HIV, strong surveillance systems and a robust workforce trained in epidemiology, surveillance, and data management will be key to addressing gaps in HIV and TB programming and sustaining epidemic control. The 2023 COP PEPFAR funding for Rwanda FETP will continue to support the objectives aligned with Pillar 3, specifically Focus Area 2 - Strengthening the Public Health Workforce and Focus Area 6 - Strengthening Pandemic Preparedness and Response Capabilities, as well as several objectives outlined in the Rwanda National Action Plans for Health Security (NAPHS), including advocacy for the recognition and establishment of field epidemiologists in the human resources structure, and expanding FETP to increase the intake of epidemiologists and veterinarians.

In COP23, the DOD-PEPFAR Rwanda Program through implementing partner AHC, will ensure there is adequate staffing and proper alignment of the staff needed to provide HIV services and support to the Rwanda Defense force (RDF). This agreement will create capacity in providing quality HIV prevention activities, clinical management, diagnosis, and treatment at the RDF health facilities to enhance improvement in RDF health systems and security in service delivery as well as create program sustainability.

AHC will continue to engage RDF leadership and personnel at all levels to strengthen military capacity for ownership. Informed by the Twinning Model, AHC will continue to practice joint planning and implementation, and technical leadership twinning that supports the RDF to build program capacity, capability, durability, and ownership for sustainability in line with DHAPP/PEPFAR and GoR priorities and thus contributing to Rwanda achieving 95-95-95 UNAIDS goal by 2030.

USAID's approach to improve HRH for supply chain and pharmacy services includes developing training materials for classroom and online trainings, providing structured on-the-job training to properly mentor and support implementation, and providing certificate-based training for central level staff. USAID also advocates for a good governance structure of supply chain and pharmaceutical services at all levels of the health system, especially the establishment of a working team in the MOH at the directorate level. USAID continues to support the professionalization of the supply chain and pharmacy workforce and collaborates with MOH and the East Africa Community Regional Centre of Excellence for Vaccines, Immunization and Health Supply Chain Management (RCE-VIHSCM). USAID also provides digital solutions to implement the Rwanda Digital Supply Chain Strategy and the Rwanda National Vision & Strategy for Pharmaceutical Traceability Leveraging GS1/Global Standards. In COP23, PEPFAR will continue to strengthen the current HRH initiatives for the supply chain and pharmacy workforce in Rwanda.

In COP 23, USAID OVC/DREAMS service delivery is fully funded through local CSOs with a technical assistance mechanism that will support in building the capacities of the newly

awarded local partners and spearhead transition of digital systems to align with GOR reporting systems and structures. The HRH investments will also support social workforce strengthening including DREAMS mentors, linkage facilitators and case management volunteers.

Pillar 4: Transformative Partnerships

PEPFAR Rwanda has a long history of establishing strong bilateral and multilateral partnerships. PEPFAR's collaboration and relationship to the MoH and RBC has resulted in impressive achievements since the establishment of the program in 2004. The G2G cooperative agreement between CDC and MoH to provide clinical HIV services in Rwanda has resulted in direct PEPFAR support to 64% of PLHIV on treatment. The RMS Ltd, established through USAID and PEPFAR funds, transformed procurement in Rwanda. In COP23, 97% of PEPFAR supported commodities will be purchased through RMS Ltd.

PEPFAR is supporting the establishment of multi-sectoral advisories to ensure our key and vulnerable populations have the support to thrive beyond their health. OVC and DREAMS beneficiaries will benefit from the involvement of key ministries such as MINEDUC, MIGEPROF, MoH, MINALOC, Ministry of Youth and Sport, and Ministry of Labor.

PEPFAR investments go beyond the direct support to the HIV response in Rwanda. Investments in laboratory data systems proved to be the foundation for the COVID response in 2020. Rwanda will establish regional manufacturing in partnership with BioNTech with support from the European Union. PEPFAR's support to Rwanda FDA will directly benefit regional manufacturing and the pending Africa Medical Agency (AMA) which will call Rwanda home.

Pillar 5: Follow the Science

PEPFAR-Rwanda's national HIV response remains informed by evidence derived from solid science. Besides the routine program data and surveys & surveillance that generate data for program improvement, well-designed evaluations have been conducted using rigorous scientific methods.

Rwanda is one of the countries that participated in the TRACE (Tracking with Recency Assays to Control the Epidemic) Evaluation led by the International Center for AIDS care and prevention (ICAP) and RBC which evaluated *HIV* recency testing, positivity yield, and intimate partner violence (IPV) among persons newly diagnosed with HIV. The study was conducted in FY22 and had national coverage. The key findings included: Recent cases were more likely to be linked to sexual contacts with recent infections while long-term cases were more likely to be linked to

known positive contacts; IPV experiences significantly decreased after HIV diagnosis and there was no increase in IPV experiences after the return of recency results; there was no difference in IPV instances between recent and long-term cases. The study also showed that 21.4% of persons initially considered as newly diagnosed in the study were virally suppressed, suggesting that they could have been re-testers. This last finding has prompted discussions on enhanced screening of those receiving HTS to minimize unnecessary repeat testing among those with previously known HIV-positive diagnosis (re-testers) in COP 22, COP23 and beyond. It will save on test kits that can be used where the real need is and reduce over-reporting on HTS_TST_POS numbers.

In FY22, PEPFAR supported a study implemented by Society for Family Health (SFH) and RBC with technical support from CDC entitled *"Formative assessment of structural, social, clinical, and behavioral determinants to PrEP take and Retention Among high-risk population in Kigali, Rwanda"*. The key findings of the study include high PrEP awareness and an uptake of 64% among FSW (92%); FSWs aged 25-24 years and those aged 35-64 years were more likely to initiate PrEP; Retention on PrEP among FSW was high (98%). For MSM, awareness of PrEP was at 70% with an 80% uptake among those aware of PrEP. Being a sex worker, living in households of 3-5 members, not having medical insurance, having 3 or more regular sexual partners, never used condoms for every sexual act in the last 3 months, and being circumcised were associated with a higher likelihood of retention on PrEP. The findings of this study, together with the PSE and IBBSs for FSW and MSM informed the COP23 programmatic strategies for prevention among KPs as well as setting PrEP targets for these populations.

In FY23, ICAP is working with RBC to assess *structural barriers to HIV services access by Men who have sex with Men (MSM) in Rwanda*. It is anticipated that the findings of this study will be available before the end of FY23, and the data will be available to inform MSM programs from FY24 (COP23).

Besides studies conducted in Rwanda, the PEPFAR team relies on published work conducted in settings with similar socio-demographic characteristics as well as HIV epidemiological conditions similar to those found in Rwanda. Modeling tools, such as EPP-Spectrum, which are based on scientifically proven methods serve as complementary data sources. Data from two studies conducted in Rwanda by UNICEF and WHO on rates of HIV seroconversion among pregnant women and HIV-positive breastfeeding women who interrupt treatment during the post-partum period will be used to improve the EPP-Spectrum estimates of children living with HIV in Rwanda. It was initially anticipated that these findings would inform COP 23 programming for children, but this did not happen as the follow-up period for the post-partum study is 24 months which is beyond the COP 23 planning period.

Strategic Enablers

Community Engagement and Leadership:

PEPFAR Rwanda engages the community throughout our programs up to the leadership levels. PEPFAR coordination office (PCO) co-hosts quarterly meetings with UNAIDS for umbrella CSOs as a platform to share updates and concerns facing beneficiaries in the community. Programs regularly engage the community for feedback on implementation. OVC, DREAMS and KP programs rely heavily on the input from community leaders and beneficiaries to ensure programs are meeting the needs of the community.

To ensure maximum community engagement in the COP process, the PCO advocated for the CPM to be hosted in Kigali. Rwandans face travel restrictions to South Africa, therefore limiting local participation in critical discussions. The CPM was held in Kigali from February 22 to 24 and had participation from CSOs, beneficiaries, DREAMS ambassadors, and the youth. It was the first in-person CPM for the team since 2017. Community engagement continued after CPM via check points, stakeholder meetings and Chair/CSO calls. Additionally, Charge d'Affaires MacLean hosted a coffee for community participants in CPM on April 19 to thank them for their engagement in the COP process and an additional point for feedback to the PEPFAR team.

Innovation

DOD/RDF program through Implementing partner – AHC will strengthen its relationship with other health facilities to provide ART to clients enrolled in RDF programs when they are temporarily far from any RDF facilities so that they don't miss their medication. This has worked during the COVID-19 pandemic and can continue with AHC supporting that client who would miss their dose otherwise. This will not concern clients who shift permanently because those will be given referrals to their nearest health facility.

An important and significant innovation put forward by the RDF is serving HIV-positive soldiers who are on mission/peace keeping abroad. In the past, HIV-positive soldiers were not allowed to go/deploy on missions abroad, but this policy has recently changed. It represents not only innovation in thinking and practice, but also reflects a significant reduction in organizational stigma and discrimination. AHC will collaborate with the RDF in planning that ensures soldiers continue to receive HIV medications and comprehensive HIV treatment and care while on mission and be included in the documentation of those served by the program.

Urumuri Clubs ("light bearers") have long been a staple of the AHC/RDF Prevention Toolbox. These drama clubs, comprised of military and civilian members, train together to provide drama presentations of real-life situations that include a choice or conflict that relates to HIV. The groups perform in marketplaces, schools, on radio and/or any public place where an

audience can be engaged. Each skit is followed by a discussion with the audience and the provision of condoms and other HIV prevention information/resources. An innovation of this very successful prevention activity is to have existing *Urumuri Club* members train new groups for each KP and PP population; a *Urumuri Club* comprised of soldiers will function in each barrack, creating a monthly forum where the members of each barrack across Rwanda can discuss and engage each other around the challenging relationships and social situations that involve HIV transmission and to work through together options that lead to better outcomes. Similarly, a group will be formed for each of the other populations: FSW, MSM, Adolescent Boys and Young men (ABYM) and adult men. Group composition will be creatively constructed to ensure that they make an impact for each target group.

Moving forward, AHC will continue to support RDF to advance health communication through social marketing and media channels (TV, radio, and social media), ensuring that the education and information is client-centered, focuses on HIV/AIDS prevention, as well as stigma and discrimination reduction toward PLHIV and individuals at high risk of HIV infection. AHC will partner with media entities to deliver adult, youth-appropriate messaging through the creation of short explainer videos, infographics in both English and Kinyarwanda, and using music though TV stations, radio, and social media platforms. AHC will work with the RDF in developing social media material to post on their social media platforms.

USAID will initiate discussions with GOR on a roadmap to scale evidence-based behavioral and social science interventions to address social norms change at the community level that include AGYW, adolescent boys and young men, and community leaders, including tackling harmful gender norms. This will be a multi-sector engagement approach that will also involve community and faith-based leaders. The USG team will also establish a national multi-sectoral AGYW advisory council consisting of DREAMS Ambassadors, youth influencers and champions to advise the national TWG on how to effectively and innovatively shape HIV/AIDS interventions to address the unique youth-appropriate service delivery to facilitate greater HIV/AIDS impact. USAID will continue to support RMS through technical assistance to implement and track progress on plans towards financial sustainability.

In COP23, following the recommendations from the listening sessions held with MSM representatives and recommendations of CSOs representatives during the CPM, PEPFAR will continue to enhance case finding among KPs to improve the quality of services through the following innovations: Rwanda will pilot intervention targeting male sex workers (MSW) in Kigali to inform the scale up in year 2. In this regard, PEPFAR IPs will work closely with the MSW key informant to reach the MSW and link them to HIV prevention services. In addition, the PEPFAR team in collaboration with IPs will establish one to two health facilities in Kigali to become MSM centers of excellence in providing the KP appropriate services and will collaborate with Kigali private clinics to provide KP appropriate services to reach MSM that are

not willing to seek services at public health facilities. Furthermore, PEPFAR Rwanda will provide support to the RBC for merging and simplifying CBS tools both paper based and electronic system to include more KP and PMTCT elements to allow longitudinal follow up and conduct regular review to inform the targeted case finding and prevention care and treatment program.

To improve the adolescent HIV services, in COP23, PEPFAR Rwanda will implement the new adolescent model "Operation Triple Zero": zero missed ARVs, zero missed appointments and zero VL. A new approach for adolescent HIV services delivery that fully involves beneficiaries in activities meant for them. With this asset-based approach, adolescents cognitive 'strength will be seen as strong ingredients to the solution of their problems and co- producers as opposed to passive recipient while supporting treatment cascade for all 95s. With this strategy, adolescents will gain more involvement, feel empowered and motivated and participate in activities meant for them led through adolescent peers/ champions thereby creating friendly environment for CALHIV and promotes sense of positive living including U=U. The strategy also embraces active participation of care givers promoting treatment literacy improving adherence, and viral load suppression

Laboratory quality improvement of testing regardless of whether its lab- or POC-based testing is a continuous process, and its management requires intentional and systematically planned activities implemented and reviewed consistently to achieve set quality goals on different essential quality elements and customer centered service satisfaction that remains a challenge despite the continued investment of resources. Since COP22, PEPFAR is working with implementing partners on an impactful laboratory CQI approach including the building of capacities in developing and use of standardized tools for delivering and assessing quality of various HIV/TB sites testing as well as digitizing those tools and implementing e-lab systems to quickly generate semi-quantitative gap analysis reports of the same. In COP23, PEPFAR will work with RBC and partners to establish an integrated laboratory data analytics platform that generates periodic profile of each testing site including the level of testing and quality audit performances. This will be used to inform gaps in CQI management and targeted interventions such as staff mentorships and training using virtual platforms, and/or testing process improvements as well as provide evidence-based approaches of quality improvement strategies and investment of increasingly meager resources where they are most needed for country ownership and sustainability of high-quality testing services in the laboratory network.

