

**RWANDA**

**Country Operational Plan**

**COP 2016**

**Strategic Direction Summary**

# Table of Contents

---

## **Goal Statement**

### **1.0 Epidemic, Response, and Program Context**

- 1.1 Summary statistics, disease burden and epidemic profile
- 1.2 Investment profile
- 1.3 Sustainability Profile
- 1.4 Alignment of PEPFAR investments geographically to burden of disease
- 1.5 Stakeholder engagement

### **2.0 Core, near-core and non-core activities for operating cycle**

### **3.0 Geographic and population prioritization**

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

- 4.1 Targets for scale-up locations and populations
- 4.2 Priority population prevention
- 4.3 Voluntary medical male circumcision (VMMC)
- 4.4 Preventing mother-to-child transmission (PMTCT)
- 4.5 HIV testing and counseling (HTS)
- 4.6 Facility and community-based care and support
- 4.7 TB/HIV
- 4.8 Adult treatment
- 4.9 Pediatric Treatment
- 4.10 OVC

### **5.0 Program Activities in Sustained Support Locations and Populations**

- 5.1 Package of services and expected volume in sustained support locations and populations
- 5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

### **6.0 Program Support Necessary to Achieve Sustained Epidemic Control**

- 6.1 Critical systems investments for achieving key programmatic gaps
- 6.2 Critical systems investments for achieving priority policies
- 6.3 Proposed system investments outside of programmatic gaps and priority policies

### **7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals**

#### **Appendix A- Core, Near-core, Non-core Matrix**

#### **Appendix B- Budget Profile and Resource Projections**

#### **Appendix C- Systems Investments for Section 6.0**

## Goal Statement

Rwanda is on the cusp of epidemic control due to its strong national HIV program administered predominantly by the Government of Rwanda (GoR) inclusive of civil society organization and different partners. Site-level analysis and joint strategic planning with GoR determined that the most effective way to reach epidemic control given declining funding is to have a nationally targeted approach, with PEPFAR and Global Fund (GF) resources shifting to support this. In COP16, PEPFAR will continue to partner with GoR in alignment with the National HIV Strategic Plan (NSP) 2013-2018, to attain epidemic control, including supporting Test and START, to develop a more cost-effective, sustainable service delivery model for persons living with HIV (PLHIV), to increase focus on case-based surveillance approaches to interrupt transmission, and to transform the HIV response into a wellness model of chronic disease management.

Rwanda has made great strides toward reaching the UNAIDS 90-90-90 goals, and is at a critical point where acceleration of progress to reach epidemic control can enable realization of an AIDS-free generation. GoR estimates to expand Test and START for all PLHIV on July 1, 2016, representing an additional estimated 18,000 eligible PLHIV.<sup>1</sup> GoR will also roll out three-month drug pick-ups for “stable patients” in order to increase efficiencies at the site level for the benefit of patients and clinical staff, and to foster sustainable cost savings.<sup>2</sup> The USG will collaborate with the GOR to rapidly monitor in real time, how these service delivery changes affect service delivery.

In FY15, it was estimated that 74% of all PLHIV were on ART and 17 of Rwanda’s 30 districts achieved saturation.<sup>3</sup> National ART saturation is expected to be achieved by the end of FY16, with an expected 82% of PLHIV on ART. With the additional PLHIV on ART under Test and START, Rwanda is expected to reach 90% ART coverage nationally.

PEPFAR has found efficiencies across all COP16 program areas to increase investment in strategies that reduce programmatic gaps in achieving 90-90-90 and beyond, including implementation, monitoring and evaluation, and increased commodities costs required for Test and START for COP16. These efficiencies include the COP15 transition to GOR for support of HRH, Blood Safety, and fifty-four health facilities, along with an additional COP16 transition of

---

<sup>1</sup> Test and START has been in effect in Rwanda since 2011 for Hepatitis B or TB co-infected PLHIV, for pregnant women on Option B+, and children under age 5. In 2013, GoR expanded the reach of Test and START to include HIV positive-partners in sero-discordant couples, female sex workers (FSWs), and men who have sex with men (MSM). Furthermore, GoR rolled out Test and START for uniformed service members in January 2016.

<sup>2</sup> A “stable patient” for the first phase of the new service delivery model is defined as a PLHIV >15 years old who has been on ART for more than two years with two viral load results of less than 20 copies and who is considered an adherent patient under ART guidelines.

<sup>3</sup> The data source for national patients on ART is the Rwanda HMIS system. PLHIV estimates are from the 2015 version of EPP Spectrum national estimates. Estimations of unmet need for ART and scale-up districts use the DHS2010 district prevalence to weight the PLHIV estimates from 2016 and prior, and uses DHS 2015 for 2017 and after, based on the timing of the DHS2015 release. .

7% of MOH salaries, for a combined reduction of MOH staff salary support of 21% in the COP16 budget. Additional cost savings were found through transforming, in partnership with GoR, low-yield HIV testing services (HTS) targets and scaling down OVC activities, as well as transitioning of procurement of 50% of non-HIV-specific opportunistic infection (OI) prophylaxis and lab commodities to GoR. During COP16, PEPFAR will focus on more effective testing of people with risk of infection and in geographic areas with more unmet need. Numbers of PLHIV on treatment and with viral suppression are targeted to increase. This will include 1) a strengthened GoR capacity to ensure outreach and linkages to treatment of OVC, 2) focused VMMC coverage in the 15-29 age range in priority locations, 3) targeted prevention and treatment activities for commercial sex workers (CSWs) and men who have sex with men (MSM), as well as priority populations with demonstrated higher than national prevalence, including adolescent girls and young women and clients of CSWs, and 4) a decreased PEPFAR staffing footprint aligned with PEPFAR program priorities. In addition, PEPFAR will work closely with GoR to develop a financially sustainable long term plan for the program to ensure continued success and impact.

## 1.0 Epidemic, Response, and Program Context

---

Rwanda's 2012 Census reported a population of 10,513,973, with 41% under the age of 15 and an annual population growth rate of 2.6%. Projection from the census estimates the 2017 population at 11,809,295. HIV prevalence has remained stable at 3.0% and in FY15 there were an estimated 212,642 PLHIV which is projected to increase to 217,252 by FY17.<sup>4</sup>

The 2010 DHS reported that 92.8% of adult PLHIV reported having ever had an HIV test, which increased to 96.2% in the 2015 DHS, although the proportion of PLHIV who knew their current positive status is unknown.

At the start of COP16, it is estimated that 91% of all PLHIV will be enrolled in HIV care<sup>5</sup>, which exceeds the first 90 of the UNAIDS 90-90-90 goals with regards to knowing HIV status. Based on COP16 projections and plans, by the end of FY16, 92% of PLHIV are expected to be in care.

With the expansion of Test and START, measuring viral suppression is of increasing importance in Rwanda's efforts to control the epidemic by ensuring that clients have less morbidity and mortality and are less likely to infect others with the virus. Two studies conducted in 2009 and 2013 assessed the proportion of those on ART with an undetectable viral load (<40 copies/ml) at 83% and 82% respectively.<sup>6</sup> These studies were prior to full rollout of routine viral load (VL)

---

<sup>4</sup> HIV prevalence was 3.0% for the 2005, 2010 and 2015 DHS surveys. national PLHIV estimates are from the 2015 EPP Spectrum population, 74% of PLHIV were on ART at the end of 2015.

<sup>5</sup> Using the PEPFAR data pack and national health management information (RHMIS) projections.

<sup>6</sup> The following two studies: Elul B et al. High Levels of Adherence and Viral Suppression in a Nationally Representative Sample of HIV-Infected Adults on Antiretroviral Therapy for 6, 12 and 18 Months in Rwanda. PLOS ONE 2013 DOI: 10.1371/journal.pone.0053586, Nsanzimana S et al. HIV care continuum in Rwanda: A cross-sectional analysis of the national programme. Lancet HIV Mar 2015

testing.<sup>7</sup> PEPFAR monitoring and evaluation data from all supported Rwandan health facilities in FY15 showed viral suppression to be 88% among those tested, with 87% of all eligible ART patients having a recorded annual result.

HIV program donor funding has decreased significantly in the past year, a trend over the past five years that is expected to continue. Rwanda's gross national income is 700 USD per capita,<sup>8</sup> it ranks 163 UNDP's human development index, and significant financial barriers remain to achieve a sustained domestically-funded HIV response.

Rwanda faces gaps to attain epidemic control and an AIDS-free generation, including systems and financial issues needed to support Test and START, development and implementation of cost-effective and sustainable service delivery models, supply chain management, greater use of data approaches to identifying new infections, and shifting to a wellness model to manage HIV-positive patients.

Rwanda's HIV epidemic is generalized, has higher key population/KP infection rates, and an urban prevalence of 6.2%, compared to a 2.2% rural prevalence. Women have a higher HIV prevalence than men (3.6% vs. 2.2% nationally, 8.0% vs. 4.4% in Kigali) and young women aged 20-24 have nearly twice the rate of infection males the same age (1.8% versus 1.0%).<sup>9</sup> Sixty-five percent of transmission is estimated to be in stable heterosexual relationships, while 20% of new infections are attributed to sex workers, their clients, and their partners.<sup>10</sup> Female sex workers (FSWs) have an estimated HIV prevalence of 45%,<sup>11</sup> while MSM preliminary prevalence data is 4%.<sup>12</sup>

In FY17 it is projected that 55,954 PLHIV will be from the three districts of Kigali city (Gasabo, Kicukiro, and Nyarugenge), representing over 26% of Rwanda's PLHIV due to their high prevalence and larger populations<sup>13</sup>.

---

<sup>7</sup> Rwanda currently has nine viral load testing sites, a tenth will be added in 2016. Previously only the National Reference Lab and the University Teaching Hospital Laboratory (Butare) were offering VL testing but, currently nine (10 by 2016) public facilities conduct VL testing. Viral load testing is now routinely required for all Rwandans on ART, six months after initiation, and then annually after that. In 2015, VL testing was added to the list of performance based financing indicators (PBF), which in combination with decentralized VL testing facilities has increased the number and proportion of VLs being done. PEPFAR provides support to national lab services strengthening, including systems to improve the quality of testing, delivery of results to facilities and implementation of information systems to aggregate quality usable data for national planning.

<sup>8</sup> 2014, World Bank.

<sup>9</sup> Rwanda DHS 2015

<sup>10</sup> UNAIDS Modes of Transmission Study (MOT) 2013.

<sup>11</sup> Female Sex Worker Behavioral Sentinel Survey (BSS) 2010. Preliminary findings from the BSS report ~51% FSW national HIV prevalence.

<sup>12</sup> BSS 2015. Previous MOT MSM estimated prevalence is 5%.

<sup>13</sup> DHS2015 district prevalence and 2012 Census data projections were used to calculate district PLHIV from the 2015 national EPP Spectrum estimates for FY2017

**Table 1.1.1 Key National Demographic and Epidemiological Data**

		Total		<15				15+				Source, Year
				Female		Male		Female		Male		
		N	%	N	%	N	%	N	%	N	%	
Total Population	2012	10,515,973	100%	2,179,173	20.70%	2,148,910	20.40%	3,271,932	31.11%	2,915,958	27.73%	NISR Census, 2012. p 10.
	2017 (projections)	11,809,299	100%	2,316,860	19.62%	2,316,961	19.62%	3,770,182	31.93%	3,405,298	28.84%	NISR Census, 2012. p139
Prevalence (%)	2010		1.8%	0.6% (0.52%-0.7%)					3.7%		2.2%	DHS, 2010 (Based on 15-49yr old)
	2015			0.2%				3.0%				DHS 2015 (Table 14.3, 14.14)
	2017							2.56% (2.27-2.88)				EPP Spectrum, 2015 2012 Census Projection
AIDS Deaths (per year)	2015	2820 (1859-4126)		588 (440-799)				2232 (1322-3484)				EPP Spectrum, 2015
	2017	2418 (1627-3655)		473(402-564)				1946 (1221-3063)				EPP Spectrum, 2015
PLHIV	2015	212,642 (191,237 - 233,586)		20,043 (17,547 - 23,091)				117,685 (104,94-130,860)		74,914 (69645- 79,635)		EPP Spectrum, 2015
	2017	217,252 (195,189 - 239,815)		16,083 (13,596 - 19,313)				123,228 (109,426 - 136,971)		77,942 (70,325 - 86,116)		EPP Spectrum, 2015
Incidence Rate (Yr)	2014							0.16 (0.08-0.19)				EPP Spectrum, 2014 (Adults 15-49)
	2016		0.27 (0.21-0.34)					0.27 (0.21-0.34)				RAIHIS

New Infections (Yr)	2015	6140 (4378-8511)											
	2017	6105 (4198-8704)											EPP Spectrum, 2015 (Adults 15-49)
Annual births	2012	321,506											NISR Census, 2012. p143
	2015	343,077											NISR Census, 2012. p144 (2015 & 2017 estimates available. No 2016)
% >= 1 ANC visit	2015		99.2%	Not Available	Not Available				99.2%				DHS 2015 (Table 9.2)
Pregnant women needing ARVs	2015	8808 (7635-10066)	2.9%										EPP Spectrum, 2014 (Mothers needing ARVs) and 2014 Program data and PEPFAR APR14
	2017	8659 (7640-9824)	Not Available										EPP Spectrum, 2014 (Mothers needing ARVs)
Orphans (maternal, paternal, double)	2009	674,556		75,728		75,157		262,810		260,861			NSP 2009, (DHS 2015, Table 2.12)
TB cases (Yr)	2015	5641		160		175		1727		3579			HMIS, 2015 (TB & ORD Division RBC)
TB/HIV Co-infection	2015	1448	26%	29	18%	28	16%	533	31%	858	24%		HMIS, 2015 (TB & ORD Division RBC)
Males Circumcised	2015	Not Available	Not Available			Not Available	Not Available			336,129 (ages 15-59)	27.8%		DHS 2015 (Table 13.22)

Key Populations												
Total MSM*	Not Available	Not Available	Not Available									
MSM HIV Prevalence	2015		Not Available							4% (Ages 18+)		MSM BSS 2015, preliminary results
Total FSW	2010	12,500										BSS Female Sex Workers, Rwanda 2010
FSW HIV Prevalence	2015								46.3% (Ages 15+)			BSS Female Sex Workers, Rwanda 2015
Total PWID	Not Available	Not Available										
PWID HIV Prevalence	Not Available		NA									
SD/Couples (Prevalence)	2015	Not Available	2.8%									DHS 2015 (Table 14.13)
Prisoners (Prevalence)	Not Available	Not Available	NA									

Table 1.1.2 90-90-90 cascade: FY 2015 HIV diagnosis, treatment, and viral suppression

National Population and PLHIV				National HIV Treatment and Viral Suppression			National HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART (#)	Retained on ART 12 Months (%)	Viral Suppression 12 Months	HIV tests conducted (#)	Positive HIV tests (#)	Newly initiating ART (includes those initiating from pre-ART and may be higher than positive tests) (#)
Total population	12,022,635 <sup>o</sup>	2.74 <sup>+</sup> (age 15-49)	212,642 <sup>+</sup>	156,471 <sup>^</sup>	91.2% <sup>=</sup>	136,292 <sup>=</sup>	3,634,746 <sup>=</sup>	29,441 <sup>=</sup>	22,512 <sup>=</sup>
Population less than 15 years	5,150,497 <sup>o</sup>	0.2 <sup>+</sup>	10,300 <sup>+</sup>	8,011 <sup>=</sup>	92.8% <sup>=</sup>	unavailable	136,349 <sup>^</sup>	470 <sup>^</sup>	633 <sup>^</sup>
Pregnant Women	383,864	2.29 <sup>+</sup>	8,989 <sup>+</sup>	9,798 <sup>=</sup>	unavailable	unavailable	372,611 <sup>=</sup>	3,726 <sup>=</sup>	3,664 <sup>=</sup>

<sup>o</sup> 2012 census projections

<sup>+</sup> EPP Spectrum 2015

<sup>\*</sup>DHS2015

<sup>^</sup> Rwanda HMIS

<sup>=</sup> 2014-15 National Annual Report

## 1.2 Investment Profile

In FY15, Rwanda's HIV response was funded primarily by three sources – PEPFAR (41.5%), GF (47.8%), and the national government (10.1%).<sup>14</sup> Overall donor funding for the Rwanda HIV program continues to decrease; since FY09, PEPFAR funding to Rwanda has decreased annually by an average of 10%. In FY16, GF HIV funds remained at \$59m down from \$100m annually in 2013 and 2014,<sup>15</sup> although it is anticipated to decrease beyond the current grant cycle ending at the end of 2017. PEPFAR funds decreased in FY17 from \$80m to \$72m,<sup>16</sup> while GoR funding is planned to increase from \$20m to \$21m. Anticipated decreases in GF and PEPFAR funding will create particular challenges for Rwanda's HIV program and will place pressure on Rwanda's health system. The MOH's ability to continue to reduce inefficiencies to realize cost savings, as well as to secure additional domestic funding for human resources and other system costs no longer funded by GF or PEPFAR in the long-term, is yet to be determined.

