Rwanda

Operational Plan Report

FY 2010

Operating Unit Overview

OU Executive Summary

Program Description:

Rwanda is the most densely populated country in sub-Saharan Africa and faces a multitude of health and development challenges. An estimated 3.1% of the adult population is infected with HIV (3.6% of adult women and 2.3% of adult males). Out of a population of approximately eleven million, 150,000 Rwandan adults and 27,000 children are estimated to be living with HIV (UNAIDS). The repercussions from the 1994 genocide in which up to a million Rwandan citizens were killed, combined with HIV, have resulted in more than a million orphans and vulnerable children and a continuing loss of approximately 5,600 persons to HIV-related illness each year. The Government of Rwanda (GOR) is committed to fighting this disease and takes a proactive role in HIV/AIDS prevention, care, and treatment care for all its citizens. This PEPFAR Operational Plan will be carried out with close cooperation between the GOR, Embassy Kigali PEPFAR team, and local partners. A key focus of this year's program will be to transition activities to GOR local ownership. Rwanda has demonstrated the political will to achieve that goal.

Rwanda's epidemic is primarily driven by heterosexual contact (75%) and mother-to-child transmission (20%). Populations most at risk for HIV in Rwanda include: discordant couples; out-of-school youth; people engaged in prostitution, their clients and partners; military and police personnel; long distance truck-drivers, and prisoners. Discordant couples are estimated to comprise 2.2% of all cohabiting couples. Current data from HIV counseling and testing in prisons show that the prevalence among incarcerated populations is approximately 7.5%. Although the median age of sexual debut for Rwandan males (20.8 years) and females (20.3 years) is relatively late, youth are estimated to comprise 14.7% of those living with HIV/AIDS, demonstrating the continued need to support youth programming. The estimated 220,000 Rwandan HIV/AIDSA orphans face unique challenges of sexual exploitation, violence, abuse, food insecurity and poverty. Furthermore, cross-generational sex poses significant risks for young females. WHO estimates that 26% of adult TB cases are also co-infected with HIV, indicating that TB remains a significant problem in Rwanda.

In FY 2010, we will use PEPFAR funding to address the programmatic areas described below in order to achieve the 3-12-12 targets.

Prevention: $27,458,969

USG prevention funding will support GOR efforts to achieve the national benchmark of halving HIV incidence in Rwanda by 2012. Prevention activities to achieve this goal include: prevention of mother-to-child transmission (PMTCT); prevention of sexual transmission; biomedical prevention; including improving blood and injection safety practices in health facilities and male circumcision within the military; and integrated counseling and testing services with a special emphasis on most at-risk populations.

In FY 2010, the USG will continue to partner with the GOR to provide comprehensive PMTCT services for all clients. The FY 2010 program will focus on limited expansion of PMTCT service delivery sites, the scale-up of early infant diagnosis and improved linkages with maternal and child health programs. In FY 2010, PEPFAR and THEGOR will work together to identify service delivery sites that can be upgraded to include PMTCT services. The GOR intends to have 100% of its health care facilities provide PMTCT services by 2012; currently over 70% of all health care facilities provide this service. Additionally, in FY 2010, PEPFAR and GOR will continue to strengthen early infant diagnosis programs, including reducing

the long turn-around times for infant HIV testing. Finally, the FY 2010 program will improve the linkages and integration between PMTCT programs and maternal and child health services, including distribution of bed nets to prevent malaria, family planning counseling and referral, syphilis screening, and nutrition counseling and support.

The USG will continue to implement a range of behavioral and biomedical prevention interventions to address the sources of new infections at a scale and quality to reduce incidence. These interventions will: target most-at-risk populations with prevention programs; promote abstinence and delayed sexual debut among youth; enhance condom distribution and promotion; target behavior change communication; encourage male circumcision in the military; provide prevention services for people living with HIV/AIDS; improve HIV program integration with family planning services; engage men more effectively in prevention; and scale up testing and counseling (TC) with an emphasis on heterosexual couples. FY 2010 funds will support health communication campaigns, help build life skills, foster prevention with positives (PwP), and support infrastructure development. The 2010 prevention program will continue to be based on best practices and emerging evidence, including the incorporation of results from the 2009 data triangulation exercise designed to gain information on most-at-risk groups and drivers of the epidemic. These programs will focus on transitioning to GOR ownership in a way that enables the GOR to sustain prevention activities in the long term.

Along with ongoing blood collection, screening and transfusion services, in FY 2010, we will expand and strengthen targeted activities within blood safety. Programs will emphasize training and quality assurance, and new protocols will be implemented to improve donor recruitment. The USG and GOR, working together, will link blood transfusion and TC services through the donor notification system in order to inform sero-positive donors of their HIV status. Injection safety activities will be sustained to reduce unnecessary injections, improve safe management of sharps and medical waste, and procure required materials for safe injections, Redacted. In addition, the FY 2010 program will emphasize monitoring accidental needle sticks in all public hospitals and health centers. The FY 2010 program will focus on building the GOR capacity in order to transition activities currently undertaken by international organizations to local entities.

Testing and Counseling (TC) has undergone a dramatic scale-up in Rwanda. By the end of FY2010, the USG will have provided counseling and testing services to over 600,000 individuals. The continued expansion of TC services in FY 2010 will focus on strengthening prevention counseling for those found to be HIV-negative, and prevention counseling, care, and treatment for those found to be HIV-positive. Given that prevention of HIV transmission among sero-discordant heterosexual couples is an effective strategy to avert new infections, we will expand significantly testing and counseling for couples. In addition, the USG will continue to support the implementation of policies, guidelines and tools to improve prevention program effectiveness. Specifically, we expect the implementation of the national policy on provider-initiated testing and counseling (PITC) and finger-prick testing to have a significant impact on FY 2010 programming.

Principal Partners: American Refugee Committee (ARC), American Association of Blood Banks (AABB), Catholic Relief Services (CRS), Center for Research on HIV, Malaria, TB and Other Infectious Disease (TRAC Plus), CHF International, Columbia University Mailman School of Public Health, Drew University, Educational Development Center (EDC), Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Emory University, Family Health International (FHI), IntraHealth International, Inc, JHPIEGO, John Snow, Inc. (JSI), Ministry of Health, Rwanda (MOH), National Center for Blood Transfusion Safety (CNTS), National AIDS Control Commission (CNLS), Partnership for Supply Chain Management (SCMS), Population Services International (PSI), Social and Scientific Systems, Inc. (SSS), Texas A&M University, United Nations High Commissioner for Refugees (UNHCR).

Care: $32,901,157

In Rwanda, PEPFAR and the GOR provide care and support activities, including provision of basic health care and support for adults and children, support for integrated TB/HIV services, and programs for orphans and vulnerable children (OVC). In FY 2010, the USG will provide care for over 184,000 individuals, including more than 70,000 OVC.

The USG will strive to ensure that all (write out) PLWHA receive support through a comprehensive network of district hospitals, health centers and community services. Clinical activities will include prevention and treatment of opportunistic infections and sexually transmitted infections (STIs), positive living and prevention counseling and interventions for PLWHA, nutritional counseling and assistance, support for treatment adherence, CD4 testing, general clinical staging and monitoring, family planning support, and linkages to community services. In FY 2010, the USG will also continue to emphasize the use of a family-centered approach for care; improvement of pain management; improved prevention and interventions counseling for PLWHA, and improved linkages. Ongoing wraparound activities in FY 2010 include: the provision of bed nets through the President's Malaria Initiative (PMI), provision of safe water treatment and hygiene education, leveraging of food aid for PLWHA; support for economic growth and livelihoods; and linkages to prevent gender-based violence. Finally, there will be a significant emphasis on pediatric care and support activities.

In FY 2010, the USG will continue to support integration of TB/HIV services in collaboration with the Global Fund. Our main priority will be to expand the implementation of regular TB screening to all ART sites, and the diagnosis and complete treatment with DOTS. Together with the GOR, we will scale up "One-stop service" TB/HIV management activities to provide comprehensive services for all TB patients with HIV/AIDS.

According to the UN, Rwanda has one of the highest proportions of orphans in the world. The USG will target support for child-headed households and the most vulnerable orphans. USG implementing partners will increase national capacity to respond to OVC priorities such as policy and legal reform, government and civil society coordination, and monitoring of services. The USG will assess OVC needs to provide a menu of services including education, health, psychosocial support, nutrition, and economic interventions to beneficiaries in USG-supported districts. HIV prevention messages will continue to be integrated into OVC programs. USG activities for OVC will wrap around PMI, microfinance, education, youth employment, and food assistance programs to provide integrated services.

Principal Partners: ARC, Avocats Sans Frontieres (ASF), CRS, CHF International, Columbia University Mailman School of Public Health, Drew University, EDC, FHI, EGPAF, IntraHealth International, Inc, JSI, MOH, PSI, SCMS, SSS, TRAC Plus, UNHCR.

Treatment: $36,472,845

Treatment activities include antiretroviral treatment (ART) programs, focused on both adults and children, and laboratory support. As of December 2009, 77,000 individuals were on treatment, representing 73% of those in need of ART and one of the highest coverage rates in sub-Saharan Africa. The USG will work to support the GOR goal of reducing morbidity and mortality due to HIV/AIDS.

In FY 2010, the USG will strengthen the MOH's capacity to improve program quality and sustainability through national and district-level support. The USG will continue to provide a standardized package of ARV services through a coordinated network of HIV/AIDS services linking ART with PMTCT, TB, maternal child health, and other services. In FY 2010, in order to help patients tolerate complex medication regimens, the USG will expand efforts to provide nutritional support to qualifying adults and pregnant and lactating women. At the community level, the USG will ensure continuity of care and adherence support through case managers, community health workers, and peer support groups. The

USG will scale up programs on rational drug use, pharmacovigilance, and supply chain management to enhance the efficiency and effectiveness of ARV treatment. Additionally, the USG will facilitate the transition of several partner-supported clinical service delivery sites to GOR management to ensure long-term sustainability. Finally, we will support a more strategic approach to ART, to include task shifting, decentralization of services, and targeted use of viral load testing.

USG FY 2010 resources for laboratory infrastructure will support key reference laboratory functions, including training, quality assurance, and developing in-country expertise for HIV-related care and treatment. The USG will continue working with the Rwandan National Reference Laboratory (NRL) to develop infrastructure plans for NRL and for the Rwanda Laboratory Network. This infrastructure plan will be a collaborative and regional endeavor as the World Bank is committed to assisting the East African Community, of which Rwanda is a member, to build laboratory infrastructure and improve laboratory services for the region. There will be an emphasis on strengthening linkages in the tiered laboratory system. The early infant diagnosis program will be scaled up to support a total of 161 PMTCT sites. Finally, the USG will continue to provide direct support to Rwandan Center for Essential Drug Procurement (CAMERWA) for the procurement, storage, and distribution of all medicines, equipment, and laboratory supplies.

Principal partners: ARC, American Public Health Laboratories (APHL), American Society of Clinical Pathology, The American Society for Microbiology, Columbia University Mailman School of Public Health, CRS, Drew University, EGPAF, FHI, IntraHealth International, Inc, Management Sciences for Health (MSH), MOH, New York AIDS Institute, NRL, Public Health Institute, SCMS, SSS, TRAC Plus, UNHCR.

Other Costs: $28,081,965

To promote sustainability through the use of reliable, high quality data and the overall improvement of the Rwandan health system, the USG will support strategic information and health systems strengthening. Additionally. U.S. Mission management and staffing will help to provide the appropriate and necessary oversight to the Rwanda PEPFAR program.

In FY 2010, our overarching strategic information priorities are the improvement of data quality, enhancement of data utilization, and the coordination of reporting systems. The USG will support implementation of the national health management information system (HMIS) and strategy and the national HIV/AIDS monitoring and evaluation system. The USG will continue providing assistance to enhance data analysis skills at the district and facility levels. We will also help Rwanda develop a more robust and sustainable health system by strengthening national health sector financing, increasing the availability of skilled human resources, providing institutional capacity building for local organizations, and improving management systems for critical health support systems such as logistics and information management.

Management and staffing funds will enable in-country United States Agency for International Development (USAID), Centers for Disease Control and Prevention (CDC), Department of State, Department of Defense (DOD), and the Peace Corps' personnel to provide direction and oversight to the implementation of this operational plan. Funding will support program monitoring and accountability, ensure USG policy compliance, underwrite technical assistance to the Rwanda national response, and cover compensation, logistics, and office and administrative costs.

Principal partners: Abt Associates, ASF, APHL, CDC, CHF International, CNLS, DOD, Drew University, FHI, Macro International, MOH, MSH, Peace Corps, SCMS, SSS, TRAC Plus, Tulane University, University of North Carolina, USAID, Voxiva.

Other Donors, Global Fund Activities, Coordination Mechanisms:

The United States is the largest HIV/AIDS bilateral donor in Rwanda: we have provided over $542 million in the first six years of the Emergency Plan. Other major donors in the HIV/AIDS sector are the Global Fund, the Clinton Foundation, and governments of Belgium, and Germany. To date, the Global Fund has awarded 12 grants to Rwanda totaling over $620 million, including National Strategy Application grants in TB and HIV/AIDS that have not yet been signed. Over the past six years, we have seen great strides in the HIV/AIDS program in Rwanda and in the GORs capacity to manage and oversee these programs. There has been over a 350% increase in the number of individuals receiving ART in just the past 4 years; with almost 74,000 individuals currently receiving the live saving treatment. In addition, over the past year the GOR has been adamantly pursuing the transition of service delivery sites from international organizations to local ownership, something that is a high priority under the PEPFAR II reauthorization.

The USG actively participates in donor harmonization on a number of levels, including the three main bodies that coordinate health activities undertaken by donors and civil society in Rwanda: 1) the PEPFAR Steering Committee, chaired by the Rwanda National AIDS Control Commission (CNLS) Executive Secretary and the PEPFAR Rwanda Team; 2) the Global Fund Country Coordinating Mechanism, chaired by the MOH Permanent Secretary and the WHO representative; and 3) the Health Cluster, chaired by the MOH Permanent Secretary and the Belgian Embassy. These three bodies include substantial representation from the GOR, donors, and civil society organizations that support the health sector.

Program Contact: Deputy Chief of Mission, Anne Casper

Time Frame: FY 2010 – FY 2011

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of						

pregnant women in the last 12 months						
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
Behavioral Surveillance Survey among Commercial Sex Workers	Population-based Behavioral Surveys	Female Commercial Sex Workers	Data Review
Behavioral Surveillance Survey among Truckers	Population-based Behavioral Surveys	Mobile Populations	Data Review
Behavioral Surveillance Survey among Youth 15-24	Population-based Behavioral Surveys	Youth	Data Review
HIV Serosurveillance among pregnant women	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Implementation
TB and TB-HIV Prevalence Survey in Prisons	Population-based Behavioral Surveys	Mobile Populations	Implementation

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
DOD			3,998,478		**3,998,478**
HHS/CDC	5,480,185	1,135,000	29,703,286		**36,318,471**
HHS/HRSA	621,139		3,767,917		**4,389,056**
PC			824,571		**824,571**
State/PRM			386,402		**386,402**
USAID	138,750		85,391,585		**85,530,335**
Total	**6,240,074**	**1,135,000**	**124,072,239**	**0**	**131,447,313**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency							Total
	DOD	HHS/CDC	HHS/HRSA	PC	State/PRM	USAID	AllOther	
CIRC	1,089,000	74,250				198,000		**1,361,250**
HBHC	278,728	1,609,106	565,201		14,253	10,019,877		**12,487,165**
HKID						12,157,200		**12,157,200**
HLAB		2,613,600				7,456,497		**10,070,097**
HMBL		3,267,001						**3,267,001**
HMIN		1,048,442				489,383		**1,537,825**
HTXD						11,490,309		**11,490,309**
HTXS	1,151,816	5,584,827	1,753,417		198,929	13,224,769		**21,913,758**
HVAB	148,500	925,650		50,000	19,800	2,372,310		**3,516,260**
HVCT	592,665	1,404,570	134,705		42,758	3,475,383		**5,650,081**
HVMS	209,500	5,557,788		724,571		5,913,530		**12,405,389**
HVOP	142,560	801,900		50,000	9,900	4,871,070		**5,875,430**
HVSI	24,750	3,766,221				2,784,651		**6,575,622**
HVTB	45,528	1,965,447	942,041		35,632	1,713,988		**4,702,636**

MTCT	106,878	1,631,254	406,573		35,849	2,838,857		**5,019,411**
OHSS	133,650	4,799,693				3,976,903		**8,910,246**
PDCS	59,727	639,650	290,768		4,338	1,221,390		**2,215,873**
PDTX	15,176	629,072	296,351		24,943	1,326,218		**2,291,760**
	3,998,478	**36,318,471**	**4,389,056**	**824,571**	**386,402**	**85,530,335**	**0**	**131,447,313**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	12,487,165	
HTXS	21,913,758	
Total Technical Area Planned Funding:	**34,400,923**	**0**

Summary:
What are the most important activities being undertaken in this technical area?
• Building capacity of and empowering local institutions at the central & decentralized levels is paramount in FY10.
• Diagnosis of OIs, specifically extrapulmonary TB, cervical cancer in HIV-positive women, cryptococcal meningitis & STDs are very much an area of focus.
• Training in histopathology for Rwandans & laboratory accreditation processes to make this a reality & sustainable. (see Laboratory Infrastructure section)
• Focus on couple counseling & follow-up of discordant couples, prevention with positives, & delivery of integrated services & promoting of one stop centre services to improve access to care & improve retention in care.
• Emphasis on diagnosis of treatment failure & targeted viral load testing.
• Moving patients to second line regimens.
• Intensified & decentralized clinical trainings & mentoring.
• Improved quantification of commodities.

What are the key differences from last year?
• Shift in focus from scaling up of additional care & treatment sites to improving the quality of current sites.
• Working on task-shifting in order to improve the ability of current sites to oversee additional patients.
• Integration of services to support the "one stop shop "model, which is client friendly & reduces referrals & subsequent loss to follow-up.

Narrative
According to the 2009 Rwanda HIV/AIDS Epidemiological Update, the median estimate of the number of HIV-positive individuals in Rwanda is 172,673. Of these, 79,877 are estimated to be in need of ART (Source: 2009 Epidemic Update; MOH & CNLS).

Cumulative national totals for 2009 show:
• As of September 2009 73,769 patients in Rwanda were receiving ART, including 46,341 at 157 PEPFAR supported sites (PEPFAR FY09 APR).
• Of the total number on ART, 5,689 (12.27%) are children below 15 years old (PEPFAR FY09 Annual Performance Report).
• Approximately 1% of adult patients were on second line regimens (Source: TRAC Plus, HAS Unit).
• There were an estimated 8,196 new adult HIV infections (Source: 2009 Epidemic Update; MOH & CNLS).

• Approximately 4,181 adults died of AIDS (Source: 2009 Epidemic Update; MOH & CNLS).
• The national ART coverage is estimated at 76%. (Note: Rwanda National Guidelines for ART set threshold for initiating ART at 350 CD4 cell/ml.)
• The 2009 National Epidemiological Update Plan aims to extend ART treatment services to 89% of all HIV positive people in need by December 2011.
• There is no reliable data available regarding the coverage of Co-trimoxazole prophylaxis among eligible HIV-positive patients, either nationally or within PEPFAR-supported clinical settings.

Key Policy Changes during FY08-09:
During FY08 and FY09, Rwanda's National HIV Strategic Plan was developed and disseminated that defines the national objectives, priorities and areas of interest for all HIV programs. In 2009, the National Guidelines for HIV management were updated and identified a Tenofovir-based regime as the first option among first-line ARV treatments. The Guidelines also call for universal ART for HIV-positive children under 18 months. The national HIV projections developed in 2009 are higher than those of previous years and estimate the total adult population expected to be HIV positive by Dec 2011 at 184,994 persons.

Transition of Track 1.0 partners
PEPFAR, under Track 1.0 mechanism grants, started transition processes to local partners in FY09. A Transition Task Force was created with leadership of the Rwanda Ministry of Health (MOH) and the USG. Clinical partners participated in the regular meetings of this task force and contributed to the transition plans developed for the various projects supported by Track 1.0 grants. The first phase of this transition will involve a limited number of sites which will be selected through a detailed and participatory assessment. These health facilities to be transitioned in March 2010 to the management of the GOR, which continues to receive TA and support from the international implementing partners in order to ensure the quality of services is maintained. Every six months an intensive monitoring of the quality of services will be performed, the results of which will guide the next phases of the transition and its expansion to non Track 1.0 grants.

PEPFAR clinical partners are currently supporting the Performance Based Financing system at the health facility level. Track 1.0 grantees will transition this support to the MOH in FY10.

Adult Care and Support
$13,173,264

As of the end of FY09, PEPFAR supported 247 health facilities providing basic care and support services to 120,757 PLWHAs. PEPFAR continues to support existing sites and to integrate, to the extent possible, VCT in to primary health care services in the 22 districts where PEPFAR is the lead donor. USG partners continues to support access to a comprehensive range of basic care and support services, including clinical and non-clinical (prevention, psychological, spiritual, and social) interventions, both at the facility and community levels. To date, the bulk of prevention, care, and treatment services for PLWHA have been provided in the health facility setting, with linkages to community care for other support services offered. Clinical services include: CD4 testing and clinical staging; diagnosis and treatment of common opportunistic infections (OIs); adherence counseling; clinical monitoring; provision of co-trimoxazole, which according to the revised national guidelines will now be offered to all HIV positive people regardless of CD4 cell counts; nutritional assessment and support; prevention counseling, including "prevention for positives"; and referrals to community-based care and support services. In FY09, integration of mental health into HIV services was initiated in a few sites, and this will be scaled up in FY10, with development and dissemination of screening tools and national guidelines by TRACPlus. Social care services continue to be provided primarily through community-based activities, with strengthened referrals to and from clinics.

Clinical partners continue to support community health insurance (Mutuelles de santé) for eligible HIV

patients and their families to enable them to access primary health care services. In addition the partners help support patients' transportation costs, and promote income generation initiatives through PLWHA associations. Nutrition education, counseling and kitchen gardens are supported by all partners to ensure nutrition support. Food by prescription and food to support newly initiating ART patients continue to be an area of need for PEPFAR programs at a national level.

Prevention, psychological, social, and spiritual services in the community are provided through national and international faith- and community-based organizations, as well as associations of PLWHAs, which are present in all of Rwanda's 30 districts. All health care providers (facility- and community-based) continue to integrate prevention messages and appropriate prevention counseling into their activities, particularly for HIV-positive individuals and their families. Specifically, PEPFAR continues to promote a linkages model, which utilizes facility-based staff, community volunteers, Community health Workers (CHWs) and existing health committees at the health facility level. The model focuses on improving communication and coordination to guarantee a continuum of care for HIV-positive individuals and their families and minimize loss to follow-up of patients, particularly in pre-ART services. Robust supervision, monitoring and evaluation of these linkages are essential to ensuring the quality of care.

In FY10, PEPFAR continues to support community-based partners in improving their monitoring so that numbers of family members receiving support are captured in program reporting. In addition to the provision of services, PEPFAR continues to build the capacity of Rwandan non-governmental, faith- and community-based organizations to ensure the smooth transition and sustainability of services by host institutions.

PEPFAR continues to procure basic care related commodities through PFSCM, in coordination with the GOR's central procurement agency, CAMERWA. These supplies include drugs for the prevention and treatment of OIs, and laboratory and diagnostic kits for improved and expanded OI diagnosis. PEPFAR continues to promote coverage of key clinical interventions (co-trimoxizole, bed-nets, safe water products, etc.) which have been demonstrated to reduce morbidity and mortality among PLWHAs. In collaboration with PMI, PEPFAR continues to support the provision of bed-nets for PLWHA and their families through JSI/DELIVER. Provision of point-of-use water purification, "Sûr'Eau" will be supported in FY10 and clinical partners will work towards the integration of safe water into basic care services. With additional resources, some clinical partners will use MCH funds to ensure safe water in facilities supported by PEPFAR. All USG Partners continues to support integration of family planning and MCH initiatives in supported sites, and introduce mental health services according to national guidelines.

In FY10 PEPFAR priorities for care include the use of a family-centered approach for care; improvement of pain management; improved prevention counseling for HIV-positives through the provision of targeted risk reduction and behavior change messages (in both clinical and community settings); support for caregivers; and improved linkages (community to clinic, within clinical services and wrap-arounds). Continuing wrap-around activities in FY10 include: the provision of bed-nets (through PMI), IGA initiatives; support for economic growth and livelihoods; and links to services for gender based violence. Improvement of psychosocial support, including mental health screening and treatment within HIV services, is a rising priority for the GOR and one that PEPFAR plans to support in FY10. Finally, PEPFAR Rwanda will support basic program evaluation activities, including assessment of patient outcomes in pre-ART settings and the impact of community-based clinical services.

Adult Treatment
$22,299,879

PEPFAR supports HIV treatment services in 23 districts but is the lead donor in 22 out of 30 districts in Rwanda. In FY 2010, PEPFAR continues to support all levels of the decentralized ART network, starting from central level institutions and extending to community level health facilities. In addition, PEPFAR

partners continues enrolling patients in ART services at currently supported sites and will expand its services to a limited number of new ART facilities. As the number of patients continues to grow, PEPFAR will carry on its work with GOR and other donors to evaluate and ensure the quality of HIV-related services. This includes programs designed to provide site and program-level feedback regarding quality of clinical services and support at central levels to update guidelines, and the development of training materials and job aids. PEPFAR also continues to provide training and clinical mentoring to assist clinicians to identify patients in need of second-line regimens by evaluating clinical, adherence-related and immunological criteria, as well as the use of targeted viral load testing.

At the central level, the USG continues working with the national Center for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics (TRAC Plus) (TRAC Plus) of the MOH, the National Reference Laboratory (NRL), and other key units in MOH through cooperative agreements and other implementing partners. PEPFAR continues to provide support to MOH to revise national guidelines, tools, curricula, and conduct training of trainers for adult HIV care and treatment. In FY 2010, with PEPFAR funding, MOH will coordinate joint supervisory visits to clinical sites in collaboration with the district health teams (DHTs) to improve data quality and use. At the district level, PEPFAR partners continue providing financial and technical support to their respective DHTs to strengthen linkages, referrals, transportation of patients and specimens, communications, forecasting, drugs and commodities distribution, and financial systems. In addition, PEPFAR partners will strengthen district level supervisory, management, mentoring and reporting capabilities.

In districts where the lead donor supporting some HIV-related clinical services is not PEPFAR but another donor, like GFATM, PEPFAR partners still support establishment of functional linkages that support continuity of care across sites and services, as well as provide TA and resources for supportive supervision. Each partner also is charged with providing direct mentoring and capacity building support to their DHT, thus building capacity to decentralize supervisory and quality assurance activities.

At site level, PEPFAR partners will support national efforts to define a standardized basic package of ARV services through support and development of a coordinated network of HIV/AIDS services linking ART with PMTCT, TB, FP, MCH and other services. Following a tiered approach to service delivery, USG partners will provide comprehensive ART services at larger facilities and basic ART services at satellite health centers. Nurses will serve as the primary HIV service provider at health centers through the implementation of task shifting, and have physician back-up based at the district hospital. PEPFAR continues support of task shifting by strengthening nurse training through pre-service and in-service training, implementation of simplified protocols, and district hospital physicians to support nurses in managing ART cases through regular mentoring visits and remote support via telephone for urgent questions.

At the community level, PEPFAR partners will ensure continuity of care and adherence support through case managers, community health workers (CHWs), and peer support groups. Through community mobilization activities, home visits, community-based registers, referral slips, patient cards and other tools, community health workers will facilitate transfer of information within and between facilities and communities to improve patient retention. CHWs will provide adherence counseling, patient education, and referrals for drug side effect management. PEPFAR partners will provide training and materials to those volunteers and link them to case managers at facilities for better referrals between facility and community.

In FY 2010, PEPFAR continues its efforts to provide nutritional support to eligible adults and pregnant and lactating women, as well as provide supplementary weaning foods to HIV exposed infants. PEPFAR will also support basic program evaluation activities, such as an evaluation of patient outcome in the national HIV care and treatment program.

Technical Area: ARV Drugs

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	11,490,309	
Total Technical Area Planned Funding:	**11,490,309**	**0**

Summary:
ARV Drugs Overview Narrative

What are the most important activities being undertaken in this technical area?
The most important activities that PEPFAR Rwanda is undertaking in the anti-retroviral drugs technical area are relative to providing technical support to the Coordinated Procurement and Distribution System that improve the quantification/procurement of ARVs, pharmacovigilance involving adverse drug reaction notification system and harmonizing the logistics management information system(LMIS).

What are the key differences from last year?
The key differences from last year's ARV program include a stronger focus on monitoring and report through improved forecasting for ARVs and accounting for consumption rates through the LMIS. The increased focus on the National Pharmacovigilance and Medicines Information Center and District Therapeutic Committees will enable for improved capacity building at both national and district levels. The elevated performance of these systems and their functioning are paramount to the success of this program area.

Narrative
The Government of Rwanda (GOR) and its USG partners are committed to scaling up quality HIV/AIDS treatment services to allow universal access to ARVs. Per calculations based on the number of ART supported sites, the USG contributes 55% of funding of ARVs and Global Fund give 45% (7th Coordinated Procurement Distribution System Quantification Report). The many successes realized to date have resulted in reduced HIV transmission and many saved lives. Yet Rwanda's continues to have an ambitious ART scale-up plan to provide high-quality and accessible care to its HIV-positive citizens. Estimation of the future needs and resources required should be done regularly, in order to account for unanticipated changes in (1) the care and treatment program, (2) donor and government committed funds, and (3) the price of inputs due to global markets (The Projected Cost of HIV Care and Treatment in Rwanda 2009-2015).

As of the end of June 2009, 70,234 patients (64,236 adults and 5,998 children) were on ARV medications (TRAC net report data). Each month an average of 1,100 additional individuals are placed on ARVs in Rwanda (over 13,000 per year). In 2008, it was estimated that approximately 150,000 persons in the country are living with HIV (EPP Spectrum Epidemiology 2008).

Adding to the HIV/AIDS treatment challenge, effective July 2009, the use of new and not significantly more expensive Tenofovir (TDF) than the AZT-containing regimen which was used as the first line treatment. This regimen is to be administered to all new patients as well as those already on first-line treatment regimens who experience treatment failure. As many as 13,200 or more patients per year could be on the TDF regimen within a year after it is implemented. According to various projections, the number of adults on ART are expected to rise from about 73,500 in 2009 to 132,000 in 2015 (HIV/AIDS in Rwanda: 2009 Epidemic Update, The Projected Cost of HIV Care and Treatment in Rwanda 2009-2015, EPP Spectrum Epidemiology 2008).

The Central Medical Stores for Rwanda (CAMERWA), TRAC Plus and the Pharmacy Task Force (PTF) work together to forecast, procure, warehouse, store, and actively distribute ARV drugs. SCMS has been supporting CAMERWA to strengthen its warehouse management, stock keeping and financial management systems including the installation of computerized management information systems in order to ensure maximum control over inventory management and the roll-out of active distribution of ARVs. These efforts are intended to minimize the risk of stock outs.

ARV drugs are procured through the Coordinated Procurement Distribution System (CPDS) for 151 PEPFAR-supported ART sites and 63,687 patients. Although there were no reported ARV stock outs of ARVs during FY 2008, emergency orders were placed in three instances to prevent stock outs from occurring. The ARVs concerned were Nevirapine, Lamivudine and Tenofovir. These situations were due mainly in part to incomplete consumption data from health facilities. Due to increased viral load testing efforts in order to identify patients with treatment failure, by the end of 2011, as many as 4,071 (5% of total ART patients) patients could be prescribed new and more expensive second line regimens. The two recommended second line regimens (as per the revised national Standard Treatment Guidelines) (AZT/3TC/LPV-r and TDF/3TC/LPV-r) will cost US $12.42 and $13.33 per patient per month respectively. Prescribing the second line regimens to this number of patients could by itself amount to over US $2.5 million. Close monitoring and coordination with other partners whose financial support helps pay for ARV medications in Rwanda's non-PEPFAR-funded ARV sites, along with ongoing evaluation of the impending regimen changes, will be of critical importance for continued ARV treatment success across the country.

Also being scaled up, coordinated, and integrated are rational drug use, pharmacovigilance, and supply chain management programs. Strategies being utilized to enhance the efficiency and effectiveness of ARV treatment include the rehabilitation of several district pharmacies and training of pharmacists to address the need for systems for routine medicine safety surveillance and to ensure that protection of public's health. The training will include pharmacists who are members of the National Pharmacovigilance and Medicines Information Center (NPMIC). The NPMIC is based in the PTF within the Ministry of Health (MOH). The goal of the NPMIC is to develop and implement medicine safety surveillance systems that will provide unbiased information, monitor safety and effectiveness, and improve rational use of essential medicines in Rwanda. Efforts during FY 2009 also resulted in the expansion of the Adverse Drug Reaction (ADR) Notification System to all district hospitals, development of the Rwanda Medicines Safety Guidelines, ADR notification form, patient alert card, and medicines information request form.

Building on existing achievements, for FY 2010 there will be continued support of the MOH/PTF with the expansion and further strengthening of the pharmacovigilance system of Rwanda. Support will be provided in the following areas:
• strengthen and support the NPMIC to fulfill all aspects of its mandates and objectives;
• develop a strategy for the decentralization of pharmacovigilance through the planning and implementation of cascade trainings utilizing the TOT approach and supportive supervision; and
• consolidate and strengthen the approach of District Therapeutic Committees(DTCs) as part of the strategy for the decentralization of pharmacovigilance at the district level by providing trainings and refresher trainings and supportive supervision.

Continued coordination and streamlining of the Logistics Management Information Systems (LMIS) is needed in FY 2010. In order to ensure stock outs do not occur, CAMERWA will be supported in utilizing the newly developed warehouse computer system. In 2008, participants attending a working meeting identified three key functions for LMIS harmonization: forms harmonization, computerization and a Master Product List for coding of drugs and health commodities. The LMIS forms have been harmonized but have not yet been rolled out nationwide. However, the Master Product List has been completed allowing for the initiation of computerization of the LMIS system. LMIS computerization is a large initiative that will involve extensive resources, both financial and human. It needs to be a collective effort, owned

by the Ministry of Health with technical assistance from implementing partners. An implementation team has been assembled to address the challenges of establishing and maintaining this system.

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	1,361,250	
HMBL	3,267,001	
HMIN	1,537,825	
Total Technical Area Planned Funding:	**6,166,076**	**0**

Summary:
Blood Safety

What are the most important activities being undertaken in this technical area?
• Rehabilitating and equipping blood collection sites.
• Strengthening blood donor recruitment.
• Processing and testing blood for transfusion transmissible infections.
• Distributing, storing and utilizing blood by district hospitals properly.
• Training of blood transfusion personnel.
• Supervision and monitoring of blood collection sites and of blood use in facilities.
• Improving quality assurance.

What are the key differences from last year?
Activities supported in FY 2010 are the same as in FY 2009 but with an emphasis on donor notification of test results, improving quality assurance and the appropriate use of blood by facilities.

Narrative
The goal of the National Center for Blood Transfusion (CNTS) of Rwanda is to reduce the risk of medical transmission of HIV and other blood-borne pathogens and to ensure adequate supplies of safe blood and blood products. CNTS is also responsible for all transfusion services in the country. The American Association of Blood Banks has been working in Rwanda since 2006 providing technical assistance to CNTS to improve blood safety. Working in close partnership, AABB and CNTS have been able to improve infrastructure by renovating the main blood transfusion center in Kigali and two regional facilities (Huye and Musanze), and to increase the capacity of CNTS to organize trainings in different areas of transfusion medicine. These areas include: immunohematology, biohazard preventive maintenance, validation of equipment, implement quality management systems, monitoring and evaluation, component preparation, blood safety practices and cold chain management. To support these projects in FY 2009, AABB hired a Blood Transfusion Medicine specialist who is seconded to CNTS to provide technical assistance on a daily basis. It is expected that this position will transfer to CNTS as AABB transitions activities to CNTS in the coming years.

Goals and strategies for FY 2010 will include technical assistance to plan at the national level, strengthen donor mobilization, increase the number of donors, improve recruitment and retention strategies, and implement the MAK computer system. AABB will support increased donor mobilization and expanded blood safety services in all five regions of the country through a knowledge, attitudes and perceptions (KAP) survey. This survey was started in FY 2009 and will be completed in FY 2010. The survey will

provide valuable information on potential donors that will allow CNTS to effectively and efficiently mobilize and retain donors who have low risk related to HIV and other transfusion transmitted infections. AABB will provide technical support for the development of processes and procedures on rational blood utilization and component therapies, as well as the training of physicians on these policies.

Injection Safety
$1,108,263

What are the most important activities being undertaken in this technical area?
• Training of health care personnel in injection safety practices.
• Procurement of injection safety supplies.
• Improving health care waste management.
• Improving monitoring and evaluation for program improvement.

What are the key differences from last year?
Activities supported in FY 2010 are similar to those supported in FY 2009 but with an emphasis on healthcare waste management and improving monitoring and evaluation to improve program performance.

Narrative
The goal of the PEPFAR Safe Injection Program is to prevent the transmission of HIV and other blood borne pathogens by reducing the number of unsafe and unnecessary injections and minimizing contact with infectious medical waste. Epidemiological modeling indicates that hospital-acquired infections contribute to the prevalence of morbidity and mortality of patients who seek healthcare services in Rwanda. Mismanagement of injections and use of other sharps may result in the transmission of deadly infections, such as HIV, Hepatitis B and Hepatitis C to patients and health care providers. However, there has been considerable improvement in the area of injection safety and waste management in health facilities. According to the national cross-sectional survey conducted in July-August 2004 in Rwanda, approximately 28% of the injections observed were about to be administered with un-sterile needles and/or syringes. Following inception of MMIS/JSI project, the situation has improved greatly, although there remains much room for improvement, as 38% of recently visited health facilities had sharps and other wastes in the compound, thus exposing the community to needle-stick injuries. Many health facilities are inadequately equipped with knowledge on injection safety and medical waste management and do not have proper waste disposal facilities.

With PEPFAR support, Rwanda will continue its safe injection activities by reducing blood-borne HIV transmission both inside and outside clinical environments. In FY 2010, the Environmental Health Desk (EHD) of the Ministry of Health will collaborate with JSI/R&T to develop terms of reference in areas which require capacity building. In addition, EHD will organize the training of healthcare workers and waste handlers on injection safety and healthcare wastes. Incinerator operators and their supervisors will also be trained on the use and maintenance of the equipment. The beneficiaries of this training program will be those who have never received training before, particularly newly employed staff. A strategic plan for prevention of infections will be developed to enable healthcare workers and waste handlers to protect themselves against HIV and Hepatitis B. EHD will identify the required materials, consumables and equipment for injection safety and healthcare waste management and link them to the procurement organization SCSM, which will in turn ensure the procurement of needed items in sufficient quantities and of the appropriate quality.

EHD, in association with JSI/R&T and key partners, will begin the construction of multipurpose waste pits and the installation of appropriate incinerators for the disposal of medical waste. Guidelines and specifications for waste pits and incinerators will be provided through a joint effort by EHD, the World Health Organization and John Snow, Inc. EHD will also organize training workshops for Community

Health Workers throughout the country and equip them with the knowledge necessary for them to sensitize communities on injection safety and best practices for medical waste.

In FY 2010 JSI/R&T, the USG and EHD will conduct joint supervisory visits to assess injection safety and medical waste management practices in health facilities and district hospitals. Monitoring and evaluation will be carried out to ensure the smooth and successful implementation of activities as well as determining areas which require immediate action. Data collected will be used for an analysis of program performance as well as for the preparation of management documents for program officers. Given that EHD will soon be taking over the responsibility of managing injection safety and medical waste management activities from JSI/R&T, EHD will be deeply engaged in all aspects of the implementation and evaluation of this program.

Male Circumcision
$1,430,000

What are the most important activities being undertaken in this technical area?
• Develop tools and guidelines related to MC.
• Train providers on MC.
• Customize appropriate messages to the populations targeted for MC.
• Develop indicators for program effectiveness.

What are the key differences from last year?
• Stronger focus on training more providers on MC.
• Integrating MC messages into a comprehensive HIV prevention package.
• Procure supplies and equipment.
• Perform M&E of MC program activities.

Narrative
The World Health Organization (WHO) and UNAIDS recommend that male circumcision (MC) be made available in countries highly affected by HIV/AIDS to help reduce transmission of the virus through heterosexual sex. According to published studies conducted in Uganda and Kenya, routine MC could reduce a man's risk of HIV infection through heterosexual sex by 65%. According to WHO, implementing MC programs in sub-Saharan Africa could prevent about 5.7 million new HIV cases and three million deaths during the next two decades if combined with condom usage, responsible behavior, and knowing the HIV status of one's partner. WHO encourages countries in Southern and Eastern Africa where HIV rates are high and circumcision rates are low to provide access to no-cost MC, for men age 13-30 and to consider adopting MC as "an important and urgent" health priority. Rwanda would benefit from MC as an additional HIV prevention strategy because it has a low male circumcision rate (2-5%) and a generalized HIV epidemic (3.1%).

The Rwanda PEPFAR five-year strategy focuses on primary prevention, especially among most at-risk populations. The strategy includes promotion of CT services, prevention and treatment of STIs, integration of the role of alcohol and GBV into HIV/AIDS messages and MC promotion in the Rwanda military. To illustrate this targeted, comprehensive strategy, during mobile CT pre- and post-test counseling sessions, individuals testing positive are linked to HIV treatment and community care and those who tested HIV negative (in the military) are counseled on advantages of MC. MC is offered as part of an expanded approach to reduce HIV infections in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted infections, promotion of safer-sex practices and condom distribution. MC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package.

The USG has worked closely with the Rwandan Ministry of Health (MOH) and other donors in a national

task force to develop policy that recognizes MC as an effective HIV prevention method alongside the ABC strategy. The MOH has also requested donor support for the initiation of MC services beginning with the Rwanda military (one of Rwanda's most at-risk populations) with subsequent provision of services to university students and neonates. MOH has already embarked on different activities which include conducting a national health service assessment for male circumcision with a goal of identifying the capacity of health facilities, both public and private, that can provide safe circumcision services and that are also geographically accessible to the general population. The data on health service assessment for MC are being analyzed and the results will be compiled in a report and shared with all stakeholders. In collaboration with the MC TWG and other partners, MOH developed a national Guideline for MC.

In FY 2009, correct communication and messaging to the Rwanda Defense Force (RPF) that benefits accrue over time and that MC does not provide complete protection was emphasized. Communication approaches occurred at the national level through media campaigns that encouraged safe male circumcision as part of a complete approach to prevention, as well as local and inter-personal communication strategies. Attention was paid to socio-cultural context, human rights and ethical principles, health services strengthening, training, gender implications, service delivery and evaluation. Conducting MC in the Rwanda military is considered vital since the military is predominately male, typically young, highly mobile and is considered a high risk group. MC was conducted on voluntary basis on HIV-negative soldiers since preliminary results from a study conducted in Uganda and presented to UNAIDS and WHO officials found that HIV-positive men undergoing circumcision might be more likely to transmit the virus to their female partners if they have sex before the circumcision wounds have healed. TRAC Plus is also conducting a national Knowledge, Attitudes and Practices (KAP) study on male circumcision. The study aims at providing baseline evidences on the knowledge, attitudes and practices regarding MC in the Rwanda general population in order to guide medium and long term strategic program planning. TRAC Plus is developing a trainers' and providers' manual on MC as per WHO guidelines on MC to be extended to health facilities which normally don't provide MC in their minimum package.

In FY 2010, correct communication on MC will continue in the RDF and in addition, TRAC Plus will continue trainings of trainers for all district hospitals, training for all providers in military health facility, rehabilitation of infrastructure, supply equipment for military health facilities and conduct M&E/Data collection. DoD will provide TA to conduct a quick research study on the "Circumcision status of military recruits". In collaboration with Drew University and the Centrale D'Achat des Medicaments Essentiels, Consommables et Equipments Medicaux du Rwanda (CAMERWA), SCMS will quantify and procure male circumcision (MC) kits for Rwandan military personnel. Drew University forecasts that an average of 50 males per week in five sites (250 total procedures per week) will be circumcised. It is thus estimated that 15,000 MC kits per year will be needed. The demand for MC procedures and kits could vary and will be closely monitored. As CPDS increasingly expands to include other commodities, SCMS will support the CPDS to ensure appropriate integration of male circumcision kits into the system, including quantification support, the development of a supply plan, and procurement of male circumcision kits.

These activities address the key legislative issues of gender, especially male norms, and stigma reduction and support the PEPFAR plan by collaborating with the GOR to implement MC as a key strategy of both Partnership Framework and the National Strategic Plan.

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	5,650,081	
Total Technical Area Planned	**5,650,081**	**0**

Funding:		

Summary:
Counseling and Testing Overview Narrative

What are the most important activities being undertaken in this technical area?
• Support the expansion of finger-prick testing and task shifting.
• Support HCT for the general population.
• Emphasize HCT services including access to mobile HCT for drivers of the epidemic such as discordant couples, youth, commercial sex workers and their clients, military and police, and truck drivers.
• Support HCT for families of PLWHA and discordant couples, including follow-up programs for discordant couples.
• Identify high-risk HIV negative persons attending HCT and develop and implement follow-up interventions for this population.
• Enhance linkages for PLWHA and discordant couples to care and treatment services.
• Employ provider-initiated testing for groups at high risk of HIV infection.
• Identify potential HIV incidence hotspots, and intensify delivery of evidence-based interventions for these target populations in areas with high HIV prevalence.

What are the key differences from last year?
• Increased emphasis on task-shifting.
• Emphasis on mobile HCT for itinerant MARPs.

Narrative
In FY 2010, PEPFAR partners will continue to provide counseling and testing services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. Currently, HIV counseling and testing (HCT) is conducted only by trained clinical providers. In order to expand access to service, PEPFAR will support the expansion of finger-prick testing and task shifting in all supported facilities. Support for prevention activities among people living with HIV and AIDS (funded in the HVOP and HBHC program areas) will help to ensure that high quality prevention counseling is routinely provided to all HIV-positive clients.

PEPFAR will continue to support HCT activities for the general population coupled with an emphasis on drivers of the epidemic such as discordant couples, youth, commercial sex workers and their clients, military and police, and truck drivers. PEPFAR will also support HCT activities targeting families of PLWHA and discordant couples.

It is estimated that 2% of heterosexual couples in Rwanda are serodiscordant (DHS 2005). Modeling of DHS data indicates that over 75% of new heterosexually-acquired HIV infections occurred within co-habiting couples (Dunkle et al, Lancet 2008). In FY 2010, PEPFAR will continue to support and expand Couples HIV Counseling and Testing (CHCT). Over 80% of women attending ANC services in PMTCT were accompanied by their partners who were also tested for HIV. Approximately 187,000 couples were tested in 2008. Of these more than 5,800 were identified as discordant, with more than 1,000 in Kigali. PEPFAR will support an evaluation of this initiative and the development of prevention interventions for the negative partners in these discordant couples. All clinical partners will implement a follow-up package of interventions for discordant couples including periodic HIV retesting for the negative partners, provision of condoms and risk reduction counseling, messages for circumcision for male negative partners, linkage to care and treatment for positive partners and options for family planning services. PEPFAR will continue to support performance-based financing to increase both the quality and quantity of testing services being provided to couples.

In order to reach most at risk populations who are less likely to access HCT services at clinical sites, PEPFAR efforts will continue to support outreach HCT. A number of complementary activities with different points of emphasis are planned: 1) Population Services International (PSI) mobile teams will focus on military members, their spouses and families, and will also conduct outreach to high risk youth; 2) through the Transport Corridor Initiative, Family Health International (FHI) will ensure HCT services at SafeTStops for long distance truck drivers, sex workers and their clients, and other mobile groups; 3) FHI will also develop HCT initiatives to identify high risk negatives using a risk score algorithm, and design follow-up interventions for these high risk negatives; 4) PSI, through the Prevention Interventions for Youth and MARPs will provide comprehensive HCT and prevention services at six Youth Friendly Centers (YFC) reaching more than 30,000 high-risk youth through the centers and outreach mobile HCT to MARPs.

Clinical partners will continue to implement HCT in health facilities in 23 PEPFAR-supported districts. Partners will use proven HIV testing approaches like Provider Initiated testing (PIT) for populations with high likelihood of HIV infection. Use of simple innovative testing methods such as finger-prick will be emphasized. Clinical partners will also enhance linkages with community partners for better referrals to prevention, care and treatment services.

These activities will be coordinated to avoid duplication and maximize coverage to most at-risk populations. Counseling and testing provided in mobile settings will follow national guidelines and ensure linkages and referrals to care. Mobile counseling and testing programs will reach 80,000 individuals. PEPFAR community partners will continue to support the promotion of HCT among OVC and their caregivers, partners and families of PLWHA, out of school youth, and truck drivers. This targeted promotion of HCT services will identify those most likely to be infected and ensure they are referred to sites where they can receive testing, counseling, and referral to appropriate care. These activities will contribute to increasing the number of people served by both community and clinical partners.

In FY 2010, PEPFAR will continue its technical and financial support to TRAC Plus for the development of policies, guidelines, and tools. Tools for follow-up interventions for discordant couples will be developed from a formative program evaluation, adapted and disseminated.

With support from PEPFAR and under the coordination of the GOR, partners working in high prevalence areas (such as Kigali) will collaborate to review PMTCT and VCT data suggestive of potential HIV incidence hotspots. Once geographically delimited high-risk populations are identified, GOR (TRAC Plus and CNLS) will coordinate the enhanced delivery of evidence-based prevention interventions to these target groups using existing clinical services. In addition, GOR will intensify and improve outreach through ongoing mobile interventions to these groups.

TRAC Plus will continue to conduct training of trainers and trainings for district supervisors. Quality Control (QC) for HIV testing is performed on 10% of all testing samples throughout the country and is managed and supervised centrally by the National Reference Lab (NRL). PEPFAR provides technical and financial support to the NRL for these activities, which are further detailed in the HLAB program area. In FY 2010, SCMS will continue to support the procurement and distribution of test kits and laboratory supplies for all PEPFAR-supported HCT activities, including lancets to implement the finger prick specimen collection method.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	8,910,246	

Total Technical Area Planned Funding:	**8,910,246**	**0**

Summary:
Health System Strengthening Overview Narrative

What are the most important activities being undertaken in this technical area?
• Strengthening transition of USG activities to the Ministry of Health.
• Harmonization of resource tracking and planning tools.
• Capacity-building to civil society organizations and local NGOs.
• Technical assistance to the MOH financial unit.
• Strengthening performance based-financing.
• Supporting the health system infrastructure Support to the MOH quality management unit and introduction of an accreditation system.
• Support to the national procurement and distribution system.

What are the key differences from last year?
• Transition activities have been introduced.
• Consolidation of awards and increased funding directly to government entities.
• Harmonizing resource tracking processes.
• Strengthening of maintenance unit to procure and maintain equipment countrywide.
• Introduction of active distribution of commodities.

Narrative
HSS Assessment:
A situational assessment of the health system was conducted in 2009 as part of the development of the second Rwandan Health Sector Strategic Plan - 2009-12 (HSSP II). This assessment identified strengths and weaknesses in the seven cross-cutting programs of the health system: institutional capacity (including strategic information and governance), human resources (see HRH Technical Area Narrative), financing, geographic accessibility, commodities, quality assurance, and specialized services and research.

HSS Efforts:
Institutional capacity is being strengthened at four levels: national, ministerial, civil society and community. At the national level, decision-making processes and coordination of donor and MOH activities at all levels through an improved sector wide approach are undergoing review and revision. The USG is intimately involved in this process. Civil society and other ministries have a role to play in institutional capacity building of the health sector but require capacity building and improved coordination. Civil society organizations, while active in the health sector, do not have the capacity to manage GFATM or USG PEPFAR funds as primary recipients. The USG plays a major role in providing technical assistance to realize this goal. At the community level, introduction of initiatives, including motivation and training of 30,000 community health workers, is underway.

Currently, the majority of health system financing is provided by external donors. The mini-budget for Jan-June 2009 estimated that development partners provided 67% of financing, excluding sector budget support. While Rwanda is committed to supporting its health system without external support, it is likely that USG and other donor support will be requested for several years. Rwanda introduced performance-based financing (PBF) in 2006, which coincided with an improvement in quality of health services. The USG both supports the development of tools and guidelines at national level and purchases HIV indicators at facility level. The social health insurance scheme, Mutuelle de Santé (Mutuelles), was introduced to increase financial accessibility to health services in Rwanda, and currently covers

approximately 68% of the population (DHS 2008).

Initiatives to improve geographic accessibility of the population to health services are aimed at both increasing the services available at static points and increasing the numbers of community health workers who can reach out to those who are not attending the static facilities. The present target of the MOH is for everyone to have access to a health facility within one hour (walking), for all health facilities to have access to electricity and safe water by 2012 and for 60,000 community health workers to be trained and supported. The GOR, along with other partners, continues to invest in construction and rehabilitation to achieve this goal. The major challenge to improving geographic access through improvements in infrastructure, equipment and transportation, is insufficient funding.

Maintenance of equipment, including laboratory and energy equipment, also remains a challenge. A sustainable maintenance strategy that includes innovative public and private partnerships was proposed by the Ministries of Infrastructure and Health in collaboration with USG and other donors. While the installation of a network of fiber-optic internet cable will assist with communication, some health facilities still need reliable access to power to unlock the full potential for electronic health (e-Health), including telemedicine. A national campaign to train and motivate 30,000 community health workers was launched as a complementary approach to improve health service utilization.

Although the availability of quality drugs, vaccines, and consumables in the health facilities has improved, stock-outs of certain medicines, including those for treating OIs, still occur both at national and district level. These stock-outs are due to several factors, including lengthy procurement procedures, lack of a national Logistical Management Information System, insufficient funds and inefficient financial management. Costs are not always recovered and health facilities cannot provide non-subsidized drugs and consumables. Patients do not always receive correct treatment due to non-rational use of drugs, which can lead to side effects, resistance, drug dependency, increased costs and prolonged hospital stays. The USG is supporting the national procurement and distribution system (CPDS - discussed under LAB and HTXD) and directly procures HIV related drugs and commodities.

Ensuring high quality of services provided and education of health professionals are key concerns in Rwanda. In addition to results-based financing and social insurance, strategies to improve supervision, accreditation, and quality are in various stages of development and implementation at each level of service delivery. The challenge is to harmonize these efforts and to include quality measurement guidelines in educational institutions.

With the transition of Track 1.0 partners occurring this year (discussed under HBHC and HTXS), it is important that the quality of care in these sites is carefully monitored in order to ensure the continuation of quality care.

HSS Accomplishments to Date:
Since its inception in FY 2004, PEPFAR has invested significantly in the various strata of capacity building. Support has been provided for policy and guideline development, national and sub national planning, the piloting and implementation of these policies and plans and monitoring at all levels. PEPFAR activities are restricted to and support the implementation of the HSSP II in line with the principles of donor harmonization. Cross-cutting capacity building activities have contributed collectively to the dual objectives of building the GOR's capacity for providing HIV services and advancing the sustainability of the PEPFAR program.

Technical assistance has been provided at the national level over the past 5 years in order to support the semi autonomous organizations and units of the Ministry of Health. At the organizational level, PEPFAR has similarly supported capacity building for Rwanda NGOs since FY 2004. The strategies used include financial and management assistance, skills-building in specific technical areas, and development of

commodities and logistics systems.

System Barriers to Accomplishing PEPFAR II Goals 4-12-12:
In addition to the barriers described above, challenges exist at each of the levels. While leadership is strong with a keen understanding of challenges, capacity for planning, management and implementation of the national plans remains a challenge. The MOH operates with a skeleton staff unable to implement the ambitious decisions and strategies that are proposed to improve the health system. Planning and resource tracking is conducted with wide representation and transparency, but the multitude of financial reporting systems causes time to be diverted from implementation of the national plans. The MOH procures and installs equipment including energy equipment in its health facilities. The GOR shows commitment to realize the goals of the national plan and strategy to provide all health facilities with water and energy by 2012. However, there is no national infrastructure plan and under-funding and competing priorities prevent the necessary infrastructure development.

Focus Areas for FY 2010:
In FY 2010, PEPFAR will continue to support ongoing capacity building activities. Additionally, new activities will be funded in the areas of governance, financing, infrastructure support and management, and quality assurance. Support for strengthening at decentralized levels will be emphasized. In line with the Partnership Framework 2009-2012 and its Implementation Plan, there will be more focused attention to technical assistance and systems strengthening through all PEPFAR-funded programs in Rwanda. All technical assistance will have clear terms of reference, objectives, and outcomes that support systems strengthening and transition of USG activities to National ownership.

Governance and financing:
PEPFAR will support health systems strengthening at each of the four levels. Under the recently awarded Integrated Health Systems Strengthening (IHSS) project, MSH will provide support to GOR to strengthen coordination at the central level among national Ministries and offices within Ministries as well as between the central level and the district level in line with the decentralization policy. In support of the Track 1.0 three-year transition, PEPFAR will continue to provide support to the MOH Coordination Unit to ensure that transition activities proceed smoothly and according to plan. To complement these activities, and in collaboration with members of the Expanded Sector Support Donor Group, harmonization of resource tracking and planning tools will be supported in FY 2010. In 2010, PEPFAR will increase its capacity-building support to CSOs and other local NGOs. The objective of this new activity is to ensure that CSOs and other Rwandan organizations have the capacity to work effectively with GOR entities to plan, oversee, and report on HIV services in Rwanda, ensuring meaningful community participation. At the individual level, legal support to PLWHAs will be strengthened through continued training of paralegals.

In 2010, PEPFAR will continue to provide technical assistance to the MOH financial unit through the IHSS project and the MOH cooperative agreement to improve its capacity for cost reduction, revenue generation, and cost-sharing of services. Technical assistance will be provided to the districts for developing improved mechanisms to help them generate, plan, manage, and be accountable for funds. PEPFAR will support the strengthening of Rwanda's performance-based financing (PBF) approach in several ways in FY 2010. In line with the vision for PEPFAR II to ultimately transition activities to national management, PBF HIV indicators for USG-support health facilities will be purchased through direct funding to MOH for the Track 1.0-funded PEPFAR partners. This experience will inform future efforts to transition PBF activities directly to GOR. Support will also be provided for the development of pre-service training modules on PBF for all relevant health professionals. In order to bolster capacity for counter-verification of PBF evaluations, PEPFAR will co-design and work with GOR to reach consensus on a strategy to use civil society organizations for PBF substantiation.

Geographic accessibility:
In FY 2010 PEPFAR will continue to support improvements in the health system infrastructure through

procurement of energy, laboratory, and medical equipment and for electrification of all USG supported health facilities that are not catered for by GOR and other donors. Support will also be provided to strengthen the GOR's ability to maintain energy, laboratory and medical equipment through the provision of skill-building technical assistance through the MOH to district technicians. Technical assistance will also be provided to managers at district level to increase their capacity to manage energy at health facilities. Infrastructural development in key areas will be supported in FY 2010 to improve coordination of MOH activities and to improve quality of teaching at the National University of Rwanda.

Quality assurance:
In FY 2010, through the IHSS award, MSH will provide technical assistance to all levels of the GOR health system to support harmonization of quality management strategies. This includes provision of staff and TA to the MOH quality management unit for implementation at the central level. Also at central level, MSH will develop training modules and train a core group of trainers and district staff. PEPFAR will also support implementation of the harmonized quality management model in all health facilities in a manner that ensures engagement of the community as an equal partner in managing quality. TA at the central level will support the incorporation of QI modules, including leadership and management, into the pre-service curricula of health professionals. To further harmonization, MSH will provide TA to support the integration of quality measures into the routine HMIS.

Other FY 2010 quality assurance support activities are focused on accreditation as well as monitoring and evaluation of the first stage of transitioning HIV/AIDS activities from USG partners to GOR. In FY 2010, PEPFAR will provide technical assistance to GOR for the development of an accreditation system for health facilities and a process to ensure that health facilities adhere to norms and standards. In order to provide the foundation for monitoring the quality of care during the transition of services from the Track 1.0 partners to GOR, PEPFAR will support a baseline evaluation at the district level in FY 2010.

Leveraging and Spillovers:
In Rwanda USG PEPFAR health systems activities support those in the National Plans in tandem with the GFATM NSA. Working through the national Technical Working Groups, gaps in implementation of the national plans, not funded through other donors are identified and supported through PEPFAR. More commonly, however, PEPFAR works in collaboration with other donors and with the GOR. Examples of collaboration include: resource tracking assessments, strengthening and harmonizing quality management, support to the national energy plan, equipment maintenance. The details have been described in the sections above.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	10,070,097	
Total Technical Area Planned Funding:	**10,070,097**	**0**

Summary:
Laboratory Infrastructure Overview Narrative

What are the most important activities being undertaken in this technical area?
• National laboratory policies for minimal laboratory standards for each tier of the laboratory network.
• Integration of clinical diagnostic laboratory services.
• Plans for harmonizing and maintaining laboratory equipment.
• Inventory management and national forecasting of laboratory supplies, reagents and test kits.

• Plans for quality assurance programs.
• Human capacity development.
• Standards for and implementation of a laboratory information system.

What are the key differences from last year?
The activities of this plan are similar to those of previous years but with a stronger emphasis in promoting a laboratory information system for data management for program improvement.

Narrative
The FY 2010 PEPFAR laboratory strategy continues to build on a tiered national laboratory system for creating sustainable infrastructure to support care and treatment of HIV-positive patients. The funding from FY 2010 will provide support and technical assistance to four key GOR institutions: 1) National Reference Laboratory (NRL); 2) University Teaching Hospital of Butare (CHUB); 3) University Teaching Hospital of Kigali (CHUK); and 4) Kigali Health Institute (KHI). A five year strategic plan for the NRL was established in 2006 and revised in 2009 and PEPFAR activities support that plan. The program plans to work with the MOH to further develop this plan in cooperation with the President's Malaria Initiative (PMI), Global Fund (GFATM), World Health Organization (WHO), World Bank (WB) and other in-country stakeholders.

The national laboratory policy and strategic plan will include, but not be limited to, the following activities:
• national laboratory policies for minimal laboratory standards for each tier of the laboratory network;
• integration of clinical diagnostic laboratory services;
• plans for harmonizing and maintaining laboratory equipment;
• inventory management and national forecasting of laboratory supplies, reagents and test kits;
• plans for quality assurance programs;
• human capacity development; and
• standards for and implementation of a laboratory information system.

Using this approach will provide a strategic vision and a better understanding of the function of laboratory partners in-country, appropriate coordination of funding and a dedication of resources for increasing laboratory infrastructure where the greatest needs exist.

In FY 2010, the PEPFAR will continue to support the NRL to strengthen linkages in the national tiered laboratory system. This includes laboratories in the national system that are linked from NRL to regional sites to district hospital sites to primary care site laboratories. The laboratory network in Rwanda is comprised of 364 health centers, 43 district hospitals, numerous private laboratories and 5 regional laboratories and 2 university teaching hospital laboratories. NRL will continue to improve the following infrastructure systems: financial, coordinated procurement, overall quality assurance, laboratory networks and referrals, and laboratory information systems. NRL will continue to support human capacity development through specialized training and ongoing technical assistance with special emphasis in FY 2010 on new HIV test technologies to define a new HIV testing algorithm using finger prick method for blood collection, training non-laboratory personnel to perform rapid HIV testing using finger prick method of blood collection and new lab technicians for OI diagnosis and continue to improve the HIV prevention, care and treatment, TB and malaria quality assurance programs.

The early infant diagnosis (EID) program currently supports 168 PMTCT sites in FY 2009 to collect dried blood spots (DBS) from children born to HIV-positive mothers. In FY 2010, the program will be scaled up to support a total of 160 PMTCT sites. In FY 2010, the program will train 399 nurses and lab technicians in DBS collection to support the continuation of scale up of infant testing.

The USG will fund the laboratory coalition partners [Association of Public Health Laboratories (APHL), American Society for Clinical Pathology (ASCP), Clinical Laboratory Standards Institute (CLSI) and the

American Society for Microbiology (ASM)] to support the NRL. These partners will provide technical assistance to NRL to develop procedures and standards, to obtain international laboratory accreditation and to implement OI and STI diagnostic assays, testing for surveillance and testing to support outbreak investigations. ASCP will be engaged in developing human capacity through curriculum improvements to standardize in-service training materials and to expand support for pre-service training of laboratory technicians at Kigali Health Institute (KHI). ASM will partner with Columbia ICAP and work closely with NRL to improve TB culture laboratories and to strengthen TB and malaria quality assurance and quality control. ASM will also work to improve the laboratory support for the diagnosis of OIs and STIs and testing for disease outbreaks and surveillance. CLSI will work with the NRL to develop laboratory policies and standards and to finalize the new 5-year strategic plan. A CDC consultant will provide technical assistance for better management of the immunology/virology unit and the tiered laboratory system.

In FY 2010, CDC will continue to support sustainable laboratory systems by providing TA for training in OI diagnosis with emphasis on MDR, extra pulmonary TB, cancers in HIV patients and parasitic infections at CHUB and CHUK. At 5 regional clinical diagnostic laboratories, NRL will provide training in new techniques to support program evaluation and surveillance and molecular virology techniques for HIV drug resistance surveillance. The USG will continue to support long-term technical positions at the NRL to assure quality HIV-related laboratory services through training and day-to-day mentorship of NRL staff. The USG will also continue bolstering management and financial capacity at the NRL by maintaining the long-term laboratory management advisor position and implementing a laboratory information system for tracking specimens, data management and reporting functions.

The Government of Rwanda (GOR) is planning to develop a new organizational structure for the Ministry of Health (MOH). This new structure is referred to as the Rwanda BioMedical Center. This new center will encompass all of the institutions within the MOH including the National Reference Laboratory. This new organizational structure will require new infrastructure for the MOH and all of its institutions. The NRL will be able to increase its available space and expand laboratory services. In FY 2009 and into FY 2010, the NRL will develop infrastructure plans for the National Reference Laboratory and for the Rwanda Laboratory Network. This infrastructure plan will be a collaborative endeavor as the World Bank is committed to assisting the East African Community to build laboratory infrastructure and improve laboratory services for the region. With this new collaborative effort, laboratory services will improve greatly in the near future.

In FY 2010, the Partnership for Supply Chain Management (SCMS) will be responsible for the procurement of all laboratory commodities purchased by PEPFAR through direct support to Centrale D'Achat des Medicaments Essentiels, Consommables et Equipments Medicaux du Rwanda (CAMERWA). CAMERWA is responsible for the procurement, storage and distribution of all medicines, equipment and laboratory supplies. This consolidated approach to procurement will increase cost savings and improve efficiencies in procurement and distribution of commodities. It also supports building infrastructure within the country to support distribution of laboratory commodities. SCMS will also continue the support of the Coordinated Procurement and Distribution System (CPDS) and logistics management activities to ensure smooth functioning of the CPDS system, quality data for quantification and strong communication between districts and CAMERWA. SCMS will work with the NRL to develop a logistics management information system that will support the procurement and quantification of reagents and supplies in Rwanda.

The USG is working with NRL to establish standard practices which will facilitate more efficient delivery of services; there are no explicit policy barriers inhibiting development of a highly functional national network.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	12,405,354	
Total Technical Area Planned Funding:	**12,405,354**	**0**

Summary:
(No data provided.)

Technical Area: OVC

Budget Code	Budget Code Planned Amount	On Hold Amount
HKID	12,157,200	
Total Technical Area Planned Funding:	**12,157,200**	**0**

Summary:
OVC Overview Narrative

What are the most important activities being undertaken in this technical area?
• Building the institutional capacity of local CBOs working to give vulnerable groups access to essential services;
• Building more resilient families through economic and social coping mechanisms;
• Building GOR capacity at both central and decentralized levels for better program coordination, monitoring and beneficiary identification; and
• Supporting and strengthening existing natural social linkages in the community for child protection, care and support;

What are the key differences from last year?
• Service provision tailored to the needs of the beneficiaries;
• Market responsive technical and vocational training and education;
• Economic and productive capacity of vulnerable households;
• Beneficiary identification and the creation of an a national OVC database; and
• Sustainable and age-appropriate minimum package of services.

Narrative
According to projections released in July 2009 by the National Institute of Statistics, Rwanda's total population in 2010 will be 10,412,485, of whom 42% will be children under the age of 15 (and 53% under 20). The double impact of genocide and AIDS has resulted in Rwanda having one of the highest proportions of orphans in the world. However, 16 years after the genocide, the majority of orphan cases in 2010 will, according to UNICEF, be attributable to HIV/AIDS. The 2007 Rwanda National Plan of Action for OVC estimates that there are 1,264,000 OVC in Rwanda, of whom 820,000 are orphans of all causes. The UNAIDS country report for 2008 puts the number of orphans due to AIDS in Rwanda at approximately 220,000. An additional 19,000 are children aged 0-14 living with HIV/AIDS.

In Rwanda, PEPFAR is the primary donor in OVC service provision and focuses on beneficiaries aged 0-17 infected or affected by HIV/AIDS. UNICEF, the other major international donor working with OVC in Rwanda, focuses only on central level TA and provides no direct services. As of September 2009, USG

assistance had reached 75,040 OVC, a 42% increase from the previous fiscal year, with a menu of services that mirror those of the GOR, including school fees, vocational training, health insurance, protection, psychosocial support, shelter and care, and HIV prevention education.

In FY 2009, a cooperative agreement was awarded to CHF international to implement a 5 year social services for vulnerable populations project, Higa Ubeho ("be determined and live"). Higa Ubeho is playing the lead role in coordinating USG efforts to assist OVC and their families as well as assisting the GOR with strengthening of district and sector level children's forums and orphan care committees. These efforts are ensuring the participation of children and local leaders in OVC activities as well as coordination of services for OVC. In FY 2009, OVC programming is using a model of service delivery through nine Rwanda Partner Organizations (RPOs) that will be scaled up in FY 2010 to include 17 RPOs in 20 districts. This model ensures that identification of beneficiaries is transparent, services are appropriate, and the program is sustainable as local capacity is built and strengthened through on-going skills transfer.

In FY 2009 all Track 1.0 OVC projects (currently serving 9,500 beneficiaries in 14 districts) will close out. To ensure a smooth transition for those still needing support, the Higa Ubeho project is planning to select Track 1.0 beneficiaries in eight districts that overlap its operational zone, while engaging GOR to pick those in the remaining six which overlap Global Fund supported districts. This overlap will ensure continued support to OVC and the retention of PEPFAR targets.

In FY 2009 the NPI funded FXB International implemented a village model of care and support. This model aims to improve the long-term well-being of OVC by reinforcing the capacities of families affected by HIV to meet their own needs and those of OVC in their care. The FXB model ensures that households are capable and committed to gradually meeting their daily needs such as healthcare, nutrition, and education of OVC by assisting them to start and expand micro enterprises and providing them with in-kind resources, training, support and supervision. As a result, FXB plans to reduce healthcare and education support by 25% in FY 2010 since the household businesses will be expected to generate regular income and the caregivers able to make savings and access micro-credit.

The Rwanda Youth Program (RYP), implemented by EDC, commenced its activities in FY 2009 and will expand in FY 2010 to provide 4,000 youth, including OVC, with market-relevant life and work readiness training and support, hands-on training opportunities, and links to the employment and self-employment job market. In FY 2010, RYP will also build the capacity of local partners to ensure that participating youth are linked to sustainable livelihood avenues either through education and training or employment and/or micro enterprise. To ensure OVC access to legal aid, PEPFAR will continue funding Avocats Sans Frontieres in FY 2010 to work with the Rwanda Bar Association and other civil society organizations to provide legal services to vulnerable groups.

In FY 2010, the overall strategy for providing services to OVC will include implementing partners directly providing OVC services or referring them to other care and support programs in PEPFAR districts. All OVC partners will focus on ensuring that as many OVCs as possible have access to and complete the nine-year education cycle at public institutions. Additionally, partners will work to ensure programmatic efficiencies in order to ensure the largest number of OVCs can be reached. PEPFAR and its partners will continue as active members of the OVC technical working group (TWG), which coordinates quality OVC programming with other stakeholders, such as UNICEF, UNAIDS, other international agencies, and local civil society organizations. The OVC TWG will, in FY 2010, scale up the use of the Child Status Index (CSI) following its successful piloting in the previous fiscal year, by training more front-line users from different implementing organizations. Service delivery and quality of care will be improved by analyzing data collected using the CSI, which is expected to provide a more comprehensive understanding of the needs of OVC and their families and better targeted responses. Higa Ubeho will oversee the task of significantly increasing the number of beneficiaries by providing the needed technical and programmatic assistance to allow local partners and communities to take the lead in providing OVC services.

In FY 2010, OVC partners will work closely with care giver groups, faith-based organizations (FBOs), and PLWHA associations to provide technical training in OVC care and support as well as institutional capacity building for these community-based organizations (CBOs0. Implementing partners will use the household centered approach which links OVC services to the family unit caring for OVC. In an effort to sustain the gains made by PEPFAR, the focus of OVC programming in FY 2010 will be to strengthen households' socio-economic capacity to care for OVC through scaling up of IGAs and saving schemes. Implementing partners will mobilize communities to increase their participation in OVC care, monitoring and evaluation. To ensure that the children most affected by HIV receive a comprehensive package of services tailored to their needs, PEPFAR partners will advance the network model by linking HIV/AIDS clinical and community partners, and by connecting affected families with wrap around activities and with non-HIV/AIDS services which are supported by other funding streams. Through these linkages, the GOR and USG clinical partners will identify, treat and follow-up HIV positive OVC.

To assist in building GOR capacity to coordinate the OVC program, PEPFAR will continue supporting a full-time staff position at MIGEPROF in FY 2010. Capacity-building priorities will include policy and legal reform, government and civil society coordination, service standards, and monitoring and evaluation. PEPFAR will also strengthen GOR's central and local level capacity to coordinate, monitor and evaluate OVC services by supporting the design, development and deployment of a comprehensive electronic beneficiary database to track service provision in the districts. This database will reduce duplication of effort by making it easier for district officials to monitor OVC receiving services, levels of support and the geographic coverage of services being provided by different organizations. PEPFAR support will also help to strengthen and streamline community level OVC identification.

The PEPFAR OVC strategy will rely heavily on leveraging other sectors to provide optimal services to the affected population, wraparound programming and adopting best practices. PEPFAR activities for OVC will wrap around PMI, microfinance, education, youth employment, food assistance, HIV prevention and testing and counseling (TC) activities to ensure integration and linkages with other USG funded/PEPFAR activities. In FY 2010 the Higa Ubeho, ROADS II, FXB, and Rwanda Youth Program will reach an estimated 63,451 OVC with a need-based, age-appropriate minimum package of services, including healthcare, education and vocational training, protection, psychosocial support, food and nutrition, shelter and care. These partners will also train 8,360 caregivers/mentors on care and support for OVC.

These activities have been developed through a consultative process with all stakeholders under the leadership of GOR and guided by the Strategic Plan of Action for Orphans and other Vulnerable Children 2007-2011 and the National Strategic Plan on HIV and AIDS 2009-2012. The FY 2010 activities have been informed by and are in line with the proposed Partnership Framework between the USG and GOR as well as PEPFAR II vision of sustainable and country-owned interventions.

Technical Area: Pediatric Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
PDCS	2,215,873	
PDTX	2,291,760	
Total Technical Area Planned Funding:	**4,507,633**	**0**

Summary:
Pediatric Care & Treatment Overview Narrative

What are the most important activities being undertaken in this technical area?
The most important activities that PEPFAR Rwanda is undertaking in the HIV Pediatric care and treatment technical area include:.
• Continued support to existing care and treatment sites to offer a comprehensive package of pediatric HIV care and treatment services.
• Revision and dissemination of guidelines, tools, and training materials used in HIV pediatric care and treatment programs.
• Refresher training for trainers and training of providers on task shifting in PEPFAR -supported health facilities.
• Maintain and reinforce quality of services through supervision and mentorship.
• Support two pediatric HIV care and treatment centers of excellence (COEs) located at the University teaching hospital in Kigali (CHUK) and at the Butare University teaching hospital (CHUB).
• Support provider-initiated testing at all pediatric in- and outpatient settings at PEPFAR supported sites.
• Reinforce psychosocial support for HIV-positive children and adolescents through promotion of children and adolescent support groups in order to address issues around status disclosure and adherence support.
• Integrate HIV pediatric care into guidelines related to the integrated management of childhood illness.
• Continue to give nutrition support to HIV-positive infants, children and adolescents through nutrition counseling using the food by prescription model.
• Support referrals for all HIV-positive children to malaria prevention services, including referral for the provision of long-lasting insecticide-treated nets (LLIN) and integration of home-based management of malaria, in collaboration with GFATM and PMI; referral to CBO's and other community partners for distribution of water purification kits and for hygiene education; health education; and legal support.

What are the key differences from last year?
The key differences from last year's HIV pediatric program include a stronger focus on:
• Improvement of quality of HIV pediatric program.
• Improvement of psychosocial support for HIV-positive children and adolescents.
• Reinforce CHUK and CHUB as training centers for pediatric care and treatment.

Narrative
It is estimated that 22,020 HIV-positive children under 15 years of age currently live in Rwanda. Most of them have acquired the infection through vertical transmission. In the 2007 sentinel surveillance of women attending antenatal clinics, the prevalence of HIV among pregnant women in Rwanda was 4.3% [3.8-4.5] of pregnant women. According to the 2009 Epidemiologic Update on HIV and AIDS in Rwanda, the projected number of HIV-positive pregnant women in 2010 is 10,600. All infants born to HIV-positive mothers are in need of follow-up services.

Approximately 6,278 HIV-positive children under 15 years of age are currently receiving ART (8.5% of all patients on ART). The USG, the Global Fund, the World Bank and the Clinton Foundation are some of the major donors working with the Government of Rwanda (GOR) to develop and implement programs for HIV-affected and infected infants, children and adolescents. Presently the USG supports HIV care and treatment services at 370 sites in Rwanda, and PMTCT services at 282 sites distributed throughout 23 of the 30 districts in the country. ART services for children are available at 190 of the 282 USG-funded PMTCT sites.

Twenty implementing partners are funded by the USG to provide care and treatment services to children in Rwanda. Approximately 62% of all children receiving ART are enrolled in programs supported by the USG.

The USG, in collaboration with the GOR and Columbia University, has provided funding for the

development of two pediatric HIV care and treatment centers of excellence (COEs) located at the University teaching hospital in Kigali (Centre Hospitalier Universitaire de Kigali, or CHUK) and at the Butare University teaching hospital (Centre Hospitalier Universitaire de Butare, or CHUB). CHUK and CHUB are the two largest referral centers in the country. Renovations for the CHUK pediatric HIV center of excellence were completed in 2008. 5 physicians, 5 trained pediatric HIV nurses, one data manager and one administrative staff work at this outpatient clinic that provides services to 319 HIV-positive children of which 129 are currently receiving ART. 163 HIV-exposed infants are also followed at this site.

Approximately 201 children are in care at CHUB (142 on ART). Personnel from the COEs conduct provider-initiated testing and counseling (PITC) for children admitted to various pediatric wards at both CHUK and CHUB, and it links HIV-positive children and their families to care and treatment services at the COE or at ART facilities closer to their homes. Since FY08, both COEs have been fully operational. They provide clinical services for complicated pediatric HIV cases, and long-distance patient management advice and mentoring. The COEs are also a major training resource for the national pediatric HIV program, addressing the gaps in practical pediatric training for HIV care and treatment providers in the country. Through ICAP, the implementing partner, the two centers will be equipped with libraries in FY 2010.

In FY 2009, PEPFAR has supported TRAC Plus in the revision of the pediatric care and treatment guidelines based on the new WHO recommendations. Implementation of the revised guidelines is ongoing. While progress has been made in scaling up services for children, the pediatric HIV program in Rwanda is still lagging behind in achieving the goal of having children represent 15% of people on treatment. Some of the challenges faced include: lack of sufficient numbers of trained health professionals with experience in pediatric HIV care and treatment service provision; lack of fully implemented PITC for the pediatric population; limited active pediatric HIV case-finding among families of persons enrolled in care and treatment or identified through VCT; limited availability of early infant diagnosis (EID) services; lack of finger-stick blood collection for rapid HIV antibody testing in children; inadequate maternal and infant follow-up services; weak linkages between PMTCT, MCH and ART programs and sites; insufficient emphasis on pediatric HIV in community mobilization activities; and limited linkages between facilities and communities to support follow-up and retention into care of children.

EID and PITC need to be improved and scaled up. The USG will work with the MOH to update, develop and disseminate HIV testing and counseling materials and job aids to support the implementation of PITC for children in Rwanda. There is also a need to improve the management of adolescent care, to support children's nutrition when necessary, to update guidelines for opportunistic infections (OIs) in children, and to systematically screen HIV-positive children for TB. Particular emphasis will be put on the provision of psychosocial support to improve treatment adherence in children. Moreover, pediatric formulations of antiretroviral drugs will be made available in collaboration with Supply Chain Management System (SCMS).

Other identified priorities include: increase the focus of the Ministry of Health (MOH) on the pediatric HIV program; provide additional human resources to the care and treatment unit within TRAC Plus to address the needs of pediatric HIV care and treatment; improve the capacity at TRAC Plus to collect and analyze data on pediatric care and treatment indicators; and harmonize data collection and reporting tools. Data on outcomes of pediatric HIV in Rwanda are lacking, and very limited information is available on the quality of pediatric HIV services, including information on retention, adherence, and treatment failure rates, the adequacy of clinical and laboratory monitoring, and on the appropriate use of second-line treatment.

The USG supports pediatric HIV care and treatment activities at all levels of the health care system. At central level, cooperative agreements and other funding mechanisms with relevant MOH units—TRAC

Plus, National Reference Laboratory (NRL), UDPC, Maternal and Child Health units of the MOH—are designed to build capacity for system strengthening, human resources development, and for improved quality of health service delivery for women and children. At TRAC Plus, the USG provides support for the development and revision of HIV-related guidelines and training materials. Recently updated pediatric HIV treatment guidelines based on WHO recommendations have been disseminated nationally. Training materials with updated pediatric HIV treatment modules have been developed and implementation has begun.

Support to TRAC Plus, UPDC, and district health teams through direct assistance to the MOH and through USG implementing partners will enhance the expansion of quality pediatric services to more decentralized levels of the health care system. The development of integrated management of childhood illnesses (IMCI) training materials by the MCH unit of the MOH in collaboration with BASICS has supported this process. Integration of IMCI in other health services at health facilities will be reinforced during FY 2010 through capacity building and mentoring by health providers.

USG support to the NRL has enabled to develop and increase the capacity of the health care system to provide EID services for HIV-exposed infants. The NRL currently receives dried blood spot (DBS) samples from 346 sites in the country, and it processes approximately 2,064 samples every month. In FY 2010, the USG will continue to provide funding to support EID capacity building by strengthening the NRL and the logistics system, and by ensuring the supply of reagents and sample collection materials. It is anticipated that by January 2010, Butare University Laboratory will become functional as a second lab to process DBS samples for EID. In FY 2010, this lab will be supported to reach full capacity to process DBS samples. EID data collection will be updated and improved. A program evaluation planned for FY 2009 will serve to support further program expansion. Moreover, the USG will continue to work with the NRL, TRAC Plus, the UPDC, and its implementing partners to expand EID access to all PMTCT sites in Rwanda and to reduce the test results turn-around times. The NRL will also receive support from the USG to further expand CD4 testing capacity throughout the country (at present 22 districts have the capacity to process CD4 samples). 15 new CD4 machines will be purchased in 2010 and placed at strategic sites in Rwanda to increase access to CD4 testing for pregnant women and children. The USG will work with the GOR and other donors to secure the provision of EID and CD4 reagents and other commodities for FY 2010 after the ending of UNITAID support to the Clinton Foundation (see laboratory section).

For FY 2010, the USG's strategic approach is to support implementation of HIV care and treatment services for children at all existing and planned USG-supported ART sites in Rwanda. USG-supported implementing partners will be asked to put in place provider-initiated testing at all pediatric in- and outpatient settings at their sites. In addition, USG partners will be asked to implement systematic testing of family members of HIV-positive patients currently enrolled in care and treatment clinics. In collaboration with TRAC Plus, USG implementing partners will reinforce psychosocial support for HIV-positive children and adolescents through promotion of children and adolescent support groups in order to address issues around status disclosure and adherence support. One child counselor per ART site will be trained to organize children support groups.

USG will continue to give nutrition support to HIV-positive infants, children and adolescents through nutrition counseling. Using the food by prescription model, food will be provided in conjunction with HIV treatment and care services in order to increase the effectiveness and coverage of these services and to improve clinical outcomes. This initiative will be linked with ongoing clinical assessments of mothers and growth monitoring of children, and it will leverage nutritional support to OVC and other food programs.

Through a partnership with SCMS, CAMERWA (Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda), the national pharmaceutical warehouse, and district pharmacies, USG will provide health facilities with appropriate ARV drugs, opportunistic infection drugs

and reagents, and support for the development of stock management and distribution.

USG will also support referrals for all HIV-positive children to malaria prevention services, including referral for the provision of long-lasting insecticide-treated nets (LLIN) and integration of home-based management of malaria, in collaboration with GFATM and the PMI; referral to CBO's and other community partners for distribution of water purification kits and for hygiene education; health education; and legal support.

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	5,019,411	
Total Technical Area Planned Funding:	**5,019,411**	**0**

Summary:
PMTCT Overview Narrative

What are the most important activities being undertaken in this technical area?
The most important activities that PEPFAR Rwanda is undertaking in the Prevention of Mother to Child HIV Transmission technical area include:
• Continue to support existing 184 PMTCT site to offer comprehensive PMTCT package.
• Revision and dissemination of new guidelines, tools, and training materials used in PMTCT program.
• Refresher training for trainers and Training of Providers in PEPFAR -supported health facilities.
• Maintain and reinforce quality of services through supervision and mentorship.
• Integrating PMTCT services into existing MCH programs with other MCH services, emphasis on FP.
• Support counseling on infant feeding and procurement of fortified weaning foods that will be provided to all PEPFAR-supported sites (for HIV-exposed infants ages 6-18 months and pregnant and breastfeeding women who need nutritional support).
• Improve HIV exposed infant follow-up, by supporting the implementation of the revised national immunization card which includes HIV-exposure status.
• Support the implementation of the national HIV early infant diagnosis scale-up plan.
• Sustainability of services and improvements in program outcomes.

What are the key differences from last year?
The key differences from last year's PMTCT program include a stronger focus on integration of PMTCT services into existing MCH programs with other MCH services, with an emphasis on FP, as well as improving early infant diagnosis and HIV-exposed infant follow up.

Narrative
The 2005 Rwandan Demographic Health Survey-III (2005 DHS) determined that the mean HIV prevalence rate in women of reproductive age was 3.6% (ranging from 8.6% in urban areas to 2.6% in rural areas). Data from the Interim Demographic and Health Survey 2007 (2007 I-DHS) report shows that 96% of pregnant women attend at least one antenatal care (ANC) visit. The proportion of total births delivered by a health professional increased from 39% in 2005 to 52 % in 2007 (ranging from 70% in urban areas to 49% in rural areas). An HIV sero-surveillance survey among pregnant women attending ANC conducted in 2007 at 30 sentinel sites showed an HIV prevalence of 4.3%. The Government of Rwanda (GOR) has developed a five-year National Strategic Plan on HIV and AIDS 2009 -2012 (NSP) and one of the goals is to halve HIV incidence in the general population by 2012. PMTCT has been identified as an important intervention which will contribute to achieving this goal.

Each year the GOR develops estimates of the burden of HIV infection and updates the HIV and AIDS Epidemiologic Bulletin using the Estimation and Projection Package (EPP) and Spectrum software. According to these models the number of HIV-positive pregnant women eligible for PMTCT in 2008 was 10,540 (range 4,990-16,780). According to TRAC Plus reporting, 68% of HIV-positive pregnant women received prophylactic antiretroviral prophylaxis in 2008. The estimated number of HIV-positive pregnant women eligible for PMTCT services in 2010 is 10,600 (range 4,940-17,210), out of 381,300 pregnancies.

As of September 2009, 363 sites (70.3% of all health care facilities) were providing PMTCT services for pregnant women in Rwanda. With FY 2009 funds, PEPFAR will be directly supporting 184 of these sites in 22 districts. Global Fund was directly supporting 187 of these sites and UNICEF supports 20 of these sites. Of the PEPFAR-supported sites, 115 have PMTCT and antiretroviral therapy (ART) services at the same venue.

The acceptance rate for HIV-testing was 98.3% among pregnant women attending ANC, resulting in 336,623 pregnant women being tested at PMTCT sites from September 2008 to October 2009. Of those tested, 9355 were HIV-positive. In total 9,492 mothers, including seronegative women who have had a seropositive partner received ARV prophylaxis (of whom 38.2% received highly active antiretroviral therapy (HAART), 44% AZT+ Sd-NVP during labour then AZT+3TC for 7 days after delivery and 17.8% Sd-NVP during labour then AZT+3TC for 7 days after delivery). During the same period, PMTCT sites reported 192,619 births (75% of all expected births), including 7,468 births from HIV-positive women. Almost all (90.5%) infants born to HIV-positive women were delivered at a health care facility in a PMTCT site. About 96% of infants born to HIV-positive mothers received NVP/AZT nationally (current Rwanda policy for HIV-exposed infants).

Nationally, partner testing has increased from 13% in 2003 to 84% in September 2009, with approximately 2.64% of partners testing positive. The discordant couple rate is 2.3% among tested couples. Approaches used to encourage partner testing included invitation letters, special week-end VCT days for men, mobilization of men through community health workers and political leaders.

The integration of PMTCT and family planning (FP) contributed to service delivery this year. USG supported the development of the 2009 national level FP/HIV integration work plan, including offering indicators for its monitoring, and scale up of FP/HIV integration at district level. After delivery, HIV-positive women received counseling on FP and as a result, many take contraceptives in the post-natal period. From January to September 2009, 75% of HIV-positive pregnant women identified at PMTCT sites delivered at health facilities and 6,091 (97.8%) mothers received ARV prophylaxis for PMTCT. ARV prophylaxis coverage has improved from 2003 to 2008. As of September 2009, 75% of PMTCT sites were offering more efficacious PMTCT regimens nationally (AZT+Sd-NVP during labor then AZT+3TC for 7 days after delivery for HIV-positive pregnant women or HAART as prophylaxis for pregnant women accessing ANC after 34 weeks; and Sd-NVP for infants at birth or within 72 hours and AZT for 4 weeks after birth).

The GOR, USG, and Global Fund are supporting Early Infant Diagnosis (EID) programs at their sites in order to identify HIV-positive children and link them with treatment as early as possible. Nationally, as of October 2009, 349 sites were offering EID (86%of all PMTCT sites, 51% of PEPFAR-supported sites) and sending dried blood spot (DBS) samples to the National Reference Laboratory (NRL) for processing. From January 2009 to September 2009, 3,905 infants age 6 weeks to 9 months were tested using DBS PCR. At 18 months of age 2,373 out of 2,810 children were tested, of which 4% were HIV-positive.

In FY 2007, PEPFAR started to provide nutrition support to HIV-exposed infants during the weaning period. As of Septembers 2009, a total of 6,000 exposed infants (age 6-15 months) had received the fortified weaning food supplements (corn and soya blend).

Each PEPFAR-funded partner provides a standard comprehensive PMTCT package comprised of same day, opt-out testing and counseling using HIV rapid tests; infant feeding counseling and support; clinical and CD4 count-based staging; provision of HAART for eligible HIV-positive pregnant women; and, combination ARV prophylaxis regimens for non-eligible HIV-positive women. In addition, PEPFAR partners support the use of safe obstetric practices during delivery, HIV testing in labor and delivery wards for women of unknown status, infant and mother follow-up, Co-trimoxazolefor prevention of opportunistic infections in infants and mothers, infant HIV testing and diagnosis when possible, and community-based services. Partners also promote family testing, work to strengthen linkages and referrals between PMTCT and ART programs, and integrate PMTCT services into existing MCH service deliver.

Despite these achievements, the PMTCT program in Rwanda still faces many challenges. These include the need to increase program coverage at various levels of the health system and improve the quality of services (including provision of more effective ARV regimens), relatively low facility deliveries, weak (but increasing) linkages and integration between PMTCT services and MCH and ART clinics, and sub-optimal access to CD4 counts, infant follow-up and EID (including long turn-around times for DBS PCR tests from the NRL to sites). Although Rwanda has high rates of breastfeeding, HIV-positive mothers have difficulty adhering to the recommended exclusive breastfeeding and early weaning, partly because they cannot afford weaning foods. They also lack knowledge of alternative nutrition options for infants and young children and are not receiving sustained infant feeding and nutrition counseling and support.

The Rwandan program will increase efforts to address these challenges in FY 2010. The GOR will extend PMTCT services to all health facilities by end of 2012, provide HIV testing and counseling to 98% of pregnant women, and provide ARVs for PMTCT to 90% of HIV-positive pregnant women. In FY 2010, PEPFAR will maintain direct support to existing sites and support 17 new sites, providing PMTCT services to an additional 15,167 pregnant women. PEPFAR will also continue to support TRAC Plus the GOR and TRAC Plus to update policies and guidelines based on the recent WHO guidelines, implement the new guidelines, improve program coordination and management (including support to decentralization and district involvement), and strengthen capacity.

In line with GOR and PEPFAR goals, PEPFAR partners will ensure that all PMTCT clients receive the standard package of comprehensive PMTCT services at all sites (detailed above). In line with the NSP, the program will support reorganization of districts to increase access to CD4 counts, EID and other lab services. In line with task shifting, the capacity of nurses at PMTCT sites will be increased to effectively conduct ART eligibility assessments and provide ART under the supervision of rotating physicians.

In FY 2010, as part of the first year of transition of Track 1.0 partners' activities, ICAP-CU and AIDS Relief will transition 23 PMTCT sites to GOR. District Health Teams and site level teams will be supported through training and formative supervision to better coordinate PMTCT and other HIV and health clinical and preventive services. This will maximize effective referrals between HIV/AIDS services, improve integration with other MCH services (e.g., distribution of bed nets to prevent malaria, family planning counseling and referral, syphilis screening, nutrition counseling and support) and improve the quality of care at the most decentralized level.

Infant feeding and nutrition will support program models for improving postnatal follow-up, counseling on infant feeding and procurement of fortified weaning foods that will be provided to all PEPFAR-supported sites (for HIV-exposed infants ages 6-18 months and pregnant and breastfeeding women who need nutritional support). This initiative will be linked with on-going clinical assessments of mothers and growth monitoring and clinical assessment of early-weaned infants and will leverage OVC and other food programs.

PEPFAR will further expand child follow-up and EID services, in collaboration with the EPI unit within the MOH by supporting the implementation of the revised national immunization card which includes HIV-exposure status and support to the implementation of the national EID scale-up plan.

PEPFAR and GOR will also strengthen the systematic follow-up of HIV-positive mothers and target the high number of home deliveries by collaborating closely with community workers, political leaders and associations of people living with HIV/AIDS (PLWHA) to promote PMTCT services in their communities, encourage early ANC attendance and promote delivery in health facilities using different models.

Case managers will continue to coordinate facility and community linkages and refer HIV-positive children from PMTCT sites and nutrition centers to ARV services. Male involvement in PMTCT activities will also continue to be supported. Women who are victims of violence will be referred to appropriate care and support.

Sustainability of services and improvements in program outcomes will be promoted through a combination of input technical assistance and output performance-based financing (PBF). Procurement, forecasting and distribution of ART, CTX and other PMTCT commodities will be further strengthened through SCMS, the MOH and the Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda (CAMERWA).

PMTCT and pediatric care and treatment will be included in the HEALTH-QUAL model, which is an integrated model for quality improvement across communicable disease control programs in Rwanda, and in the joint supervisory visits and appropriate laboratory quality assurance for CD4 and HIV testing. TRAC Plus is currently finalizing new indicators which include co-trimoxazole, ARV regimen types, pregnant women on ART and other key program indicators. PEPFAR will continue to support TRAC Plus in the improvement of national M&E capacity for PMTCT and link with other national quality improvement initiatives.