Leading with Data

Rwanda has made significant progress in addressing the HIV epidemic, with a national all-age prevalence rate of 1.76 and an estimated 91% of people living with HIV on antiretroviral therapy (2022 EPP Rwanda). However, there are still challenges that need to be addressed to

achieve the country's goal of ending the HIV epidemic by 2030. Data and leading with data have been a theme of Rwanda's HIV response in general and PEPFAR support.

The Rwanda HIV/AIDS NSP 2018-2024 is a comprehensive roadmap that outlines the country's goals and strategies for addressing the HIV/AIDS epidemic. In this plan, strategic information, and leading with data were given an enabler role in the effective planning, implementation, and monitoring of interventions. In the Mid-term Review of the NSP, key strategic issues were identified in further strengthening data generation, analysis, and data use as part of the national HIV response. As a key contributor to the national strategy, PEPFAR will support data generation through program monitoring, evaluations, surveys, and surveillance to generate new data, and promote data use to address the gaps.

In Rwanda, data triangulation and use at the central level is optimal, whereas there are data use gaps at district and health facilities. To fill this gap, in COP2023 PEPFAR will strengthen and continue its data mentorship support and use tele-mentorship and eLearning approaches. PEPFAR will also provide training on MER data collection and reporting, which has a spillover effect to improve the national data collection, use, and reporting.

PEPFAR is supporting the MoH-owned EMRs in generating patient-level granular, longitudinal data. In COP2023, PEPFAR will support and enhance EMR's functionality through enhancements, upgrades, deployment and ensure adequate support is provided to health facilities through the DH IT specialists. Nurses and data managers at health facilities will be supported to ensure data entry is up to data and quality remains high. PEPFAR will also ensure the interoperability of EMRs with other health information systems: RHMIS, LIS, and the registries by maintaining the functional software components of the RRHIE. PEPFAR will address ongoing technical issues promptly by supporting the help desk system. In all these efforts, PEPFAR will ensure data privacy and security.

The PEPFAR-supported HIV CBS, which includes recency data, generates critical granular data for surveillance and program monitoring. The recency data have been used to identify clusters of recent infections and a general indication of populations among whom transmission is happening, prompting public health response. Prevention programs have used the CBS and recency data to identify those at highest risk of HIV infection (e.g., SDC and KPs who do not self-identify as such) for appropriate interventions such as PrEP. Sexually active AGYWs and other populations at risk are also identified through CBS. Further, the Rwanda PEPFAR team uses the CBS to characterize treatment outcomes at individual patient level. So far, analysis have been conducted on retention among cohorts of patients on treatment (with a focus on profiling those not retained), regimen change and reasons for change, and viral suppression (with a focus on those not suppressing). PEPFAR will continue supporting the MOH/RBC's efforts to

implement the CBS systems in PEPFAR and non-PEPFAR sites to ensure that relevant patient level outcome data are used to improve programs nationally.

To ensure sustainability of the case surveillance system, PEPFAR will maintain the digital platform on OpenMRS ver. 2. x - including helpdesk support. PEPFAR will also continue its technical assistance to RBC on data management for HIV CBS, advanced analytics, and data visualization. Furthermore, PEPFAR Rwanda will leverage FETPFETP to improve the CBS system.

PEPFAR supports the RBC and NRL to generate data on HIV drug resistance through routine surveillance using remnant blood from viral load testing. The formative assessment conducted through a national survey will be completed in COP 22 and the PEPFAR Rwanda team propose the integration of HIV-drug resistance surveillance as part of routine service delivery hence requiring minimal additional investments but generating critical data on treatment. PEPFAR will enhance NRL capacities to analyze and use data generated from existing digital tools and LIS to inform program planning.

The quality of routine health service data is improving incrementally through continuous technical assistance. PEPFAR Rwanda will continue this effort and update the MoH's data quality framework to ensure data is accurate and reliable. Quarterly data reviews will be conducted at district and health facility level to promote data use in identifying programmatic gaps. Innovative methods, including tele-mentorship and eLearning, will be used in COP 23 to promote data use.

To ensure data from the supply chain is supporting not only logistic activities but also supplements other data streams, PEPFAR Rwanda will continue to strengthen the use of an electronic Logistic Management Information System(eLMIS) at all levels.

Improving the community-based health information and reporting system for case finding and case management with a focus on KP and PP requires another area of focus. In COP2023, PEPFAR Rwanda will continue to support OVC and DREAMS' electronic case management system. Furthermore, PEPFAR will strengthen the capacity of community-based health workers in using this platform and triangulate data from this system with other data systems.

To ensure that data for KP programming are current, the PEPFAR-Rwanda team proposes to support a PSE and IBBS among MSM in the second year of COP23. Data from previous PSE and IBBS have been effectively used to plan interventions, set targets, inform commodity forecasting and to assess service coverage among these important populations.

In conclusion, PEPFAR Rwanda will support Rwanda to sustain epidemic control by strengthening data systems and capabilities that enable programs are led with high quality data.

Target Tables

These target tables can be found with prepopulated target and PLHIV estimate data in the SDS chapter of the COP23 Target Setting Tool dossier in PAW. Where applicable, PEPFAR teams should also include population size estimates using available data from additional sources. Bilateral OU programs should include national FY25 targets in these tables and FY25 targets are not required for regional programs.

Target Table 1 ART Targets by Prioritization for Epidemic Control

ART Targets by Prioritization for Epidemic Control							
Prioritization Area	**Total PLHIV (FY23)**	**New Infections (FY23)**	**Expected Current on ART (FY23)**	**Current on ART Target (FY24) *TX_CURR***	**Newly Initiated Target (FY24) *TX_NEW***	**ART Coverage (FY24)**	**ART Coverage (FY25)**
Attained	**235,272**	**3,243**	**130,601**	**134,037**	**6,204**	**94%**	
Scale-Up Saturation							
Scale-Up Aggressive							
Sustained							
Central Support							
Commodities (if not included in previous categories)							
No Prioritization							
Total	**235,272**	**3,243**	**130,601**	**134,037**	**6,204**	**94%**	**95%**

Target Table 2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

VMMC Coverage and Targets by Age Bracket in Scale-up Districts							
	Target Populations	Population Size Estimate	Current Coverage	VMMC_CIRC	Expected Coverage	VMMC_CIRC	Expected Coverage
SNU	[15-59]	(SNUs)	(date)	(in FY24)	(in FY24)	(in FY25)	(in FY25)
	Total/	3,256,608	75.5%	160,000	80.5%	160,000	85.4%
Kigali City	319,925	344,419	92.90%	17,600	98.00%	17,600	103.1%
East	572,223	826,434	69.20%	37,600	73.80%	37,600	78.3%
North	426,072	527,043	80.80%	29,601	86.50%	29,601	92.1%
South	546,352	821,112	66.50%	43,199	71.80%	43,199	77.1%
West	595,517	737,600	80.70%	32,000	85.10%	32,000	89.44%

Target Table 3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY24 Target**	**FY25 Target**
FSW (KP_PREV)	37,646	35.50%	32,819	32,819
MSM (KP_PREV)	18,100	6.87%	10,000	10,000
Clients of FSW (PP_PREV)			24,735	24,735
AGYW 15-24 (PP_PREV)		0.82%	84,775	84,775
Male Partners of AGYW 15-24			5,164	5,164

Target Table 4 Targets for OVC and Linkages to HIV Services

Target Table 4 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC**	**Target # of OVC**	**Target # of active OVC**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files**
		OVC_SERV Comprehensive	**OVC_SERV Preventative**	**OVC_SERV DREAMS**	**OVC_HIVSTAT**
East		17,283	3,000	8,779	11,614
Kigali City		26,120	10,500	23,601	20,266
North		-			
South		16,759	3,000	5,445	11,382
West		52,831	3,500		39,161
FY25 TOTAL	392,644	112,993	20,000	37,825	82,423

Core Standards

Below is the status of PEPFAR's core standards in Rwanda:

1. **Offer safe and ethical index testing to all eligible people and expand access to self-testing**.

During FY22, Safe and Ethical index assessment identified weaknesses in index testing adverse events monitoring and response, therefore in FY24 implementation period, PEPFAR will continue to reinforce documentation on Adverse Events Monitoring and response. This includes LIVES training to clinical mentors and HCPs.

In FY23 all PEPFAR sites providing index testing received training by RBC, site and provider-level compliance assessment was conducted to ensure minimum standards were followed. In FY24, PEPFAR Rwanda will ensure all PLHIV offered index provide verbal consent/assent for HIV testing (provided informed consent prior to the elicitation interview and before contacting partners) and HIV testing to every child under age 19 years with a biological parent or biological sibling living with HIV will be offered.

In FY24, PEPFAR will ensure partners meet minimum standards for safe and ethical index testing at each site implementing index testing which include: Adherence to 5 Cs (consent, confidentiality, counseling, correct test results, and connection to prevention/treatment); IPV risk assessment and provision of "first line" response, including safety check and referrals to clinical and non-clinical services (if not provided at the site); A site level adverse event monitoring and reporting system; Providers trained and supervised on index testing procedures including 5Cs, IPV screening, adverse event monitoring, and ethics (respect for the rights of clients, informed consent and do "no harm"); Utilizing QA and accountability to remediate any gaps in provision of index testing services.

In FY24, PEPFAR sites will continue to implement a robust mechanism for detecting, monitoring, reporting, and follow up on any adverse events associated with index testing services. Each site will continue to ensure IPV risk assessment is conducted for each index partner (if IPV negative – partner notified using chosen mode – Provider/Client/Contact/Dual referrals and If IPV positive, client will be counseled and referred/linked to GBV services). IPs have developed a monitoring & reporting mechanism for any index testing related AEs.

2. **Fully implement "test-and-start" policies. Across all age, sex, and risk groups, over 95% of people newly identified with HIV infection should experience direct and immediate linkage from testing to uninterrupted treatment.**

Rwanda's most significant challenge in reaching HIV epidemic control is finding new HIV positive individuals. HIV testing is essential in achieving the first UNAIDS target of having 95% of PLHIV be aware of their HIV status by 2030. In Rwanda, the HIV program initiated a combined implementation strategy of facility-based and community-based approaches to help achieve high levels of HIV testing coverage countrywide and link them to treatment.

Following WHO recommendation, Rwanda initiated Test and Treat (Treat All Strategy) in 2016 for all populations and in all health facilities. With this policy, same day ART initiation is implemented for diagnosed HIV positive patients who are treatment naïve and are ready to start treatment, regardless of CD cell count. The national HIV guidelines recommends no more than seven days before ART initiation for patients who are not ready to start ART the same day of HIV positive results. Counselling is provided to promote adherence to treatment, and interventions to ensure timely linkage to treatment and stigma reduction are employed at all facilities. The interventions include enhanced linkage with case management, ensuring support from peer patients, QI approaches using data to improve linkage, and use of new technologies such as mobile phone text messaging for follow up and home visits.

With Treat All Strategy, the national universal ART coverage for all age groups has increased from 85% in 2016 to the current 91% according to the recent 2023 EPP Spectrum estimates. Nevertheless, the ART coverage is still low among children and adolescents, ranging from 50-80%. Rwanda plans to implement COP 23 activities with an equity focused lens by prioritizing these age groups. With a national linkage rate of 98%, treat all has increased the number of patients on ART, necessitating differentiated ART services delivery that fits patients' needs. When categorized by the ART pick up schedules, the majority of PLHIV on MMD ART pick up at six (51%), three (27%), and one (22%) respectively. This differentiated care model reduced un-necessary frequent clinic visits and freed up time for clinician to prioritize case management based on the patients need and clinical judgement.

Clients testing HIV positive receive treatment preparation education and be initiated on ART the same day where feasible after assessing their readiness. For those who are not ready to initiate treatment the same day, HCPs conduct treatment preparation sessions and ensure the ART initiation within seven days. Treatment preparation education sessions conducted individually or in group counselling sessions. Systematic recency testing of all newly diagnosed HIV positive individuals aged 15 years and older to identify cluster investigation, and enrolment in CBS is conducted as per National guidelines.

With COP 23 funding, PEPFAR will support effective and tailored early linkage to treatment strategies to sustain optimal linkage rate focusing on PPs (children, adolescents and KPs). These include enhanced Pre-ART counselling, flexible and extended clinical hours to support same day enrolment, strengthen community peer navigator program, enhanced referral and counter referral mechanism, improved tracking of non-linked PLHIV through phone calls, text messages and home visits, enhanced support groups of parents/guardians of CLHIV to improve linkage to treatment.

3. **Directly and immediately offer HIV-prevention services to people at higher risk.**

In COP 23 PEPAFR will target the following KP: commercial sex workers (CSW) including FSW and MSW, MSM and TG. In addition, PEPFAR will target PP at high risk of contracting HIV such as SDC, AGYW and clients of CSW.