PEPFAR and GF are coordinating with GoR to maximize USG and GF investment, and strategically align with domestic and other available resources to achieve epidemic control. USG initiated discussions with GoR addressing long-term financial sustainability of the program in 2015. With greater knowledge and predictability of donors' future HIV plans and funding, the GoR can begin to determine how to proactively address the impact of fewer HIV-specific dollars in the forthcoming years. Rwanda is the first country to participate in GF's Results Based Financing (RBF) Model and is the largest PEPFAR implementing partner through the USG's MOH cooperative agreement (MOH CoAg).

---

<sup>14</sup> PEPFAR 2015 Expenditure Analysis; Rwanda HIV Consolidated Operational Plan, 2013-2015; National HIV Annual Report, 2014-2015. Note that various sources with non-aligned time frames are used for the investment profile analysis. Depending on the timeframe/data view, Rwanda's national HIV response is funded roughly 43% PEPFAR, 46% GF, 10% GoR, and 1% other sources using total national HIV program expenditures of \$202m for GoR fiscal year from July 2014 to June 2015.

<sup>15</sup> GoR fiscal year 2015/16, July 2015 to June 2016.

<sup>16</sup> PEPFAR COP15 was \$80m, COP16 planning level is \$72m.

**Table 1.2.1 Investment Profile by Program Area**

<b>Program Area</b>	<b>Total FY 15 Expenditures</b>	<b>% PEPFAR<sup>17</sup></b>	<b>% GF<sup>18,19</sup></b>	<b>% GoR<sup>19,20</sup></b>	<b>% Other<sup>19,20</sup></b>
Clinical care, treatment and support	\$55,861,942	52.9%	46.2%	0.9%	0.1%
Community-based care	\$3,692,414	41.3%	58.7%		
PMTCT	\$19,384,897	19.4%	55.5%	21.9%	3.1%
HTS	\$7,622,897	76.2%	23.7%		
VMMC	\$5,840,518	100.0%			
General population prevention	\$13,166,643	6.0%	68.5%	22.5%	2.9%
Key population prevention	\$1,427,766	100.0%			
Other vulnerable populations prevention	\$726,533	100.0%			
OVC	\$7,705,830	56.0%	43.9%		0.1%
Infection Control	\$821,592	93.4%	6.6%		
Blood Safety	\$2,986,901	100.0%			
Laboratory	\$26,269,845	39.5%	60.5%		
SI, Surveys and Surveillance	\$1,288,768	86.8%	1.1%	11.3%	0.8%
HIV Coordination	\$7,324,014		78.0%	21.5%	0.5%
HSS	\$24,265,431	0.5%	55.9%	43.1%	0.5%
HRH	\$18,499,026	68.2%	31.8%		
<b>Total</b>	<b>\$196,885,017</b>	<b>41.5%</b>	<b>47.8%</b>	<b>10.1%</b>	<b>0.6%</b>

<sup>17</sup> PEPFAR 2015 Expenditure Analysis

<sup>18</sup> Rwanda HIV Consolidated Operational Plan, 2013-2015

<sup>19</sup> National HIV Annual Report, 2014-2015

**Table 1.2.2 Procurement Profile for Key Commodities**

This table represents the estimated expenditures in the “current procurement arrangements” for key commodities, based on budget. Percentage allocation is based on proposed cost split of shipments in the 2015 CPDS report, which is currently being implemented. These estimates are based on a January 2015 quantification report (CPDS 13/CPDS 9) and subsequent planning meetings for the period of 2015. Future year changes anticipated include a reduction in the overall percentage of PEPFAR’s contribution to the program.

Commodity Category	% PEPFAR	% GF	% GOR	% Other	Comments
ARVs	46.2	53.8			Based on 2015 HIV quantification report
Rapid test kits	46.2	53.8			Based on 2015 HIV quantification report
Other drugs	100				Assuming this category refers to drugs for opportunistic infections and prophylaxis for HIV patients. Based on 2015 HIV quantification report. Pfizer procures Fluconazole only, less than 1% of total cost.
Lab reagents	46.2	53.8			Based on 2015 HIV quantification report
Condoms	43	14		43	Based on 2015 MCCH quantification report. This includes socially-marketed condoms that are provided through PEPFAR and GF. Public sector condoms are quantified through the FP program and procured by USAID, UNFPA, and GOR. Annual breakdown of costs varies significantly per year. This is only inclusive of male condoms. Female condoms are procured by UNFPA.
Viral Load commodities	46.2	53.8			Based on 2015 HIV quantification report
VMMC kits			100		GOR procured VMMC kits through Global Fund funding.
MAT (methadone and other medical-assisted therapies)					N/A
Other commodities	46.2	53.8			Assuming this category refers to all other products quantified for HIV patients not captured in above categories. Based on 2015 HIV quantification report

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID Non-HIV	\$44,000,000*	\$17,200,000*	6*	\$38,082,170	Focus on key populations and OVC; improve access to service delivery and commodities availability. <i>*Please note these are tentative planning levels. The control levels have not yet been officially release and therefore planning figures are very tentative.</i>
CDC Influenza	\$400,000	\$0	0	\$0	Sustaining influenza surveillance networks and response to seasonal and pandemic influenza by national health authorities.
<b>Total</b>	<b>\$44,400,000</b>	<b>\$17,200,000</b>		<b>\$38,082,170</b>	

**Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP**

<b>Funding Source</b>	<b>Total PEPFAR Non-COP Resources</b>	<b>Total Non-PEPFAR Resources</b>	<b>Total Non-COP Co-funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
VMC	\$2,835,674	\$0	\$0	2	\$746,651	Non-COP one-time central VMC funds to support the scale up of VMC activities in Rwanda added to COP16 funding contribution. IMs co-funded through a combination of COP16 funding and central funding.
ISVP Impact Evaluation	\$620,000		0	1	0	This activity is an impact evaluation of the ISVP mechanism and will measure the impact of different economic, HIV, health, and education approaches on individual and household resilience, health, and education.
<b>Total</b>	<b>\$3,455,674</b>		<b>\$</b>		<b>\$746,651</b>	

### 1.3 National Sustainability Profile

In January 2016, PEPFAR, jointly with the GoR/MOH, organized the second year of Rwanda's Sustainability Index and Dashboard 2.0 (SID 2.0) workshop. Over 50 participants from more than 25 organizations representing civil society, the private sector, local and international NGOs, and international multilateral and bilateral agencies that contribute to the national HIV response took part in the workshop.<sup>20</sup> All SID 2.0 domains were identified as sustainable, approaching, or emerging sustainability, with notable strength in the "Governance, Leadership, and Accountability" domain with regard to planning, coordination, and public access to information. After the new version of the tool collapsed four elements of SID 1.0 (2015) into two elements for SID 2.0 (2016), the SID element of Domestic Resource Mobilization: Resource Commitments, previously identified in SID (2015) as the only unsustainable element requiring significant focus, is now identified as an emerging sustainability area needing some improvement.<sup>21</sup> Other components identified as emerging sustainability and needing further investment were Private Sector Engagement, Service Delivery, Technical and Allocative Efficiencies, and Epidemiological Health Data.

Specific priority areas identified within these domains which require strengthening for continued progress towards epidemic control were:

- Ability to measure progress towards epidemic control
- Analysis of financial expenditure/efficiency, improving unit cost estimates and optimizing service delivery models
- Available data on pediatrics and key populations (KPs)
- Domestic financial resources available for health and HIV
- Responsiveness and efficiencies of facilities-based and community-based HIV services
- Geographic allocation of resources relative to unmet need

Both PEPFAR and GF have invested substantially in Rwanda's HIV response. There is a limited domestic budget to fully fund the HIV program, and donor funding, including from PEPFAR, is rapidly reducing. Nearly 50% of PEPFAR funding and all GF support are delivered through the government, which demonstrates the high capacity of GoR and MOH systems.

The DHS 2015 was released in May 2016, and other survey results are expected in mid-2016 and will provide critical information for strategic planning and program implementation during COP16 through provision of district level pediatric prevalence, HIV incidence, and district-level general and key population HIV prevalence data.

### 1.4 Alignment of PEPFAR investments geographically to disease burden

---

<sup>20</sup> The process for holding this initial meeting was based upon the process followed for the previous year's SID.

<sup>21</sup> In the 2015 SID, the other element, Domestic Resource Mobility: Resource Generation, was identified as "approaching sustainability needing little or no investment."

HIV care in Rwanda is largely available, and in FY15 just over half of the ART patients received care in PEPFAR-supported facilities, while the other half were supported by Global Fund and GoR funding. The proportion of facilities and patients on ART as well as the HIV services that are supported by PEPFAR varies widely by district. In FY15, two districts (Gisagara and Kirehe) received no direct district-level PEPFAR support, while in the 28 districts that did, PEPFAR supported between 2% and 98% of all patients on ART. In addition to direct clinical support, PEPFAR funds other programming, such as OVC and key population outreach testing that do not correlate with the proportion of funded clinical support. PEPFAR expenditures may not reflect overall expenditure per PLHIV in the district, because higher proportional expenditures can be due to PEPFAR supporting the majority of facilities or patients in the district, and lower expenditure per PLHIV may indicate that few or no facilities are supported by PEPFAR. Therefore, examination of PEPFAR expenditures alone does not account for the full picture of support for PLHIV in Rwanda.

PEPFAR spent on average \$391.49 per PLHIV in Rwanda in 2015,<sup>22</sup> a reduction from an average of \$570.16 in 2014. When comparing FY15 PEPFAR expenditure by district (Figure 1.4.1), there are two outliers, Nyaruguru and Gatsibo, which had PEPFAR expenditure of greater than \$500 per PLHIV; however, in both of these lower prevalence districts, PEPFAR supported the service delivery for more than 90% of patients on ART and the ART coverage had reached saturation by the end of FY15. The combination of relatively low numbers of PLHIV, low unmet need for ART, and high proportional coverage by PEPFAR is a likely explanation for these outliers. Further analysis of Nyaruguru showed expenditures outside of HIV clinical services in VMMC and OVC, both of which were strategically refocused to priority districts during COP15. On further analysis of Gatsibo district, it was found to have disproportionately high expenditures in HTC, with the highest number of PEPFAR funded HIV tests and low levels of positivity. Planned repeat low-risk testing reductions in COP16 are expected to reduce the overall future expenditure per PLHIV in this district. Clinical service delivery in Gatsibo was also supported by an international NGO for nine months of the year; as clinical service delivery is transitioned from the NGO to MOH support, cost per patient is expected to decrease. The program will expect to see lower PEPFAR expenditure per PLHIV in Nyaruguru and Gatsibo as some sites from these districts transition from PEPFAR support to GoR during COP15.

While analysis of PEPFAR expenditure by PLHIV may be helpful to understand where PEPFAR funds are spent, on its own, it cannot be used to evaluate the appropriate allocation or equity of the national investments against the burden of disease due to the described limitations.

---

<sup>22</sup> Based on PEPFAR FY15 Expenditure Analysis data. This amount includes PEPFAR expenditures for commodities and the HRH Program.

Figure 1.4.1

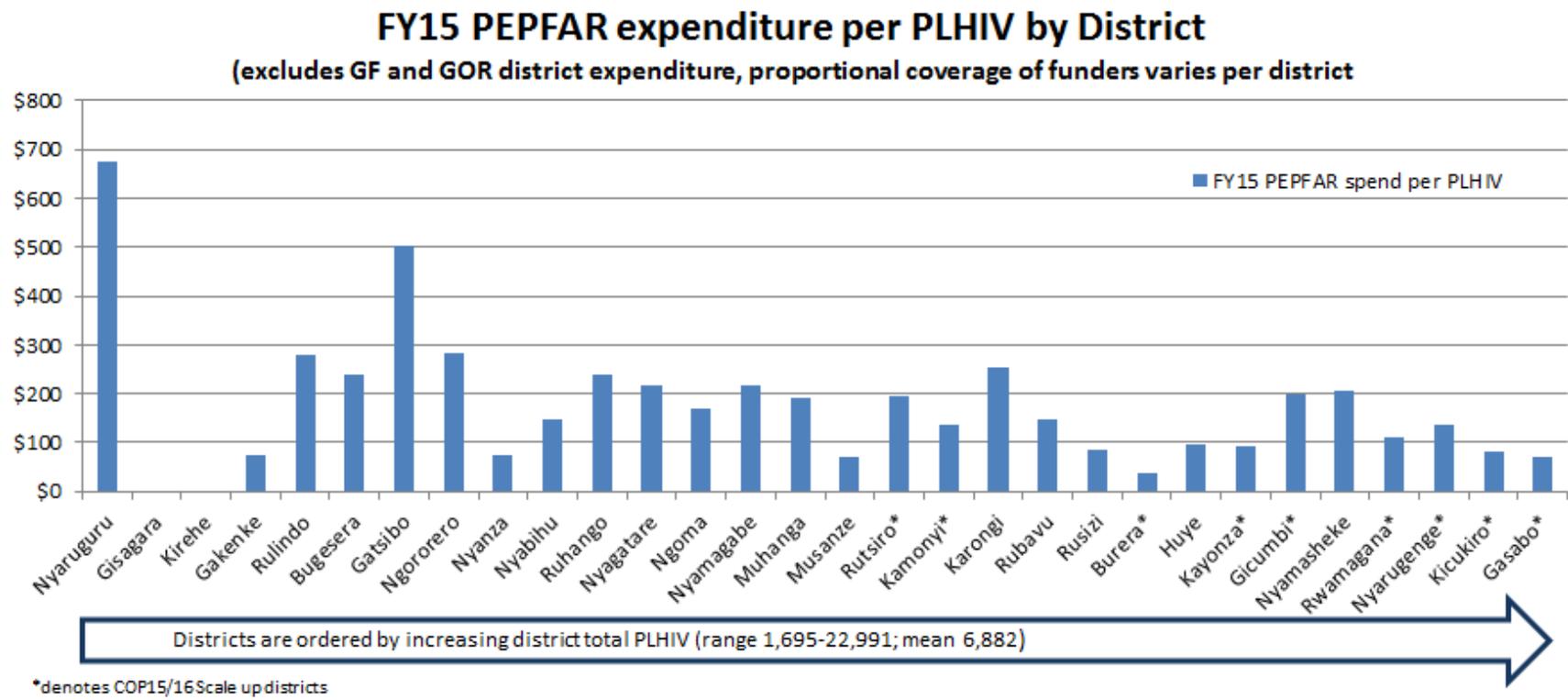


Figure 1.4.2 Rwanda National HIV Overview and 2015 Results + PEPFAR Expenditures by District

District	Adult HIV Prevalence (2010 DHS) <sup>23</sup>	2015 Estimated PLHIV 2015 EPP Spectrum PLHIV weighted by population (2012 Rwanda Census) and HIV prevalence (2010DHS)	2015 National PLHIV on ART (Rwanda HMIS)	2015 Estimated ART coverage (on ART/PLHIV)	PEPFAR Expenditures (PEPFAR EA 2015 Data)	% Spend (includes Military_Rwanda Expenditures)
<b>ABOVE NATIONAL</b>	--	--	--	--	<b>\$2,576,363</b>	<b>3.2%</b>
<b>NATIONAL</b>	<b>3.0%</b>	<b>212,642</b>	<b>156,471</b>	<b>74%</b>	<b>\$41,343,881*</b>	<b>51.2%</b>
Bugesera	1.0%	4,798	3,962	83%	\$827,342	1.0%
Burera	3.5%	7,008	2,572	37%	\$278,245	0.3%
Gakenke	1.4%	3,406	3,076	90%	\$243,166	0.3%
Gasabo	6.4%	22,567	13,993	61%	\$1,635,507	2.0%
Gatsibo	0.9%	5,411	4,377	81%	\$1,914,507	2.4%
Gicumbi	3.4%	8,219	4,360	53%	\$1,713,170	2.1%
Gisagara	1.1%	2,722	2,329	86%	\$34,132	0.0%
Huye	3.5%	7,324	5,344	73%	\$1,615,170	2.0%
Kamonyi	3.1%	6,582	3,774	57%	\$958,655	1.2%
Karongi	3.3%	6,657	5,648	86%	\$1,799,030	2.2%
Kayonza	3.7%	7,593	4,905	66%	\$714,920	0.9%
Kicukiro	7.9%	17,057	10,101	58%	\$2,000,067	2.5%
Kirehe	1.0%	4,501	3,697	82%	\$24,482	0.0%
Muhanga	2.9%	5,880	5,249	89%	\$1,194,598	1.5%
Musanze	2.7%	6,131	4,748	78%	\$435,344	0.5%
Ngoma	2.6%	5,304	4,262	81%	\$1,088,069	1.3%
Ngororero	2.1%	4,165	3,678	90%	\$1,206,319	1.5%
Nyabihu	2.7%	4,708	3,546	77%	\$705,316	0.9%
Nyagatare	1.9%	5,737	4,852	85%	\$1,194,195	1.5%
Nyamagabe	2.8%	5,805	4,435	77%	\$1,288,959	1.6%
Nyamasheke	3.6%	8,351	7,011	85%	\$1,762,823	2.2%
Nyanza	2.1%	4,392	3,963	90%	\$309,988	0.4%
Nyarugenge	8.3%	18,031	16,513	92%	\$3,702,806	4.6%
Nyaruguru	0.9%	2,336	1,930	83%	\$1,145,345	1.4%
Rubavu	2.8%	6,693	5,408	82%	\$1,009,244	1.2%
Ruhango	2.5%	4,929	4,579	90%	\$1,198,905	1.5%
Rulindo	1.7%	3,975	3,606	91%	\$910,978	1.1%

<sup>23</sup> Pre-FY2017 PLHIV estimates use DHS2010 District prevalence and 2012 Census as a weight to distribute the 2015 Spectrum total PLHIV. FY17 and subsequent year estimations use DHS 2015 district prevalence and 2012 census as a weight to PLHIV distribution.