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	3,516,260	
HVOP	5,875,430	
Total Technical Area Planned Funding:	**9,391,690**	**0**

Summary:
Sexual Prevention Overview Narrative

What are the most important activities being undertaken in this technical area?
Targeting groups and geographic locations with highest prevalence, but also programs that employ evidence-based interventions.Activities include a range of behavior change and risk reduction activities, health communication campaigns, life skills building, prevention with positives (PwP), and infrastructure development to transition and to support the GOR in maintaining sustained prevention activities.
What are the key differences from last year?
The approach include a stronger focus on MARPs with the goal of averting as many new infections as possible to reach the national benchmark of halving HIV incidence by 2012. Specific MARPs include Commercial Sex Workers (CSW), Clients of CSW, prisoners, Men who have Sex with Men (MSM),and young women aged 15-24 years.

Narrative

The 2009 HIV and AIDS Epidemiologic Update estimated the median number of infected individuals (adults and children) in Rwanda at 172, 673 (lower: 137,512 and upper: 213,173) with urban areas having a higher prevalence than rural areas (7.3% versus 2.2%, 2005 DHS) and higher levels of risk behaviors. Approximately 3.0% (95% CI: 2.6-3.5) of the Rwandan population between the ages of 15 - 49 are HIV-positive (DHS, 2005). Modeling of DHS data further suggests that over 90% of new heterosexually acquired HIV infections in Rwanda occurred within couples in cohabitation (Dunkle et al, Lancet 2008). HIV prevalence appears higher among those with, at least, secondary school education and tend to vary by employment status; those who are employed showed a slightly higher prevalence than those unemployed (2005, DHS). Compared to the general population, youth (15 - 24) have lower HIV prevalence rates; however, in both adult and youth populations, females carry the burden of HIV.

The differences in HIV prevalence between men and women are striking; for adult women, 3.6% prevalence rate compared to 2.3 % for men; female youth have a 3.9% prevalence rate versus 1.1% for male youth (NSP 2009-2010). Furthermore, for the 20-24 age groups, young women are at even greater risk, likely due to cross-generational sex. Other risk groups include mobile populations who have frequent separation from a main partner or family support structure, men in uniform (military or police), and street or other vulnerable children/youth. Conservative estimates suggest that approximately 1,264,000 vulnerable children live in Rwanda, of whom 820,000 are orphans (2005 DHS and 2002 GOR Census); furthermore, youth comprise 14.7% of PLWHA (Triangulation Training Workshop, 2008).

A June 2009 Modes of Transmission (MOT) model, for the National AIDS Control Commission (CNLS) of Rwanda, predicted that most-at-risk-populations (MARPs) may account for the majority of new infections (27-53%). Identified MARPs include sero-discordant couples (an estimated 7.6% of stable heterosexual couples, in Kigali, are sero-discordant (NSP on HIV & AIDS 2009-2012), female sex workers and clients, prisoners, and MSM. Key factors, that seem to drive the epidemic, are marginalization of MARPs, punitive penal codes affecting MARPs, stigma and discrimination, gender inequity, multiple concurrent partners, non-protective social norms and/or networks, violence against women and girls, lack of comprehensive health services for people living with HIV, low condom use and low male circumcision.

PEPFAR recognizes effective HIV prevention is critical to reversing the global spread of HIV and to safeguarding a sustainable response to the demands of this epidemic. Subsequently, understanding of the behavioral, biomedical, and structural drivers of HIV/AIDS continues to evolve.. The USG approach, therefore, continues to develop strategies to understand and help individuals and communities protect themselves from new HIV infections and live positively if already infected. USG primary and secondary prevention programs combine the core constructs of evidence-based and theory driven interventions with innovative and promising practices to best address HIV/AIDS in Rwanda.

Multiple sexual prevention interventions are being used in Rwanda with the intention of changing behavioral and social structural characteristics related to risk by influencing attitudes,skills, normative perceptions, and other mediators. Beneficiaries of sexual prevention activities include the general population, but also focus on risk groups and MARPs; for example, there are prevention activities targeting OVC, in and out of school youth, low income women, sex workers and clients, truckers and other mobile populations, seasonal workers, men in uniform, and other community members in identified 'hot spots.'

Worrisome trends continue to emerge from certain high risk groups. Recent mobile VCT with CSWs from Kigali showed very high prevalence rates of HIV. A model of optimum program targeting and selecting the appropriate mix of interventions will be developed.The program will employ a mix of condom promotion, one-on-one risk reduction counseling, periodic screenings and treatment for sexually transmitted and HIV testing.

In order to understand the magnitude of the CSW population,strategic SI activities to determine size (size estimation) and locations (mapping) of sex worker hotspots.For this to be effective interventions will improve the enabling environment for sex workers. Clients of CSWs are among the drivers of the epidemic. However, they make a diverse group to understand. Anecdotal evidence suggests that key groups include: truckers, uniformed corps, mobile men with disposable income, prisoners, etc. In FY 10, programs will continue to provide risk reduction products and services for clients of sex workers.

MSM are 4 times more likely to be infected than the general population. In other African countries, HIV prevalence found to be up to 43% among men reporting sex with other men exclusively. Rwandan HIV policy has not addressed HIV prevention among MSM, primarily due to a lack of data, MSM has been included as a priority risk group in the new NSP 2009-12. A recent study conducted by the National AIDS Control Commission (CNLS) to describe the population of MSM in Kigali and explore the nature of sexual activity between MSM found them to be a very high risk group.In FY2010, a comprehensive package of prevention services for MSM will be developed. Sensitization and training of healthcare providers to provide 'MSM-friendly' services is planned. Male sex work is prevalent in this population, and targeting male sex workers for interventions will be initiated alongside other CSW programming.
Additional prevention activities include community-based alcohol counseling, interventions to address SGBV, job creation as an HIV intervention, promotion of abstinence, fidelity, partner reduction, and related social norms influencing behaviors, targeted behavior change communication (BCC), male circumcision in the military; positive prevention, as well as wrap-around programs with health components and integrated health promotion strategies with family planning services, increasing male involvement, and scaling up VCT (esp. for MARPs), including couples CT, and enhanced condom distribution and promotion.
USG funded sexual prevention programs focusing on abstinence and fidelity (HVAB) have targeted the following key groups: youth 10-18 years old with delayed sexual debut messages and youth 15-29 years old with abstinence and/or partner reduction. Rwanda is unusual in that it is a conservative society where the age at sexual debut among females is 20 years. The USG AB program tries to reinforce this early abstinence occurrence. Outreach to young people is done in a variety of community settings (churches, drop-in centers, rehabilitation centers, schools, associations, and cooperatives). HVAB activities include provision of information on HIV risks and the importance of abstinence as an HIV prevention strategy complemented by life skills to build self-esteem and self-efficacy. These activities also promote partner reduction among MARPs and fidelity among married couples, as well as improved communications skills. In addition, programs include messages that promote gender and male involvement. Both youth and adults have been trained as peer educators to promote HVAB. In FY 2009, for example, 6,800 people were trained to provide AB messages; 1,025,093 people were reached through AB messaging and 1,551,693 individuals were reached through abstinence and/or fidelity messages. The specific interventions used included a range of mass media activities (including, but not limited to, mobile cinema, radio dramas, public service announcements and community theater), interpersonal peer communication and education, outreach to opinion leaders such as teachers, clergy, local leaders and parents (to increase their capacity to support youth in maintaining abstinence), and strengthening of youth clubs, cluster groups to implement BCC activities and schools. AB programs were also extended to the military through AIDS support clubs and counseling and testing services.
Other sexual prevention (HVOP) activities include trainings, condom promotion to prevent HIV transmission, STI management, BCC to reduce risk and improve self-efficacy, as well as other relevant health promotion strategies.Other sexual prevention programs target the following: alcohol use; at risk youth; young women in transactional or cross generational relationships; MSM; mobile populations; members of the military, sex workers and clients, PLWHA and discordant couples. The activities include: provision of quality condoms and information on their use; promotion of counseling and testing-including couples counseling and testing; strengthening of youth friendly centers; male circumcision in the military; positive prevention; and, integration of family planning, gender issues and livelihood into routine prevention activities. During FY 2009, PEPFAR reached more than 1,100,000 individuals with other prevention messages beyond AB and trained 8,849 people to promote condoms and other prevention. In addition, over 8,000 condom service outlets were created/supported to increase access to condoms, especially in 'hot spots' frequented by MARPs. USG, in keeping with MOHs determination to intensify condom promotion, supported a test of condom vending machines in 'hot spot' zones. Other prevention interventions include: a range of high-profile mass media campaigns, interpersonal communication and peer education; community outreach vis-à-vis sports and art competitions; economic empowerment opportunities; capacity building of community clusters and associations (including low income women, PLWHA, youth, fisherman etc.) to implement integrated health services while also addressing underlying

factors that exacerbate risks.
Evidence that new HIV infections and/or risk factors are higher among certain groups (e.g. uncircumcised men, married couples, young women etc), USG strives to support the National BCC strategy to encourage consistent condom use, especially as dual protection. Currently, USG contributes 48% of the total funding cost for male condoms in the country and 85% of the total cost associated with social marketing of condoms.There are more than 20 million branded and non-branded condoms in Rwanda with the majority of those being male condoms. There is little current demand for female condoms due to cultural stigma. USG and GOR collaborate to ensure national availability of condoms, limited distribution problems, and clear policies for national uptake.In FY 2009,condom stock remained solid and there are no foreseeable stock-outs. USGs vision is that cost-efficient effective private sector, public sector, and community-based distribution channels are capable of meeting the demand for high quality, affordable branded and non-branded condoms, and other health products.
USG also supports efforts to promote male circumcision combined with condom usage, responsible behavior, and knowledge of HIV status, to prevent new infections. Rwanda's male circumcision (MC) rate ranges between 2 - 5%. PEPFAR, through the DOD, supports MC within the military and hopes to see future roll out of similar programs among the general populations. Clinical training marked the beginning of the PEPFAR funded MC program. To date 21 counselors have also been trained including extensive site preparation, which included equipment and the provision of supplies;, 8 sites have been visited and are ready to roll-out MC. To illustrate the targeted, comprehensive MC strategy, during mobile CT pre- and post-test counseling sessions, individuals testing positive are linked to HIV treatment and community care and those who tested HIV negative (in the military) are counseled on advantages of MC. MC is offered as part of an expanded approach to reduce HIV infections in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted infections, promotion of safer-sex practices and condom distribution. MC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package.
USG supports the GOR's National Strategic Plan for HIV/AIDS 2009 - 2012 (NSP). The NSP exemplifies the countries dedication to clear health outcomes, shared accountability, results based approaches, targeted interventions that are evidenced-based, address stigma, provide comprehensive packages, and prevention programs, ensure continuity, and reach MARPs. GOR is committed to understanding the dynamics of HIV to gain clear insights into the unique challenges that the epidemic poses to the country, to lead countrywide integration, coordination and harmonization of prevention activities, to identify and address prevention gaps, successes and lessons learned, as well as to ensure that the national strategic plan is based on the most robust epidemiological data to date. Rwanda has set ambitious targets to address HIV/AIDS with the goals of (1) halving HIV incidence in the general population by 2012; (2) reducing morbidity and mortality among PLWHA; and (3) ensuring HIV-positive and affected people have equal opportunities. PEPFAR programs are geared at helping GOR reach its national goals.
In FY 2010, PEPFAR will continue to support integrated prevention activities with key target groups, using emerging evidence and best practices. Increased focus will be on averting new infections by targeting MARPs and 'hot spots' where MARPs are often hidden and harder to reach. To complement prevention activities, increased emphasis has been placed on building national capacity to sustain prevention activities. USG,supports technical and institutional capacity building for a range of RPOs to design, manage, and implement PEPFAR funded activities over time.

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	6,575,622	
Total Technical Area Planned Funding:	**6,575,622**	**0**

Summary:
Strategic Information Overview Narrative

What are the most important activities being undertaken in this technical area?
The most important activities that PEPFAR Rwanda is undertaking in the strategic information program area include support to the development of policies, norms, guidelines and tools; development of in-service and pre-service training of personnel in monitoring and evaluation; institutionalization of data quality assurance; upgrading, harmonization and roll-out of electronic information systems; development of interventions for the promotion of information use in decision making; development of capacity in research; and provision of support in conducting studies, surveys and surveillance activities.

What are the key differences from last year?
New activities in the strategic information program area include the provision of support for the formulation of health research and data sharing policies; the development and implementation of PhD programs in public health; the design and introduction of a harmonized system linking data collection to planning; and the development of standard operating procedures for data management and feedback. New modules will be added to two electronic information systems, and interoperability of some systems will be developed. Also, the second Demographic and Health Survey with HIV testing will be conducted.

Narrative
Context and Background:
Rwanda is at the forefront of many e-Health activities in East Africa, yet the various electronic information systems lack interoperability. Currently the routine health management information system includes data from the government and faith-based health facilities that operate under a convention with the Ministry of Health. However, the system does not include data from national reference hospitals, nor from private clinics and dispensaries.

Health workers have been burdened by excessive demands for data that in most cases are not analyzed or used effectively in planning and management. The limited availability of accurate, timely data combined with a lack of a culture of information use undermines the performance of the health services: managers and service providers are unable to identify needs and problems effectively or make evidence-informed decisions on service development.

The challenges facing the health information system include insufficient human and financial resources for monitoring and evaluation (M&E); the inadequacy of the information and communication technology infrastructure; a lack of a legal and operational framework; a dysfunctional vital registration system; a weak national epidemiological surveillance and response system; and a lack of standardized procedures for data management and of a platform for data sharing.

The USG program has complemented the activities of the government of Rwanda (GOR) and other donors in the development of local capacity in M&E and research by providing technical and financial assistance for the achievement of government's objectives. USG has alleviated the shortage of trained personnel for SI activities by funding M&E positions at the MOH and TRAC Plus. In addition, the USG and the Global Fund have been funding Data Managers at health centers and district hospitals.

In 2005, the GOR conducted a Demographic and Health Survey (DHS) with HIV testing with support from PEPFAR. The next DHS with HIV testing is planned for 2010.

Accomplishments to Date:
With the active engagement of the PEPFAR Strategic Information team and some implementing partners, the MOH drafted a national M&E Policy for the health sector, and also an M&E Strategy for the period 2009-2012. The strategy proposes a conceptual framework for linking performance assessment to a

performance improvement cycle. Establishing strong coordination mechanisms for institutionalizing M&E in the health sector is identified as a priority.

An assessment of the national health information system was undertaken using a self-assessment tool developed by the Health Metrics Network. The selection of a manageable set of performance indicators for the health sector with the participation of stakeholders is a critical step in the restructuring of the routine health information system. This activity, however, was repeatedly postponed.

The Government endorsed an ambitious national e-Health strategy. The design of new electronic information systems and the development of existing ones will be based on a foundation of an integrated e-Health architecture enabling the exchange of data among information systems.

The HIV/AIDS phone and web-based reporting system (TRACnet) funded under PEPFAR was upgraded to integrate new features. A module for PMTCT and VCT was built onto TRACnet and will be rolled out in January 2010. System requirements were defined for an electronic Integrated Disease Surveillance and Response system (e-IDSR). A web-based Partner Reporting System was successfully deployed. User training for all PEPFAR implementing partners in the country was provided thus enabling reporting of the PEPFAR semi-annual and annual results through the system.

Employing a participatory approach, M&E operational plans were developed for both the National Strategic Plan on HIV and AIDS 2009-2012, and for the National Strategic Plan of Action for Orphans and Other Vulnerable Children. The revision of data collection and reporting tools was initiated integrating PEPFAR Next Generation Indicators into the national health information system.

The results of the 2007 Service Provision Assessment Survey were disseminated, and the planning of the DHS 2010 was initiated. A mapping of commercial sex workers and a formative assessment of men who have sex with men (MSM) in Kigali were completed. Protocols were drafted for HIV sentinel surveillance among pregnant women, Behavioral Surveillance Surveys (BSS) among youth and truck drivers, HIV drug resistance monitoring, and for an HIV drug resistance threshold survey among VCT clients. The MOH published the first annual health statistics compendium.

Training of individuals in SI was supported at national and district level through various mechanisms. In total 1,540 individuals were trained in monitoring and evaluation, including 27 individuals who completed the Certificate Training Program in SI at the School of Public Health.

Goals and Strategies for the Coming Year:
USG will provide support for the implementation of the national M&E policy and strategy, and the e-Health strategy. While there is growing interest within public health programs to improve data quality and data management and to promote the use of information in decision making, the leadership of the HMIS Unit of the MOH will be crucial to ensure coordination and collaboration in activity implementation. Also, strengthening the linkages of the HMIS Unit with the MOH departments that are responsible for the implementation of the supervision and quality management strategies in the health sector will contribute to the achievement of national goals.

PEPFAR will support the Ministry of Health in the development of policies for research, and for data sharing and confidentiality in the health sector. Data quality control will be institutionalized. Training of health managers in data analysis and use will continue at decentralized levels. Standard planning procedures and guidelines, as well as data use guidelines for facility and community HMIS will be developed and disseminated.

The deployment of a community level health information system is expected to improve the monitoring of community-based interventions. An independent evaluation of the electronic medical record system

(OpenMRS) is planned while work on the improvement of the system will continue. New TRACnet modules such as the e-IDSR will be rolled out and other modules (malaria, TB) will be developed. The TRACnet system will be upgraded to meet identified new requirements. An interface will be developed between TRACnet and IQChart, an HIV-patient management information system. The Laboratory Information System will be expanded to new sites, and equipment will be procured for district hospitals to make the system operational. The logistics management information system (LMIS) will be rolled out to support the active distribution of drugs and consumables throughout the country. PEPFAR will also support the establishment of a logistics management desk within the Pharmacy Task Force at the MOH, and the staffing of a new e-Health Secretariat at the MOH with 4 e-Health technicians for a two-year period.

In FY 2009, PEPFAR Rwanda is supporting a number of surveillance- and survey-related activities, including: a Behavioral Surveillance Survey among youth 15-24 years old and a BSS+ (with HIV biomarker) among commercial sex workers and truck drivers; HIV, syphilis, and hepatitis sero-surveillance among pregnant women; HIV drug resistance surveillance and prevention; integrated disease surveillance and response (IDSR) for weekly reporting of notifiable diseases; and the 2010 DHS. These activities are intended to address key gaps in national strategic information, to facilitate planning and programming for health service delivery and to enable effective disease outbreak investigation and management.

In elaborating FY 2010, PEPFAR Rwanda worked closely with GOR counterparts to identify gaps and priority activities based on existing national strategic planning documents and funding. We will maintain support for key surveillance activities, such as IDSR; will expand some activities, such as support for HIV drug resistance surveillance and prevention; and will fund newly identified gaps in strategic information, particularly for most-at-risk populations. For example, in 2010 PEPFAR Rwanda will fund formative assessments among street youth and clients of sex workers, while expanding upon prior formative assessments among MSM in Kigali to incorporate more advanced and representative sampling methods, e.g. respondent driven sampling, and include HIV biomarkers. Finally, FY 2010 funding will support an AIDS Indicator Survey which was identified as a major priority by the national SI TWG primarily based on challenges with estimation of PMTCT and pediatric and adult ART coverage with standard methods, i.e. EPP-Spectrum.

Support will be provided to the National University of Rwanda School of Public Health (SPH) to develop post-graduate degree courses in epidemiology, biostatistics, health informatics, and research in health. Additionally, strengthening the SPH capacity to provide technical assistance to the MOH in the implementation of research activities is a strategy to increase ownership and sustainability.

A mid-term evaluation of the Rwanda National Strategic Plan on HIV and AIDS 2009-2012 will be carried out.

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	4,702,636	
Total Technical Area Planned Funding:	**4,702,636**	**0**

Summary:
TB/HIV Overview Narrative

What are the most important activities being undertaken in this technical area?
• Increase the number of TB diagnoses in persons suspected of having TB, including enhanced training, supervision, and laboratory capacity
• Improve the capacity to diagnose EPTB, including training and supervision of clinicians and improved laboratory capacity at two academic hospital-based laboratories, i.e. CHUK and CHUB
• Increase HIV testing among persons suspected of having TB
• Scale up of baseline assessments of Infection Control
• Scale up implementation of the Infection Control policy
• Support TB prevalence survey
• Implement new national Isoniazid Preventive Therapy (IPT) guidelines (anticipated in FY2009)
• Increase availability and capacity for performing Drug Sensitivity Testing (DST) to diagnose multi-drug resistance and extremely-drug resistant (MDR-XDR) TB

What are the key differences from last year?
Key differences from FY 2009 include the increased emphasis on TB suspects, the implementation of the long-awaited IPT guidelines, and support to the national TB prevalence survey.

Narrative:
Tuberculosis (TB) continues to be a significant health problem in Rwanda, particularly for persons living with HIV (PLWHA). Since 1990, expansion and enhancement of Directly Observed Therapy-Short Course (DOTS) as part of the 6-point "STOP TB strategy" has been implemented in Rwanda by the National TB Program ("Programme Nationale Integre de Lutte Contre Lepere et la Tuberculose", or PNILT) currently referred to as the TB Unit of the Center for Treatment and Research on HIV/AIDS, Malaria, TB, and Other Epidemic Diseases (TRAC Plus), Ministry of Health (MOH). In 2008, there were 7,841 new TB cases, of which 4,173 (53%) were sputum smear positive [2008 Annual Report (TRAC Plus)]. In 2008, 96% (7,510/7,841) of all cases were tested for HIV and 34% (2,560/7,510) had positive test results. During 2008, the overall and sputum smear-positive TB case detection rates were 89 and 48 cases per 100,000 persons, respectively (based on historic national TB prevalence data; note that the case detection rate for sputum-positive TB cases as calculated by WHO, which takes into account regional data and the impact of the HIV epidemic, was 29 cases per 100,000).

Of 2,560 TB cases who tested positive for HIV infection in 2008, 2,219 (87%) were initiated on co-trimoxazole prophylaxis and 1,148 (45%) initiated ART. TB treatment success rates have increased from 58% in 2003 to 86% in 2008 (treatment success remain unchanged from 2007). Rwanda currently has 80% DOTS coverage in all health facilities that offer TB services. The "one-stop" TB-HIV integrated services - defined by the provision of ART to patients with active TB disease by CDT staff - has been scaled up to 142 (75%) of all 190 current CDTs (Diagnostic and Treatment Centers).

Addressing co-infection of TB disease and HIV infection (hereafter referred to as TB-HIV) through program collaboration and integration of services remains a priority of the Rwandan government. Implementation and coordination of TB/HIV collaborative activities has been supported by TB and TB-HIV technical assistance and dedicated TB-HIV coordinators in the TB and HIV Units at TRAC Plus. In 2005, the MOH established a national TB/ HIV integration working group and approved a national policy on TB/HIV collaborative activities based on WHO guidelines.

To promote intensified TB case finding, a standardized TB screening tool (checklist) was developed in 2006. This screening tool is used with all patients at the time of enrollment in HIV care and treatment services and at routine 6-month follow-up visits. If patients screen positive, they will be given a TB diagnostic evaluation that consists of two sputum smears and chest radiograph. If active TB is diagnosed, patients are referred for TB treatment, either at the on-site or nearest CT/CDT. The screening checklist has been included in national pre-ARV and ARV registers. A survey was conducted by TRAC Plus at 18 health facilities in September - October 2008, revealing that there were variable rates of TB

screening at PEPFAR-supported sites (TRAC Plus; unpublished). In response to these findings, TRAC Plus and partners carried out intensive trainings and supervision to promote routine TB screening of PLWHA. Of 210 HIV care and treatment sites operational during the first quarter of 2009, 190 reported TB screening data at time of enrollment for 12,512 patients. Of the 190 sites reporting, overall 90% of PLWHA were screened for TB; of these, 14% screened positive; and of these, 23% were diagnosed with TB. Overall, 377 (3%) of 12,152 patients screened were diagnosed with TB.

With USG support, the National Reference Laboratory (NRL) has improved culture capacity for detection of resistant mycobacterium tuberculosis strains and drug susceptibility testing. PEPFAR funding is also supporting laboratory technical assistance, infrastructure improvements, and pre-service training for laboratory technicians in Kigali and the Butare regional laboratories. Diagnostic capacity was enhanced by numerous training activities that were carried out and followed-up with regular supervision (these are on-going in FY 2009). Specifically, 113 clinicians and lab technologists from 8 referral and district hospitals and institutions have been trained with technical assistance from the Institute for Human Virology/University of Maryland on collection of fine needle aspiration (FNA) specimens and techniques for FNA slide preparation and interpretation to improve capacity to diagnose extrapulmonary TB. From August -December of 2008, 56 EPTB cases were diagnosed overall, of which 8 were diagnosed with specialized techniques. From January - June 2009, 68 EPTB cases were diagnosed overall, of which 5 were diagnosed with specialized techniques. Columbia University's International Center for AIDS Care and Treatment Programs (ICAP-Rwanda) is providing support to the national laboratory network primarily through NRL at the central level and the 42 health facilities supported in the Western Province, including:
• Empowerment of lab technical working groups to implement national TB/HIV standards.
• Introduction of new TB diagnostic technologies to improve TB detection (MDR TB) and drug sensitivity testing (2nd line).
• Improvement of AFB smear microscopy: Switch from Kinyoun technique to Ziehl Neelsen (ZN) technique, since 1st quarter 2008.
• Training for all District Hospitals on TB External Quality System (TB EQA) in November 2009.

Progress is also noteworthy with regard to the management of multi-drug resistant tuberculosis (MDR-TB). A growing number of health facilities are involved in the follow-up and ambulatory treatment of patients with MDR-TB. Guidelines outlining MDR-TB treatment were published and disseminated in 2007. From 2005 until October 2009, 338 cases of MDR TB were diagnosed; the number of MDR TB cases declined somewhat from 102 in 2007 to 74 in 2008, with 72 cases diagnosed through the end of the 3rd quarter of 2009. In 2008 and the first three quarters of 2009, 15% and 14% of patients died during treatment and 84% and 86% completed treatment, respectively. The median time from drug sensitivity testing to treatment initiation has decreased from 86 days in 2006 to 29 days in 2008 and 14 days during the first three months of 2009. In FY 2010, PEPFAR Rwanda will continue to provide technical assistance to the MDR TB focal point at PNILT.

TB infection control (IC) assessments and training initiated in FY 2009 will continue at district hospitals and will eventually be expanded to include health centers. Redacted. Routine supervision of TB infection control practices will be implemented and integrated into existing supervision frameworks. Also, in FY 2009, limited provision of isoniazid preventive therapy (IPT) will continue for children as part of a national pilot program supported by ICAP. National IPT guidelines have not yet been finalized; however this is anticipated during FY 2009 and roll-out will commence in FY 2010.

In undertaking FY 2010 planning, the national TB-HIV TWG started by reviewing the recently developed National Strategic Plan and National Strategic Application, including costing. Gaps were identified in existing funding commitments and priority new activities, which included the following, in order of priority:

1. Increase the number of TB diagnoses in persons suspected of having TB, including enhanced training, supervision, and laboratory capacity.

2. Improve the capacity diagnose EPTB, including training and supervision of clinicians and improved laboratory capacity at two academic hospital-based laboratories, i.e. CHUK and CHUB
3. Increase HIV testing among persons suspected of having TB
4. Scale up baseline assessments of IC
5. Scale up implementation of IC policy
6. Support TB prevalence survey
7. Implement new national IPT guidelines (anticipated in FY2009)
8. Increase availability and capacity for performing DST to diagnose MDR-XDR TB
9. Disseminate revised ART National guidelines

In FY 2010, all 9 priority areas will be supported, including partial support for the national TB prevalence survey which will provide a foundation for monitoring and evaluation of TB programmatic activities. This is particularly important given longstanding concerns about the low TB case detection rates based on historic WHO data which are viewed as contentious by the MOH.

In FY 2010, PEPFAR Rwanda support for priority TB-HIV laboratory issues will continue via the Capacity Support to MOH funding to Columbia ICAP-Rwanda. In addition and consistent with the 2nd priority above, capacity building for diagnosis of extrapulmonary TB will continue, albeit in a different structure: CDC Rwanda will hire and second the TA directly to either the NRL or one of the university-affiliated referral hospitals. In addition, funding will be provided to the MOH to hire and train additional Rwandan pathologists, who will also support the incipient cervical cancer screening and management program in HIV care and treatment sites.

Technical Area Summary Indicators and Targets

Redacted

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7146	Social and Scientific Systems	Private Contractor	U.S. Agency for International Development	GHCS (State)	960,629
7148	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	GHCS (State)	396,000
7152	University of North Carolina	University	U.S. Agency for International Development	GHCS (State)	1,871,100
7156	New York AIDS Institute	Other USG Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	221,080
7158	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHCS (State), Central GHCS (State)	24,829,777
7159	Population Services International	NGO	U.S. Agency for International Development	GHCS (State)	3,769,425
7160	Population Services International	NGO	U.S. Department of Defense	GHCS (State)	1,003,860
7161	Tulane University	University	U.S. Department of Health and Human Services/Centers for Disease	GHCS (State)	2,959,100

			Control and Prevention		
7162	US Agency for International Development	Own Agency	U.S. Agency for International Development	GHCS (State)	594,000
7335	American Refugee Committee	NGO	U.S. Department of State/Bureau of Population, Refugees, and Migration	GHCS (State)	229,783
7336	CHF International	Implementing Agency	U.S. Agency for International Development	GHCS (State)	14,874,750
7337	American Society for Microbiology	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	198,000
9044	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Agency for International Development	GHCS (State)	6,613,606
9151	Family Health International	NGO	U.S. Agency for International Development	GHCS (State)	7,557,746
9152	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHCS (State)	5,916,844
9155	Education Development Center	NGO	U.S. Agency for International Development	GHCS (State)	618,750
9159	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (State)	686,000

9163	National Reference Laboratory	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,138,500
9199	Catholic Relief Services	FBO	U.S. Agency for International Development	GHCS (State)	2,779,225
9201	Avocats Sans Frontieres	NGO	U.S. Agency for International Development	GHCS (State)	148,500
9203	Catholic Relief Services	FBO	U.S. Department of Health and Human Services/Health Resources and Services Administration	Central GHCS (State)	621,139
9204	Catholic Relief Services	FBO	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	3,546,837
9205	International Center for AIDS Care and Treatment Programs, Columbia University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Central GHCS (State)	4,600,000
9206	International Center for AIDS	University	U.S. Department of Health and	GHCS (State)	2,607,317

	Care and Treatment Programs, Columbia University		Human Services/Centers for Disease Control and Prevention		
9211	Public Health Institute	NGO	U.S. Agency for International Development	GHCS (State)	266,000
9212	Texas A & M University Norman Borlaug Institute for International Agriculture	Implementing Agency	U.S. Agency for International Development	GHCS (State)	168,300
9826	Voxiva	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	990,000
9965	International Center for AIDS Care and Treatment Programs, Columbia University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,252,350
9971	American Society of Clinical Pathology	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	297,000
9978	Family Health International	NGO	U.S. Agency for International	GHCS (State)	2,795,265

			Development		
10190	John Snow, Inc.	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Central GHCS (State)	880,185
10191	National Center for Blood Transfusion (CNTS)	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	2,722,500
10193	Treatment and Research AIDS Center	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	4,088,942
10825	Ministry of Health, Rwanda	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	4,039,404
10827	American Association of Blood Banks	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	544,501

10954	Drew University	University	U.S. Department of Defense	GHCS (State)	1,958,468
10981	United Nations High Commissioner for Refugees	Multi-lateral Agency	U.S. Department of State/Bureau of Population, Refugees, and Migration	GHCS (State)	156,619
11428	U.S. Peace Corps	Implementing Agency	U.S. Peace Corps	GHCS (State)	100,000
11438	US Agency for International Development	Own Agency	U.S. Agency for International Development	GHCS (State)	235,765
11440	HHS/Centers for Disease Control & Prevention	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	834,334
11441	US Department of Defense	Own Agency	U.S. Department of Defense	GHCS (State)	133,650
12132	Francois Xavier Bagnoud Center	University	U.S. Agency for International Development		
12133	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	222,750
12134	Family Health International	NGO	U.S. Department of Health and Human Services/Centers for Disease	GHCS (State)	796,950

			Control and Prevention		
12135	JHPIEGO	NGO	U.S. Department of Defense	GHCS (State)	693,000
12136	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (State)	3,398,291
12137	National AIDS Control Commission (CNLS)	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	445,500
12138	Population Services International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,390,950
12139	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12140	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12141	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease	Redacted	Redacted

			Control and Prevention		
12142	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7146	**Mechanism Name: Monitoring and Evaluation Management Services**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Social and Scientific Systems	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 960,629	
Funding Source	**Funding Amount**
GHCS (State)	960,629

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Monitoring and Evaluation Management Services (MEMS) Project was awarded to Social and Scientific Systems Inc (SSS) in June 2008. SSS/MEMS works at national level to support USG teams and implementing partners across the country achieve the following overall objectives in Rwanda:
a) Increase the availability and quality of performance management data and information;
b) Improve monitoring and evaluation (M&E) capacity in performance management; and,
c) Improve support for evidence-based decision making.

These objectives are directly aligned to the fourth goal of the Partnership Framework: "4. The human and institutional capacity of the public health system to plan, manage, and implement sustainable health programs is strengthened at all levels" and specifically to Objective 4.1: "Evidence-based policies and plans developed, updated, monitored and evaluated, and a culture of research is promoted and inculcated."

To achieve this overall Partnership Framework objective and its specific project objectives, SSS/MEMS will work to improve the quality of data collection, aggregation and analysis for PEPFAR reporting as well as the processes for work plan development for PEPFAR. SSS/MEMS has already developed a web-

based partner reporting system to standardize reporting and target setting by USG implementing partners. This database will be updated to reflect the changes in PEPFAR indicators according to the recent PEPFAR Next Generation Indicators Reference Guide and according to guidance received from the USG PEPFAR Team. PEPFAR semi-annual and annual program results for the year will be reported through this system. The system has been made accessible to Government of Rwanda (GOR) counterparts to view reported data of all partners and this has initiated discussions on quality of data reported by partners to both USG and GOR. SSS/MEMS will therefore continue to work closely with the GOR and USG implementing partners to ensure a shared understanding of GOR and USG reporting requirements and enable HIV/AIDS service sites' harmonization with other development partners in the country, and will continue to collaborate with GOR institutions to develop and roll out an integrated data quality assessment process.

SSS/MEMS will generate burden tables related to HIV/AIDS indicators and create maps using these burden tables for use by USG and GOR counterparts in planning for interventions to improve HIV/AIDS indicators.

SSS/MEMS will continue to assess and build M&E capacities of USG implementing partners to collect, analyze and report quality data.
Further, SSS/MEMS staff will continue to participate in Ministry of Health (MOH) technical working group meetings to harmonize health indicators, develop and roll out the MOH M&E Policy and Strategic Plan.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**7146**

Mechanism Name:	Monitoring and Evaluation Management Services		
Prime Partner Name:	Social and Scientific Systems		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	89,100	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	99,000	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	88,827	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture

of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	89,100	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDTX	9,900	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	198,000	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of

the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	49,500	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS

interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	148,500	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	99,602	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out

activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	89,100	

Narrative:

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases. SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country. M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7148	**Mechanism Name: Deliver II**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 396,000	
Funding Source	**Funding Amount**
GHCS (State)	396,000

Sub Partner Name(s)

Nonelel'uluntu Womens Organization		

Overview Narrative

The purpose of the USAID | DELIVER PROJECT contract is to design, develop, strengthen and, upon request, operate safe, reliable, and sustainable supply systems that provide a range of affordable, quality essential health commodities including drugs, diagnostics and supplies to clients in country program.

The overall objective is increased availability of essential health supplies in public and private services.

USAID | DELIVER PROJECT works at the national level in Rwanda and covers all the 30 districts and their health facilities.

Through SCMS and USAID | DELIVER PROJECT, USAID supports the procurement and distribution of ARVs, test kits, lab supplies, OI drugs, condoms for HIV prevention and contraceptive commodities for HIV positive families. SCMS focuses on ARV procurement and central level support and works with district pharmacies and warehouses. DELIVER supports contraceptive commodities and public sector distribution of condoms.

In FY 2009, USAID | DELIVER PROJECT worked with the GOR on quantification and reporting, supported the integration of contraceptive commodities in HIV and coordinated with other implementing partners to avoid duplication of the health commodity supply chain management activities. The project also collected and analyzed the logistics data for condoms to ensure smooth forecasting and quantification and provided feedback to the districts and health facilities' stock managers

In FY 2010, USAID | DELIVER PROJECT will continue to support the public sector contraceptive and condom distribution program by providing technical assistance as mentioned above. The tasks will include quantification, customs clearance, distribution, LMIS harmonization, district level support and supervision/training in contraceptive logistics. The goal is to ensure condom availability at public sector clinical facilities. To accurately project condom quantification, USAID | DELIVER PROJECT will monitor condom uptake in facilities. USAID | DELIVER PROJECT will also assist the Rwanda MOH with the data collection and reporting from community level and will integrate this information into the site-level reporting.

The target population for the COP activities includes the population of reproductive age for condoms utilization and the people living with HIV/AIDS for condoms and LLINs.

The COP funding is part of the USAID | DELIVER PROJECT Task Order 1 budget and thus contributes to any activities implemented for maternal and child health and community health (quantification, system assessment, logistics management information system harmonization and computerization, data collection and analysis, supervision, training and coordination of partners). The coordination and resource mobilization meetings supported by the project contribute to the commodity security and to the sustainability of the program over time.
USAID | DELIVER PROJECT submits reports to the USAID MEMS web based reporting system in Rwanda and to USAID at the central level.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	7148		
Mechanism Name:	Deliver II		
Prime Partner Name:	John Snow, Inc.		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	267,300	

Narrative:

ACTIVITY UNCHANGED FROM FY 2009

The Programme Nationale Integre de Lutte contre le Paludisme (PNLP) coordinates all procurement and distribution of long lasting insecticide treated nets (LLINs) in Rwanda, including for PLWHA. GFTAM and PMI are the two major donors for LLINs, with GFTAM providing more than 75% of all LLINs in the past three years, with PEPFAR supplementing with LLITNs for PLWHAs and their families.
In FY 2009, with PMI funding, DELIVER provided technical assistance to the PNLP for quantification and forecasting of malaria commodities. DELIVER also procured and cleared 388,000 LLINs into the country, and deposit them at CAMERWA (national commodities central stores). Following the distribution channels already established by the PNILP, clinical partners and umbrella organizations obtained LLINs from CAMERWA and distributed them to PLWHA associations in the community. This PMI wraparound demonstrates the increased integration and collaboration between PEPFAR and PMI, as well as collaboration with other donors.

In FY 2010 PMI and PEPFAR will work with the National Malaria Control Program (NMCP) to ensure coordinated quantification, forecasting, procurement and distribution of these LLINs once in country. Furthermore, PEPFAR and PMI will collaborate to support the monitoring of product use, storage and

inventory control through Logistics Management Information System (LMIS) for all LLINs distributed in the country. Using the same partner for both the PEPFAR and PMI funded LLINs allows for effective, efficient and less costly programming.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	29,700	

Narrative:

In FY 2008, PEPFAR invested $300,000 into the procurement of long-lasting insecticide-treated nets (LLINs) for People living with HIV (PLWHA) through JSI/DELIVER. These LLINs were to be distributed among PLWHA not already covered by PMI or the GFATM. PEPFAR, PMI, and the GFATM worked together to share the costs of the procurement and distribution of the bed nets for an estimated 56,700 PLWHA. Through the same partner, PMI is providing the majority of the LLINs for children under 5 years, pregnant women and the extremely poor. PEPFAR will procure and distribute LLINs to HIV-exposed and infected children and their families. PMI and PEPFAR will ensure coordinated quantification, forecasting, and distribution of these LLINs once in country. Furthermore, monitoring of product use, storage and inventory control through Logistics Management Information System (LMIS) will be done for all LLINs distributed in country. Using the same partner for the procurement and distribution of both the PEPFAR and PMI funded LLINs will allow for more cost-effective programming.

With FY 2009 PEPFAR funding, DELIVER will provide technical assistance to the national malaria control program (Programme National Intégré de Lutte contre le Paludisme, PNLP) for quantification and forecasting of malaria commodities. In FY 2008, DELIVER received PMI funds to support a logistics officer at PNLP. This support will continue through FY 2009. This person coordinates all procurement at the PNLP including LLINs. This coordinated technical assistance will continue to strengthen the PNILP capacity in quantification, forecasting, distribution and tracking of LLINs and other health commodities for adults, pregnant women and children. DELIVER will also continue to procure and clear the LLINs into the country, in collaboration with PNLIP and CAMERWA. Clinical partners and umbrella PLWHA organizations will obtain LLINs from CAMERWA and distribute them to PLWHA associations in the community. Because children are vulnerable to malaria, especially those infected with HIV, emphasis for the supply of LLINs will be placed on delivery to families of HIV-exposed infants and infected children. Similar emphasis will be placed on delivering nets to pregnant women through broader efforts under PMI and the GF. HIV-positive pregnant women will be targeted due to the high morbidity and mortality in this group and the possible effects of malaria on infant outcomes. This PMI wraparound demonstrates the increased integration and collaboration between PEPFAR and PMI, as well as collaboration with other donors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	99,000	

Narrative:

In FY 2010, DELIVER II continues to support the public sector contraceptive commodities and condom distribution program. The tasks include quantification, customs clearance, distribution, district level support and training in contraceptive logistics. In addition, DELIVER will work in collaboration with other donors to support the public sector commodity system. The goal is to ensure condom availability at public sector clinical facilities. To accurately project condom quantification, DELIVER II monitors condom uptake in these facilities. DELIVER II also adapts distribution reporting tools, to be used by all PEPFAR clinical sites, and PEPFAR partners and integrates these data collection tools into their site-level reporting.

In FY 2010, DELIVER II will continue its work on forecasting, quantification and logistical support to USG condom supplies. Activities will also include monitoring public sector condom distribution, along with follow-up of day-to-day activities. The condom distribution will reach youth ranging in age from 15-29 who frequent bars (and other hot spots), urban men with discretionary income, MARPs, women of reproductive age for both HIV protection and FP, and the general population.

The project will continue supporting the integration of family planning and HIV/AIDS activities and ensure constant availability of condoms throughout the country. DELIVER II will continue the collaboration with the private clinics and the social marketing program. The project will also contribute to the workplace-based condom distribution and the implementation of the community-based distribution of contraceptives and condoms.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7152	**Mechanism Name: MEASURE Evaluation**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: University of North Carolina	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,871,100

Funding Source	Funding Amount
GHCS (State)	1,871,100

Sub Partner Name(s)

Futures Group, South Africa		

Overview Narrative

MEASURE Evaluation will continue to strengthen the unified national HIV/AIDS M&E system, and build capacity for data collection, analysis, dissemination and use in decision making. The specific activities to be implemented are grouped into four components. The first component focuses on capacity building and skills transfer at national institutions: CNLS and MOH/TRAC Plus. Training will be organized at national and sub-national levels to strengthen the capacity of program managers to apply M&E data in decision making and programming. The contractor will assist in the dissemination of best practices.

Technical assistance to CNLS will include assistance in the development of study protocols and in conducting studies on various aspects of HIV prevention and social impact mitigation, including process evaluations. The assistance aims to expand the role of CNLS in the design and implementation phases of studies and evaluations to reduce dependence on external technical assistance. MEASURE Evaluation will also contribute to the improvement of the functioning of the HIV/AIDS Research Committee through the provision of technical and financial assistance.

The second component includes technical assistance to MOH/TRAC Plus for the maintenance and improvement of the HIV/AIDS, TB and malaria monitoring and evaluation systems in the context of efforts to integrate the various electronic information systems in the health sector. MEASURE Evaluation will work closely with the Informatics Unit at TRAC Plus, the HMIS Unit in the MOH, and the M&E and Data Analysis units in CNLS to ensure harmony in indicators and data collection systems. Building upon existing data quality assurance tools, MEASURE Evaluation will provide assistance to the Government of Rwanda (GOR) to develop and manage protocols and procedures to assure data quality in national and decentralized information systems. Technical assistance will also be provided to integrate data reliability activities into routine quarterly monitoring and reporting activities.

In addition, MEASURE Evaluation will assist in the development of a harmonized reporting system for community level activities (basic care and support, OVC, sexual prevention activities). Support will also be provided to civil society umbrella organizations to build their capacity for M&E and to ensure that they are linked to the national HIV/AIDS M&E system.

In the third component, technical assistance will be provided to the CNLS Data Analysis Unit to review and improve the database developed by the CNLS to ensure that state-of-the-art approaches are being used – including data interchange and the introduction of other technologies as needed. Limited funding will also be available for the purchase of new software, upgrades and renewal of site licenses for software already possessed by the CNLS and TRAC Plus.

The fourth component of the technical assistance will focus on the promotion of data use in planning and management. Support will be provided to the M&E and Data Analysis units in CNLS and TRAC Plus in the analysis of program data from all databases and in the feeding of the results into the programs for improvement in service delivery. The contractor will also provide support to the organization of the Annual National HIV/AIDS Research Conference in Rwanda.

In 2008, the GOR elaborated a national monitoring and evaluation strategy for OVC which outlines the data flow from lower administrative and implementation levels to the national level. MEASURE Evaluation will continue the work started in FY 2009, providing technical assistance to strengthen this system, and building data analysis and use capacity at national and sub-national levels. MEASURE Evaluation will continue to support the key GOR institutions involved in OVC programs, namely CNLS and MIGEPROF, to strengthen the collection, analysis, reporting, quality and use of information for decision support, including program management and coordination. PEPFAR partners implementing OVC activities will regularly report service data to the OVC M&E system to ensure accurate and quality information is available.

This activity will focus on capacity building within CNLS and MIGEPROF to help operationalize the national OVC M&E strategy through long-term technical advisors seconded to national institutions. Technical assistance will be provided for training in data quality, to promote results-based management, and to provide support for the implementation of the national unified OVC M&E framework, linking it to the national HIV/AIDS M&E framework. As a result of this activity, CNLS and MIGEPROF will have the capacity and mechanism for actively monitoring the implementation of OVC activities aiming at the mitigation of the impact of HIV and AIDS.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	7152		
Mechanism Name:	MEASURE Evaluation		
Prime Partner Name:	University of North Carolina		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	1,871,100	

Narrative:

This activity is aimed at building and making functional the national M&E system.

MEASURE Evaluation will continue to strengthen the unified national HIV/AIDS M&E system, and build capacity for data collection, analysis, dissemination and use in decision making. The specific activities to be implemented are grouped into four components. The first component focuses on capacity building and skills transfer at national institutions: CNLS and MOH/TRAC Plus. Training will be organized at national and sub-national levels to strengthen the capacity of program managers to apply M&E data in decision making and programming. The contractor will assist in the dissemination of best practices.

Technical assistance to CNLS will include assistance in the development of study protocols and in conducting studies on various aspects of HIV prevention and social impact mitigation, including process evaluations. The assistance aims to expand the role of CNLS in the design and implementation phases of studies and evaluations to reduce dependence on external technical assistance. MEASURE Evaluation will also contribute to the improvement of the functioning of the HIV/AIDS Research Committee through the provision of technical and financial assistance. Additionally, funds have been budgeted under the MEASURE Evaluation mechanism for conducting during FY 2010 a mid-term evaluation of the Rwanda National Strategic Plan on HIV and AIDS 2009-2012.

The second component includes technical assistance to MOH/TRAC Plus for the maintenance and improvement of the HIV/AIDS, TB and malaria monitoring and evaluation systems in the context of efforts to integrate the various electronic information systems in the health sector. MEASURE Evaluation will work closely with the Informatics Unit at TRAC Plus, the HMIS Unit in the MOH, and the M&E and Data Analysis units in CNLS to ensure harmony in indicators and data collection systems. Building upon existing data quality assurance tools, MEASURE Evaluation will provide assistance to the Government of

Rwanda (GOR) to develop and manage protocols and procedures to assure data quality in national and decentralized information systems. Technical assistance will also be provided to integrate data reliability activities into routine quarterly monitoring and reporting activities.

In addition, MEASURE Evaluation will assist in the development of a harmonized reporting system for community level activities (basic care and support, OVC, sexual prevention activities). Support will also be provided to civil society umbrella organizations to build their capacity for M&E and to ensure that they are linked to the national HIV/AIDS M&E system.

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In 2008, the GOR elaborated a national monitoring and evaluation strategy for OVC which outlines the data flow from lower administrative and implementation levels to the national level. MEASURE Evaluation will continue the work started in FY 2009, providing technical assistance to strengthen this system, and building data analysis and use capacity at national and sub-national levels. MEASURE Evaluation will continue to support the key GOR institutions involved in OVC programs, namely CNLS and MIGEPROF, to strengthen the collection, analysis, reporting, quality and use of information for decision support, including program management and coordination. PEPFAR partners implementing OVC activities will regularly report service data to the OVC M&E system to ensure accurate and quality information is available.

This activity will focus on capacity building within CNLS and MIGEPROF to help operationalize the national OVC M&E strategy through long-term technical advisors seconded to national institutions. Technical assistance will be provided for training in data quality, to promote results-based management, and to provide support for the implementation of the national unified OVC M&E framework, linking it to the national HIV/AIDS M&E framework. As a result of this activity, CNLS and MIGEPROF will have the capacity and mechanism for actively monitoring the implementation of OVC activities aiming at the

mitigation of the impact of HIV and AIDS.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7156	**Mechanism Name: Health Qual**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Contract
Prime Partner Name: New York AIDS Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 221,080	
Funding Source	**Funding Amount**
GHCS (State)	221,080

Sub Partner Name(s)

NYCHSRO	University of Maryland	

Overview Narrative

This activity will continue activities launched in COP 08 and continued in COP 09. The overall goal of the HEALTHQUAL program is to provide technical assistance through a coaching and mentoring model to an in-country TRAC Plus and MOH/UPDC-led team to develop a more facility-driven quality management program and to assist in the Track 1.0 transitioning process in Rwanda. HEALTHQUAL will collaborate with and complement other PEPFAR related initiatives such as the HSS USAID project and CDC HSS technical support. To reach its programmatic goals, HEALTHQUAL will:

1. Support the monitoring activities for the Track 1.0 transition process and evaluation of the quality of clinical services provided during transition;
2. Provide technical assistance to TRAC Plus and MOH/UPDC to strengthen their quality improvement activities and the capacity of the transition task force to shift the currently partner-driven quality management approach to one that is facility-driven

Evaluation and quality improvement capacity building activities will be provided to those clinical sites being transitioned as well as other health facilities identified as requiring additional support. Furthermore, staff within TRAC Plus and MOH/UPDC units are target audiences for quality improvement capacity building activities and trainings provided by HEALTHQUAL.

HEALTHQUAL staff and the HEALTHQUAL Program Manager, a position subcontracted through the University of Maryland, will implement a scope of work focused on evaluating the quality of clinical services provided during the Track 1.0 transition process and activities conducted to build quality management capacity at TRAC Plus and MOH/UPDC, thereby strengthening the ability of the transition task force to effectively transition currently partner-driven quality improvement activities to a facility-driven approach.

As the monitoring and evaluation plan for the Track 1.0 transition process is developed and implemented in early 2010, HEALTHQUAL will begin to evaluate the quality of clinical services at transitioning sites based on clinical care indicators. Throughout COP 10, HEALTHQUAL will assist with periodic site level assessments conducted to address clinical quality during transition. Assessments will also be made of the quality improvement structures in place at transitioning sites and technical assistance provided to build capacity of sites to develop the programmatic structures necessary to support a comprehensive quality management program.

Through coaching and mentoring services provided to TRAC Plus and MOH/UPDC units, HEALTHQUAL will build quality management capacity in those units. Furthermore, by assisting TRAC Plus and MOH/UPDC in providing quality management training to health facilities throughout Rwanda, HEALTHQUAL will build capacity at the site level through knowledge transfer related to performance measurement and quality improvement.

Transition to country-ownership of a quality management program is at the heart of the HEALTHQUAL methodology of capacity building. All technical assistance and coaching/mentoring provided by HEALTHQUAL is aimed at developing the capacity of in-country TRAC Plus and MOH staff to conduct the necessary activities to support quality management at the national, district, and facility levels, and to assist MOH in the integration of quality management into its approach to HIV treatment as well as other public health concerns.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7156**		
Mechanism Name:	**Health Qual**		
Prime Partner Name:	**New York AIDS Institute**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	221,080	

Narrative:

HealthQual staff and the HealthQual program manager, a position subcontracted through the University of Maryland, will implement a scope of work focused on evaluating the quality of clinical services provided during the Track 1.0 transition process and activities conducted to build quality management capacity at TRAC Plus, other MOH units, and district health facilities. HealthQual will collaborate with MOH, USG, and stakeholders to facilitate the development of a national quality management program. Additionally, HealthQual will collaborate with and complement other PEPFAR initiative son health system strengthening and technical support.

As the monitoring and evaluation plan for the Track 1.0 transition process is developed and implemented in early FY 2010, HealthQual will begin to evaluate the quality of clinical services provided at transitioning sites based on clinical care indicators. Throughout FY 2010, HealthQual will conduct periodic site level assessment to address clinical quality during transition. Assessments will also be done on the quality improvement structures in place at transitioning sites and the technical assistance provided to build the capacity of sites to develop the programmatic structures necessary to support a comprehensive quality management program.

To complement and strengthen the Integrated Formative Supervision system being developed by MOH, HealthQual will assist in the development and implementation of performance measurement and quality improvement activities conducted by MOH. Through coaching and mentoring services provided to TRAC Plus and UPDC staff and unit heads, HealthQual will build quality management capacity in within the MOH. By providing quality management training to district health facilities throughout Rwanda,

HealthQual will build capacity at the site level through knowledge transfer related to performance measurement and quality improvement.

As MOH seeks to harmonize the various quality improvement activities conducted in Rwanda by different implementing partners, HealthQual will assist and collaborate on the development of a national quality management program. HealthQual staff have decades of combined experience in running a government-based HIV quality management program and will provide that expertise to the Rwandan initiative.

Transition to country-ownership of the quality management program is at the heart of the HealthQual methodology of capacity building. All technical assistance and coaching/mentoring provided by HealthQual is aimed at developing the capacity of in-country MOH staff to conduct the necessary activities to support quality management at the national, district, and facility levels, and to assist MOH in the integration of quality management into its approach to HIV treatment as well as other public health concerns.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7158	**Mechanism Name: SCMS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 24,829,777	
Funding Source	**Funding Amount**
Central GHCS (State)	138,750
GHCS (State)	24,691,027

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Under the guidance of the Ministry of Health, the Supply Chain Management System (SCMS) works in partnership with the Centrale d'Achats des medicaments essentiels du Rwanda (CAMERWA) to ensure the sustainable procurement, supply and distribution of HIV commodities including ARVs, OIs, test kits, laboratory equipment and commodities, male circumcision and injection safety equipment to the people of Rwanda at central, district and FOSA levels. This partnership is based on a Memorandum of Understanding with CAMERWA which was first signed in November 2006 and has recently been renewed through September 30, 2013.

The Memorandum of Understanding enables SCMS to provide health systems strengthening support to CAMERWA for all health commodities including essential medicines in the form of warehouse management strengthening, financial system strengthening, capacity building, skills transfer and performance management. SCMS has provided racking and shelving, layout design, material lifting equipment and warehouse operations training to enable CAMERWA to become a modern and professional warehouse, storage and distribution operation. As part of this process, SCMS is assisting CAMERWA to implement computerized management information systems to support its warehousing and financial management activities.

SCMS will further support CAMERWA with the transition process to the Rwanda Bio Medical Centre which is expected to be completed during COP 2010.

SCMS has been working with CAMERWA to strengthen its procurement systems and processes so that they comply with USG procurement regulations and support CAMERWA in its desire to become a US Government direct grant recipient. This includes the recruitment of a Procurement Adviser based at CAMERWA who is responsible for transferring knowledge in best practice in procurement of all health commodities and in supporting CAMERWA to develop its own procurement plans and framework contracts with prequalified vendors. The goal is to ensure best practices, transparency and value for money in procurement to ensure that quality drugs are supplied to as many patients as possible whilst ensuring cost effectiveness.

SCMS also works closely with the National Reference Laboratory, CAMERWA and other implementing partners to support the procurement of laboratory commodities, reagents and equipment. In addition, SCMS has been providing logistics support to strengthen the laboratory supply chain through development of a commodity data base, harmonized LMIS system and capacity building. In FY 2010, procurement will include laboratory equipment, supplies and reagents for biochemistry, early infant diagnosis (EID), hematology, microbiology, CD4, viral load and biosafety. This consolidated approach to procurement will increase cost savings and improve the efficiency in the current procurement, storage

and distribution of commodities.

A key focus of SCMS support to CAMERWA and the Pharmacy Task Force has been the development and mobilization of the Government of Rwanda's program of Active Distribution of commodities from central level to district pharmacies and health facilities. In COP 09, CAMERWA, PTF and SCMS established an Active Distribution project team to begin roll out of the initiative. A minimum of 15 districts will be part of the Active Distribution scheme by the end of FY 2010. The goal is to roll out active distribution to all 30 districts by the end of 2011.

SCMS is the lead agency building the capacity of the Coordinated Procurement and Distribution System (CPDS) to undertake quantification, forecasting and supply planning in support of the procurement decision making process. In FY 2010, SCMS will continue to support quantification activities within the CPDS, which includes the Ministry of Health (MOH), PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Clinton Foundation HIV/AIDS Initiative (CHAI), all USG clinical partners, and UNICEF. By FY 2010, SCMS will also have built capacity with the CPDS to quantify the national laboratory needs which will include Antiretroviral (ART) and non-ART supported sites.

SCMS has been providing support to the MOH in the strengthening of computerized Logistics Management Information System (LMIS) and its integration with other Health Management Information Systems in Rwanda. SCMS is working closely with e-Health department to ensure that the supply chain component of the National e-Health strategic plan is realized with applications and information systems supporting effective and efficient delivery of health commodities in Rwanda. In FY 2010, SCMS will also ensure the sustainability of the computerized LMIS and assure that its implementation leads to improved stock management, reduced drug expiry, and reduced the cost of delivering to the consumers among many other benefits. The LMIS within Ministry of Health along with its computerization will permit proper data collection and analysis for improved decision making within the national supply chain system. SCMS activities are intended to support the Partnership Framework goals by gradually transferring skills and management capacity for supply chain management to CAMERWA, PTF, NRL and other partners. An objective of the Memorandum of Understanding with CAMERWA is to strengthen CAMERWA's procurement, warehousing, and systems administration capacity so that it is able to become a USG direct grant recipient and to take over management of the procurement of PEPFAR funded commodities without the support of SCMS. SCMS technical support is further aimed at assisting CAMERWA's transition to its new status under the Rwanda Bio Medical Centre so that it is empowered to take on the greater responsibilities proposed under the new Bio Medical Centre structure.

FY 2010 will see a reduction in the level of technical assistance being provided to CAMERWA, NRL, PTF and other partners together with an increased emphasis on transfer of skills, mentoring and planning for

exit where appropriate. As part of this approach, SCMS will ensure that ownership of licenses, warranties and maintenance agreements for all laboratory equipment, computerized systems is transferred to the appropriate organization within the Ministry of Health. SCMS support to the Government of Rwanda's Active Distribution initiative will strengthen district level management and supervision of the supply chain and increase their interaction with CAMERWA. The computerized and harmonized LMIS will facilitate more accurate and timely data reporting and validation which will strengthen the quantification process of the CPDS.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7158**		
Mechanism Name:	**SCMS**		
Prime Partner Name:	**Partnership for Supply Chain Management**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,887,496	

Narrative:

Research has shown that 90% of PLWHA are affected by diarrhea, which in turn results in significant morbidity and mortality. Hand washing, sanitation, water disinfection and safe storage have been proven to significantly reduce diarrhea rates. According to the 2005 Rwanda Demographic and Health Survey, only one-third of surveyed households had access to a protected source of drinking water. A significant cause of exposure to diarrheal disease-causing pathogens is inadequate access to safe water. Only 40% of the Rwandan rural population and 60% of the urban population have access to safe water. The objectives of the point of use (POU) activities are to ensure consistent use of POU water treatment products by PLWHA; to increase access to POU water treatment products by PLWHA; and to improve knowledge of POU and its effectiveness, hygiene, and safe water storage.

In FY 2009, 200 service outlets, serving 5,000 PLWHA were provided with HIV-related palliative care. Outlets included health centers and PLWHA--managed income generating cooperatives. Messages were delivered through peer education, IPC and door to door sessions conducted by CHWs and PLWHA association members. A total of 854 people were trained to provide HIV-related palliative care, including 462 public providers (22 district personnel and two providers each from 220 health facilities providing VCT/ART) and 392 PLWHA associations and community volunteers (12 RPO TOT, 80 PLWHA association members and 300 community volunteers).

POU programming through PSI includes distribution of two products, including Sûr'Eau, a locally produced POU liquid solution which recovers the cost of production with every bottle sold, and Pur, a targeted, internationally-produced flocculent disinfectant powder sachet which is particularly effective in treating turbid water and water retrieved from surface sources. Sûr'Eau was launched in FY07 with USAID funding for distribution through community health workers, the community health insurance program, public health facilities, Rwandan Partner Organizations (RPO), and commercial distribution networks. Pur will be launched with international funds in 2010 to target communities with particularly turbid surface water, leveraging existing commercial networks and RPOs, particularly those targeting PLWHA. This activity complements PSI's child survival activities around preventing diarrheal disease in children under five years

In FY 2010 PSI will intensify the POU program targeting PLWHA to increase knowledge of POU, hygiene and safe water storage through health facilities providing VCT and ART, through faith-based RPO targeting PLWHA, and through associations of PLWHA through RRP+, the national network of PLWHA. Activities will include intensified training of trainers, peer education through trained RPO members, community-based distribution as an income generating activity for associations of PLWHA, community events, and mass media communications, which will help avoid stigmatizing the POU products for the general population. Water signage will be expanded for placement at water points in PEPFAR districts, so that safe water messages are targeted at points where communities gather. The activity will expand product availability at health facilities, ensuring access for VCT clients, regardless of HIV status. Additional starter stock will be provided to associations to expand distribution to PLWHA associations trained by partners supported by PSI. PSI will continue to integrate safe water, POU and hygiene messages into existing VCT, care and support materials in collaboration with GOR, USG clinical partners and community partners, to ensure consistent delivery of product and messages to people who present for testing.

PSI supports regular joint supervision visits between the PSI POU and M&E teams and local authorities who oversee technical quality of program implementation by RPOs. RPOs will also receive institutional support through regular financial and institutional mini-audits and ongoing mentoring by the BCSM

capacity building partners of PSI, JHU-CCP and CHF. Training impact will be monitored by improved pre- and post-test QA materials and analysis.

In line with the Partnership Framework objectives, PSI will intensify activities with a particular emphasis on strengthening associations and RPOs targeting PLWHA in cholera-prone districts, and communities sourcing turbid surface water. Intensified sub-granting to local partner organizations, and all associated supportive supervision and capacity building activities, will strengthen the capacity of RPOs to solicit, lead and report on direct funding grants in the future. Community-based distribution of the locally produced product will provide a sustainable income generating opportunity for a locally produced cost recovery product which does not require a donor subsidy. RPOs and associations of PLWHA will be strengthened through training of trainers, institutional assessments and capacity building programs, ongoing mentoring and supportive supervision by the BCSM capacity building team of PSI, JHU-CCP and CHF. This, and all BCSM activities, will contribute to the development of a Rwandan Social Marketing Institution in a sustainable manner.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	1,085,661	

Narrative:

In FY 2009, SCMS under the terms of its MoU and sub contract, worked closely with CAMERWA for the procurement, storage and distribution of all HIV-related commodities, including ARV drugs. In addition, SCMS provided technical support to CAMERWA with warehouse management, financial management, performance management and other systems strengthening activities, including MIS support via the computerized warehouse management and financial management systems. SCMS provided technical support to CPDS in the areas of quantification, financing, procurement and distribution of ARVs and other commodities. This consolidated approach to procurement increased cost savings and improved efficiencies in procurement and distribution of commodities. SCMS provided TA to the existing committees of the CPDS to conduct national annual forecasts and supply planning of ARVs using Quantimed and Pipeline software packages as the forecasting and supply planning tools, respectively. The use of these tools has enabled the CPDS to prepare quantification reports that inform a supply plan from which PEPFAR commodity procurements are initiated.

In FY 2010 SCMS will continue to support CAMERWA in these activities but will place increased emphasis on skills transfer, capacity building, ownership, and empowerment. The objective is to ensure sustainability and begin transition towards a technical assistance exit strategy. A further objective will be to support CAMERWA in its new role within the Rwanda BioMedical Center.

In FY 2009 CAMERWA, with technical support from SCMS, began implementation and roll out of the Active Distribution initiative. Active Distribution is part of the GOR's decentralization program and involves the planned distribution of health commodities from the central level down to district pharmacies and health facilities. SCMS support included recruitment of an international Active Distribution project manager for one year, with responsibility for developing the implementation methodology, roll out plan and for ensuring that warehouse systems at central and district level are appropriate and ready for Active Distribution. As part of the scope of work for this post, the project manager was required to help CAMERWA recruit a national counterpart project manager and support team. FY 2010 will see the transfer of responsibility of management of Active Distribution to the national counterpart and the roll out of Active Distribution to a minimum of 15 districts by the end of FY 2010.

In FY 2010 SCMS will continue to support the CPDS to accurately quantify the commodities needed to meet short- and long-term program goals using appropriate forecasting methodologies and selected tools. Training, mentoring and sharing best practices will enable GOR counterparts to conducting forecasting and supply planning activities on their own. In FY 2010 SCMS will continue to provide TA to ensure the smooth functioning of the CPDS system. This will include mentoring and coaching support to the MOH CPDS Coordinator plus capacity building to the CPDS quantification committee and on-going support institutionalizing CPDS policies and procedures.

SCMS will continue support to the Ministry of Health by strengthening logistics management information systems, including data collection, validation, storage and reporting at central, district pharmacy and FOSA levels. SCMS will also ensure the sustainability of the computerized LMIS and ensure that its implementation leads to improved stock management, reduced drug expiry, and reduced cost of delivering to the consumers, among many other benefits. The LMIS within Ministry of Health, along with its computerization, will permit proper data collection and analysis for improved decision making within the national supply chain system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	1,584,000	

Narrative:

From FY 2007 to FY 2009, PEPFAR transitioned towards a consolidated approach for the procurement of HIV-related commodities through the use of SCMS and NRL as the primary procurement partners. In addition, the GOR expanded the CPDS to include all HIV-related commodities, including OI drugs and diagnostics, test kits and CD4 reagents. SCMS worked closely with CAMERWA for the procurement, storage and distribution of all HIV-related commodities, including laboratory supplies. This consolidated approach to procurement has increased cost savings and improved efficiencies in procurement and

distribution of commodities. In addition, partners worked in close collaboration through joint planning and work plan development, particularly for activities that supported the LMIS and active distribution system.

In FY 2010, SCMS will works closely with CAMERWA for the procurement, storage, and distribution of rapid test kits and supplies (gloves, lancets, filter paper, test tubes and other phlebotomy supplies) for PEPFAR-supported health facilities, to target all voluntary counseling and testing (VCT), provider initiated counseling and testing (PICT) and PMTCT clients. In addition, SCMS procures additional test kits for GFATM sites and is continuing PEPFAR's support to GFATM that began in FY 2005. Test kits will continue to be procured in line with the national testing protocol, which currently includes Determine, First Response, Unigold and Capillus. By FY 2010, Capillus, which currently is the tie-breaker test will no longer be in production and so a new test would have to be chosen to replace it. To support the rollout of the new national testing algorithm, SCMS will procure additional kits for training activities to support the new testing national algorithm. SCMS will coordinate and regularly communicate with USG partners to ensure they have adequate information for the quantification and distribution of test kits, as well as to discuss issues related to test kit procurement and management.

Through the CPDS, SCMS will continue to ensure the quantification of rapid test kits on a bi-annual basis. As part of the plan to build national capacity to quantify laboratory supplies at all levels of the system and ensure smooth functioning of the CPDS system, SCMS will continuing to work closely with the CPDS to ensure appropriate integration of rapid test kits (RTKs) into the system, including development of a supply plan incorporating RTKs, that will be updated on a quarterly basis. As part of the support to the MOH, SCMS will also collaborate with the NRL and other members of the CPDS to ensure appropriate collection and dissemination of logistics data for RTKs generated from the national LMIS. This will help improve decision making at all sites, including those supported by PEPFAR and District Pharmacies, and to ensure appropriate stock management of these commodities.

As the country continues to strengthen its counseling and testing strategy and implementation, SCMS will work with CAMERWA to analyze and report on district pharmacy and health facility stock levels on a regular basis to monitor consumption trends, potential stock-outs, and make any revisions to procurement plans and projections. In FY 2010, a projected number for routine VCT will be 663,363 and for PIT (Provider Initiated testing) will be 571, 260.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	143,379	

Narrative:

Supply Chain Management System (SCMS) partners work in close collaboration through joint planning

and work plan development, particularly for activities that support the computerization of Logistic Management Information System (LMIS) and active distribution system. SCMS works with CAMERWA (Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda) to procure, store and distribute opportunistic infection (OI) drugs for all PLWHA including children at PEPFAR-supported sites.

In FY 2009, SCMS continued to provide ongoing TA to CAMERWA for quantification, PEPFAR procurement regulations and for appropriate distribution of products to all sites. Product selection conforms to GOR's minimum list of preventive care, OI and other palliative care medications, as well as to WHO QA standards. SCMS supports CAMERWA and the National Reference Laboratory (NRL) in conducting quality assurance of OI medication arriving in country through thin-layer chromatography (TLC) and use of mini-labs. As OI drugs are integrated into the Coordinated Procurement and Distribution System (CPDS), SCMS provides TA and support to the relevant CPDS committees to develop a procurement and distribution plan for OI, to conduct quantification, monitor consumption patterns and stock levels, and to provide regular reports to donors.

In FY 2010, SCMS will continue to work closely with GFATM, MOH, CAMERWA, and districts to ensure the continuous availability and management of drugs and supplies included in the national Standard Treatment Guidelines. SCMS will also work with clinical partners, CAMERWA, and the MOH to review and revise tools to support the storage, distribution, and tracking of health commodities from CAMERWA to the community level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	198,000	

Narrative:

The overall goal of this activity is to decrease new HIV infections through male circumcision (MC) among Rwanda Defense Forces (RDF) personnel. The program will be presented as part of an expanded approach to reduce HIV infections, and will be promoted in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted infections, promotion of safer-sex practices and condom distribution. MC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package.

In FY 2010, in collaboration with Drew University and the Centrale D'Achat des Medicaments Essentiels, Consommables et Equipments Medicaux du Rwanda (CAMERWA), SCMS will quantify and procure male circumcision (MC) kits for Rwandan military personnel. Drew University forecasts that an average of 50 males per week in five sites (250 total procedures per week) will be circumcised. It is thus

estimated that 15,000 MC kits per year will be needed. The demand for MC procedures and kits could vary and will be closely monitored. As CPDS increasingly expands to include other commodities, SCMS will support the CPDS to ensure appropriate integration of male circumcision kits into the system, including quantification support, the development of a supply plan, and procurement of male circumcision kits.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	489,383	

Narrative:

For injection safety, behavioral and occupational change measures will have to be under taken to ensure that all injections and needles are used in an optimally safe manner for patients and health care providers. To do so, the appropriate waste bins, sharps containers and safety boxes must be made available to all health care providers. Segregation of waste should also occur to ensure appropriate waste management. Through the provision of these commodities and changes in human behavior, risky practices which might otherwise lead to the transmission of infectious diseases or needle stick injuries will be eliminated. Information on the commodities required to avert any risk needs to be conveyed to users in a timely manner for this intervention to be a success.

In FY 2010, the Partnership for Supply Chain Management (SCMS) will work closely with Centrale D'Achat des Medicaments Essentiels, Consommables et Equipments Medicaux du Rwanda (CAMERWA) and JSI R&T for the procurement, storage, and distribution of injection safety kits and waste management supplies, including approximately 2.5 million auto-disable syringes, 35,714 safety boxes, boots and masks for PEPFAR-supported health facilities. As the CPDS continues to expand to include other commodities, SCMS will continue to work closely with CPDS to ensure appropriate integration of injection safety kits and waste management supplies, including development of a supply plan which integrates injection safety kits and waste management supplies. Regular quantification support for these commodities will also be provided to CPDS. SCMS will also ensure appropriate and timely integration of injection safety kits and waste management supplies information into the national logistics system to ensure appropriate stock management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	7,456,497	

Narrative:

In FY 2010, SCMS will continue working closely with the Centrale D'Achat des Medicaments Essentiels, Consommables et Equipments Medicaux du Rwanda (CAMERWA) to support them in conducting coordinated laboratory commodity procurements for the President's Emergency Plan for AIDS Relief

(PEPFAR) supported sites. Procurement will include laboratory equipment, supplies and reagents for biochemistry, early infant diagnosis (EID), hematology, microbiology, CD4, viral load and biosafety. This consolidated approach to procurement will increase cost savings and improve the efficiency in the current procurement, storage and distribution of commodities.

To inform these procurement decisions, SCMS will continue to support quantification activities within the Coordinated Procurement and Distribution System (CPDS), which includes the Ministry of Health (MOH), PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Clinton Foundation HIV/AIDS Initiative (CHAI), all USG clinical partners, and UNICEF. By FY 2010, SCMS should have built capacity with the CPDS to quantify the national laboratory needs which will include Antiretroviral (ART) and non-ART supported sites.

Nationally, quantifications for laboratory commodities occur every six months. On a quarterly basis, supply plans revisions will take place as a means of ensuring improved visibility on orders in the pipeline as well as the current stock on hand throughout the laboratory system. Under the current management plan, CAMERWA will begin taking over the leadership of the bi-annual quantification exercises of laboratory equipment, supplies and reagents in a stepwise manner and will be in charge of all quantification activities for all commodities by FY 2010. Overhead surcharges for SCMS procurement services that were previously paid through core funds at the SCMS Project Management Office (PMO) are now being absorbed by the country. These costs along with funds provided for technical assistance for quantification are included in the SCMS budget for FY 2010.

Through CAMERWA, SCMS will procure all of the biochemistry, hematology, and CD4 supplies for an estimated number of 202,469 patients needed in FY 2010. The revised National ART treatment guidelines call for viral load testing in cases of suspected treatment failure. To meet that need, SCMS will also quantify for and procure viral load reagents sufficient to cover the estimated needs of 5,250 PEPFAR supported patients. In addition to this site-level laboratory procurement, SCMS will procure equipment, supplies and reagents for specific central-level activities and functions, including: 1) kits and supplies for 21,000 PCR tests for the national EID program; 2) an estimated 2,500 additional viral load kits and associated supplies for the laboratory component of the national ART program impact evaluation; 3) test kits and supplies for continuing HIV serology and CD4 testing, Quality Assurance (QA) and training systems; 4) PCR supplies and reagents for expansion of PCR capacity to CHUB and as backup for the National Reference Laboratory (NRL); 5) supplies and reagents for opportunistic infections (OI) diagnostics for regional and district-level laboratories as well as supplies for ongoing microbiology.

The proper diagnosis, care and treatment of persons infected with or affected by HIV/AIDS, TB and Malaria requires the strengthening of laboratory health systems. One of the key elements of this effort is

the standardization of test kits, reagents, consumables and equipment needed at each level in the tiered laboratory system within a country. In FY 2010, SCMS will work in close collaboration with the NRL and the laboratory network to standardize equipment and laboratory supplies. Standardization is the process of harmonizing test menus, test techniques, operating procedures, and laboratory equipment for each type of test and for each level in the system. Standardizing the type of platform for laboratory equipment in chemistry, hematology, CD4 and viral load testing across different laboratory levels will offers many benefits to the laboratory system including: cost reduction due to bulk procurement; improved equipment service and maintenance of equipment due to a limited variety of platforms; ease of staff training due to common user interface on the systems; better standardization of reference ranges and test results, and thus improved continuity of care for patients who transfer from health centers to district facilities. Standardization will also help expand sustainable quality testing to improve care and treatment of people infected with and affected by HIV/AIDS, TB, Malaria and other diseases.

Currently, equipment maintenance and service are a critical challenge to the system. The Atelier Central de Maintenance (ACM), which is responsible for providing equipment maintenance in the country, has limited capacity to do so. A bulk of the existing equipment in country also lacks long term service and maintenance contracts from local vendors or respective manufacturers. In the funding provided in FY 2010, SCMS will support the ACM to improve upon the current situation with equipment maintenance and service. In FY 2010, SCMS will have the budget to procure approximately $3.1 million dollars of required equipment. This will represents approximately half the need of the laboratory system. This equipment will be used replace the equipment that is non-functional and support the needs of all PEPFAR implementing partners. In all future procurements of laboratory testing equipment, SCMS will negotiate long term contracts with various vendors and suppliers to ease the burden of service and maintenance responsibility of the ACM.

SCMS will also continue to support the laboratory logistics management System activities which by FY 2010 is expected to be generating consistent and quality logistics data for decision making. Key activities at that time period are expected to focus on supervision and continuous monitoring of the system to help ensure the smooth functioning and improved reporting rates from the logistics management information system (LMIS). The continuous support and strengthening of the logistics system will also help improve the visibility of logistics data from the Health Centers, District Hospitals and Pharmacies for improved decision making for quantification, procurement ordering and distribution.

In FY 2010, SCMS will work in close collaboration with the National Reference Laboratory and the lab network towards World Health Organization (WHO) Accreditation through improved monitoring and support of inventory management and maintenance of equipment to provide uninterrupted service. Accreditation of laboratories offers many benefits, including: strengthening of laboratory management;

working in a safe environment, delivery of a smooth and efficient service; providing prompt, accurate and validated test results in a timely manner to promote client satisfaction; capacity building and improved quality in laboratories internationally.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	10,912,056	

Narrative:

In FY 2010, funds for ARV medications will continue to support three components:

1. Under the stewardship of the Ministry of Health, SCMS works closely with the Centrale d'Achats des Medicaments Essentiels du Rwanda (CAMERWA), TRAC Plus and the Pharmacy Task Force (PTF) to forecast, procure, warehouse, store, and actively distribute PEPFAR financed ARVs. SCMS has been supporting CAMERWA to strengthen its warehouse management, stock keeping and financial management systems including the installation of computerized management information systems in order to ensure it maintains maximum control over inventory management and distribution of ARVs thus minimizing the risk of stock outs . These drugs are procured through the Coordinated Procurement and Distribution System (CPDS) for 151 PEPFAR-supported ART sites and 62,368 patients. The SCMS Procurement Adviser based at CAMERWA will complete his advisory support during FY 2010. As part of the exit strategy, SCMS will ensure that outstanding skills, knowledge and procurement processes are transferred to CAMERWA procurement staff. A strengthened procurement system making use of framework agreements, value for money and best practice procurement processes and annual procurement planning will ensure that stock outs of ARVs do not occur during FY 2010.

2. SCMS is the lead agency building the capacity of the CPDS. SCMS provides technical support and supervision to the Quantification Committee, the Resource Management Committee and the Implementation Committee to ensure optimal use of funds provided by all donors including PEPFAR. This activity also supports coordination between donors and implementing partners and includes conducting analysis of data on stock inventory and consumption patterns at CAMERWA, Districts and FOSA as well as number of patients per regimes from health facilities. SCMS also continues to participate in quarterly data quality control visits with TRAC Plus and the district pharmacies in support of the coordination of the Laboratory Management Information System (LMIS) between districts and CAMERWA. In addition, SCMS collaborates with the USAID|DELIVER project in the harmonization of family planning, malaria, and other health commodity LMIS applications and the training of the users of these applications. Although there were no reported stock outs of ARVs during FY 2008, emergency orders were placed in three instances to prevent stock outs occurring. The ARVs concerned were Nevirapine, Lamivudine and Tenofovir. These situations arose because of incomplete consumption data

from health facilities and non adherence to agreed national treatment protocols. FY 2009, therefore saw an increased emphasis on strengthening LMIS systems to improve data collection, reporting and validation at all levels in order to prevent the threat of stock outs. This included computerization of the national LMIS and training and roll out in the use of the harmonized forms. This support will continue during FY 2010 with roll out of further supply chain management training to new and existing ART sites. The objective being to minimize and prevent the risk of stock outs and to ensure a harmonized and standardized supply chain at all levels of the supply chain system in Rwanda.

3. SCMS collaborates with PTF/MOH and CAMERWA to strengthen quality assurance (QA) systems. It is critical that all medications reaching patients are safe, effective and meet quality standards. SCMS works with e PTF, CAMERWA and the CPDS to ensure prudent supplier and product selection and certification, and other components of the World Health Organization (WHO) Certification Scheme. SCMS also supports the establishment of Thin-Layer Chromatography (TLC) and mini-laboratories in collaboration with the MOH, University of Butare and the National Reference Laboratory (NRL) to test the quality of ARVs.

New and significantly more expensive treatment regimens, including Tenofovir (TDF), have started being prescribed in Rwanda beginning September 2009 for new patients starting on ARVs as well as patients determined to be failing on currently prescribed ARV regimens. Consequently, additional resources will need to be identified and carefully planned for if the scale-up proceeds not as intended. PEPFAR funds are being utilized to purchase first-line treatment regimens. All pediatric and 2nd line ARV drugs have been donated by CHAI for the past years; however the CHAI second line ARV and pediatric programs are respectively ending in 2009 and in 2010. As many as 4,071 (5% of total ART patients) or more patients predicted to be on 2nd line ARVs by the end of 2011 (with the increased VL testing efforts in identifying patients with treatment failure) could be prescribed new and more expensive second line regimens. The two recommended 2nd line regimens (as per the revised national STG): AZT/3TC/LPV-r and TDF/3TC/LPV-r will cost respectively US $ 606.63 and 621.72 per patient per year. Prescribing the second line regimens to this number of patients could by itself amount to over US $ 2,500,306.42 Close monitoring and coordination with other partners whose financial support helps pay for ARV medications in Rwanda's non-PEPFAR-funded ARV sites, along with ongoing evaluation of the impending regimen changes will be of critical importance for continued ARV treatment success across the country.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	1,073,305	

Narrative:

In FY 2009, SCMS worked in close collaboration with CAMERWA, NRL, CHUK and CHUB and will

provide technical assistance and funding for the procurement, storage and distribution of all medicines, equipment and laboratory supplies for TB OI's (Cryptococcus infections and other fungal infections) and malignancies related to HIV .

In FY 2010, SCMS will procure anatomical histology equipments with twelve months of warranty and maintenance agreements, Lab consumables and reagents for the pathology to continue diagnosis activities and expand support to the Butare and Kigali University Hospitals. This activity is conducted in collaboration with AIDSRelief, who provides trainings through the Institute of Human Virology, for laboratory technicians and physicians for improved extra pulmonary TB and HIV related malignancies diagnostic .These endeavors will enhance timely diagnosis capabilities for extrapulmonary TB among PLWHA in line with PEPFAR strategy to decrease the burden of TB on PLWHA.

These activities contributes to the Rwanda PEPFAR five-year strategy goal of integrating TB and HIV services by strengthening TB diagnostic capacity at Rwanda's major reference hospitals.

12. Social and Scientific Systems/MEMS

Social and Scientific Systems/Monitoring and Evaluation Management Systems project (SSS/MEMS) will provide monitoring and evaluation (M&E) support to all PEPFAR implementing partners carrying out activities under this budget code, thus strengthening in-country institutional capacities in M&E.

SSS/MEMS has deployed a web-based reporting system for reporting of semi-annual and annual program results' by all PEPFAR implementing partners in Rwanda. This system is updated before each reporting period to reflect changes in PEPFAR indicators and changes required as a result of feedback from users during the previous reporting period. Implementing partners are provided with user training of the system and followed up during each reporting period to ensure data quality. Data quality assessments are carried out in collaboration with GOR counterparts for the PEPFAR indicators, thus building national capacity in this area.

Meetings are held with USG teams, implementing partners and host country counterparts to ensure a shared understanding of GOR and USG reporting requirements and indicators, and to enable the capture of PEPFAR indicators in the GOR databases.

SSS/MEMS will generate burden tables and maps using reported data, to depict USG-supported service coverage for specific indicators. This will enable USG and GOR counterparts to better plan for HIV/AIDS interventions in the country.

M&E capacity building support will be provided to PEPFAR implementing partners to improve their performance monitoring plans, annual work planning processes, reporting and use of data.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7159	**Mechanism Name: Behavior Change Social Marketing BCSM**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,769,425	
Funding Source	**Funding Amount**
GHCS (State)	3,769,425

Sub Partner Name(s)

Action des Eglises Evangeliques pour la Promotion de la Sante et Developpement (AESD)	Association Rwandaise des Travailleuses Chrétiennes Féminins (ARTCF)	Cooperative Housing Foundation
Districts Non-IRS Malaria Districts	Eglise Episcopal au Rwanda, Diocese de Shyira (EER)	Eglise Presbyteriénne au Rwanda (EPR)
IRS Districts	John Hopkins Bloomberg School of Public Health, Center for Communication Programs (JHU-CCP)	New Partners Fund - men who have sex with men (MSM) /commercial sex workers (CSW) /prisoners; parent child communication (PCC)
Private Sector Federation	Réseau Rwandais des Personnes vivant avec le VIH / SIDA (RRP+)	Rwanda Network of People Living with HIV/AIDS (ASOFERWA)
Rwandans Allied for Peace and	Society for Women and AIDS in	Urunana

Progress (RAPP)	Africa (SWAA)	

Overview Narrative

In January 2008, PEPFAR Rwanda awarded a consortium of partners, with Population Services International (PSI) as the prime, a 5-year cooperative agreement to implement integrated behavior change and social marketing (BCSM) activities for HIV. The cooperative agreement also covers other significant health issues including malaria, family planning and maternal & child health. The main objectives of the 5 year agreement are to develop and manage a cost-effective marketing, sales and distribution network that improves access to branded products related to HIV/AIDS, malaria, reproductive health and child survival; to develop and implement health communication activities that enhance behavior and promote health seeking behaviors among Rwandans; to develop and enhance services and referrals, particularly mobile HIV counseling and testing, to most at risk populations (MARPs); to improve the management and technical capacity of Rwandan institution(s) to manage and implement similar programs in the future through a transfer of technical skills and capacity building, and to increase the availability of data and evidence available to inform programming in key health areas.

Social marketing and mass media communications activities under the BCSM project operate at national scale, while intensive community mobilization, mobile service outreach, and interpersonal communications operate in 15 of 22 PEPFAR-supported Districts. Key target populations and messages include youth 10-18 (for delayed sexual debut), high risk sexually active youth 15-29 (for secondary abstinence, partner reduction, correct and consistent condom use, and CT), married and cohabitating couples (for fidelity, correct and consistent condom use, and couples counseling and testing (CT), and MARPs (correct and consistent condom use, partner reduction and couples CT) including female sex workers, MSM, and people living with HIV/AIDS.

This activity contributes to Rwanda's Partnership Framework objective of halving HIV incidence in the general population by 2012 by reducing risky sexual behavior among the General Population, MARPs (including PLWHA), Discordant Couples, and Youth 15-24 through targeted evidence-based comprehensive prevention interventions including social marketing of condoms, behavior change communications (abstinence, fidelity and partner reduction, correct and consistent condom use, couples CT, and general life skills and parent-child communications for youth), and mobile outreach CT (including STI diagnosis and treatment referrals and FP/HIV integration).

Transition activities include technical and institutional capacity building for a range of Rwandan Partner Organizations to design, manage, and implement PEPFAR-funded activities over time. This includes providing institutional, technical and sub grant support for 11 local community based organizations to lead community mobilization and interpersonal communications, technical support for the sustained

development of the national Health Communications Center to lead multi-level, multi-media campaign development, technical capacity building for local CT providers to implement MARP-friendly approaches for outreach CT, integration of and training in social marketing research methodologies across research and technical partner institutions, and the development of a Rwandan Social Marketing Institution.

PLWHA-targeted interventions include a crosscutting water activity to increase knowledge and use of POU water treatment, hygiene, and safe water storage through health facilities providing VCT and ART, through faith-based RPO targeting PLWHA, and through associations of PLWHA through RRP+, the national network of PLWHA.

Cost efficiency will improve over the life of the project with condom pricing and cost recovery adjustments according to increased consumer ability and willingness to pay; continued development of a more efficient demand-based distribution system of strengthening existing commercial, institutional and community-based distribution networks; transition of direct implementation of community mobilization and interpersonal communications by PSI to more efficient community-based organizations; and coordinated mobile CT service delivery through local public providers using more cost effective CT approaches (such as finger prick).

PSI will conduct joint monitoring and evaluation activities with public, private and community partners, including routine GIS mapping of product distribution, routine analysis of CT client intake and satisfaction forms, rigorous pre- and post-test analysis of training activities, mystery client supervision of CT service delivery, and behavioral tracking surveys which will measure the impact of levels of exposure to communications activities on factors influencing key program indicators.

Cross-Cutting Budget Attribution(s)

Water	400,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7159**

Mechanism Name:	Behavior Change Social Marketing BCSM		
Prime Partner Name:	Population Services International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	396,000	

Narrative:

Research has shown that 90% of PLWHA are affected by diarrhea, which in turn results in significant morbidity and mortality. Hand washing, sanitation, water disinfection and safe storage have been proven to significantly reduce diarrhea rates. According to the 2005 Rwanda Demographic and Health Survey, only one-third of surveyed households had access to a protected source of drinking water. A significant cause of exposure to diarrheal disease-causing pathogens is inadequate access to safe water. Only 40% of the Rwandan rural population and 60% of the urban population have access to safe water. The objectives of the point of use (POU) activities are to ensure consistent use of POU water treatment products by PLWHA; to increase access to POU water treatment products by PLWHA; and to improve knowledge of POU and its effectiveness, hygiene, and safe water storage.

In FY 2009, 200 service outlets, serving 5,000 PLWHA were provided with HIV-related palliative care. Outlets included health centers and PLWHA--managed income generating cooperatives. Messages were delivered through peer education, IPC and door to door sessions conducted by CHWs and PLWHA association members. A total of 854 people were trained to provide HIV-related palliative care, including 462 public providers (22 district personnel and two providers each from 220 health facilities providing VCT/ART) and 392 PLWHA associations and community volunteers (12 RPO TOT, 80 PLWHA association members and 300 community volunteers).

POU programming through PSI includes distribution of two products, including Sûr'Eau, a locally produced POU liquid solution which recovers the cost of production with every bottle sold, and Pur, a targeted, internationally-produced flocculent disinfectant powder sachet which is particularly effective in treating turbid water and water retrieved from surface sources. Sûr'Eau was launched in FY07 with USAID funding for distribution through community health workers, the community health insurance program, public health facilities, Rwandan Partner Organizations (RPO), and commercial distribution networks. Pur will be launched with international funds in 2010 to target communities with particularly turbid surface water, leveraging existing commercial networks and RPOs, particularly those targeting PLWHA. This activity complements PSI's child survival activities around preventing diarrheal disease in children under five years

In FY 2010 PSI will intensify the POU program targeting PLWHA to increase knowledge of POU, hygiene

and safe water storage through health facilities providing VCT and ART, through faith-based RPO targeting PLWHA, and through associations of PLWHA through RRP+, the national network of PLWHA. Activities will include intensified training of trainers, peer education through trained RPO members, community-based distribution as an income generating activity for associations of PLWHA, community events, and mass media communications, which will help avoid stigmatizing the POU products for the general population. Water signage will be expanded for placement at water points in PEPFAR districts, so that safe water messages are targeted at points where communities gather. The activity will expand product availability at health facilities, ensuring access for VCT clients, regardless of HIV status. Additional starter stock will be provided to associations to expand distribution to PLWHA associations trained by partners supported by PSI. PSI will continue to integrate safe water, POU and hygiene messages into existing VCT, care and support materials in collaboration with GOR, USG clinical partners and community partners, to ensure consistent delivery of product and messages to people who present for testing.

PSI supports regular joint supervision visits between the PSI POU and M&E teams and local authorities who oversee technical quality of program implementation by RPOs. RPOs will also receive institutional support through regular financial and institutional mini-audits and ongoing mentoring by the BCSM capacity building partners of PSI, JHU-CCP and CHF. Training impact will be monitored by improved pre- and post-test QA materials and analysis.

In line with the Partnership Framework objectives, PSI will intensify activities with a particular emphasis on strengthening associations and RPOs targeting PLWHA in cholera-prone districts, and communities sourcing turbid surface water. Intensified sub-granting to local partner organizations, and all associated supportive supervision and capacity building activities, will strengthen the capacity of RPOs to solicit, lead and report on direct funding grants in the future. Community-based distribution of the locally produced product will provide a sustainable income generating opportunity for a locally produced cost recovery product which does not require a donor subsidy. RPOs and associations of PLWHA will be strengthened through training of trainers, institutional assessments and capacity building programs, ongoing mentoring and supportive supervision by the BCSM capacity building team of PSI, JHU-CCP and CHF. This, and all BCSM activities, will contribute to the development of a Rwandan Social Marketing Institution in a sustainable manner.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	752,400	

Narrative:

In collaboration with clinical partners, HCT services outside the clinics will improve the referral linkage for

care and treatment services. The clinics follow-up HIV-positive clients over a long period of time, and are well-place to focus on appropriate counseling for the prevention for positive program. Referrals are a particular challenge for transit camp inhabitants, some of whom come from other regions of the country.

Provision of HCT services will be complemented by interpersonal communication (IPC) to increase demand for HCT among MARPs, targeted condom social marketing activities and integrated BCC campaigns to address factors increasing risk for HIV transmission, such as concurrent partners, gender based violence (GBV), and alcohol abuse.

Supportive supervision and QA:
Regular, joint supervision visits by will be carried out by district health authorities and technical PSI staff (VCT Specialist, HCT QA Manager, and/or M&E Manager) to provide support to VCT counselors and ensure high quality counseling and data collection.

New activities and plans for transition:
New activities in CY 2010 will center around scaling up approaches to reach MSM. A roster of local VCT counselors meets the counseling needs, promoting sustainability of services. Sub-granting to a local partner to provide VCT services at Gikondo transit camp is being explored in FY 2009. This component will also contribute to the strengthening of a range of Rwandan Partner Organizations, including local providers who can implement outreach HCT, community based organizations which can mobilize communities and improve targeting, and the development of a Rwandan Social Marketing Institution. It will also facilitate the integration of social marketing research methodologies into the national research agenda and teaching curricula.

Capacity building activities:
Members of the VCT team (counselors, lab techs and a counselor supervisor) will be trained in a variety of topics related to VCT using, where possible, GOR curricula, including, but not limited to, general counseling, couples' counseling, stress management, FP, STIs, VCT supervision techniques, PDA data entry and high-quality data collection techniques. As with other training activities, participative, adult learning techniques will be used, as well as ongoing support and supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	792,000	

Narrative:

Working through Rwandan Partner Organizations (RPOs) in 15 districts, FY 2010 AB activities will extend the AB messages developed for the WITEGEREZA and SINIGURISHA campaigns, since shifting social

norms and attitudes requires a long term approach. The WITEGEREZA or "Don't Wait" Social Support Campaign was designed in FY 2006 by the CNLS and Ministry of Health, with financial support from USAID, KfW, and DfID and technical support from PSI to address the lack of social support for children, which can put them at risk for HIV transmission. The campaign challenged the social norms that hinder parents in their efforts to help young boys and girls to manage their sexuality. Using a traditional Rwandan proverb, "Igiti kigororwa kikiri gito," or, "A tree is only straightened while it is young" the campaign was designed to remind parents that reaching young people early gives us the best chance of shaping positive sexual attitudes and behaviors later in life.

The SINIGURISHA anti-cross generational sex (CGS) campaign was designed in FY 2007 by CNLS and launched by the Ministry of Youth in FY 2008 to empower youth to recognize their right to refuse sugar daddies and sugar mommies, resist pressure from their peers to partake in CGS, and encourage self esteem and solidarity among youth. Evidence from a campaign evaluation planned for late FY 2009 will inform the direction and content of future communication interventions, with the long term goal of changing society's view of the practice and to promote a sense of responsibility among youth and adults to take public action against cross generational practices that put youth at risk.

In response to evidence that new HIV infections are occurring primarily among married couples in Rwanda, PSI will continue to work within the national BCC strategy to promote fidelity and discourage concurrent relationships. Since CGS is a form of concurrent partnership (CP), the campaign messages will lead nicely into a CP mass media campaign on this very issue which will also be supported from HVOP funds. In FY 2010, CP messages will be developed in collaboration with CNLS and approved by the National Committee for Behavior Change Communication (CNCCC). AB messaging is expected to focus on fidelity/partner reduction.