In COP23, PEPFAR Rwanda will continue to support HIV testing targeting high risk populations through community-based testing with mobile outreach for KP and PP, linking those identified HIV positive to ART and linking individuals with HIV negative results to essential prevention services which include VMMC, other prevention services including condoms, lubricant, and PrEP services if eligible.

KP and PPs such as CSW, MSM, TG and clients of sex workers will be identified through KP community testing and referred to facility for care and treatment and prevention. AGYW are recruited through all the PEPFAR partners working with KPs, as well as through DREAMS program.

Eligible partners of SDC and index partners at high risk will continue to be recruited by PEPFAR-supported health facilities through PMTCT, Index testing and care and treatment services.

The prevention package of services offered to KPs and PPs includes targeted community HTS (mobile HIV testing, self-testing, social network testing), PrEP, risk reduction counseling retesting every 12 months, linkage to peer education services, linkage to care and treatment services, STI education, screening and treatment, condom and lubricant distribution and promotion, family planning counselling and services, GBV services, TB screening and treatment and post exposure prophylaxis (PEP). To get continuous KP feedback on services provision, PEPFAR will continue conducting regular structured listening sessions with KP group to learn about the experiences of KP when accessing health services to inform KP service delivery improvement and KP programming.

PEPFAR will continue to improve the VL suppression among KP by using specific KP adherence group support for the unsuppressed KP and regular review of use CBS data to profile the KP that are not suppressing and lay out specific strategies to support them. The Peer navigators in

collaboration with PEPFAR IPs will continue to support mobilization, referral and follow up of KP in the program.

KP/PP prevention program implementation will be measured through monthly and quarterly data review and coordination meetings with RBC, MOD, and PEPFAR IPs, CSOs and other stakeholders involved in KP services. During these meetings, the participants will review KP data, update the KP hotspots, identify challenges and best practices to inform program adjustment. In COP 23, PEPFAR team in collaboration with IPs will continue providing capacity building and mentorship to HCP on provision of KP appropriate services to reduce KP barriers to HIV prevention and treatment services, ensure the safety and security for KPs and strengthen GBV and stigma discrimination services implementation at the health facilities.

IPs will closely coordinate with health facilities to ensure linkage of HIV positive KP/PP to ART services as well as enhance support and follow up of KP for retention and drug adherence. Site visits will be carried out for all PEPFAR-partners supporting KP services to ensure quality of services and data collection and reporting.

In COP23, the USAID/PEPFAR Rwanda 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. By integrating sexual violence and HIV prevention programming into the existing curriculum, 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. Through the OVC preventive approach, the OVC program will continue to provide the prevention package through the use of the following evidence-based curricula: 1) SRH, which is approved by GoR and accepted by S/GAC with the addition of the S/GAC module on sexual consent; 2) FMP which is in use by DREAMS and OVC; and 3) CBIM which was adapted to the Rwandan context. Also, the program will continue working on good relationships with the beneficiaries to ensure the latter know their HIV status under the OVC comprehensive package. It will continue to coordinate and strengthen linkages with various stakeholders, including other HIV prevention partners, the police, and Isange One-Stop Centers, to ensure beneficiaries get their services in a friendlier manner. With help of the above-mentioned 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.

4. **Provide orphans and vulnerable children (OVC) and their families with case management and access to socioeconomic interventions in support of HIV prevention and treatment outcomes**.

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 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 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 districts in Eastern province (Rwamagana and Kayonza).

The OVC program will be fully implemented by five local partners that get USAID direct funding. The IPs will implement the comprehensive case management approach under the OVC Comprehensive package, and the OVC Preventive package targeting boys and girls aged 10-14. Under the OVC Comprehensive, it will implement key interventions enabling beneficiaries to meet the key outcomes: healthy, stable, safe, and schooled. For OVC Preventive, the OVC program will continue to implement primary prevention for HIV and sexual prevention among 10-14 boys and girls using the following evidence-based curricula: 1) *SRH,* which is approved by GoR and accepted by S/GAC with the addition of the S/GAC module on sexual consent; 2) *FMP* which is largely in use in DREAMS programming; and 3) CBIM which was adapted to the Rwandan context. USAID and OVC partners will work together with GoR entities, especially MINEDUC, on the plan to gradually transition some curricula like CBIM.

5. **Ensure HIV services at PEPFAR-supported sites are free to the public.**

PEPFAR Rwanda program met this standard. Access to HIV services, medications, and related services are offered to the public for free nationally, regardless of funder support at the facility level. Prevention, care, and treatment services will remain free of charge nationally, including all PEPFAR supported sites in Rwanda, in COP23.

6. **Eliminate harmful laws, policies, and practices that fuel stigma and discrimination, and make consistent progress toward equity.**

Overall, in Rwanda, there are no policies or laws which fuel stigma and discrimination. Homosexuality is not criminalized, however, culturally it remains taboo. The HIV NSP and National Guidelines require stigma and judgement free services for all who seek care. In practice, challenges remain with HCPs who have not received the proper training in stigma-free service delivery. PEPFAR will continue to work on supporting the national program to ensure stigma and discrimination free services are accessible to all.

7. Optimize and standardize ART regimens. Offer DTG-based regimens to all people living with HIV (including adolescents, women of childbearing potential, and children) 4 weeks of age and older.

Reducing the number of HIV related death and decrease HIV morbidity is one of the goals of Rwandan NSP 2018-2024 as it strives to achieve the 95-95-95 UNAIDS targets by 2030. To achieve this goal, the Rwanda MoH implemented proven strategies to expedite ART initiation and enhance retention and adherence to treatment. Following 2016 WHO recommendations, Rwanda initiated Treat All strategy in the same year to improve early initiation of ART, limit disease progression thereby decreasing morbidity and mortality among ART naïve patients and reduce further HIV transmission. This strategy resulted in a high number of ART patients getting ART at health facilities. In 2017, the MoH and partners in HIV response adopted differentiated service delivery allowing eligible patients to a MMD of ART with corresponding clinical visits. Currently, Rwanda implements both 3 and 6 MMD with 51% and 27% of ART being on 6 and 3 MMD respectively.

In COP 18, MoH started policy and guideline revisions to support transition of all patients from tenofovir/lamivudine/efavirenz (TLE) to Tenofovir/Lamivudine/Dolutegravir (TLD) starting with new patients on ART with the aim of full transition to TLD by June 2019. Since June 2019, all new and existing PLHIV on ART >20kg were provided with DTG 50mg based regimen including women of reproductive age. Only children <20 kg remained on the legacy medications (ABC/3TC/LPV/r) due to lack of approved pediatric DTG dosage.

By the end of FY 22, 98% of all PLHIV were on DTG based regimen of whom 98% are on TLD. Following successful TLD transition for adults, and availability of approved pediatric dolutegravir (pDTG) dosages (DTG 10mg), Rwanda started implementation of pDTG for all children from 4Kg to 20 kg in all districts. To support this process, a comprehensive forecasting and supply plan tool was developed for the monitoring and tracking of ARV inventory levels and service demand. Access to pDTG treatment was initially prioritized for new HIV positive children to limit wastage of the legacy ARV. By Dec 2022, all health facilities reported complete transition of all pediatric PLHIV on legacy medication to pDTG base regimen raising the coverage to 95% for first line regimen. However, despite high coverage for optimized pDTG, viral load suppression among children and adolescent continue to lag mainly due to 1) many health facilities completed pDTG regimen transition in less than 6 months due to phased transition approach and it might be still early to witness pDTG effect, 2) the adherence to treatment among this age group is still less optimal compared to adults. Nevertheless, the overall national viral load suppression for children and adolescents has slightly improved from 85% in 2020 to 87% in 2022.

With COP 23 funding, children and adolescents will be prioritized supporting facility and community strategies to improve case finding, timely linkage to optimized treatment, adherence, and retention strategies to improve treatment outcomes and using routine data to monitor performance and modify strategies as appropriate. COP 23 funding will also support longitudinal follow up of patient and pharmacovigilance approaches to timely detect and manage pDTG based adverse drug reactions and treatment failure.

8. **Offer differentiated service delivery models. All people with HIV must have access to differentiated service delivery models to simplify HIV care, including 6-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve ART coverage and continuity for different demographic and risk groups and to integrate with national health systems and services.**

Differentiated service delivery (DSD) is a person-centered approach that simplifies and adapts HIV services across the cascade in ways that both serve the needs of people living with and vulnerable to HIV and optimize available resources in health systems.

The national HIV program introduced DSD Model for HIV treatment in 2016 at all health facilities across the country and is well defined for clinical follow up visits, pharmacy refill and psychosocial support including tailored adherence support groups for children, adolescents, pregnant and breastfeeding women, and key populations. The DSD model categorizes PLHIV in two categories based on predefined criteria: 1) a more intensive (unstable) category with 1-month pharmacy refill and 3 months clinical follow up visits and 2) a less intensive (stable) category with 3 months to 6-month pharmacy refill but all coming for 6 months clinical follow up. Semi-annual facility clinical follow up visits are complemented by community adherence support and screening of STI and OIs. In 2020, the DSD model was updated to include 6-month pharmacy refill and 12 months clinical follow up visit and monthly community support services including adherence and retention, screening of STI and OIs including TB screening for pregnancy intentions and orientation to community based socio-economic support for vulnerable youth and adolescents.

National data for December 2022 showed an improvement on 6 (MMD) enrollment (51%) with progressive reduction of PLHIV on 1 month (22%) and 3 months MMD (27%). The enrollment of PLHIV on 6 months are expected to increase by the end of COP22, with the implementation of the revised guideline which includes adolescent, children, and pregnant and breastfeeding women into 6 MMD and clinical follow-up.

In COP23, PEPFAR will continue supporting the implementation of the DSD model with a focus on monitoring of 3 and 6 MMD implementation at all PEPFAR sites. 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 and tailored community and facility adherence

support and retention for children, adolescents, pregnant and breastfeeding women and KPs to improve VL suppression and health outcome.

9. **Integrate tuberculosis (TB) care. Routinely screen all people living with HIV for TB disease. Standardized symptom screen alone is not sufficient for TB screening among people living with HIV and should be complemented with more-sensitive and setting-specific, WHO-recommended screening tools. Ensure all people living with HIV who screen positive for TB receive molecular WHO-recommended diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.**

The National Tuberculosis Program (NTP) has made substantial progress in the integration of TB and HIV services, and this remains a key priority intervention area in both HIV and TB national Strategic Plan 2019-2024.

According to the national TB report 2022, remarkable progress to this end has been realized with systematic TB symptom screening coverage among PLHIV at >95%, 99% TB cases tested for HIV infection yielding 14.4% HIV positive and 95% ART coverage. However, TB treatment success rate among PLHIV remains lower 84.4% when compared to 88.8 % treatment success rate of all susceptible TB cases and TB associated death remains higher 13% than the death attributable to all susceptible TB cases (7.8%).

Despite this tremendous achievement, there are still gaps in TB screening and diagnosis. National data indicates a decrease of 28,4% of the presumptive TB while the positivity rate increased from 2.3 % to 3.2% when compared FY 21 to FY 22. The drop in the presumptive TB cases is likely attributed to suboptimal sensitivity of TB symptom screening leading to under-diagnosis and missed treatment with likelihood of TB-related mortality of about 13% among PLHIV compared to 7.8% overall TB deaths.

TB TPT is an important component of TB/HIV integration service delivery and as of FY 23 Q1, 25 out of 30 administrative districts were implementing TPT. National data shows improvement on TPT coverage and completion rate of 80% (171,832/215,056) and 95% respectively. PEPFAR contributes 54% (93,438/171,832) to reported coverage, maintaining 94% treatment completion and 99% TB symptom screening among PLHIV. All TB patients who tested HIV positive were initiated on ART as reported in APR 2022.

In COP23, PEPFAR will leverage funding for other donors to complete TPT provision to the remaining and new PLHIV on treatment and support targeted interventions to address the gaps in the national TB program, thus improving TB case finding, diagnosis and treatment to reduce TB-associated deaths among PLHIV. These include: 1) Improved TB case finding using sensitive TB screening and diagnostic tools: PEPFAR will support the revision of the national TB screening

and diagnostic algorithm to include adapted screening approaches for different HIV subpopulations including chest X-ray with/out Computer-Aided Detection (CAD), C-Reactive Protein (CRP), lateral flow urine lipoarabinomannan (LF-LAM) antigen testing, Molecular WHO-recommended rapid diagnostic tests (mWRDs), and enhance TB case notification among children using non-septum specimen(stool), 2) Improved TB treatment completion through psychosocial, nutrition and adherence support, 3) Enhanced early ART initiation, and TPT completion for all eligible PLHIV and 4) ensure algorithms, SOPs, laboratory and clinical training materials are developed , disseminated , implemented and monitored for quality assured testing and service delivery.

PEPFAR will continue to support TPT service provision in the context of ART MMD ensuring clinical and pharmacy pickups are aligned.

10. **Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of ≥ 1 year, or virally unsuppressed for ≥1 year should be evaluated for AHD and have CD4 T cells measured. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The WHO-recommended and PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.**

In 2016, Rwanda initiated Test and Treat (TREAT ALL Strategy). This shift towards early initiation of ART, together with targeted HIV case finding strategies and linkage to treatment, has led to an overall improvement in patients' treatment level outcome.