Rusizi	2.8%	6,832	5,033	74%	\$593,863	0.7%
Rutsiro	3.4%	6,557	4,213	65%	\$1,299,720	1.6%
Rwamagana	4.6%	8,971	5,307	59%	\$1,133,435	1.4%

\*includes PEPFAR support for commodities

## 1.5 Stakeholder Engagement

COP16 was jointly developed with GoR/MOH from the Technical Working Groups level to senior leadership (Minister of Health, Minister of State, and the Permanent Secretary).<sup>24</sup> Rwanda's GF HIV grant is a results-based funding model (RBF), and the Country Coordination Mechanism (CCM) oversees the allocation of the grant within the frame of the HIV NSP.<sup>25</sup> The PEPFAR Country Coordinator represents the USG on the CCM as a voting member and has engaged on the NSP Operational Plan.

Civil society and the private sector provided inputs for the COP16 working groups through participation in a civil society organization (CSO) Consultation held in February 2016. During the meeting, PEPFAR briefed CSOs on FY15 results, preliminary SID 2.0 findings, and other data sources to assist CSOs in understanding and contributing to the PEPFAR strategy and planning in Rwanda. The meeting engaged numerous community partners and their constituencies, including UNAIDS, the NGO umbrella groups for health CSOs and PLHIV, as well as the CCM Secretariat and MOH/Rwanda Biomedical Center. Following on the CSOs' Consultation, PEPFAR will continue to develop a regular practice of consultation with these groups, including in-person group meetings and written communication.

Joint COP16 development, adaptation and analysis of planning tools, emphasis on epidemic control and priority regions, and the required increased efficiencies in resource deployment will help to prepare Rwanda for COP16 quarterly reviews. The PEPFAR Oversight, Accountability and Response Team (POART) quarterly reviews will be merged within the context of Rwanda's own HIV NSP reviews. Given the anticipated decline in donor funding, elaborating Rwanda's HIV program sustainability plan is critical. Rwanda's HIV sustainability plan will expand on COP16 efforts to target scale-up services and jointly review data and results to make tactical mid-course corrections towards ending the HIV/AIDS epidemic in Rwanda by 2030.

## 2.0 Core, Near-Core and Non-Core Activities

---

Following on COP15 planning, the PEPFAR interagency team developed and then vetted the core, near-core, non-core (CNN) analyses with the joint USG/GoR COP16 working groups.<sup>26</sup> The CNN process considered activities required to achieve sustained epidemic control, current COP15 program and activities, challenges to achieving epidemic control, supporting Test and START, and the transition from epidemic to chronic disease management, as well as the downward donor funding projected for the national HIV response. SID 2.0 and SIMS data were considered alongside DQA/SQA and other relevant program context. The CNN analysis was used to prioritize PEPFAR's COP16 supported activities and helped to emphasize the need to focus

---

<sup>24</sup> COP16 planning processes included joint data analysis and program priority setting, while the USG team set the budget elements and reviewed them with GoR/MOH.

<sup>25</sup> The GoR/MOH is the GF HIV, TB and Malaria grants Principle Recipient (PR). The RBF grant is disbursed based on the overall achievement of seven indicators which PEPFAR also contributes to the reported results. MOH is also PEPFAR's lead clinical implementing partner and is responsible for all COP16 clinical results.

<sup>26</sup> Appendix A.

resources on core epidemic control activities. The CNN lens was also applied in defining program core packages for prevention, care and treatment, OVC, labs, technical assistance, and supply chain. Overall, the CNN analysis helped align both the USG agencies and MOH regarding priorities for the PEPFAR COP16 program for both site and above-site systems strengthening activities for achieving epidemic control.

### 3.0 Geographic and Population Prioritization

---

The USG and GoR teams are focused on the UNAIDS 90-90-90 targets and beyond to accelerate achievement of epidemic control. While Rwanda is on track to reach ART saturation nationally by the end of FY16, epidemiological estimations and program performance data suggest that with more focused planning and resource allocation, saturation in all districts is achievable by the end of FY17. With declining donor resources and a steady increasing number of PLHIV,<sup>27</sup> Rwanda is in a position where rapid and focused action to break the epidemic is critical and achievable. Anticipated declines in funding might delay achieving epidemic control.

USG and GoR planning teams jointly set geographic priority areas during COP15 development, which remain in effect for COP16.<sup>28</sup> Unmet need for ART was the most important determinant of prioritization and resource allocation because Rwanda's shift to achieve epidemic control relies heavily on ART saturation. Districts in Rwanda are relatively small geographically, with an average of 844 square kilometers and a range of 134-1937 square kilometers, having an average population of 350,532. Given the small geographic size and inter-district movement of people between the three districts of Kigali, unmet need estimation combines the three districts into one unit.<sup>29</sup> Given the information available and the relatively small district size, USG and GoR were able to target planning at the district level, making use of national, district, and sub-district information. Size estimations for some KPs are available at the sector level in areas with hot spots, with sectors having on average just under 20,000 people, and these data were used to inform prioritization decisions for targets, resources, and service-delivery package planning.

The current focus for reaching epidemic control is in the ART scale-up to saturation districts that need to reach PLHIV with ART at an accelerated pace, as well as KP scale-up hotspots where at-risk populations are more likely to live, require services, and contribute to high rates of HIV transmission.

Rwanda will prioritize PLHIV with unknown status who are living in districts with higher levels of unmet need, as well as key and priority populations (KP and PP), in order to ensure that resources are used to maximally diagnose new HIV-positive individuals and most efficiently interrupt

---

<sup>27</sup> Preliminary results from the RAIHIS 2015 indicates a national HIV incidence rate of 0.27, as opposed to the EPP Spectrum 2014 estimate of 0.16, with a predicted 16,707 new adult HIV infections per year based on 2015 population estimates.

<sup>28</sup> These prioritized areas will be updated as needed based on quarterly, semi and annual review of program results and availability of new epidemiological data.

<sup>29</sup> The districts that make up Kigali district are Kicukiro, Gasabo, and Nyarugenge.

transmission and new infections. KP CSWs and adolescent girls and young women (AGYW) and clients of CSWs, their partners, and networks are prioritized based on their prevalence, risk and current understanding of modes of transmission in Rwanda. Given the disparity in prevalence and PLHIV between Kigali and the rest of Rwanda, the three districts making up the capital will be prioritized, as this area represents the greatest burden of disease, unmet need, and highest rates of transmission and will thus be pivotal to controlling the epidemic and achieving an AIDS-free generation.

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

---

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

Rwanda's COP16 planning and target setting for number of people on ART were conducted using national level data, inclusive of PEPFAR and GF/GoR funded sites.<sup>30</sup> The GoR/USG COP16 planning team set clinical targets that reflect the commencement of Test and START as well as attainment of ART saturation in scale-up districts. Rwanda is targeted to achieve the 90-90-90 goals nationally by the end of COP16.

Using the COP16 datapack tool, the joint MOH/USG working groups applied historic trends, program, and contextual knowledge to accept or modify automatically produced targets. For scale up districts, ART coverage was targeted at 80% unless Test and START implementation or passive growth through other entry streams would result in a higher ART coverage or in the case of two districts where reaching 80% coverage was not possible given the available program data regarding testing positivity and district population. USG technical teams reviewed the planned targets against the proposed funding and the allocations of costs in the PEPFAR Budget Allocation Calculator.

A critical data gap is the lack of information regarding how many patients receiving treatment originate from outside the district. Given Rwanda's small geographic size, and with half of its districts sharing land borders with the four neighboring countries, cross border movement in relation to service delivery makes accurate estimates challenging, particularly considering the recently increased freedom of movement across East African Community borders. This is a challenge because prevalence estimates and population figures derived from demographic surveys and the census are less likely to include non-residents who may travel only to receive their treatment and return home, while service delivery information will include all those who receive services. This can lead to both under and over estimation of unmet need in individual districts,

---

<sup>30</sup>All 510 HIV sites in Rwanda are either funded by PEPFAR or GF/GoR, 209 and 291 respectively. Site allocations are mixed by district and reflect how the program scale-up has evolved. The COP16 targeting exercise adapts from the configuration of sites to apply both PEPFAR and GF/GOR resources to achieve epidemic control.

and likely to an underestimation of unmet need nationally. In order to mitigate this challenge, COP16 includes a planned evaluation seeking to understand patient cross-border and internal care seeking movements. Better understanding of service-seeking behavior at facilities will support implementation that ensures services are delivered where they are most needed. Additional difficulties in identifying and linkage to ART for KPs, PPs, and children, especially children born to KPs, could reduce Rwanda's anticipated achievements in COP16.

**Table 4.1.1 PEPFAR COP16 ART Targets in Scale-up Sub-national Units<sup>31</sup> for Epidemic Control**

SNU	Total PLHIV 2017	Expected current on ART APR FY 16 National (PEPFAR)	Additional patients required for 80% ART coverage	Target current on ART APR FY17 National (PEPFAR)	Newly initiated on ART APR FY 17 National (PEPFAR)	ART Coverage (APR 17)
Burera	2,957	2,883 (500)	0	2,918 (507)	208 (37)	42%
Gasabo	22,348	16,631 (3,843)	1,054	19,890 (4,691)	4,257 (1,078)	83%
Gicumbi	8,847	4,830 (4,180)	2,172	5,064 (4,382)	524 (453)	62%
Kamonyi	4,230	4,669 (3,891)	0	5,143 (4,331)	754 (674)	80%
Kayonza	8,087	6,057 (1,780)	343	6,880 (2,003)	1,186 (330)	90%
Kicukiro	15,384	11,667 (7,610)	507	13,750 (8,881)	2,783 (1,727)	80%
Nyarugenge	18,223	19,281 (16,107)	0	20,995 (17,461)	2,871 (2,320)	114%
Rutsiro	4,994	5,017 (4,498)	0	5,430 (4,878)	714 (650)	83%
Rwamagana	7,180	6,542 (2,244)	0	7,335 (2,524)	1,185 (415)	81%
<b>Total</b>	<b>92,250</b>	<b>77,577 (44,653)</b>	<b>4,076</b>	<b>87,404 (49,658)</b>	<b>14,484 (7,684)</b>	<b>84%</b>

**Table 4.1.2 PEPFAR COP16 Targeted Entry Streams for Newly Initiating ART Patients in Scale-up Districts**

Target Entry Streams for ART Enrollment	Target tested for HIV APR FY17	Target Identified Positive APR FY17	Target Newly initiated APR FY 17
Clinical care patients not on ART	N/A	N/A	2,707
HIV-positive Pregnant Women	54,468	1,958(known)/ 589 (new)	623
Inpatient and outpatient testing	67,112	728	561
Voluntary Counseling and Testing (self presentation)	95,344	1467	1,130
Index Case Testing	7,793	633	487
Outreach Mobile testing	84,554	3,440	2,649
Voluntary Medical Male Circumcision testing	87,572	88	
<b>Total</b>	<b>389,050</b>	<b>6,312</b>	<b>8,157</b>

<sup>31</sup> Department of Defense data is reported only at the national level, and is therefore not included in any district-level data

**Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts**

Target Populations	Population Size Estimate (SNUs)	Current Coverage (in FY16)	VMMC_CIRC (in FY17) (COP16 contribution + central funding)	Expected Coverage (in FY17)
Males 15 - 29	526,263	58%	95,938	70%
<b>Total/Average</b>	<b>526,263</b>		<b>95,938</b>	

**Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
Uniformed Personnel			4,000
Young Women (15-24)			6,499
Youth			3,030
Female Sex Workers	9,232	93%	8,594
Men who have Sex with Men (CSW)	1,670	44%	737
<b>Total</b>			<b>22,860</b>

**Table 4.1.5 Targets for OVC and Linkages to HIV Services**

	<b>Estimated # of Orphans and Vulnerable Children</b>	<b>Target # of active OVC (FY17 Target) OVC_SERV</b>
Bugesera	1,782	2,970
Burera	6,624	11,040
Gasabo	6,210	10,350
Gatsibo	3,280	5,466
Gicumbi	2,584	4,306
Huye	5,224	8,707
Kamonyi	3,325	5,542
Karongi	3,824	6,374
Kayonza	5,956	9,926
Kicukiro	998	1,663
Muhanga	850	1,417
Musanze	4,434	7,391
Ngoma	1,198	1,997
Ngororero	775	1,291
Nyabihu	516	860
Nyagatare	476	793
Nyamagabe	2,917	4,861
Nyamasheke	3,600	6,000
Nyanza	448	747
Nyarugenge	5,927	9,878
Nyaruguru	434	723
Rubavu	1,748	2,914
Ruhango	557	929
Rutsiro	5,929	9,881
Rwamagana	3,122	5,203

---

**TOTAL**

**72,738**

**121,229**

---

## Program Area Summaries 4.2-4.10

### 4.2 Key and Priority Populations Prevention

Commercial sex workers (CSWs) are the primary key populations (KPs) in Rwanda. This includes female commercial sex workers (FCSW) and men-who-have-sex-with-men (MSM) involved in commercial sex work. Results from the recent PEPFAR-funded behavioral surveillance surveys (BSS) shows a 45% national HIV prevalence with a prevalence of 51% in Kigali among FCSW. In addition, only 53% of HIV-positive FCSW knew their status, among whom, 80% were on ART. Forty-seven percent of FCSW reported using condoms consistently with both paying and non-paying sexual partners. The MSM BSS 2015 showed an HIV prevalence of 4%, not significantly different from that of the national average. However, CSWs among MSM will be considered as KP in COP16. KPs face stigma and discrimination causing limitations to full access to prevention, care, and treatment. Issues such as mobility and lack of education compound these limitations.

Priority Populations (PPs) have been re-defined in COP16 to include only groups of individuals who have an HIV prevalence greater than the national adult average of 3%. According to this definition, PPs in Rwanda include adolescent girls and young women (AGYW; 15-24 years old) who have HIV prevalence nearly twice as high as their male counterparts.<sup>32</sup> Factors associated with HIV acquisition among girls and young women include lack of access to formal education and transactional sex and associated GBV, poverty, and early onset of sexual activity. This PP also includes AGYW in refugee camps. Clients of CSWs are also considered a PP, given the high HIV prevalence in FCSWs.