By strengthening the capacity of RPOs to deliver campaign messages through interpersonal communication (IPC) activities at the community level, RPOs are complementing mass media channels and extending campaign reach. A variety of IPC approaches are used to address and overcome barriers to healthy AB behaviors among target groups (out-of-school youth, couples, opinion leaders such as teachers, religious leaders, local authorities), including peer education and life skills training, peer outreach, community dialogues, family days, sports tournaments, as well as dance, theatre and cultural events.

Supportive supervision and QA include routine joint supervision of RPO field implementation, using standardized supervision tools; will inform program design and implementation. Pre-post tests will assess training quality and performance. Message guidelines developed in FY 2009 by PSI's M&E Department will be used as tools to strengthen peer educators' capacity to carry out IPC sessions.

Description of targets: (1) # of target population reached with individual and or small scale level HIV prevention interventions that are primarily focused on AB: 55,000 and (2) # of individuals trained to promote HIV prevention programs through AB: 150. This target assumes that 6 groups of 25 out-of-school peer educators, selected by RPOs at district level, will be trained on peer education/life skills.

New activities and plans for transition in FY 2010 include intensification of existing activities, with a focus on transition to a range of RPOs, including technical and institutional capacity building and sub-granting for indigenous community based organizations who will lead community mobilization and IPC, support for the ongoing development of the national Health Communications Center, and the development of the Rwandan Social Marketing Institution.

In terms of capacity building, BCSM will continue institutional strengthening for RPOs (including the Rwandan Social Marketing Institution) through ongoing institutional assessments and follow-on capacity building in the form of trainings, routine audits and follow-on checklists, mentoring exchanges, and ongoing feedback. International technical advisors funded by BCSM will be shifted out of line management roles and "twinned" with senior Rwandan staff to design, lead and implement program activities over time. This component will also support the ongoing strengthening of the national Health Communications Center, facilitate integration of social marketing research methodologies into the national research agenda and teaching curricula, and contribute to the development of a Rwandan Social Marketing institution.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,829,025	

Narrative:

PSI HVOP activities address factors influencing condom use, high-risk sexually active youth 15-29, urban men with discretionary income, MARPs, PLWHA and couples. Activities address condom stigma, lack of condom knowledge, and social norms, and barriers to condom communications. Other strategies include hot-spot activities to increase condom access at night through a test of targeted condom vending machines, behavior change communications targeting high-risk workers such as bar maids, domestic workers and commercial sex workers, and partnerships with Rwandan partner organizations (RPO) to distribute and use new condom demonstration kits to improve condom knowledge and self-efficacy. All condom communications integrate gender considerations to empower Rwandan women to access and negotiate condom use. PSI will also co-design and implement, with GOR, a multiple concurrent partnerships campaign, to promote condom use among couples.

PSI invests in developing a cost efficient demand-based condom distribution system by strengthening commercial distribution networks to reduce dependence upon PSI as a direct source of condoms. FY 2010 sales and distribution activities will strengthen existing commercial networks by engaging new wholesalers who can serve the national commercial distribution networks. PSI will support onsite and radio wholesaler promotions, promotional support to "prime" the distribution network, and "blitzing" retail outlet creation where retail outlet and quality of coverage fall below minimum standards according to routine distribution mapping audits. With a total marketing approach, social marketing will allow public and community distribution, to ensure Rwandans access at all levels of the socioeconomic spectrum through community-based distribution of condom demonstration kits, and training of trainers for RPOs to provide condom demonstrations. PSI will work to strengthen active distribution of public sector condoms, to ensure that all health facilities and community based distribution agents, particularly those offering treatment to PLWHAs, have condoms and are distributing them to clients seeking care. PSI also supports district-led advocacy events. Four districts will receive technical and financial support for advocacy events to engage the private sector to expand condom access and availability.

Using the GEM model, PSI will conduct in-depth gender norms qualitative analysis that will provide guidance for improving programming addressing gender and male norms. PSI will continue support for the development and interpretation of the planned rounds of the Rwandan Behavior Surveillance Study (BSS), focusing on mapping commercial sex workers and their clients and identifying the factors influencing risk behavior among BSS target populations. Supportive supervision and QA will be conducted through routine GIS distribution mapping to inform condom social marketing activities, directing retail outlet creation and product promotion to areas underserved by the existing commercial distribution networks. Pre- and post-tests will assess training quality and performance. Routine joint supervision of RPO field implementation with local authorities will inform program design and implementation.

The targets:
• Condom service outlets created: 8,000 (including 3,000 new outlets and 5,000, which receive POS and IPC support in regional retail outlet creation efforts).
• Target population reached with individual and or small-scale level HVOP HIV prevention interventions: 80,000 reached through bar promotions by temporary product promoters, through trained RPOs, and by PSI staff.
• Individuals trained to promote HIV prevention programs through OP: 4,200.
Including 200 retail representatives, and 4,000 representatives of RPO's.

New FY 2010 transition activities include intensifying activities, with a focus on transitioning to a range of RPOs, including technical and institutional capacity building and sub-granting for indigenous community

based organizations who will lead community mobilization and interpersonal communications, support for the ongoing development of the national Health Communications Center, and the development of the Rwandan social marketing institution (RSMI). PSI will continue efforts to strengthen existing commercial distribution networks to reduce dependence at all levels upon a donor-funded distributor as the direct supplier of condoms. Routine market and consumer analyses will assess pricing according to consumer willingness and ability to pay, and retailer willingness to stock, so price increases reduce the product subsidy required over time.

PSI will continue building institutional capacity of RPOs, including the RSMI, through institutional assessments and follow-on capacity building in the form of trainings, routine audits and follow-on checklists, mentoring exchanges, and ongoing feedback. International technical advisors funded by PSI will be shifted from line management roles and "twinned" with senior Rwandan staff to design, lead, and implement program activities. PSI will conduct joint monitoring and evaluation activities with private, public and community partners, including routine GIS mapping of product distribution, pre- and post-test analysis of training activities, and behavioral tracking surveys to measure impact levels of exposure to communication activities on factors influencing key program indicators.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7160	**Mechanism Name: PSI-DOD**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,003,860	
Funding Source	**Funding Amount**
GHCS (State)	1,003,860

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Rwanda EP five-year strategy highlights the military as a high-risk group. A Knowledge, Attitudes, Practices survey conducted in 2004 indicated that the majority of soldiers are single and under age 34. While some practice sexual abstinence and fidelity, their mobility, age, and income make them vulnerable to HIV. For married soldiers, the distance from their families can make it difficult to maintain stable relationships. Field assignments place military personnel far from the military and public health system, reducing their access to testing, treatment, care and support services. Since COP05, the US Department of Defense has supported the Ministry of Defense through technical partner PSI to implement high quality mobile VCT, promotion of safer sexual behaviors, and strengthening of anti-AIDS clubs. Over 27,000 military personnel have been tested, with all clients testing positive referred in for follow on treatment, care and support services. This Ministry of Defense-led "center of excellence" has significantly increased access to testing, treatment, care and support. A COP08 behavioral tracking survey will measure correct and consistent condom use, and the factors influencing safer sexual behaviors.

With COP08, the US Department of Defense awarded PSI a follow-on 3-year mechanism: HIV/AIDS prevention and services support to the Rwandan Defense Forces (RDF). This award intends to reduce HIV incidence and to mitigate the impact of the HIV/AIDS epidemic among Rwandan Defense Forces, their partners and surrounding communities by increasing safer sexual behaviors among soldiers and their partners (including abstinence, fidelity away from home, and correct and consistent condom use), increasing use of high quality VCT services by RDF, their partners, and high risk individuals in the local civilian population (including commercial sex workers), and improving referrals to care and support services. It also seeks to improve knowledge, attitudes, demand for, and referrals to male circumcision services, including parallel promotion of ongoing safer sexual behaviors such as correct and consistent condom use. PSI provides technical assistance to Directorate of Medical Services in Rwanda's Ministry of Defense to implement high quality mobile VCT (bringing VCT to the battalions in the field), to strengthen anti-AIDS clubs to promote safer sexual behaviors and MC, and to produce and disseminate communications materials, including videos, print materials, training aids, etc. Communications approaches include training of peer educators, interpersonal communications (IPC) through peer education and outreach, mobile video unit (MVU) and educational sessions, and community events.

COP10 will continue to support high quality VCT services with 2 mobile testing units targeting military personnel, their partners, and surrounding community members. CT promotion and services will educate about MC and the importance of ongoing correct and consistent condom use, referring uncircumcised soldiers in for MC services. Anti-AIDS club strengthening will continue in 15 districts, with trained peer educators (PEs) conducting ABC prevention activities which also address the links between HIV, alcohol and gender-based-violence (GBV). Delivered through a range of channels, AB, OP, CT and MC messages will be informed by the findings of the behavioral survey being conducted by DMS and PSI in early COP09, focusing on the factors influencing sexual behavior and the attitudes towards MC. Spousal

access to prevention information and CT services will improve in COP10 as a result of the spouse "mapping" proposed by DMS in COP09.

This activity fits with the partnership framework objective of halving the incidence of HIV in the general population by 2012 through the reduction of sexual transmission by promoting safer sexual behaviors and male circumcision. It also contributes to the PF framework objective of reducing HIV/AIDSS-related morbidity and mortality by referring HIV positive CT clients into follow-on treatment, care and support services. For transition, this activity will continue efforts to strengthen the Ministry of Defense Directorate of Medical Services to design, implement and monitor effective CT and AB, OP and MC communications activities. It will also strengthen anti-AIDS clubs to generate income to sustain activities, and strengthen program monitoring and evaluation for improved program effectiveness, including evidence-based message development based on the FY 2009 behavioral study, and qualitative focus group discussions, effective client intake data collection and analysis, routine supervision, and routine pre- and post-test training analyses.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7160**		
Mechanism Name:	**PSI-DOD**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	539,550	
Narrative:			
In FY 2010 PSI will provide logistical and technical support to DMS to provide quality HCT services, training of the HCT team and support to ongoing, regular data analysis of client intake forms at DMS.			

Two mobile VCT units will be available in FY 2010, one for RDF members and another for their spouses, partners or surrounding community members, as required. Family planning (FP) and MC information was integrated into pre- and post-test counseling in or before FY 2009. The approach to target spouses with HCT services will also be developed in FY 2010. First, DMS has proposed to carry out a mapping exercise to understand where spouses of RDF members are located in Rwanda. Then, dedicated mobile HCT services will be organized to reach spouses in a cost-effective and efficient manner. Spouses may also be referred to fixed military clinics for VCT, if possible. The approach may be modified in FY 2010 to promote couples' HCT, because testing of the RDF member and spouse together would be expected to improve disclosure rates and ensure that the couple is adequately supported through the process. In addition, family days will be convened to promote CHCT and other relevant topics. The DMS refers HIV-positive soldiers and their spouses to care and treatment services (provided by Drew Cares International), where they are supported by prevention with positives programs. In this regard, condoms are widely promoted through the military program for dual protection, and are generously available through military pharmacies. HIV-negative, uncircumcised soldiers will be referred to MC services, when and where available (see HVMC budget notes).

In FY 2009, the client intake form (that collects basic socio-demographic and behavioral information), was re-established, supplemented by training and joint supervision by PSI and DMS of the HCT team on the importance of high-quality data collection and data entry by PDA.

Members of the VCT team (DMS counselors, lab techs and a counselor supervisor) will be trained using, where possible, GOR curricula, in a variety of topics related to VCT, including, but not limited to, general counseling, couples' counseling, stress management, FP, VCT supervision techniques, PDA data entry and high-quality data collection techniques. As with other training activities, participative, adult learning techniques will be used, as well as ongoing support and supervision.

17. Population Services International/Youth and MARPs Friendly Services

FY 2010 will continue to support comprehensive voluntary counseling and testing (CT), STI services and family planning (FP) counseling for youth and young MARPs at, and in communities around Dushishoze ("Let's take care" in the Rwandan language) youth-friendly centers, with quality of services supervised by PSI and district health authorities. FY 2010 will continue to fully support management and technical implementation at 4 fixed sites and extend MARPs-targeted mobile outreach services to an additional 4 sites, improving youth and MARPs access to high quality CT in 8 of 30 districts.

Evidence-based CT promotion and MARPs-targeted outreach services will ensure improved targeting and effectiveness of CT services. In 2007 and 2008, approximately 44,000 youth were tested at 4

centers; 2.8% of youth aged 15-24 (3.3% in girls; 2.4% in boys) tested HIV-positive. The centers successfully targeted vulnerable youth: boys tested at the youth centers were 6 times more likely to be HIV-positive than the national average, while girls were twice as likely.

In FY 2010, "moonlight" HCT and STI services (provided on weekend evenings) will be expanded to hotspots in Kigali city and around an increased number of youth centers to further improve MARPs targeting. PSI will also continue to work through youth cooperatives (where PEs are trained) and Rwandan Partner Organizations so that more vulnerable youth and traditionally hard-to-reach groups, such as motoboys and domestic workers, will be encouraged to seek VCT, STI and FP counseling and services.

FY 2010 CT efforts will continue to emphasize the importance of couples testing. Youth-friendly centers are proving to be an effective entry point for couples testing and counseling, which is a critical HIV prevention intervention in Rwanda, given that new HIV infections are occurring primarily among married, discordant couples. On average in 2007 and 2008, 23% of all clients at youth centers came as couples, 90% of whom were not yet married. Among these young couples seeking VCT at youth centers, ~6% of married couples, and ~4.5% of not yet married couples were serodiscordant, compared to 2.2% of cohabiting couples in the general population who were discordant (DHS 2005). In FY 2010, a couples' VCT pamphlet developed in FY 2008 and produced in FY 2009 will be distributed to young couples (e.g. at universities and through faith based organizations) to promote couples' HIV testing. Young couples will be reached through anti-AIDS clubs at most universities and colleges in Rwanda, which were established following the Inter-Universities Conference of the FY 2008 anti-cross generational sex campaign.

While accurate STI statistics are not available in Rwanda, being HIV-positive is clearly associated with prior history of STIs among the general population (DHS 2005) and among youth seeking VCT services at youth-friendly centers. The Center for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics (TRAC Plus) is developing revised national guidelines for management of STIs in FY 2009 and FY 2010 activities would collaborate with TRAC Plus and the MOH in the implementation of these guidelines. STI services (including screening, diagnosis, and treatment) and FP counseling will be provided as part of VCT services, thereby ensuring that youth who access the centers receive a comprehensive package of services. An STI/HIV integration model will be developed that screens high risk youth with STIs for HIV, and those with HIV for STIs (including male clients of CSWs and their sexual partners). We will also promote "repeat testing" for high-risk groups and develop innovative approaches to provide condoms and STI services to high risk youth and ensure linkages of these services to care and treatment.

Condoms will be offered liberally to all CT clients to ensure that people who test positive can protect

themselves and their partners as they seek follow-on referral services. By promoting condoms for dual protection to all clients, regardless of HIV status, the activity will avoid stigmatizing people who test positive. HIV-positive clients will be referred to nearby health centers for care and treatment and prevention for positives programs (condom distribution and promotion, promotion of FP, partner disclosure, etc). Referrals will be verified by the VCT team, through regular visits to health centers to pick up counter-referral slips. HIV negative young men will be referred to the health system to access MC services, as soon as they are available through the health system, and all CT counseling will stress the ongoing importance of safer sexual behaviors, including correct and consistent condom use. Screening tools for history of sexual abuse and history of concurrent partnerships piloted in FY 2009 will be scaled up to reach individuals vulnerable to HIV.

The existing FY 2008 and FY 2009 brand for youth and MARPs friendly service (YMFS) providers (Dushishoze) will extend from the youth-friendly centers to public providers who will be trained and receive support for providing youth- and MARPs-friendly follow-on services. In FY 2010, PSI will pilot this approach with 10 public and private providers working in areas surrounding each of 4 fixed-site youth- and MARPs-friendly centers. Once certified, providers will receive branded signage and uniforms, as well as educational materials and assistance in refurbishing their offices to make them more youth- and MARP-friendly. The youth centers will host weekly youth- and MARPs-friendly clinics, with providers serving the youth center in rotation. Providers will have an opportunity to build relationships with Dushishoze Center staff, and bring services to youth who may not be empowered to seek services on their own.

Supportive supervision and QA:
Regular, joint supervision visits by will be carried out by district health authorities and technical PSI staff (VCT Specialist, VCT QA Manager, and/or M&E Manager) to provide support to VCT counselors and ensure high quality counseling and data collection. Client intake and satisfaction forms will be entered by PDA at site level and analyzed regularly to inform program activities. Dr. D providers will receive regular continuing education, and be monitored and supported through monthly visits to Dr. D clinics to reinforce and refresh skills and to ensure compliance with quality standards. Random mystery client visits to providers will confidentially assess provider quality.

Description of targets:
• Service outlets providing VCT and STI services according to national and international standards: 6. This target includes 4 fixed sites and 2 mobile sites for moonlight VCT. The 2 mobile sites will serve the 4 fixed sites and 4 additional fixed sites funded under other funding sources, increasing access in 8 total districts.
• Individuals trained in counseling and testing for HIV and STIs according to national and international

standards: 120. This target assumes training of the local counselor team (~10) and 5 PSI VCT staff at each site, and 10 Dr. D providers in areas surrounding the 4 youth centers.
• Individuals who received VCT and received their test results: 30,800. This target maintains FY 2009 targets at or around fixed sites (6,500 per youth center) plus 100 clients per month per additional youth center through moonlight VCT.

New activities and plans for transition:
A team of ~10 local district-level VCT counselors will be established in each of 6 districts to meet counseling needs and promote sustainability of services. ~10 public providers from public and private clinics in each of 4 youth center districts will provide YMFS in their own clinics, and youth centers will host weekly provider clinics, with providers serving the youth center in rotation. This approach will maximize sustainability of YMFS services, giving providers an opportunity to build relationships with Dushishoze Center staff, and bringing services to youth who may not be empowered to seek them on their own. This activity will also support the development of the Rwandan Social Marketing institution. Finger prick VCT will significantly reduce the cost and complexity of outreach VCT services. Fixed CT site management will increasingly be managed by sub-grant through Rwandan Partner Organizations, including the National Youth Council.

Capacity building activities:
Members of the VCT team (counselors, lab techs and a counselor supervisor) will be trained in a variety of topics related to VCT using, where possible, GOR curricula, including, but not limited to, general counseling, couples' counseling, stress management, FP, STIs, VCT supervision techniques, PDA data entry and high-quality data collection techniques. Public youth-friendly Providers will be trained in delivery of YMFS, STI treatment and FP counseling and product use. As with other training activities, participative, adult learning techniques will be used, as well as ongoing support and supervision. In addition, PSI will provide technical input to TRAC Plus and CNLS to the BSS and data triangulation exercises, as required.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	173,250	

Narrative:

In FY 2010, male circumcision (MC) communications activities will focus on formative research to inform IEC materials development, IEC materials development, public opinion leader (POL) and/or peer educator (PE) training and IPC approaches, as well as VCT counselor training to integrate MC content into pre- and post-test HIV counseling. MC communications will be informed by findings of the behavioral survey conducted by Directorate of Military Services (DMS) and PSI in early FY 2009, which focused in

part on basic knowledge and attitudes related to MC. Focus group discussions will be held to explore potential barriers to MC and attitudes about prevention with condoms in light of male circumcision. MC communications will address four main areas: demand creation, education around the procedure, promotion of safe healing, promotion of sustained safer sexual behaviors after MC (partner reduction and/or consistent condom use). Together with DMS, IEC materials such as counselor aids/flipcharts, pre- and post-op pamphlets will be developed to create demand within the military and to educate men on the procedure. IPC approaches will use either POLs within the military who have undergone MC procedure, and are trained to educate and make referrals to others, or military anti-AIDS club PEs. HIV negative, uncircumcised RDF members will be referred from VCT services to MC services within the military health system.

Supportive supervision and QA:
Regular, joint supervision visits by DMS and PSI will be carried out to provide guidance and encouragement to POLs and/or PEs in each anti-AIDS club. VCT QA Managers at PSI will carry out supportive supervision of DMS VCT supervisors and counselors to ensure that MC is integrated into VCT services.

Description of targets:
• Number of target population reached with individual and or small scale HIV/AIDS prevention interventions primarily focused on MC: 15,000. The proportion of RDF members who are circumcised is currently unknown, but the vast majority of these men are HIV negative. As this is a new activity, the number of target population reached with MC messages (15,000) was estimated as approximately 15% of individuals or small groups reached by AB and OP messages.
• Number of HIV negative individuals referred for MC services: 750. This target is based on 50 HIV negative, uncircumcised soldiers referred for MC from each anti-AIDS club.
• Number of individuals trained as MC peer educators: 30. This target is based on two individuals trained per anti-AIDS club.

Plans for transition include joint development of materials, supervision and implementation of activities with DMS and other partners (e.g. JHPIEGO) to promote sustainability of interventions. In FY 2009, training approaches for VCT counselors were developed with DMS and JHPIEGO. In FY 2010, these materials will be used for refresher trainings which will reinforce counselor's capacity to integrate MC messages into pre- and post-test counseling. In addition POL/PE training curricula for demand creation and education about the procedure will be adapted from those available from other PSI platforms (e.g. Swaziland, Zambia). As with other training activities, participative, adult learning techniques will be used, as well as ongoing support and supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVAB	148,500	

Narrative:

As in most locations, the military in Rwanda is a high-risk group for transmission of HIV/AIDS. A knowledge, attitudes, practices (KAP) survey conducted in 2004 indicated that the majority of soldiers are single and under age 34. While some practice sexual abstinence and fidelity, their mobility and age make them vulnerable to engage in high-risk activities and exposure to HIV/AIDS. For married soldiers, the distance from their families can make it difficult to maintain stable relationships.

In collaboration with the Directorate of Military Services (DMS), PSI/DOD AB activities will include strengthening anti-AIDS clubs through training, support and supervision of peer educators (PEs) in 16 anti-AIDS-clubs in 14 districts. Health communication approaches will include interpersonal communications (IPC) through peer education and outreach, mobile video unit (MVU) and educational (theater, poem and drama) sessions, production and distribution of IEC materials, and income generating activities.

PEs are trained in ABC prevention to address links between HIV, alcohol and gender-based-violence (GBV). PEs will carry-out IPC sessions with their colleagues, stressing AB or C to different target audiences within the Rwandan Defense Forces (RDF) (married or single), informed by the findings of the behavioral survey that was conducted by DMS and PSI in early 2009. PEs will encourage married members of the RDF to practice abstinence (A) while on duty, and be faithful (B) to their spouses. Quality of messages delivered through IPC activities will be ensured through the use of message guidelines, to help PEs flesh out myths/misconceptions, frequently asked questions, and how to respond to questions posed to them by their peers.

An interpersonal and mass media communication strategy will be employed in order to reach both primary and secondary (spouses and other partners) target audiences, with messages about abstinence, fidelity, couples' communication, family planning (FP) and parent-child communication (PCC), complemented by IEC materials (posters, a 40-minute MVU film, and comic book) developed in FY 2008 and produced in FY 2009. Spouses' access of AB information will improve in FY 2010 as a result of: 1) the "mapping" of spouses proposed by DMS in FY 2009; and 2) increased access to HIV prevention services through a dedicated mobile VCT unit for spouses. Family days will be convened to promote FP, PCC and other topics.

In terms of supportive supervision and QA, there will be regular, joint supervision visits to be carried out by DMS and PSI to provide guidance and encouragement to PEs in each anti-AIDS club and supervision of approximately 6 IPC sessions/club and 6 clubs/month. Message guidelines developed in FY 2009 by

PSI's M&E Department will be used as tools to strengthen PE's capacity to carry out IPC sessions. In addition, film and comic book animation guides will be developed to guide PEs to conduct small group discussions.

Description of targets:

1. Number of target population reached with individual and or small scale level HIV prevention interventions that are primarily focused on AB: 23,700.
This target assumes that PSI and DMS staff directly reach 9,000 individuals through anti-AIDS club supervisions per year, and the military PEs from 15 anti-AIDS clubs reach 70,000 individuals, for a total of 79,000 individuals reached by all messages. Married or not sexually active individuals are estimated to be 30% of the total, or 23,700 individuals.

2. Number of individuals trained to promote HIV prevention programs through AB: 200.
This target assumes a total of 20 trainers are trained through a TOT, and 12 PEs trained per anti-AIDS club.

New activities and plans for transition:
Joint development of IEC materials, training curricula, supervision and implementation of activities with DMS will promote sustainability of interventions.

Capacity building activities:
TOT and PE training activities are conducted jointly by DMS and PSI use standardized curriculum developed with DMS, as well as pre- and post-tests that measure gains in knowledge (including comprehensive HIV knowledge) before and after trainings. In FY 2008, efforts were initiated to harmonize training approaches across military program partners, including Drew University and JHPIEGO, leading to increased co-facilitation of trainings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	142,560	

Narrative:

In collaboration with the Directorate of Military Services (DMS), OP activities in FY 2010 will include training, and support and supervision of military, civilian and commercial sex worker (CSW) peer educators (PEs) from anti-AIDS-clubs in 15 districts. Messages will focus on the factors influencing correct and consistent condom use (identified in the behavioral tracking survey implemented in early FY 2009) and positioning condoms for dual protection. Activities will focus on small group IPC supported by

a condom demonstration kit developed in 2009. Health communications approaches will include interpersonal communications (IPC) through peer education and outreach, mobile video unit (MVU) and educational (theatre, poem and drama) sessions, and production and distribution of IEC materials. FY 2010 will scale up the pilot initiated in FY 2009 to train military anti-AIDS clubs in retail outlet creation or community-based distribution of Prudence condoms and Sûr'Eau point-of-use water purification solution to ensure availability of condoms in retail outlets and hotspots in communities surrounding military camps. Revenues will be used to strengthen anti-AIDS clubs.

Due to considerable advocacy efforts in FY 2008 to include CSW peer educators in PSI-supported military anti-AIDS clubs, CSWs will reach their peers with messages addressing the factors influencing correct and consistent condom use and reinforcing safer sexual behaviors of military members. CSWs will also increase access to VCT services and care and treatment.

OP messages will be informed by findings of the behavioral survey conducted by DMS and PSI in early FY 2009, which focused in part on condom use by partner type and identification of the factors influencing correct and consistent use. IEC materials that promote OP messages were developed in FY 2008 and produced in FY 2009, including a 40-minute film script that integrates messages on condom use, STIs, GBV and alcohol use. The film script was developed and pre-tested in collaboration with DMS and was approved by the National Committee for Behavior Change Communication (CNCCC). Comic book scripts created in FY 2009 to continue the storylines and further develop the characters and messages in the film will be continued through FY 2010.

Supportive supervision and quality assurance include regular, joint supervision visits to be carried out by DMS and PSI to provide guidance and encouragement to PEs in each anti-AIDS club, supervision of approximately six IPC sessions per club as well as six clubs per month.

Description of targets:
• Number of targeted condom service outlets: 16.
This target assumes that community-based distribution of condoms will be established at 16 military anti-AIDS clubs.
• Number of target population reached with individual and or small scale level HIV/AIDS prevention interventions that are primarily focused on OP: 75,050.
Of the total of 79,000 individuals expected to be reached by all messages, 5% are estimated to not be sexually active. Therefore 95% of individuals (75,050) should be reached by OP messages.
• Number of individuals trained to promote HIV prevention programs through OP: 200.
This target assumes a total of 20 trainers are trained through a TOT, and 12 PEs trained per anti-AIDS club.

New activities and plans for transition:
Joint development of IEC materials, training curricula, supervision and implementation of activities with DMS will promote sustainability of interventions. In addition, establishing community based distribution of health products by military anti-AIDS clubs is a more sustainable approach than direct budget provision.

Capacity building activities:
Trainers will be trained to train others in use of the condom demonstration kit, an important tool produced in FY 2009 and standardized for national use. Military, civilian and CSW PEs in anti-AIDS clubs will be trained to use the condom demonstration kit in small group interventions.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7161	**Mechanism Name: Tulane Capacity Building**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tulane University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,959,100	
Funding Source	**Funding Amount**
GHCS (State)	2,959,100

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Capacity building is a cornerstone of PEPFARs strategic plan for a sustainable response to the HIV/AIDS epidemic in Rwanda. Under this award, Tulane University is mandated to harmonize PEPFAR support to Government of Rwanda (GOR) institutions for capacity building in health care. The purpose of Tulane's award is to support and develop public health capacity within Rwanda by strengthening the institutions in

higher learning responsible for producing the workforce for the health sector. Specifically, this award aims to strengthen local institutions responsible for providing high quality education and training to qualified candidates in the areas of public health, social work, nursing, midwifery, medical education, and human resource management.

This award links directly to the Partnership Framework in that it seeks to strengthen Rwandan institutional and human capacities, produce qualified human resources for health in the quantity that Rwanda needs, and transition to increased country ownership of health programs. . Institutional twinning and technical assistance will be employed to assist Rwandan institutions of higher learning in the health sciences assume primary responsibility for the planning and design, implementation, monitoring and reporting of education and training, research, and community outreach programs as well as for the strategic direction and financial management of their respective institutions. Benchmarks will be established to measure institutional capacity in these areas. As capacity is demonstrated consistently over time, responsibilities will be shifted progressively towards Rwandan ownership. Examples of such benchmarks include evidence of adequate preparation, planning and delivery of educational and training activities via the existence of published academic calendars and summary student course evaluations. Consistently accurate and timely invoicing of research grants and contracts is another benchmark towards financial and managerial capacity.

The geographic coverage of this award is national in scope and targets national level institutions as well as a spectrum of human resources in the health sciences sector from central to district staff level within the MOH, faculty and administrative staff within institutions of higher education, technical staff within national and international NGOs, recent university graduates entering the health sector as young professionals as well as direct service providers of psychosocial support (eg. counselors, nurses, psychologists, and social workers).

This award contributes directly to health systems strengthening in the development of human resources for health via multiple activities including pre and in-service training, management and leadership development, retention, workforce planning and institutional twinning. Additionally, this award supports its Rwandan partner institutions of higher learning via infrastructure support to enhance technology-driven, learning laboratories and establish cutting edge audio-visual conference centers. This award's focus on human resources for health and educational institutional capacity building in will contribute to the sustainability and country ownership of the health system. Developing the health workforce through continuing education and training opportunities and creating a 21st century, high-tech learning environment will provide Rwanda's health system with the tools necessary to function efficiently and effectively with reduced external support.

This award also includes a faculty development component, providing opportunities to qualified professionals at national educational institutions to pursue and complete advanced degrees up to the doctoral level. As Rwandan institutions of higher learning augment their workforce with highly trained professors in health sciences, savings will be incurred as the necessity for external expertise is reduced. The establishment of Internet-capable learning laboratories will provide students and faculty greater access to online resources, reducing the cost of expensive texts. Furthermore, such infrastructure will provide broader access to students unable to attend physically in the classroom via distance offerings.

Monitoring and evaluation plans will be linked to mutually agreed upon annual work-plans detailing the types and sources of information to be provided. Specific benchmarks related to transition of responsibility will be articulated in subcontract agreements between Tulane and its Rwandan partner institutions. Evaluations of the training courses and institutional capacity assessments will inform future activities.

54. United Nations High Commissioner for Refugees

Rwanda is host to approximately 53,000 refugees in three refugee sites around the country. Refugee populations are considered to be at high risk of infectious disease, in particular HIV, as well as SGBV and its associated consequence and psychological distress.

UNHCR has been benefiting from PEPFAR funds since 2007 to implement a comprehensive HIV/ AIDS program in Kiziba refugee site located in Kibuye district/sector. Based on the successes and lessons learnt from the past years of project implementation UNHCR through its partner will continue to strengthen the implementation of HIV/AIDS program in the Kiziba refugee site.

The goal of this program is to ensure that refugees and host communities living with HIV/AIDS have access to HIV information, quality HIV care and treatment services as well as supporting a successful Anti Retroviral Treatment adherence that assures viral suppression. UNHCR will continue to support trainings on a sustainable basis, provision of HIV/AIDS messages, basic care and treatment to HIV, TB and OIs to the greatest number of needy refugee patients and in the hosting community, consistent with PEPFAR strategy and GOR national priorities.

UNHCR will continue to strengthen and support the provision of HIV health care services ranging from prevention, care and treatment to refugees and hosting community.

To achieve these activities, UNHCR will strengthen staff capacity to use new guidelines/standards and protocols adopted by both UNHCR/GOR through conducting trainings, mentoring at different levels of

implementation.

UNHCR is committed to working in close collaboration with the Government of Rwanda, UN agencies and NGOs to strengthen its support to HIV care, support and treatment to refugees and the hosting community.

To ensure monitoring and evaluation of the planned activities, UNHCR will strengthen monitoring and data management systems, for collecting, managing, and analysis of clinical data at the health facility, strengthen feedback mechanism for better performance.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	480,100
Human Resources for Health	2,479,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7161**		
Mechanism Name:	**Tulane Capacity Building**		
Prime Partner Name:	**Tulane University**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	2,959,100	

Narrative:

Tulane's activities in FY10 will continue to support the development of institutional and human capacities to increase Rwandan ownership and establish Rwandan leadership in the production of its human resources for health. These activities will include; ongoing delivery of education and training in collaboration with key partner institutions (National University of Rwanda's School of Public Health (SPH), Faculty of Medicine (FACMED), and Department of Social Sciences (DSS)); building research capacity and improving quality of teaching; needs assessments in collaboration with other donors; strengthening administrative and financial management among partner institutions and; developing new

training courses, revising current curricula in response to recommendations of the needs assessment.

Ongoing delivery of education and training
In collaboration with the SPH, Tulane delivers a two-year, MPH day program encompassing four course modules, with candidates drawn primarily from district health teams. Course modules emphasize Rwandan health priorities and programs, including HIV/AIDS, and utilize actual case studies and data sets to support learning. An HIV certificate program is delivered jointly with the SPH entitled Strategic Information in Support of HIV/AIDS Programming. This six week program targets HIV researchers and program managers drawn from MOH units such as CNLS and TRACplus, faculty from institutions of higher learning in the health sciences, other GOR ministries (including Gender), local NGO umbrella organizations including the Rwanda Network for PLHIV (RRP+), other local NGOs and faith-based organizations. The HIV certificate program comprises the following courses: Clinical & Epidemiological Aspects of HIV/AIDS and Opportunistic Infections; Applied Behavioral Research; and Introduction to Monitoring and Evaluation Research of HIV/AIDS Programs. Through COP10 Tulane will support 10 students in pursuing their MPH and 30 in completing the HIV certificate program.

Tulane also supports an on-the-job training program, implemented by the SPH, for young professionals recently graduated from university in a variety of non-health backgrounds: economics, management, law, and social sciences among others. This Rwanda HIV/AIDS Public Interest Fellowship (RHPIF) program combines multiple short-term trainings with placement in a host agency working to combat HIV in Rwanda. Through the two-year fellowship, fellows receive an annual stipend, a personal laptop, and cell phone service, and are closely supervised by a host agency mentor and RHPIF/SPH staff. Training in computing, project management, and grant/ proposal writing is provided at the beginning at the program and then intermittently every six months, culminating in the HIV certificate program entitled Strategic Information in Support of HIV/AIDS Programming described above. Training is delivered by SPH faculty and visiting lecturers from the MOH and Tulane University. As part of COP 10 the program will groom 20 young professionals for careers in HIV/AIDS.

In collaboration with the FACMED, Tulane through its US partner, the University of Colorado Denver, Center for Global Health, is involved in the training of 23 medical post-graduates, including seven in Family and Community Medicine. This four-year, post-graduate program prepares physicians to function with a broad clinical scope at the district and health center levels of care so as to better address the burden of disease existing in Rwanda's rural communities. This program also strengthens the capacity of select district hospitals to function as University teaching institutions appropriate for the training of family medicine physicians and other specialists. Visiting faculty from the University of Colorado have also provided teaching support in critically needed strategic curricular topics not currently provided with existing teaching resources in the FACMED for post-graduate specialist programs.

In collaboration with the DSS, Tulane delivers the PSS graduate certificate program entitled Psychosocial Support to PLHIV to participants drawn from Rwanda's institutions of higher learning who are responsible for training individuals who are providing social work and psychosocial services to community members. Through COP10 the 60 participants will be drawn from university departments of social sciences, local and international NGOs, and government health institutes and departments. The PSS certificate, comprising three modules over the course of a 12 month period, seeks to build foundational knowledge and skills related to psychosocial service delivery in an HIV/AIDS context; train students in supporting treatment adherence using a bio-psychosocial framework to establish continuity of care and coordinated service delivery; and enable students to identify individual and community strengths using a Rwandan socio-cultural context and taking into consideration human resource capacity for service delivery. As part of their training, students form teams and design and deliver their own PSS training to an average 30 district level counselors, sociologists, psychologists and nurses on specialized topics, realizing a cascade effect of the training of trainers methodology. Upon successful completion of the PSS certificate, students receive nine graduate credits from Tulane University's School of Social Work (SSW) to advance their pursuit of higher degrees. From this group another 15 students will be selected to participate in a Training-of-Trainers certificate program in social work and counseling.

Evaluations of these ongoing training activities and the in-depth, nationally conducted needs assessment will inform the continuation and potential need to scale up these training courses in FY10.

Building research capacity and improving quality of teaching
Continued technical assistance will be provided to enhance pedagogic, research, and programmatic capacity. On-going activities include Tulane's faculty development initiative to continue strengthening faculties at the SPH and DSS. This initiative will support two select faculty members in the pursuit of doctoral degrees at Tulane or other appropriate institutions to ensure that Rwandan colleagues acquire the necessary qualifications to assume greater responsibility within their academic institutions. Tulane faculty will also co-chair doctoral committees and mentor DSS faculty pursuing a doctoral degrees at NUR.

Needs assessments
Tulane will support two key activities to determine training and institutional capacity building needs in the three partner institutions. Initially Tulane will collaborate with four other donors through the National Technical Working Group for Human Resources in an in-depth needs assessment. This assessment is designed to determine the health workforce needs in Rwanda, taking into account the disease burden, existing cadres and ongoing trainings (pre and in-service). Thereafter an analysis of institutional capacity, including 'institutional preparedness to transition' will be conducted.

Strengthening administrative and financial management among partner institutions
New activities under COP10 for human resources for health seek to build upon existing capacity strengthening efforts to accelerate transition and to provide partner institutions with foundational infrastructure to support their educational and training efforts. Technical assistance will target institutional management capacity of partner institutions such as SPH, FACMED, and DSS so as to develop appropriate human resource management policies and procedures taking into consideration the challenges of retention of qualified faculty in low paying academic posts. Participatory efforts will engage key stakeholders to identify innovative means of compensating faculty and key staff so as to maintain high quality and performing faculties. Technical assistance will emphasize strengthening financial management systems and reporting especially as it relates to grants and contracts management for both principal investigators and financial and administrative staff. Multiple focused, short-term technical assistance visits targeting appropriate counterparts within each partner institution will be conducted throughout the COP10 year to accelerate the transition of managerial responsibility.

New activities under COP10 will also focus on renovation and infrastructure support to establish technology-enhanced learning laboratories, an audio/visual conference center and a sound studio. A networked, thin-client learning lab for 100 students inclusive of online subscriptions to select medical journals and reference texts and a 50 person audio/video conferencing center will be established at the FACMED. A sound studio to record and review undergraduate students' emerging counseling skills in role play situations will be established at the DSS. (The current undergraduate degree program in social work at the DSS enrolls approximately 260 students.) This renovation will strengthen both institutions' ability to deliver quality education and training programs and produce the human resources for health that Rwanda needs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7162	**Mechanism Name: Central Contraceptive Procurement**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: US Agency for International Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 594,000	
Funding Source	**Funding Amount**
GHCS (State)	594,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PEPFAR continues to procure condoms for both private and public sector distribution. In FY 2008, PEPFAR supported the procurement of an estimated 14.5 million condoms for the public and private sectors. In FY 2009, PEPFAR anticipates an increase in condom demand and use. PEPFAR procured approximately 18 million condoms: 12 million for social; 4 million condoms for the public sector and 2 million for the military. The Rwandan Defense Force (RDF) condom supply was previously supported by the World Bank/MAP project, but as that project has ended, the RDF had made an emergency request for the USG to support the military through the DOD program. As part of the Rwanda strategic plan, private sector condoms will continue to be socially marketed by PSI. Public sector condoms will be managed by the GOR/CAMERWA with both the quantification and logistical technical assistance being provided by DELIVER. Purchasing condoms supports the ABC approach outlined in the Rwanda PEPFAR five-year strategy. They had previously requested 30 million condoms for FY 2010 but due to issues with their distribution plan and competition from another vendor they have reduced their request for FY 2010 to 12.3 million condoms. Furthermore, Central Contraceptive Procurement is a key partner in condom procurement; however the targets for distribution and outreach will be attributed to PEPFAR partners providing direct services. As a result, there are no direct targets for this mechanism.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	7162		
Mechanism Name:	Central Contraceptive Procurement		
Prime Partner Name:	US Agency for International Development		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	594,000	

Narrative:

PEPFAR continues to promote branded and non-branded condoms for public and private sector distribution. USG contributes 48% of the total funding cost for male condoms in the country and 85% of the total cost associated with social marketing of condoms. There are more than 20 million branded and non-branded condoms in Rwanda with the majority of those being male condoms. There is little current country demand for female condoms due to cultural stigma. USG and GOR collaborate to ensure national availability of condoms, limited distribution problems, and clear policies for national uptake. In FY 2009, the condom stock remained solid with no foreseeable stock-outs.

CCP is a key partner in condom procurement; however the targets for distribution and outreach are dependent upon PEPFAR partners who provide direct services and/or prevention interventions. Based on the GOR NSP for HIV/AIDS, in addition to the general population, specific emphasis should be placed on MARPs to best reduce incidence. The population targets, therefore, include for youth ranging in age from 15-29 who frequent bars, urban men with discretionary income, MARPs, PLWHAs, and discordant couples. The geographical coverage is nationwide.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7335	**Mechanism Name: ARC**
Funding Agency: U.S. Department of State/Bureau of Population, Refugees, and Migration	Procurement Type: Contract
Prime Partner Name: American Refugee Committee	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 229,783	
Funding Source	**Funding Amount**

GHCS (State)	229,783

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Region/Country: Gihembe Refugee Camp (Gicumbi District, Northern Province) and Nyabiheke Refugee Camp (Gatsibo District, Eastern Province), RWANDA

Number and Description of Beneficiaries Targeted: 33,498 Congolese refugees from North and South Kivu, Democratic Republic of Congo

Period of the Program: 12 months: August 1, 2010 – July 31, 2011

Dollar Amount of Project: BPRM: $240,401

Project Description:
Since 2006 ARC Rwanda has been supported by US Government's President's Emergency Plan for AIDS Relief (PEPFAR) funds to provide HIV Prevention, Care and Treatment services in Gihembe and Nyabiheke camps serving over 33,000 Congolese refugees in Rwanda. With continued funding of $240,401 ARC Rwanda proposes to strengthen and expand its comprehensive HIV/AIDS Prevention, Care and Treatment programs in both camps. Each of the nine PEPFAR program areas will be addressed in a culturally appropriate and timely manner with full and consistent community participation in the program planning, implementation and review process. Funds for these activities will also address the key legislative areas of gender, wrap around services and stigma and discrimination.

Refugee populations are considered to be at high risk of infectious disease, in particular HIV, as well as gender based violence (GBV) and other forms of violence. Recent service statistics of newly implemented VCT and PMTCT programs in two camps record a prevalence rate of 2.5% among those tested, with at least 411 individuals currently known to be living with HIV. All residents of Gihembe and Nyabiheke camps are direct beneficiaries of ARC's HIV/AIDS program activities. ARC seeks to support and assist those individuals living with HIV and AIDS and to inform and reach out to those who are at risk for HIV by influencing positive changes in knowledge, attitudes, and behaviors about HIV/AIDS among all members of the community: women, men, girls, and boys.

The overall goal of ARC's HIV/AIDS program in Rwanda is to decrease the rate of HIV infection among the targeted population and provide quality care and treatment services for infected individuals.

Monitoring and evaluation of all program activities will be done at the field level via weekly and monthly reporting and data quality control.

A. Background

It is well established that conflict, displacement, and poverty make affected populations more vulnerable to HIV transmission. However, active conflict may have protective factors as well, such as restricted mobility, which serves to slow the spread of HIV within a population. HIV transmission among Congolese refugees depends upon numerous competing and interacting factors that exist among the target population. Factors specific to the Congolese refugees residing in Rwanda include: a relatively high amount of cross-border traffic amongst refugees due to geographic ease; the duration refugees have been in Rwanda, with some camps being open for more than 12 years; no sign of the conflict abating in DRC; and Gihembe camp is in an urban setting in the highest HIV prevalence district (Gicumbi) in Rwanda at 4.5%.

ARC has on-going comprehensive programs in both camps to address HIV and AIDS. Funding in 2006/7 from the US Government's President's Emergency Plan for AIDS Relief (PEPFAR) allowed ARC an opportunity to strengthen and expand the HIV/AIDS programming and interventions for these refugees to include PMTCT, VCT, palliative and prevention. During the 2007 – 2008 funding cycle ARC once again received funding through PEPFAR, making it possible to continue to provide and expand these vital services to incorporate increased prevention activities, TB and HIV treatment including ARV. The 2008-2009 and 2009-2010 PEPFAR cycles both expanded funding in order to further integrate ARV services, including opening on-site ARV services in both camps. Since the inception of ARC's HIV program interventions in both camps, there has been a steady increase in the number of people receiving HIV/AIDS related education, testing and treatment.

B. Profile of the Target population

Gihembe Refugee Camp: According to the most recent official UNHCR statistics, the present beneficiary population residing in the Gihembe camp is officially 19,343 refugees, with MINALOC (Ministry of Local Government) indicating the presence of up to 3,000 non-registered asylum seekers in the camp and immediate surrounding area. The refugees are from North and South Kivu, eastern DRC. The total population can be divided into the following percentages: females: 55%; males, 45%. 15 % are children under the age of 5 years; and 43% are children ages 5-17. 39% of the population is between 18-59 years of age and just 3% are 60 and over.

Nyabiheke Refugee Camp: The official UNHCR population of the Nyabiheke camp is 14,155 refugees. The vast majority of refugees in Nyabiheke camp are Congolese from North and South Kivu in eastern DRC. Many were new refugees in April, 2005, as a result of mass movement into Rwanda from DRC

following persecution and destruction of their villages. After the rapid expansion to accommodate over 3,500 refugee transfers from the Nygatare and Nkamira transit centers in late 2007, and again for over 4,600 refugee transfers in late 2008, the camp is now full to capacity and all existing land has been utilized. There is a strong likelihood that the population will increase due to continued unrest in the region and cross-border movement. The GOR is in the process of making land adjacent to the camp available for further expansion.

The total population can be divided into the following percentages: females: 56 %; males, 44%. 22% are children under the age of 5 years; and 43% are children ages 5-17. 33% of the population is between 18-59 years of age and just 2% are 60 and over.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7335**		
Mechanism Name:	**ARC**		
Prime Partner Name:	**American Refugee Committee**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	8,552	
Narrative:			
The American Refugee Committee has been providing HIV services in two refugee camps. In FY 2010, ARC will continue to support the provision and expansion of palliative care services and training of health providers, laboratory technicians, and community volunteers. ARC will continue provide, or offer referrals to, diagnosis and treatment of OIs and other HIV-related illnesses (including TB), as well as routine clinical staging and systematic CD4 testing. ARC will also ensure that medical records for all HIV-positive patients are accurate and complete. In addition, ARC will: provide routine psycho-social support at its facility and within the refugee camps; conduct home-visits; identify and train home-based care			

providers; support PLWHA associations; and offer routine counseling for PLWHA on nutrition and positive living. In partnership with the World Food Program (WFP), ARC will provide supplementary food to all PLWHA in the camps regardless of their ART status. HIV prevention messages will also be delivered at food distribution centers. ARC will monitor and evaluate basic care activities through ongoing supervision, QA, and data quality controls. ARC will also continue to build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS basic care activities by strengthening data collection and data analysis processes. Lastly, ARC will continue to integrate family planning services into HIV activities and integrate HIV messages into other health and community services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	119,358	

Narrative:

The services provided by ARC are designed to follow PLWHA from the time of diagnosis through the rest of their treatment, ensuring they receive proper clinical and nutritional counseling and care. These services also include ART in accordance to national guidelines, follow-up clinical monitoring, semi-annual CD4 counts, viral load testing for appropriate patients, management of ARV drug side effects, ongoing adherence counseling, nutritional counseling, and patient referral to palliative care services. In partnership with the WFP, ARC supports supplemental food for all PLWHA on ART. ARC also supports nationally certified training for health care workers in the camps on the provision of ART, adherence counseling, clinical monitoring, management of side effects, and referrals. In FY 2010, ARC will strengthen the network of services offered between the camps and the district hospital as well as ensure the safe transportation of specimens for all laboratory tests not available in the camp.

The services provided by ARC are designed to follow PLWHA from the time of diagnosis through the rest of their treatment, ensuring they receive proper clinical and nutritional counseling and care. These services also include ART in accordance to national guidelines, follow-up clinical monitoring, semi-annual CD4 counts, viral load testing for appropriate patients, management of ARV drug side effects, ongoing adherence counseling, nutritional counseling, and patient referral to palliative care services. In partnership with the WFP, ARC supports supplemental food for all PLWHA on ART. ARC also supports nationally certified training for health care workers in the camps on the provision of ART, adherence counseling, clinical monitoring, management of side effects, and referrals. In FY 2010, ARC will strengthen the network of services offered between the camps and the district hospital as well as ensure the safe transportation of specimens for all laboratory tests not available in the camp. The services provided by ARC are designed to follow PLWHA from the time of diagnosis through the rest of their treatment, ensuring they receive proper clinical and nutritional counseling and care. These services also include ART in accordance to national guidelines, follow-up clinical monitoring, semi-annual CD4 counts,

viral load testing for appropriate patients, management of ARV drug side effects, ongoing adherence counseling, nutritional counseling, and patient referral to palliative care services. In partnership with the WFP, ARC supports supplemental food for all PLWHA on ART. ARC also supports nationally certified training for health care workers in the camps on the provision of ART, adherence counseling, clinical monitoring, management of side effects, and referrals. In FY 2010, ARC will strengthen the network of services offered between the camps and the district hospital as well as ensure the safe transportation of specimens for all laboratory tests not available in the camp.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	25,655	

Narrative:

ARC will reach more refugees with HCT by strengthening PIT for TB and STI patients, malnourished and non-thriving infants, and patients presenting with HIV-related illnesses. In line with a revised strategy for a family-centered approach to HCT, ARC will provide training for staff in approaches for reaching family members of PLWHAs including improved counseling techniques to increase disclosure and encourage partners and family members to get tested, and contact tracing through care coordinator at the refugee facility. Ongoing community-based campaigns will utilize refugee groups, refugee community leaders, and PLWHA to communicate HIV/AIDS stigma reduction messages and promote HCT. Health providers will receive training and refresher training on PIT, as well as in counseling for youth, male partners, and other targeted populations in refugee camp settings. Counseling will emphasize partner reduction, stigma, and alcohol reduction to sensitize clients to issues related to GBV, as well as confront social norms that contribute to these issues. To ensure quality HCT service delivery, ARC will provide supportive supervision of HCT staff through QA, monitoring provider performance, routine quality reviews and will continue to support and strengthen the capacity of refugee health care providers to monitor and evaluate CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	2,691	

Narrative:

The American Refugee Committee has been providing HIV services in two refugee camps. In FY 2010, ARC will continue to support the provision and expansion of palliative care services and training of health providers, laboratory technicians, and community volunteers. ARC will continue provide, or offer referrals to, diagnosis and treatment of OIs and other HIV-related illnesses (including TB), as well as routine clinical staging and systematic CD4 testing. ARC will also ensure that medical records for all HIV-positive patients are accurate and complete. In addition, ARC will: provide routine psycho-social support at its facility and within the refugee camps; conduct home-visits; identify and train home-based care

providers; support PLWHA associations; and offer routine counseling for PLWHA on nutrition and positive living. In partnership with the World Food Program (WFP), ARC will provide supplementary food to all PLWHA in the camps regardless of their ART status. HIV prevention messages will also be delivered at food distribution centers. ARC will monitor and evaluate basic care activities through ongoing supervision, QA, and data quality controls. ARC will also continue to build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS basic care activities by strengthening data collection and data analysis processes. Lastly, ARC will continue to integrate family planning services into HIV activities and integrate HIV messages into other health and community services.
Co-trimoxazole

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	14,966	

Narrative:

Provide ARV services to pediatric PLWHA in need in 2 refugee sites.

The funds allocated to American Refugee Committee (ARC) for ARV services in FY07 were earmarked primarily for Gihembe camp in order to support the creation of stand-alone ARV services at this site. In FY08 TRAC Plus began to work with the staff in Nyabiheke refugee camp to certify it as an ART site, and transfer of ART patients took place in FY 2009. The package of services includes support to ARV-specific staff to follow all PLWHA from the time of diagnosis and ensure that they receive proper clinical and nutritional counseling and care. It also includes treatment with ARV according to the national guidelines, follow-up clinical monitoring, a CD4 count and VL accordingly to the national guidelines , management of ARV drug side-effects, ongoing adherence counseling, and patient referral to basic care and support services. ARC will assist heath providers in mentoring children and adolescent support groups that are established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment and assist with addressing issues around treatment adherence.

In partnership with WFP, ARC supports the provision of supplemental food to all PLWHA on ART through the FBP program. ARC also supports nationally certified training for health care workers in the camps in provision of ART, adherence counseling, clinical monitoring, management of ART-related side effects, and in referrals. In addition, ARC will strengthen the network of services offered between the camps and the district hospital, ensure transportation of specimens for all laboratory tests not available in the camps, and strengthen communication and referral systems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVAB	10,449	

Narrative:

ARC will promote AB messages to the refugee community, including in- and out-of school refugee youth, men and vulnerable women of reproductive age. ARC will provide refresher training to anti-AIDS clubs using AB materials adapted for the refugee context. ARC will support interpersonal prevention activities that aim to increase youth access to prevention services, such as anti-AIDS clubs, life-skills training, school-based HIV prevention education, and community discussions. Messages delivered will focus on abstinence and fidelity and also include topics on the relationship between alcohol use, violence, HIV, and stigma reduction. Key influential community members such as traditional and religious leaders and refugee camp leaders will also reinforce messages of abstinence, delayed sexual debut, being faithful, reduction of GBV and responsible consumption of alcohol.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	5,224	

Narrative:

The 2004 UNHCR behavioral surveillance survey (BSS) and the FHI-supported reproductive health assessment found high-risk behaviors among refugee camp populations, including multiple partners, transactional sex, male cultural and societal norms that encourage high-risk behaviors and GBV, low condom use, and alcohol abuse. ARC will program for Prevention with Positives (PwP), targeting HIV-positive refugee patients, including discordant and married HIV-positive couples; unmarried HIV-positive refugee men and women; and ART patients. Health providers and volunteers will also target condom/other prevention messages to high-risk populations in the camps-at-large. Target populations include VCT clients who test negative, non-married and unemployed men/women, and out-of-school at-risk youth, STI clients, community health workers, and refugees with demonstrated high-risk behaviors such as alcohol abuse and a history of GBV. In Addition, in FY 2010 ARC proposes to expand the existing programming to incorporate a livelihoods component that will increase economic empowerment and reduce vulnerability to HIV/AIDS among targeted groups through participation in income generating associations, voluntary savings and lending associations, and vocational training programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	21,509	

Narrative:

This is a continuing activity from FY 2009.

American Refugee Committee (ARC) has provided ongoing site level implementation support to improve uptake and quality of PMTCT services at 2 refugee camps in Rwanda: Gihembe and Nyabiheke.

In FY 2010 ARC will continue to provide a package of PMTCT services to 1,031 pregnant women at these 2 sites. The package includes counseling and testing, including male partners and family members, screening for STIs, infant feeding counseling, implementation of more effective PMTCT regimens, prompt CD4 count and clinical staging for HIV-positive pregnant women, combination ARV regimens for non-eligible women with rapid initiation of HAART for eligible women, safe delivery, infant and mother follow-up, CTX for OI prevention and early infant diagnosis and referral. Sites will also be supported to improve human resources through high-quality training and clinical mentoring, and to improve the integration of PMTCT with FP and MCH services. In addition, ARC will ensure an effective continuum of care and improve mother and infant follow-up by increasing patient involvement and community participation in PMTCT services, using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To ensure these linkages, social workers will train and supervise community volunteers and organize monthly health center meetings with staff from all services to follow-up on referrals and other patient-related matters.

In collaboration with TRAC Plus, ARC will support couples' counseling through training and on-site mentoring to improve pre- and post-test couple counseling quality, improve follow-up mechanisms for discordant couples and women testing negative in ANC to address seroconversion and pediatric infection during pregnancy and breastfeeding.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	21,379	

Narrative:

In FY 2007 ARC began implementing the national TB/HIV policy and guidelines at their two supported sites. In FY 2010, the goal is to ensure 100% of TB patients are tested for HIV that 100% of those who are eligible receive Co-trimoxazoleand 100% of those eligible receive ART. In addition, at ARC-supported HIV care and treatment sites, 100% of patients enrolled in HIV care will be routinely screened for TB, with the continued priority in FY 2010 to ensure regular TB screening for all PLWHA, and for those with suspect TB, ensuring adequate diagnosis and complete treatment. ARC will continue to build the capacity of national health staff by providing routine trainings on TB and TB/HIV. ARC will monitor all TB activities through ongoing supervision, QA, and data quality controls, as well as national-level reporting.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7336	Mechanism Name: CSP II
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: CHF International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 14,874,750	
Funding Source	**Funding Amount**
GHCS (State)	14,874,750

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Through the PEPFAR-funded HIGA UBEHO program, USAID and its partners (led by CHF) will support stability and resiliency among 72,000 HIV/AIDS affected and other vulnerable Rwandan households. The strategic objectives of HIGA UBEHO, which means 'be determined and live' in Kinyarwanda, include increasing vulnerable household access to quality health and social services; improving household resilience through economic, nutritional and educational investments; and strengthening local government and civil society capacity for health and social service provision.

In its second year, the local and international partners of HIGA UBEHO will build upon the holistic HIV/AIDS care, treatment, prevention and household resilience framework established FY 2009 (year 1 of the program). Key features included expanded technical assistance to OVCs through economic, educational and nutritional outreach; and health and social service system strengthening through Rwandan Partner Organizations and local government capacity building.

Targeted Sexual Prevention: In FY 2010, HIGA UBEHO will reach households with OVC, and PLWHA with organized communication activities to influence community and social norms, and promote behavior change. HIGA UBEHO will deliver behavior change messages through a variety of approaches including interpersonal communication, radio, community events and print materials. These messages will give voice to PLWHA and their families, as well as service providers, providing practical, immediate actions that they can take to improve their quality of life. Messages will focus on the full package of community-

based health, social and economic development services provided within HIGA UBEHO, as well as other wrap-around programs such as malaria, sexual and gender based violence prevention, tuberculosis, prevention of mother-to-child transmission, family planning.

Economic Stability and Household Resilience: In FY 2010 HIGA UBEHO's Adult Care and Support efforts will be geared towards achieving 3 major effect objectives, using a stratified approach to economic strengthening, based upon varying levels of household skill sets and resource bases: 1) increased revenue of targeted abahizi (the term will be used for program beneficiaries. It refers to individuals who are committed to reach their objectives) through integration into profitable value chains; 2) increased employment opportunities of CHH and other youth (18-22) through marketable vocational training and apprenticeships, building upon the work of CHAMP; and 3) increased household savings through increased participation in Internal Savings and Lending Groups (ISLGs) for abahizi households. Integrated within this framework, HIGA UBEHO will provide targeted food security assistance to vulnerable households through promotion of improved agricultural process and production (e.g., Farmer Field Schools) and improved household nutrition (e.g., use of the positive deviance hearth model and media-based behavior change outreach efforts).

OVC Care: In FY 2010, HIGA UBEHO program will continue to serve as the main coordinating mechanism for PEPFAR-supported OVC activities. Using a network approach, HIGA UBEHO will link HIV/AIDS clinical and community partners by connecting community members with wrap-around and non-HIV/AIDS services that are supported by other funding streams to ensure that OVC and their families receive a comprehensive package of services tailored to their needs. In FY 2010, HIGA UBEHO will also strengthen existing natural social linkages in the community for child protection, care and support, work closely with RPOs and districts to strengthen OVC identification and create a national OVC database, assess the needs of individual OVC and their families, and offer multiple services and/or refer OVC and their families to other services in the community, based on these needs. Specifically, HIGA UBEHO will expand its support to OVCs from 43,000 to approximately, 55,000. The program will use the child status index and link closely with the GOR's National OVC M&E system to ensure proper OVC follow-up, referral and service provision.
Dovetailing on the school fees and uniforms distribution effort undertaken in FY 2009, HIGA UBEHO will indirectly engage with the schools in which they are enrolled, to address constraints to continued school enrollment and retention. The "Living A Productive Life" campaign will utilize multiple channels to mobilize greater support for school attendance and retention, including radio programming, community fairs, fun-academic (educational events which include entertainment and cultural activities) competitions and cultural performances.

Health Systems Strengthening and Capacity Building: In FY 2010, HIGA UBEHO will continue to provide

financial and technical support to 17 RPOs to improve their capacity to provide quality services to Abahazi. During the operational year, HIGA UBEHO will also introduce a community of practices to link RPO with capacity to those in need. The Community of practices will help RPOs learn from one another in technical and organizational development areas. HIGA UBEHO will increase its focus on organizational mentorship during COP 10, providing additional onsite interaction between HIGA UBEHO facilitators (CHF, CRS, CARE staff) and RPO service providers for the technical implementation of activities, financial management, service quality assurance and organizational development.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7336**		
Mechanism Name:	**CSP II**		
Prime Partner Name:	**CHF International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	2,475,000	

Narrative:

This is continuing activity under a new award

CHF/Higa Ubeho was awarded in FY 2009 to continue to support community based activities for people living with HIV/AIDS (PLHA) and their families. In FY 2010 CHF will focus on increasing the financial stability of vulnerable households through economic initiatives. These activities will be targeted towards OVC, PLHA, and their families. The overarching strategy of this program is to strengthen the stability of households through improved finances, advanced vocational skills and better nutrition. Through selection process based on the revised MIGEPROF tools for identification and profiling of vulnerable children, Higa Ubeho will identify households in need of assistance and target them for specific economic strengthening activities. Existing PLHA groups, associations and cooperatives from the previous CHAMP program will

also be targeted in this initiative. A referral system which provides forward and backward linkages across the components of Higa Ubeho will engage community groups and abahizi (participants) in this program.

Higa Ubeho activities will be geared towards achieving the major objectives: increased revenue of targeted abahizi through integration into profitable value chains; increased employment opportunities for CHH and other youth (age group 18-22) through marketable vocational training and apprenticeships; and increased household savings through greater participation in Internal Savings and Lending Groups (ISLGs) for abahizi households. Higa Ubeho will adopt a tiered and stratified approach to economic strengthening of vulnerable households, a strategy based on the reality that individual households have different resource and skill sets, and thus different needs. At the top of this pyramid, Higa Ubeho will identify strong, well organized and long established cooperatives of abahizi which will act as models for the abahizi groups in the process of organizing economic activities.. The model cooperatives will be given specialized support to ensure that they remain efficient, which will lead to increased revenues for their members. This will ensure that they not only serve as examples to the many pre-cooperatives and groups of vulnerable abahizi but also provide them new potential market outlets and sources of income.

For the resource-constrained, poor and vulnerable groups at the bottom of the pyramid, Higa Ubeho will focus on building their asset base by providing support in establishment of ISLGs and linking them to formal banking institutions (as well as the Umurenge SACCOs) as means of accessing credit. Higa Ubeho will train the ISLG members in market literacy, financial literacy and basic house hold budgeting, including prioritization of payments for health insurance, school materials and basic nutrition. Trainings in succession planning and the legal rights of children to property will be provided as well.

Higa Ubeho will also work towards building the productive capacity of the more organized pre cooperatives by engaging private input dealers to develop seed and input distribution systems. Support to agronomic excellence through farmer field schools, field days and demonstration will ensure wide dissemination of farming best practices to beneficiary communities. This will lead to enhancing food security for the most vulnerable households.

In FY 2010 Higa Ubeho will build on the work of CHAMP by targeting CHH and out of school OVC (18-22 years) with vocational training. Emphasis will be placed on identifying marketable vocational skills and providing training on these skills to CHH and youth referred through Higa Ubeho's program linkages. A select number of vocational institutions will be supported in integrating business skills training into their standard package of vocational training. In order to increase the inclusion of youth into employable vocational training, the program will initiate an apprenticeship program through which CHH are exposed to real world business environments and gain hands on skills in various sectors. Higa Ubeho will continue to provide vocational education subsidies for this training.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	11,172,150	

Narrative:

In FY 2009, the Higa Ubeho program provided financial and technical support to nine Rwandan Partner Organizations (RPOs) in 20 districts, reaching over 45,000 OVC with a menu of services and training 6,000 OVC mentors. In FY 2010 Higa Ubeho will continue to build the institutional capacity of RPOs working to give vulnerable groups access to essential health and social services, and to build more resilient families through economic and social coping mechanisms. This program will also consider the end of the Track 1.0 OVC agreements during FY 2009 and will ensure a smooth transition for their beneficiaries in the 20 districts where Higa Ubeho is operating.

Higa Ubeho will serve as the main coordinating mechanism for PEPFAR-supported OVC activities by providing TA, training and financial support to local partners to support and strengthen their capacity to provide care directly, as well as by supporting GOR programs and policies for OVC by seconding technical staff at the central level.

Higa Ubeho will continue to advance the network model by linking HIV/AIDS clinical and community partners, and by connecting community members with wraparounds and non-HIV/AIDS services which to ensure that OVC, PLWHA, and their families receive a comprehensive package of services tailored to their needs. To ensure sustainable change, Higa Ubeho will: support and strengthen existing natural social linkages in the community for child protection, care and support; work closely with RPOs and districts to strengthen OVC identification and support the GOR to build a national OVC database; assess the needs of individual OVC and their families; and offer multiple services and/or refer OVC and their families to other services in the community, based on their needs. The child status index (CSI) will be utilized to monitor the well-being of children and all information reported to the GOR's national OVC M&E system.

In addition to supporting individual OVC and their families, Higa Ubeho will indirectly engage with their schools to address constraints to continued school enrollment and retention. The "Living a Productive Life" campaign will utilize multiple channels to mobilize greater support for school attendance and retention, including radio programming, community fairs, academic competitions and cultural performances. Higa Ubeho will identify (or establish, if necessary) and build the capacity of Parent-Teacher Associations (PTAs) at participating schools, in line with MINEDUC objectives. Schools targeted under this intervention will be identified in partnership with district education officers. Criteria for selecting schools will include willingness to participate in the project and having a minimum threshold of project-supported OVC enrolled at the school. And to break the chain of absenteeism and poor

performance, Higa Ubeho will establish 'Drop-Out Prevention Response Teams' within the supported PTAs. Trained PTA members will form these teams and use common profiles to recognize the signs that a child is at risk of dropping out of school and proactively intervene using a toolkit of strategies to be developed by Higa Ubeho, based on demonstrated good practice in Rwanda.

To support primary education Higa Ubeho will offset family financial constraints by providing school kits consisting of essential school supplies and uniforms, tailored to the different needs of each grade. In addition, Higa Ubeho will sensitize communities to the importance of education, particularly for vulnerable populations such as girls and CHH as part of the "Living a Productive Life" messaging.

For children completing primary education who do not qualify for upper secondary education, or who choose not to go, assistance will be provided to enroll in a Technical and Vocational Education and Training (TVET) program. Higa Ubeho will complement existing TVET services by providing program youth with an initial interest survey and/or self-assessment tool to help them identify the program which best matches their interests.

Higa Ubeho will continue to give special attention to child-headed households and take a family centered approach to providing care. Higa Ubeho will continue to support the implementation of the OVC policy through participation on the OVC TWG, and secondment of a technical advisor in the MIGEPROF, the GOR entity charged with coordination of OVC services.

In FY 2010, Higa Ubeho is projected to reach 55,000 OVC with the comprehensive menu of services outlined in the national strategic plan of action for OVC. The program will also train 7,000 OVC mentors in psychosocial support, protection, HIV prevention, and referral strategies for education, healthcare, food and vocational training services. This program will continue to serve as a wraparound with other USG-funded programs and activities as appropriate, including for food assistance and other general health services for children supported by USG's child survival and health program, such as vitamin A distribution and immunization.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	89,100	

Narrative:

In FY 2010, Hiba Ubeho partners will continue to support the promotion of HCT among OVC and PLWHA and their families. Building upon CHAMP's success and ensuring a smooth transition of services for households with PLWHA and OVC, this program will continue to build the institutional capacity of Rwandan Partner Organizations and mobilize Community Intermediaries (including many of those trained

under CHAMP) to promote utilization and increase availability of high quality, sustainable HIV and AIDS services and wrap-around services. Higa Ubeho will support the provision of community services in the 20 PEPFAR-supported districts, especially referrals to PEPFAR-supported health facilities and programs.

Through the "Living a Productive Life" campaign, messages will be delivered to promote HCT among OVC and PLWHA and their families through a variety of approaches including interpersonal communication, radio, community events and print materials. This targeted promotion of HCT services will identify those most likely to be infected and ensure they are referred to appropriate sites to receive care and treatment. In collaboration with clinical partners and mobile HCT providers, secondary school OVCs attending holiday camps and who seek to know their HIV status will be encouraged for HCT. Higa Ubeho partners will not have any direct targets in this area, but will contribute to increasing the number of people served by clinical partners and mobile HCT activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	495,000	

Narrative:

Building on experience gained from collaborating with decentralized and national level structures, HIIGA UBEHO will provide capacity building assistance to decentralized level structures such as districts and sectors. The goal of capacity building to government entities will be to strengthen the knowledge of key staff in four core areas: (1) Beneficiary selection, (2) Service provision, (3) Program monitoring and (4) Best practices dissemination.

Higa Ubeho will conduct a capacity assessment to ascertain the capacity of districts in the above mentioned four core areas. After the assessment, Higa Ubeho will work with the district offices to develop district capacity building plans to guide the capacity building process and ensure buy-in from district-level officials. Based on the resulting plans, Higa Ubeho will train these officials on skills related to the four core areas. Higa Ubeho looks forward to training district authorities and sector staff. This training process is facilitated at the district level by the RPO point of contact of Higa Ubeho within the district.

Higa Ubeho will continue to provide technical assistance as needed to the National AIDS Control Commission (CNLS), MOH, the Ministry of Gender and Family Promotion (MIGEPROF), the Ministry of Local Government and Social Affairs (MINALOC) and other GOR stakeholders.

In FY 2010, Higa Ubeho will provide financial and technical support to 17 RPOs to reach over 55,000 OVC and 60,000 households of most vulnerable people within the intervention areas. In addition, these

RPOs will deliver a "Live a Productive Life" message to Higa Ubeho beneficiaries through 3,000 community intermediaries (CI) and 3,600 ISLG and 11,000 caregivers trained.

Higa Ubeho will work with these local organizations to build their capacity to manage programs, finances, and human resources with the goal of directly receiving donor funding in the future. As part of its efforts to strengthen civil society organizations, Higa Ubeho will initially conduct a brief assessment of each organization's management capacities, including financial, human resources, strategic planning, M&E, QA, and fundraising. Subsequently each RPO will develop individual capacity building plans to address issues not already covered in the required trainings. Higa Ubeho will then tailor support to each organization depending on its identified needs. Higa Ubeho will provide specific training to RPO staff in the following areas: human resource procedures; monitoring and evaluation; business development; project financial and grant management; organizational and good governance; program management and ethics; communication and community mobilization and participation. Higa Ubeho will also build the organizations' technical capacity by training RPO staff in a number of technical topics related to HIV prevention, care and treatment including: child rights and protection against abuse; adolescent reproductive health; family planning; psycho-social support in OVC programs and education; sexual and gender based violence, economic development; food security; and mainstreaming gender. In addition to organizational capacity building and training RPO staff on technical topics, Higa Ubeho will provide TA to these sub-grantees and their members to provide comprehensive quality services by supporting the training of community intermediaries in data collection; prevention through AB and methods beyond AB; and spiritual and psychosocial counseling skills.

Higa Ubeho will use a customized blend of formal participatory learning, on-site assistance, and practical monitoring and evaluation that ensures RPOs are using their new skills in their daily implementation. HIV/AIDS-specific intervention capacity building addresses technical weaknesses identified through the capacity assessments, while ongoing capacity building and TA are tailored to each organization's particular needs and are monitored regularly. Higa Ubeho will regularly evaluate RPO performance and capacity building effectiveness and adjust capacity building and implementation plans accordingly.

With the goal of having RPOs directly receiving and managing donor funding in the future and to ensure the link between the service providers in capacity building, Higa Ubeho will introduce a Community of Practices model to link RPO with capacity to those in need. The community of practices will help RPOs learn from one another in technical and organizational development areas. Secondly, CHF will build RPO mentoring capabilities by teaching capacity building techniques to RPOs. In this way, RPOs will, at different points, be both teachers and learners, initiating collaborative relationships that will last beyond the life of the project.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVAB	297,000	

Narrative:

In FY 2010, the Higa Ubeho (Be determined and live) program will commence activities, under a new agreement. Building upon the success of the CHAMP project and ensuring a smooth transition of services for households with PLWHA and OVC, this program will continue to build the institutional capacity of Rwandan partner organizations (RPO) and mobilize community intermediaries (including many of those trained under CHAMP) to promote utilization and increase availability of high quality, sustainable HIV/AIDS services and wrap-around services. Higa Ubeho will support the provision of community services in all PEPFAR-supported districts, especially referrals to PEPFAR-supported health facilities and programs.

In FY 2010, Higa Ubeho will target households with OVC and PLWHA with organized communication activities to influence community and social norms, and promote behavior change. Health communication messages, on abstinence, sexual delay, fidelity and partner reduction, as well as topics on social and community norms, will be delivered through a variety of approaches including interpersonal communication, radio, community events and print materials. These messages will give voice to PLWHA and their families, as well as service providers, providing practical, immediate actions that they can take to improve their quality of life. Messages will focus on the full package of community-based health, social and economic development services provided by Higa Ubeho, as well as other wrap-around programs such as malaria prevention, sexual and gender based violence prevention, tuberculosis, prevention of mother-to-child transmission and family planning.

In addition, an effective community-based referral system will allow PLWHA and their families to receive appropriate services in a timely manner without the fear of stigma or discrimination. Integrating PLWHA and their households into a network of services in health, education, social services and food security, as well as the economic stability will improve resilience.

Supportive supervision will be provided to RPOs to collect, analyze and monitor data. With this infrastructure in place, sectors should be able to collect and enter data into the beneficiary database and each sector will then be able to use the database to track beneficiaries and services in their catchment areas. Villages and Cells (Village is the lowest and Cell is the next higher administrative structure) will benefit by being able to access information to ensure better service provision and decision-making as well. RPOs will be responsible for providing regular reports and feedback at the sector level. Given the integrated nature of the proposed social services for vulnerable populations (SSVP) program, Higa Ubeho will use a comprehensive M&E system to monitor and evaluate activities effectively to inform programming, monitor progress, and evaluate impact.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	346,500	

Narrative:

In FY 2010, the Higa Ubeho (Be determined and live) program will commence activities, under a new agreement. Building upon the success of the CHAMP project and ensuring a smooth transition of services for households with PLWHA and OVC, this program will continue to build the institutional capacity of Rwandan partner organizations (RPO) and mobilize community intermediaries (including many of those trained under CHAMP) to promote utilization and increase availability of high quality, sustainable HIV/AIDS services and wrap-around services. Higa Ubeho will support the provision of community-based services in all PEPFAR-supported districts, especially referrals to PEPFAR-supported health facilities and programs.

In FY 2010, Higa Ubeho will target households with OVC and PLWHA with organized communication activities to influence community and social norms, and promote behavior change for condom use, STI management, and risk reduction. Messages will be delivered through a variety of approaches including interpersonal communication, radio, community events and print materials. These messages will give voice to PLWHA and their families, as well as service providers, providing practical, immediate actions that they can take to improve their quality of life. Messages will focus on the full package of community-based health, social and economic development services provided by Higa Ubeho, as well as other wrap-around programs such as malaria prevention, sexual and gender based violence prevention, tuberculosis, prevention of mother-to-child transmission and family planning.

In addition, an effective community-based referral system, and community-based psychosocial support will allow PLWHA and their families to receive appropriate services in a timely manner without the fear of stigma or discrimination. Integrating PLWHA and their households into a network of services in health, education, social services and food security, as well as the economic stability will improve resilience.

Supportive supervision will be provided to RPOs to collect, analyze and monitor data. With this infrastructure in place, sectors should be able to collect and enter data into the beneficiary database and each sector will then be able to use the database to track beneficiaries and services in their catchment areas. Villages and Cells (Village is the lowest and Cell is the next higher administrative structure) will benefit by being able to access information to ensure better service provision and decision-making as well. RPOs will be responsible for providing regular reports and feedback at the sector level. Given the integrated nature of the proposed social services for vulnerable populations (SSVP) program, Higa Ubeho will use a comprehensive M&E system to monitor and evaluate activities effectively to inform programming, monitor progress, and evaluate impact.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7337	**Mechanism Name: The American Society for Microbiology**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Society for Microbiology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 198,000	
Funding Source	**Funding Amount**
GHCS (State)	198,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY 2010, the American Society for Microbiology (ASM) will continue to work in coordination with the Rwandan Ministry of Health (MOH)and National Reference Laboratory (NRL) to carry-out capacity building activities, with primary emphasis on clinical microbiology laboratory capacity for HIV-related opportunistic infections (OI). Specific objectives of the program are:
1) Provide technical assistance to the NRL in microbiology and the surveillance of infectious disease outbreaks;
2) Support clinical microbiological services at select university and district hospitals; and
3) Strengthen pre-service, in-service, and continuing medical education in microbiology.

The ASM Laboratory Capacity Building Program's (LabCap) main emphasis is in transferring quality-assured laboratory diagnostic testing expertise to Rwandan laboratorians through human capacity development via training and mentoring. The end goal is to achieve sustained results and formulate a strong cadre of local Rwandan mentors to carry forward mentoring/training efforts post program

completion. In FY 2010, ASM will extend its programs to university and district hospitals throughout the country. Moreover, ASM will synergize with other partners and the Kigali Health Institute to develop/improve pre-service training programs targeting the new generation of laboratorians.

ASM looks to synergize its activities with other USG partners through dialogue and integrating microbiology components into their efforts, thus better leveraging resources. Furthermore, ASM places great emphasis on gathering information on what other donors are doing, in order to prevent duplicating efforts, and uses already-developed resources when applicable, such as training materials and guidance documents, which ASM later customizes to better fit the environment and context. Finally, the major effort for this program is human capacity building which has as its end goal the complete transfer of expertise to a large number of local Rwandan microbiologists, eventually eliminating the need to send in external experts.

Monitoring and evaluation (M&E) plans:
In FY 2009, ASM employed an M&E Specialist to develop program-specific quality indicators to better measure program impact. These same indicators will be shared with Rwanda, and they will be instructed on how to use them to continue to monitor the quality of microbiological testing. ASM, in coordination with the NRL, will continue to expand its technical assistance to the Rwandan public health laboratory network, with emphasis on clinical microbiology. The activities proposed by ASM for FY 2010 are outlined below:

Objective 1: Technical assistance (TA) to NRL
ASM's TA to NRL aims to strengthen national external quality assurance (EQA) programs for microbiology and ensure NRL moves steadily toward WHO-AFRO accreditation. ASM will work with NRL staff to develop a wok plan to improve and expand NRL's EQA activities including:
• Training of EQA division personnel
• Development of better data collection tools for lab assessments
• Advising on human resource and laboratory infrastructure build-up to face an expansion of EQA programs

ASM will also support efforts to improve quality management systems in the laboratory, and facilitate the introduction of new diagnostic algorithms, SOPs, equipment and reagents. The ASM will develop with NRL staff a plan and budget to ensure the laboratory achieve WHO-AFRO accreditation by the end of FY 2010.

Objective 2: Support clinical microbiological services at select university and district hospitals
ASM will provide on-site mentoring to lab staff at select regional laboratories, including Centre Hospitalier Universitaire de Butare (CHUB), Centre Hospitalier Universitaire de Kigali (CHUK), and the Rwamagana

District Hospital in order to:
• Improve technical competence of laboratorians
• Introduce new diagnostic tests and algorithms for bacterial OIs
• Advise on infrastructure, equipment and workflow improvements
• Implement new QA/QC procedures

Objective 3: Strengthen pre-service, in-service, and continuing medical education for microbiology
ASM will work with the American Society for Clinical Pathology (ASCP), Kigali Health Institute (KHI) and NRL to develop strategies to strengthen pre-service, in-service, and continuing medical education for microbiology. ASM will also provide educational resources to these institutions.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7337**		
Mechanism Name:	**The American Society for Microbiology**		
Prime Partner Name:	**American Society for Microbiology**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	198,000	
Narrative:			
In FY 2010, the American Society for Microbiology (ASM) will continue to work in coordination with the Rwandan Ministry of Health (MOH)and National Reference Laboratory (NRL) to carry-out capacity building activities, with primary emphasis on clinical microbiology laboratory capacity for HIV-related opportunistic infections (OI). Specific objectives of the program are: 1) Provide technical assistance to the NRL in microbiology and the surveillance of infectious disease outbreaks; 2) Support clinical microbiological services at select university and district hospitals; and			

3) Strengthen pre-service, in-service, and continuing medical education in microbiology.

The ASM Laboratory Capacity Building Program's (LabCap) main emphasis is in transferring quality-assured laboratory diagnostic testing expertise to Rwandan laboratorians through human capacity development via training and mentoring. The end goal is to achieve sustained results and formulate a strong cadre of local Rwandan mentors to carry forward mentoring/training efforts post program completion. In FY 2010, ASM will extend its programs to university and district hospitals throughout the country. Moreover, ASM will synergize with other partners and the Kigali Health Institute to develop/improve pre-service training programs targeting the new generation of laboratorians.

ASM looks to synergize its activities with other USG partners through dialogue and integrating microbiology components into their efforts, thus better leveraging resources. Furthermore, ASM places great emphasis on gathering information on what other donors are doing, in order to prevent duplicating efforts, and uses already-developed resources when applicable, such as training materials and guidance documents, which ASM later customizes to better fit the environment and context. Finally, the major effort for this program is human capacity building which has as its end goal the complete transfer of expertise to a large number of local Rwandan microbiologists, eventually eliminating the need to send in external experts.

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Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9044	**Mechanism Name: EGPAF Bilateral**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 6,613,606	
Funding Source	**Funding Amount**
GHCS (State)	6,613,606

Sub Partner Name(s)

Bugesera District	Gahini HC	Gahini Hospital
Gakenke HC	Gasange HC	Gatsibo District
Gihinga HC	Gitoki HC	Gituza HC
Humure HC	Kabarore HC	KAMUBUYE HC
Kayonza District	Kiziguro Hopital	Muhura HC
Mwogo HC	Ngarama HC	Ngarama Hosp.
Nyagahanga HC	Nyagihanga	Nyamata Hospital, Rwanda
Nzangwa Health Center	Rugarama HC	Rukara HC
Rwimbogo HC	Rwimitereri	

Overview Narrative

EGPAF has been receiving PEPFAR funds since 2007 to support the Government of Rwanda's (GOR) response to HIV under three goals: 1, strengthen five clinical district health networks to establish, maintain and supervise the key clinical services and systems necessary for quality HIV clinical services integrated into a strengthened primary healthcare system; 2, Support high quality, integrated HIV clinical services, including VCT, PMTCT, and Care and Treatment to contribute towards universal access to HIV clinical services and 3, Provide national TA in pediatric HIV/AIDS, Care and Treatment, PMTCT, and infant nutrition. EGPAF provides technical support to MOH, TRAC Plus, and PEPFAR partners to implement the HIV-exposed Infant and Young Child Feeding and Maternal Nutrition Program.

EGPAF is the lead PEPFAR partner in 5 districts in the East Province and supports 6 sites in Kigali. EGPAF provides financial assistance through 52 sub-grants to 5 administrative districts, 9 hospitals, 37 health centers and 1 prison. The target populations include women of reproductive age, pregnant and postpartum women, infants, PLHIV in care and treatment and their children, families, and communities. EGPAF supports the MOH in integrating HIV into strengthened primary health care services for pediatric and adult patients through TA; systems strengthening and institutional capacity building; financial and geographic accessibility; quantification of commodities; QI/QA initiatives; and strengthened specialized and integrated HIV and MCH services. The EGPAF program will therefore contribute to all the goals of the Partnership Framework: focusing on prevention efforts through VCT and PMTCT; reducing morbidity and mortality among PLHIV through access to care and treatment; contributing to equal opportunities for PLHIV including food and nutrition interventions and OVC; and supporting health system strengthening for sustainable public health systems.

Core actvities of the HIV program focus on improving access to VCT/PMTCT services, staging of HIV positive clients and providing OI treatment and ART where appropriate and referral for ART where necessary. EGPAF's main focus is minimizing loss to followup of pre-ART patients including pregnant

women who receive HAART Prophylaxis but are not yet eligible for ART. The organization has historically been a champion of Pediatric HIV treatment and aims to provide Early Infant Diagnosis in 100% of supported sites. The partner also implements the national TB/HIV integration model, including intensified monitoring for Multi-Drug Resistant TB.. The partner also received funding for supportive supervision, quality improvement through use of an electronic database, referrals for care and support forvictims of SGBV , and for strategies to encourage male involvement in health care.

EGPAF has directly contributed to HSS through financial and technical support to 5 district health networks including renovations and electrification, joint supervision, performance-based financing evaluations, QI/QA initiatives, logistics and supply management, staffing support, medical waste management and transportation of lab samples. EGPAF builds governance and leadership, and technical, managerial and financial capacity within the networks to allow effective program management and reinforce the ability of networks to provide sustainable, quality HIV/AIDS services. The partner also supports Human Resources for Health in the supported districts through Implementation of task shifting; in-service training in quality HIV services and integration; salary support through sub- grants. Furthermore, EGPAF supports renovations that upgrade facilities to deliver ART and support family planning and MCH services integration. Furthermore, EGPAF implements Community and Clinic IMCI, improved growth and development monitoring of infants; and infant mortality audits.

Cost efficiency over time will be achieved as EGPAF builds District staff capacity to receive and manage funding, to assign the most efficient number of staff to sites and to implement task shifting and cross-train staff to share workloads. Case managers assure linkages across services, and strengthened CHW capacity supports clinical staff. Links with community services reduce duplication of efforts and support sustainability. Service integration saves on costs for buildings, staff, and maintenance through co-location. Strengthened prevention services reduce PMTCT, and care and treatment costs. EGPAF will support sub grantees to operate in low resource environments, providing cost-accounting training for budget planning, cost driver reviews, efficiency and identification of new resources. Districts will increase responsibility in managing sub-grants, supervision, training, and QA with strong TA from EGPAF.

EGPAF's monitoring and evaluation is supported by a patient electronic database at all ARV sites, which facilitates reporting and patient retention. This facilitates data review and quality oversight and evidence-informed decision making. EGPAF will continue to provide regular clinical mentoring and reinforce district and site level data quality audits while building district and site capacity to use data for programming as part of transition. EGPAF will work with sites to improve PMTCT mother/infant tracking and medical record linkages. Improved monitoring and assessments of HIV integration into FP, MCH and TB is also a priority. EGPAF will support the MOH/TRAC Plus to develop and/or revise tools to monitor these activities.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	350,000
Food and Nutrition: Policy, Tools, and Service Delivery	250,000
Gender: Reducing Violence and Coercion	100,000
Human Resources for Health	1,776,158

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Child Survival Activities

Safe Motherhood

TB

Workplace Programs

Family Planning

Budget Code Information

Mechanism ID:	**9044**		
Mechanism Name:	**EGPAF Bilateral**		
Prime Partner Name:	**Elizabeth Glaser Pediatric AIDS Foundation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	931,322	

Narrative:

This is a continuing activity

In FY 2009, EGPAF supported adult care and support activities at 40 sites, providing 20,727 PLWHA with care and support services. Services provided by EGPAF include: clinical staging and baseline CD4 for all patients; follow-up CD4 counts; STI/OI diagnosis and management of HIV and other HIV-related

illnesses; and routine provision of CTX prophylaxis for eligible adults and children, based on national guidelines.

EGPAF implements a continuum of care (CoC) model at all supported sites, a model which includes two case managers: a community liaison agent (ALAC) and a focal point for service integration (POFIS). These two staff positions ensure that clients testing positive for HIV through any of the services at the facility are enrolled in care, family members are invited for testing, and referrals are provided to FP and HIV services. The POFIS helps to ensure early identification of infected individuals through the invitation of PLWHA family members and partners to HCT services and provides effective referrals of patients between services and sites. These referrals are tracked and in cases where family members do not present for testing, the POFIS provides additionally counseling and support to the PLWHA to bring the family in for testing. The ALAC ensures prompt enrollment in care services by liaising with all services at the facility providing testing, including PITC, and ensuring enrollment of those testing positive. Once a patient becomes eligible for ART, s/he is referred to ART services and the POFIS ensures enrollment and retention in ARV services. The CoC model also has a strong community-clinic linkages component, with defaulting patients or patients lost to follow up tracked through home visits by health providers and through the support of CHW and associations of PLWHA. By mentoring CHWs and liaising with community organizations and PLWHA associations, the ALAC, according to individual need, refers and connects patients to community-based care services such as adherence counseling, psychological and spiritual support, stigma reduction activities, OVC support, IGA and HBC activities. These networks and programs support retention in care and an improved quality of life for patients.

In FY 2010, EGPAF will continue to support the care of 20,727 existing patients, and an additional 2,771 new adult and pediatric patients. EGPAF will continue to support national level HIV care programming and will advocate for, and participate in, the development of national program tools for the optimal provision of care for PLWHA. EGPAF will maintain its support of district health networks to coordinate the provision of HIV related care services for PLWHA. EGPAF's role will include but not be limited to the following: provision of technical support through supervision and on-the-job coaching to district level supervisors and case managers to improve implementation and to ensure optimal retention of all HIV positive patients; support for quality care and ensuring a continuum of care through operational partnerships and case managers (POFIS and ALAC); and assistance to improve the sustainability of services through PBF.

In FY 2010 EGPAF will continue to integrate family planning into care services at all facilities and provide same day counseling and contraceptive refills, a service crucial to the prevention of HIV transmission. Regular care and support service consultations and family planning consultations emphasize sexual prevention and ensure condoms are available to PLWHA patients. Additionally, EGPAF will work closely

with Project San Francisco, which provides TA for discordant couple counseling and prevention with positives. EGPAF will also collaborate with the MOH to support scale up and quality improvement for couples' counseling, increase the quality of post test counseling through training and on-site mentoring, and reinforce mechanisms for follow-up of discordant couples and provision of HIV prevention and FP counseling to these couples. EGPAF will provide palliative care services, which include basic nutrition counseling and support, hygiene education, positive living and risk reduction counseling, pain and symptom management and end-of-life care. Case managers will provide referrals for all PLWHA and their families for malaria prevention services, including the provision of LLITNs in collaboration with GFTAM and PMI; and refer to CBO's and other community partners for distribution of water purification kits and hygiene education. Strengthened psychological support services for PLWHA will be made available through expanded TRAC Plus training in psychological support.

EGPAF-supported sites, in partnership with community partners and PLWHA associations, will continue to assess the individual needs of PLWHA enrolled in care and refer them to support services as necessary. These services may include adherence counseling, spiritual support, and activities addressing stigma, IGA, and HBC- services for palliative care, OVC, nutrition support, legal counseling, and end of life care, in line with national palliative care guidelines. In partnership with other food partners EGPAF will support the implementation of food by prescription for PLWHA who are malnourished and initiating ART, and will enhance linkages with other food program, such as Ibyiringiro. EGPAF will also work with districts, case managers, CHWs and community partners to develop a mapping of community services per sector and to improve referral systems. Case managers will have monthly clinic-wide case management meetings with CHWs to discuss issues pertaining to follow up of patients and referrals to services. These meetings will provide oversight of CHWs and opportunities to share key messages and health information for further sensitization in the community. EGPAF will partner with community partners and the MOH to ensure CHWs in EGPAF supported districts receive training in HIV and MCH modules and the necessary follow up and support. EGPAF will use national screening tools and management guidelines to integrate mental health in HIV services during FY 2010.

In collaboration with the supply chain partner, EGPAF will provide diagnostic kits, CD4 tests, and other exams for clinical monitoring, and will work with SCMS for the appropriate management of all OI-related and other commodities. EGPAF will support patient tracking by the ALAC and POFIS and the use of the electronic patient data base, IQ Chart, pre-ART registers to ensure monitoring of all PLWHA in care services throughout all EGPAF sites.

EGPAF will support the national QI policy through: providing financial support to Mutuelles for indigent patients and district risk pooling; national PBF and QI initiatives such as strengthening health quality committees at health centers and PAQs; performing PDSA in each district; holding biannual district level

meetings to discuss specific indicators (e.g. loss to follow up); ensuring transportation of lab samples and results; and providing supervision and mentoring. EGPAF will also work with districts and sites to strengthen data quality processes through regular data audits and data reviews in the joint supervision process to enable sites and district staff to use data appropriately and ensure quality. EGPAF will implement an assessment of the effectiveness of the continuum of care program including referrals to care and support from CT services.

In line with the Partnership Framework's sustainability and transition goals, EPGAF will work with sites to ensure that all patients receive a standard, comprehensive package of HIV services and that MCH and HIV services are co-located to the extent possible; continue to support a combination of funding through technical support, input based funding and output based financing through PBF; and ensure programmatic links to food programs and to community-based programs. In FY 2010, EGPAF will support one district hospital through training and mentoring to negotiate and manage the health facilities sub grants under its supervision through a system of payment on performance. EGPAF will support the administrative district to train and mentor the sector health units, and will assess and document implementation. EGPAF will work with the USG team and the GOR to establish benchmarks and strategies for transition. EGPAF will also learn from the Track 1.0 partners' experiences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	4,094,365	

Narrative:

In FY 2009 EGPAF provide ART to 8,094 HIV positive individuals 27 supported ART sites, the later representing 64% of all EGPAF supported facilities, which together in FY 2009 served 1,811 new ART patients, including children. EGPAF's support to ART services follows MOH guidelines and norms, and includes enrollment into care upon a positive HIV test, clinical and CD4 monitoring after initiation on treatment, CTX prophylaxis, OI/STI treatment, regular TB screening and adherence counseling. The model relies on task-shifting to allow facilities without trained doctors to dispense ARVs to stable patients under physician supervision. All patients on treatment receive the full package of HIV care and support services including positive prevention initiatives such as couples counseling, condom distribution, and family planning integration with same day counseling and contraceptive refills. EGPAF supports a continuum of care model to ensure retention of patients from HIV positive screening through ART services. This model includes clinic and community linkages for retracing of defaulting patients or patients lost to follow up and for referral to a variety of health, psychosocial and legal services. For pregnant women identified through PMTCT this model assures they are staged clinically and by CD4 and referred to ART services, EID via DBS/PCR, and that HIV positive infants receive ART according to national guidelines. All EGPAF-supported ART sites are implementing the WFP Food for ART program

for malnourished patients initiating ART and are using IQ Chart to track and monitor pre ARV and ARV patients.

In FY 2010, EGPAF will continue the services and activities described above and will support the provision of ART services to 9,543 children at existing 27 ART sites.

EGPAF will continue its national involvement in TWGs to ensure accessible, high quality treatment services in Rwanda. EGPAF will provide support to the MOH and TRAC Plus for the revision of task-shifting guidelines, development of positive prevention guidelines and tools, and support the development of training curricula and job aids for the newest treatment guidelines.

EGPAF's strong commitment to the provision of quality treatment services to all Rwandans in need will continue in FY 2010 through a variety of site and district level activities. With regard to human resource development, EGPAF will provide continued support of in-service training and mentorship for the health care providers at EGPAF supported sites, as well as district health supervisors. Training will focus on: ART protocol for adults, adolescents and children; IQChart for data managers; the continuum of care model; nutrition for PLWHA; positive prevention; and QI initiatives. Joint on-site supervision by district and EGPAF teams will allow for the review and support of program, data, and QI activities, with districts taking increased responsibility as district and provider capacity is developed. Furthermore, EGPAF and district technical staff will continue to provide routine clinical mentoring to clinicians providing care and treatment for both adult and pediatric patients at EGPAF supported sites. This includes capacity building in treatment adherence, early detection of signs of treatment failure and adverse drug reactions, OI, STI and TB screening and treatment, and technical support for integrated clinical services. The mentoring will support appropriate and consistent use of job aids, algorithms, medical record flow charts and supervision tools.