Despite this progress, PLHIV continue to present to care with advanced HIV disease – defined by WHO as having a CD4 cell count <200 cells/mm3 or a WHO clinical stage 3 or 4 disease for adults, adolescents, and children < 5 years not stable on ART or ≥five years initiating ART or re-initiating ART after 3months of treatment interruption. People presenting with advanced HIV disease are at high risk of death, even after starting ART, with the risk increasing with decreasing CD4 cell count, especially with CD4 cell count <100 cells/mm3.

In Rwanda, CD4 count test is recommended and performed for all newly identified HIV positive before ART initiation and whenever clinically indicated (ART re-initiation and ARV treatment failure) to assess AHD. WHO clinical staging is also done to categorize HIV disease severity based on new or recurrent clinical events. A package of care for PLHIV presenting AHD is implemented at facility and community level to reduce HIV Comorbidities and deaths and this includes screening, treatment and/or prophylaxis for major OIs (TB and Cryptococcus meningitis), rapid ART initiation and intensified adherence and retention support approaches. Nevertheless, lack of systematic and routine CD4 monitoring for PLHIV especially those re-engaging in program after treatment interruption or prioritizing viral load test as opposed to CD4 testing for virally unsuppressed creates a missed opportunity to detect and manage AHD.

There is no screening algorithm to screen AHD other than cryptococcal infection leaving out other possible fungal and malignant disease-causing agents that sometimes go undiagnosed and lead to severe morbidity and mortality.

In COP23, PEPFAR will support the implementation of adapted interventions to improve the quality of AHD package. These include AHD Centered Care Model/Differentiated Service Delivery to improve the screening and management of Opportunistic Infections (OIs), coinfection treatment outcome as well as tailored adherence and retention interventions, Improved quality of service provision through the development of SOPs, capacity building of CPs), mentorship, supportive supervision, and CQI.

11. **Optimize diagnostic networks for VL/EID, TB, and other coinfections**.

In 2020, the Rwanda MOH through NRL with support from the Clinton Health Access Initiative (CHAI) and partners conducted a molecular DNO exercise and specimen referral system (SRS) design. Since COP21, USG agencies were also engaged by CHAI and NRL to implement optimized scenarios of the integrated laboratory testing network and evolving a continuous monitoring framework of the implementation for efficient use of existing molecular testing instruments and other laboratory support systems for HIV VL/EID, TB, Hepatitis, and other infectious diseases such as COVID-19 and other emerging pandemic threats in the region such as viral hemorrhagic fevers (VHFs).

In COP22, PEPFAR is supporting NRL to lead efforts of this still nascent initiative for strong country led coordination and stakeholder engagements and support to provide more than 95% access for all eligible PLHIV to annual VL testing and the use of routine testing data with already established reporting mechanism from the diagnostic network. In COP23, PEPFAR considers this initiative with support to semi-annual/ annual engagements of laboratory stakeholders for monitoring of the DNO implementations and strategic partnerships for sustainable lab testing network and services of HIV, TB, and other programs towards improved testing service coverage with strong country led partnerships and efficient laboratory systems for timely ordering and return of test results across age, sex, populations, and geographical regions. Thus, PEPFAR will continue strengthening routine monitoring and evaluation framework using defined key performance indicators (KPI) to ensure optimal testing coverage and, where possible, integration of near POC testing platforms to eliminate redundancies and contingency testing capacity including decentralized sample transportation system in a finite laboratory catchment area closer to healthcare facilities

Currently, VL and EID testing is offered using a hub and spoke approach using high throughput conventional PCR and near POC instruments to address disproportionate testing demands from ART and PMCT programs, respectively. EID testing is transitioning from a standalone testing platform (mPIMA) and use the existing multi-disease testing platform (GeneXpert) established

country wide by the national TB program at all hospitals and selected health centers in PEPFAR supported sites. GeneXpert platform is used for TB diagnostics among clinically suspected PLHIV and supporting rollout of TPT among TB negative PLHIV. In COP23, all EID testing services will be fully transitioned to batched testing using conventional PCR to the single cartridge based using the GeneXpert platform that accommodates decreasing volume of EID testing and facilitate same day return of test results to promote strategies for EMTCT, timely diagnosis and rapid ART initiation of HIV exposed infants. This transition will also incorporate EID testing into TB GeneXpert CQI to ensure quality assurance of both HIV and TB testing.

Since 2018, all VL testing hubs operate a functional LIS for laboratory services delivery and monitoring of QI and QM at testing sites that are hosted centrally at the NRL and accessed through the internet at all health facilities. In COP23, there will be LIS data integration into analytics platforms (dashboards) supported by the MOH digital transformation strategy to foster CQI, monitoring and reporting on key performance and quality indicators of testing sites as well as integration of LIS with other e-health systems such as CBS and EMR (OpenMRS) used for management and clinical follow up of PLHIV. This relieves HCP from the burden of multiple siloed access to a single instance for requesting test and return of test results. The data from these systems will also be leveraged for real-time monitoring of site-level VL coverage and suppression rates, identifying testing sites necessitating CQI based on suboptimal specimen referral management and delayed return of results often due to breakdown in supply chain and testing equipment despite having in place a well-established national coordinated procurement and distribution system (CPDS) for supply chain forecast reviews and planning, procurement, inventory, and distribution of public health commodities and equipment.

12. **Integrate effective quality assurance (QA) and continuous quality improvement (CQI) practices into site and program management.**

To ensure the quality of services in COP23, the PEPFAR team in collaboration with IPs will conduct ongoing program and site standards assessments to PEPFAR supported sites through various approaches including SIMS, DQAs, index testing ethical assessment and enhanced partner management.

SIMS and MER metrics are the tools that will be used for QA and QI. The prioritization of sites to be visited will be based on both program needs and program gaps. To address program needs, PEPFAR will prioritize sites that are implementing the full package of the HIV program including prevention and care and treatment activities. Using MER data from the FY22 annual report, PEPFAR will give priority to sites that have low performance against targets for some selected indicators and/or sites that have challenges for meeting the MPR implementation. The SIMS plan will be continuously updated considering the quarterly MER results, prioritizing sites that show low performance and those that have challenges meeting MPR, including IPC. PEPFAR will

also give priority to PEPFAR supported district hospitals to continue assessing their QA/QI integration in the management and delivery of HIV care services so that they are able to support QA/QI in the health centers under their catchment area.

The OVC and DREAMS programs will continue to use SIMS in COP 23 to ensure quality of services for vulnerable children and their households and AGYW. USAID prioritizes sites by considering any new IPs, new sites added during the COP year, and sites that did not meet all the PEPFAR requirements during previous assessments and need further attention. Supply chain activities will be assessed through a Quality Management Improvement Approach (QMIA). USAID DQAs will focus on key indicators such as PrEP, HTS, OVC (HIV STAT in particular) and AGYW PREV in COP 23. Supply Chain DQAs assess the data management systems of USAID IPs by analyzing program indicators using data quality standards of validity, integrity, precision, reliability, and timeliness (V-I-P-R-T).

RDF/DOD program acknowledges SIMS as a QA and improvement tool that has helped monitor and improve community and facility sites to meet standards of quality services provided to clients and remove barriers that may affect outcomes. The RDF/DOD program will continue to ensure that RMH, Brigade clinics and KP outreach sites meet SIMS standards. This includes creating awareness among RDF and AHC staff on core essential elements to sustain and improve site performance and data quality.

During COP23, DOD through AHC will support to enhance knowledge of RDF health care providers in SIMS standards through QA and QI training based on SIMS standards. Mentorship of all SIMS standards will be conducted quarterly during field activities to ensure that all RDF health facilities understand and are in line with the most recent SIMS standards in terms of systems in place and performance measurement. This will be achieved through onsite training at RMH and brigade clinics. Trainings will be based on new MOH guidelines, data quality and compliance with SIMS standards at both facility and community.

In COP23, the PEPFAR team will continue assessing the implementation of index testing to ensure that all PEPFAR supported sites providing index testing services meet the following minimum standards for safe and ethical index testing: 1) adherence to 5C's (consent, confidentiality, counseling, correct test results, and connection to prevention/treatment), 2) IPV risk assessment and provision of "first line" response, including safety check and referrals to clinical and non-clinical services (if not provided on site), 3) a site level adverse event monitoring and reporting system, 4) providers trained and supervised on index testing procedures and 4) ethics (respect for the rights of clients, informed consent and 'do no harm'). The assessment will be conducted using standard assessment tools.

In COP23, the PEPFAR team will continue to strengthen partner management to ensure that all IP work plans are aligned with COP22 strategic objectives and include QA and CQI activities.

PEPFAR will enhance partner management though partner meetings to review achievements, identify challenges, and problem solve. To address the programmatic challenges identified in FY 23 Q1, related to the implementation of TPT, prevention program targeting MSM, SNS, and HIV case finding among children, the PEPFAR team will enhance the partner data review to identify challenges and best practices. Partners with poor performance will receive monthly site-level monitoring and mentorship with monthly data reporting.

The PEPFAR Rwanda team understands that data must be of high quality if they are to be relied upon for making good decisions on health policy, health programs, and allocation of scarce resources. Data gives the picture of what is happening; bad quality data calls the entire system into question. PEPFAR Rwanda team in collaboration with MOH/RBC and other implementing partners have been conducting DQA and built capacity to generate and use high-quality data.

The PEPFAR Rwanda team has adopted tools to collect, compile, and report quality data for planning; measure the accuracy of reporting priority indicators; and troubleshoot data quality issues. The DQA tool permits formal assessment of the data quality for priority indicators in PEPFAR supported programs. It is adopted for the PEPFAR site level and above site level programs as an integral part of performance-based measures of data accuracy for selected indicators.

In 2021, the PEPFAR team adopted the HIV/AIDS DQA Tool, which is a checklist that supports a targeted, rapid data-quality assessment focused on HIV data for use in routine data quality monitoring as part of regular M&E efforts through joint supportive supervision. The tool aims to standardize and facilitate the assessment of PEPFAR supported HIV program data quality by the PEPFAR team in collaboration with MOH, RBC, and other PEPFAR funded IPs using well-organized and/or planned supportive supervision visits at site levels. This tool has also been used by central and district staff jointly with site level teams to assist in data quality improvement efforts. The PEPFAR Rwanda team's DQA tool also offers considerations for personnel and logistics, sampling considerations, details on preparing for fieldwork, and step-by-step user guidance for using the tool.

In FY 2022, the PEPFAR Rwanda DQA process used collaborative effort among the PEPFAR Interagency team, MOH, RBC, and other IPs to promote a harmonized approach to assessing the quality of data reported, from the health facility and community levels to the national level. During this period a total of 26 out of 192 sites were visited since the DQA exercise only started in the fourth quarter. In FY 2023, the projection is to visit 140 sites which is above 70% of all PEPFAR supported sites. And, therefore, as one of ongoing quality management activities, the PEPFAR Rwanda team will continue conducting an integrate data quality assessment in PEPFAR supported sites at national level.

In FY2024, as reliable data are key to reaching and sustaining the 95-95-95 goals, PEPFAR Rwanda will continue supporting the MOH, RBC, and other PEPFAR supported IPs to strengthen the existing facility and community-based M&E systems to ensure data quality and institutionalize the processes as part of the entire data management cycle for PEPFAR routine M&E systems to ensure the limited resources are used effectively. This will ensure that progress toward established goals are accurately monitored, measured, and reported, and decisions are based on strong evidence. Moreover, the PEPFAR Rwanda team will continue analyzing the DQA results to take necessary actions at the point of service delivery as well as in the PEPFAR and the national reporting systems as soon as possible. If errors are identified in data, remediate actions have been taken. PEPFAR Rwanda will be more committed to ensure that the MER data collected are not only accurate and timely, but also to use and analyze the data to achieve maximum program impact.

13. **Offer treatment and viral-load literacy. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. Undetectable = Untransmittable (U=U) messaging and other messaging that reduces stigma and encourages HIV testing, prevention, and treatment should reach the general population and health care providers.**

Treatment and VL literacy are a critical component of a successful HIV program. Knowledge about HIV infection, benefits of early HIV testing and enrolment on treatment, and stigma reduction practices are all essential towards achieving HIV program impact. With national ART coverage of 95%, treatment and VL literacy is the key motivator to adhere to antiretroviral medications and clinical follow up visits including routine HIV VL testing, which contributes to preventing new HIV infections through treatment as prevention.

The national guidelines and strategic plan for prevention and management of HIV incorporates the importance of treatment literacy at the time of treatment initiation and throughout the continuum of care to enhance adherence and retention to HIV program. These policy documents emphasize provision of information and education about HIV treatment as not a one-off but rather a continuous activity throughout the course of lifelong HIV treatment. Knowledge of and benefits of treatment should be revisited at the time of ART initiation and re-initiation, each clinical follow up and pharmacy refill visit, shift of antiretroviral treatment regimen to another based on the current line of regimen and HIV VL test or HIV drug resistance results thereby providing room for client engagement in one's own care to make appropriate decisions and improve adherence and retention. The significance of viral suppression with respect to health and preventing viral transmission has always been at the core of the site level messaging.