PEPFAR-funded programs in Rwanda target long distance truck drivers, uniformed personnel along borders and male youth (<35 years old) involved in commercial activities in hotspots as potential clients of CSWs. Rwanda DHS 2015 shows that 7 percent of men age 15-49 have ever paid for sex and 2% had paid for sex in the past year, with 65.2% reporting condom use at last paid sex. In Kigali however, men reporting ever having paid for sex was 12.1% and in the last year was 4.9%. The HIV prevalence of men who have paid for sex in the last year was 4.7%, compared to 3% prevalence for all men in that age category. There is no indication that other traditional PP groups including, military, mobile workers, non-injecting drug users, fisher folk or refugees have HIV prevalence levels greater than that of the national average. However, those groups of mobile populations, MSM, and military located in CSW hotspots are considered part of the PP as potential clients of sex workers. PPs also include mobile populations (i.e., long-distance truck drivers, fishermen on Lake Kivu, uniformed personnel, miners, road construction workers, and refugees). Youth as PPs include young men under the age of 35 involved in commercial activities in hotspots (e.g., motorcycle taxi drivers, bartenders, etc.). Operating in hotspots, these young men are more likely to be clients/partners of FSWs, underscored by anecdotal evidence that FSWs

---

<sup>32</sup> Rwanda DHS 2015

offer sex as payment for their services. Program data show that the HIV positivity rate among moto-drivers is higher (3.5%) compared to men in the general population (2.2%).

Interventions for KPs and PPs are key priorities of COP16 to interrupt HIV transmission. PEPFAR will align COP16 activities with both MER 2.0 indicators and Rwanda's NSP 2013-2018 and will invest in core prevention interventions for KP and PP to accelerate epidemic control. Packages of services to KPs will include peer education outreach activities; provision of information on HIV and STIs; referral for HTC and linkage to ART; provision of PEP; promotion and distribution of condoms; STI screening and treatment; reproductive health including family planning and PMTCT services; SGBV sensitization and social support; prevention, diagnosis and treatment of TB referral to screening and vaccination for viral hepatitis; and risk reduction counseling. PEPFAR will also support health care provider trainings on quality HIV service delivery in a non-stigmatizing manner to facilitate access and adherence to treatment for KP and the establishment of a center of excellence for KP services to serve as resources for service providers across Rwanda. Planned analysis of new HIV surveillance data sets (DHS 2015, MSM BSS 2015, FSW BSS 2015, RAIHIS 2015, FSW size estimates, 2016) will more clearly define the demographic correlates and size estimates of high HIV positive groups among AGYW 15-24 years old and social network mapping. Clients of sex workers will be reached by interventions targeted to hotspots, as well as through sexual partner and social network mapping.

During COP16, PEPFAR aims to reach 9,311 KP and 13,895 PP with HIV preventive interventions (Table 4.1.4). To maximize funding efficiencies, PEPFAR will support KP and PP prevention interventions in facility and community based services in 43 hotspot sectors located in nine scale-up and five attained districts. In addition, HIV-positive KP and PP will be identified through scaled-up facility-based HTS activities, such as family testing, in STI clinics and outreach by peer educators in all scale-up-to-saturation districts. KP and PP specific peer educators will be used to strengthen linkage, retention, and viral suppression along the HIV continuum, especially in the context of Test and START. PEPFAR will also build advocacy with GOR for PReP for HIV negative CSWs, including identifying sustainable source of ARV supplies.

The package of services provided to PPs vary by category of targeted population. In general, the packages include peer education and outreach activities, provision of information on HIV and STIs, referral for HTC and linkage to ART, provision of PEP, promotion and distribution of condoms, STI screening and treatment, reproductive health including family planning and PMTCT services, SGBV sensitization and social support, diagnosis and treatment of TB, referral to screening and vaccination for viral hepatitis, and risk reduction counseling.

Interventions targeting KP and PP at the facility and community level will be monitored through quarterly site visits. Each intervention point serving KP and PP will maintain a record of outreach services provided and will track the approximate number of that population in the area it serves.

### 4.3 VMMC

During COP14, PEPFAR supported 65,021 VMMC procedures, but with additional central funding in COP 15, PEPFAR is expected to support 141,000 VMMCs. By the end of FY16, this will leave a gap of 34% of VMMCs to be completed in priority districts to reach 80% males 15-29 years of age in priority districts by the end of 2018; however, with COP16 and central funding in FY17, the district of Kigali will reach 80% coverage of males 15-29 years of age by the end of FY17. Rwanda's NSP objective for VMMC is to provide 66% of male adults (15-59 years) nationally with VMMC services by the end of 2018 using surgical method and innovative technologies, such as the PrePex device, which will increase the provision of VMMC in non-clinical settings. Upon achievement of these goals, GoR then intends to focus circumcision efforts on infants.

With GF resources support to Rwanda declining and since PEPFAR Rwanda resources alone are insufficient to meet the need, the NSP objective is unlikely to be achieved. However, in COP16, PEPFAR will prioritize investments in VMMC by focusing COP16 19,996 targets on males ages 15-29 in priority districts based on specific risk factors and by adding an additional 75,942 targets for males ages 15-29 in priority districts through central funding, with the overall goal of reaching 70% coverage by the end of FY17. The three districts of Kigali will be saturate at 80% and above by the end of FY17, due to the additional targets through central funding . It is expected that 80% MC coverage will be achieved in high risk areas by COP17. The VMMC program will use both PrePex and surgical service delivery, will target military populations deployed in priority districts and new recruits, and will reach highest risk sub-populations of the general population of males aged 15-29, including clients of commercial sex workers, males in discordant relationships with HIV-positive partners and males attending STI clinics in priority districts.

In 2015, the MOH adopted WHO guidelines requiring anyone undergoing a VMMC procedure to also receive a Tetanus vaccine. PEPFAR will support quality VMMC services (PrePex and Surgical), including: HTS, tetanus vaccination, infection prevention, linkage to HIV/AIDS treatment for HIV-positive individuals, age appropriate sexual risk reduction counseling including recommendations for abstinence during wound healing period, VMMC procedure, clinical follow-up of circumcised clients, adverse event management, and post-operative care.

### 4.4 Preventing Mother-to-Child Transmission (PMTCT)

In 2012, Rwanda implemented Option B+, achieving a less than 2% maternal-to-child transmission (MTCT) rate by 2015. Results from the End Term Review of the Elimination of Mother to Child Transmission (EMTCT) strategy conducted in 2015 ranked achievements in primary prevention and prevention of unintended pregnancy among HIV-positive women at 80%, while results for PMTCT and treatment scored an even higher rate of 95%. These achievements are reaffirmed by a continuous decline in positivity rate among pregnant women and reduction in MTCT rate (at 18 months) from 2.7% and 2.4% in 2010 to currently 1.0% and 1.8%, respectively.

The national coverage for PMTCT (Option B+) is 96% and all PMTCT facilities provide EID services within existing maternal, child and neonatal health services to ensure efficient HIV integration. By 2015, 98% of pregnant women and 86% of their male partners who attended ANC were tested for HIV; among HIV positive women, 98% were provided with ARV for their own health and to prevent vertical transmission of HIV infection to their fetuses or via breastmilk to their infants. These data are confirmed by SIMS assessments indicating high rates of testing for pregnant women, partners, and their exposed infants and linkage to HIV care and treatment of the identified HIV-infected infants.

Results from SIMS assessments in FY15 and Q1 for FY16 did not identify any major PMTCT gaps which necessitated immediate attention. However, in FY17, sites with high numbers of pregnant women on ART will be prioritized for SIMS.

PEPFAR supports integrated Option B+ in 159 facilities offering core package of services including testing and counseling for pregnant and breastfeeding women, male partner and family-centered testing, family planning counselling, mentorship on PMTCT and EID related services, and mother-infant pair follow-up. Services also include ARV and OI prophylaxis for exposed infants, safer pregnancy, nutrition and infant feeding counseling, education and support groups, peer educators to support adherence, and involvement of community outreach services for KPs.

Given the complexity of the PMTCT program and need for reduction of new pediatric HIV infections, PMTCT clients will be categorized as unstable under the new service delivery guidelines and will continue with monthly scripting and quarterly clinical visit for mother-infant pairs until the infant exits the PMTCT program at 18 months of age. PMTCT will strengthen community level platforms to enhance retention in care and adherence thereby limiting further vertical transmission. Community platforms are envisioned to reinforce adherence for otherwise healthy HIV-positive pregnant women initiated on lifelong ARV treatment, along with their partners and babies, and maintaining them on treatment throughout and beyond the breastfeeding period.

In COP16, PMTCT will target 3,628 pregnant women on ART, representing 95% of expected HIV-positive pregnant women. PMTCT services for scale-up and attained districts support the same interventions and core package of services that will improve PMTCT service delivery. PEPFAR will dramatically ramp up efforts to reach out to pregnant CSWs for timely testing, ARV provision, and follow-up of their exposed infants to minimize risks of pediatric HIV infections.

COP16 budgeting includes funding to provide ARVs and HIV commodities to support PEPFAR PMTCT targets. PMTCT program activities are aligned with the CNN analysis, prioritizing delivery of core activities.

## 4.5 HTS

Through a combination of social messaging, service availability, incentives for facilities testing and community outreach, Rwanda has successfully closed much of the gap to the first 90. At the start of COP16, it is estimated that 92% of all PLHIV will be in care.<sup>33</sup> In the absence of more specific information, these data may indicate that 83% to 92% of all PLHIV know their status. The HTS strategy in COP16 represents a shift away from the successful emergency epidemic response with high volumes of general testing, and towards an approach focused on those at most risk of infection and/or of infecting others, such as sex workers and their clients, pregnant women and their partners, children and sexual contacts of HIV positive people, and people who demonstrate clinical signs or symptoms associated with HIV infection. This transformation of the testing strategy is a direct response to the successes of the broader approach to testing employed previously, and will lead to a more efficient and sustainable program in the future, particularly in light of declining funding.

In COP16, HIV testing services (HTS) aims to significantly increase efficiency, with a specific focus on testing KPs and PPs and their sexual networks. HTS focuses in COP16 on pregnant women and their partners, index case testing for partners and family members of newly identified PLHIV, partner notification, tracing, testing and linkages. Key approaches to HIV testing will include the establishment of case-based surveillance systems of all new HIV positive cases, expanding mobile/outreach testing in hotspot areas, and STI clients referred from private pharmacies to HIV testing services and linkage to treatment if testing positive for HIV. HTS will decrease unnecessary testing of low risk individuals, resulting in a target of 39% fewer total tests compared to those used in FY15, 42% less than those targeted for FY16, while ensuring clients receive their testing results, providing risk reduction counseling for HIV-negative clients and linking HIV-positive individuals to ART services. In attained districts these services will be restricted to providing only facility-based HTS allowing for passive intake of new HIV-positive clients, and ceasing general community outreach VCT. The exception will be in attained districts that have sectors with hot spots, where outreach VCT for sex workers and their clients will take place based on the prioritization of the hotspot.

There will be a focused effort to scale up in higher yield priority district sites and hotspots, using fixed and community outreach approaches including testing, using a family approach to identify more HIV-positive children and adolescents, testing male partners of pregnant women, indexing partners and family members of newly identified PLHIV, testing KPs and PPs and their partners, and targeting testing, specifically mobile, within the networks of KPs in order to increase testing efficiencies. Communities will be involved in prioritization of outreach activities. PEPFAR will continue to work with MOH to transform policies that promote HIV testing efficiency and increasing timely linkage of newly identified PLHIV. These changes include revision of HTS-

---

<sup>33</sup> Using the PEPFAR data pack and national health management information (RH MIS) projections.

related performance-based financing (PBF) indicators to focus on increased linkages of identified HIV positives to care, as opposed to number of HIV tests administered and the utilization of a national patient/client unique identification code to minimize repeated HIV testing.

In COP16, effective implementation and quality improvement in HIV rapid testing will ensure all testing sites provide reliable and accurate results through the implementation of the Rapid HIV Testing Quality Improvement Initiative (RTQII) and reduce commodity costs. The National Reference Lab (NRL) will be supported to continue producing and distributing rapid HIV PT panels, provide feedback and ensure corrective actions are taken to address non-conformities. De-listing of Shanghai Kehua Colloidal gold kits by WHO in 2015 prompted putting in place an interim HIV testing algorithm and the process to establish a new HIV testing algorithm for Rwanda is on-going. Adopting the new algorithm will require training, mentorship and support supervision of testing sites to adopt new QA approaches.

Through the Core, Near-Core, Non-Core (CNN) analysis, Rwanda will invest in the following core HTS activities closely aligned to geographic and priority population targets in COP16:

- Reduce HTS testing by approximately 39% from FY15 by providing HIV testing to clients accessing clinical services through EID, PITC, and VCT with special emphasis on testing children (0-15 years old), male partners of pregnant women, index partners and family members of newly identified PLHIV, key and priority populations, and sexual networks of KPs. All health facilities and testing sites will be providing HTS using finger prick approach in all entry points except ANC clinics.
- Conduct Mobile/Outreach HTS in hotspot areas targeting KPs, PPs and clients/partners of KPs with linkages to STI/HIV prevention, care and treatment services, reproductive health and family planning services. Facilities conducting outreach mobile testing will be reviewed monthly to ensure that the activities are reaching targets and meeting positivity expectations.
- Optimization of the HTS service delivery model to strengthen linkage of newly identified HIV clients to treatment.
- Linkage between facilities and communities in particular for KPs and PPs by peer educators.
- Continuous mentorship, training, and supportive supervision on HIV testing Quality Assurance, HIV Proficiency Testing, and HIV testing information management.
- Establishment of HIV case-based surveillance systems of all new HIV positive cases.
- Work with private pharmacies located in hotspots to refer clients seeking STI treatment to HIV testing services and linkage to treatment if testing positive for HIV.

HTS activities will also continue to focus on generating demand among KPs and PPs and increasing the testing of clients at sites for other health services in high burden areas while expanding in children's hospital wards to identify more HIV-positive children and adolescents.

Special focus will be put on outreach HTS targeting KPs and PPs to improve linkages to STI/HIV prevention, care, and treatment services.

PEPFAR supported HTS at 237 sites in FY15, of which 79% of the sites (189) identified 80% of HIV positives. The 48 sites identifying the remaining 20% of positives (no site has reported zero positives) and nine sites reporting fewer than four positives per year will finalize transition to GoR during COP15 implementation. Low yield sites located in priority districts will be prioritized for SIMS visits to identify constraints and assess partner performance and testing models/practices.

#### **4.6 Facility and Community-Based Care and Support**

The expected implementation of Test and START in 2016 is expected to significantly increase the number of PLHIV receiving ART. The proposed changes to the PEPFAR facility-based package of core services include the spacing of clinical and pharmacy visits from three and one month to six and three months, respectively for patients defined as stable. Further clinical efficiencies will be achieved by limiting CD4 and full blood count, and biochemical analyses for newly initiated clients, those clients at risk for treatment failure, and specific treatment regimens. As a result, the current coverage of CD4 counts is deemed sufficient due to the decentralization of CD4 machines, and the lack of reported stock-outs. PEPFAR will support procurement of reagents and mentorship of health care providers to ensure quality clinical and immunological follow-up and decentralization of VL. Additional modifications to the service delivery model will be discussed and defined with the GoR, including subcategories of stable patients to increase cost effectiveness to support a sustainable quality national HIV program.

The GoR is increasing its national targets to 199,405 clients in care and treatment in FY17. PEPFAR's COP16 care and support program, aligned with the NSP, has targeted support for 103,841 ART patients, with a portion of the increased targets resulting from pre-ART patients commencing ART, and identification of new HIV patients through geographical re-focusing of resources to KPs testing in hotspot sectors and priority populations and more efficient provider-initiated testing. In addition, efforts will be placed on improved adherence, reduced loss to follow-up, and improved community-facility linkages, which scored low in recent SIMS and Service Quality Assessment (SQA) reports.