On a more clinical level, EGPAF will support the implementation of targeted viral load testing according to the national guidelines. EGPAF will continue its work with the MOH, districts and sites to ensure rapid turnaround of samples and laboratory results for rapid diagnosis and treatment/regimen change. In addition, EGPAF will promote a family-centered approach to care and treatment, and reinforcement same day service integration, including co-locating MCH and HIV health services, FP and HIV counseling, and TB and HIV treatment. EGPAF will also support the integration of mental health in HIV services according to national guidelines developed in FY 2009. Integrating services and using patient tracking through IQ charts, social workers and CHWs will greatly reduce loss to follow up of PLWHA, particularly pre-ART patients.

Positive prevention (PP) will be a key focus area in FY 2010. EGPAF will work with MOH, districts and

sites to ensure that positive prevention is part of routine care for PLWHA, including those on ART. The positive prevention package for adults on treatment will include: prevention counseling at all visits for all patients; ARV adherence assessments at every visit; integrated STI management; integrated FP and MCH services; and condom distribution at every visit. Through partnership with Project San Francisco and the MOH, EGPAF supported districts and sites will be trained in couples counseling, including counseling for discordant couples. EGPAF will work with districts to strengthen mechanisms for the follow up of discordant couples and will support these couples through HIV prevention and FP counseling. EGPAF will ensure that sites have the necessary IEC materials for positive prevention, couples counseling, and discordant couples counseling.

In FY 2010 EGPAF will continue the implementation of the WFP Food for ART program and support exit strategies (e.g. demonstration and kitchen gardens) to decrease dependence on external food support and to support persons exiting EGPAF programs to maintain good nutritional status. As part of this intervention, EGPAF will continue to advocate for inclusion of nutrition services in prison ART services. In addition, EGPAF will continue to support palliative care services including basic nutrition counseling and support, hygiene education, positive living and risk reduction counseling, pain and symptom management and end-of-life care.

To strengthen the continuum of care, EGPAF sites, in partnership with community partners and PLWHA associations, will continue to refer PLWHA enrolled in care to community-based care services based on their needs such as adherence counseling, spiritual support, and activities addressing stigma, IGA, and HBC- services for palliative care, OVC, nutrition services, legal support services and end of life care in line with national palliative care guidelines. Furthermore, EGPAF will assist with staff training, strengthening of referral mechanisms and linkages between HIV prevention, care, treatment, TB/HIV, FP/HIV and counseling services, improving program tools and reports, and conducting an assessment to identify gaps in the patient circuit to inform program improvement. EGPAF will work with community based partners and the MOH to ensure CHWs in EGPAF supported districts receive capacity building and training on the HIV module to better support HIV information sharing and referrals in the community.

EGPAF will support national QI policy through Mutuelles for indigent patients and district risk pooling; national PBF and QI initiatives such as strengthening health quality committees at health centers and PAQs; performing PDSA in each district; holding biannual district level meetings to discuss specific indicators (e.g. retention in care); ensuring transportation of lab samples and results; and providing supervision and mentoring. EGPAF will also work with districts and sites to strengthen data quality processes through regular data audits and data reviews in the joint supervision process to enable sites and district staff to appropriately use data and ensure quality. EGPAF will implement an assessment of the effectiveness of the continuum of care program including referrals to care and support from CT

services. In addition, EGPAF will strengthen the use of IQ Chart software at all EGPAF supported ART sites thereby improving the monitoring of pre-ART and ART clients, including children. The software tracks key clinical and visit history information for individuals in care, improves medical record and quality and strengthens program monitoring by identifying defaulting patients to facilitate patient tracking. As part of treatment services support, EGPAF will continue to support districts and sites in commodity management, quantification and will collaborate with SCMS and CAMERWA in efforts to avoid stock outs and ensure proper stock management.

In line with the Partnership Framework sustainability and transition goals, EPGAF work with sites to ensure that all patients receive a standard, comprehensive package of HIV services and that MCH and HIV services are co-located to the extent possible; continue to support a combination of funding through technical support, input based funding and output based financing through PBF; ensure programmatic links to food programs and to community-based programs.

In FY 2010, EGPAF will support one district hospital through training and mentoring to negotiate and manage the health facilities sub grants under its supervision through a system of payment on performance. EGPAF will support the administrative district to train and mentor the sector health units. EGPAF will assess and document implementation.

Capacity building of health providers and district level health authorities are an important aspect in transferring responsibility. District appropriation of services, including training, supervision, evaluation, HR funding, quality of services and data use are benchmarks for evaluating sites and districts' readiness for transition. EGPAF will work with the USG team and the GOR to establish benchmarks and strategies for transition. EGPAF will also learn from the Track 1.0 care and treatment partners' experiences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	207,460	

Narrative:

EGPAF supports a family approach to HIV services which includes HCT for families, particularly partners and children, in line with national guidelines. In FY 2009, EGPAF supported 33 HCT sites and provided testing to 114,753 persons in HCT services. EGPAF-supported sites also tested 31,082 women in PMTCT and 25,234 of their male partners. The introduction of DNA-PCR testing for infants at all EGPAF supported VCT/PMTCT sites has increased the number of HIV-positive infants identified. Additional efforts are necessary to identify a large number of the children who were infected perinatally over the last ten years and those who become infected through non-vertical transmission.

In FY 2010, EGPAF will continue to support the MOH for the following activities: implementation of the national HCT protocol, especially for children and adolescents; implementation of the PITC protocol at all entry points in the health facility; risk reduction counseling and tailored post-test counseling; positive prevention and scale up of couples CT and discordant couple follow-up; screening and treatment of STI/OI; and, linkages through the continuum of care including community-clinic linkages.

In FY 2010, EPGAF will support 38 HCT services, providing testing to 150,000 persons including 38,102 children under 18.

EGPAF's FY 2010 support at national level will include: strengthening HCT services including pediatric PITC and PITC M&E systems; implementation of innovative testing strategies including finger prick testing with same day results, couples counseling and testing and follow up of discordant couples though the continuum of care; development and implementation of national guidelines, tools, IEC materials and monitoring systems for a positive prevention program; and implementation of PEP as a prevention strategy for health facility staff, victims of SGBV and others in need of PEP treatment.

At decentralized level, EGPAF will continue to support district health networks to coordinate HIV services and to increase the percentage of adults and children that know their HIV status, by:
• Working closely with Project San Francisco and the MOH to support scale-up of couples' counseling through training and on-site mentoring; work with districts and sites to improve post-test counseling quality and follow-up mechanisms for discordant couples; provide support to these couples including HIV prevention and FP counseling and referrals and immediate enrollment in the care program
• Reinforcing prevention counseling for HIV-positive persons, providing condoms and FP services, and integrating HIV prevention education into general patient care; actively linking patients to community-based prevention and stigma reduction activities
• Supporting the implementation of routine PITC in all points of care (TB, nutrition centers, vaccinations, OI, STI, HIV, hospitalization, consultations) to reach all target groups, especially children above the age of 12 months, men and couples
• Continuing to ensure Early infant diagnosis (EID) and rapid turnaround time of infant DBS/PCR testing and results
• Encouraging HCT of families, children and adolescents in the community through CHWs, awareness building campaigns, the national stratégie avancée (includes mobile HCT); supporting a pediatric week with testing of family, children and adolescents at sites 7 days a week; including special family/child testing days during vacations and exploring opportunities for home-based HIV-testing together with community partners
• Strengthening referrals and linkages to care and treatment: EGPAF supports a continuum of care model which includes two staff positions (case managers): a community liaison agent (ALAC) and a focal point

for service integration (POFIS). The program entails immediate enrollment by the ALAC of HIV-positive clients into care from all testing points at the health facilities, including transfers, or referrals from community programs. The ALAC ensures enrollment, and defaulter and lost to follow up tracing. The POFIS ensures that referral and counter referral between services within the site or between sites are effective and identifies defaulters. The ALAC will continue to encourage testing family members of patients in care and active post-test follow-up will be ensured by the POFIS.

• Furthering support for service integration and family centered HIV prevention which will include: HIV testing of all TB clients; TB screening of HIV clients; HIV testing of FP patients and effective referrals including male circumcision (where available) and testing; and medical care and support for victims SGBV including referral to SGBV support groups in the community

• Ensuring supply of post exposure prophylaxis and training for sites in its provision

• Strengthening Quality Assurance by implementing national standard operating procedures to ensure biosafety in close collaboration with the NRL. CT funds will be used to leverage biomedical transmission/injection and blood safety through procurement of appropriate disposal of biowaste generated through the HIV program (such as incinerators and waste pits for sites).

EGPAF will support national QI policy through health insurance for indigent patients and district risk pooling; national PBF and QI initiatives such as strengthening health quality committees at health centers and PAQs; performing PDSA in each district; biannual district level meetings to discuss specific indicators (e.g. infant and adolescent testing); support HCT for all health service providers in EGPAF-supported sites and organize support group meetings to address health worker stigma reduction and burn-out. EGPAF will also work with districts and sites to strengthen data quality processes through regular data audits and data reviews in the joint supervision process to enable sites and district staff to appropriately use data and ensure quality. EGPAF will implement an assessment of the effectiveness of the continuum of care program including referrals to care and support from CT services.

EGPAF will work with community health workers, associations of PLWHA, community partners (such as CHF, CRS, World Vision) and other civil society members/organizations to support advocacy and community involvement, including local leaders and churches, to ensure mobilization of the population for CT services, support to safeguard seronegativity, and to support HCT efforts within communities such as community HTC days to reach families, children, men and non-pregnant women. ALAC and POFIS will support linkages with community services and ensure that HIV positive patients receive effective referrals to psychosocial support, patient education and positive-living counseling, and other community-based services, such as HBC, IGA through PLWHA associations, OVC, and malaria.

In line with the Partnership Framework sustainability and transition goals, EPGAF will: continue to support a combination of funding through technical support, input-based funding and output-based

financing through PBF; ensure programmatic links to nutrition programs (WFP Food and the USAID/Ibyiringiro project) to avoid duplication, ensure implementation of exit strategies (e.g. kitchen gardens), and strengthen linkages to community-based programs. Currently EGPAF is preparing the District Hospital to support sub-grantees. In FY 2010, EGPAF will work with the districts to establish a unit to centralize district level funding. EGPAF will support one District Hospital through training and mentoring to negotiate and manage the health facilities sub-grants under its supervision through a system of payment on performance. EGPAF will support the administrative district to train and mentor the sector health units. EGPAF will assess and document implementation.

Capacity building of health providers and district level health authorities are an important aspect of the transition process and a key step in transferring responsibility. District appropriation of services, including training, supervision, evaluation, HR funding, quality of services and data use are benchmarks for evaluating sites and districts' readiness for transition. EGPAF will work with the USG team and the GOR to establish benchmarks and strategies for transition. EGPAF will also learn from the Track 1.0 care and treatment partners' experiences. These actors will jointly agree on a plan to document lessons learned and progress toward transition.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	292,913	

Narrative:

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) has a well established program in Rwanda and is one of the principal implementing partners for PMTCT and HIV care and treatment. In FY 2009, EGPAF supported pediatric care activities at 37 sites, providing 3,762 HIV-positive children with care and support services.

EGPAF implements an HIV continuum of care (CoC) model (see HCBC section) at all EGPAF supported sites with two staff positions (case managers) supporting patients testing positive through the continuum of care from HIV testing through ART, supporting referrals and ensuring their effectiveness between services and sites. The case managers link clinical services to the community and vice versa to ensure effective tracing of defaulting patients or patients lost-to-follow-up. The model is described in the HCBC section and includes HIV care services at all sites including non ART sites. Once tested positive, the child is followed up in pre-ART services (with patient record number, patient files and registers) in all the sites including non ART sites. Pre-ART services include: clinical assessments (monthly for HIV-exposed infants and older HIV-positive children until 14 years, after which they are seen every 3 months); clinical staging and baseline CD4 for all patients; follow-up CD4 counts every six months, or more frequently if CD4 count is under 500; STI/OI diagnosis, treatment and management, as well as management of other

HIV-related illnesses; and routine provision of Co-trimoxazole(CTX) prophylaxis for HIV-positive children and all HIV-exposed infants until they are determined HIV free. All pediatric patients are screened for TB at least once every six months. All children with suspected TB are examined and tested for TB, and those diagnosed with TB are treated according to national guidelines. HIV-positive children exposed to an active TB case but without TB themselves are provided with INH prophylaxis for six months.

In FY 2010, EGPAF support for pediatric care will continue the above mentioned activities and will prioritize early infant diagnosis (EID), early initiation of treatment, MCH/HIV service integration, retention in care, and infant feeding counseling and support. EGPAF will also continue to support the continuum of HIV related care for PLWHA at 43 sites and to provide HIV related care for 1,111 pediatric patients.

EGPAF's support for the MOH and TRAC Plus will include advocacy and implementation at select sites of a fully integrated model of MCH/HIV and other care; and providing same day, one stop service for both mothers and babies (see PMTCT narrative for details). Together with TRAC Plus, EGPAF will conduct a program assessment of the integration model to document best practices and inform policy and programming, revise and implement a national integrated child health card with HIV status, and update guidelines to reflect the upcoming revised WHO recommendations.

Implementation of the pediatric care approach will be strengthened at the district and site level, and activities will include:

• Support to trainings and supervision of the implementation of the new pediatric care and treatment guidelines

• Identification of HIV-positive children. Ensure that all sites implement DBS PCR testing with rapid turn-around of results; that HIV-exposed infants are retained in care and receive CTX prophylaxis until their HIV status is known. Provider-initiated HIV testing and counseling (PITC) services will be expanded to all children with signs or symptoms of HIV from in- and outpatient wards, TB clinics, nutrition services, and vaccination clinics. Systematic testing of children of adults enrolled in care and treatment.

• Strengthen referral of newly diagnosed children and their immediate enrollment into the care program. Case managers will reinforce links to PLWHA associations, community health workers (CHW) and other community-based organizations to support this referral system. Bridging PMTCT, PITC, VCT and ART services and ensuring retention into care is a key component of the continuum of care model. EGPAF and districts will ensure that mothers and infants lost-to-follow-up are tracked and retained through home visits and support from CHW and associations of PLWHA (see Adult Care and Support narrative).

• Improve pediatric HIV care and treatment through a strengthened clinical mentorship program with the pediatric reference hospital established with MOH, TRAC Plus, UPDC and partners in FY 2009 in East Province (described in the pediatric Treatment section).

• Exposed infants and young children will continue to receive food support through the weaning period.

Strengthened nutritional services at EGPAF-supported sites will include staff training on infant and young child feeding practices (IYCF) and maternal nutrition; infant feeding and maternal nutrition counseling for HIV-positive mothers during pregnancy and after childbirth; nutritional assessments; food support for HIV-exposed infants and infected children; and management of malnutrition through provision of micronutrient and multivitamin supplements. EGPAF will continue to support exclusive breastfeeding campaigns and reinforce community sensitization on key IYCF and maternal nutrition messages.
• Continue to support the MOH, districts and sites to scale-up IMCI services at MCH clinics; support improved growth monitoring and implement the integrated child health card. EGPAF offers comprehensive psychosocial services to children living with HIV at 24 ART sites, with sites providing group counseling sessions, assistance with status disclosure, recreational activities, and individual counseling. In FY 2009, EGPAF held the first Ariel Camp for children living with HIV, taking 28 participants with their counselors to a campsite for 3 days of activities and exchange. In FY 2010, EGPAF will support psychosocial care at all ART sites and Ariel Camp will continue twice per year over school holidays in close collaboration with CNLS, TRAC Plus and the Rwanda Pediatric Society.
• Case managers will have monthly clinic-wide case management meetings with CHW and community partners to discuss issues pertaining to follow up of patients in the community, and referrals to service. These meetings will also provide oversight of CHW and opportunities to share key messages on pediatric HIV, care, IYCF, and health information for further sensitization in the community. By providing HIV messages on a regular basis, EGPAF sites will ensure a continuous flow of information to the community.
• EGPAF will also support referrals for all HIV-positive children to malaria prevention services, including referral for provision of LLIN and integration of home-based management of malaria, in collaboration with GFATM and the PMI; referral to CBO's and other community partners for distribution of water purification kits and hygiene education; health education and legal support.
• Through partnership with the districts, sites, Supply Chain Management System (SCMS) and in close collaboration with CAMERWA, EGPAF will provide diagnostic kits, CD4 reagents, and other laboratory commodities for clinical monitoring of children in care and on treatment. In addition, EGPAF will work with SCMS and Pharmacy Task Force (PTF) to ensure appropriate storage, stock management, and reporting of all pediatric OI-related commodities.

EGPAF will support the national QI policy through Mutuelles for indigent patients and district risk pooling; national performance-based financing (PBF) and QI initiatives such as strengthening health quality committees at health centers and PAQs; performing Plan-Do-Study-Act (PDSA) in each district; holding biannual district level meetings to discuss specific indicators (e.g. loss to follow-up); ensuring transportation of lab samples and results; and providing supervision and mentoring. EGPAF supports IQ Chart at ART sites, and will also work with districts and sites to strengthen data quality processes through regular data audits and data reviews in the joint supervision process to enable sites and district staff to appropriately use data and ensure quality. EGPAF will implement program assessments on the

integration model to document best practices and inform policy and programming.

In line with the Partnership Framework sustainability and transition goals, EPGAF works with sites to ensure that all patients receive a standard, comprehensive package of HIV services and that MCH and HIV services are co-located to the extent possible; continues to support a combination of funding through technical support, input based funding and output based financing through PBF; and ensures programmatic links to Food programs and to community-based programs.

In FY 2010, EGPAF will pilot part of their exit strategy by providing intensified technical assistance to one district hospital to manage sub grants for health centers in its catchment area; a task usually undertaken by EGPAF. This is in line with the Partnership Framework Implementation Plan. EGPAF will support the administrative district to train and mentor the sector health units. EGPAF will assess and document implementation experience to facilitate further transition of activities to host country institutions.

Capacity building of health providers and district level health authorities are an important aspect in transferring responsibility. District appropriation of services, including training, supervision, evaluation, HR funding, quality of services and data use are benchmarks for evaluating sites and districts for their readiness for transition. EGPAF will work with the USG team and the GOR to establish benchmarks and strategies for transition. EGPAF will also learn from the Track 1.0 care and treatment partners' experiences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	444,556	

Narrative:

At the end of September 2009, EGPAF provided 6,242 patients with ART, including 515 pediatric patients. In FY 2009, EGPAF supported 27 ART sites with 1,811 new patients initiating treatment, including 126 children. As per the MOH guidelines, EGPAF's support to pediatric ART services includes immediate enrollment into care for HIV-positive children, clinical and CD4 staging, early initiation on treatment, Co-trimoxazole(CTX) prophylaxis, OI/STI treatment, and TB screening. The model utilizes task-shifting to allow facilities, which do not have trained doctors, to continue dispensing ARVs to stable patients under physician supervision and provide regular care to patients on treatment. In FY 2010, EGPAF will continue the range of services and activities described above and provide national, district and site level support. It will be supporting 728 pediatric patients in 27 sites.

EGPAF will continue to support the MOH and TRAC Plus via its participation in the TWG in the revision of adolescent and child treatment guidelines, and in the development of training curricula and job aids

reflecting the latest national guidelines. EGPAF will also support TRAC Plus to define a pediatric mentorship program for HIV care and support, and it will work with UPDC to harmonize and implement the mentorship program in the East Province.

EGPAF's technical assistance to the provision of quality pediatric treatment services will continue through emphasis on site and district level support and programming.

• EGPAF will support the establishment of a pediatric reference hospital in the East Province that will be linked to the neonatal service at Rwamagana District Hospital, the PIH pediatric center at Rwinkwavu and the pediatric center of excellence supported by ICAP at CHUK.

• EGPAF will develop a focused pediatric mentoring program in the East Province in collaboration with the MOH, TRAC Plus, CHUK and NUR. Focus areas include management of patient flow, early infant diagnosis (EID), infant ART, post-care review, continuing quality improvement, appropriate infant feeding and benchmarks (e.g. CTX, dried blood spot (DBS), HIV testing, early initiation of ART, second-line ART).

• Support task shifting and provide in-service training of health care workers in provision of pediatric HIV treatment services.

• EGPAF will continue to support sites to ensure all HIV-positive infants less than 12 months are initiated on HAART, irrespective of their clinical or immunological staging, to decrease morbidity and mortality; work closely with the case managers to ensure that eligible infants and children are adequately prepared and initiated on HAART with minimal delay; through community-clinic linkages, defaulting patients or patients lost to follow-up will be tracked through home visits by health providers and through the support of CHW and associations of PLWHA.

• EGPAF will ensure all children on HAART are also provided with other routine child services including immunizations and growth monitoring through emphasis on service integration and follow-up of pediatric patients in the continuum of care model.

• EGPAF will continue its work with the MOH, districts and sites to ensure rapid turn-around time of samples and laboratory results, in particular to facilitate EID and EIT with rapid DBS/PCR results.

• Quality of care improvements will include improvements in patient flow to reduce missed school days and minimize loss to follow-up among children and adolescents; promotion of family-centered approaches to care and treatment; and reinforcement of service integration, such as maternal and child health services during HIV services.

• Support advocacy efforts to mobilize national and local leaders for action on select issues including EID and EIT and male involvement in family health.

• EGPAF will partner with community partners and the MOH to ensure CHWs in EGPAF-supported districts receive training in HIV and MCH modules and the necessary follow-up and support. Through strategic partnerships with community partners, civil society, private sector, FBO, CSO including PLWHA cooperatives, and CHW, districts will: disseminate key messages on treatment adherence, referral, and

retention; and assist sites in systematic follow-up of infants and children in the community. Case managers will support linkages with community services and ensure that children receive effective referrals to psychosocial support and other maternal child health programs, including home-based care and support, malaria and OVC programs via CHF, CRS, and PMI.

EGPAF will also work with districts and sites to strengthen data quality processes through regular data audits and data reviews in the joint supervision process to enable sites and district staff to appropriately use data and ensure quality. EGPAF will implement an assessment of the effectiveness of the continuum of care program including referrals to care and support from counseling and testing services.

In line with the Partnership Framework sustainability and transition goals, EPGAF works with sites to ensure that all patients receive a standard, comprehensive package of HIV services and that MCH and HIV services are co-located to the extent possible. EGPAF continues to support a combination of funding through technical support, input based funding and output based financing through PBF. EGPAF also ensures programmatic links to Food programs and to community-based programs.

In FY 2010, EGPAF will pilot part of their exit strategy by providing intensified technical assistance to one district hospital to manage sub grants for health centers in its catchment area; a task usually undertaken by EGPAF. This is in line with the Partnership implementation plan. EGPAF will support the administrative district to train and mentor the sector health units. EGPAF will assess and document implementation experience to facilitate further transition of activities to host country institutions.

Capacity building of health providers and district level health authorities are an important aspect in transferring responsibility. District appropriation of services, including training, supervision, evaluation, HR funding, quality of services and data use are benchmarks for evaluating sites and districts for their readiness for transition. EGPAF will work with the USG team and the GOR to establish benchmarks and strategies for transition. EGPAF will also learn from the Track 1.0 care and treatment partners' experiences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	465,167	

Narrative:

EGPAF provides support to the Ministry of Health (MOH), district health networks and health facilities to optimize all four prongs of PMTCT and ensure comprehensive and integrated service provision. EGPAF's PMTCT activities support MOH guidelines and are in line with the Partnership Framework and include: quality opt-out counseling and testing including testing during labor and delivery, positive

prevention including couples counseling and testing, PITC at all entry points within the health care system, clinical staging and CD4 count, ARV prophylaxis and treatment (combination regimens for non-eligible women and HAART for eligible women), STI, OI and TB screening and treatment, CTX prophylaxis for eligible women and exposed infants, counseling and support on infant feeding and safe weaning, nutrition assessment, and Early Infant Diagnosis (EID). In addition, EGPAF supports follow-up and referral of HIV-positive women and HIV-exposed infants and family members to care and treatment through a continuum of care model linking PMTCT with ART which includes: immediate enrollment in pre-ART (care) services even at sites without ART; referral to ART services when eligible; family testing via invitations and follow-up and community linkages. EGPAF supports HIV integration in MCH, including HIV screening at vaccinations, family planning counseling and refills at every facility visit, safer delivery practices through EMONC, and child survival through IMCI, malaria and referral to OVC services.

A core EGPAF competency, PMTCT will remain a priority in FY 2010. EGPAF will continue the above mentioned activities and prioritize efforts to scale up MCH integration and improve the PMTCT cascade; EID and early initiation on treatment (EIT); infant and young child feeding (IYCF) and maternal nutrition; task shifting; QI and M&E at all PMTCT supported services. In FY 2010, EGPAF will support 38 PMTCT sites; providing access to PMTCT to 35,319 women and reaching 2,475 women with prophylaxis.

EGPAF's FY 2010 national level support will include technical support to the MOH and TRAC Plus to revise the national guidelines and program tools on PMTCT and IYCF protocols to reflect the revised WHO recommendations; develop FP/HIV integration job aids and national tools; and revise nutritional care and support minimum standards for pregnant and lactating women.

In line with the MOH's service integration priorities and recommendation from the Fifth National Pediatric Conference, EGPAF will advocate for and implement a fully integrated model of care in select PMTCT sites. The model will provide same day, one stop service by co-locating MCH, nutrition, HCT/PITC, CD4 testing, and ART services. This will entail renovations, revised patient flow, and monitoring tools. In this one stop service model, eligible HIV-positive pregnant women will be initiated on ART in the PMTCT program, those on HAART and attending ANC at these sites will be transferred out from the main ART sites until 18 months after delivery to allow for continuity of services for both mother and child in the MCH setting. EGPAF will assess and document this approach for possible scale up at national level.

EGPAF will support the MOH in the implementation of a national integrated child health card with interventions crucial to identifying at-risk children, including HIV status, and all existing aspects of the current child vaccination card.

EGPAF will continue to support district health networks to coordinate HIV services including:

• Staff training; ongoing site supervision to support capacity building of district health networks and providers; joint supervisions with district teams to review programs, data and conduct QI activities will continue with districts taking on increased responsibility in the process of phased-out support.
• Improve pediatric HIV care and treatment through a strengthened clinical mentorship program with the pediatric reference hospital established with the MOH, TRAC Plus and partners including ICAP, PIH, and Luxembourg Development, in FY 2009 in East Province.
• Continue to support HCT in ANC, labor and delivery, postnatal and vaccination clinics; provide testing for siblings, family members and HIV-exposed infants through DBS/PCR at all EPGAF supported PMTCT sites and continue to ensure HIV exposed children are being identified at all entry points in the health facility including through PITC.
• Along with all clinical partners, work closely with Project San Francisco and the MOH to support scale up of couples' counseling through training and on-site mentoring; work with districts and sites to improve pre- and post-test couple counseling quality and follow-up mechanisms for discordant couples and women testing negative in ANC to address seroconversion and pediatric infection during pregnancy and breastfeeding.
• Continue support for EID, EIT for mother and baby through implementation of improved monitoring tools to track maternal CD4 and DBS/PCR result turnaround time.
• Support task shifting policy, including provision of HAART at all EGPAF supported PMTCT sites.
• MCH services through male champions and providing male friendly services.
• Improve retention of mother-infant pairs by bridging PMTCT and ART services through case managers in the continuum of care model (see HBHC narrative). Follow-up of mother-infant pairs will include: unique patient identifiers for HIV-positive women that link their records to their infants'; sensitization and mentoring of health care workers on the importance of EID and EIT; inclusion of mother-infant pair follow-up in PBF; follow-up of mothers and infants by community health workers (CHW), peer mothers/expert clients (such as M2M/Imbuto) and PLWHA associations.
• Support male involvement in PMTCT.
• Strengthen MCH services: dissemination of algorithms and job aids in focused antenatal care (FANC), EMONC, FP; support community and clinical IMCI, IYCF and maternal nutrition; implement the post-partum package including FP; malaria treatment and ITNs; support DH with kits for the Kangaroo technique and equipment for neonatal care; and continue support of the FP/HIV integration model within all EGPAF supported districts.
• Work with CHWs to reinforce key SGBV messages in the community and support immediate referral to health facilities with trained staff for medical care and post exposure prophylaxis and referral to SGBV support groups.
• Continue support for IYCF and maternal nutrition: integration of maternal and IYCF as part of FANC, post-partum care, vaccinations and regular infant follow-up; reinforce IYCF messages in the community; revision and/or development of IEC materials and program tools based on WHO maternal and IYCF

nutrition recommendations; support for exclusive breastfeeding campaigns in the community.
• Finalize data collection, analysis and report on the "Evaluation of the HIV exposed infant feeding program in Rwanda" PHE.
• Work with MOH, SCMS, CAMERWA, the Pharmacy Task Force, districts and sites to ensure high quality commodity procurement, quantification and forecasting and to ensure no stock-outs occur and medicines are well managed and stocked.
• Support advocacy efforts to mobilize national and local leaders for action on select issues including FP, IYCF, EBF, EID and male involvement in family health.

EGPAF will partner with community partners and the MOH to ensure CHWs in EGPAF-supported districts receive training in HIV and MCH modules and the necessary follow-up and support. Through strategic partnerships with community partners, civil society, private sector, FBO, CSO including cooperatives of PLWHA through RPP+, and CHW, districts will increase demand for PMTCT services, service utilization; disseminate key IYCF messages including safer breastfeeding practices; and assist sites in systematic follow-up of mothers and infants in the community. Case managers will support linkages with community services, and ensure that HIV-positive women and children receive effective referrals to psychosocial support and other maternal child health programs, including HBC care support, malaria and OVC programs via CHF, CRS, and PMI. EGPAF will involve community leaders and men's groups during special events such as umuganda.

EGPAF will support national QI policy through Mutuelles for indigent patients and district risk pooling; national PBF and QI initiatives such as strengthening health quality committees at health centers and PAQs; performing PDSA in each district; holding biannual district level meetings to discuss specific indicators (e.g. infant ARV prophylaxis); supporting the PMTCT IQ Chart and PMTCT modules in TRACnet; ensuring transportation of lab samples and results; and providing supervision and mentoring. EGPAF will also work with districts and sites to strengthen data quality processes through regular data audits and data reviews in the joint supervision process to enable sites and district staff to appropriately use data and ensure quality. EGPAF will assess implementation of CD4 counts during pregnancy and the implementation of EID and EIT protocols at EGPAF-supported sites to evaluate whether these national policies are being correctly implemented, address weaknesses, and review their outcomes.

In line with the Partnership Framework sustainability and transition goals, EPGAF will ensure that all patients receive a standard, comprehensive package of PMTCT services and that MCH and HIV services are co-located to the extent possible; continue to support a combination of funding through technical support, input based funding and output based financing through PBF; ensure programmatic links to food programs (WFP Food and the USAID/Ibyiringiro project) to avoid duplication, ensure implementation of exit strategies (e.g., kitchen gardens) and strengthen linkages too community-based nutrition and IGA

programs.

EGPAF will work with the districts to establish a unit to centralize district level funding. Currently EGPAF is preparing the District Hospital to support sub-grantees. In FY 2010, EGPAF will support one District Hospital through training and mentoring to negotiate and manage the health facilities sub grants under its supervision through a system of payment on performance. EGPAF will support the administrative district to train and mentor the sector health units. EGPAF will assess and document implementation.

Capacity building of health providers and district level health authorities are an important aspect of the transition process and a key step in transferring responsibility. District appropriation of services, including training, supervision, evaluation, HR funding, quality of services and data use are benchmarks for evaluating sites and districts' readiness for transition. EGPAF will work with the USG team and the GOR to establish benchmarks and strategies for transition. EGPAF will also learn from the Track 1.0 care and treatment partners' experiences. These actors will jointly agree on a plan to document lessons learned and progress toward transition.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	177,823	

Narrative:

To support the national and USG goals for reducing the number of deaths caused by TB through increased detection, successful treatment, focus on co-infection, and development of new tools for TB, EGPAF has advanced the TB/HIV one stop service model at all EPGAF supported District Hospitals and supports TB/HIV services at 40 sites. The one stop service model facilitates a comprehensive response to the needs of co-infected patients while reducing exposure of clients in regular HIV clinics to TB, provides HIV testing for all TB patients, TB screening for all HIV-positive patients and treatment for TB-positive patients. In FY 2009, with EGPAF's support, 320 HIV patients were receiving TB treatment at EGPAF sites and 1,012 TB patients had been screened for TB.

In FY 2010, EGPAF will screen 18,937 HIV patients for TB and initiate TB treatment for 303 co-infected patients. EGPAF's TB-related activities for FY 2010 will continue to support the national, district/site, and community level implementation.

EGPAF's national level activities will include support to the MOH and TRAC Plus to roll-out one stop service and ensure infection control. EGPAF will continue to work collaboratively with clinical partners, TRAC-plus, and the UPDC unit of the MOH to support TB/HIV integration and improve the quality of services at all levels; participation in the TB/HIV TWG; .work closely with TRAC Plus supervisor to

analyze quarterly reports and respond to identified weaknesses in TB services delivery and ensure the roll-out of infection control services within both out and in-patient settings for adults and children.

EGPAF's support of staff and systems at the district and sites builds human resource capacity and promotes sustainability. By working closely with staff and management at these levels EGPAF is working to ensure that there are sufficient trained personnel to carry out TB-HIV activities and sustain the program over time.

In FY 2010 EGPAF will:

• Continue to provide support to district health teams allowing them to roll-out supervision to non-PEPFAR funded sites within EGPAF supported districts, and to increase the diagnostic capacity of district hospitals and other TB treatment and diagnostic centers within EGPAF-supported districts.
• Expand the one-stop model for TB/HIV treatment from the five District Hospitals where it is currently in place to all 27 health centers which offer ARVs.
• Ensure that all of patients diagnosed with TB, or suspected to have TB, are offered an HIV test and that 100% of those testing HIV-positive are referred to, and arrive at, an ARV-treatment facility.
• Screen at least 95% of HIV-positive clients for TB during their first consultation and subsequently every six months, and ensure that 100% of those patients diagnosed with TB receive treatment.
• Work closely with sites to ensure they are better able to use the TB diagnostic algorithm, using simple criteria to diagnose TB-infected children to ensure that all exposed children receive Isoniazid prophylaxis after having excluded active TB.
• Continue to support individual sites to improve data quality, not only for reporting, but also for analysis and use for site level program improvement and to support integration of TB and HIV services at the facility level per national guidelines. Additionally, EGPAF will collaborate with TRAC Plus to have two staff persons from each district who are trained receive refresher training; they will become focal points for the TRAC-Plus coordinated mentoring activity so they can continue to provide supportive supervision to facilities in their districts.
• Increase support to DHTs to provide supportive supervision to non PEPFAR funded sites within their supported districts; to increase diagnostic capacity of district hospitals and other CDTs for both pulmonary and extra pulmonary TB, to provide treatment under DOTS and to monitor treatment failure in order to facilitate early detection and management of MDR.
• Continue to support existing sites and build capacity of DHTs to plan and implement a sustainable, integrated HIV/TB program within the existing health care delivery system.
• Continue to support, in collaboration with TRAC Plus, integrated planning and TB/HIV training for both HIV and TB services providers. EGPAF will continue to improve diagnostic capacity for TB including coordinating specimen and patient transport for appropriate diagnostic services (such as chest

radiography and FNA specimens) to referral centers and provide appropriate follow-up and prompt patient care. EGPAF sites will work with community health care workers to reinforce TB/HIV messages in the community.
• Work with districts, sites, and community health workers to identify strategies and mechanisms to improve TB diagnosis among PLHA and screen HIV positive patients for TB. The goal is to have a one stop service centre where an HIV positive individual seeking any service is also screened for TB and is appropriately served or referred for family planning.
• Ensure that health center staff is trained in infection control and implement an infection control plan consistent with national policy and guidelines.

Through its continuous technical assistance to sites via regular formative and evaluative supervision, along with improved data on TB/HIV EGPAF in collaboration with TRAC-plus, CNLS, PNILT and the national PBF program will support health facilities to maintain a system of quality improvement. By using TB/HIV data EGPAF's supported health facilities will regularly review program performance and implement recommendations.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9151	**Mechanism Name: FHI Bilateral**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 7,557,746	
Funding Source	**Funding Amount**
GHCS (State)	7,557,746

Sub Partner Name(s)

Birehe Health Center	Biryogo Socio-Medical Center / Centre Médico-Social de Birgyogo	Buramba Health Center

Busanza Health Center	Byimana	Coko Health Center / Centre de Santé Coko
CONTINUED ON SEPARATE WORKSHEET!!	Cyahinda Health Center	Cyanika Health Center
Cyeru Health Center / Centre de Santé Cyeru	Gakenke District / District de Gakenke	Gasovu Health Center / Centre de Santé Gasovu
Gihara Health Center	Gikondo Socio-Medical Center / Centre Médico-Social Gikondo	Gikongoro Prison Dispensary / Prison de Gikongoro
Gishweru Health Center / Centre de Santé Gishweru	Gitarama Health Center / Centre de Santé Gitarama	Gitega Health Center
Gitwe Health Center	Gitwe Hospital / Hôpital de Gitwe	HAGURUKA
Jenda Health Center	Kabgayi Health Center / Centre de Santé Kabgayi	Kabgayi Hospital / Hôpital de Kabgayi
Kabirizi Health Center / Centre de Santé Kabirizi	Kabuga Health Center / Centre de Santé Kabuga	

Overview Narrative

Since 2007, FHI has received PEPFAR funds to support decentralized HIV/AIDS clinical services. The project aims to achieve sustainable, universal access to holistic HIV prevention, care and treatment services in the project's coverage zone by contributing to the PEPFAR goals and to the objectives of the Rwanda National Strategic Plan 2009-2012 for HIV. During COP10, FHI will continue to:

1. Provide "basic HIV care" services (VCT, PMTCT, opportunistic infection management, prevention with PLHA, etc.) and maintain >80% PMTCT coverage in target districts;
2. Strengthen district care networks so that HIV/AIDS treatment is available to all clients in need within each district;
3. Strengthen district health systems in: infrastructure, comprehensiveness and quality of HIV services, continued integration of HIV care with TB, FP, MCH, and STI management, and expansion of integration activities to include management of childhood illnesses and other major services; patient management tools and systems,data collection and use, Quality Assurance/Quality Improvement initiatives; strengthening District Pharmacies in improved stock management, storage, procurement and regular supply to health facilities district-wide; monitoring and managing performance-based financing (PBF) grants, and District Health Unit planning, coordination, and supervision of health activities district-wide.

FHI will continue to support PBF grants to districts, district hospitals, primary health centers and other partners as needed with technical assistance (TA) and management support from FHI offices. FHI's field-

based teams will fully participate in district-organized initiatives and remain responsive to articulated needs of district leadership. The partner will continue to work towards key milestones to mainstream HIV services into Rwanda's primary and secondary healthcare facilities and to transition out of direct TA to the facilities to a district-level focus. Complementing decentralized activities, the partner will continue to contribute to national-level health sector strategies, guidelines, action plans and tools through participation in Technical Working Groups, Task Forces, coordination meetings and conferences as well as through time-bound staff secondments.

FHI's TA and material support to national government, districts, and health facilities is in line with major indicators for prevention, care and treatment of HIV as well as indicators of health system strengthening, especially at the district level. Further, aligned with the transition milestones outlined in the Partner's 5-year Cooperative Agreement, a key approach promoted through this project has been district-led planning, management and coordination of activities. To further advance this shift, during FY 2010 FHI aims to introduce in one target district a new model to finance district-wide activities through one subgrant to a district hospital. To ensure no disruption of service delivery, "safety net" features will be build in these district grants. Experiences and lessons learned from this new financing model will be applied to the four other districts in the remaining year of the project.

FHI will continue to provide intensive support for comprehensive coverage in the five target districts (Muhanga, Kamonyi, Nyamagabe, Ruhango, and Nyaruguru) in Southern Province and to select health facilities in Kigali, Gakenke and Nyanza. The project targets clients and patients in need of integrated services in the project's intervention zones.

FHI will continue to strengthen health systems through rational use of human resources for health; support for primary health insurance systems, PBF, improved infrastructure; mainstreaming and integrating AIDS care into primary and secondary level care; improved patient management and clinical skills; and district-level management and coordination of health activities.

FHI will maintain and improve cost efficiencies in FY 2010. With the introduction of district-level grants, FHI will begin to see better efficiencies in staff costs. Grants management – an important capacity building and accountability tool – comes with significant staffing demands on finance and internal audit teams, program management, and technical teams. As FHI transitions to a district focus, these demands should lessen over time and substantially improve FHI's cost effectiveness.

Additionally, FHI will continue to strongly advocate for and implement comprehensive, science-based prevention approaches spanning community and clinic-based initiatives. While difficult to measure, preventing new HIV infections is the single most important strategy for reducing program expenses and

costs to the health system.

FHI will continue to monitor progress in clinical services using strategic information and data management systems and tools; to conduct routine data verification with TRAC Plus of site-level data; to collect and use data on special projects and initiatives as indicated and in collaboration with the health facilities and health authorities; to support site-level Data Managers and data management teams to collect, interpret, and use health facility data; to conduct routine data quality audits associated with data management capacity building at the site and district levels; and to provide quarterly and annual reports to the districts, the province, and the MOH.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9151**		
Mechanism Name:	**FHI Bilateral**		
Prime Partner Name:	**Family Health International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,080,793	
Narrative:			
In FY 2009 EGPAF provide ART to 8,094 HIV positive individuals 27 supported ART sites, the later representing 64% of all EGPAF supported facilities, which together in FY 2009 served 1,811 new ART patients, including children. EGPAF's support to ART services follows MOH guidelines and norms, and includes enrollment into care upon a positive HIV test, clinical and CD4 monitoring after initiation on treatment, CTX prophylaxis, OI/STI treatment, regular TB screening and adherence counseling. The model relies on task-shifting to allow facilities without trained doctors to dispense ARVs to stable patients under physician supervision. All patients on treatment receive the full package of HIV care and support services including positive prevention initiatives such as couples counseling, condom distribution, and			

family planning integration with same day counseling and contraceptive refills. EGPAF supports a continuum of care model to ensure retention of patients from HIV positive screening through ART services. This model includes clinic and community linkages for retracing of defaulting patients or patients lost to follow up and for referral to a variety of health, psychosocial and legal services. For pregnant women identified through PMTCT this model assures they are staged clinically and by CD4 and referred to ART services, EID via DBS/PCR, and that HIV positive infants receive ART according to national guidelines. All EGPAF-supported ART sites are implementing the WFP Food for ART program for malnourished patients initiating ART and are using IQ Chart to track and monitor pre ARV and ARV patients.

In FY 2010, EGPAF will continue the services and activities described above and will support the provision of ART services to 9,543 children at existing 27 ART sites.

EGPAF will continue its national involvement in TWGs to ensure accessible, high quality treatment services in Rwanda. EGPAF will provide support to the MOH and TRAC Plus for the revision of task-shifting guidelines, development of positive prevention guidelines and tools, and support the development of training curricula and job aids for the newest treatment guidelines.

EGPAF's strong commitment to the provision of quality treatment services to all Rwandans in need will continue in FY 2010 through a variety of site and district level activities. With regard to human resource development, EGPAF will provide continued support of in-service training and mentorship for the health care providers at EGPAF supported sites, as well as district health supervisors. Training will focus on: ART protocol for adults, adolescents and children; IQChart for data managers; the continuum of care model; nutrition for PLWHA; positive prevention; and QI initiatives. Joint on-site supervision by district and EGPAF teams will allow for the review and support of program, data, and QI activities, with districts taking increased responsibility as district and provider capacity is developed. Furthermore, EGPAF and district technical staff will continue to provide routine clinical mentoring to clinicians providing care and treatment for both adult and pediatric patients at EGPAF supported sites. This includes capacity building in treatment adherence, early detection of signs of treatment failure and adverse drug reactions, OI, STI and TB screening and treatment, and technical support for integrated clinical services. The mentoring will support appropriate and consistent use of job aids, algorithms, medical record flow charts and supervision tools.

On a more clinical level, EGPAF will support the implementation of targeted viral load testing according to the national guidelines. EGPAF will continue its work with the MOH, districts and sites to ensure rapid turnaround of samples and laboratory results for rapid diagnosis and treatment/regimen change. In addition, EGPAF will promote a family-centered approach to care and treatment, and reinforcement

same day service integration, including co-locating MCH and HIV health services, FP and HIV counseling, and TB and HIV treatment. EGPAF will also support the integration of mental health in HIV services according to national guidelines developed in FY 2009. Integrating services and using patient tracking through IQ charts, social workers and CHWs will greatly reduce loss to follow up of PLWHA, particularly pre-ART patients.

Positive prevention (PP) will be a key focus area in FY 2010. EGPAF will work with MOH, districts and sites to ensure that positive prevention is part of routine care for PLWHA, including those on ART. The positive prevention package for adults on treatment will include: prevention counseling at all visits for all patients; ARV adherence assessments at every visit; integrated STI management; integrated FP and MCH services; and condom distribution at every visit. Through partnership with Project San Francisco and the MOH, EGPAF supported districts and sites will be trained in couples counseling, including counseling for discordant couples. EGPAF will work with districts to strengthen mechanisms for the follow up of discordant couples and will support these couples through HIV prevention and FP counseling. EGPAF will ensure that sites have the necessary IEC materials for positive prevention, couples counseling, and discordant couples counseling.

In FY 2010 EGPAF will continue the implementation of the WFP Food for ART program and support exit strategies (e.g. demonstration and kitchen gardens) to decrease dependence on external food support and to support persons exiting EGPAF programs to maintain good nutritional status. As part of this intervention, EGPAF will continue to advocate for inclusion of nutrition services in prison ART services. In addition, EGPAF will continue to support palliative care services including basic nutrition counseling and support, hygiene education, positive living and risk reduction counseling, pain and symptom management and end-of-life care.

To strengthen the continuum of care, EGPAF sites, in partnership with community partners and PLWHA associations, will continue to refer PLWHA enrolled in care to community-based care services based on their needs such as adherence counseling, spiritual support, and activities addressing stigma, IGA, and HBC- services for palliative care, OVC, nutrition services, legal support services and end of life care in line with national palliative care guidelines. Furthermore, EGPAF will assist with staff training, strengthening of referral mechanisms and linkages between HIV prevention, care, treatment, TB/HIV, FP/HIV and counseling services, improving program tools and reports, and conducting an assessment to identify gaps in the patient circuit to inform program improvement. EGPAF will work with community based partners and the MOH to ensure CHWs in EGPAF supported districts receive capacity building and training on the HIV module to better support HIV information sharing and referrals in the community.

EGPAF will support national QI policy through Mutuelles for indigent patients and district risk pooling;

national PBF and QI initiatives such as strengthening health quality committees at health centers and PAQs; performing PDSA in each district; holding biannual district level meetings to discuss specific indicators (e.g. retention in care); ensuring transportation of lab samples and results; and providing supervision and mentoring. EGPAF will also work with districts and sites to strengthen data quality processes through regular data audits and data reviews in the joint supervision process to enable sites and district staff to appropriately use data and ensure quality. EGPAF will implement an assessment of the effectiveness of the continuum of care program including referrals to care and support from CT services. In addition, EGPAF will strengthen the use of IQ Chart software at all EGPAF supported ART sites thereby improving the monitoring of pre-ART and ART clients, including children. The software tracks key clinical and visit history information for individuals in care, improves medical record and quality and strengthens program monitoring by identifying defaulting patients to facilitate patient tracking. As part of treatment services support, EGPAF will continue to support districts and sites in commodity management, quantification and will collaborate with SCMS and CAMERWA in efforts to avoid stock outs and ensure proper stock management.

In line with the Partnership Framework sustainability and transition goals, EPGAF work with sites to ensure that all patients receive a standard, comprehensive package of HIV services and that MCH and HIV services are co-located to the extent possible; continue to support a combination of funding through technical support, input based funding and output based financing through PBF; ensure programmatic links to food programs and to community-based programs.

In FY 2010, EGPAF will support one district hospital through training and mentoring to negotiate and manage the health facilities sub grants under its supervision through a system of payment on performance. EGPAF will support the administrative district to train and mentor the sector health units. EGPAF will assess and document implementation.

Capacity building of health providers and district level health authorities are an important aspect in transferring responsibility. District appropriation of services, including training, supervision, evaluation, HR funding, quality of services and data use are benchmarks for evaluating sites and districts' readiness for transition. EGPAF will work with the USG team and the GOR to establish benchmarks and strategies for transition. EGPAF will also learn from the Track 1.0 care and treatment partners' experiences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	4,573,029	

Narrative:

In FY 2009, FHI supported 40 health facilities (34 health centers, five district hospitals and one prison) to

provide ARV services. In FY 2010 FHI will support 14,132 adults and children already on ART and an additional 2,537 initiating ART, bringing the total number of patients on ART to 16,670.

One of the ART services supported by FHI is the provision of periodic CD4 counts in non-ART patients, which allows providers to determine ART eligibility and to refer eligible patients to the closest health facility providing treatment. In September 2009 ART sites began implementing a new first line ART regimen (which includes Tenofovir), in accordance with the revised national guidelines for treatment and follow-up of people living with HIV/AIDS (PLWHA). In FY 2010 FHI will continue to support sites to implement the revised national protocol.

In the context of scaling-up of ART services and improving access to CD4 counts, the MOH, in collaboration with its partners, plans to place a Faxcount machine for counting CD4 in two district hospitals (Gitwe and Remera Rukoma), both of which are supported by FHI for HIV services. This activity is expected to improve HIV care services in catchment area of these districts hospital through better monitoring and availability of CD4 counts. In FY 2009 the majority of patients had been on ART for three or more years, yet almost all of them remained on a first-line regimen. Early detection of treatment failure would indicate more patients in need of second line regimen and FHI will focus on targeted viral load testing as an essential part of ensuring quality of care.

The shortage of human resources for health, and physicians in particular, has been a major barrier to achieving universal access to HIV care and treatment. In September 2005, FHI launched a pilot intervention to shift ART-related tasks from physicians to nurses. Through this task-shifting initiative, nurses were trained at three primary health centers to initiate ART through prescription of ARVs to non–complex adult patients and provide follow-up care. Following the 2009 publication of the results of the evaluation showing the positive impact of the task-shifting, the Rwandan MOH fully endorsed prescription of ARVs by trained nurses and FHI began rolling out and institutionalizing task-shifting in FY 2009. In FY 2010 FHI will support MOH/TRAC Plus to develop a training module for task-shifting to facilitate rollout. District hospitals will start training nurses from health centers which fulfill certain eligibility criteria, such as: comprehensive services for HIV care in place (counseling and testing, prevention of mother-to-child transmission, and AIDS patient care and treatment); supervision and support from a district hospital already providing ART to patients; and a nurse on staff with at least two years experience providing clinical care for non-HIV pathologies. In FY 2010, at least two health centers per district will provide ART through task-shifting.

Post-exposure prophylaxis (PEP) has been and will continue to be an integral part of FHI's HIV prevention policy. For health care workers and patients exposed to HIV in health-facility settings, a comprehensive package of PEP drugs and services will be provided in accordance with existing

protocols. PEP services for sexual violence or other non-occupational exposure will continue to include: first AID, counseling, HIV/STI testing, provision of ARVs, medical care, trauma counseling, linkages with police, referrals for legal assistance, and other follow-up and support services.
In FY 2010, FHI will continue to support the integration of MCH and Family Planning in HIV services and initiate integration of mental health services according to existing guidelines developed in FY 2009. Diagnosis of OIs and loss to follow-up especially among Pre-ART patients will remain a priority in FY 2010.

In line with the Partnership Framework sustainability and transition goals, FHI work with sites to ensure that all patients receive a standard, comprehensive package of HIV services and that MCH and HIV services are co-located to the extent possible. FHI will also continue to support a combination of funding through technical support, input based funding and output based financing through PBF, as well as ensure programmatic links to food programs and to community-based services.

In FY 2010 FHI will support one district hospital through training and mentoring to manage the health facilities under its supervision through a system of payment on performance. FHI will support the administrative district to train and mentor the sector health units, and assess and document implementation. Capacity building of health providers and district level health authorities is an important element for the transfer of responsibility. District appropriation of services, including training, supervision, evaluation, HR funding, quality of services and data use are benchmarks for evaluating sites' and districts' readiness for transition. FHI will work with the USG team and the GOR to establish benchmarks and strategies for transition. FHI will also learn from the Track 1.0 care and treatment partners' experiences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	234,827	

Narrative:

Uptake of voluntary HIV testing in Rwanda continues to be phenomenally high. Since the beginning of this project, more than 200,000 clients have been tested for HIV at FHI-supported sites alone. During FY 2010, FHI will work with districts to introduce HCT to new health facility partners.

Other FHI priorities in FY 2010 include:

1. COUPLES VOLUNTARY COUNSELING AND TESTING (CHCT): As a form facilitated disclosure and a critical opportunity for prevention, a major priority in FY 2010 will be to scale-up to all health facilities supported by FHI couples HCT based on Project San Francisco's experience of delivering test results to

the couple rather than to the partners separately.

2. SYSTEMATIC AND WELL DOCUMENTED PROVIDER-INITIATED HIV TESTING (PIT): Specifically, FHI will focus on strengthening and further improving TB/HIV service integration and in particular ensuring systematic TB screening in HIV patients, not only at the initial clinical assessment but at regular intervals in the follow-up visits. Also, FHI will focus on ensuring systematic and documented PIT in malnourished children, patients with STI, and patients with other signs and symptoms of HIV disease. Finally, FHI will improve PIT through family-based testing for HIV-affected households. Because PIT data have to date not been routinely collected and reported, FHI will devise ways to document PIT that do not add more burden on health facilities.

3. DIAGNOSIS ANNOUNCEMENT TO CHILDREN AND ADOLESCENTS: Continuing FHI's collaboration with TRAC Plus to deliver HIV diagnosis to infected children and adolescents to provide them with needed psychosocial care and support, FHI will extend this process to all VCT sites it supports. As of the beginning of FY 2009, the HIV-positive diagnosis and psychosocial care program for children and adolescents was active in 28 sites.

4. IMPROVING PRIMARY PREVENTION WITHIN VCT: With a separate funding source, FHI will work with TRAC Plus to establish an effective approach for identifying most-at risk HIV-negative clients within VCT and providing with intensified and personalized risk reduction counseling. As guidelines and tools from this initiative become available, FHI will work with the districts and individual health facilities to introduce it as part of routine, clinic-based primary prevention activities. The "prevention with PLHA" interventions mentioned in the HVOP narrative will also play an important role in such primary prevention efforts linked to Testing and Counseling services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	170,053	

Narrative:

Family Health International (FHI) is one of the USG partners providing HIV care and treatment services for HIV-positive adults and children in Rwanda. In collaboration with local service providers, FHI is currently providing a comprehensive package of services for pediatric care and support which includes: testing of infants born to HIV-positive mothers early infant diagnosis EID), provision of co-trimoxazole prophylaxis (CTX) to HIV-exposed infants, follow-up services for HIV-exposed infants and HIV-positive mothers, nutrition counseling and food support for parents, safe water interventions, and other services for children under 5 years (ex. immunization, growth monitoring, IMCI services, etc.).

In FY2010, FHI will support 56 sites to continue delivering basic care and support to HIV-positive or exposed children, reaching a total of 2103 of children with pediatric care and support by the end of the year. Details on planned/ongoing interventions are described hereafter:

Increasing pediatric patient enrollment is a major priority for all PEPFAR clinical partners in FY2010 as in previous years. As such, the basic package of HIV pediatric care and support will include the promotion of EID (i.e., the extent to which infants born to HIV-positive women are tested to determine their HIV status within the first 12 months of life) which is now available at 56 of FHI-supported sites. Early virological testing for HIV will be offered at 6 weeks and at older ages according to the national algorithm. At FHI-supported sites HIV-positive children will be staged clinically and using CD4 (counts or percentages as these become available), and eligible infants and children will be enrolled in ART. Systematic chart reviews to identify children eligible for treatment based on new CD4 cut-offs will be done. FHI will continue working with the district health teams to ensure that samples collected at the sites are transferred efficiently to the processing lab at the National Reference Laboratory in Kigali, and with the MOH in order to improve reliability of result turn-around times.

CTX is a simple and cost-effective intervention to prevent Pneumocystis jiroveci pneumonia (PCP) among HIV-exposed and infected infants. PCP is the leading cause of serious respiratory disease among young HIV-positive infants in resource-limited countries and often occurs before HIV infection can be diagnosed. All infants born to women living with HIV will systematically start CTX prophylaxis at 6 weeks after birth. CTX will be continued until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding. It is estimated that 1107 infants born to HIV-positive women will be started on CTX within 2 months of birth; and 1223 infants born to HIV-positive mothers will receive an HIV test within 12 months of birth in FY2010.

Follow-up of HIV-exposed infants will be promoted through support groups of HIV-positive women based on the mother-to-mother model. In this model, women who demonstrate steady consultation attendance and good baby care are identified and used to coach new HIV-positive mothers during pregnancy and after delivery to ensure that both women and their infants access needed services. Moreover, FHI will support the implementation of the revised child health card which includes information about maternal HIV status as well as ARV prophylaxis.

Newly identified patients will be screened at enrollment and at regular intervals for signs and symptoms of common opportunistic infections or other infectious complications of HIV in children, including: candidiasis, pneumonia, malaria, meningitis, and PCP. In addition, all pediatric patients will be screened for TB at least once every six months. Children suspected of having TB will be further investigated and put on TB treatment if infection is confirmed based on current national guidance. Additionally, infants and

children on ART will also be assessed at each visit for issues related to adverse events, toxicity and adherence to ART.

All pediatric patients will have regular anthropometric evaluations to identify early signs of malnutrition and to ensure prompt initiation of nutrition rehabilitation interventions. Through the mother-to-mother group sessions supported by FHI, health workers will provide nutrition counseling, enhancing family food support through training for improved home gardening and animal breading techniques. FHI will provide food supplementation to mother-infant pairs. This latter activity will be conducted in collaboration with a Prime PEPFAR funded Community Partner, the World Food Program and Catholic Relief Services.

Using complementary USG funding, FHI-supported sites will provide health education on safe water and water purification products such as Sûr'Eau. HIV-exposed infants identified at PMTCT sites will be followed in the context of MCH services offered at existing FHI sites.

Pediatric HIV care and treatment programs in Rwanda still face many challenges, including the need for increased numbers of qualified pediatric health care providers. FHI will ensure that site-level providers are trained and/or receive refresher training session in pediatric HIV patient management, in conformity with the national guidelines. Providers will receive regularly planned in-service trainings and mentoring in pediatric HIV care and treatment.

FHI will continue working with other clinical implementing partners and the MOH to train health care providers on newly updated pediatric HIV treatment guidelines. Staff will be trained to ensure, as much as possible, the early detection of signs of immunologic and clinical failure and the initiation of second-line treatment regimens based on national protocols.

FHI will assist heath facilities in mentoring children and adolescent support groups that have been established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment or affected by HIV and assist with addressing issues around status disclosure and adherence support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	503,200	

Narrative:

In Rwanda, efforts are increasing to provide HIV/AIDS care and treatment to infants and children who are still underserved by antiretroviral treatment compared with adults. Family Health International (FHI) is committed to increasing access to HIV care and treatment for HIV-positive or HIV-exposed children. By

the end of FY2009, FHI will be supporting at least 56 health centers to provide PMTCT services and to perform HIV early infant diagnosis. This activity contributes to the identification of HIV-positive infants/children and to providing them with ART or linking them to ARV services. The number of sites providing ART services will be at least 36 by the end of FY2010; it may be more given the recent MOH instructions on task-shifting for prescription of ART by nurses. FHI/HCSP targets the following number of ART children in FY2010: 267new cases; 1666 current cases; and 1933 cumulative cases.

FHI will continue to provide technical and financial assistance for the following activities that benefit pediatric HIV patients: administer co-trimoxazole prophylaxis to HIV-positive infants at the age of 6 weeks; initiate ARV treatment to HIV-positive infants less than 12 months old and to young children according national guidelines; provide other HIV-related treatment to all eligible infants/children through the District Care Networks; and ensure that HIV test results are announced to children/adolescents and their parents/guardians with counseling and organized support groups. FHI will assist heath care providers in mentoring children and adolescent support groups that are established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment and to assist with addressing issues around treatment adherence.

Conduct routine clinical monitoring with intensification based on health status using the Acuity Case Management (ACM) approach.
Few staff are trained in pediatric HIV, and most health care workers lack confidence in HIV pediatric care and treatment in general. FHI, in collaboration with the Center of Excellence at CHUK, will provide financial support to Pediatric Practical Staff Training in 5 district hospitals. Health providers' skills will also be reinforced in screening, diagnosis and treatment of TB in infants and children by organizing training and by providing tools.

FHI will work with other partners to provide two new FACSCount machines for CD4 testing to Remera-Rukoma and Gitwe District Hospitals, and to make these machines operational. FHI will continue to support all facilities in transportation of blood samples to NRL for DBS-PCR and facilitate the procurement of pediatric drugs and lab commodities through the district pharmacies.

The establishment of District Networks of HIV Care will further strengthen the connection between ART and PMTCT programs and facilitate scaling-up of the national ARV regimen for children.

In FY2010, FHI will be enhancing HIV early infant diagnosis to be offered in 100% of health centers in targeted districts as part of standard HIV care. As such, co-trimoxazole prophylaxis will be provided at 6 weeks of age to all HIV exposed infants. In addition, FHI/HCSP will support the following: early HIV

testing using PCR/DBS at 6 weeks of age and in all infants with signs suggesting HIV infection (e.g. low weight, repetitive infections, and slow growth); care and treatment services for infants diagnosed as HIV-positive; active family-based testing of children, including home-visits as indicated; intensified and expanded counseling; education and support for post-weaning child nutrition (the latter through PHC-based initiatives with locally produced foods); and implementation of breastfeeding recommendations to mothers of these infants according to HIV-status.

FHI will continue to work closely with WFP through Food for ART Program to provide nutritional support to children affected and infected with HIV. FHI will also work with all health facilities to ensure good nutritional counseling of clients, and it will provide Job Aids patient educational materials on nutrition to the facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	297,000	

Narrative:

FHI/HCSP will promote and implement interventions targeting the general public and most-at-risk individuals as part of a comprehensive, science-based approach to primary, secondary, and tertiary prevention of HIV. In FY 2010, FHI/HCSP will prioritize cross-referrals spanning community and clinical contexts to provide individuals with multiple behavioral and biomedical prevention services and, where indicated and feasible, these will include reducing socio-economic vulnerabilities that lead to high-risk situations.

In the clinic setting, in FY 2010 primary prevention activities will entail behavior change education to reduce sexual risk, including delayed sexual onset for youth, consistent and correct condom use for youth and adults, partner testing and couples VCT, and improved STI diagnosis and management. With a separate funding source, FHI/HCSP will work with TRAC Plus to establish an effective approach for identifying most-at-risk HIV-negative clients within VCT services, and providing them with intensified and personalized risk reduction counseling. As guidelines and tools from this initiative become available, FHI/HCSP will work with the districts and individual health facilities to introduce it as part of routine, clinic-based primary prevention activities.

Comprehensive "positive prevention" programs targeting HIV-positive persons and HIV-affected couples will comprise a core set of activities for secondary and tertiary prevention health facilities in FY 2010. Systematic and expanded positive prevention programs will include:
1. Behavior change education and support to HIV-positive persons to reduce risk of transmission to HIV-negative partners.

2. Condom promotion and delivery to HIV-positive individuals and -affected couples.
3. PMTCT, dual method promotion and family planning delivery for HIV-positive women and -affected couples.
4. HIV testing for partners of HIV-positive persons and couples VCT.
5. Counseling and support for adherence to treatment.
6. Counseling and support for HIV sero-discordant couples.
7. Routine STI screening and treatment for HIV-positive patients.
8. Referral to care, treatment and support services for HIV-positive persons including to community-based program.

In two primary health centers in Kigali, FHI/HCSP will also continue to support HIV prevention and enhanced syndromic management of STIs among female sex workers. In addition to diagnosing and treating STIs in this at-risk population, this initiative also includes HIV counseling and testing, family planning services, sexual risk reduction education, provision and promotion of condoms, social support and income generation. To improve support to the women for alternative economic options, FHI/HCSP will apply successful strategies and approaches used in the separately funded ROADS II project (LifeWorks program) that focuses prevention and impact mitigation in high-risk communities located along the transport corridor.

FHI/HCSP will continue to engage in program level data analysis to better understand the needs of the community served but also to generate evidence for program improvement and planning. FHI/HCSP will continue to participate in SI activities that support better prevention programming and outcome assessment, like behavioral surveys. In FY 2010, FHI/HCSP will conduct an evaluation of their activities with MARPs in the sites they support. FHI/HCSP will also continue to support national efforts and use national tools aimed at improving M&E capacity and quality assurance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	472,509	

Narrative:

This is continuing activity from FY 2009.

In FY 2010, FHI will continue to support Rwanda's national program to offer PMTCT as a routine part of antenatal care (ANC). As of the beginning of FY 2009, 56 FHI/HCSP-supported sites (both health centers and district hospitals) were providing PMTCT. MOH's 2009 instructions on task shifting for prescription of ARV treatment by the nurses could significantly improve access to ART by pregnant women and their family members in need of treatment.

Family Health International (FHI) will provide an expanded package of services for 42,493 pregnant women at 56 existing FHI supported CT/PMTCT sites. FHI will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, intermittent preventive treatment of malaria in pregnant women (IPTp) in collaboration with PMI, ARV prophylaxis using combination ARV regimens and HAART for eligible women, infant feeding counseling and support, referral for MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis. In addition, FHI will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services and ensuring prompt CD4 count and clinical staging for HIV-positive pregnant women.

This also will include screening and treating STIs, including systematic syphilis testing for all pregnant women coming to ANC services, and HIV counseling and testing services for pregnant women and their sexual partners. In collaboration with TRAC Plus and Project San Francisco, FHI, and all clinical partners, will support couples' counseling through training and on-site mentoring improve pre- and post-test couple counseling quality and follow-up mechanisms for discordant couples and women testing negative in ANC to address seroconversion and pediatric infection during pregnancy and breastfeeding. FHI will also support HIV testing in labor and delivery wards for women of unknown status.

Pregnant women will also be offered iron and folic acid supplements in line with MCH guidelines, and they will be provided with educational materials on post-partum care, infant consultations, family planning, and other RH/MCH-related topics. In addition, systematic referral/counseling will continue for regular ANC visits, growth monitoring, vaccination services and family planning. Finally, MCH services will be enhanced through other USG funding sources, to complement the PEPFAR-funded activities.

Women meeting poverty criteria by the PHC committee will be enrolled, with their families, in the PHC's health insurance system (Mutuelles); and provided with nutritional supplements prior to birth and after birth.

FHI will strengthen follow-up and tracking systems to ensure testing of family members, routine provision of CTX PT and infant diagnosis, ongoing infant feeding counseling, CD4 monitoring and clinical staging, management of OIs, including TB and other HIV-related illnesses, psychosocial support services at clinic and community levels, identification and referral for victims of gender-based violence to appropriate care in collaboration with community care workers, peer educators and other HIV clinical partners, and access to clinical and community prevention, care, and treatment services for family members. FHI will assure

linkage to treatment for eligible women and infant follow-up by using peer support groups, community mobilization, community volunteers, home visits done by health workers to encourage them to continue in the program and to provide continuing counseling and advice. In addition, all HIV-positive women are included in child weaning courses (which include education on nutrition and food preparation). At PHCs, family planning is also encouraged and either provided directly by the health facility or the woman is referred for services.

Infants born to HIV-positive mothers will continue to receive ARV prophylaxis and IMCI services and immunization services with support from FHI under HCSP. Prophylactic treatment with Co-trimoxazoleis provided to infants at 6 weeks of age; early infant diagnosis services, now available at 43 of FHI supported sites, will be expanded to increase full coverage of sites. EID will be offered at six weeks of age and at later ages for symptomatic infants less than 18 months of age according to the national algorithm. HIV positive infants will continue to receive preventive therapy (PT) with co-trimoxazole, and HAART according to the national guidelines. In FY 2010 FHI will collaborate with Catholic Relief Service (CRS) which is the principle PEPFAR sub -awardee for the purchase and distribution of nutritional supplements to people infected and affected by HIV and AIDS including weaning food supplements in PMTCT. Under this collaboration, CRS bears the responsibly of purchase and distribution food supplements in the form of fortified weaning food to the mothers of HIV-exposed infants from age of 6 months to 18 months as well as nutritional supplements to include pregnant and lactating mothers.

Capacity building of health providers and district level health authorities are an important aspect of the transition process and a key step in transferring responsibility. District appropriation of services, including training, supervision, evaluation, HR funding, quality of services and data use are benchmarks for evaluating sites and districts' readiness for transition. FHI will work with the USG team and the GOR to establish benchmarks and strategies for transition. FHI will also learn from the Track 1.0 care and treatment partners' experiences. These actors will jointly agree on a plan to document lessons learned and progress toward transition.

Sustainability of services and improvements in program outcomes will be promoted through a combination of input technical assistance and output performance-based financing (PBF). Procurement, forecasting and distribution of ART, CTX and other PMTCT commodities will be further strengthened through SCMS, the MOH and CAMERWA.

District Health Teams and site level teams will be supported through training, formative supervision to better coordinate PMTCT and other HIV and health clinical and preventive services. This will maximize effective referrals between HIV/AIDS services, improve integration with other MCH services (e.g., distribution bed nets to prevent malaria, family planning counseling and referral, syphilis screening,

nutrition counseling and support) and improve the quality of care at the most decentralized level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	226,335	

Narrative:

In FY 2007, FHI began implementing the national TB/HIV policy using national guidelines at 59 FHI-supported health facilities. The program's achievements include an improvement in the percentage of TB patients tested for HIV from less than 70% to 95% and improving HIV-positive TB patients' access to HIV care and treatment (increased proportion of patients accessing Co-trimoxazoleand ART). In FY 2008, with the MOH, districts and individual health facilities, FHI focused on ensuring that PLHA receiving basic care services were diagnosed and treated for TB and to ensure systematic audits of the availability and use of national TB tools at FHI-supported health facilities. Additionally, in FY 2009, FYI disseminated the new MOH guidelines to help in TB diagnosis among children and this activity will continue to be reinforced in FY 2010.

Under the lead of TRAC Plus, for the FY 2010 period FHI will continue to improve services for TB/HIV management, including a strong focus on infection control standards and increased diagnostic capacity for both pulmonary and extra pulmonary TB as well as fully expanded implementation of regular TB screening for all PLHA (adults and children). For those HIV-positive clients suspected to have TB infection, the project will ensure complete treatment with DOTS, monitor for treatment failure in order to facilitate early detection of MDR TB, and track exposed family members for appropriate HIV and TB screening and or initiation of Isoniazid prophylactic therapy for children under 5 years old, as indicated in the national guidelines.

FHI recently seconded staff to the TRAC Plus TB unit within the MOH to strengthen coordinated planning and improved integrated service delivery on a national scale. These positions will continued to be supported in the FY 2010 funding period. Also under FY 2010, FHI will conduct an audit of TB infection control needs at health facilities supported by FHI, in coordination with the TB Unit at MOH. As needed and possible, infrastructural improvements will be made for better infection control. At all health facilities, education aimed both at providers and patients for TB infection control will be supported.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9152	Mechanism Name: IntraHealth Bilateral

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 5,916,844	
Funding Source	**Funding Amount**
GHCS (State)	5,916,844

Sub Partner Name(s)

Bushara Health Center	Bwisige Health Center	Byumba Health Center
Byumba Hospital, Rwanda	Gasabo District Health Unit	Gicumbi District Health Unit
Gihogwe Health Center	Gikomero Health Center	Gishaka Health Center
Gisiza Health Center	Giti Health Center	Jali Health Center, Rwanda
Kajevuba Health Center	Kayanga Health Center	Kibagabaga Hospital
Kigogo Health Center	Mildmay Center, Uganda	Miyove Prison
Muhondo Health Center	Mukono Health Center	Munyinya Health Center
Rubungo Health Center	Rushaki Health Center	Rutare Health Center
Rwesero Health Center	Tanda Health Center	

Overview Narrative

IntraHealth HIV Clinical Services Project (HCSP) serves nearly 1.5 million people living in Gasabo, Gicumbi, Nyagatare, and Rulindo districts. HCSP aims to build national and district capacity to support, manage and expand HIV/AIDS clinical activities and services in select District Health networks (DHNs). HCSP supports CT, PMTCT, ART, FP/MCH/HIV/AIDS integration, GBV, ABC prevention, prevention of medical transmission, BCS, TB/HIV integration, and nutrition.

HCSP's work is in line with the PFIP to empower districts to assume leadership and technical/financial responsibilities by 2012. In COP10, HCSP will continue to strengthen DHNs skills in financial management, budgeting, reporting, accounting, sub grant management, HR and program management, planning, and M&E. HCSP will support quarterly meetings with DHNs to monitor performance.

To build on previous cost-efficiency practices such as On the Job Training (OJT), HCSP will adopt the

following approaches: develop a procurement plan for all sub-partners to procure supplies, equipment and commodities; integrate training sessions to reduce costs; expand coverage of sites with low marginal costs; and gradually reduce salary support and input financing where possible.

HCSP's M&E program complies with Rwanda's Three Ones policy, the OGAC SI strategy, and the Rwandan M&E Plan. HCSP has improved data quality and will continue to work in close collaboration with districts and sites to strengthen M&E capacity. Two major goals for COP10 will be to support sites in collecting and analyzing their own service data for informed decision-making, and achieve 100% site-level data computerization.

Cross-cutting programs

To ensure quality service delivery and increase ART coverage/treatment compliance, HCSP will implement task shifting and the Mobile District Physician scheme. Health facility staff salaries will also be supported, although in COP10 HCSP will further negotiations with the MOH to transfer some salary support to the government. Staff retention will be promoted through work space improvement and continuous technical support for high performance-based financing scores.

HCSP will renovate 3 new sites, and will continue to conduct small renovations/maintenance for existing sites. All HCSP-supported sites currently have some energy source. But, HCSP will ensure the electrification of all sites by the end of 2012.

HCSP aims to have 95% of beneficiaries with normal anthropometric indicators after 6 months of nutrition support, and at least 95% of ART patients comply with treatment. HCSP will provide nutritional support to HIV-exposed infants between the ages of 6 and 8 months; malnourished women in the final trimester of pregnancy; and malnourished breast-feeding mothers with children up to 6 months. HCSP will also train providers in care and treatment. In collaboration with CRS and WFP, the nutrition and well-being of ART and HIV+ patients, especially mothers and infants, will be improved.

Given increased vulnerability to poverty among PLWHA, HCSP will support projects to increase household income. Approximately 350 families will receive support in nutrition-sustaining activities. PLWHA cooperatives will be engaged in these activities as well to motivate and support HIV-affected individuals and households.

HCSP will continue to build capacity of districts, health facilities and community GBV committees to prevent and mitigate GBV. Activities will include assessing GBV-related knowledge, attitudes and practices among providers; assessing HIV/AIDS service readiness to provide GBV services; increase linkages with police, communities and districts in the management of GBV survivors; and support

community sensitization and mobilization. Other key issues related to gender will be advanced, including CVCT, prenuptial CT, scaling up and involving male involvement in CVCT and PMTCT, and engaging both male and female partners. Health providers will train Community partners for Quality assurance (PAQ) teams to disseminate messages and mobilize community members.

Key Issues
HCSP will address a number of key issues including conducting a full program evaluation, continuing workplace programs by providing technical and financial assistance to PLWHA support groups and advancing gender and related cross cutting issues as discussed above.

The HCSP will also implement health-related wraparounds in child survival and safe motherhood, FP and TB.

HCSP will continue to support IMNCI training and activities; routine vaccination and follow-up of HIV-exposed children; DBS-PCR and serology testing of infants and subsequent ART and OI treatment; appropriate HIV status disclosure to children and children's support groups; and education and support for parents of HIV-infected children. Other strategic interventions will focus on mother and child health including but not limited to the promotion of 4 ANC visits per pregnancy and facility-based deliveries; quality provision of emergency obstetric and neonatal services.

With USAID FP funding, HCSP will build on its significant FP/HIV integration advances: integrated planning; reorganization of internal services, roles and responsibilities; training; MIS and monitoring; and supervision. HCSP will ensure that FP counseling and methods are available and systematically offered in all HIV/AIDS service points, with a vision of a one-stop shop model.

HCSP will continue systematic TB/HIV screening and treat all co-infected patients, while ensuring sufficient trained staff to carry out this double screening.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	309,700
Economic Strengthening	130,355
Education	1,915,430
Food and Nutrition: Policy, Tools, and Service Delivery	219,115

Gender: Reducing Violence and Coercion	417,544
Human Resources for Health	2,924,700

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**9152**		
Mechanism Name:	**IntraHealth Bilateral**		
Prime Partner Name:	**IntraHealth International, Inc**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,185,478	

Narrative:

This is a continuing activity.

In FY 2009 IntraHealth International HIV Clinical Services Project provided basic HIV care and support services to 11,500 adult HIV clients at 41 clinical sites. Services provided include: clinical staging and baseline CD4 for all patients, follow-up CD4 counts, STI/OI diagnosis and management of HIV and other HIV-related illnesses, and routine provision of CTX prophylaxis for eligible adults and children, based on national guidelines.

In FY 2010, HCSP will continue to support 41 sites including 29 ART sites. HCSP is expected to reach 15,518 individuals with these services. HCSP will support health facilities to link VCT centers, TB services, and PMTCT services to care and treatment services, as well as to routine pediatric care, nutrition services and maternal health services. Additionally, clinical services will be linked to community

services to facilitate a continuum of care. All confirmed HIV patients will be staged for level of care required, potentially receiving WHO clinical staging, a CD4 count, and/or screening and treatment of any HIV-related opportunistic infections. Retention in care of adult patients not yet eligible for ARVs is a challenge in Rwanda where patients are diagnosed early in the course of HIV infection but have few opportunistic infections which require them to come visit health facilities. In FY 2010 HCSP will reinforce patient retention strategies such as intensified psychosocial counseling at diagnosis, immediate clinical staging, CD4 cell count and home visits. In addition, engagement in prevention with positives activities and the new strategy of providing Co-trimoxazole to all HIV positive individuals will facilitate retention in care and adherence support as clients come for their Co-trimoxazole refills. Once a patient becomes eligible for ART, s/he is referred to ART services, a process facilitated by a social worker and CHW to ensure enrollment and retention in ARV services.

An electronic data base, the IQ Chart, has been installed in all ART sites, and is being expanded to include VCT and PMTCT along with ART, creating a synergy which will improve data recording, patient follow-up at, and patient tracking and will reduce loss to follow-up. HCSP will continue to train data managers and health service providers on data use for program improvement. With improved data on adult basic care and support, HCSP, in collaboration with TRAC Plus and other national quality assurance initiatives, will support health facilities to build and sustain a system of quality performance measurement and quality improvement using data to regularly review program performance and design/implement an improvement plan. As part of supportive supervision and quality assurance, HCSP will ensure that site- and district-level review meetings take place and that respective improvement plans are implemented. Selected indicators such as CD4 count, Co-trimoxazole prophylaxis, condom use, STI screening and treatment, loss to follow-up and mortality rates, and TB screening, will be used to monitor program quality. This activity supports PEPFAR goals in Rwanda and is in line with the national HIV program guidelines.

In collaboration with Community Services Providers (CSP), GFTAM and PMI, HCSP will provide LLITNs, nutrition counseling, food support through IGAs, home gardening and animal breeding training, and point of use water purification kits. In addition, IntraHealth supported sites will provide health education on safe water and use MCH funds to ensure safe water supply and storage at the supported sites. IntraHealth will also continue to integrate family planning and IMCI into the program. Using screening and management guidelines developed by TRACPlus, IntraHealth will introduce the integration of mental health services in supported sites.

In line with the Partnership Framework goals, in FY 2010 and in collaboration with District Health Networks (DHN), IntraHealth will evaluate the extent to which site graduation criteria have been achieved. Based on the results of this evaluation, and with guidance from the USG, IntraHealth will begin

its exit process while reinforcing capacity of district teams to manage HIV services delivery and maintaining service quality. IntraHealth will continue to support performance-based financing and negotiate with district authorities to gradually assume responsibility for staff salaries currently supported by the HIV Clinical Services Project (HCSP). IntraHealth will work with the USG team and the GOR to establish benchmarks and strategies for transition. IntraHealth will also learn from the Track 1.0 care and treatment partners' experiences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	3,380,733	

Narrative:

The IntraHealth HIV Clinical Services Project (HCSP) supports health facilities in the provision of an integrated package of ARV services, including clinical evaluations, CD4 monitoring and ARV prescription services; side effects monitoring, adherence support, viral load, early treatment failure detection and switching to alternative regimens or second line regimens. In FY 2010 HCSP will continue to provide the same package of services to 6,347 existing ART patients and add 2,023 new patients at 29 ART sites, with the goal providing Art to 8,370 HIV-positive individuals. HCSP will support health facilities to perform regular clinical evaluations and monitor their CD4 count according to the national treatment protocol. Patients will be regularly screened for OIs, receive adherence counseling, nutritional evaluation and counseling. Targeted viral load testing will be provided to facilitate early detection of treatment failure.

In line with the recent MOH instruction on task shifting, which authorizes qualified nurses to prescribe ARVs, HCSP will collaborate with TRAC Plus to provide clinical mentoring to all HCSP providers, who will subsequently be supported by district hospital doctors who tour the health facilities and coach nurses on their new role.

Through a partnership with Supply Chain Management Systems, CAMERWA(the national pharmaceutical warehouse), and district pharmacies, HCSP will provide health facilities with appropriate ARV drugs and train health care providers on stock management, dosage, and administration.

In collaboration with the National Reference Laboratory and regional laboratory network, HCSP will support sites to access CD4 counts and viral load test. Health facilities will be equipped with hematology and biochemistry materials and equipment, and will be provided with reagents for improved patient immunological and biological monitoring. Basic materials and equipment for clinical care, such as weight scales, height measures and otoscopes, will be provided. In collaboration with Mildmay International, HCSP will develop a program for HIV pediatric patient counseling and treatment adherence support, which will include treatment preparation sessions with child patient groups, distribution of flyers, and

visual materials. In addition at selected sites HCSP will provide ARV treatment support to at-risk children identified through home-based care or routine consultation. Parents of children on ARV will be coached and supported during routine consultations to improve their ability to respect ARV dosage, frequency of administration and precautions in particular circumstances including school, sleepovers, and vacations without parents or guardians present.

IQ Chart has been installed in all supported ART sites, and in FY 2009 the program was expanded to include VCT and PMTCT, along with ART, in order to improve data recording, analysis and use at supported clinical sites. HCSP will continue to train data managers and health service providers on the use of the software and data. With improved data on adult basic care and support, HCSP, in collaboration with TRAC Plus and the HIVQUAL project, will support health facilities to build and sustain a system of quality performance measurement and quality improvement using data to regularly review program performance and design/implement an improvement plan. As part of supportive supervision and quality assurance, HCSP staff will ensure that site- and district-level review meetings take place and that respective improvement plans are implemented. Selected indicators such as CD4 count, Co-trimoxazole prophylaxis, condom use, STI screening and treatment, lost to follow-up and mortality rates, and TB screening will be used to monitor program quality in providing basic care and support to adult HIV patients. IntraHealth with also support the integration of mental health services according to national guidelines under development. This activity supports PEPFAR goals in Rwanda and is in line with the national HIV program guidelines.

FY 2010 target estimation was set with consideration of four elements: supported sites' current populations and growth rates; national HIV prevalence; projected family planning user rates; and the opening of new sites. An effective and rigorous M&E system will be maintained to evaluate program results. HCSP will also collaborate with health center data managers, TRAC Plus and other partners to ensure quality data collection, evaluation and reporting using national the TB/HIV M&E Framework and tools.

Throughout FY 2010 and in collaboration with DHNs, HCSP will conduct an evaluation to measure the extent to which site graduation criteria have been achieved. Based on the results of this evaluation, and with guidance from USG, HCSP will begin its exit process while reinforcing capacity of district supervisors in the domains of supportive supervision, task shifting, and site support, while ensuring service data quality. HCSP will continue to support performance-based financing and negotiate with district authorities to assume responsibility for staff salaries currently supported by HCSP. This will be a gradual process aiming for complete transition of responsibility to the government by program close in 2012.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HVCT	171,996	

Narrative:

In the IntraHealth HCSP's first three years, access to VCT significantly expanded in the four target districts. In FY 2008, 170,068 individuals were tested through HCT services at 34 HCSP-supported HCT service outlets. Partnering with community health worker teams and other district stakeholders, HCSP supported HIV/AIDS community prevention services to 594,511 individuals. In FY 2009, HCSP will provide VCT to 114,000 at 35 HCT sites in its four districts. HCSP conducts HCT with respect to national protocols and algorithms.

In FY 2010, in line with the Partnership Framework Implementation Plan, HCSP will continue to support and mentor its 35 HCT sites. HCSP will also continue to conduct supportive supervision and quality assurance in collaboration with District Health Networks (DHNs), while expanding HCT via several approaches. HCT services will be extended into communities through community mobilization in collaboration with local leaders, with focus on family-based testing and couples-based prenuptial counseling. HCSP will also encourage provider-initiated testing at all supported sites. Meanwhile HCSP will continue to integrate reproductive health services in all HCT points, including in prenuptial counseling. All clients who are tested and receive a positive status will be referred for ART. In FY 2010, HCSP aims to test at least 128,850 individuals and have them receive their test results. HCSP is confident to achieve this target given its successful performance thus far in ensuring effective referrals between HCT services and other HIV/AIDS clinical service points, as well as its achievements in mobilizing communities and families to be tested owing to strong community linkages, family-oriented weekend HCT sessions and participation in national HIV-testing campaigns, among other strategies.

FY 2010 target estimation was set with consideration of four elements: supported sites' current populations and growth rates; national HIV prevalence; projected family planning user rates; and the opening of new sites. An effective and rigorous M&E system will be maintained to evaluate program results.

Throughout FY 2010 and in collaboration with DHNs, HCSP will conduct an evaluation to measure the extent to which site graduation criteria have been achieved. Based on the results of this evaluation, and with guidance from USAID, HCSP will begin its exit process while reinforcing capacity of district supervisors in the domains of supportive supervision and task shifting site support, while ensuring service data quality. HCSP will continue to support performance-based financing and negotiate with district authorities to assume responsibility for staff salaries currently supported by HCSP. This will be a gradual process aiming for complete transition of responsibility to the government by program close in 2012.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDCS	316,567	

Narrative:

In FY 2009, IntraHealth HCSP collaborated with community service providers to offer a comprehensive package of basic care and support services to 1,633 HIV-positive children at 41 sites including Co-trimoxazoleprophylaxis, nutrition counseling and food support, insecticide-treated bed nets (ITN), and safe water. In FY 2010, HCSP will continue to provide the same package to 1,633 HIV-positive children at 41 existing sites, and expand services to 401 new children from four new sites. HCSP will ensure that HIV-exposed children are followed and adhere to Co-trimoxazoleprophylaxis, in part by promoting integration with routine pediatric care, nutrition and maternal health services.

During FY 2010 at least 829 infants born to HIV-positive women will be started on Co-trimoxazoleprophylaxis within two months of birth, and they will receive their HIV status within 12 months through the early infant diagnosis (EID) program. HCSP-supported sites will link with OVC service providers operating in the Northern Zone to screen children for HIV according to national guidelines, and enroll exposed and infected children into care. In addition, HCSP-supported sites will link with all malnutrition centers within their facility or at specialized sites and provide HIV testing to all in- and outpatients. HCSP-supported sites will enroll infected children into care and treatment services.

Using a family-centered approach, HCSP will offer HIV testing to all partners and children within families of HIV-positive adults and will enroll infected family members into care and treatment services. HCSP will also help link with PLWHA cooperatives, local PLWHA networks, and administrative district authorities to support the sensitization of adult patients and the guardians of children orphaned by AIDS for the testing of children and their enrollment into care. In FY 2010, HCSP will aim for 10,567 PLWHA to receive a minimum prevention with positives package. At PMTCT sites, mothers and exposed children will be followed up through maternal HIV care and mother counseling groups using the mother-to-mother model where HIV-positive mothers who demonstrate steady consultation attendance and good baby care will coach new HIV-positive mothers to do the same. During these counseling sessions HCSP will provide ITN, nutrition counseling, and nutrition support through IGA, home gardening, animal breeding, and food support in collaboration with CHF, WFP, as well as the consortium CRS/ACDI/VOCA/World Vision.

In addition, HCSP-supported sites will provide health education on safe water and distribute water purification products. At HCSP-supported sites HIV-positive children will be staged and those eligible for ARV will be enrolled in ART. All pediatric patients will have anthropometric evaluation, and those who are found malnourished will be rehabilitated. They will be screened at enrollment and at regular intervals later on for opportunistic infections, particularly candidiasis, meningitis, and PCP. In addition, all pediatric patients will be screened for TB at least once every six months, and those suspected of having TB will be further investigated and put on TB treatment if confirmed or strongly suspected.

HIV-exposed, infected and affected children do not have the same level of vulnerability and risk of death as non-infected or affected populations. For this reason IntraHealth will work to implement a system to assess vulnerability based on a model implemented at the Mildmay pediatric HIV clinic in Uganda, and it will provide daycare services at supported sites for children at risk of dying due to extreme poverty, parental illness or other factors. The package of daycare services will include home visits for families with HIV-positive children, nursing, and medication adherence in a child-friendly environment.

HCSP will ensure that health service providers are trained or retrained in pediatric HIV care according to national guidelines, and that they receive on-the-job coaching regularly. The trainings will particularly be related to new pediatric guidelines including topics for clinical staff as well as lab technicians. To provide early initiation of ART for all HIV-positive infants, HCSP will assist in the implementation of early infant diagnosis and follow-up through training for PMTCT staff and lab technicians, and through developing efficient and reliable sample transportation systems. HCSP staff will also train service providers at health centers in clinical HIV care, basic care and support, data recording and use, and quality performance measurement and improvement.

Through a partnership with Supply Chain Management System, CAMERWA, the national pharmaceutical warehouse, and district pharmacies, HCSP will provide health facilities with appropriate ARV drugs and train health care providers on opportunistic infection drugs and reagents, stock management and distribution, patient counseling and pharmacy record keeping/data use. HCSP will collaborate with health facilities to survey energy needs for proper laboratory operation, IT equipment and drugs conservation.

IQChart, an electronic patient management system, has been installed in all supported ART sites, and in FY 2009 it was expanded to include VCT and PMTCT along with ART. HCSP will continue to train data managers and health service providers on the use of the software and data. With a link between pediatric HIV care indicators and PMTCT indicators in this database, follow-up of children exposed to HIV will be improved. With improved data on pediatric HIV care, HCSP in collaboration with TRAC Plus, the national performance-based financing program and the HealthQual project, will support health facilities to build and sustain a system of quality performance measurement and quality improvement using data to regularly review program performance and design/implement an improvement plan. As part of supportive supervision and quality assurance, HCSP staff will ensure that site- and district-level review meetings take place and that respective improvement plans are implemented. HCSP will ensure that pediatric HIV care is integrated with adult HIV care and that the family approach is reinforced. This activity supports PEPFAR goals in Rwanda and is in line with the national HIV program guidelines.

FY 2010 target estimation was set with consideration of four elements: supported sites' current

populations and growth rates; national HIV prevalence; projected family planning user rates; and the opening of new sites. An effective and rigorous M&E system will be maintained to evaluate program results. HCSP will also collaborate with health center data managers, TRAC Plus and other partners to ensure quality data collection, evaluation and reporting using national the TB/HIV M&E Framework and tools.

Throughout FY 2010 and in collaboration with district health networks, HCSP will conduct an evaluation to measure the extent to which site graduation criteria have been achieved. Based on the results of this evaluation, and with guidance from USAID, HCSP will begin its exit process while reinforcing capacity of district supervisors in the domains of formative supervision, task shifting site support, and data quality assurance. HCSP will continue to support performance-based financing and negotiate with district authorities to progressively assume responsibility for staff salaries currently supported by HCSP. This will be a gradual process aiming for complete transition of responsibility to the government by program close in 2012.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	368,562	

Narrative:

As of the end of FY 2009, IntraHealth HCSP has 41 sites in four districts. Of these facilities, 35 provide PMTCT, and 25 provide ART for adults and for children (along with the comprehensive package of VCT, PMTCT and OI). In FY 2009, IntraHealth HCSP collaborated with community service providers to offer a comprehensive package of basic care and support services to 1,633 HIV-positive children at 41 sites including Co-trimoxazoleprophylaxis, nutrition counseling and food support, insecticide-treated bed nets (ITN), and safe water interventions. In FY 2010, HCSP will continue to provide the same package to 1,633 HIV-positive children at 41 existing sites. HCSP will ensure that HIV-exposed children are followed and adhere to Co-trimoxazoleprophylaxis, in part by promoting integration with routine pediatric care, nutrition services and maternal health services.

Throughout FY 2010, IntraHealth HCSP will continue to provide the same service package to 3,170 HIV-positive and HIV-exposed infants and children. IntraHealth will also scale up pediatric participation in treatment programs to 2,273 children at a total of 29 ART sites.

To improve pediatric HIV diagnosis, HCSP will increase testing for targeted pediatric populations within the catchment area of its sites. Using each HIV adult patient enrolled in care and treatment at HCSP-supported sites as an index case, IntraHealth HCSP will offer HIV-testing for their partners and children and enroll any infected family members into care and treatment services. HCSP-supported sites will link

with OVC service providers operating in northern Rwanda to offer HIV testing services for children according to national guidelines, and ensure enrollment of HIV-positive children into care and treatment services. In addition, HCSP-supported sites will link with malnutrition and TB centers within their facilities or at specialized sites located in the vicinity to provide HIV testing to all pediatric in- and outpatients and enroll the infected children into care and treatment services. HCSP will also work to establish and strengthen linkages with PLWHA cooperatives in the local network, and the administrative district authorities and health teams to support activities aiming at raising awareness in communities on issues related to pediatric HIV, at to increase pediatric HIV testing and enrollment into care. IntraHealth will assist heath providers in mentoring children and adolescent support groups that are established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment, and to assist with addressing issues around treatment adherence.

Early infant diagnosis (EID) services, now available at 33 of IntraHealth supported sites, will be expanded to achieve full coverage of sites by the end of FY 2010. EID will be offered at six weeks of age. HCSP will also work with the district health teams to ensure that samples collected at the sites are transferred efficiently to the processing lab in Kigali, and it will collaborate with the MOH to increase reliability of result turn-around times.

At HCSP-supported sites, HIV-positive children will be staged clinically as well as using CD4 (counts and percentages as these are available). Eligible infants and children will be enrolled in ART. IntraHealth will work with other clinical implementing partners and the MOH to train health care providers on newly updated pediatric HIV treatment guidelines which include changes for early treatment of HIV-positive infants and in CD4 thresholds for treatment initiation of children between 36 and 59 months of age.

All pediatric patients will have regular anthropometric evaluations to identify early signs of malnutrition and to ensure prompt initiation of nutrition rehabilitation interventions. Newly identified patients will be screened at enrollment and at regular intervals for signs and symptoms of common opportunistic infections or other infectious complications of HIV in children, including: candidiasis, pneumonia, malaria, meningitis, and Pneumocystis jiroveci pneumonia (PCP). In addition, all pediatric patients will be screened for TB at least once every six months. Children suspected of having TB will be further investigated and put on TB treatment or INH prophylaxis if infection or exposure is confirmed based on current national guidance. Additionally, infants and children on ART will also be assessed at each visit for issues related to adverse events, toxicity and adherence to ART. Staff will be trained to ensure, as much as possible, the early detection of signs of immunologic and clinical failure and the initiation of second-line treatment regimens based on national guidance.

Pediatric HIV care and treatment programs in Rwanda face many challenges, including the need for increased numbers of qualified trained pediatric health care providers. The HCSP will ensure that site-level providers are trained or receive refresher training session in pediatric HIV patient management according to national guidelines. Providers will receive regularly planned in-service trainings and coaching sessions. In collaboration with TRAC Plus, HCSP clinical staff will be trained to become clinical mentors who will train hospital and health center service providers in pediatric clinical HIV care, palliative care, patient record-keeping, data recording and use, and in quality performance measurement and improvement.