In 2021, The MoH/RBC in collaboration with a community-led organization (Rwanda Network of People Living with HIV/AIDS) launched Undetectable=Untransmittable (U=U) initiative to reinforce messaging on benefits of undetectable viral load and stigma and discrimination reduction for people living with HIV. Despite the launch, U=U has not been scaled up and other treatment literacy messaging need to be updated, targeted, and practically provided at each patient encounter coupled with reviewing the quality of documented patient's VL test results according to the national HIV guidelines.

During COP 23 implementation, PEPFAR will support re-definition of messages of hope for people living with HIV with emphasis on priority populations and treatment literacy including updating U=U messages through national prevention and care and treatment technical working groups and building partnerships with other organizations including UN agencies. COP 23 funding will also support enhancement of community peer education in support groups understanding of treatment literacy, build the capacity of HCP to provide client-friendly environment about HIV treatment and its benefits to clients and reinforce age-appropriate disclosure of HIV status to children and adolescents to facilitate accurate HIV treatment and related follow-up testing literacy provision through education sessions.

14. **Enhance local capacity for a sustainable HIV response.**

Currently, over 90% of PEPFAR Rwanda's IPs partners are local and indigenous organizations. The largest investments of the PEPFAR Rwanda portfolio support MoH, RBC and RMS which will ensure long-term sustainability of services delivery and commodity procurement. In FY24, PEPFAR Rwanda will continue to encourage transitions of responsibilities and work according to the national and PEPFAR priorities.

15. **Increase partner government leadership.**

The MoH is not only leading the HIV response in Rwanda but is PEPFAR Rwanda's largest IP. Through CDC, the MoH, and RBC account for 30% of the operating unit budget. PEPFAR engages at the leadership level and co-chairs the national technical working groups. Beyond government engagement, USG 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 GF 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.

The MoH has revised and approved the national CPDS guidelines and uses the CPDS as a national coordination mechanism to jointly forecast, procure, and distribute HIV commodities. The CPDS is also used as a national platform to mobilize resources from all stakeholders. The CPDS helps Rwanda to ensure commodity security for HIV programs, and leverage resources from all sources to sustain the epidemic control.

16. **Monitor morbidity and mortality outcome.**

PEPFAR-Rwanda has focused on the development of person-centered data systems. Using HIV as the entry point, electronic systems – such as EMR – capture information on co-morbidities and provide opportunities for referrals for appropriate care. Such data also enable analysis on the most common co-morbidities and causes of death among HIV-infected persons.

Although health information systems, data management and surveillance systems were primarily developed to support the HIV response, they were designed in a generic way that supports other chronic and acute conditions. For example, the HIV case surveillance system developed on OpenMRS has been adapted for use in Covid-19 case surveillance. Common systems such as outpatient registration systems based on OpenMRS are also used beyond HIV programs. These examples suggest that PEPFAR supported systems can be leveraged to support data management for infectious and non-infectious diseases among HIV-infected persons and the general population seeking health services at PEPFAR supported health facilities in Rwanda. In COP 23, PEPFAR will support the maintenance of such systems – including the RHIES – which promotes data sharing across diseases and beyond HIV. PEPFAR is supporting the creation of a shared health record, which is normalized individual patient level data stored centrally but drawn from different systems, (in line with the Government of Rwanda's *"One Citizen, One Record"* approach. A shared health record is being developed using COP22 resources as part of the RHIES. The small-scale use (either in specific districts or facilities) using COP23 resources will inform large-scale, national implementation and use for improved clinical care (including cross-disease/cross-facility referrals), longitudinal follow-up of patients with co-morbidities leading to improved outcomes.

PEPFAR resources do not directly support the national Civil Registration and Vital Statistics (CRVS) system. However, documentation of causes of death among HIV infected persons contributes to the improved recording of mortality data, which indirectly strengthens mortality surveillance. The HIV CBS also supports tracking of individual level outcomes, including death. This will strengthen mortality surveillance among HIV patients. Data analysis on mortality surveillance will start in COP22 and continue in COP23 and beyond.

17. **Adopt and institutionalize best practices for public health case surveillance.**

PEPFAR has also invested in supporting the development and use of the national unique person identifier that is linked to the NIDA database. Using COP 22 resources, the unique person identifier was tested at 3 health facilities in Kigali City (Kibagabaga District Hospital, We-Act Clinic and Cor-Unum Health Center). The results showed that the unique ID is ubiquitous (not localized to a particular health facility), robust and easy to generate. Record matching was possible using the search engines implemented in the registration module of the EMR.

The unique ID has been used to link clinical and laboratory records to support HIV case surveillance in a test environment and small-scale use. A laboratory order request for VL test was made in OpenMRS, received by the laboratory information system (VLSM) and once the request was processed, the result was electronically returned to the EMR. This needs further testing that will be carried out in FY23 before large-scale rollout. The Rwanda team is also assessing the feasibility of integrating an existing home-grown client registry vs. other open-source solutions such as OpenCR and JeMPI to handle patient identity management.

Once scaled up, the unique identifier will improve record linkage resulting in better HIV care coordination, enhanced management of co-morbidities, availability of de-duplicated data for HIV program monitoring and case surveillance. The unique patient ID is at the center of the RHIES and shared health record described above. COP 23 resources will be used to support the GoR efforts to enhance data security as part of health data governance policies and to scale-up the use of unique patient identifier for better HIV care among various populations including KPs.

USG Operations and Staffing Plan to Achieve Stated Goals

CDC Management and Operations

Staffing Structure Analysis and Adjustments

Each year, CDC examines its staffing footprint to determine critical needs, identify gaps, improve efficiencies, and build local staff capacity. Using the Level of Effort (LOE) Workload Management Indicators, the CDC senior management team assesses the level of effort needed by each staff member based on his/her core competencies and function as it aligns with three key areas:

- Projected PEPFAR/OU COP priorities and strategic direction
- Ability to adequately respond to interagency requirements and coverage.
- Capacity to deliver high-quality technical support and maintain partner management responsibilities.

The staffing structure assessment is conducted on an ongoing basis throughout the year, both formally and informally, and guides management decisions for right-sizing, balanced against shrinking or growing PEPFAR requirements. For fiscal year 2024, CDC adjusted its staffing footprint through the abolishment of a U.S. direct hire (USDH) position. The USDH position was the Cooperative Agreement (CoAg) and Finance Branch Chief role which was transitioned to the CoAg and Finance Team Lead, a locally employed staff role. The assessment resulted in repurposing a vacant position to meet the needs of the FETP program.

Vacant Positions

There are currently 3 positions that have been vacant for at least 6 months:

1. Clinical Services Transition Specialist: CDC has since transitioned this function to MOH, as planned, appropriate and reflective of sustainability, and therefore no longer a critical role for CDC staffing. This position will be repurposed into the FETP Program Specialist. CDC anticipates that the FETP Program Specialist will begin this role at the start of FY 2024.
2. Grants Specialist: Due to a change in scope of duties, this position required reclassification, which took nearly 5 months to complete due to administrative processes. The HR department has posted the position and recruitment is fully underway. CDC anticipates filling the position before the end of FY 2023.
3. Monitoring and Evaluation Specialist: This position required reclassification, which is underway. The position was adapted to meet the needs of the program, PEPFAR

monitoring and evaluation requirements while managing critical gaps in the deployment of digital health information exchange. In considering long-term succession planning, this position will eventually perform supervisory responsibilities to accommodate long-term plans that may result in footprint reduction. CDC anticipates filling the position within the first quarter of FY 2024.

Cost of Doing Business (CODB) Budget

Despite efforts to reduce CODB costs, such as the abolishment of a USDH position for FY2024, there are several non-discretionary costs that have impacted the CODB budget. For example, the Capital Security Cost Share (CSCS) cost has increased by 11% since COP19 and continues to do so incrementally with each year. The CODB budget also had to factor in the relocation costs for one USDH, the addition of an eligible family member, and increased educational allowance amounts.

USAID Operations and Staffing

USAID currently has 3 vacant positions funded by PEPFAR. The Commodities Specialist and Health Program Assistant positions recently became vacant. Interviews for the Health Program Assistant position will commence following COP 23 submission and the position description for the Commodities Specialist will be reviewed and the position will be re-advertised later in FY 23. The final vacant position is for an Acquisition and Assistance Specialist (A&A) that was new in COP 22 to support the award management of multiple local partners, including RMS. A candidate is currently in the final stage of recruitment for this A&A position. USAID has no new positions proposed in COP 23 and has reduced its CODB costs in COP 23 from COP 22.

DOD Operations and Staffing

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 is retiring in FY23, but a replacement will be hired same year in FY23 (using COP22 CODB funds). Requested funding for CODB for COP2023 is $200,000. The requested COP23 CODB decrease from COP22 is due to part of COP22 CODB funds being earmarked to cover retirement benefits for the Program Manager retiring during FY23 (COP22).

PEPFAR Coordination Operations and Staffing

The PEPFAR Coordination Office (PCO) 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. There will be no changes to the PCO staffing footprint in COP23.

APPENDIX A – PRIORITIZATION

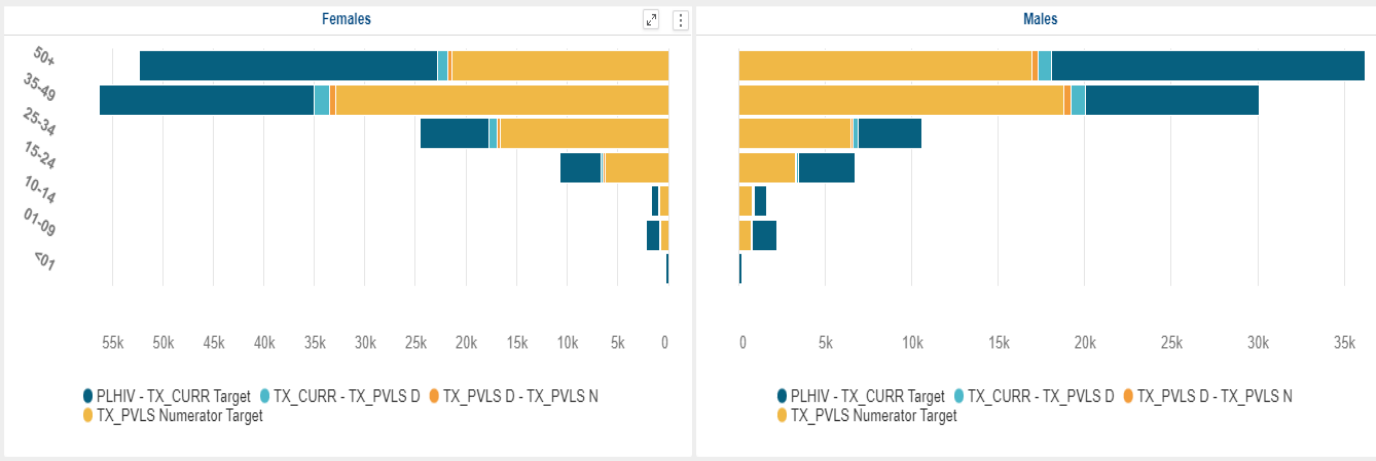


Figure A.1 Epidemic Cascade Age/Sex Pyramid

Note: the ART program gap is calculated using PLHIV on ART treatment in PEPFAR supported health facilities. PEPFAR support accounts for 60% of the national ART cohort in Rwanda.

APPENDIX B – Budget Profile and Resource Projections

Please note that COP 23/FY 25 budget profile and resource projections are only available for bilateral, not regional, programs. Regional OUs will include only FY 24 information.