The basic package of clinical services will continue to include clinical assessment and monitoring, routine provision of CTX prophylaxis, nutrition assessment and counseling, TB prevention, screening and management, PHDP services, and support groups for children and adolescents. This package of services will be the same in all PEPFAR-supported sites. However, the cost per patient in sustained districts will be reduced, reflecting decreased overhead costs in staffing, training, and program management.

Rwanda's OVC program plays an important role in providing assistance in identifying beneficiaries, identifying and validating volunteers for caregivers, providing home visits, accompaniment to clinical services, and participation in household economic strengthening

(HES)/food security activities. PEPFAR will leverage these community linkages to strengthen enrollment and adherence to treatment.

PEPFAR and GoR will leverage three existing community service platforms – OVC programs, peer educators, and community PLHIV associations – to improve testing yields among OVC beneficiaries, treatment adherence, and mitigate stigma and discrimination, while emphasizing knowledge and observation of clients’ rights. Support groups and peer education in the communities will be strengthened to provide assistance for treatment adherence. In order to cater to priority populations on treatment, approaches will continue to be strengthened including: clinical services reorganization for adolescents with special days/times dedicated to address their needs, family testing for reaching children, adolescents and discordant couples, and task shifting to improve access and availability of services.

#### 4.7 TB/HIV

Tuberculosis (TB) prevalence in Rwanda is estimated at 89 per 100,000 in the general population, and nearly one in four TB patients is co-infected with HIV. TB prevalence is four-to-five times higher in male than female patients. HIV testing among TB patients has increased over the years nationally; by July 2015, 6,201 (98%) out of 6,352 TB patients were tested for HIV, of these 1,447 (25%) were co-infected by HIV. For patients with HIV/TB co-infections, 1,142 (79%) were initiated on ART according to national reports.

Rwanda has modified its HIV guidelines since 2013 and now recommends ARV treatment for all TB-HIV co-infected people and use of GeneXpert to diagnose TB in all HIV-positive patients, patients with suspected MDR TB and people who live in TB hotspots and crowded zones. Currently, Rwanda has 16 GeneXpert machines, six of which are in districts supported by PEPFAR with a high prevalence of HIV/TB. In COP16, PEPFAR will continue providing TA to MOH to support use of GeneXpert machines and its reagents along with funding for sample transportation.

HIV testing and initiation of ARVs for HIV-positive TB patients are provided at all health facilities using the “one-stop TB-HIV” model. Similarly, patients are screened for TB and treated at HIV clinics as part of the integrated model. During COP16 process, PEPFAR has identified tuberculosis prevention, screening, and treatment among PLHIV as core activities for success of the program; these activities will be provided at all health centers, district, provincial, and referral hospitals. Additional core activities that PEPFAR will continue to support in COP16 include intensified TB case finding (ICF), TB infection control (IC) interventions, fine needle aspiration, and digital X-ray machine. Further, community volunteers and community health workers will facilitate access to services for hard to reach populations, such as children under five and KPs.

These activities include in-service trainings on HIV and TB prevention, screening and treatment so that patients receive HIV and TB care in one location for the duration of their TB treatment.

Due to multiple drug combinations, risk of interaction between ART and TB drugs, TB/HIV patients are categorized as unstable patients under the new service delivery model; therefore, these patients will continue with monthly pharmacy refill and clinical visits quarterly. However, the program anticipates to utilize community health workers for identification and referral of “coughers” to the nearest health facility and to reinforce adherence to treatment for TB/HIV patients. Based on current targets and anticipated TB/HIV patients, there are no expected stock outs in COP16.

Results from previous SIMS assessments identified lack of community linkage for TB/HIV patients as a major gap. During COP16, PEPFAR will work with the MOH to strengthen community services. These services include TB screening by community health workers, adherence support for TB/HIV co-infected people, linkage and referral to care, DOT, and sensitization. Sites with high patient volume or sites with gaps identified during SIMS assessment visits will be prioritized in the FY17 SIMS action planner. The level of effort will be increased in scale-up to saturation districts to contribute toward epidemic control. The cost per patient will be higher in scale-up districts due to a larger package of community services, clinical mentorship and higher number of targets as well as reduced costs in staffing and program management in attained districts.

## 4.8. Adult Treatment

As a result of the implementation of Test and START, the proportion of ART coverage for adults in Rwanda is anticipated to increase from 73.6% in FY15 to 88.8% in FY17. Currently, data on ART coverage among KPs are not available but are expected to be available through the BSSs by the end of FY16. During COP16 implementation, Rwanda targets to provide ART to 190,120 adults; PEPFAR contribution is estimated at 53.2% (103,841) in 192 sites.

PEPFAR has identified adult ART services as core to the HIV program. In FY17, PEPFAR will continue to support 192 facilities offering core services including clinical assessment and monitoring, TB and OIs screening and management, and adherence counselling. Services will also include ARV, ARV toxicity and resistance monitoring, and community outreach services for KPs. In COP16, PEPFAR will focus more resources to support treatment programs in scale-up districts and provide an improved package of community services, as reflected in a higher number of targets in these areas.

In FY17, Rwanda will focus on increasing ART efficiency, reducing national costs of HIV services through the new service delivery model in which the adherence sessions currently provided before ART initiation will be shortened to allow a rapid ART initiation for the newly identified patients. The new service model includes increased pharmacy refill amounts (from one to three months) and clinical visits (from three to six months) for stable patients. Key population patient pharmacy refills will be reduced from one month to three months and with continued clinical visits every three months. The definition of stable patients is currently being defined in national guidelines as those on ART for at least 24 months with two consecutive viral load (VL) suppression results and with good adherence to ART.

COP16 will differentiate between stable and unstable patients with different unit expenditures per patient categorization, based on efficiencies in the service delivery model. Newly initiated ART and unstable patients will continue monthly pharmacy refill and quarterly clinical visits. Patients who are pregnant, have TB, Hepatitis co-infections, are virally unsuppressed, and on second and third line ARVs are defined as unstable for purposes of the new service delivery model. For efficiency, routine CD4 testing has been eliminated and CD4 test will be reserved only for the newly identified patients as baseline for identification of those needing cryptococcal prophylaxis. FBC and biochemistry monitoring will be performed only for the patients on tenofovir and Zidovudine. Routine VL monitoring will continue annually for suppressed patients and every six months for patients at risk of treatment failure. PEPFAR will support procurement of VL reagents and the sample transport network for VL specimens from PEPFAR-supported sites. Cost-effective modifications of this model will continue to be developed to ensure a financially sustainable, quality national HIV program.

PEPFAR funds will refocus HSS initiatives to strengthen systems critical to the treatment program, which include TA for forecasting, and procurement of HIV commodities, including ARVs and lab commodities, QA activities for HIV testing, in-service training, provision of ARVs, clinical management, and strengthened data systems to monitor and evaluate the new model of service delivery and program performance.

PEPFAR and GF funds will continue to support the procurement of ARVs to support PLHIV on ART. Due to the increase of PLHIV who are on treatment as a result of Test and START, PEPFAR is aligning COP16 to support the significant increase in commodities, expected to begin in July 2016.

In FY15 and Q1 for FY16, through SIMS, PEPFAR identified community- facility linkage systems and weak supply chain for HIV test kits as major gaps, which will be prioritized in COP16. PEPFAR will reinforce the community services through enhanced coordination with Rwanda's network of PLHIV, peer educator communities and OVC platforms to ensure linkage, adherence, and retention to treatment. PEPFAR will address health-care stigma and discrimination through provision of in-service trainings to health care providers. Prevention partners and community volunteers will be utilized to improve linkage with clinical services and their relationships within the community to facilitate and improve access to services for hard-to-reach populations. In FY17, sites with high patient volume and sites with gaps identified in FY15 and FY16 will be prioritized for SIMS site visits to identify methods to strengthen the quality of services and increase partner performance. Moreover, PEPFAR will support the MOH to develop and establish a standardized and sustainable national system on continuous quality improvement (CQI) and mentorship for the national HIV program.

To increase country ownership and adapt to the decline in available donor funding, the USG will work with the GoR to develop a long-term staff transition plan, including efficiencies from the COP15 transition to GOR of support for HRH, Blood Safety, and fifty-four health facilities, along with an additional COP16 transition of 7% of MOH salaries, for a combined reduction of MOH staff salary support of 21% in the COP16 budget. During COP16 implementation, in collaboration with GoR, a long-term transition plan for further reductions in PEPFAR support under the MOH CoAg will be developed for implementation beginning in COP17.

#### **4.9 Pediatric Care and Treatment**

Rwanda has made remarkable improvement in the coverage of ART in the general population and PMTCT over the past years. With the implementation of the Option B+ strategy, HIV mother-to-child transmission has significantly dropped and remained below 2% for the last three years. However, based on previous epidemiological projections and estimated HIV prevalence, treatment coverage for children infected by HIV in Rwanda was estimated to be low (40% for children vs. 78% for adults), using an HIV prevalence of 0.6%. The national goal is to identify

more HIV-positive children, link them to treatment, and retain them on treatment in order to reach 80% ART coverage for all children infected by HIV by 2019. Aggressive identification and diagnosis of HIV-infected children, through key services was considered a key strategy to increase pediatric care and treatment.

In COP16 and onward, Rwanda's HIV program will take previous epidemiological projections through program data and DHS 2015 prevalence data into account to revise pediatric HIV testing strategies and adjust estimates of children living with HIV. Although the PITCT is implemented across all sites, Rwanda is proposing to target only children with HIV suspicious symptoms to improve efficiency in HIV case finding among infants, children, and adolescents. At all sites, the program will strengthen EID for HIV-exposed infants (all exposed infants will be tested for HIV), enhance targeted PITC by testing all children presenting with HIV symptoms and signs, test all children of adults receiving any HIV service (PMTCT, Care and treatment), test all children with suspect tuberculosis and malnourishment, and test all children receiving OVC services.

As part of core activities, PEPFAR will focus on improving identification of pediatric HIV patients through enhanced PITC at all relevant entry points, strengthening linkage and retention into treatment, testing HIV-exposed children and those born to CSWs, and expanding testing among OVC beneficiaries. In addition, DNA PCR capacity has been expanded, and sample referral systems for laboratory services have been improved to ensure early HIV infant diagnosis and geographical access countrywide. PEPFAR, in collaboration with the GoR, will continue to scale up pediatric ART coverage across all PEPFAR supported scale up to saturation and attained districts to achieve epidemic control by the end of FY17. Efforts will also be made to strengthen follow-up of HIV positive and exposed infants through improved community linkages. The pediatric package of core services includes provision of cotrimoxazole prophylaxis, improving TB diagnosis, adherence, assessment and support, HIV disclosure, growth and viral load monitoring, and provision of adolescent friendly health services covering issues related to school, adherence, sexuality/reproductive health and stigma. Routine VL monitoring is recommended for all children and adolescent receiving ART every 12 months. Given the higher risk of treatment failure and lack of data on HIV drug resistance among children under 15, strategies to improve adherence and retention will include HIV status disclosure for children and adolescents, enhanced quality counselling and strengthened community services including children born to CSWs.

In FY15 and Q1 for FY16, data from SIMS has highlighted gaps in documentation of pediatric growth monitoring, adherence to treatment, and facility-community linkages, which will be addressed in COP16 through the training of health care providers and clinical mentorship. In FY17, sites with identified gaps in FY15 and FY16 will be prioritized for SIMS visits to strengthen the quality of services and increase partner performance. While Rwanda plans to initiate a new service delivery model for adult and adolescent stable patients, children under 15 have been categorized as "unstable" and will continue with monthly pharmacy refill and quarterly clinical visits. However, Rwanda will strengthen the community HIV services platforms to improve

linkage and retention in treatment and adherence for all PLHIV including children born to KPs. At the community level, community healthcare workers and volunteers will be used to mobilize and refer children to health facilities for HIV services. Facilities will also work with community structures including support groups and peer educators for adherence support promotion, and retention in care. Outreach interventions including mobilized children testing will be organized to promote access to services for children of CSWs and OVC. In COP16, PEPFAR will use data from the Violence Against Children Survey (VACS) to inform GBV prevention among HIV infected children.

PEPFAR has supported the MOH to optimize national pediatric ARV forecasting and procurement. In FY17, PEPFAR jointly with the MOH through its GF grant will continue to procure pediatric ARVs per the national supply plan.

#### 4.10 OVC

In Rwanda, the policies and objectives related to the wellbeing of orphans and vulnerable children is captured in two national documents: the Integrated Child Rights Policy (ICRP, 2011) and HIV/AIDS National Strategic Plan (NSP, 2013-18). The ICRP serves as the comprehensive child policy framework that addresses the rights and needs of children in the country.<sup>34</sup> This document also ensures coordination and consistency in interventions across various thematic areas and ministerial mandates. Rwanda's NSP outlines social mitigation objectives that are important to OVC and their families: (1) ensure economic opportunity and security of PLHIV, (2) protect OVC targeting school attendance >85% in the 10-14 age group, and (3) reduce stigma and discrimination.

The OVC program reflects collaboration between USG, Ministry of Gender and Family Promotion (MIGEPROF) through the National Commission for Children (NCC), Ministry of Health (MOH) officials and OVC partners, including INGOs and CSOs. As an example, prior SIMS assessments have identified the need to strengthen the link between facility and community services. Through the collaboration described above, these organizations developed an identification protocol to guide the enrollment process for new beneficiaries, with special emphasis on covering the gap between community and health facility-based linkages and referrals. The Rwanda Biomedical Center, which operates under the MOH, is leading the development of other tools to better systematize the linkages between community and facility services. The tools will be designed to ensure cross communication and coordination between the two levels of service. Additionally, OVC partners have begun entering formal (non-binding) collaborations with local health facilities

---

<sup>34</sup> The policy aims to strengthen families, provide a family environment for all children, and ensure universal access to education and health services. It emphasizes children's participation; protection from abuse, violence and exploitation; priority for children without discrimination; and accountability of GoR and (non)State actors to ensure the respect and human rights of children.

to establish integration of processes, including periodic communication, that link community and facility services in their daily operations.

The OVC program in Rwanda is aligned with the nine scale-up districts that have been identified as having the highest HIV prevalence in the country, along with an additional four scale-up districts specific to the OVC program also based on HIV prevalence above the national prevalence. The OVC program is no longer implementing a minimum or comprehensive package of services, but rather a case management approach. The services provided include access to health services, child and adolescent protection, household economic strengthening, food security and nutrition, WASH, education, and psychosocial support. Non-core activities have been transitioned to the GoR, local communities, and parents. These include therapeutic nutrition services, rehabilitation of construction of water springs, and psychosocial counseling in schools.

To achieve results in epidemic control and HIV impact mitigation, the strategic approach in COP16 will be (1) targeted testing referral for specific OVC subpopulations considered to be at risk of HIV infection (e.g., children who are malnourished, offspring of HIV-positive parents, in child-headed households, and adolescents), (2) continued integration of prevention programs, with emphasis on the unique needs of adolescent girls and young women, (3) continued use of community volunteers to better link with clinical services, support adherence and facilitate access to services for hard to reach populations; and (4) no enrollment of new beneficiaries. Beneficiaries are graduated rather than transitioned from the OVC program. After three years of service, they are targeted to develop increased economic independence.

In COP15, the OVC program has a target of 129,542 OVC beneficiaries; and during COP16, it is expected to reach 121,229 OVC beneficiaries, representing no new beneficiaries for the OVC program. Further discussion on the transition plan for the OVC program is described in section 5.2.

## 5.0 Program Activities in Sustained Support Locations and Populations

---

### 5.1 Package of services in sustained support locations and populations

PEPFAR will continue providing support and direct assistance to the GoR to ensure high quality delivery of HIV services through COP16 in both ART and PMTCT sites from sustained SNUs. Patients in these districts will continue to receive a minimum package of care, including passive enrollment for new clients into care and treatment services as per ART national guidelines. In COP16, PEPFAR will increase ART efficiencies, reduce national costs of HIV services, and support the national implementation of new HIV services delivery models. Stable patients will receive

community HIV services that include adherence support and counselling, linkage and referral to care for defaulting patients, and co-infection assessment between two clinical visits. Newly initiated ART and other unstable patients will continue monthly pharmacy refill and quarterly clinical visits as per current ART guidelines. Core package of services that PEPFAR will continue to support in sustained SNUs include routine clinic visits, screening and management of opportunistic infections including TB/OIs and STIs, viral load testing and CD4 for newly initiated clients and patients at risk of treatment failure. PEPFAR will also continue to support passive HIV testing through PITC and PMTCT and linkage to treatment.