Through work with the Supply Chain Management System (SCMS) and CAMERWA, the national pharmaceutical warehouse, the district-level pharmacy, the National Reference Laboratory (NRL) and the regional laboratory network, the HCSP will ensure training of health service providers on HIV-related opportunistic infections, ARV drug and reagent stock management and distribution, adherence counseling, and on good pharmacy record-keeping and data use.

IQChart has been installed in all supported ART sites, and in FY 2009 the system was expanded to include VCT and PMTCT along with ART. HCSP will continue to train data managers and health service providers on the use of the software and data. With a link between pediatric HIV care and PMTCT indicators in this database, follow-up of children exposed to HIV will be improved. Basic pediatric HIV care and support and treatment data will be used to regularly review program performance and design/implement appropriate interventions to improve the quality of services provided to children and their families. HCSP staff in charge of each district will ensure that meetings to review internal data take place on a regular basis and that the improvement plan is implemented at individual sites. Yearly district-level meetings are planned where each facility will share their performance data and improvement strategies. HCSP will ensure that pediatric HIV care is integrated with adult HIV care and that the family approach is reinforced.

An effective and rigorous M&E system will be maintained to evaluate program results. HCSP will collaborate with health center data managers, TRAC Plus and other partners to ensure quality data collection, evaluation and reporting using the national TB/HIV M&E Framework and tools.

Throughout FY 2010 and in collaboration with DHNs, HCSP will conduct an evaluation to measure the extent to which site graduation criteria have been achieved. Based on the results of this evaluation, and with guidance from USAID, HCSP will begin its exit process while reinforcing the capacity of district supervisors in the domains of supportive supervision, task shifting site support, and data quality assurance. HCSP will continue to support performance-based financing and negotiate with district authorities to progressively assume responsibility for staff salaries currently supported by HCSP. This will

be a gradual process aiming for complete transition of responsibility to the government by program close in 2012.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	346,083	

Narrative:

IntraHealth HCSP has expanded and advanced PMTCT services in Rwanda. During HCSP's second year, pregnant women received comprehensive PMTCT services at 35 PMTCT sites. Male involvement rates were also high at PMTCT sites with 17,336 male partners tested (80%). Male participation rates at Nyagatare Health Center and Kibagabaga Hospital reached 100% in certain months. A total of 2,364 couples received pre-nuptial counseling and testing service at HCSP-supported PMTCT sites; among these couples, 17 were sero-discordant.

During FY 2009 HCSP effectively integrated family planning and safe motherhood counseling within the PMTCT service package to address primary prevention of HIV infection; prevent unintended pregnancies among women infected with HIV; and prevent mother-to-child transmission of HIV. As of September 2009, 557 HIV-positive couples receiving services at HCSP-supported sites were using a FP method. In collaboration with the World Food Program (WFP), 33 PMTCT/CT HCSP service sites were provided with weaning food and nutritional support for 1,500 families. Throughout FY 2010, in collaboration with DHNs, HCSP will continue to facilitate supportive supervision of these same services at 35 PMTCT sites. To promote integration with routine FP/MCH/RH services, HCSP will support provider training and IEC material dissemination, as well as ensure that FP methods are available and offered in all HIV/AIDS clinical service points.

In FY 2010, HCSP will provide an expanded PMTCT package of services to 24,037 pregnant women at 33 existing CT/PMTCT sites. Target estimation was set with consideration of four elements: supported sites' current populations and growth rates; national HIV prevalence; projected family planning user rates; and the opening of new sites. The PMTCT package includes training master trainers to ensure on-the-job training and ensuring linkages between PMTCT and HIV care and treatment, MCH, and nutrition in HCSP-supported sites. Linkages with the surrounding community via PAQ teams and PLWHA cooperatives will also be reinforced. An emphasis will be placed on following-up HIV-exposed infants as well as conducting CD4 counts for all HIV-positive pregnant women and providing treatment for all those found eligible. HCSP will also provide supplemental food for HIV-positive infants, and pregnant or lactating women. All health providers will be trained on couples counseling therefore implement interventions for discordant couples and reinforce repeat testing for HIV-negative partners. Services will be provided to keep discordant couples in care, ensure that positive partners of negative women receive

ART and the negative partners remain negative.

In line with the Partnership Framework Implementation Plan, HCSP will gradually transfer supervision and management of PMTCT sites to DHNs and, graduating sites as outlined in the original program proposal document and with guidance from USG. Expanding PMTCT services also involves cross-cutting issues such as strengthening Human Resources for Health, food and nutrition, and preventing and reducing gender-based violence.

HCSP will provide support to District health networks and health facilities to optimize all four prongs of PMTCT and ensure comprehensive and integrated service provision. HCSP's PMTCT activities support MOH guidelines and are in line with the Partnership Framework and include: quality opt-out counseling and testing including testing during labor and delivery, positive prevention including couples counseling and testing, PITC at all entry points within the health care system, clinical staging and CD4 count, ARV prophylaxis and treatment (combination regimens for non-eligible women and HAART for eligible women), STI, OI and TB screening and treatment , CTX prophylaxis for eligible women and exposed infants, counseling and support on infant feeding and safe weaning, nutrition assessment, and Early Infant Diagnosis (EID). In addition, HCSP will supports follow-up and referral of HIV-positive women and HIV-exposed infants and family members to care and treatment through a continuum of care model linking PMTCT with ART which includes: immediate enrollment in pre-ART (care) services even at sites without ART; referral to ART services when eligible; family testing via invitations and follow-up and community linkages. HCPS supports HIV integration in MCH, including HIV screening at vaccinations, family planning counseling and refills at every facility visit, safer delivery practices through EMONC, and child survival through IMCI, malaria and referral to OVC services. An effective and rigorous M&E system will be maintained to evaluate program results.

Throughout FY 2010 and in collaboration with DHNs, HCSP will conduct an evaluation to measure the extent to which site graduation criteria have been achieved. Based on the results of this evaluation, and with guidance from USG, HCSP will begin its exit process while reinforcing capacity of district supervisors in the domains of supportive supervision and task shifting site support, while ensuring service data quality. HCSP will continue to support performance-based financing and negotiate with district authorities to assume responsibility for staff salaries currently supported by HCSP. This will be a gradual process aiming for complete transition of responsibility to the government by program close in 2012.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	147,425	

Narrative:

As of FY 2009 IntraHealth HCSP supports TB HIV services at 40 health facilities. TB-HIV collaborative activities have the following components: HIV testing for all TB patients; Co-trimoxazole preventive therapy for co-infected patients; TB testing for HIV-positive clients and TB treatment; Co-trimoxazole preventive therapy for those diagnosed with TB; and TB infection control measures at the four district hospitals at which staff were trained on infection control.

In FY 2010, IntraHealth HCSP will continue the same package of services at 40 existing sites to screen 21,134 HIV-positive clients for TB and provide TB treatment for 226 HIV-positive clients. HCSP will collaborate with TRAC Plus, the district support department at the MOH, and the local district team to ensure that new HIV services are put primarily in facilities that already have TB services in order to facilitate integration efforts. In addition to the core activities of TB-HIV integration, HCSP will improve finding active TB cases among PLWHA enrolled in care by training motivated community volunteers, traditional healers, drug dispensers and lab technicians in the use of a five-question questionnaire so that laboratory tests, drug refills, traditional healers, and home visits are also opportunities to screen PLWHA for TB. In addition, HCSP will ensure with in-service training that there are sufficient numbers of trained personnel to support VCT services to also screen HIV-negative people for TB using the same questionnaire, given that symptoms that motivate HIV testing are similar to TB symptoms even in HIV-negative patients. HCSP will ensure that TB service providers are trained in HIV service provision and that Co-trimoxazoleand ARVs are available to them in order to provide HIV services to TB patients during TB care before they are transferred to the ART ward at the end of their treatment. In line with MOH policies and strategic plans, HCSP will ensure that laboratory staff is trained in the newly-adopted TB diagnosis and that HIV and particularly pediatric patients are supported with transport and exam costs during investigation for smear-negative and extra pulmonary TB diagnoses. HCSP will ensure good compliance to ionized preventive therapy for all children under five who are living with smear-positive diagnosed adult TB patients according to national guidelines. In addition, HCSP will ensure that health center staff is trained in infection control and in implementing their infection control plan. In collaboration with DHNs, HCSP will conduct supportive supervision and coordinate with civil society partners to mobilize the community.

FY 2010 target estimation were based on four elements: supported sites' current populations and growth rates; national HIV prevalence; projected family planning user rates; and the opening of new sites. An effective and rigorous M&E system will be maintained to evaluate program results. HCSP will also collaborate with health center data managers, TRAC Plus and other partners to ensure quality data collection, evaluation and reporting using national the TB/HIV M&E Framework and tools. HCSP continuously reviews data collection tools to make sure collected TB/HIV data are accurate.

Throughout FY 2010 and in collaboration with DHNs, HCSP will conduct an evaluation to measure the

extent to which site graduation criteria have been achieved. Based on the results of this evaluation, and with guidance from USAID, HCSP will begin its exit process while reinforcing capacity of district supervisors in the domains of supportive supervision and task shifting site support, while ensuring service data quality. HCSP will continue to support performance-based financing and negotiate with district authorities to assume responsibility for staff salaries currently supported by HCSP. This will be a gradual process aiming for complete transition of responsibility to the government by program close in 2012.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9155	**Mechanism Name: Basic Education/Youth Employment**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Education Development Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 618,750	
Funding Source	**Funding Amount**
GHCS (State)	618,750

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Rwanda Youth Program is a 4 year project financed by the United States Agency for International Development (USAID) and implemented by Education Development Center, Inc. (EDC). The Rwanda Youth Program (RYP) will provide youth, ages 14-24, in Rwanda's capital city, Kigali, with market-relevant life and work readiness training and support, hands-on training opportunities, and links to the employment and self-employment job market over a four year period. The program is targeting a total of 12,500 Urban youth of which 5000 will be orphans and vulnerable children. Youth are both male and female, with varied levels of education, and demonstrating the drive to improve their skills and assets to better connect with livelihood and market opportunities.

The project goals are to:
• Increase Livelihood Opportunities for Youth
• RYP will empower youth with the necessary tools and resources to enter into a positive development pathway that will lead to increased lifelong livelihood opportunities;
• Develop a Thriving Youth Livelihood Support System RYP will build capacity and create linkages between youth, the Rwandan economy and the public and private institutions so that youth can access increased opportunities for productive engagement in Rwandan society.

Program's main activities and partners:
The Rwanda Youth Project will work with a cadre of youth-serving organizations (local and international) to implement project activities. Implementing institutions will include NGOs, Civil Society Organizations (CSO), government agencies, education and training providers and Private-Sector firms.

All participants will receive a modular, 80-hour work readiness training course designed as a core program. This interactive, dynamic curriculum is designed to promote functional literacy and numeracy as well as essential workforce readiness and employability skills training such as leadership, communication, work habits, financial literacy and numeracy. Upon successful completion of the program, participants will receive a project-sponsored work readiness certificate.

Complementary specialized training will be determined based on market demand and provided by local institutions. This could for instance include topics such as counseling support to OVCs, HIV/AIDS prevention, English, advanced entrepreneurship and business plan development and short term specialized technical training.

Beyond training, RYP will work with local partners to increase their capacity in linking the program's youth graduates to sustainable livelihood pathways, either through pursuing formal and non formal education and training or linking them to jobs, internships and/or helping them to start small businesses.

Specific activities and targets in Fiscal year 2010
FY 2010 will be the second year of implementation of the Rwanda Youth Program (RYP). Activities will focus on youth services for 4000 youth. It is expected that all 4000 youth will benefit from a common "health and well-being package" focused on HIV/AIDS prevention and referrals, nutrition, health and safety at the workplace, in addition to the 80 hours workforce readiness curriculum. These youth will also benefit from employability and coaching services to help them transition to a more sustainable livelihood pathway.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9155**		
Mechanism Name:	**Basic Education/Youth Employment**		
Prime Partner Name:	**Education Development Center**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	495,000	

Narrative:

The Rwanda Youth Program is a four year project financed by USAID and implemented by the Education Development Center, Inc. (EDC). The Rwanda Youth Program (RYP) provides youth, ages 14-24, in Rwanda's capital city, Kigali, with market-relevant life and work readiness training and support, hands-on training opportunities, and links to the employment and self-employment job markets. By the end of the four years the program will serve 12,500 urban youth, of whom 5,000 will be orphans or vulnerable children. Participating youth are both male and female, with varied levels of education, but all demonstrate a drive to improve their skills and assets to better connect with livelihood and market opportunities.

The project goals are to:

• Increase livelihood opportunities for youth. RYP will empower youth with the necessary tools and resources to establish a positive development pathway which will lead to increased economic opportunities;

• Develop a thriving youth livelihood support system. RYP will build capacity and create linkages between youth, the Rwandan economy, and public and private institutions so youth can access increased opportunities for productive engagement in Rwandan society.

Activities and partners

The Rwanda Youth Project will work with a cadre of youth-serving organizations (local and international) to implement project activities. Implementing institutions will include NGOs, Civil Society Organizations (CSO), government agencies, education and training providers and private-sector firms.

All participants will receive a modular, 80-hour work readiness training course designed as a core program. This interactive, dynamic curriculum is designed to promote functional literacy and numeracy as well as essential workforce readiness and employability skills training such as leadership, communication, work habits, and financial literacy. Upon successful completion of the course, participants will receive a project-sponsored work readiness certificate.

Complementary specialized training will be determined based on market demand and will be provided by local institutions. Examples of such training include counseling support to OVCs, HIV/AIDS prevention, English, advanced entrepreneurship and business plan development and short term specialized technical training.

Beyond training, RYP will work with local partners to increase their capacity to link the program's youth graduates to sustainable livelihood pathways, either through pursuing formal and informal education and training or linking them to jobs, internships and/or helping them to start small businesses.

Specific activities and targets in FY 2010

FY 2010 will be the second year of the implementation of RYP. Activities will focus on youth services for 4,000 youth. It is expected that all 4,000 youth will benefit from a common "health and well-being package" focused on HIV/AIDS prevention and referrals, nutrition, health and safety at the workplace, in addition to the 80 hours workforce readiness curriculum. These youth will also benefit from employability and coaching services to help them transition to a more sustainable livelihood pathway.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	49,500	

Narrative:

The Rwanda Youth Program is a four year project which will provide youth, ages 14-24, in Rwanda's capital city, Kigali, with market-relevant life and work readiness training and support, hands-on training opportunities, and links to the employment and self-employment job market. The program is targeting a total of 12,500 urban youth of which 5,000 will be orphans and vulnerable children. Youth are both male and female, with varied levels of education, and demonstrating the drive to improve their skills and assets

to better connect with livelihood and market opportunities.

The project goals are to:
• Increase Livelihood Opportunities for Youth: RYP will empower youth with the necessary tools and resources to enter into a positive development pathway that will lead to increased lifelong livelihood opportunities;
• Develop a Thriving Youth Livelihood Support System: RYP will build capacity and create linkages between youth, the Rwandan economy and the public and private institutions so that youth can access increased opportunities for productive engagement in society.

Program's main activities and partners:
The Rwanda Youth Project will work with a cadre of youth-serving organizations (local and international) to implement project activities. Implementing institutions will include NGOs, civil society organizations (CSO), government agencies, education and training providers and private-sector firms.

All participants will receive a modular, 80-hour work readiness training course designed as a core program. This interactive, dynamic curriculum is designed to promote functional literacy and numeracy as well as essential workforce readiness and employability skills training such as leadership, communication, work habits, financial literacy and numeracy. Upon successful completion of the program, participants will receive a project-sponsored work readiness certificate.

Complementary specialized training will be determined based on market demand and provided by local institutions. This could include, for instance, topics such as counseling support to OVCs, HIV/AIDS prevention, English, advanced entrepreneurship and business plan development and short term specialized technical training.

Beyond training, RYP will work with local partners to increase their capacity in linking the program's graduates to sustainable livelihood pathways, either through pursuing formal and non-formal education and training or linking them to jobs, internships and/or helping them to start small businesses.

Specific activities and targets in Fiscal year 2010:

FY 2010 will be the second year of implementation of the RYP. Activities will focus on youth services for 4,000 youth. It is expected that all 4,000 youth will benefit from a common "health and well-being package" focused on HIV/AIDS prevention (i.e. fidelity, abstinence, partner reduction and social norms) and referrals, nutrition, health and safety at the workplace, in addition to the 80 hours workforce readiness curriculum.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	74,250	

Narrative:

The Rwanda Youth Program is a four year project which will provide youth, ages 14-24, in Rwanda's capital city, Kigali, with market-relevant life and work readiness training and support, hands-on training opportunities, and links to the employment and self-employment job market. The program is targeting a total of 12,500 urban youth of which 5,000 will be orphans and vulnerable children. Youth are both male and female, with varied levels of education, and demonstrating the drive to improve their skills and assets to better connect with livelihood and market opportunities.

The project goals are to:
• Increase Livelihood Opportunities for Youth: RYP will empower youth with the necessary tools and resources to enter into a positive development pathway that will lead to increased lifelong livelihood opportunities;
• Develop a Thriving Youth Livelihood Support System: RYP will build capacity and create linkages between youth, the Rwandan economy and the public and private institutions so that youth can access increased opportunities for productive engagement in society.

Program's main activities and partners:
The Rwanda Youth Project will work with a cadre of youth-serving organizations (local and international) to implement project activities. Implementing institutions will include NGOs, civil society organizations (CSO), government agencies, education and training providers and private-sector firms.

All participants will receive a modular, 80-hour work readiness training course designed as a core program. This interactive, dynamic curriculum is designed to promote functional literacy and numeracy as well as essential workforce readiness and employability skills training such as leadership, communication, work habits, financial literacy and numeracy. Upon successful completion of the program, participants will receive a project-sponsored work readiness certificate.

Complementary specialized training will be determined based on market demand and provided by local institutions. This could include, for instance, topics such as counseling support to OVCs, HIV/AIDS prevention, English, advanced entrepreneurship and business plan development and short term specialized technical training.

Beyond training, RYP will work with local partners to increase their capacity in linking the program's graduates to sustainable livelihood pathways, either through pursuing formal and non-formal education

and training or linking them to jobs, internships and/or helping them to start small businesses.

Specific activities and targets in Fiscal year 2010:

FY 2010 will be the second year of implementation of the RYP. Activities will focus on youth services for 4,000 youth. It is expected that all 4,000 youth will benefit from a common "health and well-being package" focused on HIV/AIDS prevention (like condom promotion, STI management, and other risk reducing messages) and referrals, nutrition, health and safety at the workplace, in addition to the 80 hours workforce readiness curriculum.

The project will measure output and outcome indicators on a quarterly basis which will allow both project management and the USG to monitor the pace of implementation against the plan, verify that key outputs are being delivered, and provide periodic measures of program benefits. Project outputs will be measured quantitatively. Project outcomes will be measured both quantitatively and qualitatively.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9159	**Mechanism Name: SPS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 686,000	
Funding Source	**Funding Amount**
GHCS (State)	686,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The MSH/RPM Plus program has been working in Rwanda since 2003 with funding from USAID under

PEPFAR and, since 2007, under PMI. In 2003, RPM Plus was invited by USAID to examine the capacity of the pharmaceutical and laboratory systems to support the ART national program. In April 2004, RPM Plus shared its assessment findings with the national and international institutions involved in scaling up ART in Rwanda, and as a result, an action plan was developed for strengthening the pharmaceutical sector and ensuring the availability of ARVs in the country. In June 2004, the RPM Plus country office was established in Kigali, and since then, RPM Plus has been working closely with the MOH at both national and peripheral levels of the pharmaceutical system to improve selection, procurement, distribution, and use of ARVs, antimalarials, and other essential medicines and health commodities.

The MSH - USAID cooperative agreement RPM Plus came to an end in September 2007. In Rwanda as in many other countries, MSH is receiving funds under the newly awarded USAID program Strengthening Pharmaceutical Systems (SPS) to enhance the results achieved under of RPM Plus. The work of SPS is focused in four areas: good governance, strengthening pharmaceutical management systems, expansion of access to essential medicines, and containment of antimicrobial resistance.

During FY 2008, PEPFAR supply chain activities were effectively transferred to Supply Chain Management System (SCMS), while SPS focused its technical assistance on medicine safety specifically in the areas of pharmacovigilance and rational medicines use, at national and peripheral levels, which are specific areas of expertise of the SPS Program.

Promoting Medicine Safety and Rational Medicine Use in Rwanda

In many countries, national drug authority is responsible for ensuring the quality, safety, and efficacy of the medicines available in the country through activities such as medicine registration, quality control testing, and pharmacovigilance. Although Rwanda is in the process of establishing a national drug authority, it is not yet functional. Despite the fact that Rwanda does not have a national drug authority or experience in pharmacovigilance interventions, PEPFAR in FY 2008, in collaboration with other donors (PMI and Global Fund), funded the implementation of a pharmacovigilance system in Rwanda to be coordinated by the Pharmacy Task Force (PTF). SPS helped the PTF, the National Malaria Control Program (PNILP), and other in-country counterparts develop a national plan for pharmacovigilance beginning in FY 2007 with PMI funds in close collaboration with the U.S. Centers for Disease Control and Prevention (CDC) and the MOH. During FY 2008 implementation period, Rwanda identified the establishment of an adverse drug reaction notification system as one of its highest priorities.

Pharmacovigilance ensures medicine safety and includes prevention, detection, and understanding of:

- Adverse drug reactions and side effects
- Drug interactions with food or with other drugs
- Medical errors

• Lack of efficacy and antimicrobial resistance
• Quality problems and counterfeit products

Pharmacovigilance is important in PEPFAR because the experience of use of ARV is still limited; ARVs are used always in combination (Tri- therapy) which increases the risk of drug interactions; ARVs are used for life, which increases the risks of cumulative toxicity; AIDS patients often need to take other medicines for prophylaxis or treatment of other infections, which increases even more the risks of interactions and toxicities; ARV manufacturers and suppliers are constantly increasing and the market is becoming more competitive, which requires more vigilance to avoid quality related problems; scaling up ART requires putting in place mechanisms to protect the patients from unsafe drugs.

Rational Medicines Use (RMU) requires the development and implementation of policies and guidelines that define what the medicines are going to be used for in country and how these medicines will be used. Therefore, RMU activities imply an absolute need to work with the MOH, with the prescribers, with the dispensers, and with the community. An important component of RMU is the need to respect the standard treatment guidelines for specific health conditions, such as treatment of AIDS. RMU is important for a variety of reasons, but two of the most significant reasons are; it increases the quality of care of a patient and contains costs of the health care system.

RDU is important for PEPFAR because adherence to ARVs is essential to ensure the benefits of the therapy, to reduce failure and need to change to second line treatments that are more expensive. Care of HIV patients imply other medicines besides ARVs, such as medicines for the prevention and care of opportunistic infections, dispensers can play an important role between clinicians and patients, although ARVs are not dispensed in the private sector, patients —including HIV-positive patients— seek advice and medicines in private pharmacies. Scaling up the number of patients accessing ART should not be done at the expense of the quality of treatment.

MSH SPS is working closely with the Ministry of Health, Pharmacy Task Force and TRAC Plus to help build their capacity to achieve the above results thereby strengthening the in-country capacity to continue these activities in the future.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9159		
Mechanism Name:	SPS		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	396,000	

Narrative:

Support the MOH/PTF, Association Rwandaise des Pharmaciens (ARPHA) and La Rwandaise d'Assurance Maladie (RAMA) to improve RMU, pharmaceutical care, and good dispensing practices in the public and private sectors

In FY 2009 SPS provided significant assistance to the PTF to improve the rational use of medicines and dispensing practices at decentralized levels. SPS developed a plan to improve dispensing practices at pharmacies in public sector health facilities. SPS also produced targeted training materials and job aids for the dispensers. Trainings were conducted using the job aids and included modules on monitoring and evaluation at hospitals. This activity also included capacity building for district hospital pharmacists in selected districts, transferring to them the skills required to conduct training and supervision on proper dispensing practices at lower-level health centers.

During FY 2009, SPS implemented the following activities:

• Assisted the MOH/PTF to promote RMU through public education and participation in national health campaigns.
• In collaboration with MOH/PTF, supported the establishment of DTCs in four additional district hospitals with training on DTC, RMU, AMR, pharmaceutical care and good dispensing practices; implemented an action plan through effective supervision.
• Assisted MOH/PTF to support 18 DTCs to carry out their work plans by implementing quarterly monitoring-training-planning meetings.
• Assisted MOH/PTF and ARPHA to implement RMU and pharmaceutical care interventions in the private sector.
• In collaboration with the MOH/PTF and DTCs, conducted a drug use study to identify problems and

design interventions to effectively address RMU issues in Rwanda.

In FY 2010, SPS will continue to support the MOH/PTF with its goal of expanding and strengthening of the Drug and Therapeutics Committees (DTCs) by doing the following:

• Assist the MOH/PTF to develop a strategy for it to assume full technical responsibility for supporting existing DTCs; assist the MOH/PTF with the implementation of that new approach to consolidate and strengthen existing DTCs.
• Carry out decentralized trainings led through the TOT approach.
• Assist the MOH/PTF to develop a strategy in collaboration with the existing DTCs to allow functioning DTCs to effectively roll out and monitor DTC activity in select health facilities in their districts.
• Continue to provide follow-up TA to enhance DTC efficiency and actions in the areas of RMU, AMR, and pharmacovigilance.
• Consolidate facility-level infection control activities, and initiate simple infection prevention awareness campaigns through community health workers (CHWs) and expand to all district hospitals.

Support for establishment of the Rwanda Food and Drug Authority by doing the following:

• Develop strategies, appropriate organizational structures, HR systems, roles and responsibilities, standards, guidelines, and SOPs.
• Define infrastructure and equipment requirements.
• Adapt and adopt relevant tools, such as electronic medicine registration.
• Train and engage in local capacity building for medicine registration, inspection, and licensing.

Support the pharmaceutical accreditation initiative by doing the following:

• Support PTF to draft roles and responsibilities, SOPs, job aids to support the district pharmacists to define their roles and responsibilities in the decentralized health system in Rwanda.
• Assist the district pharmacist to define their roles within the district health team.
• Present a plan to implement from national strategies on ADR, RMU, pharmaceutical care (PC) activities.
• Mentor/support new and veteran district pharmacists through TA at the district level on provision of pharmaceutical care, consolidation of ADR and other reporting system with the national system, and collaboration with faith based health facilities through Rwandan Faith-based Medical Stores (BUFMAR).
• Expand involvement with the private sector pharmacies by establishing a link with national health insurance schemes; develop a framework and an approach (including the necessary structures, roles and responsibilities) required for measuring and monitoring standards of quality for pharmaceutical

services both in the public and private sector.
• Develop an accreditation scheme and checklist based on a set of standards for licensing and inspection of pharmaceutical services.
• Provide support for the implementation of the accreditation standards.
Support the MOH to develop a medicine pricing list and all the activities required for implementation

Expand Community Case Management (CCM) intervention by doing the following:

• Support the Community Health desk to standardize inventory management practices for CHWs and monitor the use of the drugs at community level through quarterly indicators collected at hospitals and randomized field visits
• Support pharmaceutical information reporting by CHWs
• Incorporate RMU into health centers supervision
• Support RMU in the private sector

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	290,000	

Narrative:

Establish a Pharmacovigilance and National ADR Notification System

Given the lack of a national drug authority in Rwanda, the PTF has assumed responsibility for establishment and oversight of the national pharmacovigilance system. USAID funds made available through initiatives such as PEPFAR and PMI have provided the necessary resources needed to assist the government of Rwanda with attaining its goal of establishing a broad-based medicine safety system.

Since 2007, the SPS Antimicrobial Resistance (AMR) portfolio has provided technical assistance to the SPS Rwanda program to develop a comprehensive strategic action plan to establish a pharmacovigilance system in Rwanda, which will be implemented by local SPS staff in collaboration with national counterparts, such as the PTF. The pharmacovigilance system, which had to be developed from scratch, includes the establishment of a national pharmacovigilance and medicines information center. Stakeholders have defined the functions of the planned comprehensive system in the document, "Strategic Approach for the Establishment of a Pharmacovigilance System in Rwanda."

With PEPFAR/PMI funds and by leveraging AMR core funds and technical resources, SPS in collaboration with the PTF and the PNILP have carried out the following steps—
• Organized and conducted a stakeholder workshop to advocate for a pharmacovigilance system in

Rwanda. At the workshop—
– Set up a technical working group to follow-up on stakeholder recommendations
– Designed the pharmacovigilance system and drafted a one-year work plan
– Developed technical documents and tools to set up and run the system, including guidelines, terms of reference, ADR notification form, patient alert card, and medicines information request form; field-tested the ADR notification form at all levels of the health care system
– Developed a pharmacovigilance training curriculum, including a training-of-trainers (TOT) component, to implement a cascade training plan
• Developed with PTF a strategy to give Drug and Therapeutics Committees (DTCs) a paramount role in decentralizing Rwanda's pharmacovigilance system
• Conducted a TOT on pharmacovigilance
• Initiated contacts with the WHO Uppsala Monitoring Centre regarding Rwanda's membership in the international drug safety network
• Trained local staff from PTF, the National University of Rwanda, and SPS in pharmacovigilance
• Assessed the pharmacovigilance activities and limited medicine safety system in Rwanda

During FY 2009, SPS Rwanda leveraged technical assistance and funds of SPS AMR portfolio with PEPFAR and PMI funds to assist the MOH PTF with the establishment of the National Pharmacovigilance and Medicines information Center (NPMIC) to address the need for systems for routine medicine safety surveillance and to ensure that protection of public's health. The NPMIC is based within the PTF within the MOH. The goal of the NPMIC is to develop and implement medicine safety surveillance systems that will provide unbiased information, monitor safety and effectiveness, and improve rational use of essential medicines in Rwanda. Efforts during FY 2009 also resulted in the expansion of the pharmacovigilance/Adverse Drug Reaction (ADR) Notification System to all district hospitals through the launching of the NPMIC and the development of the Rwanda Medicines Safety Guidelines, ADR notification form, patient alert card, and medicines information request form.

In FY 2010, SPS will continue to support the MOH/PTF with the expansion and further strengthening of the pharmacovigilance system of Rwanda building on existing achievements. Support will be provided in the following areas:

• Strengthen and support the National Pharmacovigilance Medicine and Information Center established during FY 2009 to fulfill all aspects of its mandates and objectives
• Develop a strategy for the decentralization of pharmacovigilance through the planning and implementation of cascade trainings utilizing the TOT approach and supportive supervision
• Consolidate and strengthen the approach of DTCs as part of the strategy for the decentralization of pharmacovigilance at the district level by providing trainings and refresher trainings, supportive

supervisions.
• Consolidate and expand "medicines safety" activities to all districts
• Develop and implement active surveillance studies targeted at ARVs and ACTs
• Develop and implement a strategy for medicines safety monitoring at the community level aimed at the community health workers (CHW) program

Address Antimicrobial Resistance (AMR)

During FY 2009, SPS provided small-scale technical support for the country-level AMR advocacy and containment initiatives in Rwanda. This support covered a wide spectrum including identification of key AMR related problems and interventions address noted problems. SPS rendered technical assistance and support to the MOH/PTF in this particular area through the following activities funds of PEPFAR—

• Supported the National University of Rwanda School of Pharmacy with the modification of it curriculum to include comprehensive coverage of AMR, RMU, and pharmacovigilance topics
• Supported the PTF in organizing a "call-to-action" 2nd stakeholders meetings to launch a nationwide campaign to contain AMR and implement the action plan developed to address AMR advocacy and containment in Rwanda
• Worked with the Pharmacy Task Force, establish the AMR working group (or taskforce) within the framework of the PTF or other national MOH structure
• Conducted an assessment of the AMR situation in Rwanda to include:
– Key informant interviews of stakeholders and document review to determine
? Drug use behaviors
? Resources and services availability
? Available of key antimicrobials
? Consumption of key antimicrobials
? Knowledge and attitudes about AMR
– Antimicrobial use studies and utilization (drug use study at select key hospitals and clinics)
? WHO indicators drug use indicators
? MSH antimicrobial hospital indicators
? Antimicrobial availability and usage patterns
– AMR Surveillance Capacity

In FY 2010, SPS will continue to support the MOH/PTF's effort to address issues of AMR in Rwanda. In addition to supporting the continuation of work started under FY 2009, SPS will provide the following support as well during FY 2010:

• Provide support to implement on a national scale select key interventions to address AMR to Include: – STG dissemination and use – Training and education for physicians and pharmacist on rational antimicrobial use and AMR – Training and education for patients and general public on proper antimicrobial use, infection prevention and AMR – Provide support to the MOH/PTF to develop a strategy to effectively capacity the staff of MOH/PTF to technically support the existing DTCs with minimal guidance from SPS – Provide technical support for the on-going curriculum reform activities at the National University School of Pharmacy to introduce AMR, RMU, and PV training – Utilize the Infection Control Assessment Tool (ICAT) to conduct infection control assessments and implement improvement of IC practices

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9163	**Mechanism Name: National Reference Laboratory**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Reference Laboratory	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,138,500	
Funding Source	**Funding Amount**
GHCS (State)	1,138,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY 2010, PEPFAR will continue to maintain an agreement with the National Reference Laboratory

(NRL) for direct funding of certain key reference laboratory functions. These functions include the following:
1) assisting the laboratory network to develop quality systems for their laboratories;
2) provide external quality assessments for the laboratory network;
3) provide reference testing for the laboratory network;
4) perform operational research;
5) training for the laboratory network; and
6) strategic planning for laboratory services.

As the lead institution in Rwanda's national laboratory network, the NRL plays a critical role in the successful expansion of HIV programs in prevention, diagnostics, training of laboratory technicians and other health care workers and support for care and treatment services nationally. The NRL has been a close collaborator in PEPFAR efforts for many years and has benefited from PEPFAR's technical and financial support through several implementing partners. Resources have already been invested in NRL by USG to support infrastructure, technical activities and management capacity. Support will continue in FY 2010 through USG direct technical assistance, laboratory coalition partners (ASCP, ASM, APHL and CLSI) and through other partners such as Columbia University and the University of Maryland. The NRL will conduct training for its laboratory personnel and support staff in good laboratory practices and laboratory management. The NRL will conduct integrated laboratory training workshops on HIV, malaria, and tuberculosis diagnoses and quality assurance/quality control, microbiology, biochemistry and hematology programs.

In the areas of data management and evaluation, the NRL will organize a monitoring and evaluation (M&E) team to monitor the performance of laboratory activities such as supervision visits, refresher training, laboratory test data and quality assurance data from the laboratory network. The NRL will hire a M&E expert to lead this team. External quality assessments (EQA) will continue to be a major emphasis of the NRL's oversight of the laboratory network. To expand EQA to all levels of the laboratory network and to decentralize the program, district hospital laboratories will provide EQA oversight for health centers in their districts and the NRL will provide EQA oversight for district and university hospital laboratories.

The NRL will train lab staff in the management of donor funds, drug susceptibility testing, ARV drug resistance testing, laboratory logistics management, and quality management systems to improve their managerial and technical skills. The NRL will conduct an assessment of the laboratory network to determine if service delivery meets the needs of the clinical programs.

The NRL will continue to improve the maintenance program for equipment at the NRL and in the laboratory network. Maintenance contracts will be purchased for all equipment and a maintenance plan

will be put in place for the laboratory network. The NRL will work with Atelier Centre de Maintenance (ACM) to expand and improve its maintenance and oversight of equipment in the health sector including the laboratory.

The Government of Rwanda (GOR) is planning to develop a new organizational structure for the Ministry of Health. This new structure is referred to as the Rwanda BioMedical Center (RBC). This new center will encompass all of the institution within the MOH including the National Reference Laboratory. This new organizational structure will require new infrastructure for the MOH and all of its institutions. This new infrastructure will allow the NRL to increase its available space and expand laboratory services. In FY 2009 and into FY 2010, the NRL will develop infrastructure plans for the National Reference Laboratory and for the Rwanda Laboratory Network. This infrastructure plan will be a collaborative endeavor as the World Bank is committed to assisting the east African community to build laboratory infrastructure and improve laboratory services for the region. With this new collaborative effort, laboratory services will improve greatly in the near future.

The purchase of laboratory equipment and reagents for the NRL and the Rwanda Laboratory Network is managed by CAMERWA with assistance from the Partnership for Supply Chain Management (SCMS). Some specialized pieces of equipment (PCR and sequencing equipment) will be purchased by the NRL directly. The NRL will continue to work with CAMERWA and SCMS to develop a logistics management information system (LMIS) to improve procurement, inventory management and quantification activities for the laboratory network.

The NRL will continue to work with the Association of Public Health Laboratories to implement a laboratory information system for the NRL and for its expansion to other sites within the laboratory network.

The USG will continue to support the NRL to perform operational research, develop protocols and analyze data as a means of program evaluation, the introduction of new testing methodologies and strategic planning for the laboratory network in Rwanda.

Staff development and capacity building will continue to be emphasized in FY 2010. The USG will assist the NRL in salary support and other programs designed to improve staff commitment and effectiveness, such as performance based financing.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9163**		
Mechanism Name:	**National Reference Laboratory**		
Prime Partner Name:	**National Reference Laboratory**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	1,138,500	

Narrative:

COP FY 2010
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2) provide external quality assessments for the laboratory network;
3) provide reference testing for the laboratory network;
4) perform operational research;
5) training for the laboratory network; and
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and tuberculosis diagnoses and quality assurance/quality control, microbiology, biochemistry and hematology programs.

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The NRL will continue to improve the maintenance program for equipment at the NRL and in the laboratory network. Maintenance contracts will be purchased for all equipment and a maintenance plan will be put in place for the laboratory network. The NRL will work with Atelier Centre de Maintenance (ACM) to expand and improve its maintenance and oversight of equipment in the health sector including the laboratory.

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The USG will continue to support the NRL to perform operational research, develop protocols and analyze data as a means of program evaluation, the introduction of new testing methodologies and strategic planning for the laboratory network in Rwanda.

Staff development and capacity building will continue to be emphasized in FY 2010. The USG will assist the NRL in salary support and other programs designed to improve staff commitment and effectiveness, such as performance based financing.
In FY 2010, the USG will collaborate with NRL in support of long term capacity building needed in the laboratory of CHUK. NRL, in collaboration with CHUB lab, will organize training for one microbiologist and one histotechnician.
The USG under the guidance of NRL will assist in the purchase of equipment and reagents for the laboratory and the training of six physicians in anatomical pathology.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9199	**Mechanism Name: Ibyringiro**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Catholic Relief Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,779,225	
Funding Source	**Funding Amount**
GHCS (State)	2,779,225

Sub Partner Name(s)

Africare	Agricultural Cooperative Development International Volunteers in Overseas Cooperative Assistance	CARITAS NYUNDO
Elizabeth Glaser Pediatric AIDS Foundation	World Vision	

Overview Narrative

The Ibyiringiro project will continue to improve the livelihoods, security, and resiliency of households impacted by HIV and AIDS through 3 Strategic Objectives:

SO1: Improve the services available to People Living with HIV (PLWHA) and Orphans and Vulnerable Children (OVC). Ibyiringiro will continue its work with clinical sites and Community Health workers (CHW) to ensure adequate care and support to PLWHA. 776 currently served CHW will receive refresher training on nutrition and palliative care. CHW kits will be replenished based on needs. The Ibyiringiro project will continue its family/household-centered approach by training family members about improved nutrition practices, care for HIV positive children, household food production and opportunities to increase household income. Ibyiringiro will continue to work with HIV-positive individuals to educate household groups. PLWHA, especially children, pregnant women and lactating mothers nutritional status will be monitored and receive nutrition counseling. In order to ensure follow-up of the nutrition and health status of HIV positive children who graduated from the food assistance done at PMTCT sites, IBYIRINGIRO will link these OVC and their families to existing Ibyiringiro supported groups/cooperatives, especially the nutrition program, agriculture and saving and lending groups. The livelihoods and resiliency of PLWHA and OVC households will be strengthened through continuous assistance in setting up backyard nutritious gardens. In this regard, Ibyiringiro will continue to use peer educators or farmer field school approach, where PLWHA will be trained on bio-intensive agriculture techniques at the village level.

PLWHA associations will be facilitated to receive support from HIV negative people through establishment of Savings and Internal Lending Groups (SILC). Existing SILC groups will continue to receive support to improve their capacity to manage their saving and to push groups to give out more loans to members. The project will also increase the capacity of SILC groups to reach the next stage managing self-identified IGAs. During the cycle, SILC groups will receive basic business skills training in order to help them manage IGAs.

The strategy will also identify PLWHA households interested in small animal husbandry. Selected healthy animals will be given to PWHA with a basic training on how to raise animals. These animals will help them to improve their gardens with organic manure, improve their nutrition with animal products and gain some profits in selling animals.

SO2: Cooperatives of PLWHA provide high quality services to their members.
Most associations that have been supported by Ibyiringiro at this stage have already started their registration process. These associations will be supported until they complete the national registration.

New PLWHA associations will be selected and assisted with the transformation process into cooperatives. At the same time, Ibyiringiro will strengthen their capacity to establish sustainable managerial, financial and organizational systems. A comprehensive package of training and follow-up will be implemented to achieve the above goals. Ibyiringiro will continue to provide the four sessions of training which are: advocacy, leadership and good governance, cooperative structure and management, and finally business planning skills development.

SO3: Improved nutritional status of infants and mothers enrolled in PMTCT programs.
Ibyiringiro will continue to contribute to the national efforts to improve the nutrition education and providing high quality weaning food to HIV-positive mothers following TRAC Plus standards. For the weaning period from the 6th to 18 months, mothers will have improved access to fortified weaning foods at PMTCT sites throughout the life of the project.

Ibyiringiro will continue to provide nutrition and food assistance to at least 2,000 mothers frequenting ANC and PMTCT sites. Mothers will continue to receive counseling on AFASS, EBF and safe weaning when appropriate. Ibyiringiro will continue to work through different national technical working groups to continuously review and improve approaches as well as the management committee.

The Ibyiringiro project will continue to coordinate with key organizations such as TRAC Plus, CNLS/CDLS, RCA, MINAGRI, RRP+, MOH Nutrition and Community Health Desks through national technical working groups to ensure project interventions are in line with the GOR priorities and standards.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9199		
Mechanism Name:	Ibyringiro		
Prime Partner Name:	Catholic Relief Services		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,410,750	

Narrative:

This is a continuing activity.

In FY 2009 CRS/Ibyiringiro supported 41,386 clients across 24 districts to receive basic care and support services (BCS). In FY 2010, CRS/Ibyiringiro will continue to work with clinical and community partners using community health workers (CHWs) to ensure adequate palliative care support to PLWHA. The 776 CHWs currently working with CRS/Ibyiringiro will receive refresher training on palliative care, particularly on how to assess nutritional status using mid upper arm circumference (MUAC) and body mass index (BMI) measurements and how to provide nutritional counseling. CHW kits will be replenished based on the needs identified. CHWs and clinics will continue to strengthen the continuum of care for PLWHA between the clinic and the community. To this end PLWHA will be linked to facilities by CHWs. All moderate to severe cases of malnutrition will be immediately reported to the health center and severe cases will be followed by the district hospital. CHWs and other community support groups will refer HIV exposed children, pregnant and lactating women living with HIV/AIDS who need nutrition and food support to PMTCT services and food distribution sites.

CRS/Ibyiringiro will continuously update its mapping of health facilities and HIV prevalence to facilitate linkage with other community and clinic HIV services. The project will continue its family-centered approach by working with different community-based associations to improve the health and nutritional status of over 15,300 PLWHA and their families through the "positive deviant" nutrition approach. All nutrition education programs will be integrated with hygiene and sanitation sessions. A major component of the positive behavioral practices will be supporting PLWHA to have increased access to diverse foods through small gardens. To this end CRS/Ibyiringiro will use peer educators or the "farmer field school" approach, where PLWHA will be trained in bio-intensive agriculture techniques at the village and household levels using a demonstration plot. Households will receive some basic supplies, including

seeds for vegetables and fortified crops, which will help transform their kitchen gardens into important sources of nutrition.

To address issues of stigma and discrimination, Savings and Internal Lending Communities (SILC) will try to attract PLWHA, as membership alongside HIV negative individuals in SILCs reduces discrimination against PLWHA and gives them an opportunity to better their lives and communities. Target communities will be sensitized about the importance of establishing Savings and Internal Lending Groups and supported in efforts to organize themselves into savings groups. This program will increase the capacity of the SILC to reach the next stage of development-- the management of self-created income generating activities (IGAs). As part of the program SILC groups will receive training on basic business skills in order to help them manage IGAs. This training will also attract and help identify PLWHA households interested in small animal husbandry. Of the PLWHA households interested in animal husbandry beneficiaries will be selected based on the recommendations of local leaders and PLWHA cooperatives, keeping in mind the need for beneficiaries to own a minimum amount of land for grazing and upkeep. Healthy animals will be given to PLWHA, along with basic training on how to raise and care for them. These animals will improve the nutritional intake of PLWHA, increase their income though the sale of animals and animal products, and fertilize their gardens with organic manure.

CRS/Ibyiringiro will also support national efforts to develop the management capacities of PLWHA cooperatives. In FY 2010 the project aims to increase the capacity of 50 PLWHA associations (comprising 4500 members) sufficiently for them to acquire legal status as cooperatives. Selected PLWHA associations will be assisted with the transformation process into cooperatives and supported until they obtain national registration as cooperatives. Training and assistance for registration will be prioritized for associations based on assessments and the current ability of the association to become registered and begin IGAs. Once they receive registration, the cooperatives will be trained in good governance, financial management and accountability, allowing them to establish sustainable managerial, financial and organizational systems. CRS/Ibyiringiro will provide the four training sessions offered on it training menu: advocacy; leadership and good governance; cooperative structure and management; and business planning skills. The training will use existing training tools developed by CRS/Ibyiringiro in collaboration with RCA.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	173,250	

Narrative:

In supporting improved services available to People Living with HIV (PLWHA) and orphans and vulnerable children (OVC), the Ibyiringiro project will continue to improve the livelihood security and

resiliency of households impacted by HIV and AIDS through 3 strategic objectives (SO):

SO1: The services available to PLWHA and OVC are improved.
Ibyiringiro will continue its work with clinical sites and community health workers (CHW) to ensure adequate care and support to PLWHA. Existing 776 CHW will receive refresher training on nutrition and on basic care and support. CHW kits will be replenished based on the needs.

The Ibyiringiro project will continue its family/household centered approach by strengthening the capacity of family members to adopt improved nutrition practices, to care for HIV-positive children, to enhance household food production and the generation of household income. Ibyiringiro will continue to work with community health workers to educate groups of households. The nutritional status of PLWHA, and especially of children and pregnant and lactating women will be monitored, and they will receive nutrition counseling. In order to ensure follow-up of the nutrition and health status of HIV-positive children who graduated from the food assistance done at PMTCT sites, Ibyiringiro will link these OVC and their families to Ibyiringiro-supported groups/cooperatives, especially the nutrition program, agriculture, and saving and lending groups. The livelihoods and resiliency of PLWHA and OVC households will be strengthened through assistance in setting up backyard nutritious gardens. In this regard, Ibyiringiro will continue to use peer educators or a farmer field school approach to train PLWHA in biointensive agriculture techniques at the village level.

PLWHA associations will be facilitated to receive support from HIV-negative people through the establishment of Savings and Internal Lending Communities (SILC). Existing SILC groups will continue to receive support to improve their capacity to manage their savings and to encourage them to give out more loans to members. The project will also increase the capacity of SILC to reach the next stage of managing self-identified income-generating activities (IGAs). During the cycle, SILC groups will receive training in basic business skills in order to help them manage IGAs.

The strategy will also identify PLWHA households interested in small animal husbandry. Animals will be given to selected PLWHA together with basic training on how to raise animals. The animals will help them to improve their gardens with organic manure, enrich their diet with animal products, and generate additional income by selling animals.

SO2: Cooperatives of PLWHA provide high quality services to their members.
Most of the associations that have been supported by Ibyiringiro at this stage have already started their registration process. These associations will be supported until they get the national registration. New selected PLWHA associations will be assisted with the transformation process into cooperatives. At the same time, Ibyiringiro will strengthen their capacity to establish sustainable managerial, financial and

organizational systems. A comprehensive package of training and follow-up will be implemented to achieve the above goals. Ibyiringiro will continue to provide the four sessions of training which are: advocacy, leadership and good governance, cooperative structure and management, and finally business planning skills development.

SO3: Improved nutritional status of infants and mothers enrolled in PMTCT programs.
Ibyiringiro will continue to contribute to the national efforts to improve the nutrition education and to provide high quality weaning food to HIV-positive mothers pursuant to TRAC Plus standards. For the weaning period from the 6th to 18 months, mothers will have improved access to fortified weaning foods at PMTCT sites throughout the life of the project.

Ibyiringiro will continue to provide nutrition and food assistance to at least 2,000 mothers frequenting ANC and PMTCT sites. Mothers will continue to receive counseling on acceptable, feasible, affordable, sustainable exclusive breastfeeding and safe weaning when appropriate.

Ibyiringiro will continue to work through different national technical working groups to continuously review and improve approaches. In addition, it will rely on databases for a better follow-up of progress and achievements.

Using the food by prescription model, food will be provided in conjunction with HIV treatment and care services in order to strengthen the effectiveness and uptake of these services and to improve clinical outcomes.

The Ibyiringiro project will continue to coordinate with key organizations such as TRAC Plus, CNLS/CDLS, RCA, MINAGRI, RRP+, the nutrition and community desks at the MOH, and through different national technical working group to ensure project interventions are in line with the GOR priorities and standards. Ibyiringiro will continue also to coordinate with existing PEPFAR clinical implementers, such as CHAMP, and other national HIV program implementers such as WFP, Global Fund, and PMI to capitalize on the high potential for complementarities and synergy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,195,225	

Narrative:

This is continuing activity from FY 2009.

In FY 2010, Ibyiringiro will continue to contribute to the national efforts to improve nutrition education and

provide high quality weaning food and supplemental food respectively to HIV-exposed infants and pregnant and lactating mothers.

Ibyiringiro will improve access to fortified weaning foods for HIV-affected young children and their mothers. Ibyiringiro will procure 300,000 Kg of corn soy blend (CSB) and distribute to 184 PEPFAR-supported hospitals and health centers in collaboration with EGPAF, IHI, ICAP and FHI. Mothers will be assisted to adopt safer and more effective infant and young child feeding practices through group education and individual counseling. Clinical staff will receive continuous support to provide quality nutrition-related services to HIV-affected infants and mothers. Additionally, 200 health care providers will be followed up through workshops to improve their skills on infant and young child feeding (IYCF) education, nutritional counseling and messaging as well as client monitoring and CSB stock management.

Ibyringiro will support the revision, adaptation and printing of IEC materials on IYCF (a take home brochure for mothers summarizing key HIV-exposed IYCF topics, a flipchart and an interactive film on expression and flash heating of mother's milk for health care workers to use during counseling sessions.

PMTCT sites will continue cooking demonstrations on how to prepare the CSB as a complementary food and other foods. Health center staff will continue to provide counseling sessions to 4,504 mothers in areas of breast health, proper lactation, acceptable, feasible, affordable, safe and sustainable (AFASS) weaning and IYCF.

Results of the rapid assessment on nutritional knowledge, practices and attitudes of pregnant and lactating HIV-positive women, done by PATH/EGPAF, will inform the planned extension of Ibyiringiro project activities in supporting nutritional counseling to HIV-positive mothers.

Ibyiringiro will continue to provide nutrition and food assistance to at least 2,000 HIV-positive pregnant and lactating mothers frequenting ANC and PMTCT where the supplemental feeding to exposed children is already on-going. The women will be selected based on national nutritional guidelines and include any HIV-positive women who are either pregnant or breastfeeding, not receiving any other food aid, or from a food insecure family (especially woman who eats once per day and recognized indigent by the local authorities).

Providing supplemental rations to mothers will increase attendance at ANC and PMTCT sites during pregnancy and post-natal period. Mothers will continue to receive counseling on AFASS, EBF and safe weaning when appropriate. Each mother will receive an individual ration of 6Kg of CSB per month from pregnancy to 6 months after delivery.

While CRS will continue to ensure the procurement of CSB and its distribution to the 184 sites, EGPAF will continue to ensure the technical lead among the different partners, including training of FOSA staff, provision of job aids and BCC tools.

All PEPFAR clinical implementing partners will participate actively in the nutrition steering committee led by TRAC Plus to ensure a continuous improvement of the interventions through joint supervision and continuous feed-back and monthly exchange.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9201	**Mechanism Name: Legal Aid**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Avocats Sans Frontieres	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 148,500	
Funding Source	**Funding Amount**
GHCS (State)	148,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID/Rwanda awarded a four-year $847,375 cooperative agreement to Avocats Sans Frontières (ASF) on May 28, 2008. This project will improve access to justice for Rwanda's poor and vulnerable and contribute to the strengthening of the rule of law, in which law serves the most vulnerable.

The project has established a legal advice center in Gisenyi city and mobile legal advice centers that serve rural areas in the District of Rubavu, and three prisons in different regions of Rwanda. These mobile legal advice centers will help to build awareness among the population of their legal rights and the

mechanisms available to them to protect these rights. Awareness will also be delivered through radio programs on the local Radio Broadcast. Legal services will be provided in partnership with lawyers who are members of the Rwandan Bar Association and local and national associations and NGOs which do provide legal aid. Beneficiaries will include the general population as well as persons in pre-trial custody, specifically OVC, victims of GBV, and persons affected by important diseases and especially HIV/AIDS. The grantee will work in close coordination with Rwandan government institutions, relevant USAID implementing partners (including PEPFAR clinical partners in the area), and local civil society groups such as the Rwandan Bar Association and local and national associations and NGOs.

FY 2010 Avocats Sans Frontières (ASF) will continue this important project and further focus the activities on providing legal services to OVC and PLWHA and those at risk or affected by HIV/AIDS in areas served by the project. Prisoners in Rwanda have some of the highest rates of HIV infection in the country, and sooner or later, they will go back to society. The project will also focus on addressing the issue of GBV by assisting in the prosecution of sexual crimes. This activity addresses the key legislative issues of gender - particularly equity, access to justice, and reducing violence.

ASF will continue to coordinate with local organizations such as ADEPE (Action pour le Développement du Peuple), ARPCH (Association pour la Recherche, la Promotion et la Connaissance des Droits de l'Homme), AVEGA (Association des Veuves du Genocide d'Avril 1994), Haguruka (this is a Rwandan name that means "stand up"), and Kigali Bar association. Furthermore, ASF will work with lawyers from these organizations and build their capacities to provide legal aid services to local vulnerable populations.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9201**		
Mechanism Name:	**Legal Aid**		
Prime Partner Name:	**Avocats Sans Frontieres**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HKID	74,250	

Narrative:

USAID/Rwanda awarded a four-year $847,375 cooperative agreement to Avocats Sans Frontières (ASF) on May 28, 2008. This project will improve access to justice for Rwanda's poor and vulnerable and contribute to the strengthening of the rule of law, in which law serves the most vulnerable.

The project has established a legal advice center in Gisenyi and mobile legal advice centers which serve rural areas in the district of Rubavu and three prisons in different regions of Rwanda. These mobile legal advice centers help build awareness among the population about their legal rights and the mechanisms available to them to protect these rights. Awareness will also be heightened through local radio productions. In FY 2010 legal services will continue to be provided in partnership with lawyers who are members of the Rwandan Bar Association, as well as local and national associations and NGOs which provide legal aid. Beneficiaries will include the general population as well as persons in pre-trial custody, specifically OVC, victims of GBV, and persons affected by chronic diseases, particularly HIV/AIDS. The grantee will work in close coordination with Rwandan government institutions, relevant USAID implementing partners (including PEPFAR clinical partners in the area), and local civil society groups such as the Rwandan Bar Association and local and national associations and NGOs.

In FY 2010 ASF will continue this important project and further focus the activities on providing legal services to OVC, PLWHA and those at risk or affected by HIV/AIDS in areas served by the project. The project will also focus on addressing the issue of GBV by assisting in the prosecution of sexual crimes. This activity addresses the key legislative issues of gender - particularly equity, access to justice, and reducing violence.

ASF will continue to coordinate with local organizations such as Action pour le Développement du Peuple (ADEPE), Association pour la Recherche, la Promotion et la Connaissance des Droits de l'Homme (ARPCH), Association des Veuves du Genocide d'Avril 1994 (AVEGA), Haguruka (a Rwandan name that means "stand up"), and Kigali Bar association. Furthermore, ASF will work with lawyers from these organizations and build their capacities to provide legal aid services to local vulnerable populations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	74,250	

Narrative:

USAID/Rwanda awarded a four-year $847,375 cooperative agreement to Avocats Sans Frontières (ASF) on May 28, 2008. This project will improve access to justice for Rwanda's poor and vulnerable and

contribute to the strengthening of the rule of law, in which law serves the most vulnerable.

The project has established a legal advice center in Gisenyi city and mobile legal advice centers that serve rural areas in the district of Rubavu and three prisons in different regions of Rwanda. These mobile legal advice centers will help to build awareness among the population about their legal rights and the mechanisms available to them to protect these rights. Awareness will also be heightened through local radio productions. In FY 2010 legal services will continue to be provided in partnership with lawyers who are members of the Rwandan Bar Association, as well as local and national associations and NGOs which provide legal aid. Beneficiaries will include the general population as well as persons in pre-trial custody, specifically OVC, victims of GBV, and persons affected by chronic diseases, particularly HIV/AIDS. The grantee will work in close coordination with Rwandan government institutions, relevant USAID implementing partners (including PEPFAR clinical partners in the area), and local civil society groups such as the Rwandan Bar Association and local and national associations and NGOs.

In FY 2010 ASF will continue this important project and further focus the activities on providing legal services to OVC, PLWHA and those at risk or affected by HIV/AIDS in areas served by the project. Prisoners in Rwanda have some of the highest rates of HIV infection in the country, and given their eventual reintegration to society, are a particularly important population to address. The project will also focus on addressing the issue of GBV by assisting in the prosecution of sexual crimes. This activity addresses the key legislative issues of gender - particularly equity, access to justice, and reducing violence.

ASF will continue to coordinate with local organizations such as ADEPE, ARPCH, AVEGA, Haguruka and Kigali Bar association. Furthermore, ASF will work with lawyers from these organizations and build their capacities to provide legal aid services to local vulnerable populations.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9203	**Mechanism Name: AIDSRelief**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: Catholic Relief Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 621,139	
Funding Source	**Funding Amount**
Central GHCS (State)	621,139

Sub Partner Name(s)

Bushenge District Hospital	Futures Group, South Africa	Gatare Health Centre
Gisakura Health Centre	Hanika Health Centre	Kamonyi Health Centre
Karambi Health Centre	Karengera Health Centre	Kibingo Health Centre
Kibogora District Hospital	Mugera Health Centre	Mukoma Health Centre
Muyange Health Centre	Nyamasheke District Health Unit	Nyamasheke Health Centre
Rangiro Health Centre	Ruheru Health Centre	UMSOM-IHV
Yove Health Centre		

Overview Narrative

AIDSRelief is a comprehensive anti-retroviral therapy program in ten countries over sub-Saharan African and the Caribbean. In Rwanda, AIDSRelief is providing antiretroviral treatment to more than 3,721 people, including 524 children. Based on its successes and lessons learned from the past year of project implementation, the AIDSRelief program in Rwanda will continue to expand access to treatment services to reach 4,972 patients on ART by the end of February 2011.

The goal of this Consortium is to ensure that people living with HIV/AIDS have access to quality HIV care and treatment and that they are supported for adherence to ART that assures viral suppression. AIDSRelief intends to expand, on a sustainable basis, the provision of ART to the greatest number of needy patients in these ten countries, consistent with good medical science, national priorities and programs, and cost-effective deployment of program resources. In this regard, AIDSRelief is committed to work in close collaboration with the Government of Rwanda and the in-country US government team to help strengthen the infrastructure of the MOH in general, through increasing liaison with the District Health Team, and specifically, the capacity of the health staff of its points of service to provide quality antiretroviral therapy.

AIDSRelief has established a multi-disciplinary technical assistance team for Rwanda, the Country Technical Coordinating Team (CTCT), which is responsible for overseeing the implementation of the

program. The CTCT includes people with expertise in HIV/AIDS clinical care for adults and children, palliative care, patient adherence, laboratory diagnostics, prevention of mother-to-child transmission, drug procurement and pharmaceutical services, financial and grant compliance, and the management of strategic information. Together with corresponding sections of the Government of Rwanda, the Ministry of Health/TRAC and the in-country US Government team, the CTCT of AIDSRelief will make an impact on this epidemic, for the benefit of all persons now living with HIV/AIDS in Rwanda.

AIDSRelief is contributing to the achievement of Partnership Framework goals through its activities notably the expansion of the geographical coverage in Nyamasheke District, the improvement of the quality of the comprehensive HIV Treatment, care and support provided; and the strengthening of national staff expertise on HIV Prevention, Treatment, Care and Support at National, District and Health facility levels:

• AIDSRelief has expanded its HIV services from 3 to 20 LPTFs in Nyamasheke and Burera districts within the past four years.
• As of October 31, 2009, the program has enrolled 9,722 patients in care, of which 3,721 are on ARV treatment. Overall, there has been over a 34% increase in both care and treatment enrollment between FY08 and FY09.
• AIDSRelief has strengthened staff capacity for the use of the new PMTCT protocol, focused on evidence-based maternal and pediatric HIV care; trained and mentor site staff on early HIV diagnosis (DBS, clinical) and provided transition feeding assistance to exposed Infant.
• At all AIDSRelief supported sites, PLHIV systematically receive opportunistic infection prophylaxis, treatment and other co-infection treatment according to national guidelines.
• An effective system was put in place by AIDSRelief with facility-based case managers, health community leads, health care workers, and community-based volunteers to ensure continuum coverage and quality of basic care and psychosocial support to PLHIV with contributes to reduction of stigma and discrimination of PLHIV and OVC in the community.
• In collaboration with CAMERWA and SCMS, AIDSRelief provided TA to health facilities to ensure the availability and rational use of quality drugs and commodities.

AIDSRelief is supporting 20 Health Facilities including 19 (17 health centers, 2 district hospitals) in Nyamasheke District, Western Province serving a population of 353,207 and one health center in Bungwe Sector in Burera District Northern Province serving 24,810 inhabitants.

AIDSRelief is contributing to health system strengthening at all levels. Staff at Health facilities received intensive clinical training and mentoring, training on data management and use of IQChart software for patient management and monitoring, technical support on finance, compliance and administration. At

community level, AIDSRelief emphasized on community outreach and home care through PLVIH association, community health leads and volunteers. As part of AIDSRelief Rwanda's commitment to build the national capacity in HIV care and treatment services, AIDSRelief has been working closely with government counterparts, TRAC Plus-CIDC and the National Reference Laboratory (NRL), training and mentoring over 150 health professionals. Training contents ranged from basic HIV care and treatment to strengthening the capacity for diagnosis of extra pulmonary TB among PLVIH.

To ensure monitoring and evaluation of the planned activities, AIDSRelief will strengthen monitoring and data management systems, for collecting, managing and analyzing clinical data at LPTFs, work with TRAC Plus in providing technical assistance to the sites to integrate, modify and improve their existing medical records system to meet the reporting requirements of TRAC PLUS/MOH, donor and other stakeholder.

With TRAC Plus/MOH, AIDSRelief will continue to identify areas of system strengthening in term of strategic Information to enable organizations to enhance and sustain HIV service delivery and promote integration of supervision, mentoring activities with district hospitals' support teams and TRAC/MOH mentoring teams, through the on-going assessment of local partner's strengths and weaknesses in the area regarding strategic information as a part of on-going mentorship.

In FY10, AIDSRelief will continue to provide technical support to PEPFAR partners using IQChart (International Quality Clinical HIV/AIDS Registry Tool), mentors Monitoring and Evaluation officers on the updated version of IQChart containing PMTCT, OIs and STIs indicators and support the National Strategic Information Technical Working Group in process of rolling out the new HIV data management system and Partnering with MoH on the EMR and HMIS working group.

AIDSRelief will continue to build the data quality culture of LPTF staff to ensure quality (clean, complete and valid) of chronic care data through Data Quality Audit mentoring activities at District and LPTFs level. Continue to support CTCT in defining clinical indicators for LPTF in order to address gaps in program and services in providing local partners with data analysis tools and methods, and build capacity at LPTF in data collection and analysis (IQChart)

AIDSRelief Strategic information staff will continue to build LPTFs capacity to ensure compilation and timely submission of reports required by stakeholders & donors including TRACPLUS, CDC, OGAC and other LPTF & CTCT specific reports. In accordance to transition to local partner strategy, the SI team will provide relevant Technical Assistance to ensure LPTFs receive information in timely manner and are able to generate their own reports, Continue Technical Capacity transfer to local partners that will focus on

reinforcing data management capacity and monitoring, building data demand and information use (DDIU) so that local partners can generate their own reports, thereby enhancing data ownership (Sustainability). SI team and District health Directorate team to develop a plan and outline activities that promote the use of SI to enhance Local Partner service delivery.

Using paper registers, Electronic Data management system IQChart, by supporting data manager and community support staff, to monitor routine CD4 follow up, patient appointment adherence and tracing patient lost to follow-up to address HIV patient retention and use of other patient-level data to improve programmatic operations.

AIDSRelief will continue the mentorship on IQChart in LPTFs to strengthen their capacity to accurately collect, enter, store and retrieve program data for use in planning, monitoring, reporting, and improving quality, and demonstrated ability to fulfil GOR/MOH and donor reporting requirements.
AIDSRelief will continue the ongoing Information Technology support (Computer Software and Hardware troubleshooting, including anti-virus update) in all LPTFs

In collaboration with TRAC Plus and Measure Evaluation project, promote DDIU (Data Demand and Information Use) at National, District and LPTFs level. Continue the mentorship for capacity building of LPTF staff to ensure they can manage and maintain the health management information system.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9203**		
Mechanism Name:	**AIDSRelief**		
Prime Partner Name:	**Catholic Relief Services**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	621,139	

Narrative:

This is a continuing activity from FY09.

In FY09, AR supported 16 ART sites and provided ART services to 3,197 adults patients on ART as of October 31 and expect to reach 3,390 patients actively on ART by the end of February 2009.
In FY10, AR will continue to provide ARV services for 1,909 existing patients and 692 new patients at 11 ART supported sites. Nevertheless AR will continue to support the 5 transitioned ART sites for quality treatment for 1,481 existing patients and 434 new patients.
AR will continue to support LPTF to enroll patients tested positive in treatment by rapidly check for CD4 count, initiate treatment and actively support evaluation of patients on ART for eventual treatment failing as to provide them with appropriate ART treatment. In collaboration with the district hospital team, regular follow-up visits will be made to these sites. Clinicians from the district team will review ART and non-ART complicated cases. Nurses at these sites will continue to be trained and mentored for provider-initiated-testing, to follow-up patients, and to detect and refer complicated cases to district hospitals. Supported by international technical assistance, AR will continue to support Quality Improvement with a review of indicators, medical dossiers and viral load measurements to develop and strengthen clinical capacity for more efficient and quality-assured patient management. AR will ensure participation in the District Health Team meetings by health center staff, country program staff for better collaboration. AR will work with the National Reference Laboratory to expand the diagnostic resources for HIV at the sites. AR will work to improve reporting linkages with CAMERWA and to continue mentoring health center staff in their ability to receive, manage, and forecast the needs for ARVs and drugs for OI and palliative care.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the national HIV PBF project and according to the new support approach, in improving key national HIV performance and quality indicators, CRS will shift its support of output financing based on sites performance to a technical participation on health facility performance evaluations and on PBF technical extended team meetings. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. DHTs is now playing a critical role in the oversight and management of clinical and community service delivery. AR will strengthen the capacity of two DHTs to coordinate an effective network of palliative care and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

In FY09, AR has effectively started rolling-out the Pilot Program to Strengthen Delivery of Services to

Victims of Sexual Violence at 3 supported sites according to national guidelines. The pilot program aims to strengthen a comprehensive response to cases of sexual violence with a focus on clinical management and the role of the health facility as both a place of referral from the police and the community and a referrer to other services including more extensive psychosocial and trauma counseling, legal assistance, temporary shelter, and longer-term reintegration of the victim into the community. AR provided training on comprehensive management of SGBV clients to clinical staff, counselors, CST and community health workers of those 3 pilot sites but also to other supported sites and participated in the development of the national SGBV guidelines, workplan and budget. In FY10, AR will continue to support the 3 pilot sites and expand its support to other 17 sites by providing refresher training and mentoring to clinical staff, providing clinical equipment, drugs and PEP kits, IEC and reporting tools. In collaboration with the district hospital staff, AR will support and conduct ongoing quality assurance and supportive supervision for health providers. The community role will be strengthened in order to improve access of victims to quality services through refresher training for community support team and community health workers and sensitizations and creation of support groups for SGBV survivors facilitating their integration in the community. Linkages between clinical services (PMTCT, VCT, ART, etc) and other sexual violence services will be strengthened for an effective support to victims through a reinforcement of the existing referral and communication system. AR will also participate actively in the strengthening of the SGBV national coordination and response.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9204	**Mechanism Name: CRS Supplemental**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: Catholic Relief Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,546,837	
Funding Source	**Funding Amount**

GHCS (State)	3,546,837

Sub Partner Name(s)

Bushenge District Hospital	Futures Group, South Africa	Gatare Health Centre
Gisakura Health Centre	Hanika Health Centre	Kamonyi Health Centre
Karambi Health Centre	Karengera Health Centre	Kibingo Health Centre
Kibogora District Hospital	Mugera Health Centre	Mukoma Health Centre
Muyange Health Centre	Nyamasheke District Health Unit	Nyamasheke Health Centre
Rangiro Health Centre	Ruheru Health Centre	UMSOM-IHV
Yove Health Centre		

Overview Narrative

AIDSRelief is a comprehensive anti-retroviral therapy program in ten countries over sub-Saharan African and the Caribbean. In Rwanda, AIDSRelief is providing treatment to more than 3,721 people, including 524 children. Based on its successes and lessons learned from the past year of project implementation, the AIDSRelief program in Rwanda will continue to expand access to treatment services to reach 4,972 patients by the end of February 2011.

The goal of this Consortium is to ensure that people living with HIV/AIDS have access to quality HIV care and treatment and that they are supported for successful adherence that assures viral suppression. AIDSRelief intends to expand, on a sustainable basis, the provision of ART to the greatest number of needy patients in these ten countries, consistent with good medical science, national priorities and programs, and cost-effective deployment of program resources. In this regard, AIDSRelief is committed to working in close collaboration with the Government of Rwanda and the in-country US government team to help strengthen the infrastructure of the MOH in general, through increasing liaison with the District Health Team, and specifically, the capacity of the health staff of its points of service to provide quality antiretroviral therapy.

AIDSRelief has established a multi-disciplinary technical assistance team for Rwanda, the Country Technical Coordinating Team (CTCT), which is responsible for overseeing the implementation of the program. The CTCT includes people with expertise in HIV/AIDS clinical care for adults and children, palliative care, patient adherence, laboratory diagnostics, prevention of mother-to-child transmission, drug procurement and pharmaceutical services, financial and grant compliance, and the management of strategic information. Together with corresponding sections of the Government of Rwanda, the Ministry of Health/TRAC and the in-country US Government team, the CTCT and AIDSRelief will make an impact

on this disease, for the benefit of all persons now living with HIV/AIDS in Rwanda.

AIDSRelief is contributing to the achievement of Partnership Framework goals through its activities notably the expansion of the geographical coverage in Nyamasheke District, the improvement of the quality of the comprehensive HIV Treatment, care and support provided; and the strengthening of national staff expertise on HIV Prevention, Treatment, Care and Support at National, District and Health facility levels:

• AIDSRelief has expanded its HIV services from 3 to 20 LPTFs in Nyamasheke and Burera districts within the past four years.
• As of October 31, 2009, the program has enrolled 9,722 patients in care, of which 3,721 are on treatment. Overall, there has been over a 34% increase in both care and treatment enrollment between FY08 and FY 2009.
• AIDSRelief has strengthened staff capacity for the use of the new PMTCT protocol, focused on evidence-based maternal and pediatric HIV care; trained and mentor site staff on early HIV diagnosis (DBS, clinical) and provided transition feeding assistance to exposed Infant.
• At all AIDSRelief supported sites, PLWHA systematically receive opportunistic infection prophylaxis, treatment and other co-infection treatment according to national guidelines.
• An effective system was put in place by AIDSRelief with facility-based case managers, health community leads, health care workers, and community-based volunteers to ensure continuum, coverage and quality of basic care and psychosocial support to PLWHA which contributes to reduction of stigma and discrimination of PLWHA and OVC in the community.
• In collaboration with CAMERWA and SCMS, AIDSRelief provided TA to health facilities to ensure the availability and rational use of quality drugs and commodities.

AIDSRelief is supporting 20 Health Facilities including 19 (17 health centers, 2 district hospitals) in Nyamasheke District, Western Province deserving 353,207 and one health center in Bungwe Sector in Burera District Northern Province deserving 24,810 inhabitants.

AIDSRelief is contributing to health system strengthening at all levels. Staff at Health facilities received intensive clinical training and mentoring, training on data management and use of IQChart software for patient management and monitoring, technical support on finance, compliance and administration. At community level, AIDSRelief emphasized community outreach and home care through PLVIH associations, community health leads and volunteers. As part of AIDSRelief Rwanda's commitment to build the national capacity in HIV care and treatment services, AIDSRelief has been working closely with government counterparts, TRAC Plus-CIDC and the National Reference Laboratory (NRL), training and mentoring over 150 health professionals. Training contents ranged from basic HIV care and treatment to

strengthening the capacity for diagnosis of extra pulmonary TB among PLVIH.

To ensure monitoring and evaluation of the planned activities, AIDSRelief will strengthen monitoring and data management systems for collecting, managing and analyzing clinical data at LPTFs. AIDSRelief will work with TRAC Plus by providing technical assistance to the sites to integrate, modify and improve their existing medical records system to meet the reporting requirements of TRAC Plus/MOH, donor and other stakeholders.

With TRAC Plus/MOH, AIDSRelief will continue to identify areas of system strengthening to enable organizations to enhance and sustain HIV service delivery. Specific efforts will focus on promoting integration of supervision and mentoring activities with district hospitals' support teams and TRAC/MOH mentoring teams, on-going assessment of local partner's strengths and weaknesses, and mentorship in the area of strategic information.

In FY 2010, AIDSRelief will continue to provide technical support to PEPFAR partners using IQChart (International Quality Clinical HIV/AIDS Registry Tool). AIDSRelief will mentor Monitoring and Evaluation officers on the released vision of IQChart containing PMTCT, OIs and STIs indicators; support the National Strategic Information Technical Working Group in process of rolling out the new HIV data management system; and Partner with MOH on the EMR and HMIS working group.

AIDSRelief will continue to build the data quality culture of LPTF staff to ensure quality (clean, complete and valid) of chronic care data through Data Quality Audit mentoring activities at District and LPTFs level. AIDSRelief will continue to support CTCT and district health teams in defining clinical indicators that will help LPTF address gaps in program services. AIDSRelief will also continue to provide local partners with data analysis tools and methods, and build capacity at LPTF in routine program data collection and analysis (using systems including but not limited to IQChart).

AIDSRelief Strategic information staff will continue to build LPTFs capacity to ensure compilation and timely submission of reports required by stakeholders & donors including TRAC Plus, CDC, OGAC and other LPTF & CTCT specific reports. In accordance with transition philosophy, the SI team will provide relevant Technical Assistance to ensure LPTFs receive information in a timely manner and are able to generate their own reports. AIDSRelief will continue technical capacity transfer to local partners that will focus on reinforcing data management capacity and monitoring, building data demand and information use (DDIU) so that local partners can generate their own reports, thereby enhancing data ownership (Sustainability). The SI team and District health Directorate team will develop a plan and outline activities that promote the use of SI to enhance Local Partner service delivery.

AIDSRelief will continue the mentorship on IQChart in LPTFs to strengthen their capacity to accurately collect, enter, store and retrieve program data for use in planning, monitoring, reporting, and improving quality, and demonstrated ability to fulfill GOR/MOH and donor reporting requirements. AIDSRelief will continue the ongoing Information Technology support (Computer Software and Hardware troubleshooting, including anti-virus update) in all LPTFs.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9204**		
Mechanism Name:	**CRS Supplemental**		
Prime Partner Name:	**Catholic Relief Services**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	565,201	

Narrative:

This is a continuing activity from FY 2009.

In FY 2009, CRS/AIDSRelief (AR) provided basic care and support services (BCS) to 8,332 adult HIV positive individuals at 20 sites, in 2of the 30 districts of Rwanda. In FY 2010 AR will continue to provide BCS to8972 adults at those sites, which include 18 health centers and 2 district hospitals.

In FY 2010 AR will continue to improve the timeliness of BCS services for better patient follow-up and outcomes. BCS provided by AR include: clinical staging and baseline CD4 count for all patients; follow-up CD4 every six months, or every 3 months for patients with CD4 cell counts <500, in accordance with national clinical guidelines; routine provision of co-trimoxazole (CTX) prophylaxis for all adults living with HIV, as per national guidelines revised in 2009; basic nutritional counseling and support; positive living and risk reduction counseling; pain and symptom management; and end-of-life care. In addition, AR will

continue to provide psychosocial counseling for HIV-positive female victims of domestic violence and as part of a "prevention with positives" strategy. To ensure comprehensive services across a continuum, AR will continue to refer patients enrolled in facility-based care services to community-based BCS services, including: adherence counseling; provision of long-lasting insecticide treated bed-nets (LLINs) for PLWHA and their families in collaboration with GFATM and PMI; provision of spiritual support, stigma reducing activities, OVC support, IGA activities, and home-based care (HBC) services for end-of-life care. AR will also facilitate access to point of use purification commodities to PLWHA at supported sites. Nutritional services will be strengthened by training providers on nutritional counseling, as well as by conducting nutritional assessments using anthropometric measurements. AR will assist in the management of malnutrition through the provision of micronutrient and multivitamin supplements and the creation of linkages to the CRS Ibyiringiro project for clinically eligible PLWHA and children, in line with national nutrition guidelines. will be done through expanded To expand psychological and spiritual support services for PLWHA at both the clinic and community levels, AR-supported health facility and community-based providers will receive training from TRAC Plus on GBV counseling, positive living messaging, and prevention with positives. AR will continue to integrate natural family planning messages and methods, as well as IMCI, into HIV services.

In collaboration with the supply chain partner, AR will provide diagnostic kits, CD4 tests, viral load tests and other tools for clinical monitoring, as per national guidelines. AR will work with the supply chain partner to ensure the appropriate storage, stock management, and reporting of all OI- and STI-related commodities. AR will continue to provide TA to TRAC Plus by participating in TWGs which review care and treatment guidelines/tools developed by that institution, or in any way requested by TRAC Plus.

In FY 2010, the transition of TRACK 1.0 activities will lead to a redistribution of sites supported by AR. AR will continue to provide BCS for 2,896 existing patients and 927 new patients at fourteen AR-supported sites, while BCS services for 2,729 existing patients and 513 new patients at six sites will be provided by the Government of Rwanda. However AR will continue to support quality improvement efforts at the six transitioned sites.

In FY 2010, AR will expand its prevention with positives strategy to enable PLWHA to adhere better to treatment, avoid sexual risk behavior and engage in positive living. Expanded services will emphasize quality of care via the Continuous Quality Improvement program. AR will also focus on securing the continuum of care through linkages with community-based organizations, and ensuring the sustainability of services through performance based financing.

AR will continue to assist health facilities in developing community health care and home care services, alternative testing, and mobile medication dispensing. AR, in conjunction with local health centers, will

conduct contact tracing of all patients who test positive for HIV at AR-supported sites. AR will support health facilities in their use of community volunteers and support group members to follow up HIV positive clients in their communities and to encourage spouses and family members to be tested. Depending on the availability of funds, these volunteers will provide HIV testing in their communities and identify discordant couples who need intensive prevention counseling. Community workers/volunteers will receive refresher training on the recognition of signs and symptoms of key OIs, the provision of basic palliative care, the implementation of basic care packages, the management of medication toxicities, and the proper utilization of referral systems. Community volunteers will continue to be supported through professional associations and the provision of PBF based on the number of patients they assist and quality of services provided.

PBF is a major component PEPFAR Rwanda's strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the national PBF project and in line with the transition of activities to national institutions, AR will support PBF by participating in health facility performance evaluations and serving PBF technical advisory teams.

In order to ensure a continuum of care, AR data clerks will liaise with other testing services to identify and reconnect with treatment those patients previously lost to follow up. AR will develop effective referral systems between clinical care providers and psychosocial and livelihood support services through the use of patient routing slips for referrals between community services and health facilities.. In addition AR will strengthen the capacity of two district health teams to coordinate an effective network of palliative care and other HIV/AIDS services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	911,198	

Narrative:

(Track 1.0) This is a continuing activity from FY 2009.

In FY 2009 AR supported 16 ART sites and, as of February 2009, had provided ART services to 3,390 adult patients. In FY 2010 AR will continue to provide ARV services for 1,909 existing patients and 692 new patients at 11 of the currently supported sites; the other five sites will be transitioned to management of the MOH. However, AR will continue to delivering services at the five transitioned ART sites, providing quality treatment for 1,481 existing patients and 434 new patients.

AR will continue to support Local Partner Treatment Facilities (LPTFs) in enrolling patients who test positive for HIV into treatment. Patients who test positive will immediately be provided a CD4 count and

initiated into appropriated treatments, and subsequently actively supported throughout their ART treatment, and also CD4 tests for all HIV-positive people tested at non-ART sites will be done and Bactrim provision before they become eligible to ART and then transferred to ART sites In collaboration with district hospital teams, regular follow-up visits will be conducted to these LPTFs. Clinicians from the district team will review ART and non-ART complicated cases and nurses from the team will mentor the site's nurses on provider-initiated testing follow-up of patients, and the detection and referral of complicated cases to district hospitals. Supported by international technical assistance, AR will continue to promote quality improvement through reviews of indicators, medical dossiers and viral load measurements. The results of these reviews will be used to develop and strengthen clinical capacity for more efficient and high-quality patient management. AR will ensure the participation of district health team in meetings with health center staff and AR personnel in order to improve collaboration between stakeholders. AR will work with the National Reference Laboratory to expand diagnostic resources for HIV at supported sites. AR will also work to improve reporting linkages with CAMERWA and to mentor health center staff on strategies to effectively receive, manage, and forecast the need for ARVs and drugs for OI and palliative care.

PBF is a major component PEPFAR Rwanda's strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the national PBF project and in line with the transition of activities to national institutions, AR will support PBF by participating in health facility performance evaluations and serving PBF technical advisory teams.

AR will strengthen the capacity of two DHTs to coordinate an effective network of palliative care and other HIV/AIDS services. The basic package of financial and technical support will include staff for oversight, implementation, transportation, communication, training of providers, and other key responsibilities.

In FY 2009, AR participated in a pilot program to strengthen the delivery of services to victims of sexual and gender-based violence (SGBV) at three supported sites. The goal of the program was to ensure a comprehensive response to cases of SGBV, with a focus on clinical management and the role of the health facility as both a place of referral (to/from the police) and as a referrer to follow-up services, such as more extensive psychosocial and trauma counseling, legal assistance, temporary shelter, and reintegration into the community. In FY 2009 AR provided training on the comprehensive management of SGBV clients to clinical staff, counselors, and CHWs at the three pilot sites as well as its other supported sites. AR also participated in the development of national SGBV guidelines and strategies.

In FY 2010 AR will continue to support the pilot program at the three initial sites and will expand it to seventeen other AR-supported sites. AR will assist in the implementation of the program by providing

refresher training and mentoring to clinical staff, providing clinical equipment, drugs and PEP kits, and IEC and reporting tools. In collaboration with the district hospital staff, AR will support and conduct ongoing quality assurance and supportive supervision for health providers. The community role will be strengthened through refresher trainings for local support teams and CHWs in order to improve access for victims to quality services. Support groups for SGBV survivors will be created to facilitate their reintegration into the community. Linkages between clinical services (PMTCT, VCT, ART, etc) and sexual violence services will be strengthened through the reinforcement of the existing referral and communication systems. AR will also participate actively in the strengthening of the national response to SGBV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	134,705	

Narrative:

This is a continuing activity from FY 2009.

In FY 2010, Catholic Relief Services under the consortium AIDSRelief (AR) will reach 43,098 individuals at 14 supported sites with a strategic mix of targeted PIT, family-centered HCT, and client-initiated HCT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. Support will be provided to six transitioned sites to give quality HCT services to 13,605 individuals. PIT services will target adult and pediatric in-patients presenting with TB and other HIV-related OIs and symptoms, malnourished children, HIV-exposed infants, and STI patients. PIT will be implemented with a revised counseling component whereby pre-test counseling is more focused with emphasis placed on post-test counseling. Moreover, community workers will be trained as counselors in order to provide continuous support beyond the consultation to encourage testing acceptance, family and/or partner tracing, and support for those who received their test results.

AR will work with religious institutions, community DOTS programs, and OVC and HBC programs to identify those infected, in particular HIV-exposed infants, family members of PLWHA, and OVC. HCT providers will continue to provide traditional HCT (client-initiated) for those who wish to know their status, in particular for pre- and post-nuptial couples, ANC male partners, and youth. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up.

In order to counsel and test those individuals most likely to be HIV-positive, CBTS will conduct contact tracing of all patients who test positive for HIV at AR sites. Contact counselors will be responsible for accompanying HIV-positive clients to their community, encouraging their spouses and family members to

be tested, providing HIV testing, and identify discordant couples who are in need of intensive prevention counseling. To strengthen the continuum of care for PLWHA and their families, partners will establish a formalized referral system to link community care and clinical services. AR in collaboration with CHF, will ensure that HIV-positive patients are provided patient education, positive living counseling and referral for community-based services, such as IGA, through PLWHA associations, OVC, and HBC programs. At the health facility level, partners will ensure a system for supportive supervision of nursing and counseling staff, including training of select staff in supervision for HCT, use of quality control checklists, and data quality control.

AR will monitor site performance and provide patient referral tools for the timely enrollment of HIV-positive patients diagnosed in any service at the site. AR will support sites to track PIT and contact tracing data for use at site level for program improvement and reporting. Through regular supervision at sites, patient satisfaction surveys, and HIV testing records reviews, AR will ensure that basic ethical practices and confidentiality related to HIV counseling and testing are practiced at all sites.

PBF is a major component of the Rwanda strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the national HIV PBF program, CRS will shift its support for output financing based on site performance to technical participation on health facility performance evaluations and on PBF technical extended team meetings. Payment of indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. District Health Teams (DHTs) are now playing a critical role in the oversight and management of clinical and community service delivery. AR will strengthen the capacity of two DHTs to coordinate an effective network of HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	290,768	

Narrative:

This is a continuing activity from FY 2009.

As of October 2009, CRS/AIDS Relief (AR) is providing basic care and support to 719 HIV-positive children at 20 sites. By the end of FY 2010 the number of beneficiaries is expected to increase to 978 children at 20 sites, including 18 health centers and 2 district hospitals. The package of services is provided in collaboration with local community service providers and includes co-trimoxazole prophylaxis, nutrition counseling and food support, insecticide-treated bed nets (ITN), and safe water interventions. In

addition, AR supports the provision of follow-up services for HIV-exposed infants who are maintained on co-trimoxazole prophylaxis until their HIV status can be confirmed.

FY 2010 starts the first year of transition of TRAC 1.0 partners' activities. AIDS Relief will transition to the Ministry of Health (MOH) 11 HIV care and treatment sites which will be selected based on their demonstrated capacity to continue implementing high quality care for children with minimum support.

AR will continue to provide basic care and support for 356 existing children and 213 new children at 14 AR-supported sites. AR will also continue to support the 11 transitioned sites for quality care and support for 337 existing children and 63 new children. AR supports the implementation of new guidelines/tools developed by TRAC Plus.

To address the need to expand the diagnosis of HIV in the pediatric population, AR will increase testing for targeted pediatric populations within the catchment areas of its existing sites. Using each adult HIV patient enrolled in care and treatment at AR-supported sites as an index case, AR will offer HIV testing for their partners and children and enroll the infected family member/s into care and treatment services. To provide early initiation of ART for all HIV-positive infants, AR will assist in the implementation of early infant diagnosis and follow-up through training for PMTCT staff and lab technicians, as well as through developing efficient and reliable sample transportation systems. AR-supported sites will link with OVC service providers operating in the same districts to offer HIV testing services for children according to national guidelines, and to ensure enrollment of HIV-positive children into care and treatment services. In addition, AR-supported sites will link with malnutrition and TB centers within their facilities or at specialized sites located in the vicinity to provide HIV testing to all pediatric inpatients and outpatients, and to enroll the infected children into care and treatment services. AR will also work to establish and strengthen linkages with PLWHA associations in the local network, and the administrative district authorities and health teams to support activities aiming at increasing community awareness of issues related to pediatric HIV and to increase pediatric HIV testing and enrollment into care.

Local partners have repeatedly expressed the need for appropriate pediatric psychosocial resources including tools, job aids, and curricula. AR will support the implementation of new guidelines /tools and the pediatric and adolescent patient file. AR will also continue working with the pediatric support groups for improved psychosocial management of HIV-positive and -affected children and adolescents.

At AR-supported sites, HIV-positive children will be staged clinically and immunologically (using CD4 counts or percentages), and eligible infants and children will be enrolled in ART as per the new national Pediatric Guidelines. AR will work with the MOH and other clinical implementing partners to train health care providers on the updated pediatric HIV treatment guidelines which include changes for early

treatment of HIV-positive infants and in CD4 thresholds for treatment initiation of children between 36 and 59 months of age. Systematic chart reviews will continue in FY 2010 to identify children who are eligible for treatment according to the new protocol.

All pediatric patients will have regular anthropometric evaluations to identify early signs of malnutrition and to ensure prompt initiation of nutrition rehabilitation interventions. Newly identified patients will be screened at enrollment and at regular intervals for signs and symptoms of common opportunistic infections or other infectious complications of HIV in children, including: candidiasis, pneumonia, malaria, meningitis, and Pneumocystis jiroveci pneumonia (PCP).

AIDS Relief will work to implement a system to assess the vulnerability of HIV-exposed, infected and affected children. It will conduct home visits for families with HIV-positive children in order to identify and manage accordingly those that need special attention. In order to ensure a continuum of HIV care, AR data clerks will continue to liaise with community-based treatment specialists (CBTS) and OVC service providers to ensure referral to care services of pediatric patients identified through PMTCT programs, PLWHA associations, malnutrition centers, and OVC programs.

AR will ensure that site-level providers are trained or receive refresher training in pediatric HIV patient management according to the new national guidelines. Providers will receive in-service training and coaching on a regular basis. In collaboration with TRAC Plus, AR will continue to dedicate personnel to the national team that will provide continued mentoring to clinical staff at AR supported sites.

Through work with the Supply Chain Management System (SCMS) and CAMERWA (Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda), the national pharmaceutical warehouse, the district-level pharmacy, the National Reference Laboratory (NRL) and the regional laboratory network, AR will ensure training of health service providers on the management of HIV-related opportunistic infections, drug and reagent stock management and distribution, adherence counseling, good pharmacy record-keeping and data use.

In FY 2009, AR worked closely with TRAC Plus to implement a mentoring program to train health care providers in the management of HIV and HIV/TB in adults and children. This program will continue in FY 2010 to support the building of capacity at site and district level to provide quality clinical services for children. With improved data on pediatric HIV care, AR, in collaboration with TRAC Plus and the national performance-based financing unit within the MOH will support health facilities to build and sustain a system of performance measurement and improvement. This system will use basic pediatric HIV care and support and treatment data to regularly review program performance and to design/implement appropriate interventions with a view to improving the quality of services. AR staff in charge of each

district will ensure that meetings to review data take place on a regular basis and that the improvement plan is implemented at individual sites. Yearly district-level meetings are planned where each facility will share their performance data and improvement strategies. AR will ensure that pediatric HIV care is integrated with adult HIV care and that the family approach is reinforced.

Performance-based financing (PBF) is a major component of the Partnership Framework for ensuring long-term sustainability and for maximizing performance and quality of services. In coordination with the national HIV PBF project and according to the new support approach to improving key national HIV performance and quality indicators, Catholic Relief Services will shift its support for output financing to technical participation to health facility performance evaluations and extended PBF technical team meetings. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. District health teams (DHTs) are now playing a critical role in the oversight and management of clinical and community service delivery. AR will strengthen the capacity of two DHTs to coordinate an effective network of basic care and support and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	296,351	

Narrative:

This is a continuing activity from FY 2009.

As of October 2009, AR supported 16 ART sites and provided ART services to 524 children. It expects to reach 556 children actively on ART by the end of February 2009.

In FY 2010, AR will continue to provide ARV services to 220 existing children and 112 new children at 11 AR-supported sites. AR will also continue to provide support for quality treatment of 332 existing children and 70 new children at 6 ART sites that will be transitioned to the Ministry of Health (MOH). AR will continue to support local partner treatment facilities (LPTFs) to enroll patients in treatment by initiating early infant diagnosis, treatment and new CD4-based protocol. AR-supported sites will continue to check for opportunistic infections (OIs) and other HIV-related illnesses, to identify treatment failure among patients on first-line regimen, and to offer appropriate treatment. AR will allocate a full-time TA at TRAC Plus to support pediatric HIV treatment programs in order to improve the quality of services.

In collaboration with the district hospital team, regular follow-up visits will be made to ART sites.

Additionally, infants and children on ART will also be assessed monthly at each visit for issues related to adverse events, toxicity and adherence to ART. AR will assist heath facilities in mentoring children and adolescent support groups that have been established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment and to assist with addressing issues around treatment adherence.

Clinicians from the district team will review complicated ART and non-ART cases. Nurses at these sites will continue to be trained and mentored for provider-initiated testing, to follow-up patients, and to detect and refer complicated cases to district hospitals. Supported by international technical assistance, AR will continue to support Quality Improvement with a review of indicators, medical dossiers and viral load measurements to develop and strengthen clinical capacity for more efficient and quality-assured patient management. AR will ensure participation of health center and country program staff in District Health Team meetings for better collaboration. AR will work with the National Reference Laboratory to expand the diagnostic resources for HIV at the sites. Furthermore, it will endeavor to improve reporting linkages with CAMERWA, and it will continue mentoring health center staff to improve their ability to receive, manage, and forecast the needs for ARVs and drugs for OI and palliative care.

Performance-based financing (PBF) is a major component of the Rwanda PEPFAR strategy for ensuring long-term sustainability and for maximizing performance and quality of services. In coordination with the national HIV PBF project and according to the new support approach to improving key national HIV performance and quality indicators, Catholic Relief Services will shift its support for output financing based on sites performance to technical participation to health facility performance evaluations and extended PBF technical team meetings. Full or partially reduced payment of basic care and support as well as other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. DHTs are now playing a critical role in the oversight and management of clinical and community service delivery. AR will strengthen the capacity of two DHTs to coordinate an effective network of basic care and support and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	406,573	

Narrative:

This is a continuing activity from FY 2009.

In FY 2010 AIDSRelief (AR) will provide an expanded package of services for 18,047 pregnant women. In all, 413 of these HIV-positive women are expected to complete the course of ARV prophylaxis. AR will continue to provide support for the 6 transitioned sites to MOH for PMTCT quality services.

AR will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, ARV prophylaxis using combination ARV regimens and HAART for eligible women, infant feeding counseling and support, referral for MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis. In addition, AR will ensure access to a comprehensive network of services for PMTCT clients and their families, including linking PMTCT services with other HIV and MCH interventions, assuring an effective continuum of care by increasing patient involvement and community participation in PMTCT services and ensuring CD4 count for all HIV-positive pregnant women.

Linking with MCH services, AR will strengthen follow-up and tracking systems to ensure testing of family members, routine provision of CTX and HIV early infant diagnosis, ongoing infant feeding counseling using new nutritional assessment tools. AR supported sites will continue CD4 monitoring and clinical staging, management of OIs, including TB and other HIV-related illnesses, psychosocial support services at clinic and community levels, identify and refer women who may be victims of gender-based violence to appropriate care and access to clinical and community prevention, care, and treatment services for family members.