Table B.1 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Intervention

	Budget		
Intervention	**2023**	**2024**	**2025**
	$67,079,000	**$64,725,050**	**$60,538,798**
	$67,079,000	**$64,725,050**	**$60,538,798**
ASP>HMIS, surveillance, & research>Non Service Delivery>Key Populations	$75,000		
ASP>HMIS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	$1,225,107		
ASP>Health Management Information Systems (HMIS)>Non Service Delivery>AGYW		$120,000	$112,349
ASP>Health Management Information Systems (HMIS)>Non Service Delivery>Non-Targeted Populations		$668,681	$625,432
ASP>Human resources for health>Non Service Delivery>Non-Targeted Populations	$275,714	$335,427	$313,732
ASP>Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	$957,541	$894,080	$836,253
ASP>Management of Disease Control Programs>Non Service Delivery>AGYW		$214,656	$200,972
ASP>Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		$1,542,110	$1,442,371
ASP>Management of Disease Control Programs>Non Service Delivery>OVC		$45,272	$42,387
ASP>Not Disaggregated>Non Service Delivery>AGYW	$213,144		

ASP>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$1,853,031		
ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>AGYW	$531,693		
ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>Non-Targeted Populations	$597,379		
ASP>Procurement & supply chain management>Non Service Delivery>Non-Targeted Populations	$274,629	$578,629	$541,205
ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Non-Targeted Populations		$363,041	$339,561
C&T>HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$1,563,200	$125,000	$117,031
C&T>HIV Clinical Services>Service Delivery>Children	$3,420,382	$3,608,672	$3,138,881
C&T>HIV Clinical Services>Service Delivery>Military	$410,000	$439,903	$411,857
C&T>HIV Clinical Services>Service Delivery>Non-Targeted Populations	$6,803,981	$6,013,897	$5,626,162
C&T>HIV Clinical Services>Service Delivery>Pregnant & Breastfeeding Women	$1,415,212	$1,344,451	$1,257,495
C&T>HIV Drugs>Non Service Delivery>Non-Targeted Populations	$681,000	$200,000	$187,249
C&T>HIV Drugs>Service Delivery>Children	$284,573		
C&T>HIV Drugs>Service Delivery>Non-Targeted Populations	$10,081,094	$10,415,550	$10,415,550
C&T>HIV Laboratory Services>Service Delivery>Military	$30,000	$44,500	$41,663
C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Populations	$3,159,204	$3,117,786	$3,000,167

C&T>HIV/TB>Service Delivery>Non-Targeted Populations		$280,356	$280,356
C&T>Not Disaggregated>Non Service Delivery>Key Populations	$46,022		
C&T>Not Disaggregated>Non Service Delivery>Military	$15,196		
C&T>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$258,494		
HTS>Community-based testing>Service Delivery>AGYW	$394,727		
HTS>Community-based testing>Service Delivery>Key Populations	$304,585	$664,392	$621,692
HTS>Community-based testing>Service Delivery>Non-Targeted Populations	$66,222	$445,553	$441,270
HTS>Facility-based testing>Service Delivery>Children		$520,000	$0
HTS>Facility-based testing>Service Delivery>Military	$45,392	$42,392	$39,689
HTS>Facility-based testing>Service Delivery>Non-Targeted Populations	$463,990	$439,514	$416,338
HTS>Not Disaggregated>Service Delivery>Non-Targeted Populations	$71,985		
PM>IM Closeout costs>Non Service Delivery>Non-Targeted Populations	$5,000		
PM>IM Program Management>Non Service Delivery>Non-Targeted Populations	$6,618,555	$7,123,995	$6,702,060
PM>USG Program Management>Non Service Delivery>AGYW		$210,000	$196,611
PM>USG Program Management>Non Service Delivery>Non-Targeted Populations	$8,271,561	$9,596,803	$8,982,323
PREV>Comm. mobilization, behavior & norms change>Non Service Delivery>AGYW	$910,703		

PREV>Condom & Lubricant Programming>Service Delivery>Non-Targeted Populations	$326,315	$281,100	$281,100
PREV>Non-Biomedical HIV Prevention>Non Service Delivery>AGYW		$1,086,664	$1,017,382
PREV>Non-Biomedical HIV Prevention>Service Delivery>AGYW		$50,000	$0
PREV>Not Disaggregated>Non Service Delivery>Non-Targeted Populations		$125,000	$117,031
PREV>Not Disaggregated>Service Delivery>Key Populations	$761,348	$811,097	$758,637
PREV>PrEP>Service Delivery>AGYW	$602,126	$579,792	$545,732
PREV>PrEP>Service Delivery>Key Populations	$894,506	$700,267	$678,466
PREV>PrEP>Service Delivery>Non-Targeted Populations	$1,060	$31,435	$29,879
PREV>Primary prevention of HIV and sexual violence>Non Service Delivery>AGYW	$504,961		
PREV>Primary prevention of HIV and sexual violence>Non Service Delivery>OVC	$560,766		
PREV>Primary prevention of HIV and sexual violence>Service Delivery>AGYW	$730,572		
PREV>Primary prevention of HIV and sexual violence>Service Delivery>OVC	$270,817		
PREV>VMMC>Non Service Delivery>Non-Targeted Populations	$174,300		
PREV>VMMC>Service Delivery>Military	$1,600,000	$1,200,000	$1,123,493
PREV>VMMC>Service Delivery>Non-Targeted Populations	$1,425,700	$1,050,000	$982,089
PREV>Violence Prevention and Response>Non Service Delivery>AGYW		$484,022	$453,162
PREV>Violence Prevention and Response>Non Service Delivery>OVC		$354,592	$331,985
PREV>Violence Prevention and Response>Service Delivery>AGYW		$683,400	$639,829

PREV>Violence Prevention and Response>Service Delivery>OVC		$185,828	$173,980
SE>Case Management>Non Service Delivery>OVC	$170,109	$291,154	$272,591
SE>Case Management>Service Delivery>AGYW	$488,515		
SE>Case Management>Service Delivery>OVC	$387,657	$954,753	$753,445
SE>Economic strengthening>Non Service Delivery>OVC	$75,759	$179,758	$168,297
SE>Economic strengthening>Service Delivery>AGYW	$1,461,695	$2,030,646	$1,901,180
SE>Economic strengthening>Service Delivery>OVC	$1,026,208	$1,159,483	$1,085,560
SE>Education assistance>Service Delivery>AGYW	$1,376,590	$1,349,618	$1,263,573
SE>Education assistance>Service Delivery>OVC	$734,588	$654,851	$613,101
SE>Legal, human rights & protection>Non Service Delivery>OVC	$148,845		
SE>Legal, human rights & protection>Service Delivery>AGYW	$485,782		
SE>Legal, human rights & protection>Service Delivery>OVC	$358,737		
SE>Psychosocial support>Non Service Delivery>AGYW	$202,682	$199,175	$186,476
SE>Psychosocial support>Non Service Delivery>OVC	$187,181	$174,208	$163,101
SE>Psychosocial support>Service Delivery>AGYW	$559,432	$531,432	$497,550
SE>Psychosocial support>Service Delivery>OVC	$238,433	$182,115	$170,503

Table B.2 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Program Area

	Budget		
Program	**2023**	**2024**	**2025**
	$67,079,000	**$64,725,050**	**$60,538,798**
	$67,079,000	**$64,725,050**	**$60,538,798**
C&T	$28,168,358	$25,590,115	$24,476,411
HTS	$1,346,901	$2,111,851	$1,518,989
PREV	$8,763,174	$7,623,197	$7,132,765
SE	$7,902,213	$7,707,193	$7,075,377
ASP	$6,003,238	$4,761,896	$4,454,262
PM	$14,895,116	$16,930,798	$15,880,994

Table B.3 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Beneficiary

	Budget		
Targeted Beneficiary	**2023**	**2024**	**2025**
	$67,079,000	**$64,725,050**	**$60,538,798**
	$67,079,000	**$64,725,050**	**$60,538,798**
AGYW	$8,462,622	$7,539,405	$7,014,816
Children	$3,704,955	$4,128,672	$3,138,881
Key Populations	$2,081,461	$2,175,756	$2,058,795
Military	$2,100,588	$1,726,795	$1,616,702
Non-Targeted Populations	$45,155,062	$43,627,957	$41,677,159
OVC	$4,159,100	$4,182,014	$3,774,950
Pregnant & Breastfeeding Women	$1,415,212	$1,344,451	$1,257,495

Table B.4 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Initiative

	Budget		
Initiative Name	**2023**	**2024**	**2025**
	$67,079,000	**$64,725,050**	**$60,538,798**
	$67,079,000	**$64,725,050**	**$60,538,798**
Community-Led Monitoring	$354,516	$330,000	$308,962
Condoms (GHP-USAID Central Funding)	$300,000	$300,000	$300,000
Core Program	$48,920,494	$47,268,508	$45,108,893
DREAMS	$10,144,890	$9,544,528	$8,940,411
LIFT UP Equity Initiative		$1,000,000	$0
OVC (Non-DREAMS)	$4,159,100	$4,032,014	$3,774,950
VMMC	$3,200,000	$2,250,000	$2,105,582

APPENDIX C – Above Site and Systems Investments from PASIT and SRE

Health Information Systems and Program Monitoring

As the Government of Rwanda continues implementing the Digital Transformation Agenda (2021 – 2024), the PEPFAR team identified components of the national systems which are critical in the delivery of high-quality HIV care. Since FY21, the country team has systematically reviewed the gaps in key digital health systems used to generate and manage data at individual patient and aggregate levels. Some of the gap identified and prioritized were:

1. Lack of high-quality epidemiological program monitoring and routine surveillance. Lack of high-quality data for clinical care is also a key gap in delivering HIV care services at facility level.
2. Limited data sharing between core systems like EMR, laboratory information systems (LIS) and the Rwanda Health Information System (RHMIS/DHIS-2) for clinical care, program monitoring and routine surveillance.
3. Limited data use at various levels of the HIV program implementation.
4. Lack of a unique patient identifier to track patients across service delivery points and across facilities.
5. Limited technical capacity to develop, host and support systems at health facility, sub-national and national levels.

In COP23, PEPFAR-Rwanda will support the following activities to address the gaps identified above:

Support the enhancements, deployment and maintenance for the OpenMRS ver. 2.x (EMR) to generate critical data for HIV clinical care, case surveillance and program monitoring. The EMR is currently deployed at PEPFAR-supported 192 sites. The FY24 resources will be used to ensure that the systems functional status is maintained, and data are up to date for efficient use in care and reporting. To further enhance efficiency in reporting and improve the quality of MER indicators, PEPFAR will support automated data exchange between the EMR and RHMIS. All PEPFAR indicators for the 95-95-95 cascade are abstracted from the national RHMIS. The unique patient identifier has been developed by the MOH and RBC to align with various scenarios of patient identity management and record linkage. This has been piloted at 3 health facilities in Kigali and will be scaled up in FY23 and FY24.

Further, in FY24, PEPFAR will maintain functional software components of the Rwanda Health Information Exchange (RHIE) to support data sharing between key system used for HIV programs in supported sites. Activities Include maintaining interoperability between RHMIS,

EMR, LIS and the registries support HIV programs (e.g. client registry and facility registry). PEPFAR will also contribute to the maintenance of infrastructure at RBC/MOH to support the RHIE including cloud-based data storage (renting space from RISA) and the recurrent cost of Internet connectivity to ensure timely data exchange and reporting to the national RHMIS which PEPFAR relies on for the MER indicators.

A capacity building approach will be adopted in developing, deploying and maintaining the systems to ensure that they are sustainable. The District Hospital IT Specialists will be trained during systems deployment and maintenance, and they will cascade support to the facilities within their catchment areas.

Surveys and Surveillance

Strong surveillance systems are a critical component of a sustainable health systems infrastructure. In Rwanda, this was illustrated by the COVID-19 pandemic. Health infrastructure, laboratory systems, and surveillance systems developed for HIV were utilized in the COVID-19 response.

Gaps in epidemiologic data among general and key populations were identified in the mid-term review of the National HIV Strategic Plan and prioritized for support. In FY24, PEPFAR will continue supporting various surveys and surveillance activities to generate important data to be triangulated with routine program data and to monitor treatment outcomes.

Rwanda's HIV case surveillance, which has two components, will be used to support case finding through index, family and SNS testing as well as to assess individual patient level treatment outcomes. The case surveillance data are analyzed together with recent infection surveillance data. Key outcomes of interest will enable the program to characterize cases that are not suppressed, those changing regimens and reasons for such changes, and those not retained on treatment. The case surveillance system will also provide data for mortality surveillance. So far, case surveillance data have been used to identify clusters of recent infections which prompted further investigation. PEPFAR resources will be used to support data management, visualization and use for public health response.

PEPFAR will continue to support HIV drug resistance monitoring through the CADRE approach which entails genotyping remnant blood samples with viral load ≥1,000 copies /ml from routine viral load testing and monitoring. This activity started in FY22 through a formative survey which ends in FY23 but will continue beyond FY24 as a routine surveillance activity.

PEPFAR will work closely with Global fund to support integrated bio-behavioral surveys (IBBS) and population size estimations (PSE) among key populations including FSW and MSMs. Preparations for the next round of MSM IBBS and PSE will start in FY24 with the data collection expected in FY25.

HIV Services integration

Although Rwanda has made significant progress towards achieving HIV global Targets, critical gaps remain to improve access to an integrated HIV services along continuum of care and optimize the quality of HIV services.

Through the above site support, PEPFAR will in COP23 continue supporting targeted interventions that support the delivery of high-quality integrated HIV services. These include enhanced continuous quality improvement and mentorship of district clinical mentors to ensure quality patient centered HIV services delivery, improved policy environment and core standards of services for NCDs and HIV integration, advanced HIV diseases and improved TB screening and diagnosis through guidelines, tools, capacity building of master trainers and program monitoring.

Human Resource for Health

Main HRH systems gaps include but not limited to:

- Limited Workforce capacity build; Lack of sustained capacity building system; Limited funding resource and staff turnover;
- Activities in PASIT were developed responding to identified gaps, as well as the benchmarks, outputs and outcomes are developed addressing PASIT identified gaps, all activities expected timeline and specific deliverables for each milestone, output and outcomes.
- All systems including eLearning, tele-mentorship and CQI are developed using government systems and platforms to ensure sustainability.

Laboratory Systems Strengthening for Quality Service Delivery and Public Health Response

Since the last 20 years, PEPFAR investments and partnerships in laboratory systems strengthening have contributed and played a significant role in building and maintaining capacities and capabilities of the Rwanda's public health laboratory network for continuous quality improvement and timely service delivery services for sustained HIV response and leveraged for COVID-19 pandemic response. This manifested in reaching high coverage (>90%) of HIV/TB testing services among targeted populations in PEPFAR supported sites and recency testing network for surveillance of recent HIV infections among newly HIV diagnosed as well as support the CADRE approach for HIVDR surveillance using the routine VL testing network and related data systems. In addition, is the established national laboratory systems for quality assurance of testing and managing referral of specimen collection from patients at primary healthcare facilities to decentralized testing hubs and online return of test results using centrally hosted laboratory information systems, specimen transportation systems, and national external quality assessments programs offering PT programs and structured CQI

approaches for sustained quality improvement and management systems at laboratories in the network towards accreditation. However, there still exist structural and functional gaps in those systems for strengthening including data systems infrastructure and integration, laboratory data management and use for CQI in service delivery and skilled human resources in various capacities that will be the focus to enhance and maintain COP22 implementation for COP23 in the areas including but not limited to the DNO and related stakeholder engagements, data driven continuous quality improvement implementations to target testing sites with suboptimal quality assurance standards and real-time monitoring of testing performance of the laboratory network and related support systems such as supply chain management of laboratory commodities and equipment maintenance towards sustained high coverage of testing for patients enrolled in the HIV/TB treatment programs as well as targeted interventions for case finding while seeking efficiencies with increasingly limited available resources.