For further efficiencies in COP16, PEPFAR has calculated unit expenditures (UEs) for stable and unstable patients based on the clinical definition of each group. Cost savings from the new service delivery model will be captured in the UE per stable patient. The personnel and recurrent expenditure components of the COP15 unit expenditure for clinical services was reduced by 18% to reflect fewer clinical visits. In addition, since fewer tests will be conducted for a stable patient, the laboratory component of the unit expenditure was also adjusted accordingly.

Sustained district targets for ART were set projecting passive enrollment of 4.7% from the projected COP15 targets. This was based on examination of previous and projected results from FY13-FY15, slowing down due to ending of active case findings and enrollment, also considering that 50% of pre-ART patients will be enrolled before COP15 implementation ends and 85.7% of the remaining pre-ART patients will commence ART in COP16. Total targets by district were set based on the estimations of unmet need and with the goal of achieving ART saturation in all regions nationally by the end of FY17. Total targets by districts were allocated to both PEPFAR and GF supported sites within the districts based on and planned program changes.

**Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained/Attained Support Districts**

<b>Sustained Support Volume by Group</b>	<b>Expected result APR 16</b>	<b>Expected result APR 17</b>	<b>Percent increase (decrease)</b>
HIV testing in PMTCT sites	78,231	78,310	0.1%
HTS (only maintenance ART sites in FY 17)	524,503	444,212	(15.3%)
Current on ART	47,132	51,389	8.3%

## **5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations**

During COP16, in collaboration with the GoR, PEPFAR will continue to identify and implement additional efficiencies, identify program costs for transition to the GoR, and reduce the scope of activities across all program areas to correspond with lower overall levels of HIV program funding

beyond COP16 while continuing to increase numbers of PLHIV on ART to reduce numbers of new infections.

PEPFAR will work with GoR to transform the national HIV program and create lasting efficiencies by moving from universal testing to targeted testing with additional focus in geographically prioritized areas and hot spots. These include reducing low HIV-risk voluntary counseling and testing (VCT), reducing and focusing provider-initiated testing and counseling (PITC), and increasing targeted mobile outreach testing in hotspots. Within VCT, PEPFAR is working to develop with the GoR a two-year transformation plan that will include the cessation of PEPFAR support for VCT except for partners of HIV-positives or other individuals at risk. PEPFAR will also work with GoR to determine whether the introduction of co-payments for non-referred or non-risk-based testing except in hotspot areas due to high HIV prevalence and VCT positivity could be another transformation strategy to find further efficiencies and cost-savings in the HIV program.<sup>35</sup> In addition, PEPFAR is initiating transition of non-ARV commodities with the plan that all non-HIV-specific laboratory and OI commodities will be transitioned to the GoR in COP17. PEPFAR will also review which HIV-specific lab and OI commodities might begin to be transitioned in COP17 based on past procurement performance to minimize risk of stock outs for key HIV program commodities. PEPFAR will commit to exploring future ways in COP16 to continue the transition of supply chain management to GoR.

PEPFAR is also working with the GoR to ensure outreach and linkages to treatment while reducing PEPFAR's OVC program community care and support activities. PEPFAR will further target the reach of the VMMC program to certain risk factors within the 15-29 age range in prioritized geographic locations. Activities include targeting prevention activities on CSWs and MSM CSWs, aligning priority population activities on populations with a prevalence higher than national prevalence estimates (i.e., adolescent girls and young women, uniformed personnel along borders, youth, and clients of CSWs), and aligning the PEPFAR staffing footprint with PEPFAR program priorities in order to accommodate additional PEPFAR funding reductions. The COP15 transition of 54 sites from PEPFAR funding to the MOH and GoR's financial ownership along with an increased proportion of commodities demonstrate increased host-country ownership of the HIV program and contribute to building an affordable, optimal, and sustainable system.

For Rwanda, the OVC transition plan is based on the graduation of beneficiaries. Starting with FY15, all OVC programs in Rwanda adopted a three-year program implementation model. When beneficiaries are enrolled, they are informed about the expected timeframe of the program key services and outcomes. As part of the case management approach, partners also develop a sustainability or exit plan for each household. In COP16, the OVC program will not enroll new beneficiaries; transition of the program is based on the graduation model.

---

<sup>35</sup> Methods of reducing low-HIV risk VCT in COP16 include the following: counselor training, community messaging to reduce VCT demand, cessation of mobile VCT for the general community, increasing index case testing and community testing referrals for those at risk of HIV, integration of VCT testing into outpatient services, and developing further efficiency alternatives in light of downward funding and in advance of cost transitioning.

PEPFAR has five OVC partners in FY16, which include three PEPFAR directly-funded CSOs and two international organizations. One international partner ends in COP15. The newest implementing partner, which started in FY15, implements only in scale up SNU. All SNUs use the same graduation process. All new beneficiaries are enrolled in scale up districts only. For further efficiency, each partner also will consolidate its OVC footprint by September 2016. This transition aligns with the scheduled graduation of beneficiaries in those geographic areas.

In Rwanda, education support requires particular attention. PEPFAR provides limited support for boarding schools; the majority of beneficiaries attend free public education. Because boarding school fees are high, partners are unable to hand over beneficiaries to government entities or other partners. The OVC program estimated that five percent of OVC beneficiaries are in their final class level (S3 & S6) in boarding secondary schools. This cohort requires continued support for school fees to graduate in FY17. After FY17, OVC partners will physically transition out of all sustained SNUs, but will continue to support an estimated 5% of beneficiaries (5,512) who will have one year to complete their schooling, which is expected by September 2018. Partners work together with local authorities and other stakeholders, who are actively involved in the graduation process, to systematize linkages and connections with existing structures and services for other needed support.

In COP16, PEPFAR will reduce its support to recurrent costs funded under the MOH CoAg by 7%, which includes facility operating expenses and MOH staff salary. During COP16 implementation, PEPFAR Rwanda will continue in collaboration with GoR to develop a strategic long term transition plan to review and for further reductions in PEPFAR support under the MOH CoAg for use during COP17 planning and beyond.

Finally, in COP16, PEPFAR will work closely with the GoR to develop efficiencies and an affordable service delivery models. Beginning in December 2016,<sup>36</sup> the GoR intends to reconfigure its service delivery approaches to achieve greater efficiency and reduce costs by moving stable patients to six month clinical visits and providing for three-month prescription refills. Based on the success of the new service delivery model, GoR will review and strategically reduce costs to the national HIV program and to the patient by exploring and implementing adjustments to the service delivery model (e.g., moving to 12-month clinical visits and 6-month prescription drug refills, developing community-based models, and expanding the definition of “stable patient”).<sup>37</sup>

The USG will collaborate closely with the GOR to rapidly monitor in, how these service delivery changes affect service delivery, from the client, facility and cost perspectives. This will be undertaken in a simplified, real time monitoring mode to support the GOR in assessing and

---

<sup>36</sup> Dependent upon the availability and placement of a one-time “top up” of commodities to support multi-month prescription refills.

<sup>37</sup> A “stable patient” for the first phase of the new service delivery model is defined as a PLHIV >15 years old who has been on ART for more than two years with two viral load results of less than 20 copies and who is considered an adherent patient under ART guidelines. Under this initial definition, an estimated 60-65% of all PLHIV on ART would be defined as “stable.”

providing solutions to any challenges and also quantify impacts related to clients, facilities (e.g., health workers, clients served, commodities availability, etc.) and cost of services. Additionally, prior to COP16 implementation, each site will assess the number of stable patients and clinical services implementing partners will contact sites regularly to ensure that all sites are implementing the new service delivery model according to the national guidelines

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

---

### 6.1 Critical Systems Investments for Achieving Key Programmatic Gaps (850 words)

Rwanda has made considerable progress in diagnosing, treating, and virally suppressing HIV-positive individuals in order to achieve epidemic control. However, there remain challenges in identifying and bringing into the cascade the remaining HIV-positive individuals, especially KPs and PPs, in order to reduce the incidence of new infections. Currently, Rwanda has a low HTS positivity (0.7%) due to policies that encouraged broad population screening.

PEPFAR Rwanda identified the following systems gaps that currently present barriers to achieve sustained epidemic control:

1. Inadequate supply chain management capacity to ensure commodity security; and
2. Improved targeting strategies to understand source of new HIV infections, reaching new positives, linking them to treatment, and increase number of PLHIV with viral load suppression.

#### **Inadequate Supply Chain Management Capacity to Ensure Commodity Security**

A key programmatic gap is inadequate supply chain management capacity to ensure commodity security, particularly in the area of GoR's procurement efficiency. Although Rwanda's in-country distribution system and supply chain design enables a high level of commodity availability in health facilities, national institutions and processes must be further strengthened to ensure sufficient and reliable supply of products at the right price.

#### **Understanding Major Source of New HIV Positives - Identify, Reach, Link and Reduce Suppression**

There is limited understanding of which populations/subpopulations are key to HIV transmission and infection in the Rwandan epidemic. In COP16, PEPFAR will implement strategies aimed at increasing HIV testing efficiencies and ensure health facilities in newly identified hotspots are implementing HIV testing strategies. These strategies include defining innovative strategies to target groups with high prevalence; targeting high burden areas and groups that have high risk behaviors; robustly monitoring to decrease ineffective testing; revising the national PBF policy to maximize HIV testing efficiency; and targeting the right places based on the mapping exercises. Other approaches include HIV-positive partner and social network mapping and case surveillance, as well as integrated HIV testing in STI clinics.

COP16 will be an opportunity to refocus system approaches and investments to address these gaps in the clinical cascade. It will also be important to strengthen M&E and reporting systems to

measure the efficacy of revised testing frameworks, new models of service delivery and effective maintenance of KPs and PPs in the cascade of care.

Table 6.1.1 Key Programmatic Gap #1: Inadequate Supply Chain Management Capacity to Ensure Commodity Security						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
Procurement capacity for HIV commodities	<ul style="list-style-type: none"> <li>Reduced system disruptions, improved commodity availability; annually measured improvements 2016-2019</li> <li>Implementation of a functional Rwanda Food and Medicine's Authority</li> </ul>	Supply plan monitoring and annual quantification exercises	OHSS	\$226,324	Global Health Supply Chain Project (GHSC)	
Availability of reliable logistics data for decision making	<ul style="list-style-type: none"> <li>Integration of HMIS with eLMIS 2017</li> <li>Improved forecast accuracy, above 85%</li> </ul>	Data management improvement, eLMIS/HMIS integration, product bar coding	OHSS	\$336,129	GHSC	
Warehouse space and operational efficiency to ensure product quality and timeliness and optimal resource utilization	<ul style="list-style-type: none"> <li>Optimized MPPD business processes according to warehousing management best practices 2017</li> <li>Sufficient storage space for increased volume of products</li> <li>Improved efficiencies in MPPD resource management</li> </ul>	Procurement capacity building and warehouse operations streamlining with MPPD	OHSS	\$217,233	GHSC	
National supply chain monitoring and policy making	<ul style="list-style-type: none"> <li>Supply chain management governance framework established 2016</li> <li>Key performance indicators leveraged and performance monitoring improved</li> </ul>	Support to LMO on institutionalization and supervision	OHSS	\$252,330	GHSC	
Laboratory network capacity to ensure sufficient supply chain management of laboratory commodities	<ul style="list-style-type: none"> <li>Approved rapid test kit algorithm in 2016</li> <li>Adoption of laboratory harmonization policy and equipment maintenance contracts, implementation of network optimization plan</li> </ul>	Technical assistance in improving laboratory logistics network reform	OHSS	\$209,217	GHSC	
<b>TOTAL</b>				<b>\$1,241,234</b>		





**Table 6.1.2 Key Programmatic Gap #2: Improved targeting strategies to understand source of new HIV infections, reaching new positives, linking to treatment, and increase PLHIV with viral load suppression.**

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
How to identify/reach/link (KPs and PPs) as a major source of new HIV-positives	95% of PLHIV know their HIV status by 2019  Health facilities in newly identified hotspots are implementing HIV testing strategies specific to KPs/PPs in their health	Provide TA support to improve the existing military data systems; update data reporting tools to monitor HIV care and connected to the central data base	HVSI	\$15,000	Charles Drew University	
		Provide TA and quality assurance to 7 RDF laboratories; work in collaboration with RDF medical services to maintain referral laboratory status at the Rwanda Military Hospital	HLAB	\$50,000	Charles Drew University	
	100 % of HIV RT use standard logbook and 95% of sites achieve 100% PT	Support implementation of RTQII at PEPFAR-supported testing sites through scale-up DTS PT and use of standardized logbooks to routinely monitor adherence to QA standards of HIV testing sites	HLAB	\$200,000	TSSS	Quality Management 9.1 Score: 1.33
<b>TOTAL</b>				<b>\$265,000</b>		

## 6.2 Critical Systems Investments for Achieving Priority Policies

As Rwanda moves towards Test and START, the country must refocus its efforts to build a system capable of cost effectively managing HIV over time, while more effectively reducing infections and treating existing PLHIV using chronic disease management. These systems are critically important to maintain the great progress made in the reduction of new HIV infections. Program investments in Test and START and the new HIV service delivery model will address policy level support and institutionalize systems to ensure better quality and planning for the HIV program. It will also improve the efficiency of identification of HIV-positive clients and assure that newly identified patients are enrolled on treatment within one week or less, retained on treatment, and virally suppressed.

Existing systems must be improved to more effectively monitor the programmatic goals of Test and START, the efficiency of the new service delivery model, and the impact of these initiatives on the HIV epidemic. Rwanda also lacks a case-based surveillance system to monitor PLHIVs as they interact with the health care system and to identify health needs of KPs and PPs. PEPFAR Rwanda will support MOH to expand the use of unique patient identification to detect hotspots, and treat and virally suppress KPs and PPs more effectively. COP16 will concentrate on increasing the effectiveness of national unique patient identification, strengthening program monitoring systems and examining opportunities to leverage other information system activities to improve the health of PLHIV.

There is the need to monitor the quality of program performance with regard to efficiency of testing, retention in care, drug adherence, and drug resistance as Test and START is expanded in 2016 and as more efficient and cost-effective service delivery models are implemented.

COP16 will focus on maintaining quality of services at PEPFAR-supported sites through clinical mentorship of health care providers and strengthening facility/community engagement to put PLHIV on treatment and monitor them on a regular basis through training of health care providers. In addition, training programs will shift from traditional didactic trainings to developing more sustainable, institutionalized training systems.

HSS investments for COP16 will focus on strengthening MOH's systems capacity for improved HIV testing and service delivery, strengthened national laboratory capacity, and increased information systems capacity to better measure and monitor the clinical cascade through Test and START and the new service delivery model. COP16 also includes an additional investment in commodities to support the rollout and implementation of three-month drug pick-ups in the amount of \$4,011,100.<sup>38</sup>

---

<sup>38</sup> \$3,677,180 in central funding and \$333,920 in an additional COP16 contribution toward commodities toward the "start up" costs of implementing three-month drug pick-ups.