AR will ensure linkage to treatment for eligible women and infant follow-up by using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. In collaboration with new USAID partner, AR will refer PMTCT clients and their families to HBC, OVC support, IGA, and facility-and community-based MCH services promoting key preventive interventions such as bednets, immunizations, hygiene/safe drinking water and nutritional support. These community-based services will assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants, as well as promote MCH and PMTCT health-seeking behaviors. In addition AR will ensure referrals of pediatric patients from PMTCT sites and nutrition centers to ARV services.

In collaboration with TRAC Plus and Project San Francisco, AR, and all clinical partners, will support couples' counseling through training and on-site mentoring to improve pre- and post-test couple counseling quality, improve follow-up mechanisms for discordant couples and women testing negative in ANC to address seroconversion and pediatric infection during pregnancy and breastfeeding.

Health center staff will receive new and refresher on-the-job training on new national PMTCT protocol. In collaboration with DHTs, AR will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E. DHTs will build their QA and M&E skills, including in data collection, data use, and reporting.

Through CAMERWA/SCMS, AR will ensure ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials are available in all AR supported sites. AR will also collaborate with RPM+ to improve the capacity of providers in drug management, coordinated site-level storage, inventory, tracking and forecasting. In addition, AR will collaborate with new USAID partner, GFATM, and PMI to refer PLWHA and their families for malaria prevention services including bednet provision. In collaboration with CRS/Ibyiringiro, HIV-exposed infants – starting at six months, pregnant and lactating mothers in need of all PMTCT sites will receive respectively weaning food and supplemental food.

At PMTCT sites, enhanced follow-up of mothers and exposed infants will be promoted through support groups of HIV-positive women based on the mother-to-mother model. In this model, women who demonstrate steady consultation attendance and good baby care are identified and used to coach new HIV-positive mothers during pregnancy and after delivery to ensure that both women and their infants access needed services. During these groups sessions AR will provide nutrition counseling, enhancing family food support through training for improved home gardening and animal breading techniques. In addition, AR supported sites will provide health education on safe water and provision of water purification products. HIV-exposed infants identified at PMTCT sites will be followed in the context of existing MCH services offered at existing AR sites. Mother and infant information will be transferred from PMTCT to other MCH programs through the "carte de liaison" currently in use. Early infant diagnosis services, now available at 19 of AR supported sites, will be expanded to increase full coverage of sites by end of FY 2009. EID will be offered at six weeks of age and at later ages for symptomatic infants less than 18 months according to the national algorithm. AR will also work with the district health teams to ensure that samples collected at the sites are transferred efficiently to the National Reference Laboratory in Kigali and work with the MOH to increase reliability of result turn-around times.

DHTs play a critical role in the oversight and management of clinical and community service delivery. In line with the Partnership Framework sustainability and transition goals, AR will provide a package of support to two DHTs to strengthen their capacity to coordinate an effective network of PMTCT and other HIV/AIDS medical services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities. Support to DHTs will focus on strengthening the linkages, referral systems, transport, communications and financing systems.

PBF is a major component of the GOR's strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the national HIV PBF project, AR will shift its support from output financing based on sites performance to technical participation on health facility performance evaluations and on PBF technical extended team meetings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	942,041	

Narrative:

Clinical Services:
In FY07, AIDSRelief (AR) began to implement the national TB/HIV policy and guidelines at their 14 supported sites. The program's achievements include an improvement in the percentage of TB patients tested for HIV and improving the HIV-positive TB patient's access to HIV care and treatment (increased proportion of patients accessing Co-trimoxazoleand ART).

In FY 2010, the goal is to ensure at least 95% of all TB patients are HIV tested, 100% of co-infected patients receive Co-trimoxazoleand 100% of those eligible receive ART at 11 AR supported ART sites to achieve high HIV testing in TB patients. Additionally, AR will provide TA support to 5 transitioned Track 1.0 ART sites for them to achieve the same goal. Lower than expected numbers of PLHIV in care and treatment are diagnosed and treated for TB. The priority in FY 2010 will be to expand implementation of regular TB screening for all PLHIV, and for those with suspect TB, ensuring adequate diagnosis and complete treatment with DOTS.

In FY 2009 AR supported sites with staff materials and training routine recording and reporting for the national TB/HIV programmatic indicators. Initial uptake and quality of services has been variable at different sites. In FY 2010, AR will continue to support individual sites to collect quality data, and to report and review these data in order to understand and improve their program and support integration of TB and HIV services at the patient and facility level, per national guidelines.

In order to ensure effective integration of TB and HIV, AR is supporting integrated planning and TB/HIV training to both HIV service providers, TB service providers and at central level. AR also plans to increase support to integrate diagnostic services, including coordinating specimen transport for both programs, and patient transport for appropriate diagnostic services (such as chest radiography and diagnostics required for extrapulmonary TB) to referral centers and appropriate follow-up.

In FY 2010, AR will continue to support existing sites for the implementation of the TB/HIV component of the clinical package of HIV care such expansion of TB screening to PLHIV accessing other HIV services,

such as, VCT/PMTCT sites, as well as family members of HIV positive patients reached through home base care and community programs; timely and appropriate TB diagnosis and treatment via DOTS for all PLHIV that are TB suspects. Support sites to implement routine collection, recording, and reviewing of standard national TB/HIV program indicators at sites to inform and improve services at the patient and facility level. These data will also be routinely reported to the district and national levels through TRAC Plus and PNILT to inform the national program; support on-going trainings on TB screening and management and TB control at sites; support sites to develop community based cases finding of TB and HIV patients' case management and referrals between the HIV and TB services. In addition, all pediatric patients will be screened for TB at least once every six months. Children suspected of having TB will be further investigated and put on TB treatment or INH prophylaxis if infection or exposure is confirmed based on current national guidance.

Capacity Building:
The objective of these activities is to increase the capacity of TRAC Plus (MOH), the Central University Hospitals in Kigali (CHUK) and Butare (CHUB), and the National Reference Laboratory (NRL) in the area of TB/HIV integration such that the GOR becomes capable of leading implementation and scale-up of these activities. Technical assistance (TA) currently includes updating and revision of national guidelines, development of training manuals for national trainers, support for conducting operational research activities, support to the clinical mentoring (training of trainers) program for District Hospital staff. In addition, TA is provided to CHUK/CHUB and NRL in support of improved diagnosis of extrapulmonary tuberculosis (EPTB) by use of fine needle aspiration (FNA) and histopathology services.

During FY 2009, AR is supporting the TRAC Plus HIV/AIDS/STI (HAS) Unit to conduct national level trainings of trainers (TOTs). These TOTs include didactic and practical material on TB for HIV-positive patients, as well as other aspects of clinical care included in the national HIV care and treatment clinical guidelines; to date, 6 TOTs have been conducted for doctors with 169 total participants (doctors) and (3 sessions + 3 refresher TOTs) for nurses with 168 total participants (nurses). Ongoing support is provided to TRAC Plus for 2-weeks long pediatric practical trainings organized in CHUK (9 participants per session). AR has been supporting TRAC Plus in development /revision and dissemination of national guidelines on TB/HIV (adult OIs, STI, adult and pediatric ART guidelines, discordant couples' tools). AR TA supports evidence-based decisions in several areas related to TB/HIV in adults and MCHC. AR is supporting MOH/TRAC Plus in documenting a model of adolescent services adapted to Rwanda context. Support is being provided to the TB/HIV focal person at TRAC Plus HAS unit for report preparation and revision, and AR participates in national technical working group (TWG) meetings.

In addition in FY 09, AR provided TA, training and materials to CHUB and CHUK national hospital pathology laboratories for the diagnosis of smear negative and EPTB. A total of 81 doctors were trained

in lymph node aspiration; additionally, 127 doctors were trained on TB/FNA techniques during national/district trainings on general adult and pediatric TB/HIV issues, while lab technicians were trained in specimens processing. AR initiated integration of TB/FNA by liaising with the TB Unit to ensure that this strategy is being taken in account in planning. In accordance with TRAC Plus, AR supports national capacity building by participating in pre-service training on TB/HIV for medical students (30 hours) and postgraduate students (CHUK). For FY 2010, AR will continue to allocate two full-time TA staff for provision of technical assistance in TB/HIV and adult and pediatric HIV care and treatment programming, implementation, and monitoring in the HAS Unit/TRAC Plus, and will continue to work in collaboration with the TB Unit. Clinical mentoring on management of complex cases for TRAC Plus Clinic (doctors and nurses) and CHUK staff will continue. Clinical mentoring (TOT) to referral/district hospitals will continue. TA will continue to be provided to the TRAC Plus HAS unit TB/HIV focal person, and continued participation in the national TWG meetings will occur. Support of MOH for evidence based guidelines/tools development and operational research will continue.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9205	**Mechanism Name: Rapid Expansion of ART for HIV-Infected Persons in Select PEPFAR Countries**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 4,600,000	
Funding Source	**Funding Amount**
Central GHCS (State)	4,600,000

Sub Partner Name(s)

ARBEF	AVEGA genocide widow clinic	Bamporeze
Bethsaida health Center	Butare University Teaching Hospital	Gisenyi District Hospital
Kabaya District Hospital	Kibuye District Hospital	Kicukiro Health CenterAVEGABethsaida Health Center
Kigali University Teaching Hospital	Mugonero District Hospital	Muhima District Hospital
Murunda District Hospital	Ndera pneuropsychiatric Hospital	Polyclinique Carrefour
RRP+	Shyira District Hospital	

Overview Narrative

ICAP is one of the USG partners providing HIV care and treatment services for HIV-positive adults and children in Rwanda. By the end of FY 2009, Columbia was supporting 56 sites in 9 districts to offer high quality HIV care and treatment services. In addition, Columbia supported the Government of Rwanda's effort to integrate services with the aim of maximizing efficiency and effectiveness of HIV services. In this respect, Columbia supported TRAC Plus to introduce the integration of mental health and HIV at Ndera Pneuropsychiatric hospital, and the Maternal and child health unit and TRAC Plus to pilot a tool for the screening of family planning needs. In addition, using its multidisciplinary, quality and family centred approach to the provision of HIV care local while targeting capacitation and sustainability, Columbia supported district teams to own, oversee, supervise and mentor health centers under their jurisdiction. In FY 2010, Columbia will enhance this transfer of skills to UPDC and the district teams, starting with the progressive transfer of responsibility for subagreement management and then program management, monitoring and evaluation and reporting.

Columbia will support 9 DHTs to strengthen their capacity to coordinate an effective network of PMTCT and other HIV/AIDS medical services. Support to DHTs will focus on strengthening the linkages, referral, transport, communications and financing systems necessary to support an effective PMTCT and other HIV/AIDS care network. Columbia will provide financial and technical support to DHTs, including staff positions, transportation, communication, training of providers using the trainers trained by TRAC+, and other support to carry out their key responsibilities. PBF is a major component of the Rwanda exit strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, Columbia has shifted some of its support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of PMTCT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national quality supervision tool. In FY 2010

ICAP will continue to assist DHTs to strengthen the M&E system through training service providers and managers in appropriate use of M&E tools as well as use of data for planning and activity monitoring. ICAP will assist the national and district program to improve data collection and reporting on key indicators. In FY 2010, ICAP will transition the management of some of the subagreements as well as the M&E and reporting functions of TRAC clinic to the MOH depatrment UPDC. During this transition, ICAP will provide support to UPDC on financial and project management as well as reporting to UPDC. ICAP will train and mentor relevant UPDC staff on aspects of project management and reporting and gradually withdraw its support as the capacity of UPDC develops. With the support of the 3 technical advisers seconded to UPDC, ICAP will intensify the training and mentorship of UPDC on the measurement and assessment of the quality of care; gradually leaving this exercise to them.

In FY 2009, Columbia provided basic care services (BCS) to 38,302 and ART to 19,170 PLWHA at 46 sites; which included 4,646 and 4,777 new patients enrolled into care and ART respectively. In FY 2010, ICAP will continue to provide high quality BCS at the 46 existing sites to 38,302 existing patients and an additional 6,070 new patients; and continue to provide high quality ART to the existing 19,170 patients and initiate 3,591 new patients on ART (in accordance with the new generation indicators bringing the cumulative total in care to 44,372 and on ART to 22,761. To ensure comprehensive services across a continuum, ICAP will continue to support the referral of patients enrolled in care to community-based BCS services based on their individual needs.

In FY 2009, Columbia supported TRAC Plus and Ndera Neuropsychiatric Hospital to integrate HIV and mental health services. Under this approach, mental health patients are evaluated for their mental illness as well as HIV/AIDS. Depending on the mental and medical status, an HIV test is proposed and performed either immediately (if the patient is very ill with signs of AIDS) or later (after stabilization) if the medical situation is not worrisome or suggestive of advanced AIDS disease. In FY 2010, ICAP will work with Ndera Neuropsychiatric Hospital, TRAC Plus and the Mental Health unit to scale up mental health and HIV integration services to the other 9 ICAP-supported district hospitals.

In FY 2009, ICAP continued to support high quality pediatric HIV care and treatment services at the two model centers and 44 other sites. A comprehensive package of basic care and support services was provided to 4,688 HIV-positive children and treatment to 2,570. ICAP has been instrumental in initiating family testing as a means to identify HIV-positive children and other adults in the household who would benefit of early care interventions. In FY 2010, ICAP will continue to provide a comprehensive package of care to 4,688 old HIV-positive children and 400 new ones. And provide treatment services for 242 new children to reach a cumulative total of 5,088 of children in care and 2,812 of children on ART by end of FY 2010. To address the need to expand diagnosis of HIV in the pediatric population ICAP will continue to strengthen testing for targeted pediatric populations within the catchment area of its existing sites. Using

each HIV adult patient enrolled in care and treatment at ICAP-supported sites, as an index case, ICAP will offer HIV-testing for their partners and children and enrolls the infected family members into care and treatment services.

At PMTCT sites, support groups of HIV-positive women will be strengthened based on the mother-to-mother model and PEARL program approach. Early infant diagnosis services, now available at all ICAP PMTCT supported sites, will be strengthened. EID will continue to be offered at six weeks of age and at any other ages for symptomatic infants less than 18 months post natal according to the national algorithm. ICAP will continue support to the district health teams to ensure that samples collected at the sites are transferred efficiently to the processing lab at the National Reference Laboratory in Kigali and work with the MOH to increase reliability of result turn-around times.

The prevention of unintended pregnancy amongst HIV-positive women is one of the most cost-effective means of preventing mother to child transmission. In FY 2009, Columbia supported the Maternal and child health unit of the Ministry of Health and TRAC Plus to pilot, at 3 sites in Kigali, a tool for the screening of family planning desires amongst HIV patients. In FY 2010, Columbia will support the MOH institutions in finalizing the review of the tool and scaling up its utilization at national level.

In FY 2009, ICAP supported MOH to develop SGBV guidelines and piloted the initiative at Muhima and Gisenyi District Hospitals. In FY 2010, ICAP will continue to support the Ministry of Health during the national training of trainers on SGBV and roll-out SGBV in HIV programs considering the lessons learned from one year implementation program of the SGBV pilot phase. ICAP will scale-up the initiative at 5 district hospitals and 10 health centers. ICAP will train Peer Educators on SGBV to enable them to sensitize community on prevention of SGBV. In collaboration with the Rwanda National Police, ICAP will support the health facilities to assure that the SGBV victims receive the services on time as recommended in national guidelines.

In the context of the transition plan, ICAP-CU will transition its sub-Agreement with CAAC to MOH. During COP 10, ICAP-CU will continue to actively participate in the PBF extended technical working group, and provide support DHTs and site staff for capacity building through training in use of PBF tools, improvement of site documentation, sites performance evaluation, site data quality assurance to improve key national HIV performance and quality indicators. Full or partially reduced payment of BCS and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. In collaboration with MOH Community Desk and RRP+ ICAP-Cu will continue to support the two local NGOs for capacity building in implanting community PBF through its Peer Education Program (PEARL) to improve key community health indicators.

Under the transition arrangements/planning, CDC will channel funding for some of the ICAP-supported sites to UPDC or another entity to be identified jointly by CDC and GOR, and the PBF funds directly to CAAC. In FY 2010, ICAP will support UPDC to provide technical support and mentorship to the transitioned sites and support develop the capacities of UPDC in financial and programmatic management and reporting. ICAP will continue its support to CAAC in financial management, training of districts staff on PBF as well as the evaluation and verification of bills.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9205**		
Mechanism Name:	**Rapid Expansion of ART for HIV-Infected Persons in Select PEPFAR Countries**		
Prime Partner Name:	**International Center for AIDS Care and Treatment Programs, Columbia University**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	4,600,000	

Narrative:

In FY 2009 Columbia provided a comprehensive package of ART services to 23,309 patients at 46, including 2,330 children. In FY 2010 Columbia will completely transition the provision of ART services at TRAC Plus clinic to the MOH. Columbia will support the provision of ART at the remaining 45 sites, providing ART to 22,888 existing patients and initiating ART with 3,325 new patients, including 333 pediatric patients. The package of services provided in FY 2010 will include treatment with ARV drugs, routine CD4 follow up, CD4 tests for all HIV-positive people tested at non-ART sites and Bactrim provision before they become eligible to ART and then transferred to ART sites, viral load testing screening, management of ARV drug side effects, and patient referrals to community-based care. In FY 2010 Columbia will expand quality clinical services, continue support to DHTs, increase sustainability

through quality assurance and capacity building, delegate greater responsibility to district teams, and strengthen SI at all levels. To ensure a continuum of care, Columbia will support the training and supervision of community volunteers including CHWs, PLWHA association members, and other caretakers. In FY2010 ICAP will provide support to the MOH and TRAC Plus for the revision of task-shifting guidelines,and will provide continued support of in-service training and mentorship for the health care providers at ICAP supported sites, In FY 2010 Columbia will support TRAC Plus and Ndera Neuropsychiatric Hospital to scale up the integration of mental health and HIV treatment at the nine Columbia-supported district hospitals. Columbia will support the training of two doctors and four nurses from each district hospital in mental health and HIV service integration, in addition to providing support for the finalization and roll out of mental health screening tools to the nine hospitals. Columbia will also promote the development of a referral and counter-referral system between Ndera Hospital and Columbia-supported facilities. Finally, Columbia will support mentorship and supervision visit by the neuropsychiatric hospital's staff to the nine district hospitals.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9206	**Mechanism Name: MCAP Supplemental**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,607,317	
Funding Source	**Funding Amount**
GHCS (State)	2,607,317

Sub Partner Name(s)

ARBEF	AVEGA genocide widow clinic	Bamporeze
Bethsaida health Center	Butare University Teaching Hospital	Gisenyi District Hospital
Kabaya District Hospital	Kibuye District Hospital	Kicukiro Health Center, Rwanda
Kigali University Teaching Hospital	Mugonero District Hospital	Muhima District Hospital
Murunda District Hospital	Ndera pneuropsychiatric Hospital	Polyclinique Carrefour
RRP+	Shyira District Hospital	

Overview Narrative

ICAP is one of the USG partners providing HIV care and treatment services for HIV-positive adults and children in Rwanda. By the end of FY 2009, Columbia was supporting 56 sites in 9 districts to offer high quality HIV care and treatment services. In addition, Columbia supported the Government of Rwanda's effort to integrate services with the aim of maximizing efficiency and effectiveness of HIV services. In this respect, Columbia supported TRAC Plus to introduce the integration of mental health and HIV at Ndera Pneuropsychiatric hospital, and the Maternal and child health unit and TRAC Plus to pilot a tool for the screening of family planning needs. In addition, using its multidisciplinary, quality and family centred approach to the provision of HIV care local while targeting capacitation and sustainability, Columbia supported district teams to own, oversee, supervise and mentor health centers under their jurisdiction. In FY 2010, Columbia will enhance this transfer of skills to UPDC and the district teams, starting with the progressive transfer of responsibility for subagreement management and then program management, monitoring and evaluation and reporting.

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At PMTCT sites, support groups of HIV-positive women will be strengthened based on the mother-to-mother model and PEARL program approach. Early infant diagnosis services, now available at all ICAP PMTCT supported sites, will be strengthened. EID will continue to be offered at six weeks of age and at any other ages for symptomatic infants less than 18 months post natal according to the national algorithm. ICAP will continue support to the district health teams to ensure that samples collected at the sites are transferred efficiently to the processing lab at the National Reference Laboratory in Kigali and work with the MOH to increase reliability of result turn-around times.

The prevention of unintended pregnancy amongst HIV-positive women is one of the most cost-effective means of preventing mother to child transmission. In FY 2009, Columbia supported the Maternal and child health unit of the Ministry of Health and TRAC Plus to pilot, at 3 sites in Kigali, a tool for the screening of family planning desires amongst HIV patients. In FY 2010, Columbia will support the MOH institutions in finalizing the review of the tool and scaling up its utilization at national level.

In FY 2009, ICAP supported MOH to develop SGBV guidelines and piloted the initiative at Muhima and Gisenyi District Hospitals. In FY 2010, ICAP will continue to support the Ministry of Health during the national training of trainers on SGBV and roll-out SGBV in HIV programs considering the lessons learned from one year implementation program of the SGBV pilot phase. ICAP will scale-up the initiative at 5 district hospitals and 10 health centers. ICAP will train Peer Educators on SGBV to enable them to sensitize community on prevention of SGBV. In collaboration with the Rwanda National Police, ICAP will support the health facilities to assure that the SGBV victims receive the services on time as recommended in national guidelines.

In the context of the transition plan, ICAP-CU will transition its sub-Agreement with CAAC to MOH. During COP 10, ICAP-CU will continue to actively participate in the PBF extended technical working group, and provide support DHTs and site staff for capacity building through training in use of PBF tools, improvement of site documentation, sites performance evaluation, site data quality assurance to improve key national HIV performance and quality indicators. Full or partially reduced payment of BCS and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. In collaboration with MOH Community Desk and RRP+ ICAP-Cu will continue to support the two local NGOs for capacity building in implanting community PBF through its Peer Education Program (PEARL) to improve key community health indicators.

Under the transition arrangements/planning, CDC will channel funding for some of the ICAP-supported sites to UPDC or another entity to be identified jointly by CDC and GOR, and the PBF funds directly to CAAC. In FY 2010, ICAP will support UPDC to provide technical support and mentorship to the

transitioned sites and support develop the capacities of UPDC in financial and programmatic management and reporting. ICAP will continue its support to CAAC in financial management, training of districts staff on PBF as well as the evaluation and verification of bills.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9206**		
Mechanism Name:	**MCAP Supplemental**		
Prime Partner Name:	**International Center for AIDS Care and Treatment Programs, Columbia University**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	905,749	

Narrative:

This is a continuing activity.

In FY 2010, ICAP will continue to provide BCS to 38,302 existing patients and add an additional 5,621 new patients at 46 existing sites, as well 10 additional sites which formerly provided only CVT, PMTCT, and OI treatment Services in the BCS package include clinical staging and baseline CD4 count for all patients follow-up CD4 tests, management of OIs, and routine provision of CTX prophylaxis for eligible adults, children and exposed infants based on national guidelines. Patients may also receive basic nutritional counseling and support, positive living and risk reduction counseling, pain and symptom management, and end-of-life care. In addition, ICAP will continue to provide psychosocial counseling including counseling and referrals for HIV-positive female victims of domestic violence. To ensure comprehensive services across a continuum of care, ICAP, through a partnership with peer educators and other community services providers, will refer patients enrolled in care to community-based BCS services based on their individual need. These services include adherence counseling, spiritual support,

stigma-reducing activities, OVC support, IGA activities, and HBC services for end-of-life care. In collaboration with the supply chain partner, ICAP will continue to provide diagnostic kits, CD4 tests, and other exams for clinical monitoring, and will work with the supply chain partner to ensure appropriate storage, stock management, and reporting of all OI-related commodities.

Services will emphasize quality of care, continuum of care through effective linkages and referrals, and sustainability of services through technical support to PBF. Strengthened nutritional services through training will include counseling, nutritional assessments using anthropometric indicators, and management of malnutrition through provision of micronutrient and multivitamin supplements, and links to Ibyiringiro food support for clinically eligible PLWHA and children, in line with national nutrition guidelines. ICAP will also support referrals for all PLWHA and their families, particularly children under five and pregnant women, for malaria prevention services, including provision of LLITNs in collaboration with GFATM and PMI; and referral of PLWHA and their families to CBOs and other community-service providers for distribution of water purification kits and health education on hygiene to reduce cases of diarrheal diseases. In addition, family planning education, counseling and methods will be provided to PLWHA and their spouses. This service will be located within the counseling unit of the site to reduce need for referrals. Strengthened psychological and spiritual support services for PLWHA at clinic and community levels will be done through expanded TRAC training in psychological support for all ICAP-supported health facilities and community-based providers, including GBV counseling, positive living, and counseling on prevention with positives.

In FY 2010, Columbia will expand quality clinical services, continue support to the DHTs, increase sustainability through quality assurance and capacity building activities, delegate more management responsibilities to district teams, and strengthen SI at all levels. In order to ensure a continuum of HIV care, ICAP, in collaboration with local organizations such as the Rwanda Network of PLWHA (RRP+), ARBEF and Bamporeze.ICAP will support health facilities in HIV patient follow-up, and organize referrals to care services for HIV patients to minimize lost to follow-up in collaboration with TRACPLUS and MOH. In FY 2010 ICAP will provide direct oversight of community volunteers, including CHWs, PLWHA association members, and other caretakers, and will continue to work with Peer Educators for Adherence, Referral, and Linkages (PEARL), RRP+ and other community based organizations to develop effective referral systems between clinical care providers and psycho-social and livelihood support services. Depending on the needs of individuals and families, health facilities will refer PLWHA to community-based HBC services, adherence counseling, spiritual support through church-based programs, stigma reducing activities, OVC support, IGA activities (particularly for PLWHA female and child-headed households), legal support services, community-based pain management and end-of-life care in line with national palliative care guidelines.

In FY 2009 ICAP served as one of the partners for the OGAC Special Initiative on Sexual and Gender Based Violence, piloting the program at two health facilities. In FY 2010, in collaboration with the Population Council, the national police, and the MCH unit of the MOH, ICAP will extend SGBV services to all ICAP-supported district hospitals, emphasizing the development of health care providers' capacity to treat and manage SGBV clients, as well as the strengthening of SGBV M&E systems.

In FY 2009, ICAP supported the Government of Rwanda's effort to integrate services, with the aim of maximizing efficiency and effectiveness of HIV services. To this end ICAP supported TRAC Plus in the integration of mental health and HIV services in a neuropsychiatric hospital. In this model mental health patients are screened for HIV and those found to be HIV+ are enrolled into HIV care and ART as necessary. After discharge, they are followed up for mental health and HIV care by the same unit. The approach has revealed that it is feasible to provide HIV services to mentally ill patients and that HIV is a significant problem for this population. In FY 2010, ICAP will continue to support the integration of mental health and HIV care at all nine ICAP supported district hospitals. ICAP will support the training of two doctors and four nurses from each district hospital in mental health and HIV service integration, in addition to supporting the finalization and roll out of mental health screening tools at the nine hospitals. ICAP will also support the development of a referral and counter-referral system between the neuropsychiatric hospital and its supported facilities. Finally, ICAP will support mentorship and supervision visits by the neuropsychiatric hospital's staff to the nine district hospitals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	87,368	

Narrative:

In FY 2009 Columbia provided a comprehensive package of ART services to 23,309 patients at 46, including 2,330 children. In FY 2010 Columbia will completely transition the provision of ART services at TRAC Plus clinic to the MOH. Columbia will support the provision of ART at the remaining 45 sites, providing ART to 22,888 existing patients and initiating ART with 3,325 new patients, including 333 pediatric patients. The package of services provided in FY 2010 will include treatment with ARV drugs, routine CD4 follow up, CD4 tests for all HIV-positive people tested at non-ART sites and Bactrim provision before they become eligible to ART and then transferred to ART sites, viral load testing screening, management of ARV drug side effects, and patient referrals to community-based care. In FY 2010 Columbia will expand quality clinical services, continue support to DHTs, increase sustainability through quality assurance and capacity building, delegate greater responsibility to district teams, and strengthen SI at all levels. To ensure a continuum of care, Columbia will support the training and supervision of community volunteers including CHWs, PLWHA association members, and other caretakers.

In FY2010 ICAP will provide support to the MOH and TRAC Plus for the revision of task-shifting guidelines,and will provide continued support of in-service training and mentorship for the health care providers at ICAP supported sites,

In FY 2010 Columbia will support TRAC Plus and Ndera Neuropsychiatric Hospital to scale up the integration of mental health and HIV treatment at the nine Columbia-supported district hospitals. Columbia will support the training of two doctors and four nurses from each district hospital in mental health and HIV service integration, in addition to providing support for the finalization and roll out of mental health screening tools to the nine hospitals. Columbia will also promote the development of a referral and counter-referral system between Ndera Hospital and Columbia-supported facilities. Finally, Columbia will support mentorship and supervision visit by the neuropsychiatric hospital's staff to the nine district hospitals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	229,831	

Narrative:

In FY 2009, ICAP supported counseling and testing services at 35 sites including one prison and the neuropsychiatric hospital. In FY06 about 127,000 clients have been counseled and tested. This number was reached using a mix of outreach activities, local authority mobilization and effective referral to the health facilities, linkage within healthcare units and follow-up through a coordinated response between health facilities and the community; in addition to the geographical extension of HCT services including the organization of counseling and testing campaigns and PITC.

During FY 2010, ICAP-CU will continue to support counseling and testing at the existing 35 sites. ICAP will closely work with other partners and GOR to design an efficient model of counseling and testing for couples and an enhanced monitoring and evaluation system for proper tracing and tracking purposes. Through this approach, ICAP will provide counseling and testing services to an estimated 130,000 clients including 1,000 from TB and PITC in all three regions. This activity will be attained through integration of various approaches including community based mobilization for counseling and testing in collaboration with local authorities, an enhanced referral to health facilities and follow up as well as maximization of all entry points with the health care facilities. These include conventional HCT, ANC and general consultation rooms plus nutritional centers and admission wards using PITC and provided in a manner that respects human values, ensures confidentiality , and reduces stigma and discrimination.

PICT services will target adult and pediatric patients presenting with HIV-related OIs and TB symptoms, malnourished children, HIV-exposed infants, STI patients and all admitted patients. A system to ensure

coordination between the different counseling and testing units will be utilized to enhance adherence and minimize lost to follow up. During FY 2010, ICAP will support the strengthening of the M&E system (documentation, utilization of tools, data analysis, sharing and reporting) in all services providing PITC.

In order to ensure quality, ICAP will continue to support supportive supervision in frame work of mentorship and standard of care, designing tools and implementation of multi-disciplinary team work at the health facilities to prepare district health teams' capacity for their future problem identification, solving and self-evaluations. ICAP will continue to support counseling and testing indicators embedded in Performance Based Finance (PBF) as a way of improving both quantity and quality of service provision. ICAP will support the quality of data and its utilization for improving the quality of care through regular data quality audits, data analysis training and data sharing workshops and feedback.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	301,137	

Narrative:

In FY 2009, ICAP has been supporting pediatric HIV care at 46 sites in the western province, in Kigali region and in Huye district in Rwanda. Site support included staff training and mentoring on identification of HIV-positive children at various entry points of care, their enrolment in care and treatment program, and long term follow-up. In addition, ICAP site support teams have been providing guidance to sites for the strengthening of their care system: patient flow, delivery of a standardized package of care at follow-up visits, regular multidisciplinary team meetings, appropriate documentation of pediatric care practices, and regular use of a standards of care (SOCs) tool to monitor progress in delivering quality care for children. By September 2009, 4,027 children were enrolled in care including 2,172 children on ART.

FY 2010 starts the first year of transition of TRAC 1.0 partners' activities to the Ministry of Health (MOH): ICAP-CU AIDS will transition 12 HIV care and treatment sites that will be selected based on their demonstrated capacity to provide high quality care for children with minimum support.

ICAP will continue to collaborate with the district to ensure refresher training of health care providers on pediatric HIV care at the 46 supported sites. This will include, among other topics related to pediatric HIV care, the new national pediatric treatment guidelines, identification and management of treatment failure cases, and psychosocial support to children, adolescents and their families. A specific emphasis will be put on early infant diagnosis and the implementation of a reliable and efficient sample transportation system. ICAP will assist heath facilities in mentoring children and adolescent support groups that have been established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care, on treatment or

affected by HIV, and to assist with addressing issues around status disclosure and treatment adherence.

ICAP pediatric and clinical advisors will be carrying out monthly site visits for staff mentoring during which support will continue to be provided for the strengthening of the care system and of children support group activities, and for the active tracking of follow-up defaulters. ICAP will also continue to provide support to sites for the appropriate documentation of pediatric HIV care practices, for the use standards of care (SOCs) tools, as well as for regular multidisciplinary meetings to discuss SOCs findings and to address identified challenges.

All these activities will be contributing to the site maturation process that will be monitored through global SOCs scores and an assessment of the capacity health care providers to design interventions to address identified challenges.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	127,684	

Narrative:

In FY 2009, ICAP has been supporting pediatric HIV care at 46 sites in the western province, in Kigali region and in Huye district in Rwanda. Site support included staff training and mentoring on identification HIV-positive children at various entry points of care, their enrolment in care and treatment program, and long term follow-up. In addition, ICAP site-support teams have been providing guidance to sites for the strengthening of their care system: patient flow, delivery of a standardized package of care at follow-up visits, regular multidisciplinary team meetings, appropriate documentation of pediatric care practices, and regular use of a standards of care (SOCs) tool to monitor progress in delivering quality care for children. By September 2009, 4,027 children were enrolled in care, including 2,172 children on ART.

In FY 2010, ICAP will continue to collaborate with the district to ensure refresher training of health care providers on pediatric HIV treatment at the 46 supported sites. This will include, among other topics related to pediatric HIV treatment, the new national pediatric ARV treatment guidelines, identification and management of ART failure cases, and psychosocial support to children, adolescents and their families for ART adherence.

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meetings to discuss SOCs findings and to address identified challenges.

All these activities will be contributing to the site maturation process that will be monitored through global SOCs scores and an assessment of the capacity of health care providers to design interventions to address identified challenges. FY 2010 starts the first year of transition of TRAC 1.0 partners' activities. ICAP-CU AIDS will transition to the Ministry of Health (MOH) 12 HIV care and treatment sites which will be selected based on their demonstrated capacity to continue implementing high quality care for children with minimum support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	649,107	

Narrative:

The uptake of PMTCT services in Rwanda is high as indicated by ANC attendance and HIV counseling and testing. However mother and infant follow-up is weak due to high rates of home delivery and infants lost to follow-up. ICAP-CU has provided ongoing site level implementation support to the district hospital multidisciplinary teams to improve uptake and quality of services. The PMTCT package includes: CT, screening for STIs, infant feeding counseling, implementation of PMTCT regimens, prompt CD4 count and clinical staging for HIV-positive pregnant women, combination ARV regimens for non-eligible women and rapid initiation of HAART for eligible women, safe delivery, infants and mother follow-up, CTX for OI prevention, infant HIV testing, and support for human resources by providing high-quality training and clinical mentoring.

ICAP-CU has been successful, particularly with regard to the provision of more efficacious PMTCT regimens, male partner counseling testing and integration of PITC at consultation points, MCH units and hospitalization wards. ICAP-CU has introduced systems to improve CD4 testing uptake in HIV-positive pregnant women which has helped to improve uptake and quality of PMTCT services at ICAP-CU supported sites. ICAP-CU has successfully implemented PMTCT standards of care at all supported sites. In FY 2009, ICAP in collaboration with TRAC Plus and MCH unit within MOH ICAP developed and piloted an FP/HIV screening questionnaire at 3 ICAP-supported sites. Data from the 3 sites revealed the existence of unmet FP needs among HIV-positive patients; and a formal evaluation to assess feasibility and usefulness of the tool will be done later in the year. The results from the evaluation will be used by TRAC Plus and MCH unit to review the screening tool and scale up its utilization in HIV clinics nationwide. ICAP will reinforce its outreach teams and the MOH health animators with training, and transportation in order to track PMTCT clients lost to follow-up and arrange home visits if needed.

In FY 2010, ICAP-CU will provide an expanded package of services to 27,174 pregnant women at 32

existing CT/PMTCT sites. Emphasis will be placed on quality services and continuum of care through operational partnerships, and sustainability of services through PBF, and use of data for mentorship and planning interventions. All (100%) HIV-positive women (1,086) are expected to complete the course of ARV prophylaxis.

ICAP-CU will support PMTCT services providers in HIV care and treatment with emphasis on pediatric care. In addition, ICAP-CU will ensure that all newborns to HIV-positive mothers are put on Co-trimoxazolepreventive therapy until confirmation of their HIV-negative status. ICAP-CU will sustain the PMTCT follow-up system through support to the sites for formal meetings and referrals to ensure that mothers and exposed children are followed up regularly in PMTCT ward but also from vaccination, TB and nutrition wards and to care and treatment ward.

ICAP-CU will strengthen follow-up and tracking systems to ensure testing of family members, routine provision of CTX PT and infant diagnosis, ongoing infant feeding counseling and support in collaboration with the World Food Program and other partners, CD4 monitoring and clinical staging, management of OIs, including TB and other HIV-related illnesses, psychosocial support services at clinic and community levels, identify and refer victims of gender-based violence to appropriate care in collaboration with community care workers, peer educators and other HIV clinical partners, and access to clinical and community prevention, care, and treatment services for family members. ICAP-CU will assure linkage to treatment for eligible women and infant follow-up by using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To ensure these linkages, social workers will train and supervise community volunteers and organize monthly health center meetings with staff from all services to follow-up on referrals and other patient-related matters. In collaboration with RRP+, two local NGOs (Bamporeze and Rwandan Association for the Well-Being of the Family (ARBEF)), health providers and peers educators will refer PMTCT clients and their families to HBC, OVC support, IGA, and facility- and community-based MCH services promoting key preventive interventions such as bednets, immunizations, hygiene/safe drinking water and nutritional support. These community-based services will assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants, as well as promote MCH and PMTCT health-seeking behaviors. In addition social workers will ensure referrals of pediatric patients from PMTCT sites and nutrition centers to ARV services. ICAP-CU will support sites to prepare inventories and projections to requisite ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials from CAMERWA. ICAP-CU will also collaborate with MSH/RPM+, CAMERWA and SCMS to improve the capacity of DHTS and site providers in drug management, coordinated site-level storage, inventory, tracking and forecasting. In addition, ICAP-CU will collaborate with GFATM, PMI and other community partners to refer 728 PLWHA and their families for malaria prevention services including bednet

provision. In collaboration with CRS, ICAP-CU will provide weaning food for exposed infants, pregnant and lactating women in need. In addition ICAP-CU will continue to leverage food aid from the World Food Program to meet the other nutritional needs of these food insecure households.

In FY 2009, ICAP-CU collaborated with Catholic Relief Service (CRS) which is the principle PEPFAR sub-awardee for the purchase and distribution of nutritional supplements to people infected and affected by HIV and AIDS including weaning food supplements in PMTCT. Under this collaboration, CRS bears the responsibly of purchase and distribution food supplements in the form of fortified weaning food to the mothers of HIV-exposed infants from age of 6 months to 18 months in the first 18 sites. During FY 2010, ICAP-CU will continue this partnership with CRS and EGPAF - the technical assistance provision arm of the program to scale up supplementary and replacement feeding supplements from the current 29 sites to all PMTCT sites. Currently, the program has extended nutritional supplements to include pregnant and lactating mothers. During the primary phase of this extended program, ICAP-CU will closely work with CRS and EGPAF to ensure proper distribution, documentation on site mentorship as well as reporting and feedback mechanisms. ICAP-CU through this partnership ensures proper on-site supplies management (in-good condition storage, enrolment forms, registration books and ration cards), routine assessment to verify dates for expiration and works with the site staff to ensure proper documentation and timely reporting. In collaboration with EGPAF, ICAP-CU will continue to provide IEC materials on infant feeding and family nutrition and other tools for monitoring the feeding of enrolled infants to hospitals and health centers. Building on program data from the current small scale nutritional assessment exercise at a few selected sites, ICAP-CU will perform a basic program evaluation to assess nutritional faltering during weaning phase in PMTCT program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	306,441	

Narrative:

The overall goal of this activity is to build capacity of the Ministry of Health to support national TB/HIV integration at all levels. TB/HIV capacity building includes development, revision or updating of TB/HIV guidelines for adults and children, creating training materials and job-aids, sharing best practices, improving TB diagnosis, and enhancing supervision, monitoring and evaluation of TB/HIV collaborative activities.

In FY 2009, Columbia University supported the TB and HIV/AIDS/STI (HAS) Units of TRAC-Plus to strengthen TB/HIV program and service integration. Several meetings of the TB/HIV technical working group were organized to assure coordination and joint planning of national TB/HIV collaborative activities. The TB/HIV national guidelines were revised and updated, M&E system revised and implemented

nationwide to accurately capture data on TB/HIV integrated activities. The TB/HIV training curriculum was revised and updated and trainings were organized at district level nationwide. TB/HIV practical trainings were organized for all TB diagnostic and treatment centers nationwide followed by intensive supervision and mentoring to assure quality implementation of HIV testing of TB suspects and patients, CPT for those HIV-positive and prescription of ART if indicated. TB screening for PLWHA was reinforced at USG partner supported sites and a collaborative approach between ICAP and MOH allowed for strengthening of TB screening at the non-USG supported HIV care and treatment clinics. A Public Health Evaluation on best methods to screen HIV-positive children was carried out and preliminary results disseminated. ICAP supported MOH to share TB/HIV best practices at different national and international fora.

In FY 2010, Columbia University will continue to support TB/HIV collaborative activities at central level through a TB/HIV team leader position to coordinate TB/HIV activities between different institutions of the MOH and ICAP. These include providing support to the national TB/HIV working group for revising and updating guidelines, curriculums, and tools, including support for training and dissemination of guidelines at decentralized level. It also includes providing support for supervision of quality TB and HIV service delivery to co-infected patients - particularly to strengthen the implementation of routine HIV counseling and testing especially in TB suspects, prevention education, and referral for HIV care (if needed) for all patients with TB at the TB/DOT clinics. By the end of FY 2010, 90% of all TB suspects will be tested for HIV. Additionally, it includes strengthening of implementation of standardized symptom-based TB screening and intensified TB case-finding for patients living with HIV, with a special focus for the non-USG supported ART clinics. ICAP will continue to support the TB Unit of TRAC-Plus to scale up the TB Infection Control (TB IC) Program through revision of guidelines, tools and job aids. By the end of FY 2010, all District Hospitals in Rwanda will have a TB IC Plan, implementing at least the minimum package of TB IC activities.

Through collaboration with TRAC-Plus and UPDC, ICAP will strengthen mentorship and supervision capacity at central and district level to improve quality of TB diagnosis in TB suspects. This approach is based on TB/HIV standards of care evaluation, district evaluation meetings and supportive supervision and mentorship. In FY 2010, training will be organized for 10 DHT. These trainings will jointly address TB/HIV and the pediatric HIV quality improvement programs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9211	**Mechanism Name: GHFP**

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Public Health Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 266,000	
Funding Source	**Funding Amount**
GHCS (State)	266,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY 2010 USAID/Rwanda will have one continuing staff, a Commodity and Logistics Advisor engaged through the Global Health Fellows Program. This activity includes personnel costs, equipment and services to support PEPFAR management of the position.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9211**		
Mechanism Name:	**GHFP**		
Prime Partner Name:	**Public Health Institute**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXD	266,000	

Narrative:
In FY 2010 USAID/Rwanda will have one continuing staff, a Commodity and Logistics Advisor engaged through the Global Health Fellows Program. This activity includes personnel costs, equipment and services to support PEPFAR management of the position.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9212	Mechanism Name: SPREAD
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Texas A & M University Norman Borlaug Institute for International Agriculture	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 168,300	
Funding Source	**Funding Amount**
GHCS (State)	168,300

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Sustaining Partnerships to enhance Rural Enterprise and Agribusiness Development (SPREAD) Project is a 5-year cooperative agreement (2006-2011) between the U.S. Agency of International Development and Texas A&M University in the United States. SPREAD provides technical assistance to rural cooperatives and private enterprises throughout Rwanda involved in high-value commodity chains, primarily specialty coffee, but now expanding to include birds-eye chili pepper and pyrethrum production in order to increase incomes and improve livelihoods of farming families. SPREAD strives for an innovative and holistic development approach through the integration of a community health component while continuing to enhance and expand its agribusiness efforts in specialty coffee and pyrethrum.

The Community Health Program leverages SPREAD's unique access to rural, income-generating populations by using existing cooperative structures and extension systems to disseminate health

information and services, while adding value to what it means to be a cooperative member. The health component focuses on BCC activities for HIV prevention, FP/RH and MCH promotion through building capacity for health-seeking behaviors of cooperative members and their families, increasing access to health information and services via cooperative structures, and reinforcing linkages to local health service providers. SPREAD believes that meeting farming families' health needs will improve health among Rwanda's rural communities and serve to increase buy-in among existing cooperative members, attract new members, and enhance coffee quality and cooperative development.

SPREAD's health program works primarily on Goal #1 of the GOR/USG Partnership Framework, to reduce incidence of HIV in the general population, by targeting farmers in rural areas with BCC interventions primarily for sexual prevention and PMTCT. SPREAD's health program works also on Goal #2 of reducing morbidity and mortality of PLWHA through supporting follow-up visits by Health center staff for those who test positive for HIV.

SPREAD is In the Southern Province, Huye District (5 sectors: Mbazi, Huye, Maraba, Simbi and Kigoma) and Nyamagabe District (5 sectors: Gasaka, Kamegeri, Cyanika, Kibilizi and Mbazi). In the Western Province: Nyabihu District (Kabatwa and Bigogwe sectors) and Rubavu District (Mudende and Bugeshi sectors), and in the Northern Province: Musanze District (Kinigi sector). SPREAD's target populations are coffee farmers and their families in the Southern Province, and pyrethrum farmers and their families in Northern and Western Provinces.

SPREAD strategies to become more cost efficient over time are founded on the integrated Agribusiness/Health approach that allows the Project to use the same funds, staff and community resources for cross-sectoral activities. The Health program was integrated into the coffee program by building on existing coffee extension agents (Animateurs de Café) who added the HIV/AIDS prevention messages in their daily activities. Youth and Adult Peer Educators were initially trained as health educators, and are now being integrated into the coffee production committees in their agricultural zones to assist cooperatives in coffee activities. Instead of spending resources creating new training curriculum and IEC materials, SPREAD reprints existing materials from MINISANTE and local health partners such as PSI's Centre Dushishoze and the Rwanda arm of the International Planned Parenthood Federation (ARBEF). Finally, SPREAD also saves costs on mobile health services offered during harvest season by facilitating local health centers to conduct these outreach activities, which also corresponds with their mandate to conduct "stratégies avancées."
SPREAD's M&E plans include conducting supervision visits in the field and monthly follow-up meetings with Animateurs and Peer Educators for refresher trainings on topics selected by participants, to discuss the past month's activities and to receive reports. The coop health agents collect data on how many unique individuals were reached with specific health messages and how many people are referred to and

receive health services from local health centers, while health centers collect data on mobile FP,VCT services. SPREAD staff then compiles and analyzes data, which guides implementation.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: **Mechanism Name:** **Prime Partner Name:**	**9212** **SPREAD** **Texas A & M University Norman Borlaug Institute for International Agriculture**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	81,675	

Narrative:

SPREAD works through training cooperative health agents (in coffee and pyrethrum sectors) to educate and try to change behaviors of other farmers and cooperative members in order to prevent HIV and promote sound reproductive and maternal and child health. SPREAD has trained existing coffee extension agents (Animateurs de Café) to integrate health education into their coffee activities, as well as new peer educators, both youth and adult groups, who were selected by their peers in coffee farmers' zones. SPREAD uses a combined curriculum made up of parts of the national MOH module for training community health agents, PSI's Peer Education training module, and Peace Corps' Life Skills manual. These agents deliver BCC sessions for HIV Prevention, Reproductive Health/Family Planning education and Maternal and child health promotion. Animateurs also refer clients to the health center or hospital for needed services, such as VCT, ANC, and FP. The animateurs use IPC in their sessions and meet more than 25 people in one session, while peer educators work on BCC and try to meet between 10-15 people in each session. Every health agent conducts around four sessions per month.

SPREAD's AB component targets youth ages 17-25 with HIV/AIDS prevention and reproductive health

education. The focus is on promoting abstinence and teaching life skills in order to build self-esteem and to enable better use of information in decision making. The adult target group is over 25 years old, and they receive BCC messages which focus on fidelity and condom use for dual protection (HIV/STIs and FP), and the involvement of men in reproductive health care, especially VCT for married couples and during ANC for PMTCT. SPREAD also tries to use multi-media approaches to community mobilization and education, such as community theater and soccer competitions, and health messages integrated into Radio Salus' weekly coffee radio program "Imbere Heza" ("Bright Future"). SPREAD works closely with local partners: PSI's Dushishoze Centers and the Rwanda arm of the International Planned Parenthood Federation (ARBEF) to train cooperative health agents (animateurs, peer educators); and Africare in Nyamagabe to conduct mobile cinema on HIV prevention topics. SPREAD also prints marketing materials, such as t-shirt, bags and umbrellas, to reward and facilitate the work of the cooperative health outreach workers. These materials are also an opportunity to provide BCC messages and to promote SPREAD's integrated approach to health and agribusiness. Currently the slogans aim for integrated agribusiness/health messages: "Good health for coffee development" and "Let's work together for healthy families and strong cooperatives."

Description of Supportive Supervision and Quality Assurance:
For supportive supervision and quality assurance, SPREAD staff work to build agents' capacity to conduct strong outreach and BCC through monthly refresher trainings and field observation during agents' community outreach activities. SPREAD is consistently aiming to refine its M&E system through tools revision and evaluative discussions with USG and local stakeholders.

Indicator Targets:
Targets for sexual and other risk prevention for FY 2010 are to reach 65,000 people with AB/OP messages, 39,000 of which will be primarily receiving AB education. The animateurs and peer educators will spend approximately 60% of their time discussing AB messages and 40% on OP.

New activities for FY 2010, and plans for transition:
The transition plan will be produced through collaboration with partners (local health centers/officials and cooperatives) in which the sustainability activities and roles of each partner will be detailed. Some ideas include integrating health agents into monthly community health worker meetings at health centers and building capacity of cooperatives to help fund and monitor health activities in the field.

Description of capacity building activities:
Since FY 2010 will be the last year of SPREAD, the focus will be on reinforcing existing activities and sustainability plans, such as enabling cooperatives, agribusinesses, community groups and local government/health centers to continue with select health initiatives, such as combined

health/agribusiness extension, mobile services, and community theater and soccer teams.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	86,625	

Narrative:

SPREAD works through training cooperative health agents (in coffee and pyrethrum sectors) to educate and try to change behaviors of other farmers and cooperative members in order to prevent HIV and promote sound reproductive and maternal and child health. SPREAD has trained existing coffee extension agents (Animateurs de Café) to integrate health education into their coffee activities, as well as new peer educators, both youth and adult groups, who were selected by their peers in coffee farmers' zones. SPREAD uses a combined curriculum adapting parts of the national MOH module for training community health agents, PSI's Peer Education training module, and Peace Corps' Life Skills manual. These agents deliver BCC sessions for HIV prevention, reproductive health/family planning education and maternal and child health promotion. Animateurs refer clients to the health center or hospital for services they need, such as VCT, ANC, and FP. The animateurs use IPC in their sessions and meet more than 25 people in one session, while peer educators work on BCC and meet between 10-15 people in each session. Every health agent conducts approximately four sessions per month.

SPREAD's OP component targets youth ages 17-25 with HIV/AIDS prevention and reproductive health education, specifically promoting testing for HIV and STIs and correct and consistent condom use if abstinence is not an option, and teaching life skills in order to build self-esteem and to enable better use of information to improve reproductive health decisions. The adult target group is over 25 years old, and BCC messages focus on fidelity and condom use for dual protection (HIV/STIs and FP), and the involvement of men in reproductive health care, especially VCT for married couples and during ANC for PMTCT. Gender issues and alcohol abuse are significant barriers which the health program would like to help communities work through in order to prevent HIV and promote family health. The health program equips field agents with adequate high-quality IEC and condom demonstration materials, such as wooden penises, condoms, and brochures for educational purposes. In addition, to improving condom availability, SPREAD initiated small kiosks at cooperative offices and coffee washing stations to sell Prudence and the point-of-source water purification treatment (Sûr'Eau).

SPREAD also tries to use multi-media approaches to community mobilization and education, such as Community Theater and soccer competitions, and health messages integrated into Radio Salus' weekly coffee radio program Imbere Heza (Bright Future). SPREAD works closely with local partners, PSI's youth centre Dushishoze and the Rwanda arm of the International Planned Parenthood Federation (ARBEF) to train cooperative health agents (animateurs, peer educators); and Africare in Nyamagabe to

conduct mobile cinema on HIV prevention topics. SPREAD also prints marketing materials, such as t-shirt, bags and umbrellas, to reward and facilitate the work of the cooperative health outreach workers. These materials are also an opportunity to provide BCC messages and to promote SPREAD's integrated approach to health and agribusiness. Currently the slogans aim for integrated agribusiness/health messages: "Good health for coffee development" and "Let's work together for healthy families and strong cooperatives."

For supportive supervision and quality assurance, SPREAD staff work to build agents' capacity to conduct strong outreach and BCC through monthly refresher trainings and field observation during agents' community outreach activities. SPREAD is consistently aiming to refine its M&E system through tools revision and evaluative discussions with USG and local stakeholders. SPREAD tries to maintain strong communication with donors and sub-partners to ensure quality interventions.

Our targets for Sexual and Other Risk Prevention for FY 2010 are to reach 65,000 people with HIV prevention messages. This number is an estimation based on the number of people reached through cooperative health agents' outreach activities in year 1 of the program, taking into account expansion in the Northern and Western Provinces for integration into the pyrethrum sector.

The transition plan will be produced through collaboration with partners (local health centers/officials and cooperatives) in which the sustainability activities and roles of each partner will be detailed. Some ideas include integrating health agents into monthly community health worker meetings at health centers, setting up permanent community condom distribution sites building upon FY 2009 World AIDS Day activities, and building capacity of cooperatives to help fund and monitor health activities in the field.

Since FY 2010 will be the last year of SPREAD, the focus will be on a program evaluation and reinforcing existing activities and sustainability plans, such as enabling cooperatives, agribusinesses, community groups and local government/health centers to continue with select health initiatives, combined health/agribusiness extension, mobile services, and community theater and soccer teams.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9826	**Mechanism Name: HIV/AIDS Reporting System/TRACNet**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: Voxiva	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 990,000	
Funding Source	**Funding Amount**
GHCS (State)	990,000

Sub Partner Name(s)

International Center for AIDS Care and Treatment Programs, Columbia University	Kigali Institute of Science and Technology (KIST)	National University of Rwanda, School of Public Health
Voxiva SARL		

Overview Narrative

GOAL: The ultimate long-term goal of the TRACnet project is to improve quality of care through effective and efficient use of health data by health care providers, program managers and political leaders in Rwanda under the PEPFAR program over five years of implementation.

LINKS TO PARTNERSHIP FRAMEWORK: The overall goal and each of the specific objectives and activities of this project will contribute to the accomplishment to Partnership Framework Goals in Strategic Information.

1. Working with the Government of Rwanda, Voxiva's efforts to Improve data quality in TRACNet will extend automated data quality checks for new modules, support for a data audit and expand the data quality tool developed in FY 2009 with ICAP in order to support the development and implementation of data quality assurance mechanisms.

2. Activities to promote data use will focus on the use of data for monitoring, evaluation, supervision and contribute to the national plan for the promotion of data use. In FY 2010, data use activities will focus on modules introduced in FY 2009, specifically TB and IDSR with courses held by the School of Public Health to build the capacity of health managers to analyze and use these data to enhance program management and response. It should be noted that TRACnet users will be able to leverage GOR and USG efforts to improve IT infrastructure at MOH, TRAC Plus, CNLS and health facilities, making increasing use of more robust infrastructure and connectivity to increase a focus on data analysis and

use, especially at the facility level.
3. Voxiva will also work with TRAC Plus to maintain and upgrade TRACnet, adding a malaria module in FY 2010 and contributing to the implementation of the National e-Health strategy by assuring that data collected by new modules can be exported to the performance-based financing system, integrating with IQ charts and continuing to implement the national and international standards that are adopted by the Ministry of Health.
4. Through all activities, Voxiva will seek to build local human capacity to sustain and expand TRACnet; developing a program of mentorship and in-service and pre-service training based in the School of Public Health and other local institutions, assuring that Rwanda can sustain and build on TRACnet to meet the ongoing needs of the health sector.

GEOGRAPHIC COVERAGE: TRACnet is national in scope. During FY 2010, data will be collected from and feedback provided to all health facilities across the country. It is anticipated that by the end of 2010, there will be more than 2000 trained users routinely accessing the system to monitor and report on HIV/AIDS, TB and Integrated Disease Surveillance and Response (IDSR) Programs.

CONTRIBUTIONS TO HEALTH SYSTEMS STRENGTHENING: TRACnet contributes to strengthening of health systems in several ways:
1. The project supports health systems strengthening in a variety of ways: building a national information system for evidence-based decision making in key areas; human resource capacity building for HIS, use of NIT to improve health care delivery and health data management.
2. The data collected will be availed for enhanced monitoring and supervision of health programs, facilitating the identification of under-performing sites, analysis of performance issues and feedback to sites.
3. Standard reports and dashboards will foster evidence-based management and decision-making at all levels.
4. Training of district level managers will strengthen a key level in Rwanda's decentralized health system.

CROSS-CUTTING PROGRAMS/KEY ISSUES: Human resource capacity building is a critical dimension of the TRACnet program in FY 2010, with the implementation of in-service training programs in the maintenance and use of TRACnet directed at national and district level officials and data managers and the establishment of pre-service training at the School of Public Health. As a complementary activity, Voxiva will continue to work with the GOR to build capacity in the local private sector.

TRACnet will also expand its health-related wraparounds to provide more comprehensive program support by expanding TRACnet to incorporate malaria reporting in FY 2010.

COST EFFICIENCY: In FY 2010, three new modules – IDSR, TB and Malaria – will be making use of the same platform, infrastructure and cost basis of TRACnet, increasing the value and cost-efficiency of the investment in developing the base system.

MONITORING AND EVALUATION: FY 2010 activities and work plan may well be modified to reflect the findings of the external evaluation planned for second quarter in FY 2009. The Technical Support Unit will continue to monitor system usage (number of users, power users, sessions); human capacity development (trainees, skill development); data use (number and distribution of standard reports); and data quality (timeliness and completeness, data audit findings).

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9826**		
Mechanism Name:	**HIV/AIDS Reporting System/TRACNet**		
Prime Partner Name:	**Voxiva**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	990,000	

Narrative:

In FY 2010, Voxiva will work in support of TRAC Plus and contribute to three areas of Strategic Information: HMIS, Monitoring and Evaluation, and disease surveillance, complementing TRAC Plus and Ministry of Health activities under this program area.

The collaborative TRACnet program will pursue an active program with the following objectives:
• Improving data quality: Led by sub-grantee ICAP Columbia, the TRACnet program will support an annual data audit, incorporate automated data quality checks in new modules, and work to achieve >90% completeness and timeliness for the reporting of VCT/PMTCT, TB and IDSR data by the end of FY 2010.

TRAC Plus will be supported to provide supervision to enforce the implementation of standard operating procedures (SOP) and Data Quality Assurance and Improvement tools. Maintenance and updating the master registries (users, health and administrative hierarchies) will continue as an ongoing activity of the Technical Support Unit.

• Promoting data use at health facilities, districts, at national level, and by implementing partners. Users will be trained to create and transmit automated feedback and standard reports for all levels (facility, district, central) for all modules in the system. District data use workshops will be held by the School of Public Health, and the effectiveness of health programs associated with TRACnet will be documented.

• Maintaining and upgrading TRACnet: Within the limits of available resources, Voxiva will continue to maintain and upgrade the TRACnet system in line with the needs and priorities of the Government of Rwanda (GOR) and in support of the TRACnet Sustainability Strategy. The implementation of the 5-year technology road map will continue, enhancing support for HMIS and integrating with priority areas of the national e-Health strategy, with the following as examples of the kind of activities to be supported: Integration of TRACnet with two systems will be operational: PBF (exchanging relevant reports) and OpenMRS (submission of aggregate HIV data). The integration with PBF will be upgraded from a semi-automatic process of reports interchange to automated data exchange using web services. The design of the interface for the integration with IQChart will be developed and implemented in sites where IQChart is used. The requirements for alignment with national ID standards will be specified in collaboration with the National ID Program and under the guidance of the National e-Health Task Force. In subsequent COPs, integration will be carried out to support patient authentication for patient-level interventions. The plan for integration with the National Data Warehouse will be developed with a focus on needs assessment for the interoperability and definition of data interchange standards and interfaces. High level requirements for integration with GESIS will be collected, in line with the plan for strengthening this system. By end of FY 2010, TRACnet will share the same facility and administrative hierarchies and codes with the Community Information System (SIScom).

• Building local human capacity in Rwanda's institutions to collect, manage and use good quality data and to build on and maintain TRACnet to meet the ongoing strategic information needs of the health sector. In FY 2010, Voxiva will undertake SI activities that support specific objectives related to capacity building. During FY 2010, TRAC Plus staff members are expected to be able to handle advanced TRACnet system implementation activities such as development and configuration, business analysis, and infrastructure maintenance. Voxiva will provide the necessary technical assistance for this purpose, while making every effort to ensure that all technical assistance is designed with capacity building components such as a mentoring activity, workshops or some other type of training. In addition, the School of Public Health will build on its successful data analysis and use initiatives focused on hospital officials and district data managers and offer ongoing workshops in analysis and use of Strategic Information.

HMIS

In its first years, TRACnet was operated somewhat independently from the national HMIS. Given that TRACnet was initially introduced in a small number of health facilities offering ART and was only used to collect data for ART indicators that was a justifiable approach. However, it was always clear for the GOR that TRACnet would merge over time with other systems constituting the national HMIS. As the HIV/AIDS program has grown, so has TRACnet to the point where it has achieved a national footprint with coverage of all districts and an active reporting currently from more than half of health facilities that offer ART. In FY 2009, with the national implementation of PMTCT/VCT, virtually all health facilities will be actively reporting into TRACnet. In FY 2009, TRACnet is expected to expand to incorporate Integrated Disease Surveillance and Response (IDSR). In FY 2010, TB and Malaria programs will be added. With this growth, even if harmonization and integration of information systems were not a national policy, it would be imperative to integrate TRACnet with other HMIS systems.

In FY 2009, a technology roadmap is being prepared that will lay out the technical integration of TRACnet and HMIS. Also, in FY 2010, Rwanda is expected to be connected to the submarine high-speed internet cables and will have completed the fiber optic ring linking all districts. As USG and other support for health infrastructure is expanding, all district hospitals and many health centers will enjoy high speed internet connectivity across the wireless communications infrastructure. Higher bandwidths, and more access options and packages for end users will reduce costs and allow many more health officials to use a variety of analytic and other tools available in TRACnet. Therefore, we expect in FY 2010 to be able to put increasing emphasis on on-line training tools and support for power users across the country, while continuing workshops for districts led by the SPH with increasing participation from facility-level users.

Another driver for integration and harmonization is Rwanda's vision for health information and related technologies. Rwanda has articulated a national e-Health strategy that lays out a framework to achieve a national, integrated architecture that serves its citizens and strengthens the health care system. Several advances are underway including a National ID system; the development of an enterprise architecture based on an approach adopted by the Health Metrics Network and comprising key systems such as the national ID infrastructure; centralized data warehouse systems; facility-based HMIS systems; community-based information systems; laboratory and pharmaceutical information systems; hospital systems; financial incentive systems, etc. The facility-based electronic medical record system (EMR) will connect through an integration architecture that can work on multiple channels (Web/internet, phone, mobile phone, PC clients and hand-held smart phones) and become accessible to all participating and authorized systems. By this timeframe, each citizen could access health services anywhere in the country where information about them is readily obtainable by authorized health professionals and made available to systems that need to use it in order to advance service quality.

TRACnet already incorporates several standards likely to be adopted by Rwanda. The first is data

standards. At the moment, Rwanda's health IT systems are focused on key program areas and offer limited but growing support for common data registries, vocabularies and standards. TRACnet will support a core set of data vocabularies and standards, and an extended, program specific set geared towards achieving a target vision of a fully interconnected ecosystem of health IT functionalities. As of the end of FY 2010, the following will be incorporated in TRACnet: disease codes and listing; national ID, shared facility registry and geographic references.

TRACnet will be integrated with other systems. In FY 2009, basic integration with OpenMRS will be available and will allow the exchange of aggregate data and reduce the burden of reporting from sites using this electronic medical record. In FY 2010, we will expand integration with another system – such as IQChart – following the priorities established by CDC and GOR.

Monitoring and Evaluation (M&E)

TRACnet will continue to be used to collect the core facility-based data for TRAC Plus for the monitoring and evaluation of Rwanda's national HIV/AIDS. In FY 2009, the TRACnet Support Unit is forging closer relationships with the M&E group in TRAC Plus. This will continue in FY 2010 with a concerted training and support effort so that the M&E group can make full use of the standard analytic tools in TRACnet and prepare its own reports and charts.

Disease Surveillance

In FY 2010, the roll-out of the electronic Integrated Disease Surveillance and Response (eIDSR) system will be available for all health facilities, providing nationwide electronic surveillance and response capacity. Building on the pre-existing paper system, this will allow Rwanda to leapfrog many of the known problems of implementing and maintaining paper-based IDSR systems and rapidly introduce a number of specific tools and benefits in FY 2010, for example:

• automated tools to enhance data quality (e.g. validation checks, standardized disease list and access to online case definitions via Web and IVR, monitoring timeliness and completeness of weekly reports, reminders for report submission);
• opportunity to review and confirm reports and automated confirmation of report submission;
• automated real time submission and notification of immediately notifiable diseases and other events (such as a maternal death);
• support for supervision and feedback to submitting facility;
• automated aggregation and analytic tools to reduce burden, increase data quality, and facilitate analysis at all levels; and
• significantly reduced cost.

CDC and TRAC Plus may also wish to consider incorporation in FY 2010 of algorithms that Voxiva has

implemented in other settings where they have been proven to be extremely effective for the early detection of disease (for example, CUSUM, X-Bar, and Moving Range). As IDSR moves into widespread use in FY 2010, data quality, analysis and use of IDSR will become a major focus of the project team with the objective of achieving and maintaining > 95% reporting rates for weekly reporting. The School of Public Health will support IDSR in-service training and incorporate pre-service training on this module into its program in epidemiology.

Other
By the end of FY 2010, TRACnet will be supporting routine data collection from every health facility in Rwanda and provide the tools to store and analyze data on all aspects of the HIV/AIDS, TB and malaria programs and IDSR. As recommended in the Notice of Award, in order to achieve these ambitious goals, Voxiva will provide the increasing level of effort needed in three key areas:
• Increased participation of local partners (SPH and KIST) in building local capacity to sustain TRACnet. This shall include international technical assistance and an internship program with such topics as health informatics, system administration, business analysis, configuration and basic development as well as other initiatives to implement the sustainability strategy and human capacity development plan completed in FY 2009. Voxiva will specifically collaborate with KIST to integrate into existing KIST training curricula for the development and maintenance of the TRACnet technology.
• Implementation of the technology roadmap; incorporation of standards and integration/ harmonization of systems in keeping with the national e-Health strategy; and other enhancements prioritized in the roadmap.
• Increased support needed for national implementation of four program areas cutting across all our interventions to assure data quality, data analysis and use, and decentralization of ongoing support to districts and national programs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9965	**Mechanism Name: Strengthening the Capacity of the Ministry of Health**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,252,350	
Funding Source	**Funding Amount**
GHCS (State)	1,252,350

Sub Partner Name(s)

CHUK	NRL	PNILT
TRACnet	UPDC	

Overview Narrative

In 2008, ICAP was awarded a cooperative agreement, Strengthening the Capacity of the Rwandan Ministry of Health (SCMOH), to strengthen the capacity of the Rwandan Ministry of Health (MOH) and district health teams to integrate TB/HIV, provide quality pediatric HIV care, and laboratory support to HIV and TB programs, building on the successes of the UTAP Program. The program emphasizes knowledge and skills transfer to GOR partners to ensure long term impact and builds on earlier successes through the UTAP program. UTAP began in 2003, and included a range of technical assistance to the MOH, including TB/HIV program integration, HIV-related laboratory services strengthening, expanding pediatric HIV care and treatment services, strengthening the capacity of Rwandan nurses to treat PLWHA, and public health evaluations.

In the first year of the SCMOH project, ICAP made significant progress in implementing planned activities. As a new program, the first few months focused on program start up activities, and most importantly, collaborating with key MOH partners on work plans to secure full buy-in to the project and to assure that the activities meet the capacity building and technical assistance needs of the government. ICAP also began recruiting new staff and negotiated subcontracts with key partners. Major achievements thus far include:

1. Supported the national TB/HIV integration Technical Working Group (TWG), including development of a plan of action for 2009
2. Assisted UPDC and TRAC Plus with on-site training in TB screening at 71 non-USG supported care and treatment sites, follow-up supervision, evaluation of TB/HIV standards of care and strengthening of the TB/HIV M&E capacity of the sites teams and district health teams
4. Supported the National Reference Laboratory (NRL) and the two university teaching hospitals (CHUK, CHUB) to improve the lab infrastructure by renovating and equipping the TB labs and defining the minimum package of activities for each level of the lab network

5. Supported NRL with the development of a QA/QC program within the TB lab network by implementing integrated supervision tools and strengthening and expanding existing QC programs
6. Supported CHUK with the development of the concept and work plan for the practical training program in pediatric HIV at the pediatric model center and conducted a first training session in October, 2009 for 9 participants from health facilities in Kigali

This program emphasizes systems strengthening and the transfer of skills and competencies as central components of ICAP's activities. A variety of approaches ensure capacity-building at all levels:
• ICAP staff transfer capacity to the staff and institutions of TRAC Plus, MOH, and partners via technical working groups, meetings, trainings and institutional support.
• Tools and best practices are shared with MOH and other partners including USG and non-USG funded institutions
• The capacity of district health team (DHT) and health facility staff is strengthened via educational and training activities including on-site implementation workshops, supervision and mentoring, and support for evidence-based program and performance management, as well as off-site training to enhance knowledge and skills.

In the second year of the SCMOH program, ICAP continues to strengthen the capacity of TRAC Plus, UPDC and District Health Teams (DHTs) by supporting implementation of a quality assurance approach for TB/HIV and pediatric HIV through decentralized training, supervision and mentoring. Support continues to TRAC Plus to scale up the full package of TB/HIV collaborative activities at sites nationwide. ICAP is providing support to CHUK for expansion of the pediatric HIV practical trainings. In addition, ICAP is currently supporting the laboratory network for improvement of quality control and implementation of new diagnostic techniques for TB diagnosis.

In FY 2010 ICAP will continue to strengthen the capacity of TRAC Plus, UPDC, partner institutions and DHT by supporting decentralized training, supervision and mentoring of TB/HIV integration activities. ICAP will provide continuous support to TRAC Plus and its partners to scale-up the "one-stop" TB service model and routine screening of PLWHA to all TB and HIV service sites nationwide with additional focus on TB infection control. The ICAP TB/HIV and M&E teams will also provide technical support enabling TRAC Plus to fully integrate M&E of TB/HIV services within the national system. In collaboration with TRAC-plus and UPDC, ICAP will continue to organize decentralized evaluation meetings each semester in order to permit the analysis of TB and HIV data and to inform the program at district and national level. In addition, ICAP will continue to collaborate with TRAC Plus and UPDC to scale up implementation of the quality improvement program based on Standards of Care (SOC) evaluation for TB/HIV which will be utilized by DHTs in collaboration with on-site providers.

ICAP will continue to strengthen HIV-related laboratory services by supporting central level labs (NRL, CHUs) and the national laboratory network. This will include support to the TB and HIV lab technical working group to plan, implement and coordinate the national TB and HIV lab activities. Key activities in FY 2010 will be to train TB and HIV lab specialists at the central and peripheral level, and to strengthen implementation of new TB lab techniques introduced in the first and second year of the program to improve the quality of diagnosis. Quality improvement within the lab network will be addressed by supporting supervision, QA/QC program implementation by lab level and specific diagnosis areas. To reinforce the management of the laboratory network, specific support will be provided to NRL to secure the national supply of lab reagents, equipment and consumables, and to improve lab data management and analysis in order to generate accurate lab indicators to monitor the lab program. In FY 2010, ICAP will continue support to NRL for the WHO-AFRO accreditation process for the HIV and TB central level labs.

In addition, in FY 2010, ICAP will continue providing technical assistance to key MOH partners to increase national capacity to provide quality HIV care and treatment services for children. With TRAC Plus and UPDC, ICAP will continue its support of the national pediatric TWG, which includes participation from all implementing partners. ICAP will continue support for the revision of necessary national program tools and job aids and will provide financial support and technical guidance to CHUK on implementation of the practical training program. In addition to support to the TWG, ICAP will provide technical support to UPDC to implement a standardized approach to pediatric HIV care and treatment quality improvement at the district level and to evaluate the system.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9965**
Mechanism Name:	**Strengthening the Capacity of the Ministry of Health**
Prime Partner Name:	**International Center for AIDS Care and Treatment Programs, Columbia University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	123,750	

Narrative:

ICAP is committed to strengthening national capacity to deliver high quality pediatric HIV services through intensive support to TRAC Plus, UPDC and the University Teaching Hospital of Kigali (CHUK), with a focus on training and quality improvement. ICAP gives technical assistance to TRAC Plus through the pediatric technical working group. Another major accomplishment has been the development of an approach for the CHUK national pediatric training center. The first training was organized in October 2009 for 9 participants from different health facilities in Kigali.

In FY 2010, ICAP will continue to support TRAC Plus through a high level Senior Pediatric HIV Advisor to supervise the implementation of the new pediatric care and treatment guidelines, to develop or update related job aids as required, and to plan for the evaluation of its implementation. In addition, support will be provided to TRAC Plus to organize quarterly meetings of the pediatric HIV technical working group to share lessons learnt by different partner institutions in pediatric program implementation; to promote harmonization, standardization and quality improvement of pediatric care; and to jointly seek solutions for identified challenges.

ICAP will continue to support 2 additional staff at CHUK (Pediatric HIV Training Officer and Pediatric HIV Nursing Officer). In addition, ICAP has a direct sub-agreement with CHUK for organization of practical training sessions on pediatric HIV care and treatment for multidisciplinary teams from district hospitals and health centers. 9 practical training sessions will be organized during FY 2010. Each session will accommodate 9 members of 3 different multidisciplinary teams from district hospitals and health centers nationwide. The cadre of pediatric nurses at CHUK will train staff from clinical sites on issues related to testing children in various clinical settings, on counseling children's parents as well as on HIV diagnosis disclosure for older children. In addition, Columbia University will support CHUK in establishing a library and in gaining access to scientific journals on pediatric HIV care and treatment. A group of physicians from the CHUK pediatric HIV model center will provide long-distance mentoring, discuss the management of difficult cases with district hospital staff, and serve as an on-site training resource for health care providers from the various districts hospitals and health centers. This assistance is expected to improve the clinical skills of health professionals managing pediatric HIV cases at the peripheral level. ICAP will also support a stakeholders gathering to develop and implement a CHUK training evaluation plan so as to assess progress made, identify challenges and ways for improvement.

ICAP will also continue to provide support to UPDC through the District Support Specialist and the Pediatric HIV District Support Nursing Officer to strengthen implementation at district and site level of a

quality approach using pediatric HIV standards of care evaluation. Training in the quality assurance approach will be carried out for 10 DHT, followed by intensive supervision and site support by the UPDC teams in collaboration with ICAP.

ICAP will also work with TRAC Plus, UPDC and CHUK to train and supervise a cadre of TRAC Plus and UPDC mentors who will be critical in harmonizing the approach of pediatric HIV care best practices for all the sites, and continuously improve overall pediatric care quality throughout the country.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	321,750	

Narrative:

ICAP is committed to strengthening national capacity to deliver high quality pediatric HIV services through intensive support to TRAC Plus, UPDC and the University Teaching Hospital of Kigali (CHUK), with a focus on training and quality improvement. ICAP supported the drafting of terms of reference for the national pediatric HIV working group. Another major accomplishment has been the development of the approach for the CHUK national pediatric training center, and the first training was organized in October 2009 for 9 participants from different health facilities in Kigali.

In FY 2010, ICAP will continue to support TRAC Plus through a high level Senior Pediatric HIV Advisor to supervise the implementation of the pediatric care and treatment guidelines, to develop or update related job aids as required, and to plan for the evaluation of its implementation. In addition, support will be provided to TRAC Plus to organize quarterly meetings of the pediatric HIV technical working group to share lessons learnt by different partner institutions in pediatric ART program implementation; to promote harmonization, standardization and quality improvement of pediatric treatment; and to jointly seek solutions for identified challenges.

ICAP will continue to support 2 additional staff at CHUK (Pediatric HIV Training Officer and Pediatric HIV Nursing Officer) in addition to a direct sub-agreement with CHUK for organization of practical training sessions on pediatric ART for multidisciplinary teams from district hospitals and health centers. 9 practical training sessions will be organized during FY 2010. Each session will accommodate 9 members of 3 different multidisciplinary teams from district hospitals and health centers nationwide. The cadre of pediatric nurses at CHUK will be used to train staff from clinical sites on issues related to testing children in various clinical settings, on counseling children's parents', and on HIV diagnosis disclosure for older children. A group of physicians from the CHUK pediatric HIV model center will provide long-distance mentoring support, discuss management of difficult cases with district hospitals staff, and serve as on-site training resource for ART providers from the various districts hospitals and health centers. This

assistance is expected to improve the clinical skills of health professionals managing pediatric HIV cases at the peripheral level. ICAP will also support a stakeholders gathering to develop and implement a CHUK training evaluation plan so as to assess progress made, identify challenges and ways for improvement.

ICAP will also continue to provide support to UPDC through the District Support Specialist and the Pediatric HIV District Support Nursing Officer to strengthen implementation at district and site level of a quality approach using pediatric HIV standards of care evaluation. Training in the quality assurance approach will be carried out for 10 DHT, followed by intensive supervision and site support by the UPDC teams in collaboration with ICAP.

ICAP will also work with TRAC Plus, UPDC and CHUK to train and supervise a cadre of TRAC Plus and UPDC mentors who will be critical in harmonizing the approach of pediatric ART best practices for all the sites, and continuously improve overall quality of pediatric treatment throughout the country.

ICAP will continue to support Quality Improvement with a review of indicators, medical dossiers and viral load measurements to develop and strengthen clinical capacity for more efficient and quality-assured patient management. ICAP will ensure participation of health center and country program staff in District Health Team meetings for better collaboration. ICAP will work with the National Reference Laboratory to expand the diagnostic resources for HIV at the sites. ICAP will also work to improve reporting linkages with CAMERWA and continue mentoring health center staff to strengthen their ability to receive, manage, and forecast the needs for ARVs.

5. Columbia University Mailman School of Public Health/MCAP

In FY 2009, ICAP has been supporting pediatric HIV care at 46 sites in the western province, in Kigali region and in Huye district in Rwanda. Site support included staff training and mentoring on identification HIV-positive children at various entry points of care, their enrolment in care and treatment program, and long term follow-up. In addition, ICAP site-support teams have been providing guidance to sites for the strengthening of their care system: patient flow, delivery of a standardized package of care at follow-up visits, regular multidisciplinary team meetings, appropriate documentation of pediatric care practices, and regular use of a standards of care (SOCs) tool to monitor progress in delivering quality care for children. By September 2009, 4,027 children were enrolled in care, including 2,172 children on ART.

In FY 2010, ICAP will continue to collaborate with the district to ensure refresher training of health care providers on pediatric HIV treatment at the 46 supported sites. This will include, among other topics related to pediatric HIV treatment, the new national pediatric ARV treatment guidelines, identification and

management of ART failure cases, and psychosocial support to children, adolescents and their families for ART adherence.

ICAP pediatric and clinical advisors will be carrying out monthly site visits for staff mentoring during which support will continue to be provided for the strengthening of the care system and of children support groups activities, and for the active tracking of follow-up defaulters. ICAP will also be providing support to sites for the appropriate documentation of pediatric HIV treatment practices, for the use standards of care tools to monitor progress in delivering quality care to children, as well as for regular multidisciplinary meetings to discuss SOCs findings and to address identified challenges.

All these activities will be contributing to the site maturation process that will be monitored through global SOCs scores and an assessment of the capacity of health care providers to design interventions to address identified challenges. FY 2010 starts the first year of transition of TRAC 1.0 partners' activities. ICAP-CU AIDS will transition to the Ministry of Health (MOH) XXXX HIV care and treatment sites which will be selected based on their demonstrated capacity to continue implementing high quality care for children with minimum support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	410,850	

Narrative:

Since 2004, ICAP has provided financial and technical support to the National Reference Laboratory (NRL) and to the entire national laboratory network to improve laboratory infrastructure and capacity for TB and HIV/AIDS testing, care and treatment.

In FY 2009, through ICAP's long-term Lab advisors placed at NRL, comprehensive technical assistance and implementation support has strengthened essential elements of the laboratory system and improved the quality and consistency of services. ICAP has conducted assessments of laboratory services and together with district health teams (DHTs) and NRL supervisors have conducted training of laboratory staff both offsite and onsite trainings that included ART laboratory monitoring, equipment operation and preventive maintenance, comprehensive laboratory tests including TB microscopy and early infant diagnosis (EID) using dried blood spot (DBS) samples for DNA PCR.

The National Reference Laboratory and two referral laboratories located in Rwanda (Kigali University Teaching Hospital (CHUK), and Butare University Teaching Hospital (CHUB)) are being equipped to perform more complex testing such as TB culture, TB molecular diagnostics (PCR), TB drug susceptibility testing and identification of Mycobacterium Avium Complex (MAC) and other atypical

mycobacteria. In FY 2010, ICAP will continue to provide technical assistance to the 3 labs in ensuring the development of the required capacities for using these new technologies. In addition, the NRL and the two referral laboratories will oversee the training and supervision of TB-related activities in the lower tier labs to improve the quality of microscopy-based diagnostic tests. A joint approach has been developed for specimen transportation from the lower tier labs to the reference laboratories for TB culture and other specialized tests.

In FY 2010, ICAP will continue to provide technical assistance in conducting training at NRL, CHUK and CHUB for TB solid and liquid culture, molecular diagnostic (PCR) detection of MDR-TB and the identification of MAC and other atypical mycobacterium as the demand is expected to grow in FY 2010 with scale-up of active TB case findings among PLWHA and their families. ICAP will provide technical assistance to conduct 2 refresher courses planned for staff of NRL, CHUK and CHUB in the new TB diagnostic techniques.

ICAP will provide technical assistance to strengthen and expand quality assurance (QA) programs within the laboratory network in both international and national EQA programs, to support continuous improvement via on-site supervision, coaching and mentorship and by revising and implementing SOPs, log books and documentation and records. ICAP will continue to provide technical and logistic support to implement and expand systems for specimen transportation among testing health centers, district hospitals and referral hospitals.

ICAP will continue to provide technical support to strengthen laboratory management towards accreditation of the higher tier of laboratories: NRL, CHUK, CHUB, King Faysal Hospital and Kanombe Military Hospital. To assist in having a relevant data management system at the central level of the lab network, ICAP will provide assistance to the NRL and APHL to support the implementation and decentralization of the LIS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	396,000	

Narrative:

In FY 2009, Columbia continued to implement the national TB/HIV policy and guidelines at 44 ICAP supported sites including 2 state prisons. The program's achievements in 2008, 98% of all patients with TB were tested for HIV, 91% of all infected patients received Co-trimoxazolepreventive therapy and 46% received ART. At 44 MCAP-supported HIV care and treatment sites, 93% of patients newly enrolled in HIV care in 2008 were screened for TB.

In FY 2010, Columbia will continue to support 46 existing sites and add 10 new sites for the implementation of the TB/HIV component of the clinical package of HIV care. The priority in FY 2010 will be to expand HIV testing to all TB suspects and enroll those positive in HIV care and treatment, expand implementation of regular TB screening for all PLHIV, and for those suspected to have active TB, ensuring adequate quality diagnosis and complete treatment with DOTS.. In FY 2010, Columbia will continue to support individual sites to continue early case detection, quality case management and follow-up. In addition, in FY 2010, ICAP will support scale up of the implementation of the TB infection control policy as well as the national PIT policy at ICAP supported ART sites. ICAP will ensure high quality recording of individual patient information, collect quality data, and to report and review these data. ICAP will then use program data to understand and improve their program and to support integration of TB and HIV services at the patient and facility level based on national guidelines. Efforts will be made to progressively transition the supervision and mentoring of the TB/HIV activities at site level to the district teams. This will be done through a collaborative approach based on evaluation of TB/HIV standards of care, district evaluation meetings and supportive supervision and mentorship of the district team.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9971	**Mechanism Name: American Society for Clinical Pathology**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Society of Clinical Pathology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 297,000	
Funding Source	**Funding Amount**
GHCS (State)	297,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Since 2008, the American Society for Clinical Pathology (ASCP) has worked closely with the USG team in Rwanda, the Rwandan Ministry of Health (MOH) and Kigali Health Institute (KHI) to assist in improving patient care by providing in-service and pre-service training to strengthen laboratory systems and infrastructure in Rwanda. ASCP has trained laboratorians in the areas of hematology to improve their skills on the bench. Over the past two years ASCP has also assisted in the pre-service program for laboratorians in Rwanda. This year is the first year that in-coming students to KHI's Biomedical Laboratory Sciences program are being taught with a new curriculum that ASCP assisted in creating.

During FY 2009, ASCP continued to work with KHI by providing an external examiner for technical assistance in the examination process to evaluate students and the overall program and with a second faculty mentorship planned for the spring of 2010. ASCP will also be working with five laboratories including the National Reference Laboratory (NRL) to begin preparing for WHO accreditation. ASCP will help prepare the laboratorians through the first two Strengthening Laboratories Towards Accreditation (SLMTA) trainings as well as hands-on mentoring. In FY 2010, ASCP will complete the third of three SLMTA trainings and directly mentor laboratory faculty prior to the first WHO assessment. ASCP will also work with the NRL on strengthening human resource capacity through laboratory management, chemistry, hematology and phlebotomy trainings. ASCP will continue to work with KHI on effectively implementing the new curriculum through mentorship and build faculty and program capacity.

As part of the sustainability and transition priorities highlighted in the second phase of PEPFAR, ASCP is committed to implementing an engagement plan with Rwanda. The activities planned for FY 2010 promote a more sustainable approach; which emphasizes building capacity, ownership and leadership in Rwanda. The intention of ASCP's efforts is to better position the Ministry of Health to assume primary responsibility for the national response to HIV/AIDS laboratory programs with ASCP playing a supportive role.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9971**		
Mechanism Name:	**American Society for Clinical Pathology**		
Prime Partner Name:	**American Society of Clinical Pathology**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	297,000	

Narrative:

Since 2008, the American Society for Clinical Pathology (ASCP) has worked closely with the USG team in Rwanda, the Rwandan Ministry of Health (MOH) and Kigali Health Institute (KHI) to assist in improving patient care by providing in-service and pre-service training to strengthen laboratory systems and infrastructure in Rwanda. ASCP has trained laboratorians in the areas of hematology to improve their skills on the bench. Over the past two years ASCP has also assisted in the pre-service program for laboratorians in Rwanda. This year is the first year that in-coming students to KHI's Biomedical Laboratory Sciences program are being taught with a new curriculum that ASCP assisted in creating.

During FY 2009, ASCP continued to work with KHI by providing an external examiner for technical assistance in the examination process to evaluate students and the overall program and with a second faculty mentorship planned for the spring of 2010. The NRL will identify areas of need and partner ASCP in assisting 5 laboratories in pursuit of WHO-AFRO accreditation. ASCP will also be working with five laboratories including the National Reference Laboratory (NRL) to begin preparing for WHO accreditation. ASCP will help prepare the laboratorians through the first two Strengthening Laboratories Towards Accreditation (SLMTA) trainings as well as hands-on mentoring. In FY 2010, ASCP will complete the third of three SLMTA trainings and directly mentor laboratory faculty prior to the first WHO assessment. ASCP will also work with the NRL on strengthening human resource capacity through laboratory management, chemistry, hematology and phlebotomy trainings. ASCP will continue to work with KHI on effectively implementing the new curriculum through mentorship and build faculty and program capacity.

As part of the sustainability and transition priorities highlighted in the second phase of PEPFAR, ASCP is committed to implementing an engagement plan with Rwanda. The activities planned for FY 2010 promote a more sustainable approach; which emphasizes building capacity, ownership and leadership in Rwanda. The intention of ASCP's efforts is to better position the Ministry of Health to assume primary responsibility for the national response to HIV/AIDS laboratory programs with ASCP playing a supportive role.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9978	**Mechanism Name: ROADS II**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,795,265	
Funding Source	**Funding Amount**
GHCS (State)	2,795,265

Sub Partner Name(s)

Abishizehamwe: Bugarama PLHAs Clstr Comm Pall Prog	ADESPCR: Kigali Youth Cluster HIV/AIDS Program	ASOFERWA: Kigali Low Income Wmn Cluster HIV/AIDS Prog
ASSETAMORWA: Kigali Motorcyclists' HIV Prev Prog	Bugarama Islamic Health Center	Byumba Diocese: Gatuna Church Clstr for Comm HIV
CODEPEK: Rusizi Fishers' Federation HIV/AIDS Program	COFEM: Rusizi low income HIV/AIDS Program	COODIPRIB-Duteraninkunga: Bugarama Low income HIV/AIDS
DAI -Support to Lifeworks	Gihogwe Health Center: Gatsata Mobile C&T	Howard University - Support to Rwanda Pharmacist Association
JHPIEGO SA	JHU/CCP- Support to AFRICOMNET and Community Mobilization for FP	Ngoboka Dufatanye Rusizi PLHAs Cluster Comm.
North Star Foundation- Support to Willness center	Program for Appropriate Technology in Health	Rubaya Health center -- ART, C& & FP/MCH
Rusizi Health Center St Francois: Outreach C&T svcs	Solidarity Centre - Support to ACPLRWA	TBD

Overview Narrative

The Roads to a Healthy Future (ROADS II) Project-a five-year Leader with Associate award managed by FHI-extends HIV prevention, care, and support services to most-at-risk population (MARPs) in underserved, often remote communities. The project targets high-risk groups: drivers and their assistants and community with whom they interact such as sex workers, in street youth, members of the uniformed services and stop-over site communities that includes in and out of school youth, low income women, fishermen and fish sellers, motorcyclists, PLWHA, OVC and other community members living in those hot spot areas. ROADS II currently works in four Rwanda corridor communities: Kigali City, Gatuna (Uganda border); Rusizi (DRC border); and Bugarama (intersection of DRC, Rwanda, and Burundi). The project plans to add up to two sites, including Gisenyi. There are plans to extend activities implementation to Rusumo site bordering with Tanzania border. The focus will be to target the areas where the new HIV infections are mostly occurring

The overall goal of ROADS II is to stem HIV transmission and mitigate its impact among the most-at-risk populations while leaving communities stronger in their ability to address HIV. ROADS II also improves and extends FP and MCH services in target sites. To support these goals, ROADS II has the following primary objectives: (1) Develop and implement effective programs that increase services in prevention, care and treatment for HIV/AIDS, malaria, FP/RH and child survival. Services will be delivered to individuals who live/work along the transport corridors that link Rwanda to other countries in the region, as well as those residents in border towns, areas generally without access to high quality services and (2) Increase the capacity of local Rwandan organizations to respond to the health issues affecting their communities, with approaches that are innovative and appropriate and solutions that are locally relevant and sustainable.

ROADS II activities include community-based alcohol counseling, interventions to address SGBV, and job creation as an HIV prevention and care strategy, particularly focusing on MARPs. Building on work initiated under FY 2009, ROADS II will continue to strengthen skills in reduction of risk behavior, increasing quality treatment of STI through STI screening and treatment among MARPs. Furthermore the project will continue to support people infected and affected by HIV/AIDS by improving economic opportunities and social protection, promoting nutrition and food security by increasing vegetable farming through kitchen gardens and ensuring social protection for orphans and vulnerable children. ROADS II will expand interventions to more MARPs groups in Kigali beyond the transport corridor including street youth. ROADS II will also continue to market the SafeTStop concept, which uses consistent but adapted strategies, branding and materials across countries to reach MARPs as they move from country to country, to signal availability of quality services, including those provided through private drug shops and pharmacies.

The LifeWorks Partnership, an innovative strategy that was developed under the first ROADS project's

award, is contributing significantly to the increase of income for vulnerable groups. It is designed to provide small business services to local community associations and cooperatives. LifeWorks works with the private sector to create and provide opportunity for small community groups to have access to income generating activities and markets for their products. ROADS II supports the Government of Rwanda's (GOR) National HIV/AIDS plan and, through successful program implementation, intends to significantly contribute to halving the incidence of HIV by 2010, reducing morbidity and mortality among people living, and ensuring equal opportunities to those infected or affected by HIV, while also supporting the GOR's efforts to scale-up FP/RP and maternal child health (MCH) services.

Under this Associate award, ROADS II contributes to health systems strengthening. ROADS II has strengthened capacity of more than 300 community groups to manage HIV programming. This included training in process indicator reporting, data analysis, monitoring and evaluation, as well as financial management. ROADS will continue to provide TA in capacity development for association management, sub-agreements and community mobilization.

ROADS II M&E framework includes qualitative and quantitative data collection by volunteers, validated at the cluster level -Implementing agency, and validated at the second level by the ROADS II site coordinators in collaboration with PLWHA volunteers, cluster steering committees members, cluster coordinators and clinical care sites. ROADS II will collect relevant quantitative data using its reporting structure and integrate it into its existing database. Through case studies and success stories, the project will document person-level impact. ROADS II will also conduct focus groups with beneficiaries, different volunteers of the program and community leaders to assess the quality and impact of the support provided. Formative supervisory visits will be provided to local implementing partners as part of the routine monitoring and review mechanism. Best practices and lessons learned will be monitored and shared with other partners for possibility of bringing them to scale. The data will be used for local planning, budgeting, management, and decision-making.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	30,000
Economic Strengthening	300,000
Education	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	100,000
Human Resources for Health	40,000

Water	50,000

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities
Mobile Population
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**9978**		
Mechanism Name:	**ROADS II**		
Prime Partner Name:	**Family Health International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	247,500	

Narrative:

During FY 2009, ROADS II's CBO partners continued to expand and strengthen care and support activities along the transport corridor, working at Gatuna (Rwanda /Uganda border), Kigali, Gisenyi, Rusizi, and Bugarama (Rwanda/DRC/Burundi border). With support from FHI/ROADS II, local partners provided community care and support to 2,610 PLWHA at 14 facilities, achieving 131% of the year targets. This work improved the quality of life for PLWHA by mitigating the health and socio economic effects of HIV/AIDS at individual and household level. Through home visits, 157 trained volunteers carried out activities including: provision of psychosocial support to PLWHA; formal and informal education on HIV prevention; adherence counseling; nutrition counseling and education on the importance of a balanced diet; life skills development; increased access to prevention and treatment of opportunistic infections; and referrals to home-based care services and health facilities. To respond to food insecurity among vulnerable PLWHA, FHI/ROADS II worked with a local agronomist identified at the sector level to improve agriculture technology. At the end of the reporting period, 1,587 PLWHA families

had established kitchen gardens to improve vegetable production and 6,982 PLWHA family members are benefiting from this support. PLWHA clusters have mobilized communities to support the most vulnerable PLWHA and as a result, 425 PLWHA have received direct nutrition and other support, including items such as clothes, sugar, food and sosoma (flour, soya, wheat, maize and sugar). The project uses a family-centered approach to care, sensitizing and referring family members for counseling and testing, and other needed services.

In FY 2010, FHI/ROADS II will provide 7,500 eligible adults and children with at least one care service at one of its five sites. During FY 2010, ROADS II will strengthen its LifeWorks program, under the rationale that economic strengthening, coupled with appropriate HIV/AIDS education can enable people to make positive decisions regarding their own HIV-behaviors. When appropriate, LifeWorks interventions will also aim to promote community volunteerism.