Supply Chain and Pharmaceutical Services

PEPFAR used the August 2022 National Supply Chain Assessment Report, the December 2022 WHO Global Bench Marking Tool Assessment Report of the RFDA, and FY22 and FY23 Q1 program data to identify the key gaps. Hence, the main gaps identified were supply chain data quality, reagents expiry and stockout, delay of VL results, new systems developed but yet to be implemented. In addition, PEPFAR considered the coordinated annual HIV quantification report and quarterly supply plan as critical for commodity planning of the government of Rwanda and its partners. To address these gaps and ensure proper planning of HIV commodities, PEPFAR will contribute to strengthen the key supply chain and pharmaceutical services and regulation of the existing systems and modernize them to increase efficiency and improve program management.

PEPFAR in COP23 will strengthen the use of eLMIS in 98% of the 596 ART sites to improve quality of the supply chain MER data, to have real-time stock visibility, and for on time resupply of commodities. Hence, PEPFAR will support on-the-job (OJT) eLMIS training in selected sites (250) out of the national sites (594), improve data quality and timelines of eLMIS to be above 80%, and increase the use of eLMIS from current 97% to 98% of ART sites. Moreover, PEPFAR will strengthen the implementation of the integrated regulatory information management systems (iRIMS) of the RFDA, improve the RFDA registration and quality assurance capacity and systems, and strengthen the pharmacovigilance monitoring systems (PViMS) implementation.

PEPFAR will also support the annual national quantification exercises and the quarterly supply plan review related activities of the Rwanda HIV program. This will help to ensure HIV commodity security and proper funding coordination for the HIV program. In addition, PEPFAR will provide OJT for the supply chain guru on the Quantification Analytic Tool (QAT) to improve forecasting and procurement planning.

In addition, PEPFAR will strengthen the implementation of Lab bundling and the piloting of the Lab vendor managed inventory (VMI) system. Modernization of the viral load management system is recommended in COP 23 guidance, and hence piloting the VMI will help to improve efficiency in the VL lab supply in Rwanda and to improve the VL test turnaround time. This will contribute to reducing wastage of lab reagents and consumables and improve beneficiaries' satisfactions.

PEPFAR prepared an interim output and measurable indicators to track these systems investment and some of them include: Annual Quantification report for HIV program for the period of FY24/FY25 and Quarterly supply plans report for HIV program commodities in FY24, number of OJT provided in the FY24, improved data quality comparing eLMIS vs physical count and stock cards, trend reports in the use of eLMIS, national plans for the implementation of VL VMI, VMI piloting and report, implementation of iRIMS and PViMS, reduce registration backlogs by 50% as result of registration system improvement.

All these supply chain and pharmaceutical services activities at national and subnational levels are in alignment with the government of Rwanda’s plans. The goals of these systems investment are to modernize the supply chain and regulatory systems, ensure commodity security, and gain efficiencies.

APPENDIX D – Examples of Optional Visuals for Drafters

The visualizations below are examples among other options of the type of visuals country teams may find useful to add to narratives, however they are not required.

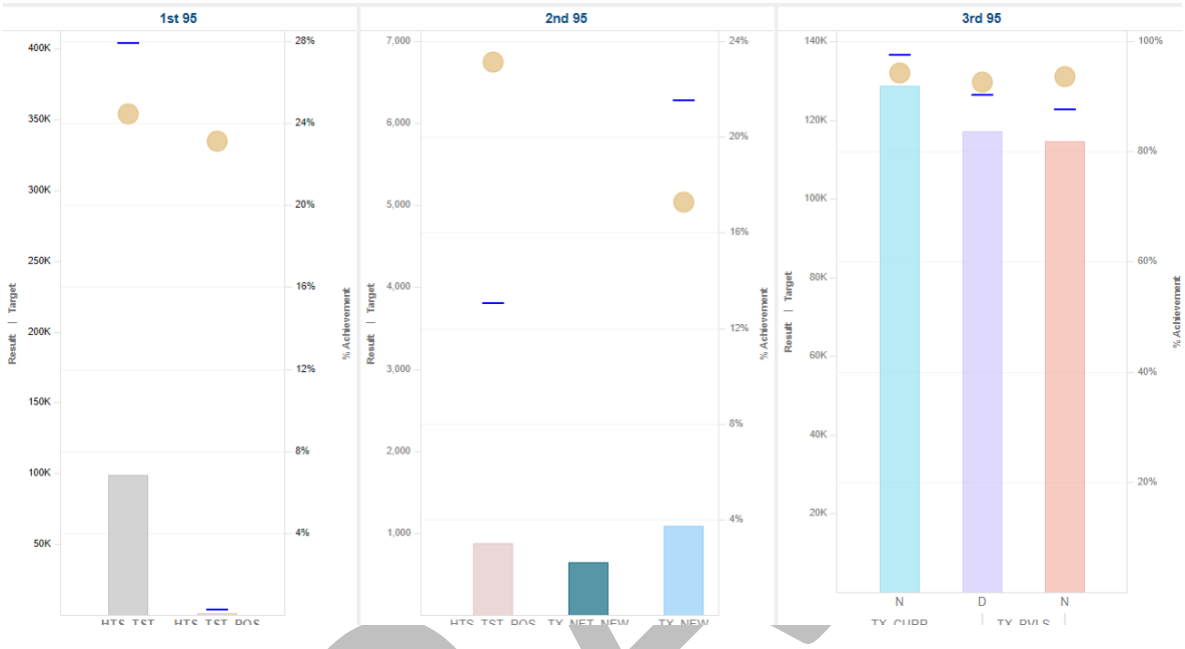


Figure D.1 Overview of 95/95/95 Cascade, FY23 Q1

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

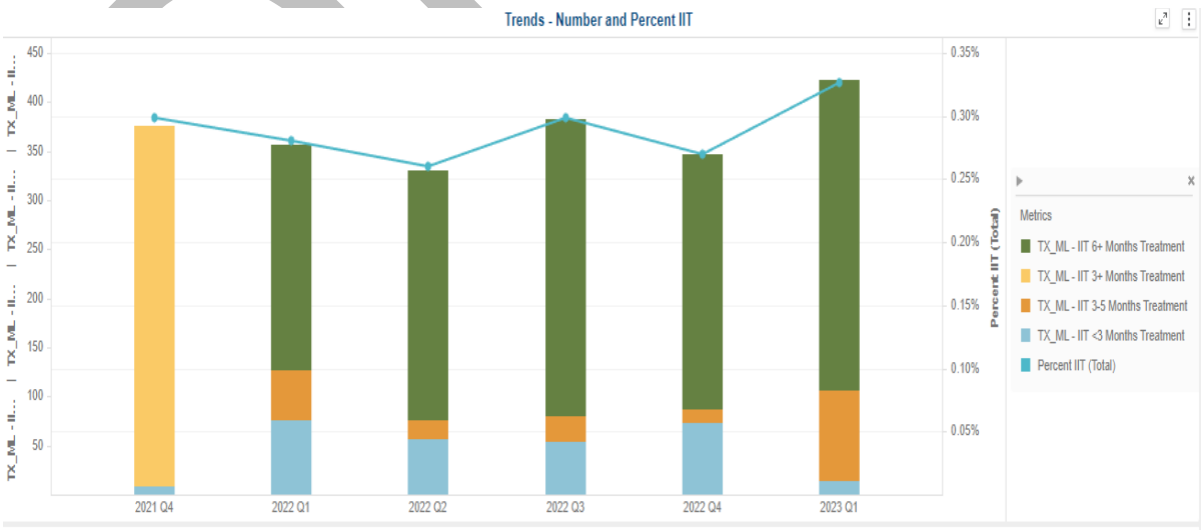


Figure D.2 Clients Gained/Lost from ART by Age/Sex, FY23, Q1 Rwanda

This visual comes from the treatment, single OU dossier, interruptions in treatment (IIT) chapter, IIT Trends page. Select last 4 quarters. **(optional)*

--OR--

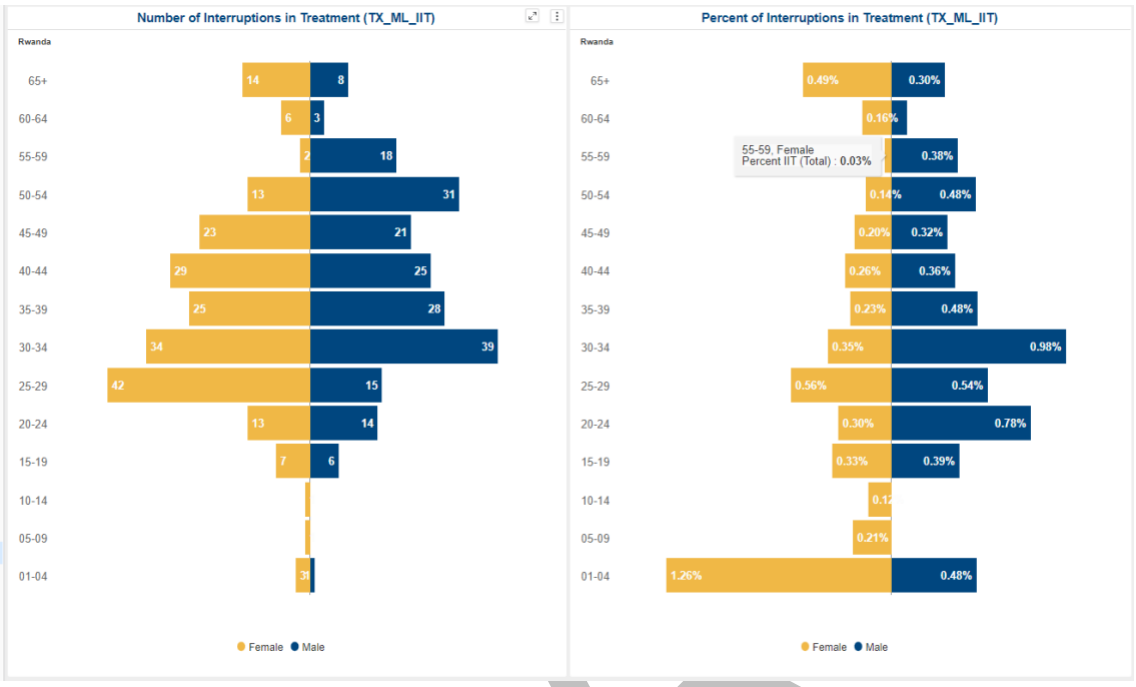


Figure D.3 The age and sex pattern of TX_ML ITT in Rwanda, FY23Q1

**This visual comes from the treatment, single OU dossier, interruptions in treatment (IIT) chapter, IIT Age/Sex pyramid page. Select most recent quarter if using.*

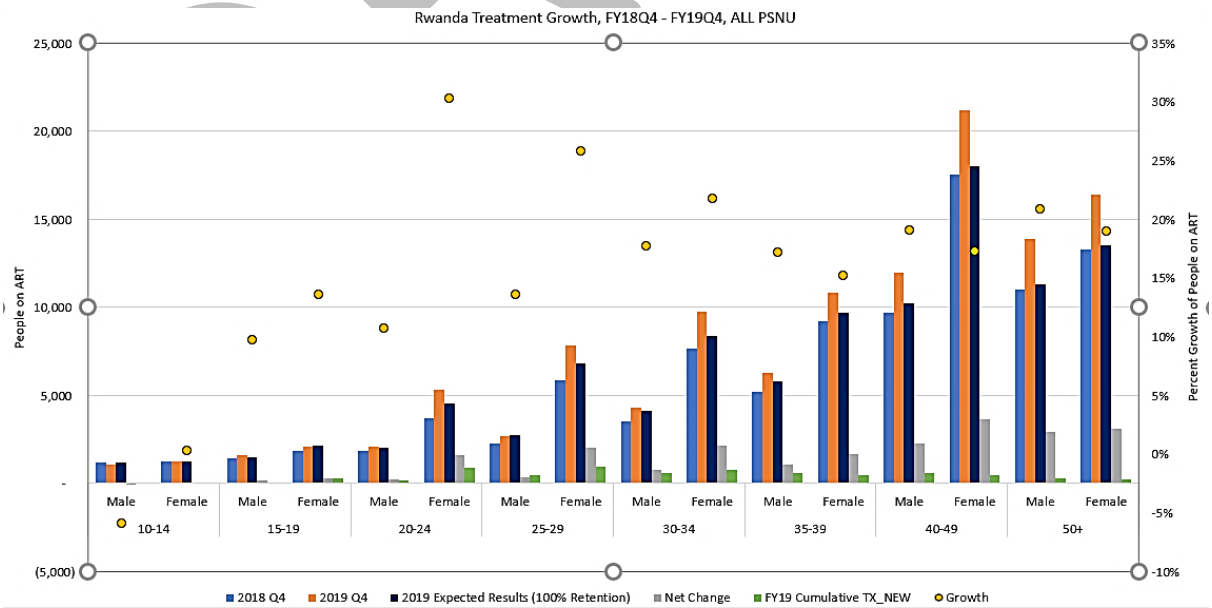


Figure D.4 Net change in HIV treatment by sex and age bands FY2021 Q4 to FY2022 Q4