**Table 6.2.1: Test and Start Implementation**

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
Institutionalize systems within MOH to better improve planning, efficiencies, and increased ownership of the HIV program in light of funding decreases	Increased capacity of MOH to plan and cost the national HIV program, using evidence-based interventions designed to target populations at greatest risk of HIV infection.	Provide technical assistance to the national HIV program to implement costed, affordable models to sustain HIV epidemic control and manage HIV as a chronic disease (design program, tools development, etc.)	OHSS	\$200,000	TBD	Service Delivery 6.2 Score: 0.74 6.3 Score: 0.83 6.4 Score: 0.74
		Develop and establish a standardized and sustainable national system on continuous quality improvement and mentorship for the national HIV program	HTXS OHSS	\$200,000	TBD	Service Delivery 6.1 Score: 0.74 7.2 Score: 1.00
		Continue capacity building in epidemiology, surveillance monitoring, reporting and data use in HIV and infectious diseases through the FELTP program	HTXS OHSS	\$160,000	TSSS	Strategic Info 15.5 Score: 0.67
Inadequate continuous quality improvement of HIV core tests and specialized tests for epidemic control	100% of VL and EID sites achieve 100% PT	Provide supervision and mentorship of VL and EID sites	HLAB	\$210,000	TSSS	
		Participate in ILB PT Panels for VL and EID	HLAB	\$210,000	TSSS	

		Laboratory equipment performing HIV core tests and specialized testing serviced and maintained regularly	HLAB	\$60,000	TSSS	
Acute shortage of skilled laboratory workforce to perform HIV core tests and specialized testing (e.g.: VL and EID) due to high turnover of staff	HIV core tests and specialized tests performed by skilled staff	Provide adequate skilled staff to perform HIV core tests and HIV specialized tests at NRL and decentralized levels	HLAB	\$38,461	TSSS	Laboratory 8.3 Score: 1.67
Inadequate continuous quality improvement of HIV services	Increase the number of health care providers capable to provide the high quality of HIV services	Support the capacity building of health care providers through training of trainers, develop and implement e-learning system	MTCT CIRC HVCT HBHC PDCS HVTB HTXS PDTX	\$165,000	TSSS TBD	6. Service Delivery score 6.67
		Develop and establish a standardized and sustainable national system on continuous quality improvement and mentorship for the national HIV program	MTCT CIRC HVCT HBHC PDCS HVTB HTXS PDTX	\$200,000	TBD	
		Carry out supervision, mentorship, quality improvement from district to health centers	MTCT CIRC HVCT HBHC PDCS HVTB HTXS PDTX	\$165,000	TBD TSSS	

Support quality improvement of Rwanda's HIV program services including VMMC, PMTCT, TB	MTCT CIRC HVCT HBHC PDCS HVTB HTXS PDTX	\$750,000	TSSS	
--	--	-----------	------	--

Table 6.2.2 Improve Systems Critical to Implement New Service Delivery Model						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
Inadequate community strategies for linkage to care, retention and adherence general population (including children as well as for key and priority populations including children of FSWs and MSMs)	Improved strategies for linkage to care, retention and adherence general population as well as for key and priority populations including FSW, MSMs, children, adolescents and pregnant women	Develop and establish a standardized and sustainable community pediatric HIV national program	PDTX PDCS OHSS	\$750,000	TSSS	Service Delivery 6.8 Score: 0.93

Inadequate continuous quality improvement of HIV core tests and specialized tests for epidemic control	Sustainable sample transportation in place	Develop and implement an efficient sustainable sample transportation system from HC to DH and from DH to central Laboratory	HLAB	\$40,000	TSSS	Quality Management 9.1 Score: 1.33
Acute shortage of skilled laboratory workforce to perform HIV core tests and specialized testing (e.g.: VL and EID) due to high turnover of staff	HIV core tests and specialized tests performed by skilled staff	Provide adequate skilled staff to perform HIV core tests and HIV specialized tests	HLAB	\$38,461	TSSS	Laboratory 8.3 Score: 1.67
	Maintenance and support of LIS and BLIS performed by skilled staff	Provide adequate skilled staff to ensure maintenance and support of LIS and BLIS	HLAB	\$260,000	TSSS	

**Table 6.2.3. Lack of effective mechanisms to efficiently measure impact of PEPFAR investments on test and start and new service delivery models, focus on identification of key populations and support data-driven decisions for achieving epidemic control**

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
Limited data tracking and reporting systems to measure impact of PEPFAR investments on achieving epidemic control	Improved impact measures through the provision of electronic linkages and systems that support routine monitoring and specialized surveillance to provide quality data for decision-making	Design, development and implementation of electronic linkages and systems to report required indicators and individual level data to improve data quality and accessibility for programs	HVSI	\$300,000	TSSS	13. Epidemiological and Health Data Score: 6.7

	Support GoR to plan and implement case-based surveillance system that will allow for monitoring HIV as chronic disease and linkage of PLHIVs (KPs and PPs) to services	HVSI	\$241,800	TSSS	
GoR implementation of a national patient information confidentiality and security policy for electronic data and the use of unique patient identifiers in <3yrs	Support GoR to plan and implement Unique Patient Identifiers/Unique Health Identifiers (UPID) to provide for linkage of patient records to better understand individual health service needs, health status and	HVSI	\$150,000	TSSS	
Improve MOH's data quality management system in order to have accurate, timely and complete HIV program data, as measured by quarterly, DQA reports to > 90% green in <3yrs	Support development and implementation of rigorous data quality improvement, through activities for health care professionals on data collection and management, regular continuous data quality improvement and site mentorship	HVSI	\$110,100	TSSS MOH Clinical Services	
	Support GoR to implement indicator-focused EMR content allowing for improved program planning, decision making and indicator reporting	HVSI	\$300,000	TSSS	

Insufficient reliable, subnational and local HIV epidemiologic data to identify key and focus populations	Improved ability to measure impact of PEPFAR investments on key populations	Implementation of key population size estimate survey by province and district to estimate unmet need	HVSI	\$100,000	TSSS	Epidemiological and Health Data Score: 6.27
		Protocol development and implementation of exploratory study on the internal movement of PLGHIV and identify best strategies to estimate unmet need	HVSI	\$95,500	TSSS	
		Implementation of HIV Drug Resistance survey in PLHIV enrolled in Test and START	HVSI	\$85,000	TSSS	
Delayed turnaround times (TAT) of EID and VL results to ensure that infants receive their HIV test results promptly for timely link to care and ensure that patients on	Achieve 2 weeks Test and START for EID and VL test results reporting	Upgrade, maintain and support laboratory information system at NRL and Roll out Basic Laboratory Information System (BLIS) at VL testing sites, specimen referral and transportation system	HLAB	\$260,000	TSSS	

### 6.3 Proposed system investments outside of programmatic gaps and priority policies.

**Table 6.3 Other Proposed Systems Investments**

Systems Category (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
<b>Laboratory</b>							
Inadequate continuous quality improvement of HIV core tests and specialized tests for epidemic control	11 DH laboratories enrolled in SLMTA process	Third 90	Laboratory equipment performing HIV core tests and specialized testing serviced and maintained regularly	\$13,000	HLAB	TSSS	
<b>Commodities</b>							
Support to three- month drug pick- ups for “stable patients”	Support to the rollout and implementation of three-month drug pick-ups by procuring additional ARVs to maintain buffer stocks	Second 90	Increased efficiencies on clinical staff, patients, and overall program costs	\$3,677,180 (Central Funding)	HTXD	GHSC	
	Support to the rollout and implementation of three-month drug pick-ups by procuring additional ARVs to maintain buffer stocks	Second 90	Increased efficiencies on clinical staff, patients, and overall program costs	\$333,920 (COP16 contribution)	HTXD	GHSC	
		Second 90		\$120,000		GHSC	

## 7.0 Staffing Plan

---

The PEPFAR team reviewed and assessed staff-to-program alignment within the context of sustained epidemic control. Overall, PEPFAR staff percent of time and number of FTEs are aligned to the core and near-core activities in the COP16 SDS. There is an emphasis on PEPFAR FTE-funded staff in technical areas that are key to the Rwanda COP16 approach, including clinical care and treatment, PMTCT, HTS, SI, OVC, and Laboratory.

PEPFAR agencies that are managing site-level data have staff skills to conduct necessary data analysis and interpretation as well as data application for program improvement. Overall, the estimated cost of doing business (CODB; agency management and operations) considers a variety of factors. Agencies have anticipated increased ICASS and Capital Sharing-Cost Sharing (CSCS) rates as well as staff salary increases. Agencies have found efficiencies to keep the overall CODB down to accommodate lower future PEPFAR planning levels.

In COP16, the PEPFAR team has six vacancies, five of which are planned to be filled and one of which will be removed from COP16. Four vacancies are with CDC and are expected to be filled within COP16 implementation. CDC is not requesting any new positions in COP16. Even within an increased CDC workload due to the expansion of its clinical services and prevention portfolios from COP14 through COP16 program shifts, CDC has reduced its remaining level of staffing by repurposing existing positions and shifting staff to align with PEPFAR program priorities. One of the CDC vacant positions had been vacant for more than one year but has been repurposed to fit within PEPFAR priorities. Additionally, CDC will reduce its staffing footprint for COP16 by eliminating one existing position. One of the six vacant positions is with USAID and is a US Direct-Hire position that has been on the bid list since December 2015, with the expectation that it will be filled during COP16 implementation. USAID also reduced its staffing footprint for COP16 by one position and has plans to further reduce the staffing footprint in COP17 by approximately 25%. The remaining vacant position is in the PEPFAR Coordination Office for a Liaison position to support PEPFAR coordination with the MOH/GoR and GF funding, which will be removed from COP16.

Beginning in COP17, Peace Corps will no longer receive any PEPFAR funds, including staff funding. No new positions are proposed for COP16 for any PEPFAR agency. Cost efficiencies in CDC's CODB over COP15, despite a significant increase in workload, was offset by a 269% increase in CSCS of \$543,039 with a net increase of \$1,429.

# APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<ul style="list-style-type: none"> <li>• Provide systematic HTS to all clients accessing clinical services through EID, PIT and VCT</li> <li>• Enhance linkages to health facilities and community-based outlets for HTS, STI screening, care and treatment and Preventions services for KPs and OVPs</li> <li>▪ Clinical mentorship for HCP to improve quality services for PLHIV at PEPFAR supported sites including CMEs and CQI,</li> <li>▪ HIV status disclosure, adherence, and psychosocial counseling and support for PLHIV at PEPFAR supported sites</li> <li>• Intensified TB case finding for PLHIV and quality of TB infection control</li> <li>• Provision of quality VMMC services (PrePex and Surgical) including: HTS, Tetanus Vaccination, Infection prevention, Linkage to HIV/AIDS care and treatment for HIV-positive tested individuals, VMMC procedure, Clinical follow-up of circumcised clients, Adverse event management, Post-operative care.</li> <li>• Provide core package of services for ANC and PMTCT services for pregnant and breastfeeding women and exposed infants, including: testing and counseling for pregnant and breastfeeding women; provision of male partner and family centered testing; family planning counselling to prevent HIV transmission services; safer pregnancy, nutritional and infant feeding counseling; provision of ART for HIV positive pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical and financial assistance to health facilities to put in place strategies intended to increase the use of HIV services among KPs and OVPs (High).</li> <li>• Training of HCP at PEPFAR supported sites on management of HIV/AIDS, OIs, STI, HepB, SGBV, cervical cancer and other HIV related diseases, on delivering adolescent friendly services, on new policies, protocols/guidelines and procedures for optimal PLHIV management.</li> <li>• Support to M&amp;E activities at facility level in order to ensure data quality and data use in program management.</li> </ul>	
Sub-national level	<ul style="list-style-type: none"> <li>• Laboratory support to enhance sample transportation (from HC to DH and to Reference laboratories).</li> <li>• Roll out adolescent HIV friendly services; especially for adolescent girls and young women</li> <li>• Provision of HIV prevention messaging</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct sensitization meetings for health workers and opinion leaders in the community to reduce stigma and discrimination among key and other vulnerable populations</li> </ul>	

across OVC program activities and improve linkages to HIV Prevention and Care & Treatment services.

- Reach Key and vulnerable populations and their partners with HIV Prevention messages through IPC sessions
- Support to OVC through provision of access to health and HIV clinical services, case management, WASH activities, food security and nutrition, education, psychosocial support, economic strengthening activities

**National level**

- Procurement of commodities, including testing commodities, ARVs, OI drugs, laboratory commodities, condoms and lubricant
- Support data use/ evidence-based strategic planning for HIV epidemic control at the Rwanda USG, National(GOR) and district levels
- Support EMR planning and implementation at PEPFAR
- Perform HTS (ELISA, Western blot, RTPCR) in accordance with national guidelines and perform EID, CD4, VL and HIV related tests at NRL and Lab network as per national guidelines; validate use of DBS for VL testing
- Conduct training of trainers
- Develop a unique patient ID and tracking system to enhance linkage and retention in care and treatment (High).
- Development and distribution of guidelines, training materials, job aids and other tools for all HIV program areas and other OBBI, key populations and adolescent HIV services
- Update current training approaches to find efficiency
- Establish routine monitoring and surveillance system in KPs to demonstrate program effectiveness and inform program improvement over time
- Conduct secondary analysis of BSS for MSM, FSW, RDHS2015, AIS and HIV drug resistance survey data (MED)
- Conduct key population size estimation for MSM and FSW by Province and District (2016) (HIGH)
- Provide quality assurance for HIV core tests at NRL and lab network
- Provide support for laboratory accreditation process
- Build capacity of national HIV surveillance system through FELTP
- Develop and implement the new HIV service delivery model

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16**

	<b>Core Activities</b>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
<b>HTS</b>	<ul style="list-style-type: none"> <li>• Provide systematic HTS to all clients accessing clinical services through EID, PIT and mobile VCT with special emphasis on testing children 0-15 years.</li> <li>• Procurement of HIV test kits and other testing commodities</li> <li>• Increase and ensure access to HTS services for Key and Priority Populations through improved partner coordination and</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a unique patient ID and tracking system to enhance linkage and retention in care and treatment (High).</li> <li>• Conduct training of trainers to expand access to HTS services (VCT and PITC, EID) at all sites in line with NSP goals (High).</li> <li>• Training providers around screening for GBV/ IPV based on clear protocols that emphasize clients' safety and confidentiality (Medium).</li> <li>• Training HTS and PMTCT service providers in how to counsel and appropriately refer women and men who report experiencing GBV/IPV (Medium).</li> </ul>	

- 
- supervision.
  - Perform Early Infant Diagnostic (EID) testing ensuring rapid turn-around times, accurate forecasting on commodities and reagents and quality control.
  - Establish and maintain a fast track result relay for all positive DBS sample results.
  - Coordinate services with Lab to efficiently process DBS samples, maintain accurate databases and provide regular reports to the MOH and PEPFAR.
  - Implement Rapid HIV Testing Quality Improvement Initiative (RTQII):
  - 1)HTS policies; 2) National HTS algorithm; 3) strengthening workforce , (3)supervise the implementation of HTS using finger pricks and certification of HTS providers; 4) Implement a standardized HTS quality log-book and conduct post-market surveillance of RTKs.
  - Laboratory support to enhance sample transportation (from HC to DH and to Reference laboratories/VL testing sites).
  - Perform HIV EIA (Elisa) on all HRT with indeterminate results.
  - Conduct outreach HTS services targeting KPs
  - Enhance linkages to health facilities and community-based outlets for HTS, STI screening, care and treatment and Preventions services for KPs and OVPs.
  - Support HTS activities with logistical and technical support to RDF health providers to provide quality services.
  - HTS services delivery through mobile unit and Army week activities
  - Outreach HTS services delivery targeting RDF (couples / partner testing).
  - HTS linkages for couples/partners to care and treatment services including discordant and concordant couples
  - Counselling on FP methods for identified HIV positive clients
  - Provide technical and financial assistance to health facilities to put in place strategies intended to increase the use of HIV services among KPs and OVPs (High).
  - Continuous HTS training of Health Care Providers to improve quality of service delivery approaches (Medium)
  - Joint supervision visits to HTS services including RDF health facilities (High)
  - Support training of HTS supervisors at RDF health facilities (Medium)
  - Support the RDF to conduct M&E and program evaluation (High).