In FY 2010 FHI/ ROADS II will continue to apply the "Safe T Stop model" at its five current sites and expand the program to Rusumo as well. Through partners, ROADS II will train additional volunteers in basic palliative care, including counseling on hygiene and ART adherence, as well the provision of referrals for clinical services, various forms of support (psychosocial, spiritual, and social), and preventive services including reproductive health services and family planning. ROADS II will offer technical support to volunteers, providing them with condoms, safe water tablets (Sûr'Eau), safe water vessels, and mosquito nets to be distributed to the families of PLWHA. The project will also continue to support economic empowerment through household vegetables gardens and the LifeWorks program, which will enhance self -sufficiency clients and caregivers. In addition, the project will continue to help PLWHAS access health services by paying health insurance premiums for the most vulnerable individuals.

The implementation of activities will fit into the overall ROADS II M&E framework. Qualitative and quantitative data will be collected by the volunteers, validated at the cluster level and validated in collaboration with PLWHAs volunteers, cluster steering committees members, cluster coordinators and clinical care sites. ROADS II will collect relevant quantitative data using its reporting structure and integrate it into its existing database. Through case studies and success stories, the project will document person-level impact. ROADS II will also conduct focus groups with beneficiaries, PLWHAs volunteers and community leaders to assess the quality and impact of the support provided. Formative supervisory visits will be provided to local implementing partners as part of the routine monitoring and review mechanism. Best practices and lessons learned will be monitored and shared with other partners to determine the feasibility of scale-up. A data collection and analysis system will establish to measure and follow progress and results. Baseline data will be collected in FY 2010 and compared with annually-collected data subsequently. The monitoring and evaluation system will track several risky behaviors, including multiple partnering, use of condoms, incidence of sexually transmitted infections, as well as a

number of health-seeking behaviors. Results will be compared against economic process indicators to test the hypothesis that a positive change in household income, if set within wider HIV programming, can contribute to securing the basic needs for PLWHA and lead to positive behavior change.

In line with the Partnership Framework objectives, FHI is building the capacity of local organizations in program management, skills acquisition, quality improvement and M&E to ensure sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	316,800	

Narrative:

In FY 2009, FHI/ROADS II partners provided technical support to local community-based partners and ensured that services and support for OVC was strengthened at four sites: Kigali city; Gatuna (Uganda border); Rusizi (DRC border on Bukavu side); Bugarama (intersection of DRC, Rwanda and Burundi). Key activities carried out by the caregivers through home visits included: efforts to improve health care, food and nutrition support;, education of tutors on the importance of balanced diets; psychosocial support; education on HIV prevention; and child protection through children rights education. As of the end of September 2009, a total of 1,703 OVC were served by the local community members. Among them, 1,067 OVC were visited by caregivers to complete the child status index (CSI) developed by the Ministry of Gender and Family Promotion (MIGEPROF). A total of 961 OVC received direct assistance, which included educational support (i.e. school fees payment and material provision), enrollment and payment into the government insurance program, psychosocial support through holiday events, and home visits by OVC care givers. The quality of OVC services offered by the program was assessed using the CSI.

In FY 2010, FHI/ROADS II plans to extend activities in Gisenyi (it's fifth site) and continue to support activities initiated in previous fiscal years. Through community cluster networks, ROADS II will provide 4,000 OVC with at least three services and continue to strengthen the capacity of households and local community groups to ensure program effectiveness. Services will be linked closely through a strong referral network including health facilities, CBOs, FBOs, and local NGOs to meet the daily needs of OVC. This referral network is a key strategy for transition. To address the longer-term needs of orphan-headed households, ROADS' lifework partnership will conduct a baseline assessment to identify new economic opportunities, conduct job training for job creation, and develop other economic opportunities for OVC families and care givers. The kitchen gardening for vegetables and rabbit-farming activities initiated under previous fiscal years to ensure food security and alleviate financial instability will be reinforced. The platform for delivering services will continue to be the cluster model, which brings together community based partners in a coordinated response, with joint capacity building to care for vulnerable children. In

FY 2010, FHI/ROADS II will collaborate with the local authorities to reinforce the committee for OVC at sector and cell levels. This will help local authorities ensure sustainability.

Monitoring and Evaluation: The activities of this project fit into the overall ROADS II M&E framework. Qualitative and quantitative data will be collected by the volunteers, validated at the cluster level (implementing agency) and validated at the secondary level by the ROADSII site coordinators in collaboration with OVC caregivers, cluster steering committee members and cluster coordinators. ROADS II will collect relevant quantitative data using its reporting structure and integrate it into its existing database. Through case studies and success stories, the project will document person-level results as well as impact achievements. ROADS II will also conduct focus groups discussions with beneficiaries, OVC caregivers and community leaders to assess the quality and impact of the support provided. The child status index (CSI) initiated during FY 2009 will continue to be used to evaluate the program vis-à-vis OVC needs. Formative supervisory visits will be provided to local implementing partners as part of the routine monitoring and review mechanism. Best practices and lessons learned will be monitored and shared with other partners for possibility of bringing them to scale. The data will be used for local planning, budgeting, management and decision making.

In FY 2010, ROADS II will build the capacity of the Sector Social Affairs Officers in OVC data management and OVC care and support, as well as encouraging them to establish the OVC committee to take care all OVC matters. ROADS II will also strengthen its Lifeworks component, under the rationale that economic strengthening, coupled with appropriate HIV/AIDS education can enable people to make meaningful decisions regarding their own HIV-behaviors as well as to respond to the basic needs. Where appropriate, Lifeworks interventions will also aim at sustaining community volunteerism.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	346,500	

Narrative:

From July 2007 to September 2009, ROADS II worked with the existing health facilities to introduce an innovative strategy to identify those who are most at risk for HIV and have less access to existing HCT services. HCT services have been either integrated in the established recreational centers or outreach strategy from the fixed HCT service was used. At the end of September, ROADSA II supported five HCT outlets to provide counseling and testing services to targeted high risk groups in five sites. The community mobilization and sensitization through cluster model generated significant interest and demand for HCT at upgraded facilities. In total, the five HCT outlets served 29,315 people who were counseled, tested and received test results. In general, the HIV prevalence was high among people tested especially among those self-identified as at risk (15%): sex workers and truckers. The results

show outreach HCT in high risk environments is a key strategy to reach men (10,824 female verses 14,740 male). All tested HIV positive were referred to clinical services for care and support. FHI/ROADS II ensured quality assurance by applying the national guidelines. In addition, all HCT providers have been trained based on the national standards and requirements. Regular supervisions have been done by the district hospital supervisors and all qualified staff from the health facilities support by FHI technical staff.

During FY 2010, ROADS II will continue to extend HCT services and will integrate services in the newly established recreational centers. The strategy for offering HCT at later hours will continue. One of the new strategies will be home-based HCT once TRAC Plus begins implementation of finger-prick testing. Testing all family members will be the entry point to referring for the full menu of health services, including child survival, FP/RH, malaria prevention and treatment, PMTCT, TB and pediatric care and treatment. The second strategy will be to focus on high risk groups/zones identified by the community by using the checklist criteria that will be developed for that purpose. Building on the new strategy of identifying and managing STI patients that ROADSII will set up during FY 2010, all STI patients will be identified and counseled for HIV testing. All of those new strategies will be developed with direct beneficiaries to minimize or reduce stigma. These new strategies will be developed in close collaboration with TRAC Plus and local health facilities to insure sustainability. In total, ROADS II plans to reach 15,000 individuals with HCT services in 7 HCT service outlets.

Activities will be implemented in the sites of Kigali city, Gatuna, Rusizi, Bugarama, and Gisenyi. ROADS II will facilitate on-going monitoring of HCT service delivery. Monitoring and supervision of the HCT sites will help understand client profile, target high risk groups, ensure uniform high quality, obtain on-going feedback for program staff, and track progress towards increased service provision. In addition, data analysis of monthly reports will help to measure progress towards achieving objectives. Regular M & E will include the following activities: 1. Client Profile- A client intake form and a register will gather key information about HCT clients, and will be analyzed each month to obtain regular information about the profiles of clients accessing services. In addition, ROADS II will also use a register to note all clients. A client exit form will be used in each mobile HCT unit with results analyzed on a semi-annual basis to assess client satisfaction. Each client will be asked to fill the exit form, but it will be voluntary. Information will be examined every six months; for quality control reasons, 10% of all lab samples from clients will be sent to the National Reference Laboratory for verification.; 2. Quality Assurance-Quality of services is important to client utilization of HCT, it will be essential to assess the quality of the services being offered at outreach HCT sites.

In order to ensure a high quality of services, a technical staff from the health facility will supervise and conduct a weekly visit and feedback meeting with the HCT counselors. In addition, technical staff from

FHI Country office and the district hospital will visit the outreach HCT sites once a quarter to ensure that each site is adhering to standardized protocols and procedures, harmonized quality standards and to receive feedback from local partners. A supervision guide for HCT sites will be used for this purpose. Feedback will be provided to program staff on how to improve quality of service delivery. All HCT sites will report monthly on quantitative data for HCT; FHI will report to the Mission both quantitative data and narrative on activities undertaken during the reporting period; semi-annual reports will evaluate achievements against PEPFAR targets (i.e. progress indicators). The regular analysis of client intake forms, quality assurance activities, and site supervision visits will ensure a high quality of services and on-going improvement counseling to meet the specific needs of the clients. The data gathered will be analyzed at the end of the project to evaluate the overall impact in terms of increased access and HCT client-uptake, high risk targeting, and quality of services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	198,000	

Narrative:

At the end of FY 2009, FHI/ROADS II provided technical assistance to 338 community based organization through 13 established community clusters. To build the capacity of those clusters, FHI hired technical staff such as program coordinators and accounts for the clusters. Each cluster has now established steering committees to better coordinate the implementation of activities. FHI provided technical assistance to each team in financial and human resources management, governance, record keepings, conflicts resolution, procurement and inventory. Clinical based partners who are providing HCT, STI care and treatment were also strengthened in the same areas, with extra attention paid to quality assurance. Health service providers were hired through direct sub-agreements to support service delivery when applicable.

In total, FHI/ROADS II supported 47 training sessions during the fiscal year 2009 in which 1,483 individuals participated, including 746 cluster members, peer educators and PLHAs caregivers. These training addressed community mobilization for HIV prevention, as well as care and treatment issues. A total of 315 OVC caregivers and 47 primary school teachers were also trained. Furthermore, 24 religious leaders were trained in SGBV and family planning, and 19 cluster members were trained as trainers in Magnet Theater. Finally, 71 low income women were trained as trainers in mushroom farming as a strategy for income generation.

To ensure sustainability and transition, the following mechanisms have been put in place: establishment of community clusters; continuous involvement in programming and implementation; partnership with the local authorities; provision of technical support to clusters to hire qualified staff; training of technical staff

and steering committee members in governance; monitoring and evaluation; and financial and human resources management.

Despite these efforts, implementing agencies still face major challenges, particularly in program and financial management, monitoring and evaluation and data utilization. In addition, there is a need to build the capacities of the new partners who will implement the new strategy of providing comprehensive HIV intervention to MARPs.

During the FY 2010, activities supported by FHI/ROADS II will be designed to continue and strengthen on-going effort and to respond to the new needs. FHI/ROADS II will continue to apply the cluster model which permits extensive stakeholder participation in identifying priorities and delivering a locally-relevant set of responses. The stakeholders' participation to the decision making, planning and execution of activities ensures an appropriate response to local needs and leads to program sustainability.

FHI/ROADS II will continue to provide technical support to implementing partners building their capacity to institute and manage HIV prevention and care activities in their communities. ROADS II is instrumental in providing technical guidance around HIV in the transport sector, and will work closely with TRAC Plus and other GOR institutions to incorporate alcohol and GBV issues into HIV programming for MARPs.

FHI/ROADS II has established strong linkages with local authorities, which contributed significantly to achievements thus far. For example, local authorities took a lead in the establishment of recreational centers, providing the land and contributing to the support of cooperatives in strengthening the Lifeworks initiative. In most of the trainings supported by FHI/ROADS II, implementing partners are using the sectors' facilities free of charge. In addition, some supported anchor leaders are serving on district or sector recreational center advisory councils.

During the FY 2010, FHI/ROADS will continue to work closely with local authorities and partners, in addition to collaborating with other donors. To ensure the sustainability of outreach HCT activities, FHI/ROADS II will continue to support existing health facilities in close collaboration with district hospitals.

Training remains the cornerstone of ROADS II. In FY 2010 at least 1,400 individuals will be provided with technical assistance for various HIV-related activities, and more than 360 organizations will receive institutional support for community mobilization, care, and treatment efforts. To improve the services provided to street youth, particularly those who are HIV positive, ROADS II will strengthen the capacity of local organizations improve outreach efforts through direct sub-agreements.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVAB	770,715	

Narrative:

FHI/ROADS II, addresses HIV prevention, care and treatment activities reaching most-at-risk populations located and moving along the transport corridors in Rwanda (i.e., Kigali City, Gatuna, Rusizi, and Bugarama). The targeted high-risk populations include drivers and their assistants, commercial sex workers (CSW), members of the uniformed services and stop-over site communities that includes in- and out-of-school youth, low income women, fishermen and fish sellers, PLWHAs, OVC and other community members. These populations are targeted with regionally coordinated SafeTStop information and services. SafeTStops provide products, information and support for the prevention, care and treatment of HIV/AIDS in these communities.

During FY 2009, interventions to promote HIV/AIDS prevention through behavior change communication (BCC) was a major component of FHI/ROADS II approach to address key drivers of the epidemic. The behavior change interventions included peer education through small groups discussions, one-to-one contact, IEC/BCC material distribution, as well as other health promotion activities. These combined strategies reached 84,582 individuals with AB messages, which represent 100% of the annual target. Similar activities, in addition to scaled-up ones, will continue in FY 2010.

In FY 2010, ROADS II will continue to support and strengthen activities in six sites (one site in Gisenyi will be added) through the community clusters of low income women, youth, truckers, fishermen, motorcyclists, PLWHA, and OVC, to implement integrated HIV prevention services as well as address some of the underlying factors that exacerbate risk. AB activities will focus on vulnerable youth (between 12 and 18 years old) living in high-risk zones who may be prone to earlier sexual debut, low-income women, and other community members living around the truck stop areas. The combined messages that promote abstinence and faithfulness will be carried out among low-income women and community members over 18 years of age and to youth who are sexually active. Activities will include addressing key risk factors in hot spots along the ROADS Rwanda sites, where mobility, poverty and inadequate and insufficient health services exacerbate the risk for HIV-infection. HVAB activities will be integrated and linked to counseling and testing; reduced alcohol consumption; reducing gender based violence; and improved HIV outcomes through referrals. Dialogue among couples will be promoted through family day strategies and community magnet theater performances. Through these different strategies, FHI/ROADS II partners expect to reach 55,000 individuals.

To ensure quality supportive supervision, FHI/ROADS II will conduct regular formative supervision. Other mechanisms to support quality assurance include site assessments and programming (when indicated), trainings and refresher courses for all community volunteers, regular monthly meetings for

community volunteers and cluster coordination, quarterly coordination meetings for all clusters involved in activities implementation, local leaders, facilities and national umbrella organizations (e.g., Youth, RRP+, Women), FHI/ROADS II partners will continue to receive feedback on system weaknesses that have been identified for improvement.

To ensure sustainability and transition, FHI/ROADS II has developed the community clusters, who are involved in all steps of programming and implementation, partnership with the local authorities in all steps, providing technical support to clusters to hire qualified staff, training technical staff and steering committee members in governance, monitoring and evaluation, financial, and human resources management.

Implementation of activities will fit into the overall ROADS II M&E framework. Qualitative and quantitative (service statistic) data will be collected by the volunteers, validated at the cluster level by implementing agencies and validated at the second level by the ROADS II site coordinators in collaboration with peer educators, cluster steering committee members and cluster coordinators. FHI/ROADS II will collect relevant quantitative data using its reporting structure and integrate it into its existing database. FHI/ROADS II will regularly collect information and success stories to be shared with others partners. If applicable, FHI/ROADS II will collaborate with TRAC Plus to make sure the covered sites and target groups are included in the behavioral surveillance survey (BSS) to document person-level results as well as impact achievements. FHI/ROADS II will also collect qualitative information with beneficiaries, peer educators and community leaders to assess the quality and impact of the HIV activities implemented. Formative supervisory visits will be provided, to local implementing partners, as part of the routine monitoring and review mechanism. Best practices and lessons learned will be monitored and shared with other partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	915,750	

Narrative:

FHI/ROADS II extends HIV prevention, care and support services to MARPs in underserved zones, often-remote communities. Activities are currently implemented in four Rwanda corridor communities: Kigali City; Gatuna (Uganda border); Rusizi (DRC border); and Bugarama (intersection of DRC, Rwanda and Burundi) with planned expansion to a Gisenyi site (DRC border) during FY 2010. The targeted high-risk populations include drivers and their assistants, commercial sex workers (CSW), members of the uniformed services and stop-over site communities that includes in- and out-of-school youth, low income women, fishermen and fish sellers, motorcyclists, mechanics located at Gatsata, PLWHAs, older OVC and other community members. These populations are targeted with regionally coordinated SafeTStop

information and services. SafeTStops provide products, information and support for the prevention, care and treatment of HIV/AIDS in these communities. ROADS II activities include messages that promote behavior change, increase access to condoms, and counseling and testing services. ROADS II also facilitates prevention for positives intervention by working with PLWHA association and focusing intervention on households.

Through direct sub-agreements, ROADS II uses different mechanisms to ensure quality of services, achievement of outcomes and impact. These include: initial training and refresher courses for all cluster members, hiring technical staff for each implementing agency, organization of regular monthly meetings for community volunteers and cluster coordination bodies, implementing quarterly coordination meetings between cluster members, local leaders, referral to facilities and national umbrella organizations (e.g., Youth, RRP+, Women), and formative supervision from ROADS II and districts technical staff. ROADS II trained all program coordinators and community volunteers from implementing agencies in data quality assurance.

In FY 2010, ROADS II will continue to support and strengthen activities implementation in sites through the community clusters to reach MARPs and other individuals interacting with the MARPs and will continue to work with strategic partners. ROADS II collaborates with more than 360 local community clusters. Activities will include addressing key risk factors in hot spots along the ROADS II sites, where mobility, poverty and inadequate and insufficient health services exacerbate the risk for HIV infection.

ROADS II will reinforce and expand the HIV intervention that targets street youth especially in Kigali City as a new high-risk group. ROADS II will conduct a baseline assessment in Kigali City to understand the life, the risk vulnerability and the needs of street youth. This baseline assessment will also provide information on different organizations that support street youth in Kigali. Through its sub-agreement mechanism, ROADS II will identify local partners to be supported to provide a comprehensive intervention for street youth and to prepare the transition process.

Those combined strategies will reach 244,000 people with individual and/or small groups level evidence-based interventions. This will include 67,000 MARPs composed of sex workers, truck drivers, in street youth, PLWHIV, mechanics, motorcyclists and low income women, that will be reached with a minimum package of compressive intervention that include trainings for new peer educators, to promote prevention messages, consistent and proper use of condoms , reduction of alcohol consumption, reduction of the violence and provide vocational training. ROADS II will continue to coordinate and link high-risk groups to other relevant health services. ROADS II will continue to strengthen these services through SafeTStop model that mobilizes the community around HIV prevention, care, treatment and impact mitigation.

For M & E, qualitative and quantitative data will be collected by the volunteers, validated at the cluster level by implementing agencies and validated at the second level by the ROADS II site coordinators in collaboration with peer educators, cluster steering committee members and cluster coordinators. ROADS II will collect relevant quantitative data using its reporting structure and integrate it into its existing database. ROADS II will regularly collect information and success stories to be shared with others partners. ROADS II will ensure covered sites and target groups are included in the behavioral surveillance survey (BSS) to document individual-level results as well as affect achievements. ROADS II will also collect qualitative information with beneficiaries, peer educators and community leaders to assess the quality and impact of the HIV activities implemented. Formative supervisory visits will be provided to local implementing partners as part of the routine monitoring and review mechanism. Best practices and lessons learned will be monitored and shared with other partners for possibility of bringing them to scale. The data will be used for local planning, budgeting, management and decision-making.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10190	**Mechanism Name: Injection Safety**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 880,185	
Funding Source	**Funding Amount**
Central GHCS (State)	880,185

Sub Partner Name(s)

Nonelel'uluntu Womens Organization		

Overview Narrative

JSI R&T/JSI project has been implementing injection safety and proper health care waste management interventions for five years in Rwanda (2004 - 2009). During this period JSI R&T worked with the MOH/Environmental Health Desk (EHD) to reach goals that were assigned to the project, and provided technical support to the MOH to put in place transition structures to conducted most of activities.

Ending the first phase of the project, JSI R&T/JSI obtained an award to continue implementing the program over the next five years.

During this second phase, JSI R&T will concentrate its efforts on reinforcing mechanisms to ensure capacity building within the MOH through a team of implementers within the Environmental Health Desk of the MOH and other partners (including SCMS), so that they can be able to continue implementing injection safety and health care waste management without JSI R&T.

The establishment of the COP 09 activities is based on priorities set by the MOH: capacity building, procurement and commodities supply, health care waste management, infection prevention and control, behavior change and communication and monitoring and evaluation.

In the area of capacity building, JSI R&T will provide technical assistance to the Environmental Health Desk by training its technical staff.

Also JSI R&T will assist the EHD to organize and conduct training of 1,600 new health providers, 462 environmental health officers, 300 waste handlers and 90 incinerators' operators.

JSI R&T will also focus on pre service training by extending the integration of IS & HCWM aspects into training curricula of laboratory technicians. Training in nursing schools will be reinforced by supporting the directorate of nursing and training schools to install a sustainable supervisory system of trainees in nursing practicing hospitals.

In the area of logistics and procurement, JSI R&T will mainly work with SCMS and MOH in supplying IS commodities (autodisable syringes, safety boxes) and personnel protective equipments. JSI R&T will continue to provide information and data that will help in forecasting, procurement and distribution of commodities.

In the area of infection prevention and control, JSI R&T will assist the MOH/Quality of Care to promote and reinforce the use of standard precautions, particularly systematic hand washing practices within health facilities, by supplying alcohol and alcohol serving bottles to 9 pilot hospitals.

Also, JSI R&T and MOH will continue sensitization of district health directors and district pharmacy managers on the importance of inserting injection safety and health care waste management supplies into the cost recovery and budgeting mechanism to ensure sustainability.

Regarding BCC, JSI R&T plans to work with the MOH, URUNANA and the Rwandan Association of Diabetics (RAD) to produce and disseminate BCC messages towards the community and diabetics, through printed materials, radio and community outreach shows to assuring that community members are aware of ways to prevent risks related to unsafe injections.

In regards with diabetics (insulin dependent patients), JSI R&T plans to conduct joint supervisions with the MOH/EHD and RAD to reinforce best practices of injections and safe management of used syringes at home.

In clinical settings, JSI R&T plans to work with the EHD, the National Reference Laboratory and the National Center for Blood Transfusion, through joint supervisions, to promote best practices of blood withdraw and transfusion, in the context of phlebotomy.

In the area of health-care waste management, the major activities include the support to the MOH in building appropriate incinerators and secured waste pits in district hospitals and health centres.

Also, JSI R&T will continue working with the MOH/EHD and districts to define ways to securely collect and transport filled safety boxes from health centers to district hospitals for incineration.

In Monitoring and Evaluation domain, JSI R&T will hire a M&E specialist to strengthen the program and to facilitate joint supervision (JSI R&T, MOH & Districts) at the facility level.

Concerning the safety of health personnel, JSI R&T, MOH and districts will continue to monthly collect and analyze data on PEP in order to jointly define appropriate solutions to problems identified. In addition, JSI R&T and MOH will conduct advocacy to partners on the immunization of health personnel against hepatitis B.

JSI R&T and the Ministry of Health have agreed to work closely in the implementation of the present workplan.

Finally, periodic meetings between JSI R&T and its task force and the EHD will be held for tracking the implementation of planned activities and the level of transferring roles and responsibilities to MOH.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10190**		
Mechanism Name:	**Injection Safety**		
Prime Partner Name:	**John Snow, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMIN	880,185	

Narrative:

FY 2010 Funding:

FY 2010 funding for JSI R&T will allow the project to continue building capacity of the Ministry of Health (MOH) and district teams to expand interventions to newly created and uncovered health facilities. In this way, the establishment of FY 2010 activities will focus on the reinforcement of injection safety (IS) and health care waste management (HCWM) best practices through capacity building, health care waste management, behavior change and communication (BCC) and monitoring and evaluation (M&E).

In the area of capacity building, JSI R&T will, through training and joint supervisions, continue to ensure that the MOH Environmental Health Desk (EHD) team is complete and equipped with capacity to support district and health facility teams in implementation of best practices. Also JSI R&T will assist the EHD to plan and conduct the training of 1,060 new health providers and 276 waste handlers. At the same time, JSI R&T will organize a refresher course for district/hospital trainers. The project will also continue the distribution of comprehensive brochures that highlight the best practices of IS and HCWM.

Pre-service training will also continue by extending the integration of IS and HCWM aspects into training curricula of environmental health technicians, nurses and laboratory technicians at institutions where they are taught. JSI R&T and the MOH will continue to monitor and reinforce the supervision system of

nurses in training during their practical training at practicing centers.

In the area of logistics and procurement, JSI R&T will continue to work mainly with SCMS and MOH in supplying IS commodities (auto-disable (AD) syringes, safety boxes), personnel protective equipments (PPE) to project sites. As the transition of procurement for IS and HCWM supplies from JSI R&T to SCMS continues in FY 2010, JSI R&T will continue to provide advice on the specifications of these supplies, as needed. In addition, supply of alcohol and alcohol serving bottles to promote systematic hand washing practices within all health facilities will be scaled up from the pilot facilities to the entire country.

JSI R&T will continue to provide device specifications and quantification of needs to SCMS and the MOH, and support efforts aimed at inserting these commodities into cost recovery systems and budgets of districts and facilities in order to assure sustainable availability of appropriate and sufficient quantities of injection safety products.

Regarding BCC, JSI R&T envisages continuing to work with the MOH, URUNANA and the Rwandan Association of Diabetics (RAD) to sensitize the community and diabetics, through printed materials, radio and community outreach shows on risks related to unsafe injections. With diabetics specifically (insulin dependent patients), JSI R&T will conduct joint supervisions with the EHD and RAD to reinforce best practices of injections and safe management of used syringes at home.

In clinical settings, JSI R&T will continue joint supervisions, in collaboration with the EHD, the National Laboratory of Reference (NRL) and the National Blood Transfusion Center (CNTS), to promote best practices of blood draw and transfusion, in the context of phlebotomy and support development and dissemination of guidelines. JSI R&T will participate in a public-private partnership with Becton Dickinson to improve phlebotomy practices in Rwanda.

In the area of HCWM, the project will continue to provide support to the MOH in its efforts to extend the installation of appropriate incinerators and secured waste pits within health facilities and provide for their proper maintenance. In the same light, JSI R&T will continue working with the EHD and districts to strengthen mechanisms of securely collecting and transporting filled safety boxes from health centers to district hospitals for incineration.

In the context of reinforcing public and private sectors involvement in HCWM, JSI R&T and MOH will focus on the collaboration with Kigali Institute of Science, Management and Technology (KIST) and Compagnie Pour le Developpement et Environnement (COPED) to produce locally safety boxes and expand the existing system of plastic waste recycling.

In the monitoring and evaluation domain, JSI R&T will continue joint supervisions (JSI R&T, MOH & districts) and monitoring of interventions to identify various issues regarding IS and HCWM practices, systematic wearing PPE, use and maintenance of incinerators, etc. in order to continuously fine-tune strategies.

JSI R&T will continue to encourage the MOH to ensure periodic meetings of the Environmental Health Task Force to continuously track the implementation of planned activities and monitor the transition process from JSI R&T leadership of IS and HCWM to the MOH.

Concerning health workers' safety, JSI R&T, MOH and districts will continue to monitor accidental exposures, PPE and the status of hepatitis B vaccination among health workers and support the formulation of policies and guidelines to address concerns and gaps.

In order to assess the impact of BCC interventions, JSI R&T plans to carry out a knowledge, attitude & practices (KAP) survey, the results of which will be used to produce new trainings and BCC materials to continue to support MOH's efforts to sustain IS and HCWM interventions

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10191	**Mechanism Name: Blood Safety Follow-on**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Center for Blood Transfusion (CNTS)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,722,500	
Funding Source	**Funding Amount**
GHCS (State)	2,722,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The mission of the National Center for Blood Transfusion (CNTS) is to collect, analyze, and distribute safe blood in adequate quantities and quality to 100% of patients in need in Rwanda. Blood donor activities are based exclusively on voluntary, non-remunerated donations. Transfusion medicine is essential for the appropriate management of different health conditions. Conditions involving blood loss, such as malaria, surgery, obstetrics-gynecology and others cannot be effectively handled without the availability of blood and blood products. Rwanda like other African countries is faced with high morbidity and mortality of children under 5 years due to malaria. Therefore, the quantity of blood collected should be increased to collect at least 40,000 units of blood to ensure that all national requirements for blood and blood products in both public and private hospitals are attended to and to make sure that there is no shortage of blood and blood products in our centers.

Infrastructure

Gihundwe blood transfusion post will be renovated and brought to the level of regional center for blood transfusion (RCBT). This will enable easy accessibility of hospitals to the transfusion facility. This will also solve the problem of hospitals in that region driving long distances to Huye Blood Transfusion Center for blood requests.

Vehicles

Following the establishment of new hospitals and an MOH-initiated campaign underway to sensitize people on the importance of early treatment, CNTS expects an increase in the number of people seeking health care, which may trigger a greater need for blood transfusion services. This demand in turn creates a need for more vehicles. In addition, the newly rehabilitated RCBTs will start sensitization, recruitment, blood collection, screening distribution of blood products and blood donor result notification services in FY 2010, activities which will require six additional vehicles.

Equipment

RCBT Karongi and Gisenyi will be equipped and staffed with medical equipment and begin functioning like existing RCBTs. Twelve fire extinguishers will be purchased for the newly rehabilitated regional blood centers. In addition incinerators will be installed at four RCBTs for the purposes of waste management. Computerization systems will be installed at newly rehabilitated RCBTs for proper administration of blood and blood components. New medical equipment will be purchased to replace the old or broken machines.

Blood collection

In FY 2010 the number of blood collection session at CNTS Kigali will be increased from 20 to24, while the number of blood collection session at CRTS Butare and CRTS Ruhengeri will be increased from eight to ten. The blood collection in these sessions should meet the increasing demand for blood products in health facilities.

Donor recruitment will be strengthened in the eastern province, the western province and Kigali. Secondary schools will continue to be targeted as a potential source of donations. To increase donations CNTS will increase repeat donors from 65% to 66%, continue to provide incentives, strengthen media programming, initiate CLUB-25, introduce haemoglobin testing by use of CuSO4 method, initiate blood donor notification program for positive tests and purchase consumables.

Blood testing

ABO and Rhesus grouping will continue for each blood donation using a fully automated testing system. CNTS will continue to conduct fetal-maternal immunization surveillance and tests for irregular antibodies using a tube indirect antiglobulin test. Standard operating procedures (SOPs) will be written and used for preventive maintenance for laboratory equipments, which will in turn ensure the quality of laboratory results. All blood donations will be routinely screened for HIV, HBV, HCV and syphilis. Quality control and external quality assessments will continue and expand to all areas of testing.

Transfusion and Blood Utilization

CNTS will introduce leucoreduced blood components for selected patients and will expand blood components production and quality controls. Furthermore, CNTS will explore the feasibility of viral inactivation of blood units and will work to implement guidelines for the rational and appropriate use of blood products in hospitals. CNTS will also strengthen the implementation of protocols for cold chain management and continue the validation of blood transportation system. There will be increased emphasis on strengthening the inventory management systems for blood components at CNTS and hospitals.

Training

CNTS will continue to strengthen laboratory best practices and develop new twinning programs for laboratory technicians in order to improve standards. For the purposes of strengthening the donor notification program, CNTS nurses will receive training in counseling of patients before and after results are given to blood donors. CNTS will continue its program of capacity building and training to ensure sustainability of the program.

Quality assurance

In conjunction with technical assistance from AABB, CNTS will implement the twelve quality system

essentials for a good quality management program. CNTS will continue external quality assessment for serology and blood grouping with South African and Australian laboratories. To ensure the efficacy and effectiveness of the quality assurance program, the quality assurance officer will receive additional training. CNTS will continue to pursue accreditation/certification by the AABB. CNTS will strengthen a haemovigilance system to ensure the reporting of adverse reaction.

Monitoring and Evaluation
Data gathering and analysis will be strengthened and monitoring of blood use in hospitals will be emphasized.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10191**		
Mechanism Name:	**Blood Safety Follow-on**		
Prime Partner Name:	**National Center for Blood Transfusion (CNTS)**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	2,722,500	

Narrative:

FY 2010 Funding:
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Monitoring and Evaluation

Data gathering and analysis will be strengthened and monitoring of blood use in hospitals will be emphasized.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10193	**Mechanism Name: TRAC Cooperative Agreement**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Treatment and Research AIDS Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 4,088,942	
Funding Source	**Funding Amount**
GHCS (State)	4,088,942

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TRAC Plus (Centre for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics) is an autonomous organization within the Ministry of Health, whose mission is "to provide evidence-based, technical leadership for the prevention and control of HIV & AIDS, tuberculosis, malaria and other epidemics, through independent applied research, multi-stakeholder participation, improved quality of services and strengthened health systems, thereby contributing to the improvement of the health status of the Rwanda population". TRAC Plus consists of 6 operational Units:

• HIV/AIDS/STIs (HAS) – mandated to control HIV/AIDS and STIs in Rwanda through the development of guidelines and policies, implementation of programs and monitoring and evaluation

• Malaria – mandated to run the malaria program in Rwanda

• Tuberculosis – mandated to control TB infection in Rwanda

• Surveillance, Bioinformatics & Information Technology (SBI) - providing cross-cutting support

• Epidemic Infectious Diseases (EID) – provides insights for the prevention, control and response to other infectious diseases

• Finance and Administration – providing cross-cutting support

In FY 2009 the Department of Epidemiology within the HAS Unit conducted multiple HIV surveillance activities aimed at better understanding the state of the HIV epidemic in Rwanda. These include HIV sentinel surveillance at antenatal care facilities, a behavioral surveillance survey (BSS+) among sex workers, youth and truck drivers, and standard WHO HIV drug resistance surveys. Additionally, TRAC Plus trained 210 data collectors or enumerators that constitute a pool of human resources availed for future surveys.

Quality of care for patients enrolled in HIV services was a high priority for TRAC Plus in FY 2009 resulting in revised guidelines on HIV clinical prevention, care and treatment being disseminated. In addition TRAC Plus conducted training of trainers on the updated HIV guidelines for clinical providers at the district level. A total of 163 health workers, including nurses and medical doctors, have been trained in prevention, care, treatment and nutrition for HIV and TB patients. This contributed to improved quality of services provided to HIV patient across the country.

Another focus for TRAC Plus in FY 2009 was on data quality and use of information. Efforts have been made to develop data quality assessment tools. Central level, as well as district level, data audits have been conducted with feedback provided to the point of data collection. This process also includes capacity building at the district level to perform the similar data quality audit during their supervision activities. The data quality audit as a routine activity will contribute to improve the ownership and use of data by health centers and district hospitals authorities.

PMTCT, VCT, care and treatment program indicators have been revised and appropriate reference sheet has been developed to guide data collectors at health facility level. A module of these new indicators is currently being built onto the TRACnet system. During FY 2009 TRAC Plus managed the TRACnet system and provided training on the system to 194 health workers. These trainees are the end-users who report monthly program achievements via the TRACnet system. As of December 2009, 279 health facilities providing HIV AIDS services are reporting in TRACnet. In collaboration with Voxiva Inc, TRAC Plus printed and distributed information summarizing health facility achievements, something that was well received by the health care providers as the lack of feedback was a major criticisms.

In FY 2010 TRAC Plus will continue to build on experiences gained in previous years to strengthen its capacity. Activities identified for FY 2010 will cover prevention, care and treatment, strategic information.

In FY 2010, TRAC Plus will adjust PMTCT, care and treatment guidelines, revise tools and update training curricula as needed. The revised tools will be disseminated to all health facilities offering HIV services. At the district level, TRAC Plus will continue to support capacity building through the implementation of revised HIV guidelines, trainings and refresher training of trainers. In turn these trainers

will train providers on HIV prevention, care and treatment services at the decentralized level. Emphasis will be put on the implementation of task shifting to facilitate scale-up of PMTCT and other HIV care and treatment services, including ART. Moreover, TRAC Plus in collaboration with USG implementing partners and the Global Fund, will continue to support the expansion of quality adult and pediatric HIV care and treatment services by providing continued clinical mentorship to clinical staff at the district level. District staff mentors will train hospital and health center service providers in adult HIV treatment, patient record-keeping, data recording and use, and quality performance measurement and improvement.

To ensure quality of pediatric training at decentralized level, TRAC Plus will supervise training on pediatric HIV care and treatment for facility-based and community-based providers at decentralized levels. In collaboration with the UPDC unit within the MOH, TRAC Plus will assist district health teams in mentoring child and adolescent support groups established at health facilities as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide on-going support for children in care and on treatment or affected by HIV and assist with addressing issues around disclosure and adherence support. One child counselor per ART site will be trained to organize children support groups.

In FY 2010, TRAC Plus will emphasize quality improvement in pediatric care and treatment at ART sites and improving pediatric enrollment and retention into care. In collaboration with Columbia University and the Institute of Human Virology (IHV), TRAC Plus will implement a harmonized mentorship program to improve the quality of pediatric HIV care, treatment and support at district hospitals. PEPFAR will continue to support TRAC Plus in the sustainability of CHUK pediatric practical training and decentralization of this training at others sites. In order to reach the goal of universal access by treating all children in need of ART, TRAC Plus with PEPFAR support, will continue to upgrade HIV services in PEPFAR supported districts. In order to improve the enrollment of HIV-positive children into care and treatment, TRAC Plus, in collaboration with National Reference Laboratory, will assist district team to scale-up early infant HIV diagnosis.

TRAC Plus will also implement prevention with positive (PwP) activities and integrate them into care and treatment. The activities will reinforce and follow up programs started in FY 2009, by assuring training of physicians and community counselors who will be providing prevention counseling for HIV-positives. The activities will also reinforce the five prevention steps for HIV-positive individuals. In addition, they will assure training and incorporate PwP activities as a standard of care in ART sites. This will help ensure that people living with HIV/AIDS (PLWHA) will benefit from the tailored interventions to reduce transmission rates to HIV uninfected populations. Clinical and lay community counselors will promote couples counseling and testing and provide PwP messages to all their clients, but particularly PLWHA, to reduce their high risk behaviors through abstinence, being faithful to one partner or promoting secondary

abstinence and counseling and discussing condom use for those discordant couples. Trained lay community counselors will benefit from training HIV positive individuals on aspects of health, including prevention interventions to all their HIV positive clients.

In FY 2010 TRAC Plus will strengthen the TB/HIV monitoring and evaluation system by revising M&E tools based on the WHO recommendation and by improving the data analysis and its utilization for decision making. The TB unit will continue scale-up the implementation of TB infection control policy in health facilities through development of infection control plans, their supervision, and monitoring & evaluation. In addition TRAC Plus will continue to conduct an annual assessment of TB transmission risk among health care workers and, in collaboration with WHO, will conduct a national TB prevalence survey. FY 2010 funding will continue to support the MDR and X-DR TB surveillance and laboratory networking for sample transportation and ensure that MDR cases adhere to their treatment regimens.

USG PEPFAR has been supporting the Field Epidemiology and Laboratory Training Program (FELTP). In FY 2009 short courses were provided to 60 participants. In FY 2010 the two-year master's level course will be introduced. In FY 2010, TRAC Plus EID Unit will play a critical role in the implementation of the training during the practical, on-the-job training periods. This will complement the efforts of the USG team and the School of Public Health.

In FY 2010, the Department of Epidemiology in the HAS Unit of TRAC Plus will conduct multiple surveillance activities aimed at better understanding the state of the HIV epidemic in Rwanda. These include HIV sentinel surveillance at antenatal care facilities, syphilis and hepatitis B and C surveillance incorporated into HIV sentinel surveillance, and a behavioral surveillance survey (BSS+) among sex workers and street children. Standard HIV drug resistance surveys (early indicators, threshold and monitoring surveys) will be continued and scaled-up, in collaboration with USG, WHO, UNICEF, UNAIDS, UNFPA, GLIA and the National Reference Laboratory. Additionally, TRAC Plus will conduct a formative assessment of commercial sex workers' partner behaviors to inform the HIV/AIDS prevention program. A second data triangulation survey of HIV/AIDS program coverage was performed in December 2009 with technical assistance from the University of California San Francisco (UCSF) and CDC/Atlanta. A third data triangulation survey is planned in 2010, again utilizing technical support from UCSF and CDC/Atlanta. TRAC Plus will assume greater responsibility for this activity as the objective is to build local capacity for triangulation activities in Rwanda.

The focus of M&E activities in FY 2010 under the TRAC Plus cooperative agreement will be on the improvement of data quality, planning, reporting, and utilization of data for program management and service delivery. TRAC Plus will support data analysis and use as it relates to clinical prevention, care, treatment, to monitor the quality of services provided. As far as HMIS is concerned, TRAC Plus efforts will

focus on maintenance, upgrading and implementation of the OpenMRS and the TRACnet system. TRAC Plus will conduct data quality assessment at central level and at health facilities level in order to improve the collection, use and dissemination of information. One of the keys to improve health data is to improve their source by putting in place mechanisms that help in the daily activity of health data management; it is in this regard that the MOH, through TRAC Plus, has opted to develop and implement an electronic medical record to improve data management.

The SBI Unit at TRAC Plus will continue the process of implementing and scaling up the national electronic medical record (openMRS) and will help in various areas of data entry, management and reporting from individual data to their aggregation to be sent to the central level for decision making. The first implementation will cover HIV program (care and treatment, VCT and PMTCT) by developing electronic registers and automated aggregated reports from those electronic registers that are sent every month at TRAC Plus; later on a primary health care module will be developed.

In FY 2010, with the integration of new VCT and PMTCT indicators into TRACnet, the emphasis will continue to be put in data quality improvement reported into TRACnet System throughout decentralized trainings of districts supervisors, data managers and M&E officers. Feedback mechanisms will be enhanced, TRACnet data quality audit exercise and integrated supervisions will be continued and quarterly dissemination workshops will held on achievements in terms of TRACnet reporting completeness and timeliness. TRACnet end-users trainings and TRACnet TOTs will continue.

FY 2010 funding will also support the upgrade and maintenance of the electronic disease surveillance system set up in FY 2009 through collaborative efforts of the EID and SBI units within TRAC Plus, the National Reference Laboratory, MOH and USG. To maintain an operational and IT conducive working environment, funding of procurement of IT equipment will be supported as well as broadband internet connectivity and IT facilities hosting fees.

In order to accommodate the increase in activities and assure the successful implementation of programs, TRAC Plus is in need of cross-cutting support of functional units and activities. This support includes various facets, such as staff capacity building and training for the effective management of the funds and activities of this cooperative agreement's resources management in technical, administrative, financial and human resources elements. In addition, the cross-cutting support activities will co-ordinate and implement infrastructure improvement, personnel management, financial management as well as equipment and supplies procurement.

TRAC Plus will continue to provide support for the implementation of all project activities in the areas of planning, procurement, logistics, finance and personnel-related issues. Equipment and expendable

supplies will be provide for all technical units and will continue as routine activities. TRAC Plus will continue to ensure financial management and reporting for the cooperative agreement, quarterly financial reports will continue to be submitted on a timely basis.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10193**		
Mechanism Name:	**TRAC Cooperative Agreement**		
Prime Partner Name:	**Treatment and Research AIDS Center**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	168,300	

Narrative:

In FY 2009, TRAC Plus revised the national HIV care and treatment training curriculum and integrated modules on psychosocial support, nutritional assessment, counseling, management of malnutrition, and screening, diagnosis and management of STIs. TRAC Plus also coordinated the update of OI and STI guidelines and printed copies for national distribution. In additional TRAC Plus, with PEPFAR support, adapted the generic prevention with positives tools developed by CDC to reflect Rwanda's language, social norms and culture, and conducted a training of trainers with these revised tools.

In FY 2010 TRAC Plus will continue to implement prevention with positive activities and integrate them into care and treatment protocols. These activities will follow up programs started in FY 2009 and reinforce them through the training physicians and community counselors providing prevention counseling for HIV positive individuals. The activities will also reinforce the National Five Prevention Steps for HIV Infected Individuals and establish prevention with positives activities as a standard care at ART sites. These actions will ensure that PLWHA benefit from tailored interventions designed to reduce transmission rates to HIV negative populations. Clinical and lay community counselors will promote

couples counseling and testing and provide prevention with positives messages to all their clients, but particularly PLWHA, to reduce their high risk behaviors through abstinence, being faithful to one partner, "secondary abstinence," and condom use for discordant couples. Lay community counselors will benefit from training on the unique health needs and challenges of HIV positive individuals.

The TRAC Plus specialist on STIs will work with CDC and clinical partners to coordinate trainings, data analysis and data use. This collaboration will lead to a better understanding of the epidemiology of STIs in Rwanda and will inform implementing partners' work, particularly with high risk groups. The STI specialist will ensure that site staff are well trained and tools are available to screen, diagnose, and treat clients with STIs and their partners. The specialist will also make sure socio-demographic data on those clients is gathered, as that information may inform future prevention strategies.

TRAC Plus will supervise decentralized trainings on palliative care, both for facility-based providers and community-based providers. TRAC Plus will also design, in collaboration with the PBF and Community Health Units at MOH, HIV indicators to monitor PBF at community level. The nutrition advisor at TRAC Plus will provide oversight for all nutrition programming activities at the national level and provide supervision for nutrition training of health care providers, as well as the implementation of nutrition services at site and community levels. The TRAC Plus nutrition advisor will also work with the nutrition TWG and CRS to revise nutrition support tools related to food by prescription. Lastly, TRAC Plus in collaboration with SCMS, will provide timely and accurate data to CPDS on OI and STI drug and diagnostics supply consumption, as well as OI and STI-related morbidity and mortality. This information will facilitate the procurement and management of drugs and reagents.
TRAC Plus will also supervise decentralized training on prevention with positives both for facility-based providers and community-based providers. TRAC Plus C will also design, in collaboration with Health QUAL and the MOH Community Health Unit, key HIV program-related indicators to monitor prevention with positives interventions at community level and facility levels.

These activities support the PEPFAR five-year strategic goals of promotion of a continuum of HIV care, as well as the Rwandan national plan for palliative care and integration prevention and HIV care interventions. This activity is also in line with the Partnership Framework objectives of empowering national institutions to assume greater oversight of HIV services and ensuring sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	440,844	

Narrative:

In FY 2009, with the PEPFAR support, TRAC Plus conducted training of trainer's sessions for care and

treatment service provision for 550 individuals. In turn these trainers supported the training of HIV service providers at the decentralized level. Care and treatment guidelines have been revised based on WHO recommendations. Moreover, care and treatment tools such as adults medical file, appointment cards, pharmacy cards, and registers have been revised, printed and disseminated to all health facilities.

In order to improve the M&E system of HIV care and treatment program, indicators has been revised and incorporated in to TRACnet system.

In FY 2009 TRAC Plus put emphasis on the quality of care for patients on ART, and in this framework conducted an assessment to track lost follow up patients at 364 sites. This exercise has allowed 11,913 patients who were previously lost to follow up to return to care.
In FY 2010, TRAC Plus will revise care and treatment guidelines and tools as well as update training curricula as needed. Those revised tools will be disseminated to all health facilities offering and treatment. Furthermore, TRAC Plus will continue to support the district level capacity building in adult care and treatment. This assistance includes support for implementation of care and treatment guidelines, and training or refresh training of trainers. In FY 2010 the emphasis will on the implementation of task shifting to facilitate scale up of ART.

TRAC Plus, in collaboration with USG, implementing partners and the Global Fund, will continue to support the expansion of quality of adult care and treatment services by providing continued mentoring to clinical staff at district level. Mentor staff will train hospital and health center service providers in adult HIV treatment, patient record-keeping, data recording and use, and quality performance measurement and improvement. Two additional clinical mentors will be supported through COP10 to assist in quality improvement of HIV services at the 23 sites transitioned to the MoH. In addition, in partnership with MOH/UPDC, TRAC Plus will undertake formative supervision related to HIV care and treatment integration activities within each district at least twice per year. This supervision will be done with a standard checklist to assess the quality of care and treatment HIV services. The supervisory team will provide regular feedback to sites and share best practices in HIV care and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	297,000	

Narrative:

In FY 2009, TRAC Plus revised guidelines for prevention, the process of multiplication, translation and dissemination is on-going. PIT guidelines have been developed, and multiplication and dissemination is in process.

In FY 2010, TRAC Plus will continue to conduct TOT sessions on HCT and refresher training using the most recent norms and guidelines. TRAC Plus will also give supportive supervision to trainers who will conduct provider's trainings at district level. In collaboration with the Prevention TWG and other partners, TRAC Plus will continue to update national HCT norms and tools (e.g. client forms, reporting forms, registers, educational and supervision tools) and will disseminate them to all health facilities providing CT services. Ongoing revisions are necessary in order to address new approaches to HCT and PIT, couple testing and discordant couple follow-up as new strategies of the national HCT program. The finger prick method of specimen collection will be incorporated in HCT activities; this will involve training of providers in FY 2010. As HCT in Rwanda has expanded to include mobile testing and PIT, in FY 2010, TRAC Plus will put more emphasis on counseling and testing of the high risk and vulnerable groups such as MSM, sex workers, military, truck drivers and people living with disability.

Another priority of FY 2010 in HCT is to put in place pre-ART services in HCT sites without ART services and ensure linkages of infected people to care and treatment. Trainings and tools for implementation of this system will be developed accordingly and disseminated to health facilities. Other activities which will continue in FY 2010 are the payment of 2 staffs and ensuring the capacity building of HCT staffs, salaries of HCT desk and office equipment.

In FY 2010 USG will support TRAC Plus to carry out a program evaluation to assess HIV acquisition rates in serodiscordant couples identified in PMTCT programs in Rwanda. Since 2007, TRAC Plus recommended that men should be encouraged to participate in antenatal activities with their female partners. Male participation in antenatal clinic (ANC) visits has been high: 78% of women who receive HIV testing in ANC/PMTCT sites throughout Rwanda also bring their male partners for testing. In 2008, approximately 187,000 couples were tested through partner HIV testing at >300 ANC/PMTCT sites in Rwanda. Of these, more than 5,800 were identified as discordant couples, meaning one partner's test results were HIV-positive, and the other partner's test results were HIV-negative. Of the 5,800 couples identified, more than 1000 were in Kigali. The evaluation will seek to identify clinical and social-behavioral factors associated with HIV acquisition in the negative partner. This evaluation will assist national planners in designing follow-up prevention interventions for discordant couples.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	61,875	

Narrative:

The USG works closely with relevant units of the MOH to develop and implement plans to extend HIV services for children in Rwanda. Since the initiation of PEPFAR, the USG has provided funding and TA support to the Treatment and AIDS Research Center (TRAC) of the MOH.

In FY 2009, the USG provided funding to the TRAC Plus unit of the MOH to strengthen central, district and site-level capacity to increase access and quality of pediatric HIV care and treatment services in Rwanda. TRAC Plus provides supervisory and technical support to districts and health facilities in the provision of services for HIV, malaria, TB and other infectious diseases following a network model. TRAC Plus also conducts training of trainers in pediatric HIV care and treatment and provides leadership in the development of work plans and agendas, guidelines, training materials as well as general coordination to support scale-up of pediatric HIV care services in Rwanda.

In FY 2009, TRAC Plus initiated psychosocial care and support services for children and adolescents through formative supervision /mentorship in collaboration with implementing partners and districts hospitals. These services include HIV diagnosis disclosure support groups in more than 122 ART health facilities.

In FY 2010, TRAC Plus will develop and revise pediatric HIV care and treatment guidelines training materials, job aids and other tools as needed with TA from PEPFAR implementing partners. In addition, TRAC Plus will revise the pediatric HIV care and treatment training curriculum to include the management of opportunistic infections (OI), adolescent care and the new recommendations from WHO. Training of trainers will be conducted on the revised tools and guidelines.

To ensure quality of pediatric training at decentralized level, TRAC Plus will supervise training on pediatric HIV care and treatment for facility- and community-based providers at decentralized levels. In collaboration with the UPDC unit within the MOH, TRAC Plus will assist district health teams in mentoring children and adolescent support groups that have been established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment or affected by HIV and assist with addressing issues around status disclosure and adherence support. One child counselor per ART site will be trained to organize children support groups.

In order to improve the enrollment of HIV-positive children on treatment, TRAC Plus in collaboration with the National Reference Laboratory will assist district teams to scale up early infant diagnosis (EID) and follow-up through training of PMTCT staff as well as lab technicians, and through developing efficient and reliable sample transportation systems.

In FY 2010, TRAC Plus will emphasize quality improvement in pediatric care and treatment at ART sites and improving pediatric enrollment and retention into care. In collaboration with Columbia University, TRAC Plus will continue a mentorship program to improve the quality of pediatric HIV care, treatment and

support as well as to integrate mental health into pediatric HIV care. This budget will support salaries of two clinical psychologists to assist the mental health integration.

PEPFAR will continue to assist TRAC Plus to improve national M&E capacity for pediatric care and support and to link with the national system (HMIS). The revised pediatric HIV indicators and harmonized data collection tools developed in FY 2009 will be implemented nationally. In collaboration with SCMS, TRAC Plus will provide timely data on OI diagnostics and drug consumption, as well as data on OI related morbidity and mortality for more accurate drug and reagent quantification and forecasting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	131,175	

Narrative:

In FY 2009, PEPFAR funded TRAC Plus to ensure continuation and strengthening of different activities. With TA from PEPFAR implementing partners, TRAC Plus developed and revised pediatric HIV care and treatment guidelines according to new WHO recommendations. A manual on pediatric care and treatment in Rwanda has been developed in order to harmonize pediatric care and treatment in all sites. TRAC Plus revised pediatric indicators to be reported through the TRACnet system. A training of trainers was conducted on the revised guidelines. With TA from PEPFAR implementing partners, a center of pediatric practical training is functional at CHUK. In addition, pediatric mentorship was started in some sites.

In FY 2010, TRAC Plus will emphasize quality improvement in pediatric care and treatment at ART sites. It will also emphasize improving pediatric enrollment and retention into care. In collaboration with Columbia University and the Institute of Human Virology (IHV) of AIDS Relief, TRAC Plus will implement a harmonized mentorship program to improve the quality of pediatric HIV care, treatment and support at district hospitals. In collaboration with the UPDC unit within the MOH, TRAC Plus will continue the training of trainers and will supervise the training of facility- and community-based providers on pediatric HIV care and treatment. PEPFAR will continue to support TRAC Plus to ensure the sustainability of practical pediatric training at CHUK and the decentralization of this training to others sites.

With PEPFAR support, TRAC Plus will continue to upgrade HIV services in PEPFAR supported districts with the aim of achieving universal access of eligible children to ART.

In addition, TRAC Plus will develop an action plan for adolescent care and treatment programs and it will integrate adolescent health into the training curriculum for pediatric HIV care and treatment.

PEPFAR will continue to assist TRAC Plus to improve national M&E capacity for pediatric care and support and coordinate with the national HMIS (TRACnet) system. The revised pediatric HIV indicators and harmonized data collection tools developed in FY 2009 will be implemented nationally. Moreover, in collaboration with the Performance-Based Financing (PBF) working group and the Community Health Unit of the MOH, TRAC Plus will design pediatric HIV-related indicators to monitor PBF activities at the community level. It will also revise the set of pediatric HIV indicators for which data are collected at health facilities. In collaboration with SCMS, TRAC Plus will provide timely data on ARV consumption including data on pediatric ARV for more accurate drug and reagent quantification and forecasting.

These activities support the PEPFAR five-year strategic goals to promote a continuum of HIV care as well as the Rwandan National Plan for integration of HIV prevention and care interventions at national, district and site-levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	1,527,831	

Narrative:

In FY 2010, TRAC Plus interventions within the Strategic Information domain will cover three major areas: surveys and surveillance; HMIS; and Monitoring and Evaluation. Over the years, the PEPFAR program has contributed to building local capacity within TRAC Plus to conduct national survey and surveillance activities such as the behavior surveillance surveys, KAP surveys, operational research and data triangulation. These efforts allow the gradual transition of the responsibility for these interventions to TRAC Plus.

In FY 2010, TRAC Plus will conduct multiple surveillance activities aimed at better understanding the state of the HIV epidemic in Rwanda. These include HIV, syphilis and hepatitis B and C sentinel surveillance at facilities providing antenatal care services and a behavioral surveillance survey (BSS+) among sex workers and street children. HIV drug resistance surveys (early warning indicators, threshold surveys, monitoring surveys) will be conducted in collaboration with CDC, WHO, UNICEF, UNAIDS, UNFPA, GLIA and the National Reference Laboratory. Moreover, TRAC Plus will conduct a formative assessment of clients of commercial sex workers to inform the HIV/AIDS prevention program. The surveillance team within the EID unit will be strengthened with additional staff. Surveillance tools will be developed for data collection, and health agents across the health system will be trained in their use.

TRAC Plus, with technical assistance from the University of California San Francisco (UCSF) and CDC/Atlanta, conducted the first HIV data triangulation exercise in 2008, and a third one is planned for 2010. The technical support provided so far has built capacity within TRAC Plus to undertake this

activity. Various sources of data will be used including behavioral, environmental and health status data.

The focus of M&E activities in FY 2010 under the TRAC Plus cooperative agreement will be on the improvement of data quality, reporting, and utilization of data for program management and service delivery. TRAC Plus will support data analysis and use as it relates to clinical prevention, care, and treatment. The M&E unit of TRAC Plus will continue to train district level supervisors and data managers from district hospitals in order to build their capacity to enhance data quality and the application of the generated information in the improvement of service provision. Those trained at district level will in turn have the responsibility to train health providers within their respective catchment areas. TRAC Plus will also continue to conduct integrated periodic supervision visits to health facilities in collaboration with the MOH to ensure quality of services. A data quality assessment at central and health facility levels will be carried out including capacity building at district level to support this initiative.

In the sphere of HMIS development, TRAC Plus efforts will focus on the maintenance, upgrade and implementation of the OpenMRS and the TRACnet system. The Ministry of Health has adopted OpenMRS as the national patient monitoring system to be implemented by TRAC Plus. Initial modules built on the system are HIV-related and allow the monitoring of HIV patients and drugs. Plans are underway to roll-out the system across the country. In FY 2010, PEPFAR will support the recruitment of program developers and the training of end-users of the system. OpenMRS is expected to make data management and reporting easier. The system will be connected to TRACnet, and a non-HIV primary health care package will be added to it.

Since the introduction of the TRACnet system three years ago, TRAC Plus has played an important role in its roll-out throughout the country. The training of end-users of the system relies heavily on TRAC Plus. With the addition of new modules onto TRACnet, TRAC Plus has set up a TRACnet technical support unit in collaboration with Voxiva, Inc., to provide technical assistance to district hospital and health center personnel who are using the system. TRAC Plus will recruit a TRACnet System Administrator that will back up the technical support unit and ensure more in-country management of the system as well as provide help to the end-users. The ART module is being updated to incorporate newly defined indicators, the PMTCT VCT module will be rolled out in COP09, while the Integrated Disease Surveillance and Response (IDSR) system is being built. TRAC Plus will train district hospital staff to act as trainers for the roll-out the TRACnet system. In FY 2010, TRAC Plus will endeavor to further improve the quality of data reported into TRACnet through training of health facility supervisors, data managers and M& E officers at sub-national levels. Feedback mechanisms will be strengthened, TRACnet data quality audits integrated in supervision visits will continue, and quarterly dissemination workshops will be held on the completeness and timeliness of reporting.

ICT equipment and statistical software packages will be acquired under this cooperative agreement to support activities of TRAC Plus. Internet connectivity of TRAC Plus will also be supported.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	266,969	

Narrative:

In FY 2009 USG supported the national planning process in the understanding that robust plans are the foundation on which to build capacity in the heath sector as a whole. TRAC Plus played a vital role in the development of the Health Sector Strategic Plan and the National Strategic Plans for HIV, Malaria and TB. The National Strategic Plans for HIV and TB were the basis on which the GFATM National Strategies Application was developed, in tandem with the PEPFAR Partnership Framework. In FY 2010, TRAC Plus will increase its role in supporting evidenced based planning at national level. This process will be strengthened through an enhanced ability to develop project proposal, research protocols and to analyze existing data. The budget for this activity includes payment of a senior project manager within the organization who will build capacity of junior staff at TRAC Plus

Rwanda is a landlocked country with porous borders. In the past few months the country experienced an outbreak of H1N1, and cholera outbreaks occur sporadically each year. The information necessary to monitor these outbreaks and the expertise needed to respond appropriately in a timely fashion do not yet meet international standards. To build the capacity of the country to respond effectively and efficiently to such outbreaks USG PEPFAR has been supporting the Field Epidemiology and Laboratory Training Program. In FY 2009 short courses were provided to 60 participants. In FY 2010 training at a masters level will be introduced. In FY 2010 TRAC Plus play will play a critical role in the implementation of the training during the practicum activities. This will compliment the efforts of the USG team and the School of Public Health. These funds will also support the tuition of 10 residents, as well as travel for international conference such as quarterly FELTP seminar and EIS conference.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	74,250	

Narrative:

As of December 2008, TRAC Plus created a desk for biomedical prevention within the prevention department. The purpose of this action was to assist in scaling-up activities related to male circumcision and prevention with positives. These activities were incorporated into a comprehensive prevention strategy focused on assisting people with HIV to take measures to avoid exposing other people to infection. TRAC Plus (biomedical prevention desk) has engaged in a variety of activities, including conducting a national health service assessment for male circumcision, the goal of which was to identify

the capacity of health facilities, both public and private, to provide safe circumcision services. The data on health service assessment for MC are being analyzed and the results will be compiled into a report. In collaboration with the MC TWG and other partners, TRAC Plus has developed National Guidelines for Male Circumcision, a protocol which is awaiting approval from MOH.

In FY 2010 TRAC Plus will also conduct a national knowledge, attitudes and practices (KAP) study on male circumcision. That study aims to provide baseline information on the KAP regarding MC in the Rwanda general population. The results of this survey will guide medium and long-term strategic program planning on MC. In accordance with WHO guidelines on MC, TRAC Plus is developing trainers' and providers' manuals on MC which will be distributed to health facilities which do not provide MC in their minimum package of services.

In FY 2010, TRAC Plus will continue trainings of trainers for all district hospitals, as well as training for all providers in military and police hospitals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	224,105	

Narrative:

In FY 2010 TRAC Plus will conduct three training of trainer's sessions for PMTCT service provision and supervision for 120 district-level supervisors. In turn these trainers from all districts will support training of providers in HIV services at decentralized level. These training sessions cover all aspects of the expanded national PMTCT protocol, including ARV prophylaxis, PCR testing for HIV-exposed infants, CTX for all HIV-exposed infants, routine CD4 testing and clinical staging for all HIV-positive pregnant women, and counseling on infant feeding and nutrition for HIV-positive pregnant women and HIV exposed infants. In collaboration with Project San Francisco (PSF), TRAC Plus is developing M&E tools in order to reinforce follow-up of discordant couples.

In addition TRAC Plus is conducting the phase 1 implementation of the use of revised child health card which includes information on HIV exposure in three districts to determine whether an individual medical record in supporting longitudinal care of children contributes to better care. Upon completion of this phase, TRAC Plus will evaluate the experience to determine whether the revised child health card should be scaled up to national level. Moreover TRAC Plus is conducting a rapid assessment of HIV-exposed infant follow-up system in Rwanda, in order to guide the intervention towards the improvement of tracing of HIV-exposed infants and strengthening the HIV-exposed infant follow-up.

In FY 2010, in order to reduce the post-natal transmission of HIV, TRAC Plus in collaboration with the

national PMTCT TWG will revise PMTCT norms and tools according to the new WHO recommendations and will disseminate them to all health facilities providing PMTCT services. To ensure quality of PMTCT services and consistent implementation of the new PMTCT guidelines, TRAC Plus will continue to conduct refresher training of trainers and supervisors (TOT and TOS) and supporting training of providers at decentralized level in the expanded PMTCT protocol. In addition it will conduct quarterly supervision of all districts. With TA from CDC and PSF, TRAC Plus will emphasize the quality of intervention targeting couples testing and follow-up of discordant couples as well as the follow-up of HIV-exposed infant.

In FY 2010, TRAC Plus will also reinforce the M&E system for the PMTCT program, in particularly the M&E of the implementation of new PMTCT protocol, through the improvement of M&E tools, and documentation of best practices implemented by different partners. The budget for this activity includes payment of two PMTCT technical advisors within TRAC Plus/PMTCT desk and their capacity building.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	896,593	

Narrative:

The overall goal of this activity is to build capacity at central level for development of TB/HIV guidelines, tools, supervision, and monitoring and evaluation, as well as reinforcing the central and peripheral level health facilities capacity in the diagnosis of extrapulmonary tuberculosis (EPTB) through development of EPTB training guidelines, tools and training sessions.

In FY 2009, TRAC Plus has been supporting TB/HIV collaborative activities at the central level through continuation of existing TB/HIV advisors to oversee collaborative activities, which support guidelines, curricula, tool revision, networking with clinical partners, as well as supervision of all PEPFAR and non-PEPFAR sites for quality TB and HIV services to co-infected patients.

In FY 2010, PEPFAR will continue to support the positions of the national advisors at TRAC Plus, including both TB and HAS Units. The advisors will lead national activities on TB/HIV as related to guidelines, norms and tools review. They are part of the national team of TB/HIV supervisors in addition to those located at AIDS Relief, FHI, CDC, and WHO. They will plan and coordinate TB/HIV training at the central and peripheral level. In collaboration with PEPFAR clinical partners and Global Fund, TRAC Plus will implement one-stop TB/HIV service in 43 hospitals and all health centers providing ART. The team will participate in quarterly joint supervisions of TB/HIV activities conducted with other MOH desks at the district level, report issues, and gives feedback to the national technical working group.

In FY 2010 TRAC Plus will strengthen the TB/HIV monitoring and evaluation system by revising M&E tools based on the WHO recommendations and by improving the data analysis and its utilization for decision making. PEPFAR will continue supporting the TB unit within TRAC Plus in development of training guidelines and tools to increase the capacity in EPTB diagnosis.

The TB unit will scale up the implementation of TB infection control policy in health facilities through development of infection control plans, their supervision, and monitoring & evaluation. In addition, TRAC Plus will conduct an annual assessment of TB transmission risk among health care workers. FY 2010 funding will continue to support the MDR and X-DR TB surveillance and laboratory networking for sample transportation and ensure that MDR cases adhere to their treatment regimens. TB unit at TRAC Plus will train 986 providers on TB infection control and support them implement the TB infection control activities based on available funds from PEPFAR implementing partners and global fund support at the site level. In order to improve the adherence of TB patients TB unit will supervise community DOTS approach by supervising the community health workers(CHW), developing tools related to community DOTS as well as by facilitating transportation of CHWs. PEPFAR will continue supporting the TB unit within TRAC Plus in development of training guidelines and tools to increase the capacity in EPTB diagnosis.

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site level. In order to improve the adherence of TB patients TB unit will supervise community DOTS approach by supervising the community health workers(CHW), developing tools related to community DOTS as well as by facilitating transportation of CHWs. In addition, PEPFAR will provide partial funding to support a national TB prevalence survey which is anticipated to provide a sound basis for strategic information and planning through 2015.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10825	**Mechanism Name: MoH CoAg**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health, Rwanda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 4,039,404	
Funding Source	**Funding Amount**
GHCS (State)	4,039,404

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ministry of Health (MOH) vision of the Rwandan health sector is to continually improve the health of the people of Rwanda, through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty. Ministry of Health is by far the largest provider of health services through its network of 416 health centers, 40 district hospitals and 4 national referral hospitals. In addition, it is responsible for coordinating services provided by NGOs and faith based organizations throughout the country.

The main responsibilities of the Ministry of Health are to develop policies, strategies and guidelines. It provides supervision to the district hospitals and is in charge of managing all human and financial

resources for health in Rwanda. In FY 2009 with PEPFAR support, MOH/HIV integration task force is supporting the district level capacity building in HIV Prevention, care and treatment. This support includes support for district level in planning, implementation, coordination, supervision and district performance improvement meetings. In collaboration with TRAC Plus, MOH staff undertakes formative supervisory supervision related to HIV prevention, care and treatment integration activities within each district at least twice per year. MOH has enhanced information systems and a national web-based data warehouse platform to facilitate data analysis and information sharing. MOH has trained 302 data managers at the district level. In addition MOH has developed a community health information system through the development and dissemination of the reporting forms and registers for community health workers (CHW). MOH has rolled-out the CHW Information System with training of trainers at the health sector level and assisting with trainings by CHWs in their catchment areas.

FY 2010, MOH/UPDC will continue to support the district level capacity building in HIV prevention, care and treatment. This includes support for district level in planning, implementation, coordination, supervision and district performance improvement meetings. It will also support the HIV services integration into district health programs, as well as improved linkages between HIV programs. MOH in collaboration with USG implementing partners and Global fund, will continue to support the expansion of quality of HIV services to more decentralized sites of the health care system by providing continued mentoring to clinical staff. In addition, in collaboration with TRAC Plus, and PEPFAR implementing partners as well as Global Fund, MOH will undertake regular formative supervision to the district hospitals that in turn, will provide assistance to health centers in their catchment area. A supervision protocol and tools for district managers to improve both service delivery and data use for decision making at the district and health facility levels have been developed and will be implemented in FY 2010.

The Ministry of Health will continue to strengthen the capacity of district level managers to facilitate the search for the root causes of unsatisfactory performance of health facilities. In coordination with TRAC Plus the M&E Task Force of MOH will revitalize the national disease surveillance system to timely and completely reporting across the health information system. In addition MOH will develop a Standard Operating Procedure (SOP) for data management and feedback to provide clear guidance on data management at all levels of the health system. All data managers and information officers at district level will be trained in data management. A total of 922 will be trained with PEPFAR financial support.

During the course of PEPFAR I, health facilities were provided with the physical requirements to provide HIV services of -high quality. The majority of health facilities have been rehabilitated and provided with energy. A national strategy has been developed towards the Economic and Development Poverty Reduction Strategy goal of providing all health facilities with a source of power by 2012. In FY 2010 the remaining 45 facilities will be provided with a source of power and 10health centers and 8 district

hospitals will be rehabilitated in order fulfill the TB infection control requirement.

Through PEPFAR equipment has been procured for laboratories and health facilities to allow HIV service delivery. In FY 2010, through this award, support for a sustainable maintenance system will be provided. At central level this will include; performance incentives against clear objectives for maintenance unit staff; training of six central level maintenance staff in biomedical engineering, and technical assistance for the maintenance unit to provide training for technicians, develop contracts with the private sector and provide robust procedures for the procurement of spare parts and tools for maintenance and repair of medical and laboratory equipment.

Environmental Health Desk (EHD) of the Ministry of Health in collaboration with MMIS/JSI will develop the Terms of Reference in areas that require capacity building. EHD will identify areas that require capacity building and organize the training of healthcare workers and waste handlers on injection safety and healthcare wastes. Incinerator operators and their supervisors will also be trained on the use and maintenance of incinerators. A strategic plan for prevention of infections will be developed to enable healthcare workers and waste handlers to protect themselves against HIV and Hepatitis B. EHD will identify all of the required materials, consumables and equipment for injection safety and healthcare waste management and link them to the procurement organization SCMS which will in turn ensure the procurement of needed items in sufficient quantities and of the right quality. EHD in the Ministry of Health in collaboration with MMIS/JSI and key partners will implement the plan of constructing the multipurpose waste pits and installation of appropriate incinerators for the disposal of medical waste. Guidelines and specifications of waste pits and incinerators will be provided in collaboration with EHD, World Health Organization and John Snow, Inc. EHD will also organize training workshops in all Sectors for Community Health Workers and equip them with knowledge that will enable them to sensitize communities on injection safety and medical waste best practices. Monitoring and evaluation will be carried out to ensure smooth and successful implementation of activities as well as determining areas that need urgent problem solving and advice. MOH in collaboration with partners will define the indicators to measure performance.

USG will continue to support the laboratory by assisting the MOH to build human capacity for histopathology for the diagnosis of extra pulmonary tuberculosis and the diagnosis of cancers in HIV patients. It will support long term capacity needed in the laboratory of CHUK. Indeed, CHUK laboratory plan to organize training for one Microbiologist and one Histopathologist with a background of Medical Doctor and one technician for Histopathology. In addition, USG will support the purchase of equipment and reagents for the laboratory and the training of six physicians in anatomical pathology. Two physicians will be sent abroad for training in pathology while two physicians located at CHUK and two located at CHUB will be trained in country.

FY 2010 starts the first year of transition of Track 1.0 clinical partners' activities; therefore ICAP-CU and AIDS Relief will transition respectively 12 and12 HIV care and treatment sites to Ministry of Health (MOH). In FY 2010, MOH will insure continuum of provision of a comprehensive package of PMCT, CT, adult and pediatric care and treatment, TB/HIV services at 24 transitioned sites. Transition of the management and oversight of the activities formerly supported through the Track 1.0 clinical partners will require additional financial management and reporting responsibilities. Therefore, during FY 2010 a second technical assistance position will be provided to ensure the necessary skills and experiences are available to fulfill these responsibilities.

At PMTCT sites, support groups of HIV-positive women will be strengthened in collaboration with community health workers through the organization of monthly meetings and home visits as needed. Early infant diagnosis (EID) will be strengthened by reducing the laboratory results turn-around time and linking identified HIV-positive infants to care and treatment services. EID will continue to be offered at six weeks of age and at any other ages for symptomatic infants less than 18 months post natal according to the national algorithm. MOH will continue support to the district health teams to ensure that samples collected at the sites are transferred efficiently to the processing lab at the National Reference Laboratory in Kigali.

The prevention of unintended pregnancy amongst HIV-positive women is one of the most cost-effective means of preventing mother to child transmission. In FY 2010, MOH will also support the revision, printing and dissemination of FP/HIV integration guidelines and tools. Moreover MOH will assist district team in training health providers on FP/HIV integration. In collaboration with national police and clinical partners, MOH will coordinate the national training of trainers on SGBV and roll-out SGBV in HIV programs considering the lessons learned from one year implementation program of the SGBV pilot phase.

To address the need to expand diagnosis of HIV in the pediatric population, MOH will continue to strengthen testing for targeted pediatric populations within the catchment area of its existing sites. Using each HIV adult patient enrolled in care and treatment as an index case, MOH will offer HIV-testing for their partners and children and enrolls the infected family members into care and treatment services.

In order to ensure continuum of HIV care and treatment, MOH through the Community Health desk will continue to support 24 health facilities in HIV patient follow-up, and organizing referrals to HIV care and treatment services for HIV patients. MOH will work with elected community health workers to develop effective referral systems between clinical care providers and psycho-social and livelihood support services, through the use of patient routing slips for referrals and counter referrals from community to

facilities and vice versa. MOH will support Health facilities in assessing individual PLWHA needs, organize monthly clinic-wide case management meetings to minimize lost of follow up of patients in care and treatment and provide direct oversight of community health workers. Depending on the need of individuals and families, health facilities will refer PLWHA adherence counseling, stigma reducing activities, OVC supporting activities, legal support services, community-based pain management and end-of-life care in line with national palliative care guidelines. In FY 2010, MOH will work with ICAP and Ndera Neuropsychiatric Hospital, TRAC Plus and the Mental Health unit to scale up mental health and HIV integration services to the 24 transitioned sites to MOH.

With the leadership of PBF unit within Ministry of Health and in collaboration with ICAP and AIDS Relief, MOH will continue to support the financing based on site performance in improving key national HIV services performance and quality indicators.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10825**		
Mechanism Name:	**MoH CoAg**		
Prime Partner Name:	**Ministry of Health, Rwanda**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	535,057	
Narrative:			
This a continuing activity under a new mechanism FY 2010 is the first year of transition of Track 1.0 partners' activities. Under the transition frame work, ICAP and AIDS Relief will transition 12 and 11 HIV care and treatment sites respectively, to Ministry of Health (MOH). In FY 2010, MOH will ensure the continuum of a comprehensive package of HIV care			

and support services to patients at the 23 transitioned sites. The package of services includes: clinical staging and baseline CD4 count for all patients; follow-up CD4 every six months; management of OIs and other HIV-related illnesses; OI diagnosis and treatment; routine provision of CTX prophylaxis for all eligible adults based on national guidelines; prevention with positive intervention; basic nutritional counseling and support; positive living and risk reduction counseling; pain and symptom management; and end-of-life care. In addition, MOH will continue to provide psychosocial counseling and referrals for HIV-positive female victims of domestic violence. To ensure comprehensive services across a continuum, MOH, through a partnership with community health workers, will refer patients enrolled in care to community-based services based on their individual need. Such services may include adherence counseling, spiritual support, stigma-reducing activities, OVC support, IGA activities, and HBC services for end-of-life care.

Through SCMS, MOH will ensure the provision of OIs drugs, CD4 tests and other commodities and laboratory supplies for clinical monitoring of patients on care. Coordination with SCMS will ensure that sites have reliable forecasting and stock management systems and will provide accurate reporting to SCMS and CAMERWA on needed commodities for adult HIV care and support.

In FY 2010 MOH will emphasize on the quality of care, the continuum of care through effective linkages and referrals, and sustainability of services through PBF. Strengthened nutritional services through training and provision of nutritional care will include counseling, nutritional assessments using anthropometric indicators, and management of malnutrition through provision of micronutrient and multivitamin supplements, as well as links to CRS food support for clinically eligible PLWHA in line with national nutrition guidelines. MOH will also, in collaboration with GFATM and PMI, support referrals for all PLWHA and their families, particularly children under 5 years old and pregnant women, for malaria prevention services, including provision of LLINs.. MOH will also provide referrals for PLWHA and their families to community-service providers for distribution of water purification kits and health education on hygiene to reduce the incidence of diarrheal diseases. In addition, family planning education, counseling and methods will be provided to PLWHA and their spouses. Strengthened psychological support services for PLWHA at clinic and community levels will be done through expanded TRAC training in psychological support for all health facilities and community-based providers, including GBV counseling, positive living, counseling on Prevention for Positives, and follow up of discordant couples. Moreover, MOH in collaboration with ICAP will support the integration of mental health and HIV services at all MOH supported district hospitals. Health providers will be trained in mental health integration and roll out of mental health screening tools to all sites.

In FY08, MOH initiated a new community health policy which calls for the election of male and female leaders for every 100 households to deliver and lead community health activities. These community

health workers (CHWs) will be organized in cooperatives motivated through community PBF, and reimbursements based on the number of patients they assist and quality of services provided. MOH will support facilities to train, equip, and supervise community health leads.

In order to ensure a continuum of HIV care and treatment, MOH, through the Community Health desk, will continue to support health facilities in HIV patient follow-up, and organizing referrals to care services for HIV patients. MOH will work with elected CHWs to develop effective referral systems between clinical care providers and psycho-social and livelihood support services, through the use of patient routing slips for referrals and counter referrals from community to facilities and vice versa. MOH will support health facilities in assessing individual PLWHA needs, organize monthly clinic-wide case management meetings to minimize lost of follow up, and provide direct oversight of CHWs. Depending on the need of individuals and families, health facilities will refer PLWHA to adherence counseling, stigma reducing activities, OVC supporting activities, legal support services, community-based pain management and end-of-life care, in line with national palliative care guidelines.

In collaboration with the Population Council, the National Police and USG clinical partners, the MOH-MCH unit piloted the Sexual Gender Based Violence Initiative at care and treatment sites in FY 2009. The pilot phase allowed the implementation of an SGBV client assessment tool and newly developed HIV/SGBV integration guidelines, as well as the documentation of the lessons learnt to guide the scale up plan for subsequent years. In FY 2010, MOH, in collaboration with TRAC Plus, the National Police and clinical partners will coordinate the scale up of the HIV/SGVB initiative at all district hospitals. These efforts will include developing the capacity of health care providers in SGBV client management as well as the strengthening of SGBV M&E systems.

The MOH will continue to strengthen and assume more oversight of output based financing for PBF, which has been a major component of the Rwandan strategy for ensuring long-term sustainability and maximizing performance and quality of services. With the leadership of MOH's PBF unit, the MOH will continue to support financing based on site performance as a means of improving national HIV performance and quality indicators. Lessons learned during the transition of Track 1.0 activities in FY 2010 will be used to improve the implementation of the Partnership Framework.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	456,615	

Narrative:

This a continuing activity under a new mechanism

FY 2010 is the first year of transition of Track 1.0 partners' activities. Under the transition frame work, ICAP and AIDS Relief will transition 12 and 11 HIV care and treatment sites respectively, to Ministry of Health (MOH). In FY 2010, MOH will ensure the continuum of a comprehensive package of HIV care and support services to patients at the 23 transitioned sites. The package of services includes: clinical staging and baseline CD4 count for all patients; follow-up CD4 every six months; management of OIs and other HIV-related illnesses; OI diagnosis and treatment; routine provision of CTX prophylaxis for all eligible adults based on national guidelines; prevention with positive intervention; basic nutritional counseling and support; positive living and risk reduction counseling; pain and symptom management; and end-of-life care. In addition, MOH will continue to provide psychosocial counseling and referrals for HIV-positive female victims of domestic violence. To ensure comprehensive services across a continuum, MOH, through a partnership with community health workers, will refer patients enrolled in care to community-based services based on their individual need. Such services may include adherence counseling, spiritual support, stigma-reducing activities, OVC support, IGA activities, and HBC services for end-of-life care.

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Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	150,089	

Narrative:

In FY 2010, starts the first year of transition of TRAC1.0 partners' activities; therefore ICAP-CU and AIDS Relief will transition respectively 12 and 11 HCT sites to Ministry of Health (MOH).

During FY 2010, MOH will insure continuity of counseling and testing service at 23 transitioned sites. MOH will provide counseling and testing services to clients including patients from TB service as well as those tested through PITC. The approach of PITC will target adult and pediatric patients presenting with HIV-related OIs such as TB symptoms, malnourished children, HIV-exposed infants, STI patients and all admitted patients. A system to ensure coordination between the different counseling and testing units has been developed and will be re-enforced to enhance adherence and minimize lost of follow up. This activity will be attained through integration of various approaches including community based mobilization for counseling and testing in collaboration with local authorities, an enhanced referral to health facilities and follow-up as well as maximization of all entry points with the health care facilities. These include ordinary HCT, ANC and general consultation rooms plus nutritional centers and admission wards using PITC and provided in a manner that respects human values, ensures confidentiality , and reduces stigma and discrimination.

In FY 2010, MOH will continue to support couples testing at the transitioned sites and reinforce the follow-up of discordant couples. In addition MOH will strengthen counseling and testing M&E system (documentation, utilization of tools, data analysis and reporting) in all services. In order to maintain quality assurance of the services, MOH will continue to support integrated formative supervision of district team. Health center staff will receive new and refresher in-service training on VCT and PITC guidelines.

MOH will continue to support counseling and testing indicators embedded in Performance Based Finance (PBF) as a way of improving both quality and quantity of service provision. MOH will continue to support the quality of data and its utilization for improving the quality of care through regular data quality audits, data analysis training and data sharing workshops and feedback.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	152,888	

Narrative:

In FY 2009, with PEPFAR support, the Ministry of Health (MOH)/HIV integration task force supports capacity building in pediatric HIV care and treatment at the district level. Support is provided in planning, implementation, coordination, and supervision of activities; in holding district performance improvement meetings; to enhance the integration of pediatric care and treatment activities in other district health programs; and to improve linkages between HIV programs. MOH, in collaboration with USG implementing partners and the Global Fund, also supports the expansion of quality pediatric services to

more decentralized sites within the health care system. Moreover, MOH and TRAC Plus staff undertake formative supervision of pediatric HIV care and treatment activities in each district at least biannually.

In FY 2010, MOH/UPDC will continue to strengthen the capacity of districts to plan, implement, supervise and to coordinate pediatric HIV care and treatment activities. The provision of support for the expansion of quality pediatric services at decentralized levels will also continue through mentoring of health care providers working in hospitals and health centers in pediatric clinical HIV care, basic care and support, patient record-keeping, data recording and use, and quality performance measurement and improvement. During biannual formative supervision visits to districts, a standard checklist will be used to assess the quality and integration of pediatric HIV services. Supervisors will provide regular feedback to sites and share with them best practices in pediatric care and treatment.

FY 2010 starts the first year of transition of TRAC 1.0 partners' activities to the MOH: ICAP-CU and AIDS Relief will transition 12 and 11 HIV care and treatment sites, respectively. MOH will insure the continued provision of a comprehensive package of pediatric HIV care and treatment services at23. This package of services is provided in collaboration with local community service providers and includes co-trimoxazole prophylaxis, nutrition counseling, food support, and safe water interventions. In addition, district supported sites provide follow-up services for HIV-exposed infants who are maintained on co-trimoxazole prophylaxis until their HIV status can be confirmed through the early infant diagnosis program. Sites will link with malnutrition and TB centers within their facilities or at specialized sites located in the vicinity to provide HIV testing to all pediatric in- and outpatients and enroll the infected children into care and treatment services. Districts will endeavor to establish and strengthen linkages with PLWHA cooperatives in the local network, and the administrative district authorities and health teams to support activities aiming at increasing awareness in communities on issues related to pediatric HIV with a view to increasing pediatric HIV testing and enrollment into care. At PMTCT sites, enhanced follow-up of mothers and exposed infants will be promoted through support groups of HIV-positive women based on the mother-to-mother model. In this model, women who demonstrate steady consultation attendance and good baby care are identified and used to coach new HIV-positive mothers during pregnancy and after delivery to ensure that both women and their infants access needed services. HIV-exposed infants identified at PMTCT sites will be followed in the context of existing MCH services offered at supported sites. Relevant HIV-related information on mothers and infants will be transferred from PMTCT to other MCH programs through the "carte de liaison" that is currently in use in Rwanda. MOH will also strengthen the capacity of district health teams to ensure that samples collected at the sites are transferred efficiently to the National Reference Laboratory in Kigali and to Butare University laboratory for processing. At MOH-supported sites, HIV-positive children will be staged clinically and using CD4 (counts or percentages as these become available), and eligible infants and children will be enrolled in ART. MOH will work with clinical implementing partners to train health care providers on newly updated

pediatric HIV treatment guidelines which include changes for new regimen, early treatment of HIV-positive infants, and in CD4 thresholds for treatment initiation in children between 36 and 59 months of age.

All pediatric patients will have regular anthropometric evaluations to identify early signs of malnutrition and to ensure prompt initiation of nutrition rehabilitation interventions. Newly identified patients will be screened at enrollment and at regular intervals for signs and symptoms of common opportunistic infections or other infectious complications of HIV in children, including: candidiasis, pneumonia, malaria, meningitis, and Pneumocystis jiroveci pneumonia (PCP). In addition, all pediatric patients will be screened for TB at enrolment and at each follow up visit using the set of 5 questions developed by the National TB Program (PNILT). Children suspected of having TB will be further investigated, and if infection or exposure is confirmed, they will be put on TB treatment or INH prophylaxis based on current national guidance. Additionally, infants and children on ART will be assessed at each visit for issues related to adverse events, toxicity and adherence to ART. Staff will be trained to ensure, as much as possible, the early detection of signs of immunologic and clinical failure, and the initiation of second-line treatment regimens based on national guidance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	48,463	

Narrative:

In FY 2009, with the PEPFAR support, the Ministry of Health (MOH)/HIV integration task force supports capacity building in pediatric care and treatment at the district level. Support is provided in planning, implementation, coordination, and supervision of activities; in holding district performance improvement meetings; to enhance the integration of pediatric care and treatment activities into other district health programs; and to improve linkages between HIV programs. MOH, in collaboration of USG implementing partners and the Global Fund, also supports the expansion of quality pediatric services to more decentralized sites within the health care system. Moreover, MOH and TRAC Plus staff undertake formative supervision of pediatric HIV care and treatment activities in each district at least twice per year.

In FY 2010, MOH/UPDC will continue to strengthen the capacity of districts to plan, implement, supervise and to coordinate pediatric HIV care and treatment activities. The provision of support for the expansion of quality pediatric services at decentralized levels will also continue through mentoring of health care providers working in hospitals and health centers in pediatric clinical HIV care, basic care and support, patient record-keeping, data recording and use, and quality performance measurement and improvement. During biannual formative supervision visits to districts, a standard checklist will be used to assess the quality and integration of pediatric HIV services. Supervisors will provide regular feedback

to sites and share with them best practices in pediatric care and treatment.

FY 2010 starts the first year of transition of TRAC1.0 partners' activities to the MOH: ICAP-CU and AIDS Relief will transition 12and11HIV care and treatment sites, respectively. MOH will insure the continued provision of a comprehensive package of pediatric HIV treatment services at23 transitioned sites.. The package includes treatment with ARV drugs, routine CD4 follow-up according to the national guidelines, viral load testing, screening and management of ARV drug side effects, treatment adherence counseling and patient referral to community-based care.

MOH will work with health facilities on the implementation of updated pediatric HIV treatment guidelines which include changes for early treatment of HIV-positive infants and in CD4 thresholds for treatment initiation of children between 36 and 59 months of age. MOH will ensure that site-level providers are trained or receive refresher training sessions in pediatric HIV patient management. This training will include, among other topics related to pediatric HIV care, the new national pediatric treatment guidelines, identification and management of treatment failure cases, and psychosocial support to children, adolescents and their families. All pediatric patients will have regular anthropometric evaluations to identify early signs of malnutrition and to ensure prompt initiation of nutrition rehabilitation interventions.

Providers will receive regularly planned in-service trainings and coaching sessions. MOH supervisors will carry out monthly site visits for staff mentoring during which support will continue to be provided for the improvement of service provision, the strengthening of children support group activities, and for the active tracking of follow-up defaulters.

Through the Supply Chain Management Services (SCMS), MOH will ensure the provision of antiretroviral drugs, CD4 tests, and other commodities and laboratory supplies for the clinical monitoring of infants and children on ART. Work with SCMS will also ensure that sites have reliable forecasting and stock management systems in place and that they provide accurate reports to SCMS and CAMERWA on their commodity needs for pediatric care and treatment.

In addition, MOH in collaboration with AIDS Relief and ICAP, will continue to train managers and health service providers in the use of the IQChart software. With improved data on pediatric HIV care and treatment, MOH, in collaboration with TRAC Plus, the national performance-based financing program, and the HEALTHQUAL project, will support health facilities to build and sustain a system of quality performance measurement and improvement. Basic pediatric HIV care, support and treatment data will be used to regularly review program performance and to design/implement appropriate interventions to improve the quality of services provided to children and their families. MOH staff in charge of each district will ensure that meetings to review internal data take place on a regular basis and that the improvement

plans are implemented at individual sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	550,440	

Narrative:

PEPFAR II strategic thinking is built around host country ownership and participation during the program life-cycle. This is strongly reflected in the full and active involvement of the Ministry of Health (MOH) in the identification, design and implementation of activities in the strategic information technical area. Support provided to the MOH embraces two of the three SI technical areas, namely HMIS and Monitoring and Evaluation. PEPFAR will continue to support ongoing interventions funded through the Cooperative agreement established with the US Centers for Disease Control and Prevention (CDC).

Through PEPFAR's technical and financial support, key strategic documents have been developed during FY 2008 and FY 2009. They include the national Monitoring and Evaluation policy, the Monitoring and Evaluation strategic plan, the Health Information System strategic plan and the e-Health strategic plan. These strategic plans are at different levels of implementation, and PEPFAR will support these efforts during FY 2010.

The Ministry of Health will continue to strengthen the capacity of district level managers to facilitate the search for the root causes of unsatisfactory performance of health facilities. In coordination with TRAC Plus, the M&E Task Force of the MOH will revitalize the national disease surveillance system to achieve timely and complete reporting across the levels of the health system. PEPFAR funding will support the recruitment of 4 staff for the e-Health Secretariat within the Ministry of Health.

In addition to these on-going interventions, the SI TWG has identified new activities to be carried out during FY 2010. These interventions will contribute to the strengthening of the current health information system and provide quality data to PEPFAR and the health sector in general.

MOH will develop standard operating procedures (SOP) for data management and feedback. This document will be widely distributed to provide clear guidance on data management at all levels of the health system. It will be also useful for the district authorities given their roles in the decentralization process. Data managers and information officers at district level will be trained in data management with PEPFAR financial support.

The MOH is engaged in an effort to increase its technical assistance to its decentralized bodies at the district level. In FY 2010, steps will be taken to conduct regular formative supervision to the district

hospitals that in turn will provide assistance to health centers in their catchment area. A supervision protocol and tools will be developed for district managers to improve both service delivery and data use for decision making at the district and health facility levels.

During FY 2009 the Ministry of Health published its first annual health statistics bulletin that was compiled from various data sources. This document has proved to be a useful compendium of health statistics. The second bulletin will be developed during FY 2010 with technical and financial support of PEPFAR. The document will be widely disseminated through different channels including workshops and websites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	679,890	

Narrative:

During the course of PEPFAR I health facilities were provided with the physical resources necessary to provide high quality HIV services. Through this initiative, the majority of health facilities have been provided with a power source. A national strategy has been developed to achieve the Economic and Development Poverty Reduction Strategy's goal of providing all health facilities with a source of power by 2012. In FY 2010, with PF funds, the remaining facilities will be provided with a source of power.

Through PEPFAR, equipment has been procured for laboratories and health facilities to allow HIV service delivery. In FY 2010, through this award, support for a sustainable maintenance system will be provided. At central level this will include: performance incentives against clear objectives for maintenance unit staff; training of six central level maintenance staff in biomedical engineering; technical assistance for the maintenance unit to provide training for technicians; development of contracts with the private sector; and creation of procedures for the procurement of spare parts and tools for maintenance and repair of medical and laboratory equipment. The funds will allow emergency procurement of spare parts, tools, equipment and materials for reparations and maintenance. At the district level this will include provision of training and logistics to district level technicians to allow them to provide preventative maintenance and reparations of health facility equipment (including energy equipment) in collaboration with the private sector and health facility staff. Supply of logistics (including motorbikes) to district level technicians will be in tandem with other donors that offer this support. USG supported facilities will be the primary recipients of USG procured equipment.
In FY2010 five new positions will be supported at the Ministry of Health to support and coordinate transition activities and reinforce capacity building in M&E. The new coordinator, financial administrator, two M&E officers, and one data manager will work together to improve the quality of HIV services at the 23 sites being transitioned to the MoH in FY10.
In FY 2010 awareness-raising campaign will begin on maintenance of equipment, targeted at district level

managers and supervisors at health facilities. These personnel will receive training on planning and budgeting for equipment maintenance and replacement, while staff will be trained on the correct use and care of equipment, thus preventing an estimated 50% of equipment failures. All appropriate communication strategies will be use to achieve this goal.

In FY 2010 the award will allow senior maintenance staff to participate in international conferences, helping them stay current in their knowledge of cost saving and environmentally friendly technologies, as well as innovative maintenance strategies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	168,257	

Narrative:

Introduction

It is anticipated that hospital-acquired infections contribute to morbidity and mortality of patients that seek healthcare services in Rwanda. Mismanagement of injections and use of other sharps may result in the transmission of infectious diseases, such as HIV/AIDS, Hepatitis "B" and Hepatitis "C" to the consumers and the health care providers.

Background

According to the national cross-sectional survey conducted in July-August 2004 in Rwanda, about 28% of the injections observed were about to be given with un-sterile needles and/or syringes. Following inception of JSI/R&T project, the situation has greatly improved although a lot needs to be addressed as 38% of the health facilities visited had sharps and other wastes in the compound, thus exposing the community to needle-stick injuries (MOH data). Health facilities were not equipped with knowledge in injection safety and healthcare waste management and did not have proper waste disposal facilities.