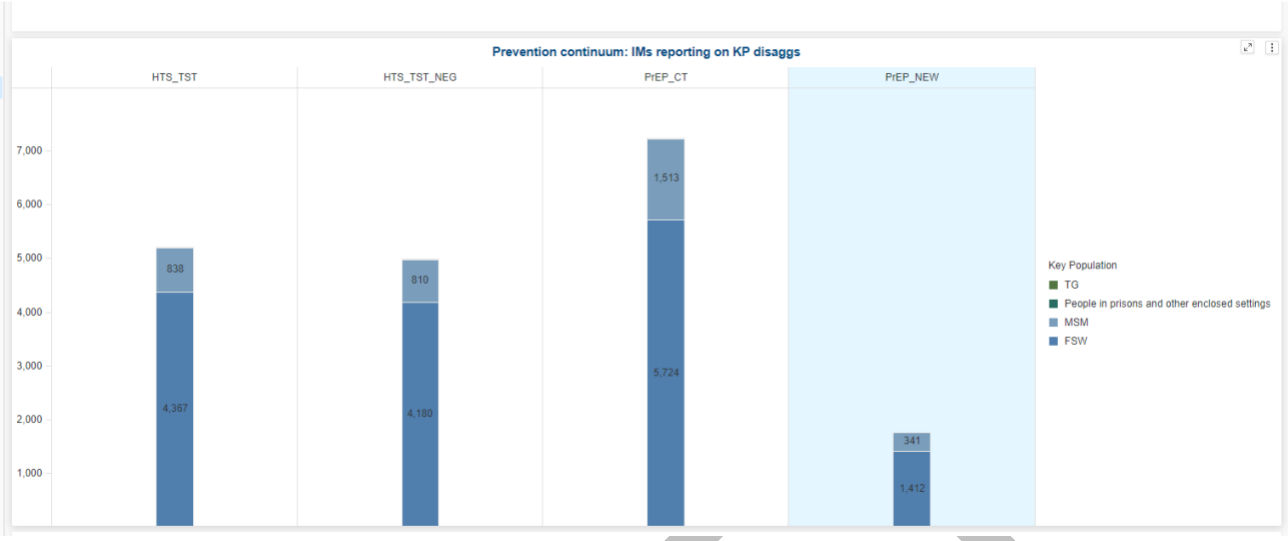


Figure D.5 Prevention Continuum by Key Population Group, FY23Q1, Rwanda

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

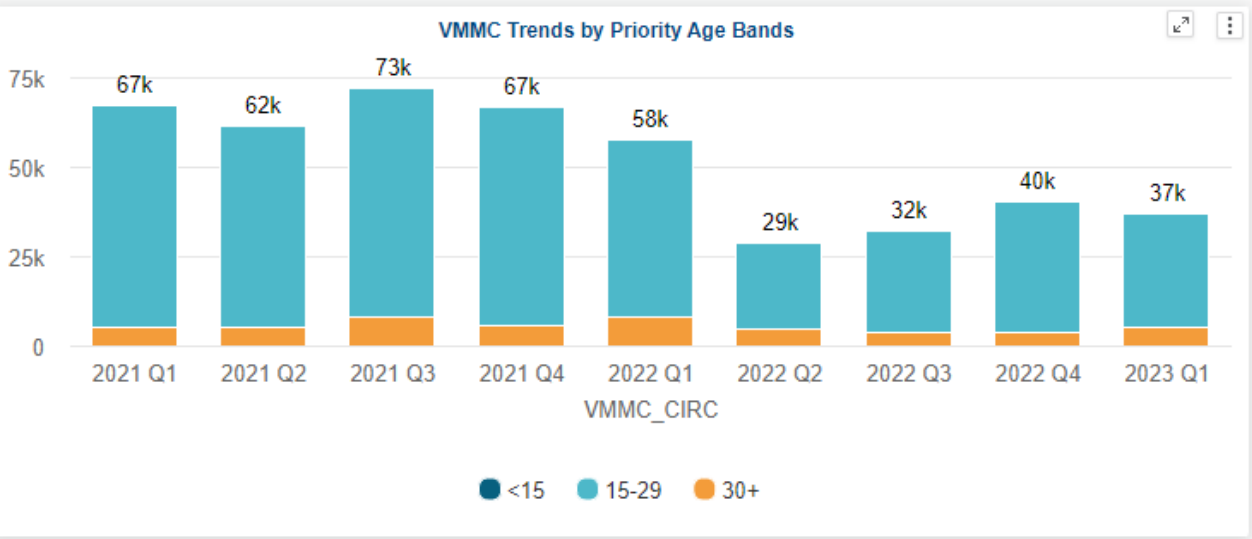


Figure D.6 VMMC Quarterly Trends by Age, FY2021Q1-FY2023Q1

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

Concept Title: Surge case finding at health facilities (HFs) and using Community Health Workers (CHWs) in communities to close the Children Living with HIV (CLHIV) gap in targeted high burden areas in Rwanda: Programmatic Benefits

Proposed activities: The proposed activity is in line with pillar one and will have two main components, **Component-A** will focus on identifying undiagnosed CLHIV 5-14 years born to PLHIV enrolled in the HIV care & treatment program at the HF level. We intend to use both health care providers (HCPs) to review the patient charts and Peer Educators (PEs) to trace peers and their children, and **Component-B** will focus on identifying undiagnosed CLHIV 5-14 years born to parents with unknown HIV status or undiagnosed Orphans and Vulnerable Children (OVC) at the community level. Implementation of these two approaches will have the immediate benefit of filling gaps in programmatic activities within the targeted high burden geographic areas and populations. In addition, these components will target hard to reach populations by supplementing case finding activities under the Case-Based Surveillance (CBS) - (Index/Family and SNS Testing) in our core-prevention program with the aim of identifying and linking all undiagnosed CLHIV to treatment.

Component A: This approach will implement the following strategies to improve efficiencies in finding undiagnosed CLHIV: 1) intensively engage HCPs to conduct chart reviews of PLHIV enrolled between 2009-2018 and generate an inventory of all biological and non-biological children listed by PLHIV accessing care mainly through care and treatment (CBS-Index/Family testing) in addition to PMTCT, and Female Sex Workers (FSW) services. We will use this opportunity as a one-time mass review and roll it out into a standardized routine activity; 2) the HCPs will update the chart for those PLHIV who had children after enrollment in care. 3) Using PEs to track and bring to health facilities (HFs) all children identified through the inventory for HIV testing and linkage to treatment as found appropriate.

Component B: This component will involve utilizing CHW who are already engaged in implementing Maternal Child Health (MCH) and malaria activities at the community level, as well as linkage facilitators who work with the OVC and DREAMS program and civil society organizations working with FSW at the community level. A comprehensive approach will be used to identify undiagnosed CLHIV at community level through 1) Utilizing CHW and linkage facilitators in high burden areas to identify high risk households with a) Children missing immunization clinics, b) Pregnant women not attending ANC clinics, c) undiagnosed OVC and malnourished children, d) Teen/AGYW mothers, e) Children looked after by their grandparent(s), f) offspring of FSW, and g) families who do not use the HFs at all, and to mobilize children in these

households to get tested for HIV, and interviewing parents/guardians at HFs. 2) The CHW will coordinate with HFs to arrange the testing for children identified in community. By conducting testing at the HFs, linkage to treatment will be strengthened and same day ART initiation will be ensured. HIV high risk households will be identified, and CHWs in their respective communities will concurrently mobilize occupants over the period of eight weeks. We anticipate that activities will be conducted within two-four months.

Selection of high burden areas and populations to target: As per the most recent 2023 EPP-Spectrum and NAOMI sub-national unit estimates, the City of Kigali, Western and the Eastern Provinces have shown the largest first-95 gap in CLHIV and will be used to target populations with a high proportion of CLHIV. HIV testing of children and interviewing parents or guardians will be conducted at HFs serving the catchment area to facilitate linkage to treatment. Results will measure the absolute number of newly diagnosed CLHIV cases and, characterize the children making up the newly diagnosed CLHIV cases.

The priority population of focus: Children 5-14 years

Justification: EPP-Spectrum 2023 estimates the total number of CLHIV in Rwanda to be 9,331 with only 5,360 CLHIV aware of their HIV positive status as of December 2022, yielding a gap of 43%. Contrary to all other indicators including a high coverage rate in the PMTCT program, this gap in HIV diagnosis for children has persisted, leading to the question whether this gap is due to an over-estimation of the total number of CLHIV by EPP-Spectrum (denominator) or a performance program gap (numerator). The biggest number of undiagnosed CLHIV is in the City of Kigali followed by the Western, and Eastern Provinces. Rwanda is currently supporting PMTCT and CBS (index testing services including Family testing) at all PEPFAR supported sites. However, these entry points miss children not living with their parents, children not listed at the time of enrollment, and CBS only covers 52% of PLHIV in PEPFAR supported sites, and 31% at national level. The total number of newly diagnosed CLHIV currently will take Rwanda 5 years to close the current gap (if conditions remain constant). These LIFT UP funds will allow for a surge case finding of undiagnosed CLHIV in FY2024 to narrow this gap.

Index and PMTCT testing modalities are priorities in Rwanda and quality improvement activities are being implemented. However, despite the implementation of effective strategies to track HIV exposed children, program data from April FY22 indicates that 12% of infants have not been tested and lack final PMTCT outcomes. Additionally, based on CBS results, 10% of children born to PLHIV have not been tested for HIV. Component A will surge the family testing numbers through tracing children lost-to-follow-up and bringing them back to HFs for testing and linkage to treatment. In addition, the index/family testing approach is missing women and children who do not seek services at facilities, and only captures children of parents attending ART facilities.

Further, orphans and children who are not living with their biological parents would be missed, and that is why Component-B targeting the community is being proposed.

Objectives:

a) Surge case finding and linkage activities among CLHIV in selected high burden areas and hard to reach mothers living with HIV in Rwanda using:
    i. HFs entry points namely care and treatment (CBS-Index/Family testing), PMTCT, and FSWs - using HCPs to review, update patient charts and PEs to trace mothers and their children
    ii. Community entry points namely houses children missing immunization, houses with OVC, houses with pregnant and breastfeeding women missing ANC-PMTCT services, houses with teen mothers - using CHW
b) To profile identified undiagnosed CLHIV and their mothers to provide insight on who are the undiagnosed children living with HIV in FY24 (COP23) and inform future case finding strategies.
c) To enhance monitoring and evaluation to actively track testing of all elicited children.

Multi-sectoral involvement: Inequalities in HIV testing, HIV positive status awareness, and case finding across children and young adults to be addressed by this proposed activity are multi-sectoral in nature requiring interagency collaboration to achieve program-wide benefits in Rwanda. The interagency collaboration will focus on bringing together and engaging critical stakeholders in a coordinated and integrated effort to serve children and young adults whose need cross multiple socio-economic sectors. Therefore, the proposed activity coordination and monitoring technical committee will involve all critical stakeholders including but not limited to USAID, DOD, Ministry of Health (MOH)/Rwanda Biomedical Center (RBC), Rwanda Network of People living with HIV (RRP+), National Child Development Agency (NCDA), and Ministry of Gender and Family Promotion (MIGEPROF), UNICEF with CDC taking the lead in developing SOPs and tools that will be used and implementing the case finding SOPs. This protocol will have interagency collaboration to provide technical support as subject matter expert in their areas of expertise.

Desired Budget: Component A will require a budget of four hundred thousand US dollars (USD 400,000), and Component B will require a budget of six hundred thousand US dollars (USD 600,000)

Measurable Outcomes: Increased case finding and linkage to care among children living with HIV in the targeted high-risk areas and hard to reach populations.

Equity Approaches Incorporated in the Proposed Activity Address the Following Considerations:

- Integrating children and AGYW programs proactively to remedy health inequities in HIV testing and case finding among these two priority populations
- Implementing innovative strategies supported by behavioral and social sciences survey methods to remedy health inequities among children

Use of Results: The results will be made available to inform programmatic activities on who and where to target HIV testing services. This information will also inform the adjustment in the case finding strategies.

Impact: This activity will profile the unmet need by person-place-time, closing the HIV testing, awareness, and case finding gaps and in turn mitigate morbidity and mortality in children. This activity will expand case-finding among CLHIV in the selected areas-populations and linkage to care will be facilitated for all newly identified CLHIV. We anticipate that the information gained from these activities will inform where the gaps in awareness among CLHIV are geographically, and characteristics of children who are HIV positive and unaware of their status to better target case-finding activities.

Interagency Concurrence: The proposal was developed with interagency participation and MOH/RBC. The activity will be implemented using CDC and USAID-implementing mechanisms and continue to involve DOD, and RBC throughout the duration design, data collection and analysis. This proposal received interagency concurrence and will benefit the entire country.