Care and Treatment	Core Activities	Near-core Activities	Non-core Activities
	<ul style="list-style-type: none"> <li>▪ Clinical mentorship for HCP in HIV/AIDS management and other related diseases.</li> <li>▪ Effective tracking and linkage to treatment of PLHIV tested HIV positive and not yet in care.</li> <li>▪ Psychosocial follow up, adherence assessment and LTFU tracking for PLHIV in care who missed appointments.</li> <li>▪ Clinical assessment, staging and laboratory monitoring for all PLHIV in care at enrollment and at each follow-up visits,</li> <li>▪ Screening, prevention, diagnosis and management for TB, OIs, STIs, HepB, mental disorders &amp; other HIV-related illnesses for PLHIV.</li> <li>▪ Nutrition assessment, counseling and education.</li> <li>▪ Linkage to community programs.</li> <li>▪ PHDP interventions</li> <li>▪ HIV status disclosure, adherence, and psychosocial counseling and support for PLHIV at PEPFAR supported sites;</li> <li>▪ Implementation of support groups for children and adolescents including peer education, disclosure and adherence.</li> <li>▪ Procurement and provision of ARVs, OIs drugs &amp; laboratory commodities</li> <li>▪ Management of ARV drug side effect, treatment failure and second line initiation;</li> <li>▪ Intensified TB case finding for PLHIV</li> <li>▪ Maintain and improve the quality of TB infection control</li> <li>▪ Provide high quality of service to the SGBV victims including PEP, psycho social support, and medical care,</li> <li>▪ Roll out adolescent HIV friendly services; especially adolescent girls and young women.</li> </ul>	<ul style="list-style-type: none"> <li>• Development and distribution of guidelines, training materials, job aids and other tools for all HIV program areas and other OBBI, key populations and adolescent HIV services.</li> <li>• In service training of HCP at PEPFAR supported sites on management of HIV/AIDS, OIs, STI, HepB, SGBV, cervical cancer and other HIV related diseases, on delivering adolescent friendly services, on new policies, protocols/guidelines and procedures for optimal PLHIV management.</li> <li>• Quarterly pediatric HIV training and experience sharing meetings for DHs multidisciplinary team-Medical Doctors, Nurses and Social Workers.</li> <li>• Revise and update current training approaches to identify ways to improve the Pediatric HIV Modules and revise training schedule to ensure major emphasis is given to pediatric HIV care and treatment.</li> <li>• Development of a harmonized approach to establish and implement effective linkages with other community based services for PLHIV.</li> <li>• Support Integrated Supportive Supervision</li> <li>• Support procurement of consumables (VIA, LEEP, cryotherapy) and Implementation of Cervical Cancer screening and management for HIV positive women.</li> <li>• Provide TA in human resource development that includes pre-service and in-service training of RDF health personnel</li> <li>• Provide technical support (training &amp; supervision) at RDF health sites</li> <li>• M&amp;E activities at facility level in order to ensure data quality and data use in program management.</li> <li>• Clinical mentorship and Trainings of healthcare providers, legal officers, and judicial police officers on management of SGBV victims at PEPFAR supported health facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide TA in human resource development that includes pre-service training of RDF health personnel (3-year program)</li> <li>• Training of histo-pathologists</li> </ul>

Prevention	Core Activities	Near-core Activities	Non-Core Activities
	<ul style="list-style-type: none"> <li>Provision of quality VMMC services (PrePex and Surgical) including: HTS, Tetanus Vaccination, Infection prevention, Linkage to HIV/AIDS treatment for HIV-positive tested individuals, VMMC procedure, Clinical follow-up of circumcised clients, Adverse event management, Post-operative care.</li> <li>Provide core package of services for ANC and PMTCT services for pregnant and breastfeeding women and exposed infants, including: testing and counseling for pregnant and breastfeeding women; provision of male partner and family centered testing; family planning counselling to prevent HIV transmission services; safer pregnancy, nutritional and infant feeding counseling; provision of ART for HIV positive pregnant women</li> <li>Follow up through 18 months of age of HIV exposed infants: CTX prophylaxis, growth monitoring, EID and post weaning RHT (Rapid HIV Testing);</li> <li>Tracking of HIV Exposed Infants and/or MIPs (Mother Infant Pairs) LTFU (Lost to follow up) prioritizing those with a positive DBS result;</li> <li>Fast track HIV positive babies/infants to treatment program; Provide HIV testing (DNA PCR and/or RT), Evaluate and link infants and women to OVC services in the community.</li> <li>Distribute and promote correct and consistent use of condoms</li> </ul>	<ul style="list-style-type: none"> <li>Training of Health Care Providers on VMMC techniques (PrePex) (High)</li> <li>Demand creation and production of IEC materials for VMMC and HIV prevention (High).</li> <li>Support Health Facilities to conduct VMMC M&amp;E (High)</li> <li>Improve the process of forecasting, procurement and distribution supplies for VMMC (High).</li> <li>Integration or referral/linkage to/from other men's health services and programs that promote gender equitable norms (Medium).</li> <li>Scale up PMTCT continuous quality improvement activities at all MOH/PEPFAR supported sites (High)</li> <li>Ensure PMTCT data quality by updating data collection and reporting tools (High).</li> <li>Develop strategies to facilitate linkage of HIV exposed infants to post-natal services including MNCH services (High).</li> <li>Condom rebranding campaigns (Medium)</li> <li>Condom packaging, sale and distribution of health products (Prudence) (High)</li> <li>Conduct monthly coordination meetings of Peer Educators from key populations CBOs and distribute promotional material (Tool Kits) (High)</li> <li>Conduct sensitization meetings for health workers and opinion leaders in the community to reduce stigma and discrimination among key and other vulnerable populations (High)</li> <li>Supervision of Anti-AIDS clubs (Low)</li> <li>Conduct MVU sessions and other special events during Army week activities (Medium).</li> <li>Develop a system to link and track KPs enrolled in care and treatment program (High)</li> <li>Establish routine monitoring and surveillance system in KPs to demonstrate program effectiveness and inform program improvement over time (High)</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen existing "recreation centers" for truckers and community members around truck parks and support integration of services including HTS, STI screening and treatment, condom provision, and referral as needed.</li> <li>Training providers around screening for GBV/IPV based on clear protocols that emphasize clients' safety and confidentiality</li> </ul>

and condom compatible lubricants through the peer networks of key populations, health facilities and community-based outlets.

- Condom and lubricants procurement
- Conduct core package of behavior change communication (BCC) focusing on:
  - increasing knowledge on correct and consistent use of condoms and HTS services among Key populations
  - providing HIV prevention / sexual reproductive health messages through life skills training and other approaches targeting KPs
  - Reducing the use of alcohol and other substances to reduce risk of HIV infection
  - Provision of HIV prevention messaging across OVC program activities and improve linkages to HIV Prevention and Care & Treatment services.
  - Reach Key and vulnerable populations and their partners with HIV Prevention messages through IPC sessions

OVC	Core Activities	Near-core Activities	Non-core Activities
-----	-----------------	----------------------	---------------------

- 
- Assessment of child and family needs for enrollment, including children with special needs
  - Conducting monthly/quarterly monitoring and develop care/case management plans for children and families
  - Providing identified services or referrals with follow-up to address the needs
  - Conducting close follow up of referrals from clinical services and the OVC/MVC list from District/Sector authorities
  - Implementing special studies to identify gaps in programming
  - Assuring basic health care including ART, therapeutic nutrition, immunizations, HCT
  - Conducting planning and coordination meetings for enrollment of HIV affected children and families in OVC/MVC programs and service provision as identified in case management.
  - Support OVC/MVC partners to systematize referrals and follow-up and tracking of HIV testing of beneficiaries
  - Support peer educators and community volunteers to provide HIV risk reduction education and link to HCT for testing for OVC/MVC, caregivers and family; life skills education and goal setting
  - Working with clinical service providers, support accompanying beneficiaries to health facilities, provide timely reminders, encourage and support families to respect clinical schedules and appointments to reduce LTFU and adherence to ART
  - Integration of HIV prevention messaging into all OVC/MVC activities with emphasis on awareness raising on HTS across program activities
  - Provision of positive parenting skills for all ages
  - Community volunteers conduct home visits to provide support, facilitate linkages with services and also identify, educate and refer cases of abuse and gender based violence (GBV); protection from violence
  - Integration of child rights, gender roles and GBV messages into existing structures and program activities
  - For PLHIV: Awareness sessions on their
- Participation in District OVC/MVC Committees to coordinate activities, assure needed services and resources are available for OVC/MVC and families (assures quality) [HIGH]
  - Developing service directories (facilitates effective referrals and follow-up) [MEDIUM]
  - Developing and implementing procedures for closing and transitioning children and their families from program support [HIGH]
  - Provision of mutuelle de santé for OVC/MVC not otherwise able to obtain coverage (ISLG participants are encouraged to pay mutuelle de santé for their households) [HIGH]
  - Support external linkages and partnerships between local organizations and service providers and national institutions for supporting GSLA members' initiatives [LOW]
  - Graduate GSLA groups towards external financial services as a self-sustainability approach [MEDIUM]
  - Facilitating access to primary and secondary school through long-term or open ended subsidies [MEDIUM]
  - Provision of start-up kits for TVET graduates [MEDIUM]
  - Planning for and conducting OVC Essential Indicators special study [HIGH]
  - OVC impact assessment to examine the extent to which selected Household Economic Strengthening (HES) intervention(s) improve the health, nutrition and well -being of target populations, especially PLHA, OVC and their families [HIGH].
  - Identifying and addressing specific data quality issues in OVC/MVC programs [HIGH]
- Therapeutic nutrition
  - Support to health facilities to improve WASH conditions; rehabilitation of water springs
  - Support psychosocial counseling in schools
  - Support to cooperatives: financial management trainings, business plan development and project management
  - Training of community volunteers on children's rights and GBV
-

---

rights

- Facilitate birth registration through working with families to assure that OVC/MVC have birth certificates
  - Support life skills education for OVC/MVC including Education awareness for community stakeholders on HIV education, child rights, gender, focusing on sexual and reproductive health concerns of adolescent girls
  - Support savings and loan associations for priority populations including CSW, PLHIV, and OVC/MVC and their families and household members to increase access to incomes and reduce vulnerabilities
  - Support small-business trainings and promote a market readiness orientation among priority populations building on the findings from the Household Economic Assessment (HEA) to enhance household economic resilience, including changes to household assets, dietary and income diversity
  - Facilitate parent support groups using peers and Positive Deviance/Hearth approach
  - Integration of nutrition related messaging across program activities
  - Conducting beneficiary nutrition assessments
  - Provision of referrals for nutrition assessment and support
  - Establishing and supporting farmer field Schools (FFS). FFSs serve as agricultural learning centers where farmers can “learn by doing” about basic agricultural principles and new techniques such as bio-intensive agriculture. FFSs contribute to strengthening the economic, health and nutrition status of the families.
  - Support the integration of WASH messaging into program activities
  - Support health facilities and community based organizations (CBOs) to improve water and sanitation (WASH) conditions, especially among most vulnerable PLHA and OVC/MVC households; Water purification, installation of tanks etc.
  - Support community ECD centers for vulnerable children including promotion of
-

---

testing of children and families and support for ART adherence

- Support the integration of ECD into home visiting and work with parents/guardians to reinforce ECD outcomes, to monitor the child's well-being and to assure referral of children for testing, EID and follow-up
  - Facilitating access to primary, secondary and Technical and Vocational Education and Training (TVET ) schools through temporary and targeted support for: school materials (uniforms and school materials) for all levels, feeding programs and school fees for boarding secondary and TVET school students
  - Provision of adolescent girl-sensitive package to help transition from adolescence to adulthood and HIV risk reduction
  - Support psychosocial health/wellbeing among children and their caregivers through individual and group counselling by trained community volunteers or through relationship-based activities (1 volunteer approximately follows 9-15 OVC/MVC), at least monthly
  - Documentation of referrals and linkages
  - Support psychosocial counseling at schools especially related to cases of abuse or violence at home or in foster families; for adolescents, especially girls, also for out of school youth
  - and for families
  - Capacity building of local CSOs to provide quality services to OVC/MVC and their families
  - Developing systems/registries for tracking linkages with clinical services with OVC/MVC programs
  - Identify and map different categories of KPs in the targeted geographic areas and track mobility.
  - Provide comprehensive community-based HIV prevention services through Peer education and outreach for behavioral HIV prevention among KPs
  - Provide prevention package of services at facility and community level for HIV negative KPs
  - Implement Test, Link and retain into Care
-

for KPs

- Support early enrollment into Anti-Retroviral Treatment (ART) for KPs and monitor viral load (VL) suppression.
- Provide and facilitate access to Post Exposure Prophylaxis (PEP) to KPs in need in all health facilities
- Provide training to Health Care Providers on the minimum package and how to provide quality HIV services to KPs
- Provide comprehensive positive health dignity and prevention (PHDP) interventions for KPs to reduce risk of sexual transmission of HIV.
- Community mobilization efforts aimed at addressing and transforming harmful gender norms and inequities to ensure that the specific dynamics of harmful norms in KPs are integrated.
- Training health care providers on needs and issues affecting KPs that foster non-stigmatizing attitudes in order to facilitate access and adherence to treatment among KPs.

Program Systems Support	Core Activities	Near-core Activities	Non-Core
HSS		<ul style="list-style-type: none"> <li>• Support to MOH to develop HCW sustainability plan for service provision.</li> <li>• Support MOH to build capacity for HIV program management through highly-skilled seconded staff.</li> <li>• Emphasis on building capacity and institutionalizing processes to manage and sustain the HIV program (standardizing continuous quality improvement for service delivery, coaching and mentoring of HCWs, community-facility linkages to improve retention and adherence, increase CHW engagement.</li> <li>• Support the Field Epidemiology and Laboratory Program (FELTP) and short courses on research, design and implementation, and publications for health</li> </ul>	<ul style="list-style-type: none"> <li>• Institutional capacity building for pre-service training in medicine, nursing, health management, and clinical teaching hospitals to sustain high quality.</li> <li>• Clinical and faculty mentorships for pre-service education.</li> </ul>

<b>Lab Strengthening</b>	<ul style="list-style-type: none"> <li>• Perform EID, CD4, VL and HIV related tests at NRL and Lab network as per national guidelines</li> <li>• Procurement of HIV lab commodities, including testing</li> <li>• Support LIS and BLIS planning and implementation prioritizing the VL sites</li> <li>• Support RTQII at PEPFAR supported sites</li> </ul>	<ul style="list-style-type: none"> <li>• Support the laboratory network accreditation process according to the national plan; Conduct SLMTA workshops, mentorships and improvement projects in enrolled laboratories (HIGH)</li> <li>• Supervision and mentorship supporting the decentralization of biomedical and immunological monitoring tests/viral load/HIV DNA PCR (EID); including: *Supervise and train EID and Viral Load testing sites other core lab tests (HIGH)</li> <li>• Competence on site trainings, certification of HTS testers and capacity building (HIGH)</li> <li>• Support HIV division in development and implementation of workplace and biosafety program for health professionals. (Infection control in general, for TB, blood borne pathogens) (MED)</li> </ul>
<b>Quality Improvement</b>		<ul style="list-style-type: none"> <li>• Carry out the Integrated Supportive Supervisions (ISS) at health centers including HIV service quality improvement by District teams.</li> <li>• Conduct District level Integrated Supportive Supervision (ISS) including HIV service quality improvement by Central level teams.</li> <li>• Conduct refresher trainings of HCPS on integrated comprehensive management of PLHIV at MOH/PEPFAR supported sites.</li> <li>• Conduct training of HCPs trainings on new HIV service delivery model guidelines at MOH/PEPFAR supported sites.</li> <li>• Carry out quarterly formative supervision on financial and administrative management in MOH/PEPFAR-supported health facilities</li> </ul>
(no core)		



## APPENDIX B

### B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$6,157,029	\$65,842,971	\$72,000,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$2,172,749
HVAB	Abstinence/Be Faithful Prevention	\$0
HVOP	Other Sexual Prevention	\$1,402,838
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$445,914
HVCT	Counseling and Testing	\$4,081,451
HBHC	Adult Care and Support	\$3,056,452
PDCS	Pediatric Care and Support	\$1,010,128
HKID	Orphans and Vulnerable Children	\$5,316,723
HTXS	Adult Treatment	\$18,103,856
HTXD	ARV Drugs	\$16,312,149
PDTX	Pediatric Treatment	\$2,141,394
HVTB	TB/HIV Care	\$1,040,986
HLAB	Lab	\$2,073,475
HVSI	Strategic Information	\$2,364,401
OHSS	Health Systems Strengthening	\$2,332,942
HVMS	Management and Operations	\$3,987,513
<b>Applied Pipeline</b>		<b>\$6,157,029</b>
<b>TOTAL</b>		<b>\$72,000,000</b>

## APPENDIX C

### Systems Investments for Section 6.o

Included Activities	Excluded Activities
<b>Human Resources for Health (HRH): Systems/Institutional Investments</b>	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
<b>Human Resources for Health (HRH): Personnel Costs for Service Delivery</b>	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
<b>Governance</b>	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
<b>Finance</b>	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
<b>Systems Development</b>	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
<b>Institutional and Organizational Development</b>	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
<b>Strategic Information</b>	

Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A
<b>Laboratory</b>	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents and supplies, travel and transport, building rental and utilities will not be included