More than 36%of the service providers interviewed reported at least one needle stick injury during the same survey. Recapping with two hands was observed in 47% of preventive injections and in 59% of therapeutic injections. The community is also exposed to hazardous sharp waste. In order to minimize risks of transmission of HIV/AIDS and other blood borne pathogens through unsafe injections, the Ministry of Health (MOH) has phased out the use of sterilizable injection instruments (syringes and needles). Furthermore, a National Injection Safety and Health Care Waste Management sub-policy has been developed and approved by the MOH Senior Management in 2009. The healthcare waste management strategic plan is currently being developed and guidelines will soon be updated, printed and distributed to health facilities.

INJECTION SAFETY AND HEALTH CARE WASTE MANAGEMENT IN FY 2010

Reduction of blood-borne HIV transmission in clinical environments
The Environmental Health Desk (EHD) of the Ministry of Health in collaboration with JSI/R&T will develop the terms of reference in areas that require capacity building. EHD will identify areas that require capacity building and organize the training of healthcare workers and waste handlers on injection safety and healthcare waste. Incinerator operators and their supervisors will also be trained on the use and maintenance of incinerators. All beneficiaries of this training program will be those who have never been exposed to these training before, especially newly employed staff. A strategic plan for prevention of infections will be developed to enable healthcare workers and waste handlers to protect themselves against HIV and Hepatitis B.

EHD will identify all of the required materials, consumables and equipment for injection safety and healthcare waste management and link them to the procurement organization SCSM which will in turn ensure the procurement of needed items in sufficient quantities and of the right quality.

Reduce blood-borne HIV transmission outside clinical environments
EHD in the MOH in collaboration with JSI/R&T and key partners will implement the plan of constructing the multipurpose waste pits and installation of appropriate incinerators for the disposal of medical waste. Guidelines and specifications of waste pits and incinerators will be provided in collaboration with EHD, World Health Organization and John Snow, Inc. EHD will also organize training workshops in all sectors for community health workers and equip them with knowledge that will enable them to sensitize communities on injection safety and medical waste best practices.

EHD in collaboration with JSI/R&T and USG will conduct joint supervisory visits on injection safety and healthcare waste management practices in health facilities and district administration. A monitoring and evaluation specialist will be hired to ensure smooth and successful implementation of activities as well as determining areas that need urgent problem solving and advice. Collection of data for analysis of the program for appreciation or re-planning will be organized and preparation of reports for program management officers will also be organized.

EHD is keen to follow up all steps of the implementation of the program so that when JSI/R&T completes the transition exercise with MOH/EHD through transferring of competences, roles and responsibilities, the MOH/EHD will have enough experience to run the program effectively and efficiently.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	758,042	

Narrative:

PMTCT services uptake in Rwanda is high as indicated by ANC attendance and HIV counseling and testing. However mother and infant follow-up is weak due to high rates of home delivery and infants lost to follow-up. ICAP-CU and AIDSRelief have provided ongoing site level implementation support to the district hospital multidisciplinary teams to improve uptake of PMTCT. The PMTCT package includes CT, screening for STIs, infant feeding counseling, implementation of more efficacious PMTCT regimen, prompt CD4 count and clinical staging for HIV-positive pregnant women, combination ARV prophylaxis for non-eligible women and rapid initiation of HAART for eligible women, and delivery following safer practices, infants and mother follow-up, CTX for OI prevention and infant HIV testing; and supporting human resources by providing high-quality training and clinical mentoring.

In FY 2010, under the first year of transition of Track 1.0 partners' activities, ICAP-CU and AIDSRelief will transition PMTCT supported sites to MOH.

MOH will ensure continuity of provision of a comprehensive PMTCT package at the transitioned sites, including CT, screening for STIs, infant feeding counseling, implementation of more efficacious PMTCT regimen, prompt CD4 count and clinical staging for HIV-positive pregnant women, combination ARV prophylaxis for non-eligible women and rapid initiation of HAART for eligible women, and delivery following safer practices, infants and mother follow-up, CTX for OI prevention and infant HIV testing including early infant diagnosis. In additional MOH will support human resources by providing high-quality training of PMTCT providers. Task-shifting instruction is being implemented at PMTCT sites (which will in the future also provide ART) in order to decrease loss to follow up, which must be avoid during pregnancy in particular. Supportive supervision and mentorship will further be reinforced. MOH will also promote integration with other MCH (including malaria interventions, nutrition support, IMCI) and linkages with OVC services. MOH will also identify and refer victims of gender-based violence (GBV) to appropriate care.

In FY 2010, MOH will use community health workers to increase health facility delivery for HIV-positive women thus ensuring completion of the more efficacious PMTCT regimen. In addition, MOH will reinforce district's outreach team workers in order to track PMTCT defaulters and conduct home visits if needed.

Ministry of Health will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing male partner involvement and community participation in PMTCT services. Health center staff will receive new and refresher in-service training on new PMTCT protocol, including use of site-level algorithms and checklists, as well as laboratory monitoring. MOH will sustain the PMTCT

follow-up system through support to sites for formal meetings and referrals to ensure that mothers and exposed children are followed regularly in PMTCT ward but also from vaccination, TB and nutrition wards to care and treatment.

To ensure the FP/HIV integration, in FY 2010 MOH will also support the revision, printing and dissemination of FP/HIV integration guidelines and tools. Moreover MOH will assist district team in training health providers on FP//HIV integration. In addition MOH will support salary of FP/HIV technical advisor and will develop and disseminate the GBV guidelines and tools.

MOH will collaborate with Catholic Relief Service (CRS) which is the principle PEPFAR sub-awardee for the purchase and distribution of nutritional supplements to people infected and affected by HIV and AIDS including weaning food supplements in PMTCT as well as nutrition support to eligible pregnant and lactating mothers.

To improve HIV exposed infant follow-up, MOH will facilitate the implementation of the updated immunization card containing HIV information by printing and disseminating this card nation-wide.

With the leadership of PBF unit within Ministry of Health and in collaboration with ICAP and AIDSRelief, MOH will continue to support the financing based on site performance in improving key national PMTCT performance and quality indicators.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	173,250	

Narrative:

In FY08, the USG supported the renovation of the laboratory at CHUK for microbiology, tuberculosis and histopathology. In FY 2009, the USG will continue to support the laboratory by assisting the Ministry of Health (MOH) to build human capacity for histopathology for the diagnosis of extrapulmonary tuberculosis and for the diagnosis of cancers in HIV patients

In FY 2010, the USG will support long term capacity building needed in the laboratory of CHUK. Indeed, the CHUK laboratory plans to organize training for one microbiologist and one histotechnician. The CHUK lab will need also to strengthen the management of routine activities in the purchase of equipment, consumables and reagents.

The USG will support the purchase of equipment and reagents for the laboratory and the training of six physicians in anatomical pathology. Several physicians will be sent abroad for specialized training in

pathology while two physicians supported by GOR located at CHUK and two supported by GOR located at CHUB will be trained in country. The two physicians at CHUK will be trained by the CDC-hired histopathologist seconded to the MOH and the two physicians at CHUB will be trained by the pathologist on staff at that location. Once the pathologists abroad have completed their training and returned to Rwanda, GOR will seek to send several other physicians for training. This cycle will continue until all are trained. By identifying local physicians to be trained as pathologists in country and abroad, a pool of Rwandan pathologists will be developed to sustain the program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	366,413	

Narrative:

The objective of TB-HIV collaborative activities is the establishment and expansion of "one stop services" where patients have access to a complete package of services for both HIV/AIDS and TB diagnosis and treatment. Support includes initial infrastructure development (labs and referral systems), mentoring and supervision to clinical staff, expansion and improvement in screening and diagnosis of TB for HIV-positive adults and children, improved and integrated monitoring and evaluation, and improved TB case detection rates. Infrastructure improvements are crucial in TB prevention.

As outlined in the Partnership Framework, in FY 2010 MOH in collaboration with PNILT will implement key policy areas for TB infection control activities in Rwanda in order to reduce the likelihood of TB transmission in health care facilities. These activities will include rehabilitating health centers (n=TBD) and 8 districts hospitals according to national TB infection control requirements. Patient waiting areas and TB admission patient wards will be rehabilitated at specified health facilities. In addition, MOH will improve and expand its current District-level supervision activities to include activities relating to the quality of diagnosis of TB suspects.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10827	**Mechanism Name: Technical Assistance to the National Blood Transfusion Center**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Association of Blood Banks	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 544,501	
Funding Source	**Funding Amount**
GHCS (State)	544,501

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Blood Safety seeks to reduce the medical transmission of HIV through technical support from the American Association of Blood Banks (AABB) provides technical assistance to the National Center for Blood Transfusion (CNTS) to ensure for the provision of adequate supplies of safe blood to all health care facilities in Rwanda. Through twinning, AABB institutional partners will provide expert guidance and technical assistance to the CNTS, resulting in better practices in donor recruitment, blood collection, laboratory quality assurance, blood bank management and transfusion practice. This support will include training, monitoring, guidance, oversight and mentoring through site visits and performance evaluation. This linkage will strengthen the CNTS and improve institutional capacity for effective program management. Furthermore, it will result in enhanced sustainability and safety of the blood supply through human resource capacity building for current and future CNTS staff members. This will be accomplished through the development of a comprehensive, job-specific training plan designed to build confidence and didactic knowledge of blood safety activities. The AABB gap analysis performed in 2009 provided information which, together with follow-up discussions, will be used to form an action plan for further activities for 2010 and beyond.

The activities planned for this period are based on the priorities as identified in the gap analysis. The first activity will center on donor qualification and screening. Currently, the CNTS does not utilize a standardized donor history questionnaire to screen the donor population. The activity planned to address this deficiency will incorporate a design, training and implementation phases in which where expert consultants will assist the CNTS in designing an adequate donor questionnaire to screen out potential high-risk donors. In addition, this workshop will focus on the appropriate transfer of knowledge and skills necessary to equip the CNTS staff in utilizing this tool. The final phase of this activity will involve AABB oversight of the implementation of this tool out in the field. AABB expert consultants will be on hand to assist as the tool is incorporated into daily practice. This overall strengthening of donor screening will also include training and implementation on donor hemoglobin screening using copper sulfate

methodology and donor temperatures. The appropriate procedures and forms will be developed in collaboration with CNTS staff and implemented simultaneously with the donor history questionnaire. Workshop participants will include donor services personnel (phlebotomists, recruiters, counselors, data clerks) as well as the quality assurance officer.

Another priority activity that which will be carried out during this time-frame involves the elaboration of a strategy to perform donor notification of positive HIV test results. Currently, no partnership exists between the CNTS and the HIV counseling and testing (VCT) clinics for the handling of those donors who test positive for HIV. This workshop activity will assist the CNTS in defining the policy and approach to notifying donors. A feasibility study will be carried out to assist the CNTS in defining the appropriate human resources necessary to undertake this responsibility as well as additional equipment needed (e.g., vehicles for donor notification purposes). Due to Because of infrastructure limitations with the national postal service, donor notification is best carried out in person by qualified and trained CNTS staff members. Because this is a new function, the requisite training in counseling will need to be provided to CNTS staff members charged with this duty. In addition, new educational material will need to be developed to provide both staff member and donor with the knowledge to refer/seek treatment options at locally available VCT clinics.

An absolute prerequisite to donor notification is the identification of a suitable partner for the CNTS to perform confirmatory testing prior to notification. The appropriate partnership will need to be developed in terms of test methodology, sample requirements, testing schedules, and policy development. Due to the fact that this partnership involves other Ministry of Health departments, close communication will need to be maintained at the highest levels to ensure this priority is addressed. This e above workshop activity will incorporate an create an opportunity to elaborate on the necessary policy and forms required for confirmatory testing.

Another priority area to be addressed during this time period is the appropriate management of equipment. An area that was discovered in dire need of corrective action pertains to the proper validation of equipment used in the collection, testing, processing and storage of blood components is an issue in dire need of corrective action, as is the. An additional area of need was identified in the ongoing preventive maintenance of such equipment. An extensive workshop will be planned to target both the quality assurance officer, biomedical engineer, managers of laboratories and chief technologists in the importance of proper installation, operational and performance qualification,; as well as ongoing preventive maintenance. This workshop will provide basic knowledge and understanding on designing and documenting equipment validation studies. An additional focus of this workshop will be the twinning of the CNTS biomedical engineer with the AABB consultant engineer to train on equipment maintenance and testing.

Twinning has also been identified as an important area to focus on for the development and enhancement of knowledge for CNTS Staff. In particular, AABB will help to identify an appropriate partner to facilitate the twinning experience. Furthermore, in collaboration with the twinning partner, AABB will help develop in collaboration with the twinning partner the appropriate twinning curriculum, objectives, outcome measures and evaluation tools. The twinning program will focus on the transfer of knowledge for implementing quality systems and as such the first identified participants will be the Quality Assurance Officer. It will be expectation that the twinning participants will bring back the knowledge gained and begin training others and implementing quality systems within the CNTS.

A workshop activity focusing on standard operating procedure (SOP) writing skills and incorporating best practices will be carried out with key CNTS personnel to facilitate the strengthening of SOPs. Many of these revisions will focus on improving the process control of the CNTS over its products and services. Didactic knowledge of change control and document control will be provided to the workshop participants.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10827**		
Mechanism Name:	**Technical Assistance to the National Blood Transfusion Center**		
Prime Partner Name:	**American Association of Blood Banks**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	544,501	
Narrative:			
The American Association of Blood Banks (AABB) provides technical assistance to the National Blood Transfusion Center (CNTS) to ensure the provision of adequate supplies of safe blood to all health care facilities in Rwanda. Through twinning, AABB partners will provide expert guidance and technical			

assistance to CNTS, resulting in better practices in donor recruitment, blood collection, laboratory quality assurance, blood bank management and transfusion practice. This support will include training, monitoring, guidance, oversight and mentoring through site visits and performance evaluation. This linkage will strengthen CNTS and improve institutional capacity for effective program management. Furthermore, it will result in enhanced sustainability and safety of the blood supply through human resource capacity building for current and future CNTS staff members. This will be accomplished through the development of a comprehensive, job-specific training plan designed to build confidence and knowledge of blood safety activities. The AABB gap analysis performed in 2009 provided information which, together with follow-up discussions, will be used to form an action plan for further activities for 2010 and beyond.

The activities planned for this period are based on the priorities as identified in the gap analysis. The first activity will center on donor qualification and screening. Currently, CNTS does not utilize a standardized donor history questionnaire to screen the donor population. The activity planned to address this deficiency will incorporate design, training and implementation phases in which expert consultants will assist CNTS in designing an adequate donor questionnaire to screen out potential high-risk donors. In addition, this workshop will focus on the appropriate transfer of knowledge and skills necessary to equip CNTS staff in utilizing this tool. The final phase of this activity will involve AABB oversight of the implementation of this tool in the field. AABB expert consultants will be on hand to assist as the tool is incorporated into daily use. This overall strengthening of donor screening will also include training and implementation on donor hemoglobin screening using copper sulfate methodology and donor temperatures. The appropriate procedures and forms will be developed in collaboration with CNTS staff and implemented simultaneously with the donor history questionnaire. Workshop participants will include donor services personnel (phlebotomists, recruiters, counselors, data clerks) as well as the quality assurance officer.

Another priority activity which will be carried out during FY 2010 involves the elaboration of a strategy to perform donor notification of positive HIV test results. Currently no partnership exists between CNTS and HIV counseling and testing (VCT) clinics regarding the handling of those donors who test positive for HIV. This workshop will assist CNTS in defining the policy and approach to notifying donors. A feasibility study will be carried out to assist CNTS in defining the appropriate human resources necessary to undertake this responsibility as well as additional equipment needed (e.g., vehicles for donor notification purposes). Due to limitations with the national postal service, donor notification is best carried out in person by qualified and trained CNTS staff members. Because this is a new function, the requisite training in counseling will need to be provided to CNTS staff members charged with this duty. In addition, new educational material will need to be developed to provide both staff member and donor with the knowledge to refer/seek treatment options at locally available VCT clinics.

An absolute prerequisite to donor notification is the identification of a suitable partner for CNTS to perform confirmatory testing prior to notification. The appropriate partnership will need to be developed in terms of test methodology, sample requirements, testing schedules, and policy development. Due to the fact that this partnership involves other MOH departments, close communication will need to be maintained at the highest levels to ensure this issue is addressed. This activity will create an opportunity to elaborate on the necessary policy and forms required for confirmatory testing.

Another priority area to be addressed during this time period is the appropriate management of equipment. The proper validation of equipment used in the collection, testing, processing and storage of blood components is an issue in dire need of corrective action, as is the ongoing preventive maintenance of such equipment. An extensive workshop will be planned to target the quality assurance officer, biomedical engineer, managers of laboratories and chief technologists in the importance of proper installation, operational and performance qualification, as well as ongoing preventive maintenance. This workshop will provide basic knowledge and understanding on designing and documenting equipment validation studies. An additional focus of this workshop will be the twinning of the CNTS biomedical engineer with the AABB consultant engineer to train on equipment maintenance and testing.

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A workshop focusing on standard operating procedure (SOP) writing skills and incorporating best practices will be carried out with key CNTS personnel to facilitate the strengthening of SOPs. Many of these revisions will focus on improving the process control of CNTS over its products and services. Didactic knowledge of change control and document control will be provided to the workshop participants.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10954	**Mechanism Name: HIV Care and Treatment to the Rwanda Defense Forces (RDF)**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: Drew University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,958,468	
Funding Source	**Funding Amount**
GHCS (State)	1,958,468

Sub Partner Name(s)

Drew Cares International		

Overview Narrative

Under the Rwanda Defense Force (RDF), there are a total of three military hospitals and five brigade clinics throughout the country. Drew University began working in two military hospitals and three brigade clinics in FY 2005. The support includes TA and training on ARV and palliative care, M&E, and lab infrastructure.

In addition, Drew University will provide 2300 pregnant women with HIV counseling and testing for PMTCT who will then receive their results and be provided with an expanded package of PMTCT services including: CT with informed consent; male partner and family centered testing; Intermittent preventive Treatment in pregnancy (IPTP) in collaboration with PMI; ARV prophylaxis using an expanded bi-therapy regimen and ARV treatment for eligible women; infant feeding counseling and support; referral for FP and MCH services; and close follow-up of exposed infants for effective transfer to appropriate services. In collaboration with CRS who is procuring local fortified food, Drew University will provide weaning food for exposed infants in need. Through the Directorate of Military Services (DMS) and a combination of input TA and output performance-based financing, Drew University will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services.

Drew University will train RDF providers with new and refresher on-the-job training in the expanded national PMTCT protocol, including use of site-level algorithms and checklists, as well as for laboratory

monitoring. In collaboration with DMS, Drew University will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E of PMTCT. Drew University will support DMS build their QA and M&E skills, including in data collection, data use, and reporting.

Additionally, it is increasingly becoming hard for HIV-positive soldiers to disclose their status to their spouses in the absence of a professional counselor. To respond to this, both the RDF and Drew University plan to use RDF HIV-positive males as the entry points to their families. Drew University will build a strong family tracking approach based on the information systems where cross-cutting data of each HIV-positive soldier has been collected and categorized during the mobile treatment and care unit, implemented at the brigade level. To do this, Drew University will organize training sessions for identified at-risk spouses of HIV-positive soldiers, and simultaneously conduct HIV counseling and testing.

In this "pool" of at-risk soldiers' spouses, Drew University will promote PMTCT-seeking behavior and support identified HIV-positive soldiers' spouses to bring their children for HIV testing. Drew University will strengthen the community outreach services such as home based care especially in hard-to-reach areas, to encourage HIV-positive women to have their children tested. Drew University will maximize the potential of health centers (with PMTCT services) in targeted areas, through training, linkages, referrals and physical hand-over of dossiers, to take-over follow-up of the identified HIV-positive soldiers' spouses in a sustainable manner. During FY 2010, couple HIV counseling will be an important tool of improving PMTCT services uptake, as part of a comprehensive approach to HIV treatment and care in RDF settings. Drew University will ensure that PMTCT services at RDF health settings conform to national and international standards through training of 85 health service providers in 8 RDF health facilities on PMTCT service delivery skills, and provision of materials and equipments. Drew University will make linkages with other USG food partners, such as WFP and CRS/IBYIRINGIRO, in order to ensure access to adequate nutrition support for pregnant and lactating mothers as well as infants.

In collaboration with other USG partners, Global Fund, and PMI, case managers and providers will refer PMTCT clients and their families to HBC, OVC support, IGA, and facility- and community-based MCH services promoting key preventive interventions such as bednets, immunizations, hygiene/safe drinking water and nutritional support. These community-based services will assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants, as well as promote MCH and PMTCT health seeking behaviors which will intensify case finding and improve adherence to the new regimen. In addition these case managers provide quality HIV treatment to infected children and ensure referrals of pediatric patients from PMTCT sites to ARV service and to nutrition centers.

Through CAMERWA/SCMS, Drew University will ensure ARV drugs, CD4 tests, RPR test kits, PCR, rapid

HIV test kits, and hemoglobin testing materials are available in all supported sites.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10954**		
Mechanism Name:	**HIV Care and Treatment to the Rwanda Defense Forces (RDF)**		
Prime Partner Name:	**Drew University**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	278,728	

Narrative:

In FY 2009, with PEPFAR assistance, Drew University supported BCS at three military hospitals and five brigade clinics, providing palliative care to 2,006 PLWHA. Basic care services supported by Drew included clinical staging and baseline CD4 count for all patients; follow-up CD4 tests; management of OIs and routine provision of CTX prophylaxis for eligible adults, children and exposed infants based on national guidelines; basic nutritional counseling and support; positive living and risk reduction counseling; pain and symptom management; and end-of-life care. Drew also provided psychosocial counseling and referrals for HIV-positive female victims of domestic violence in the community served.

In addition, Drew trained peer educators to provide social support to HIV+ individuals, and periodic discussion group workshops were organized to increase treatment adherence and share success stories. In collaboration with the CHAMP project, the Global Fund and PMI, Drew referred the 2,006 PLWHA and their families to malaria prevention services, including the provision of bed nets. Drew assisted the RDF to strengthen referrals to community-based support groups for improved treatment adherence and increased access to non-clinical HIV care services. Through the Partnership for Supply Chain Management, Drew provided OI-related drugs, CD4 testing, and OI diagnostics for the clinical management of PLWHA. Drew worked with SCMS to ensure appropriate stock management, inventory

control, and storage for all USG-procured commodities at Drew-supported sites.

In FY 2009 Drew developed and distributed an HIV care package to all HIV+ individuals receiving care at its supported sites and contributed to the Mutuelles health insurance plan for all individuals receiving HIV care at Rwandan Defense Force (RDF) sites. Through PEPFAR support, Drew ensured the provision of improved quality of HIV treatment and care services, and trained 85 RDF providers at the facility level in diagnosis and treatment of STI/OIs/mental health disorders. To improve the health of HIV+ patients, Drew implemented a mobile treatment and care unit (MTCU) affiliated with the health facility, which conducted outreach HIV staging, clinical evaluation and treatment initiation and conducted follow-up with hard-to-reach HIV+ patients. The MTCU ensured the provision of a continuum of care and treatment services, which included but is not limited to: basic HIV laboratory tests; STIs/OIs screening and treatment; provision of CTX prophylaxis; ART; ART adherence support; psychosocial support; family planning; nutrition counseling; prevention for positives; HIV status disclosure; spiritual care; bereavement care; and hygiene and malaria education. BCS activities were implemented in conjunction with other services such as VCT, FP, ART, TB/HIV, OIs, and/or STIs at RDF facilities.

In FY 2010, these activities will continue at three military hospitals and five brigade clinics. Drew will continue to provide technical assistance to RDF to strengthen linkages between community-based and clinic based HIV care services. At brigade and/or community levels, Drew will support: the formation of civilian and military allied associations of PLWHA and train members in provision of home-based care services; access to locally available and/or self-initiated nutritional support; HIV prevention with positives, which includes training of caregivers on adequate management, distribution and use of care package; and clinical HIV detection and referral. Drew will intensify its support in regular follow-up and referral of clients in order to retain clients through quality services delivery. In FY 2010, Drew will also conduct an operational research to determine the causes of increasing loss to follow-up of pre-ART and ART patients at supported sites. Drew will also continue to support SGBV initiatives being piloted in collaboration with the Population Council, the National Police, MOH-MCH unit and other USG partners. SGBV activities will be extended to other supported sites once initial assessments have been completed.

Drew University will continue to support capacity building in the military for program management, clinical care of patients and in M&E systems and data use for decision making and progressive transition activities to the host institution for sustainability of HIV services. To ensure comprehensive services across a continuum of care, Drew, through a partnership with peer educators and other community services providers, will refer patients enrolled in care to community-based BCS services based on their individual need. These services include adherence counseling, spiritual support, stigma-reducing activities, OVC support, IGA activities, and HBC services for end-of-life care. In collaboration with the supply chain partner, Drew will continue to provide diagnostic kits, CD4 tests, and other exams for clinical

monitoring, and will work with the supply chain partner to ensure appropriate storage, stock management, and reporting of all OI-related commodities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	1,151,816	

Narrative:

Drew University works to improve the capacity of the Rwandan Defense Force (RDF) to provide quality HIV treatment and care for military personnel, their partners and families, and community members who live in the areas surrounding military facilities. In FY 2009, with PEPFAR assistance, Drew University supported services at three military hospitals and five brigade clinics, providing treatment to 2,006 PLWHA.

Through its mobile team and eight services sites, Drew ensured the provision of a continuum of care and treatment services, which includes: basic HIV laboratory tests; clinical staging and CD4 counts for all patients; a control CD4 count every six months; STIs/OIs screening and treatment; provision of CTX prophylaxis; ART; ART adherence support; psychosocial support; referrals for victims of SGBV; family planning; nutrition counseling; prevention for positives; HIV status disclosure; spiritual care; bereavement care; and hygiene and malaria education.

In addition to treatment services, in FY 2009 Drew trained peer educators to provide social support to HIV+ individuals, and periodic discussion group workshops were organized to increase treatment adherence and share success stories. In collaboration with the CHAMP project, the Global Fund and PMI, Drew referred the 2,006 PLWHA and their families to malaria prevention services, including the provision of bed nets. Drew assisted the RDF to strengthen referrals to community-based support groups for improved treatment adherence and increased access to non-clinical HIV care services. Through the Partnership for Supply Chain Management, Drew provided OI-related drugs, CD4 testing, and OI diagnostics for the clinical management of PLWHA. Drew worked with SCMS to ensure appropriate stock management, inventory control, and storage for all USG-procured commodities at Drew-supported sites.

In FY 2010, Drew will continue to provide technical and material support to three military hospitals and five brigade clinics located in the districts of Kicukiro , Nyamagabe, Gatsibo, Muhanga, Musanze, Huye, Ngoma and Rusizi to ensure the provision of quality anti ART to 2,006 HIV-positive individuals, including 300 newly diagnosed cases. Drew will provide technical assistance to the RDF to strengthen linkages between community-based and clinic-based HIV care services. At brigade and/or community levels, Drew will support the formation of civil-military allied associations of PLWHA and will train members in provision of home-based care services. Drew will also support access to locally available and/or self-

initiated nutritional support for those patients facing food instability.

In FY 2010 Drew will emphasize HIV prevention with positive through the training of lay counselors on the appropriate management, distribution and use of care package and the training of clinical providers to assess patients with regard to risk behaviors, medical adherence, STIs, family planning, and condom use. Providers will also be mentored on the most effective customized prevention messages for HIV positive patients. In FY 2010 Drew will further train 85 RDF medical personnel in HIV case detection and referral to HIV care and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	53,115	

Narrative:

In FY 2010, Charles Drew University will continue to work with the RDF and TRAC Plus to improve infrastructure for and increase access to HCT services in 8 RDF health settings located in the districts of Kicukiro, Muhanga, Musanze, Nyamagabe, Gatsibo, Ngoma, Rusizi and Huye. Drew will employ counseling techniques that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. Couples HIV Counseling and Testing (CHCT) will be expanded and integrated in HCT services as a prevention Intervention and PIT will be rolled out as a testing strategy. Drew University plans to reach 5,000 clients during the FY 2010 and counseling will include messages on alcohol reduction, prevention for positives, GBV, disclosure of status to partner, partner testing, and counseling for negatives - including ABC messaging and provision of condoms. A renewed emphasis will be made on prevention counseling and follow-up for positive clients, discordant couples and activities to reach high risk groups with HCT. These activities will be coordinated to avoid duplication and maximize coverage to most at-risk populations. Drew will coordinate its activities with other partners such as CHF, PSI, and FHI/ROADS to avoid duplication, strengthen referral linkages and continue to support the promotion of HCT among most at risk populations including the military. Drew University will provide technical support in the area of M&E to ensure quality of HCT services following the standard testing algorithms. In this regard, Drew University plans to undertake operational research to assess the effectiveness of the referral system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	59,727	

Narrative:

Approximately 2,295 HIV-positive adults are enrolled in care at the health facilities of the Rwanda Defense Forces (RDF). Of these, 2,006 are receiving ART. In FY 2010 Drew University will provide support to significantly increase services for the pediatric population reached through military health care

facilities. In FY 2009, Drew University provided an integrated package of care and support services for HIV-exposed infants and HIV-positive children at all 8 Drew University sites.

In FY 2010, the activities established in FY 2009 at the three military hospitals and five brigade clinics will continue. Drew CARES will provide care and support for 85 HIV-exposed as well as infected children. Care and support for HIV-exposed infants identified in PMTCT will include access to early infant diagnosis using dried blood spots, provision of Co-trimoxazoleprophylaxis until their HIV status is known, infant feeding support, and tracking of mothers and infants lost-to-follow-up for re-engagement in care. To provide early initiation of ART for all HIV-positive infants, Drew University will assist in the implementation of early infant diagnosis and follow-up through training for PMTCT staff as well as lab technicians, and through the development of an efficient and reliable sample transportation system. Drew University's care and support model for HIV-positive children includes provision of regular clinical assessments (monthly for HIV-exposed infants and every six months for older, stable children); staging and baseline CD4 counts or percentages for all HIV-positive children; follow-up CD4 every six months or more frequently as needed; management of HIV-related illnesses, including OI diagnosis and treatment; and routine provision of Co-trimoxazoleprophylaxis for eligible children and for all HIV-exposed infants. Drew University will support the implementation of the new pediatric care and treatment guidelines through training and supervision. All pediatric patients will be screened for TB at least once every six months. Children suspected of having TB will be investigated to establish a diagnosis, and treatment will be initiated as per national guidelines. Children without active TB disease but who were exposed to an active case will be provided with INH prophylaxis.

In addition, sites will provide nutritional counseling, pain and symptom management, end-of-life care, and integrated management of childhood illness (IMCI) at its MCH clinics. Sites will also distribute long-lasting insecticide-treated nets (LLIN), implement safe water interventions, and provide basic hygiene education and community outreach services including referral for complimentary food support. In collaboration with TRAC Plus, Drew University will provide refresher training for health care providers in psychosocial care for children living with HIV/AIDS and launch psychosocial care services at all its ART sites. In order to improve treatment adherence, Drew University will assist health facilities in mentoring child and adolescent support groups that have been established at the sites as a component of psychosocial support for HIV-positive children and adolescents.

Activities aiming at strengthening nutritional services at Drew University-supported sites will include training of health care providers and counseling to HIV-positive mothers during pregnancy and after delivery to enable them to make informed choices about infant feeding. The nutritional support package for children is comprised of nutritional assessments using anthropometric indicators, the provision of food support to HIV-exposed infants, and management of malnutrition with micronutrient and multivitamin

supplements. Drew University will ensure programmatic linkages to the Title II food support for clinically eligible PLWHA and children (implemented by PEPFAR and World Food Programme in selected districts), and to the USAID/Ibyiringiro project which provides complementary food support for HIV-exposed infants at USG supported sites in Rwanda. Drew University will also reinforce vegetable gardening at health facilities that have received PMTCT food support though the World Food Programme.

Drew University supported sites will establish HIV community outreach services by working with trained community health workers. Key HIV messages emphasizing pediatric HIV, care and nutrition will be discussed during monthly meetings at the health facilities. By providing HIV messages on a regular basis, sites aim to ensure a continuous flow of information to and from the community in order to increase awareness and increase service utilization. The facility-based military focal points and community health workers in the military neighborhood constitute an effective system to ensure continuity of care, promote retention in care, and to improve coverage and quality of pediatric HIV services. Drew University will also support the development of systems for referral of HIV-positive children to access malaria prevention services, including the provision of LLIN and home-based management of malaria.

Through work with the Supply Chain Management System (SCMS) and CAMERWA (Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda), the national pharmaceutical warehouse, the district-level pharmacy, the National Reference Laboratory (NRL) and the regional laboratory network, Drew University will ensure training of health service providers on the management of HIV-related opportunistic infections, drug and reagent stock management and distribution, adherence counseling, good pharmacy record-keeping and data use.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	15,176	

Narrative:

Approximately 2,295 HIV-positive adults are enrolled in care at the facilities of the Rwanda Defense Forces (RDF). Of these, 2,006 are receiving ART. While the number of children currently enrolled in care and treatment at these facilities is small, in FY 2010 Drew University will provide support to significantly increase services for the pediatric population reached through military health care facilities.

In FY 2010, Drew University will continue with its support to all 8 RDF facilities in Rwanda. In line with national policies and sustainability strategies, the Kaduha Military Hospital--the second military facility located in Nyamagabe--will begin improving clinical HIV service provision using a performance-based financing (PBF) model.

In FY 2010, Drew University will continue to support the provision of quality ARV services to251 children currently on treatment and to30 new pediatric patients at 5 ART sites. Drew University will also support the initiation of early infant diagnosis and the implementation of the new CD4-based treatment protocol. Moreover, ART sites will continue to monitor patients for treatment failure and to offer appropriate second-line treatment.

In collaboration with the district hospital team, regular follow-up visits will be made to these sites. Infants and children on ART will be assessed monthly at each visit for issues related to adverse events, toxicity and adherence to ART. Drew University will also assist heath providers in mentoring children and adolescent support groups that are established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment, and to assist with addressing issues around treatment adherence.

Clinicians from the district team will review complicated ART and non-ART cases. Nurses at RDF sites will continue to be trained and mentored in provider-initiated testing, the follow-up of patients, and in the detection and referral of complicated cases to district hospitals. With international technical assistance, Drew University will continue to support Quality Improvement of patient management with a review of indicators, medical dossiers and viral load measurements. Drew University will ensure the participation of health center and country program staff in District Health Team meetings for better collaboration. It will work with the National Reference Laboratory to expand the diagnostic resources for HIV at the sites. Drew University will also endeavor to improve reporting linkages with CAMERWA (Central Purchasing of Essential Drugs, Medical Consumables and Equipment in Rwanda) and continue mentoring health center staff with a view to increasing their ability to receive, manage, and forecast the needs for ARVs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	24,750	

Narrative:

Drew University will continue to assist the Rwanda Defense Forces (RDF) to improve IT infrastructure at RDF hospitals and brigade clinics for monitoring the health status of HIV-positive soldiers and civilians receiving care within the military health system. Drew University will also assist the RDF in monitoring the effectiveness of referral of newly diagnosed HIV cases from brigade and mobile clinics to RDF hospitals for evaluation and treatment. Moreover, the capacity of RDF will be built in the utilization of HIV-related data in a continuous quality improvement process. Planned activities include the improvement of the existing data system to match with new developments in health information systems within the military setting; an evaluation of Drew University's HIV treatment and care services in RDF;

and an assessment of the extent to which information systems have facilitated HIV service delivery. Specifically, Drew University will:

• Provide material and technical assistance to improve the data system that enables the military to conduct routine HIV testing of all military personnel.
• Design and implement data reporting tools to monitor HIV treatment and care outreach activities such as home-based care and other community-clinical linkages.
• Develop a secondary target tracking system for all patients receiving HIV treatment and care in RDF sites, including military spouses, partners and family members, and enroll them in HIV care services that are medically indicated such as prevention for positives, VCT, PMTCT, and nutrition services.
• Strengthen the health management information system of the military, and improve data quality.
• Develop a data access network among RDF sites enabling HIV treatment and care providers to update data through the main server using access codes.
• Ensure that the national coding system for all patients receiving care in RDF health facilities is implemented to enable universal access to patient data at major RDF service delivery outlets.
• Initiate the use of personal digital assistants (PDAs) and improve the electronic medical record system for HIV-positive patients.
• Train RDF health providers and policymakers in data analysis and in the use of the generated information to improve the quality of HIV treatment and care services.
• Conduct a mid-term evaluation of HIV treatment and care service delivery in RDF.

Drew University will work closely with the MOH/Monitoring and Evaluation Taskforce to ensure alignment with the national HMIS strategy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	222,750	

Narrative:

The overall goal of this activity is to decrease new HIV infections through male circumcision among Rwanda Defense Forces (RDF) personnel. The program will be presented as part of an expanded approach to reduce HIV-infections, and will be promoted in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted infections, promotion of safer-sex practices and condom distribution. Male circumcision (MC) will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package.

The World Health Organization (WHO) and UNAIDS recommended that MC be made available in countries highly affected by HIV/AIDS to help reduce transmission of the virus through heterosexual sex.

According to data from two NIH-funded studies conducted in Uganda and Kenya, routine MC could reduce a man's risk of HIV-infection through heterosexual sex by up to 65%. According to the WHO, implementing circumcision programs in sub-Saharan Africa could prevent about 5.7 million new HIV cases and three million deaths during the next two decades, if combined with other –factors such as condom usage, responsible behavior and knowing the HIV status of one's partner. The WHO is encouraging countries to provide access to no-cost MC to countries in Southern and East Africa, where HIV rates are high and circumcision rates are low, to consider adopting MC as an important and urgent health priority, with the target group being boys and men ages 13 to 30 years. However, Drew recognizes that it is critical for men to know that, although they are circumcised, they can still contract HIV and transmit it to their partners. Therefore, circumcised men should continue to practice abstinence, have fewer sex partners and use condoms. It is important that MC is provided to men who are HIV negative, emphasizing that it is important to know one's HIV status prior to receiving MC.

Drew will provide regular supportive supervision and follow-up to soldiers who have been circumcised in order to prevent infection and ensure compliance with MC management protocols. Together with PSI, IEC/BCC messages will be tailored to sensitize circumcised soldiers on basic hygiene, delayed safe sex and the need for medical follow-up for infection control both at RDF health facilities and the mobile clinic.

In FY 2010, Drew will ensure that male circumcision efforts are further rolled out in RDF as an additional method for HIV prevention for 6,000 men. In collaboration with JHIPEGO, Drew will take care to ensure that providers are well trained, physical and clinical infrastructures meet hygiene and safety standards, and communities and patients are sensitized on the risks and benefits of MC. RDF is an ideal institutional setting to begin the roll out of MC as an HIV prevention intervention, as the RDF has taken a lead in controlling HIV among Rwandan troops, who are primarily young, sexually active males. In addition, with the help of Drew through PEPFAR support, the RDF has expanded HIV care and treatment to three military hospitals and five brigade clinics. Drew will build capacity for MC in the RDF through the development of treatment protocols, training of providers, sensitization of soldiers and their partners for circumcision and the enhancement of physical infrastructure of clinical sites so that proper circumcision may be conducted.

MC will be conducted on a voluntary basis on HIV-negative soldiers, as studies have demonstrated that since HIV-positive men who have undergone circumcision may be more likely to transmit the virus to their female partners if they have sex before the circumcision wounds have healed. Attention will be paid to socio-cultural context, human rights and ethical principles, health services strengthening, training, gender implications, service delivery and evaluation. Conducting MC in the Rwanda military is considered vital since the military is predominately male, young, and highly mobile, characteristics which put this group at a higher risk of infection.

These activities address the key legislative issues of gender (particularly male norms) and stigma reduction. Furthermore, these programs reinforce the PEPFAR strategy of strong collaborating with the GOR, as well as the Partnership Framework and National Strategic Plan for HIV/AIDS, both of which prioritize prevention efforts among military personnel.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	106,878	

Narrative:

Under the Rwanda Defense Force (RDF), there are a total of three military hospitals and five brigade clinics throughout the country. Drew University began working in two military hospitals and three brigade clinics in FY 2005. The support includes TA and training on ARV and palliative care, M&E, and lab infrastructure.

In addition, Drew University will provide1,841 pregnant women with HIV counseling and testing for PMTCT who will then receive their results and be provided with an expanded package of PMTCT services including: CT with informed consent; male partner and family centered testing; distribution of long-lasting insecticide treated net (LLIN) in collaboration with PMI; ARV prophylaxis using an expanded bi-therapy regimen and ARV treatment for eligible women; infant feeding counseling and support; referral for FP and MCH services; and close follow-up of exposed infants for effective transfer to appropriate services. In collaboration with CRS who is procuring local fortified food, Drew University will provide weaning food for exposed infants in need. Through the Directorate of Military Services (DMS) and a combination of input TA and output performance-based financing, Drew University will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services.

Drew University will train RDF providers with new and refresher on-the-job training in the expanded national PMTCT protocol, including use of site-level algorithms and checklists, as well as for laboratory monitoring. In collaboration with DMS, Drew University will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E of PMTCT. Drew University will support DMS build their QA and M&E skills, including in data collection, data use, and reporting.

Additionally, it is increasingly becoming hard for HIV-positive soldiers to disclose their status to their spouses in the absence of a professional counselor. To respond to this, both the RDF and Drew

University plan to use RDF HIV-positive males as the entry points to their families. Drew University will build a strong family tracking approach based on the information systems where cross-cutting data of each HIV-positive soldier has been collected and categorized during the mobile treatment and care unit, implemented at the brigade level. To do this, Drew University will organize training sessions for identified at-risk spouses of HIV-positive soldiers, and simultaneously conduct HIV counseling and testing.

In this "pool" of at-risk soldiers' spouses, Drew University will promote PMTCT-seeking behavior and support identified HIV-positive soldiers' spouses to bring their children for HIV testing. Drew University will strengthen the community outreach services such as home based care especially in hard-to-reach areas, to encourage HIV-positive women to have their children tested. Drew University will maximize the potential of health centers (with PMTCT services) in targeted areas, through training, linkages, referrals and physical hand-over of dossiers, to take-over follow-up of the identified HIV-positive soldiers' spouses in a sustainable manner. During FY 2010, couple HIV counseling will be an important tool of improving PMTCT services uptake, as part of a comprehensive approach to HIV treatment and care in RDF settings. Drew University will ensure that PMTCT services at RDF health settings conform to national and international standards through training of 85 health service providers in 8 RDF health facilities on PMTCT service delivery skills, and provision of materials and equipments. Drew University will make linkages with other USG food partners, such as WFP and CRS/IBYIRINGIRO, in order to ensure access to adequate nutrition support for pregnant and lactating mothers as well as infants.

In collaboration with other USG partners, Global Fund, and PMI, case managers and providers will refer PMTCT clients and their families to HBC, OVC support, IGA, and facility- and community-based MCH services promoting key preventive interventions such as bednets, immunizations, hygiene/safe drinking water and nutritional support. These community-based services will assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants, as well as promote MCH and PMTCT health seeking behaviors which will intensify case finding and improve adherence to the new regimen. In addition these case managers provide quality HIV treatment to infected children and ensure referrals of pediatric patients from PMTCT sites to ARV service and to nutrition centers.

Through CAMERWA/SCMS, Drew University will ensure ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials are available in all supported sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	45,528	

Narrative:

In FY 2009, Drew University supported 85 HIV and TB services providers at facilities for continuous

TB/HIV integration using the TRAC/PNILT TB/HIV training module, counseled all 2000 TB patients registered at three military hospitals and five brigade clinics for HIV test and provided testing services to 90% of those who accepted to take the test. Drew University supported facilities to strengthen referral mechanisms within the same facility and between facilities which enabled patients diagnosed with TB and HIV adhere to TB treatment via DOTS, and had access to Co-trimoxazoleprophylaxis and follow-up of CD4 and ART services if eligible. In addition, Drew University through regular supervision to supported sites ensured that TB/HIV data were recorded and reported following national guidelines and staff conducted quarterly M&E meeting with PLWA associations, community health workers with the aim analyzing data and use them for program quality improvement.

In FY 2010, these activities will continue at three military hospitals and five brigade sites. Drew University will provide 2,006 HIV-positive clients with TB preventive therapy and eligible patients for ART. Drew University will ensure that TB clinical care continues to be part of a continuum of a comprehensive HIV/AIDS care strategy by improving the infrastructure at RDF hospitals and brigade clinics and train RDF health providers to diagnose, treat and through an established information system, monitor and report TB progression trends.

Drew University will ensure that the provision of preventive Co-trimoxazoleprophylaxis continues to be integrated into a HIV care package, so as to encourage TB prevention and reduce clinical treatment. With EP support, Drew University will ensure that 100% of HIV+ individuals enrolled into care in RDF sites receive TB testing and treatment (if positive) and in the same manner, 100% of TB patients will be tested for HIV through PIT. 100% of HIV+ TB patients eligible for ART will be automatically enrolled and followed-up through in-facility referrals and linkages. TB preventive Co-trimoxazoleprophylaxis will also be provided to HIV+ enrolled on care whether on and/or pending starting ART. To ensure successful TB prevention, Drew will support TB awareness-raising activities, mainstreamed at brigade/community-level through existing associations of HIV+ individuals. Drew will strengthen data collection and reporting system using the next generation TB/HIV indicators provided by PEPFAR.

These activities support Rwandan national plan for TB/HIV and EP to prevent, diagnose and treat patients with both TB and HIV patients.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10981	**Mechanism Name: Refugees UNHCR**

Funding Agency: U.S. Department of State/Bureau of Population, Refugees, and Migration	Procurement Type: Grant
Prime Partner Name: United Nations High Commissioner for Refugees	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 156,619	
Funding Source	**Funding Amount**
GHCS (State)	156,619

Sub Partner Name(s)

Ahaa		

Overview Narrative

Rwanda is host to approximately 53,000 refugees in three refugee sites around the country. Refugee populations are considered to be at high risk of infectious disease, in particular HIV, as well as SGBV and its associated consequence and psychological distress.

UNHCR has been benefiting from PEPFAR funds since 2007 to implement a comprehensive HIV/ AIDS program in Kiziba refugee site located in Kibuye district/sector. Based on the successes and lessons learnt from the past years of project implementation UNHCR through its partner will continue to strengthen the implementation of HIV/AIDS program in the Kiziba refugee site.

The goal of this program is to ensure that refugees and host communities living with HIV/AIDS have access to HIV information, quality HIV care and treatment services as well as supporting a successful Anti Retroviral Treatment adherence that assures viral suppression. UNHCR will continue to support trainings on a sustainable basis, provision of HIV/AIDS messages, basic care and treatment to HIV, TB and OIs to the greatest number of needy refugee patients and in the hosting community, consistent with PEPFAR strategy and GOR national priorities.

UNHCR will continue to strengthen and support the provision of HIV health care services ranging from prevention, care and treatment to refugees and hosting community.

To achieve these activities, UNHCR will strengthen staff capacity to use new guidelines/standards and protocols adopted by both UNHCR/GOR through conducting trainings, mentoring at different levels of

implementation.

UNHCR is committed to working in close collaboration with the Government of Rwanda, UN agencies and NGOs to strengthen its support to HIV care, support and treatment to refugees and the hosting community.

To ensure monitoring and evaluation of the planned activities, UNHCR will strengthen monitoring and data management systems, for collecting, managing, and analysis of clinical data at the health facility, strengthen feedback mechanism for better performance.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Child Survival Activities

Budget Code Information

Mechanism ID:	**10981**		
Mechanism Name:	**Refugees UNHCR**		
Prime Partner Name:	**United Nations High Commissioner for Refugees**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	5,701	

Narrative:

This is a continuing activity from FY 2009.

Kiziba Refugee Camp is host to approximately 19,000 refugees. Refugee populations are considered to be at higher risk of infectious disease, and HIV in particular, as well as GBV and other forms of violence, and economic and psychological distress.

In FY 2009 UNHCR partners provided basic care and support to 122 HIV positive adults. This package of

services included Co-trimoxazoleprophylaxis and nutrition counseling.

In FY 2010, UNHCR partners will focus on the basic care package, which includes preventive care services, clinical care, psychological, spiritual and social support services, CTX prophylaxis for eligible adults, and prevention counseling for positives.

In FY 2010 UNHCR partners will provide basic care services to 200 adults and strengthen nutritional services, including nutritional assessment, and nutrition counseling. UNHCR partners will ensure the provision of, or referrals for, diagnosis and treatment of OIs and other HIV-related illnesses (including TB), routine clinical staging and systematic CD4 testing, and the maintenance of medical records for all HIV-positive adults.

In collaboration with USAID clinical partners and Columbia University, UNHCR partners will work with the Byumba, Kibuye, and Ngarama DHTs to ensure that health clinic providers receive training or refresher training on basic management of adults living with HIV/ AIDS, including training on ART adherence support. UNHCR partners will monitor and evaluate basic care activities through ongoing supervision, quality assurance, and data quality controls, and will continue to build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS basic care activities through the strengthening of routine data collection and data analysis.

In Kiziba Refugee Camp, UNHCR partners will, through CAMERWA, procure and distribute palliative care and OI drugs, laboratory supplies and diagnostic kits. UNHCR will construct a new morgue at the site.

UNHCR partners will continue to support the continuation of care through the establishment of referral and tracking systems for comprehensive basic care and support services for adults living with HIV/AIDS. UNHCR partners will continue to work with their respective district hospitals to ensure an ongoing system of referrals and care between camps and other health services, such as transport of blood specimens for CD4 testing, management of complicated OIs, and periodic monitoring of ART patients.

UNHCR will provide technical support and monitoring of partners' activities and data collection, and ensure appropriate reporting through strengthening coordination meetings with HIV/AIDS focal point.

PBF is a major component of the Rwandan strategy for ensuring long term sustainability and maximizing performance and quality of services. In coordination with the national HIV/PBF project, UNHCR partners will shift their support from output financing based on site performance to participation in health facility performance evaluations and on PBF technical teams. UNHCR will strengthen the capacity of health care

providers in the camps to coordinate an effective network of adult care and support services. The basic package of financial and technical support will include implementation guidance, transportation, communication, and training of providers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	79,571	

Narrative:

This is a continuing activity from FY 2009

Kiziba Refugee Camp is host to approximately 19,000 refugees. Refugee populations are considered to be at high risk of infectious disease, in particular HIV, as well as GBV and other forms of violence, and economic and psychological distress.

As of FY 2010, UNHCR partner will focus on the care and treatment full package of adult care and treatment services, provision of ART for eligible adults in line with national guidelines. UNHCR partner will continue to provide care and treatment services to adults and strengthen nutritional services, including nutritional assessment, and nutrition counseling.

UNHCR partner will ensure the provision of routine clinical staging and systematic CD4 count testing, medical records for all HIV-positive adults. Co-trimoxazole prophylaxis will be provided to all eligible HIV positive adults.

In collaboration with USAID clinical partners and Columbia, UNHCR partner will work with the Kibuye DHTs to ensure that health clinic providers receive training or refresher training in management of adults living with HIV/AIDS including training on ART adherence support. UNHCR partner will monitor and evaluate care and treatment activities through ongoing supervision, quality assurance, and data quality controls, and will continue to build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS care and treatment activities through ongoing strengthening of routine data collection and data analysis.

UNHCR partner will continue to support the continuation of care and treatment through the establishment of referral and tracking systems for comprehensive care and treatment services for adults living with HIV/AIDS. UNHCR partner will continue to work with the respective district hospitals to ensure an ongoing system of referral and treatment between the camps and other HIV health facilities, such as transport of blood specimens for CD4 count testing and management of complicated OIs, and periodic monitoring of ART patients.

UNHCR will provide technical support and monitoring of IP activities and data collection, and ensure appropriate reporting through strengthening coordination meetings with HIV/AIDS focal points.

PBF is a major component of the Rwandan EP strategy for ensuring long term sustainability and maximizing performance and quality of services. In coordination with the national HIV/PBF project and according to the new support approach in improving key national Adult care and treatment performance and quality indicators, UNHCR will swift it support of output in financing based on site performance to a technical participation on health facility, performance evaluations and on PBF technical extended team meeting. UNHCR will strengthen the capacity of the health service providers to coordinate an effective network of adult care and treatment services. The basic package of financial and technical support will include technical support, implementation, transportation, communication, training of services and other supports to conduct key responsibilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	17,103	

Narrative:

This is a continuing activity from FY 2009

In FY 2010, UNHRC through its implementing partner American Humanitarian Association (AHA) will use a strategic mix of targeted PIT (Provider Initiated Testing), family centered and client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach out to those individuals most likely to be infected.

This activity will support CT services at Kiziba Refugee Camp. PIT services will target adults and pediatric in-patients presenting with OIs and TB symptoms, malnourished children, HIV-exposed infants and STI. Moreover community workers will be trained as counselors in order to provide continuous support beyond the consultation to encourage testing acceptance, family and or partner tracing and support to those who receive their test results.

UNHCR/AHA will support six CT providers to continue to provide traditional CT (client initiated) services for clients who wish to know their status in particular for discordant couples, ANC male partners and youth. Counseling messages will emphasize prevention including abstinence, fidelity, and alcohol reduction, SGBV sensitization, disclosure of test results and follow-up.

UNHCR/AHA will strengthen and ensure that HIV-positive patients are provided with patient education,

positive living counseling and referral for community based services such as IGA through PLWHA associations, OVC, and home based care programs.

At the health facility level, partners will ensure a system for supportive supervision for nurses and counselors including training of staff in support supervision for CT, use of quality control check list and data control.

PBF is a major component of the Rwandan strategy for ensuring long term sustainability and maximizing performance and quality of services. In coordination with the national HIV/PBF program and according to the new support approach in improving key national VCT performance and quality indicators, UNHCR/AHA will swift its' support of output financing based on site performance to a technical participation on health facility, performance evaluations and on PBF technical extended team meeting.

UNHCR/AHA will strengthen the capacity of health service providers in Kiziba to coordinate an effective network of VCT services. The basic package of financial and technical support will include technical support, implementation, transportation, communication, training of service providers and other supports to conduct key responsibilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	1,647	

Narrative:

This is a continuing activity from FY 2009.

Kiziba Refugee Camp is host to approximately 19,000 refugees. Refugee populations fall among vulnerable groups exposed to epidemics and different kinds of social abuse. Particularly, they are susceptible to HIV, GBV, economic and psychological distress.

As of FY 2010, UNHCR through its implementing partner, American Humanitarian Association (AHA) will focus on the provision of the basic care package including a full range of pediatric preventive care services: Co-trimoxazoleprophylaxis (CTX) for 30 eligible children and exposed infants in line with national guidelines; clinical care; psychological, spiritual and social support services; and prevention and counseling for positives. UNHCR/AHA will strengthen nutritional services, including nutritional assessment, nutrition counseling, and management of malnutrition through provision of micronutrients and multivitamin supplements for clinically eligible malnourished children and infants.

UNHCR/AHA will ensure the provision of, or referrals for diagnosis and treatment of opportunistic

infections (OI) and other HIV-related illnesses (including TB), routine clinical staging and systematic CD4 testing, and medical records for all HIV-positive infants. Infants born to HIV-positive mothers will be provided CTX, early infant diagnosis through PCR, and ongoing clinical monitoring and staging for ART.

In collaboration with USAID clinical partners and Columbia, UNHCR/AHA will work with the Byumba, Kibuye, and Ngarama district health teams (DHTs) to ensure that health care providers receive training or refresher training in basic management of children and infants, including training in the identification and management of pediatric HIV cases, in ART adherence support, and in the identification and management of treatment failure cases. The trainings will also include the new national pediatric treatment guidelines. A specific emphasis will be put on early infant diagnosis and on the implementation of a reliable and efficient sample transportation system. Moreover, UNHCR/AHA will assist DHTS in mentoring children and adolescent support groups that have been established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment or affected by HIV, and assist with addressing issues around status disclosure and treatment adherence. One child counselor per ART site will be trained to organize children support groups that will help providing psychosocial support to children and adolescents.

UNHCR/AHA will monitor and evaluate basic care activities through ongoing supervision, quality assurance, and data quality controls, and will continue to build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS basic care activities through ongoing strengthening of routine data collection and data analysis.

UNHCR/AHA will procure and distribute through CAMERWA all palliative care and OI drugs, laboratory supplies and diagnostic kits.

UNHCR/AHA will continue to support the continuation of care through the establishment of referral and tracking systems for comprehensive basic care and support services for pediatric HIV-positive and exposed infants. UNHCR/AHA will continue to work with the respective district hospitals to ensure an ongoing system of referral and care between the camps and other HIV care and support services, such as transport of blood specimens for CD4 and PCR testing, management of complicated OIs, and monitoring of ART pediatric patients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	9,977	

Narrative:

This is a continuing activity from FY 2009.

Kiziba Refugee Camp is host to approximately 19,000 refugees. Refugee populations fall among vulnerable groups exposed to epidemics and different kinds of social abuse. Particularly, they are susceptible to HIV, GBV, economic and psychological distress.

In FY 2010, UNHCR, through its implementing partner American Humanitarian Association (AHA), will continue to strengthen its support to eligible children at the Kiziba refugee site and the host community. HIV-positive children will be provided clinical monitoring and staging for ART. In collaboration with USAID clinical partners and ICAP (Columbia University), the UNHCR partner will work with the Kibuye DHTs to ensure that health service providers receive training or refresher training in basic management of infants born to HIV-positive mothers, including training in ART adherence support and the identification and management of HIV-positive infants. UNHCR/AHA will assist heath providers in mentoring children and adolescent support groups that are established at the sites as a component of psychosocial support for HIV-positive children and adolescents. These clubs will be used to provide ongoing support for children in care and on treatment, and to assist with addressing issues around treatment adherence.

UNHCR/AHA will monitor and evaluate pediatric HIV activities through ongoing supervision, quality assurance, and data quality controls. It will continue to build the capacity of local refugee health care providers to monitor and evaluate pediatric HIV/AIDS activities through strengthening of routine data collection and analysis for basic care.

UNHCR/AHA will procure and distribute through CAMERWA all drugs for basic care and support, drugs for opportunistic infections (OI), and laboratory supplies and diagnostic kits. UNHCR/AHA will work to ensure appropriate storage, management and tracking of commodities.

UNHCR/AHA will continue to support the continuum of care and treatment through the establishment of referral and tracking systems for comprehensive pediatric HIV patient management and support services. UNHCR/AHA will strengthen linkages between basic care and support, TB and ART services at the Kiziba refugee site and for the hosting community. UNHCR/AHA will continue to work with the Kibuye district hospital to ensure a functioning referral and counter-referral system between the camp and health facilities providing HIV care and treatment. UNHCR partner will also ensure the monitoring of infants on ART.

UNHCR/AHA will provide technical support and monitoring of AHA's activities particularly in data collection, and appropriate reporting.

Performance-based financing (PBF) is a major component of the Rwandan PEPFAR strategy for ensuring long term sustainability and for maximizing performance and quality of services. UNHCR/AHA will continue to support PBF through direct collaboration with MOH's , input technical assistance and output performance-based financing (PBF). The basic package of financial and technical support will include support for implementation, transportation, communication, training of health care providers, and other type of support for HIV-related pediatric health interventions among the refugee population.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	9,351	

Narrative:

This is a continuing activity from FY 2009.

Kiziba Refugee Camp is host to approximately 19, 000 refugees. Refugee populations are at higher risk of diseases, particularly HIV, as well as other forms of violence, economic and psychological distress. While the program has been ongoing in Kiziba camp, there is still need to strengthen the program among the refugee populations and host community in Kiziba.

In FY 2010, UNHCR will continue to promote AB messages to the refugee community, including refugee youth in- and out-of-school, men, and vulnerable women of reproductive age living in Kiziba refugee camp and the hosting community.

UNHCR will continue to train or, as necessary, provide refresher training to 25 health staffs and peer educators using AB materials adapted for the refugee context. UNHCR will support interpersonal prevention activities that aim to increase youth access to prevention services, such as anti-AIDS clubs, life-skills training, school-based HIV prevention education, and community discussions. Messages delivered will not only focus on abstinence and fidelity, but will also include topics on the relationship between alcohol use, violence, HIV, and stigma reduction. Young girls in the refugee community, particularly female OVC, are vulnerable to predatory sexual behaviors of older men, as well as child sexual abuse, domestic violence, and sexual harassment at school. Prevention efforts under this activity will focus on changing social acceptance of cross-generational and transactional sex.

Key influential community members such as traditional and religious leaders and refugee camp leaders will also reinforce the messages of abstinence, delayed sexual debut, being faithful, reduction of GBV and responsible consumption of alcohol. As many risky behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, UNHCR will strengthen referrals mechanisms, coordination and networking with other partners to provide refugee clients and

their family members access to IGA, OVC programs, food support, vocational training, trauma counseling, legal support, and mental health care.

UNHCR will strengthen its support to community structures to create opportunities for exchange and peer support, linkages to IGA and vocational training, promotion of healthy RH behaviors, and psychosocial support and counseling.

This activity addresses the key legislative issues of gender, stigma and discrimination through HIV/AIDS BCC messages, and linking to other sectors for strengthening income-generation opportunities and access to food support for vulnerable refugee women, girls and their families.

This activity reflects the priorities of the PEPFAR strategy and the GOR national prevention plan by reaching vulnerable and high-risk groups with HIV prevention, care, and treatment services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	4,676	

Narrative:

This is a continuing activity from FY 2009.

Kiziba Refugee Camp is host to nearly 19,000 refugees. Refugee populations are considered at higher risk for diseases, particularly HIV, as well as other forms of violence, economic and psychological distress.

In FY 2010, with PEFAR support, UNHCR through its implementing partner American Humanitarian Association (AHA) will continue to support activities in Kiziba Refugee Camp. BCC will target 80 high-risk and vulnerable refugee populations and use anti-HIV/AIDS clubs, peer educators, community forums, and relevant IEC materials. Key messages will promote risk reduction behaviors, condom use, and address social norms, GBV, and alcohol abuse.

To monitor and track the reach of these messages and condom uptake, UNHCR will integrate program-level indicators, including DELIVER-supported condom distribution and tracking indicators into existing reporting forms and tools.

This activity reflects PEPFAR priorities and the GOR National Plan for HIV Prevention by strengthening integrated health communication campaigns to prevent transmission of HIV to high-risk groups, promote condom use among at-risk populations, and increase demand for high quality CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	14,340	

Narrative:

This is a continuing activity from FY 2009.

Kiziba Refugee Camp is host to approximately 19,000 refugees. Refugee populations are considered to be at high risk of infectious disease, in particular HIV, as well as GBV and other forms of violence, and economic and psychological distress.

In FY 2010, UNHCR through its implementing partner American Humanitarian Association (AHA) will continue to provide PMTCT services in Kiziba Refugee Camp. UNHCR/AHA will provide a PMTCT package of services camps for445 pregnant women, including an estimated 25 HIV-positive women at Kiziba refugee camp. The PMTCT package includes CT with informed consent, including male partners and families; ARV prophylaxis using combination ARV regimes and HAART for eligible women; screening for STIs; infant feeding counseling; implementation of effective PMTCT regimens; prompt CD4 count and clinical staging for HIV-positive pregnant women; safe delivery follow-up; follow-up of infants and mothers; CTX for OI prevention; integration of FP and MCH services; testing and close follow-up of HIV-exposed infants for effective referral to appropriate services and early infant diagnosis; and supporting human resources by providing high-quality training and clinical mentoring.

In addition, UNHCR/AHA will assure an effective continuum of care and mother-infant follow-up by increasing partner involvement and community participation in PMTCT services using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To ensure these linkages, social workers will train and supervise community volunteers and organize monthly health center meetings with staff from all services to follow-up on referrals and other patient-related matters.

In collaboration with TRAC Plus and Project San Francisco, UNCHR, and all clinical partners, will support couples' counseling through training and on-site mentoring to improve pre- and post-test couple counseling quality, improve follow-up mechanisms for discordant couples and women testing negative in ANC to address seroconversion and pediatric infection during pregnancy and breastfeeding

In partnership with WFP, supplemental food will be provided to all pregnant and breastfeeding women, and weaning food to all infants born to HIV-positive mothers (from 6-24 months). Health providers will receive refresher on-the-job training in the expanded national PMTCT protocol and UNHCR/AHA will

conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching and strengthening capacity of sites in M&E.

UNHCR/AHA will support the transportation of EID and CD4 specimen from the refugee camp to the National Reference Laboratory and to health facilities equipped with CD4 count machines for Kiziba refugee camp.

UNHCR/AHA will monitor and evaluate PMTCT activities through ongoing supervision, quality assurance, and data quality controls, and will continue to strengthen the capacity of the refugee health care providers to monitor and evaluate PMTCT activities through ongoing strengthening of routine data collection and data analysis.

PBF is a major component of the Rwandan strategy for ensuring long term sustainability and maximizing performance and quality of services. In coordination with the national PBF program, UNHCR/AHA will continue to support input technical assistance and output performance-based financing (PBF). The basic package of financial and technical support will include technical support, implementation, transportation, communication, training of services and other supports to conduct key responsibilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	14,253	

Narrative:

In FY 2008 UNHCR through its implementing partner American Humanitarian Association (AHA), began implementing the national TB/HIV policy and guidelines at Kiziba Refugee Camp.

In FY 2010, UNHCR partner will continue to ensure that 100% of all TB patients are HIV tested, and that all who qualify receive Co-trimoxazoleand ART. UNHCR partner priority will strengthen the implementation of regular TB screening for all PLWHA, and for those with suspected TB, ensuring adequate diagnosis and complete treatment with DOTS.

With PEFAR funds, UNHCR partner will strengthen the integration of diagnostic services including coordinating specimen and patient transport to referral centers with appropriate diagnostic services (such as chest radiography and diagnostics required for extra pulmonary TB).

In FY 2010, UNHCR will continue to support the Kiziba refugee site for the implementation of the TB/HIV component of the clinical package of HIV care. This activity has seven components:
1) Strengthen routine provider-initiated HIV testing of TB patients at refugee camp sites, continue to

report the number and proportion of TB patients who received counseling and testing at supported TB sites.
2) Provide Co-trimoxazoleprophylaxis to all HIV-positive TB patients and ensure referral to HIV care and treatment services.
3) Strengthen regular TB screening, appropriate diagnosis and TB treatment with DOTS. Increase TB screening to PLWHA accessing other HIV services such as VCT/PMTCT, as well as family members of HIV positive patients will be reached through home base care and community programs.
4) Ensure timely and appropriate TB diagnosis and treatment via DOTS for all PLWHA that are TB suspects.
5) Support supervision and monitoring to refugee sites to ensure routine data collection, recording, and reviewing of standard national TB/HIV program indicators aimed at ensuring improved services at the patient and facility level.
6) Support on-going training of doctors, nurses, social workers, and HIV and TB services providers on TB/HIV integration and standard operational protocols using national training modules.
7) Support refugee sites for effective TB and HIV patients' case management and referrals.

These activities reflect the Rwanda National strategic Plan by strengthening the integration of TB/HIV services through the implementation of policies and increased coordination of prevention, counseling, testing, care and treatment services. Lessons learned from integrating TB and HIV reveals the need to strengthen HIV/TB programs in the refugee sites and in neighboring communities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11428	**Mechanism Name: Peace Corps**
Funding Agency: U.S. Peace Corps	Procurement Type: USG Core
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHCS (State)	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

These funds will be used to support technical area staff.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11428**		
Mechanism Name:	**Peace Corps**		
Prime Partner Name:	**U.S. Peace Corps**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	50,000	

Narrative:

Peace Corps Rwanda will support volunteers to engage in sexual prevention activities aiming at promoting abstinence and being faithful messages in the general population in Rwanda. Since reopening, the program has sworn in 20 PEPFAR volunteers, and has assigned them to 11 of the 22 GOR's priority districts. They are conducting community-based training, outreach and education on sexual prevention and have effectively reached 6,000 youth and adults with AB intervention activities.

In terms of geographic coverage, PEPFAR-supported Peace Corps volunteers are currently working in Ngoma, Kamonyi, Karongi, Nyamsheke, Ngororero, Nyarugenge, Ruhango, Nyamagabe, Muhanga and Rwamagana districts. Expansion of activities to other districts, where health services are still scarce is the future goal.

In FY 2010, Peace Corps Volunteers will be placed with local organizations promoting abstinence and

faithfulness among in- and out-of-school youth and young married couples. Data from the DHS 2005 indicate that women are infected at younger ages than men. Further, HIV prevalence in youth aged 15-24 years is 1.5% for females compared to 0.4% in males. To help mitigate HIV transmission, Peace Corps volunteers will live and work at their respective communities for two and a half years, at the sector and district levels, where they will scale up prevention activities targeting most-at-risk populations. Specifically, they will work closely with local partners to conduct community-based activities focused on partner reduction, reducing trans-generational sex and informal transactional sex, increasing girls/women's empowerment, male involvement and male norms, strengthening youth friendly health centers, helping to establish discordant couples' groups and activities focused on prevention for positives, and promotion of testing and counseling. Lastly, they will facilitate linkages between providers of HIV/AIDS prevention, care and treatment.

Peace Corps volunteers receive different trainings to promote quality assurance of their work:
• Pre-Service Training (PST): Trainees receive health technical training that prepare them to start work on HIV and AIDS related activities.
• In-Service Training (IST) and Mid-Service: Volunteers receive health technical training that helps in building their capacity and develop their competencies and skills on HIV and AIDS activities.

Peace Corps mechanisms for M&E include:
• Peace Corps volunteer quarterly reports: Volunteers submit quarterly reports of the HIV/AIDS activities which are reviewed by Peace Corps staff; these reports are recorded into a Volunteer Information Database.
• Peace Corps volunteers site visits: Staff regularly visit to monitor and supervise volunteers HIV/AIDS activities in collaboration with volunteers host agencies.
• Counterpart/Supervisor surveys: Help in identification of Peace Corps effectiveness of their HIV/AIDS activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	50,000	

Narrative:

Peace Corps Rwanda will support volunteers to engage in condoms and other sexual prevention activities at the grass roots level in Rwanda's imidugudu and sectors. Since reopening, the program has sworn in 20 PEPFAR volunteers, and has assigned them to 11 of the 22 GOR's priority districts. There, they are tasked to help reinforce the GOR's efforts in the prevention of HIV/AIDS transmission. Through collaboration with their counterparts, volunteers have carried out various HIV other prevention activities throughout their communities.

In FY 2009, under the HVOP program area, Peace Corps conducted HIV/AIDS training during pre-service and in-service trainings. To ensure consistent messaging as well as strengthen PC/R's capacity for networking and collaboration, training was conducted in partnership with GOR and other PEPFAR partners.

Request for funding for the HVOP program area will decrease for FY 2010, and will support costs associated with the 27 month long service of 20 new Peace Corps volunteers who will support various local partners develop and implement prevention programs that address consistent and correct condom use, STI management, GBV, alcohol use and other critical behaviors and/or norms that may increase risk to HIV. Peace Corps volunteers activities' will target the overall population, and will include women, men, youth, OVCs, PLWHA, and MARPs.

In terms of geographic coverage, PEPFAR-supported volunteers are currently working in Ngoma, Kamonyi, Karongi, Nyamsheke, Ngororero, Nyarugenge, Ruhango, Nyamagabe, Muhanga and Rwamagana districts. Post hopes to expand volunteer activities to other PEPFAR districts, where health services are still scarce.

In FY 2010, Peace Corps volunteers will continue to promote HVOP activities at the community, sector and district levels. Specifically they will focus on strengthening youth friendly health centers and anti-AIDs clubs, establishing discordant couples' groups, promoting correct and consistent condom use, testing and counseling and prevention for positives. Additionally, they will facilitate linkages between providers of HIV/AIDS prevention, care, treatment, and other wrap-around services. Peace Corps/Rwanda will also support volunteers getting involved in cross-cutting projects, reinforcing host agencies' efforts in the integration of health education with nutrition and income generating activities. This is timely, as kitchen gardens and food security were identified by the GOR as a priority in the fight against HIV/AIDS, poverty, malnutrition and other health issues.

Peace Corps volunteers receive different trainings to promote quality assurance of their work:
• Pre-Service Training (PST): Trainees receive health technical training that prepare them to start work on HIV and AIDS related activities.
• In-Service Training (IST) and Mid-Service: Volunteers receive health technical training that helps in building their capacity and develop their competencies and skills on HIV/AIDS activities.

Peace Corps mechanisms for M&E include:
• Peace Corps volunteer quarterly reports: Volunteers submit quarterly reports of the HIV/AIDS activities which are reviewed by Peace Corps staff; these reports are recorded into a Volunteer Information

Database. • Peace Corps volunteers site visits: Staff regularly visit to monitor and supervise volunteers HIV/AIDS activities in collaboration with volunteers host agencies • Counterpart/Supervisor surveys: Help in identification of Peace Corps effectiveness of their HIV/AIDS activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11438	**Mechanism Name: USAID Rwanda Mission**
Funding Agency: U.S. Agency for International Development	Procurement Type: USG Core
Prime Partner Name: US Agency for International Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 235,765	
Funding Source	**Funding Amount**
GHCS (State)	235,765

Sub Partner Name(s)

(No data provided.)

Overview Narrative

These funds will be used to support technical area staff.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11438**		
Mechanism Name:	**USAID Rwanda Mission**		
Prime Partner Name:	**US Agency for International Development**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	49,138	

Narrative:

Since FY 2004, USAID has supported the GOR in its Adult Care and Support activities, and will continue to support access to a comprehensive range of basic care and support services, including clinical and non-clinical (prevention, psychological, spiritual, and social care services) interventions at both the facility and community level. In FY 2010 USAID will continue to support the GOR nationwide plan to rapidly scale-up HIV prevention, care, and treatment services.

USAID anticipates continuing direct financial and technical support to Rwanda NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV treatment. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS which oversees community and home-based care activities in Rwanda.

In FY 2009, as part of the USG's commitment to a multi-sectoral comprehensive care approach to PLWHAs, PEPFAR incorporated best practices of IGAs into the design of a new community care program starting. Through PEPFAR, Title II food assistance, and economic growth activities, PEPFAR is engaged in promoting IGAs in Rwanda to improve livelihoods through increased incomes from running profitable businesses. USG supports a range of IGAs including a ten year investment in the specialty coffee value chain for farmers to one-time small grants to community associations for livestock or arts and crafts. Many of PEPFAR and other donor financed IGAs target vulnerable populations including people living with HIV.

It is envisioned that follow-on IGA activities in community care will be managed by the Economic Growth team and provide opportunities for wrap around programming. USAID is interested in identifying how many of these IGAs are operated by PLWHAs and/or associations funded through PEPFAR as well as the impact of these programs. This will enable PEPFAR to move to a more structured approach to IGA programs and ensure long-term sustainability of those programs.

To monitor and support the implementation of these activities, three positions are funded through this activity. These positions include the vacant PSC Community Health Advisor, partial funding for the FSN Senior Clinical Advisor, and the FSN Care and Support Specialist. In FY 2010, it is proposed to add a new FSN Nutrition Specialist position.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	2,154	

Narrative:

In FY 2010, USAID will continue supporting all levels of the decentralized ART network, starting from central level institutions and extending to the community as the most peripheral point of service. USAID will continue to work with GOR and other donors to evaluate and ensure the quality of HIV-related services. The enrolment of patients in the currently supported sites, and expansion of services to a limited number of new ART facilities will continue.

USAID anticipates continuing financial and technical support to Rwanda NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV treatment. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS.

The FSN Senior Clinical Advisor position is partially funded from the HTXS Program Area.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	19,960	

Narrative:

This activity cuts across all Program Areas, and will support all FY 2010 activities. Currently, HVSI funds two PEPFAR staff dedicated to strategic information – an SI Liaison Officer and an FSN M&E Program Manager. The SI Liaison serves as the principal field counterpart to the Core Team SI Advisor and supports all PEPFAR implementing agencies. This position provides leadership and directs high quality technical expertise to the USG PEPFAR team in Rwanda in the development and implementation of strategic information systems to meet the needs of PEPFAR. The SI Liaison also advises senior GOR counterparts in the strengthening of one national monitoring and evaluation (M&E) system in Rwanda and promotes the application of data to improve program performance.

The M&E Program Manager provides TA to USG on all M&E activities, with a primary focus on PEPFAR monitoring and reporting activities. The Program Manager manages the synthesis, analysis and transmission of all PEPFAR-funded partner reports, correspondence, and work plans. The Program Manager also contributes to overall strategy development through analysis of partner reports and country

data.

In addition to these key SI positions, USAID/Rwanda anticipates continuing financial and technical support to local NGOs and GOR agencies by sponsoring attendance at conferences, workshops and technical meetings on HIV prevention, care, and treatment, as well as on health systems development.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	20,120	

Narrative:

USAID/Rwanda has been providing local and international TA to GOR institutions and limited direct grants to local NGOs since FY 2004. In FY 2009, PEPFAR expanded the TA to further build local capacity. These resources covered the cost of sponsoring and attending conferences, workshops and technical meetings on HIV prevention, care and treatment. USAID anticipates continuing this financial and technical support role in FY 2010.

USAID will also support direct TA to GOR agencies as needed, in particular CNLS. In addition, PEPFAR will continue to utilize the expertise and resources of the USAID Energy team to help the PEPFAR clinical partners to better gauge the energy needs of their facilities. This will help ensure that facility upgrades are able to accommodate all necessary equipment and activities. Assistance will include: review of the capacity of Rwandan companies to maintain renewable and hybrid energy systems; train PEPFAR partners and health care staff on renewable energy systems; and recommend methods for partners to self-finance replacement parts to ensure sustainability of the energy systems.

Through Atelier Centrale de Maintenance (ANC), USAID will provide support for the overall National Maintenance of these systems. ANC will develop an inventory of energy services, and a maintenance plan for existing and future energy sources that PEPFAR funds for delivery of HIV services.

The already filled PSC Health Economist position is supported by OHSS funds. In FY 2010 an additional FSN Systems Strengthening position is proposed with OHSS funding.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	34,920	

Narrative:

In FY 2010 USAID will build upon AB activities developed in FY 2009, and will continue local and international technical support to the GOR. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS and the Ministry of Gender and Women in Development (MIGEPROF).

Additionally, USAID will continue to provide financial and technical support to Rwandan NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV prevention. In FY 2009, the Prevention Advisor position was changed from a Global Health Fellows Position to a PSC. In FY 2010 this position will be partially funded through HVAB. The funding for this position is distributed in HVAB and HVOP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	84,420	

Narrative:

USAID/Rwanda has been providing local and international TA to GOR agencies and limited direct grants to local NGOs since FY 2004. In FY 2010, OP activities will continue to strengthen activities developed in FY 2009 to build local capacity, and provide HVOP services in Rwanda. USAID anticipates continuing direct financial and technical support to Rwandan NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV prevention. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS which oversees HIV prevention activities in Rwanda.

Partial funding for the HIV/AIDS Prevention Advisor is supported through HVOP. Funding for this position is distributed in HVOP and HVAB.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,800	

Narrative:

In FY 2010, USAID will continue to support sustainability of PMTCT services. USAID will also continue to provide support to GOR for program coordination and management (including support to decentralization and district involvement), and capacity building. In line with GOR and PEPFAR strategy and sustainability goals, USAID will ensure through its partners that sustainability of service improvements are reflected in program outcomes. In FY 2010 the currently vacant FSN-PMTCT Advisor position will be supported through PMTCT budget code funding.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	22,253	

Narrative:

To support the Commodity and Logistics Advisor, and to build the National staff capacity, ultimately leading to transfer of responsibilities at the National level, an additional position for a locally hired Commodities and Logistics Specialist is proposed for FY 2010.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11440	**Mechanism Name: CDC Country Office GHAI/TA**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: USG Core
Prime Partner Name: HHS/Centers for Disease Control & Prevention	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 834,334	
Funding Source	**Funding Amount**
GHCS (State)	834,334

Sub Partner Name(s)

(No data provided.)

Overview Narrative

These funds will be used to support technical area staff and TDY assistance. For all positions secunded to GOR entities will be provided by the GOR entity with physical space. Additionally, these recruitements will be done jointly with the appropriate GOR entity.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	11440		
Mechanism Name:	CDC Country Office GHAI/TA		
Prime Partner Name:	HHS/Centers for Disease Control & Prevention		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	834,334	

Narrative:

The activities funded under this funding mechanism include:
1) HSS Adviser and support to the HSS activities
2) support to the PEPFAR gender initiative
3) FELTP
4) support to TRACK 1.0 transition

1) In FY 2007, the need for a Systems Strengthening Advisor was identified to facilitate and advocate policy changes needed to better implement PEPFAR. This position provides technical advice to the MOH and other GOR institutions on integrated and cost-effective health policies related to health finance, human capacity development and training, quality of care and infrastructure development; assists the GOR in coordinating/ consolidation of training activities, refresher courses and evaluation of training quality to support HIV and other health programs; serves as a liaison between (and technical expert to) the private sector and the donor community to ensure optimal use of resources and program activities/ strategies are complementary. The advisor works in close collaboration with various units of the MOH involved in the provision of services for HIV affected or infected adults and children to identify, develop, update, finalize and/or disseminate necessary HIV program policies and guidelines, training materials and job aids.

In FY 2009 the advisor provided support in the alignment of the Partnership Framework with the Health Sector Strategic and National HIV plans and the National strategies Application. This included support to the MOH in the finalization of the second HSSP, strengthening the Sector Wide Approach to promote closer coordination of USG activities with MOH and other donors.

In FY 2010 the advisor will support the donor coordination efforts of the health sector; provide advice on the transition of selected USG activities to the Ministry of Health; coordinate infrastructural development, including support in the development of a national health infrastructure plan, between MOH, Ministry of Infrastructure and USG clinical partners; support the Health Human Resources needs assessment and development of recommendations to inform future USG support to HRH in Rwanda moving towards incorporation of in service training into pre service training; provide advice to the MOH on harmonization

of the multitude of performance/quality management initiatives currently implemented; provide support to the PEPFAR gender focal person; support the ADS in efforts to ensure translation of PEPFAR supported evaluations/surveys/ research/assessments into policy and practice; assist USG PEPFAR to fulfill national reporting requirements and; assist in the monitoring and evaluation of USG PEPFAR supported activities.

Funds will allow the advisor to travel outside Rwanda be exposed to best practices and understand lessons learned in other developing country's health systems. Equally dissemination of best practices in Rwanda to countries in the region will be possible.

In FY 2010, short term TA will also be required to support the systems strengthening program.

2) A comprehensive review of gender mainstreaming in PEPFAR, World Bank and Global fund programs illustrated a deficit in systematic sensitization of the PEPFAR implementing partners in mainstreaming gender into routine activities. In the Rwandan PEPFAR program this deficit has been acknowledged. In FY 2010 technical assistance from the gender unit of CDC will solicited to assist the Rwanda USG PEPFAR team to address this deficiency. Specific activities for the Technical Assistance will be: to conduct a workshop for implementing partners to present effective gender mainstreaming strategies and techniques; to meet with individual partners to discuss current barriers faced regarding integration of gender-sensitive approaches and how to overcome such barriers; to brief PEPFAR Rwanda activity managers on USG gender-related policies and offer programmatic guidance; and to examine recent APR results to identify areas for improvement in increasing gender equity in access to HIV/AIDS services. The activities will be conducted in collaboration with the gender focal person and relevant activity managers.

3) HIV/AIDS, tuberculosis (TB), avian influenza, and malaria are diseases of concern in Rwanda. In large areas of the country, malaria is endemic predominantly due to P. falciparum, which exists throughout the entire country during the whole year. Rwanda has several other diseases of epidemic potential including H1N1, cholera, dysentery, and meningitis. Cholera is almost endemic in areas around Lake Kivu. There is an increasing threat of emerging infectious diseases due to Rwanda's proximity other countries where viral hemorrhagic fevers are common.

There is currently only one trained epidemiologist and no field epidemiologists in the Rwandan public health sector. The Rwanda FELTP will allow participants to serve the government at the national, provincial, district and local levels while undergoing training. In addition, there is no training plan for public health laboratory managers or veterinary field epidemiologists. This program will provide human capacity development within the public health workforce to strengthen the capacity of Rwanda in applied

epidemiology, laboratory, and management across public health institutions The absence of trained field epidemiologists has led to a weak surveillance system with delayed identification and understanding of outbreaks because it relies primarily on information from front line health providers (nurses and medical officers). This program will assist in strengthening the public health surveillance system, as well as laboratory-based surveillance for infectious diseases.

The RFELTP is based on the model developed by the US CDC's 50-year history with Epidemic Intelligence Service (EIS). This model was exported to other countries in the 1980's. There are currently several programs in Africa—Ghana, Uganda, Tanzania, Kenya, Southern Sudan, Zimbabwe, and South Africa. The South African and Tanzanian programs are supported by PEPFAR, as are the newly developing programs in Ethiopia and Nigeria. The FELTP is ideally suited for building human capacity in Rwanda. As FELTP trainees will remain in Rwanda during their training and afterwards they will continue to serve the Ministry of Health at the national, provincial, district and local levels during their participation in the program. On completion of training, the participants will function in positions that enable them to contribute to the public health system both as leaders and trainers, thereby sustaining health program infrastructure in Rwanda.

The FELTP will use a multi-phased approach to address these gaps by: 1) conducting situational analysis to identify management skills and performance gaps and to create an action plan for faculty and curriculum development and institution-building; 2) training of a large pool of nationals in epidemiology, laboratory and sound public health practice; 3) technical assistance by providing support to FELTP graduates in such areas as conducting needs assessments, conducting in-country investigations and supervising applied learning projects; and 4) ensuring sustainability by addressing such issues as local funding, and integrating FELTP with other programs and program evaluation.

The School of Public Health, along with the National Reference Laboratory (NRL) have been identified as "prime partners" for the implementation of the RFELTP. These institutions are moving towards developing a comprehensive national public health institution that is based upon the CDC model and consists of a national reference laboratory, and epidemiologic support services for provincial and district level health activities. In addition, the RFELTP will partner with the National University of Rwanda, School of Public Health (NUR/SPH) to offer a masters level degree, with specializations in applied epidemiology, public health laboratory management, or veterinary epidemiology to participants that successfully complete the requirements of the program.

The FELTP model is designed to provide funding and technical resources for the first 5-10 years of the project, while the program is being established. During this time, the program is becoming embedded within the Ministry of Health on the organization chart, budget, and career path for human resources in

the country. More specifically the program will allow for: • Improved program monitoring and evaluation to achieve comprehensive evidence-based HIV disease management services; • Improved quality data and data analysis (specific to person, place and time); • Functional laboratory services and information systems; • Improved laboratory QA and QC and training in support of VCT and HIV rapid testing methodologies; and • Improved monitoring for HIV related opportunistic infections and ART drug resistance. • Improved ability to address opportunistic diseases among Rwandans living with HIV/AIDS • Improved ability to address strategic information needs for HIV/AIDS, tuberculosis and malaria programs. • Strengthening local or local partner organizations, particularly in management, leadership and policy development.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11441	**Mechanism Name: DOD Rwanda Office**
Funding Agency: U.S. Department of Defense	Procurement Type: USG Core
Prime Partner Name: US Department of Defense	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 133,650	
Funding Source	**Funding Amount**
GHCS (State)	133,650

Sub Partner Name(s)

(No data provided.)

Overview Narrative

These funds will be used to support technical area staff.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11441**		
Mechanism Name:	**DOD Rwanda Office**		
Prime Partner Name:	**US Department of Defense**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	133,650	

Narrative:

The overall goal of this activity is to decrease new HIV infections through male circumcision (MC) among Rwanda Defense Forces (RDF) personnel. The program will be presented as part of an expanded approach to reduce HIV infections, and will be promoted in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted infections, promotion of safer-sex practices and condom distribution. MC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package.

The World Health Organization (WHO) and UNAIDS recommended that MC be made available in countries highly affected by HIV/AIDS to help reduce transmission of the virus through heterosexual sex. According to data from two NIH-funded studies conducted in Uganda and Kenya routine MC could reduce a man's risk of HIV infection through heterosexual sex by up to 65%. According to WHO, implementing MC programs in sub-Saharan Africa could prevent about 5.7 million new HIV cases and three million deaths during the next two decades if combined with other factors such as condom usage, responsible behavior and knowing the HIV status of one's partner. WHO is encouraging countries to provide access to no-cost MC to countries in Southern and East Africa, where HIV rates are high and circumcision rates are low to consider adopting male circumcision as an important and urgent health priority, with the target group being boys and men ages 13 to 30 years. In addition, DoD recognizes that

it is critical for men to know that even if they are circumcised, they can still contract HIV and transmit it to their partners. Therefore, circumcised men should continue to practice abstinence, have fewer sex partners and use condoms. It is important that MC is provided to men who are HIV-negative, emphasizing that it is important to know one's HIV status prior to receiving MC.

In FY 2009, communication and messaging targeting Rwandan military personnel emphasized the many benefits of MC but also reiterated that MC does not provide complete protection against HIV. Communication campaigns occurred at the national level through mass media outlets, which encouraged safe MC as part of a complete approach to prevention. Local and inter-personal communication strategies also employed.

Conducting MC in the Rwanda military is considered vital since the military is predominately male, young, and highly mobile, characteristics which put this group at high risk of infections. In FY 2010 MC will be conducted on a voluntary basis on HIV-negative soldiers, as studies have demonstrated that HIV-positive men who have undergone circumcision may be more likely to transmit the virus to their female partners if they have sex before the circumcision wounds have healed. Attention will be paid to the socio-cultural context, human rights and ethical principles, health services strengthening, training, gender implications, service delivery and evaluation. In the coming year DoD will provide TA to the Rwandan military so it may conduct a research study on the "Circumcision status of military recruits".

These activities address the key programmatic issues of gender (particularly male norms) and stigma reduction. Furthermore, these programs reinforce the PEPFAR strategy of strong collaborating with the GOR, as well as the Partnership Framework and the National Strategic Plan for HIV/AIDS, both of which prioritize prevention efforts among military personnel.

Under the Rwanda Defense Force (RDF), there are a total of three military hospitals and five brigade clinics throughout the country. DoD and the Directorate of Military Services (DMS) works together to promote HIV prevention, care and treatment among members of the Rwanda Defense Forces (RDF). While many soldiers practice sexual abstinence and fidelity, their living situation, mobility and age increase their vulnerability to contracting HIV. The estimated HIV prevalence in the RDF is 4.5% (from where) and, consequently, the PEPFAR five-year strategy highlights the military as a high-risk group.

In FY 2009, DoD worked with DMS to strengthen the capacity of the RDF through periodic TA visits from the Department of HIV/AIDS Prevention Program (DHAPP) and through collaboration with clinical partners and the RDF (Rwanda Defense Forces). The first component of this activity involved providing three short-term TA visits from DHAPP headquarters prevention specialists who supported the RDF health providers with prevention, clinical management, diagnosis and treatment of HIV/AIDS. More

specifically, DoD provided TA to reinforce referral mechanisms between military VCT sites and prevention, care and treatment services. TA also helped improve the integration and linkages between facility based and community based services. Through periodic TA, DoD provided technical and institutional expertise to Drew University and to the RDF to strengthen their capacity to manage and improve clinical activities in PMTCT, TB/HIV, basic care and support, TC, and ART. In addition, TA enabled the RDF and Drew University to improve their performance and promotion of professional medical staff providing HIV/AIDS care and treatment.

DoD is working to ensure that Rwandan Defense Forces (RDF), their family members and communities surrounding the military installations have equitable access to a high quality, sustainable continuum of care through HIV and AIDS services. In FY 2010, TA will help military health providers improve treatment of OIs, STI and TB among HIV-positive military personnel and civilians receiving care at military facilities. In addition, this targeted TA will strive to increase treatment adherence. To address mental health issues related to HIV infection this TA will also improve the quality of psychosocial support services and build capacity treatment of mental ill-health in PLWHA receiving treatment and care at military health sites.

This activity contributes to the Partnership Framework and the National Strategic Plan for improving prevention and treatment services, building on existing services and ensuring quality and equitable access to HIV treatment in an expanded number of sites/districts.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12132	**Mechanism Name: NPI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Francois Xavier Bagnoud Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

FXB implements 12 community-based programs that aim to improve the well-being of 3,451 OVC affected by HIV/AIDS by strengthening the capacities of 960 destitute households in the districts of Muhanga, Nyamagabe and Rubavu. In order to achieve this goal, FXB will provide OVC with a comprehensive set of services:

• FXB will support 1,917 primary and 631 secondary school-aged children as well as 120 out of school youth in vocational training centers, by providing them with school/training materials, uniforms and by covering parental contributions. FXB will also monitor school attendance and school performance by carrying out monthly school visits as well as by establishing close partnerships with school personnel.

• FXB will facilitate beneficiaries' access to health care services, notably by enrolling them in the Mutuelle de Santé.

• Health education sessions focusing on prevention, early diagnosis and adherence to treatment will be organized monthly to reduce the incidence of prevalent diseases and ensure that beneficiaries take responsibility for their own health. To further ensure that hygienic principles are well integrated and respected, identify any problems, and help resolve any outstanding health issues, weekly home-visits will be carried out.

• FXB will also assist with larger development projects to safeguard children's health and well-being: as a result, 14 water sources – each serving 210 households – will be created.

• Targeted nutritional support – including support for infant feeding – will be provided. During weekly beneficiary meetings, nurse counselors educate all enrolled families on proper nutritional needs and diets. In parallel, through home-visits, they ensure that food is used and consumed properly as well as that all household members are well nourished.

• 960 households will receive raw materials to start small kitchen gardens, as a source of sustainable and balanced nourishment.

• Confidential individual counseling sessions will be organized daily at the community drop-in centre or weekly during home-visits for adults, children and youth.

• FXB will finalize 70 memory books to help OVC cope with loss of a parent, reduce psychosocial ill-feelings attached to it and help children regain a sense of belonging.

• FXB staff will host monthly awareness-building sessions for all caregivers in the program, as well as quarterly sessions targeting local members of government, educators, and faith-based leaders, to discuss child abuse, exploitation, and domestic violence. These sessions will also participate in further training caregivers in caring for OVC.

• FXB will provide legal advice and guidance as well as legal referral services to beneficiaries.

• The FXB-Village will also ensure the sustained health and well-being of OVC through the formation of

community-based associations tasked with protecting OVC. These associations will participate in identifying families in need of assistance, making health and counseling referrals, providing guidance to caregivers, and informally monitoring children's safety and well-being.
• FXB will assist each household to expand a small business by providing in-kind resources, training, and on-going support and supervision. To further ensure that economic principles are well integrated and respected at household level and assess each household's progress, identify problems, and help resolve any outstanding issues, weekly home-visits will be carried out.
• A collective IGA will be provided to groups of 10 households to strengthen the economic capacities of caregivers and create an additional safety net.
• Additional livelihood trainings will be organized by FXB to provide skills specific to collective IGA, as well as banking and savings, responsible credit, and basic financial literacy and management.
• T o reduce sexual transmission of HIV and AIDS and increase recognition of factors increasing vulnerability to HIV and AIDS, FXB will organize workshops composed of 2 to 3 sessions – each lasting a day – for children aged 10 to 14, youth aged 15 to 25, caregivers, parents, teachers and local authorities as well as PLWHA.
• FXB will also provide material support and education to youth anti-AIDS clubs, focusing on HIV prevention and other life-skills to motivate their peers to learn about HIV and to delay sexual activity.
• FXB will work continually to encourage all program participants, adults and children alike, to be tested for HIV. FXB nurse counselors – in collaboration with local health services – will accompany beneficiaries throughout the process, providing them with counseling before and after testing.
• FXB staff will regularly visit beneficiaries to supervise and guide them through the program. The team will ensure that the objectives of the program are met and will trouble-shoot any challenge. In May 2010, an internal evaluation focusing on quantitative and qualitative data that measure the outcome of the program will be conducted

From mid 2010, as per FXB processes, caregivers will be asked to contribute to school and medical costs at a rate of 25%. Indeed, with regular generation of income, savings and internal credit systems, heads of households are typically capable of covering 25% in all school-related costs.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12133	**Mechanism Name: Strengthening Blood Transfusion Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Public Health Laboratories	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 222,750	
Funding Source	**Funding Amount**
GHCS (State)	222,750

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Association of Public Health Laboratories (APHL) implements specific short-term best practices to strengthen laboratory services while working systematically to gain long-term improvements in quality management and infrastructure of laboratories. APHL adapts its work plans and training materials to meet the specific needs and outcome objectives of each country plan. Once the set of activities is identified for the year, APHL organizes the technical assistance (TA) teams and logistical support to complete the activity successfully. Groups of members as well as staff have received training in core activity curricula such as laboratory management so that we can respond in a timely and effective manner to TA requests. A hallmark of APHL performance has been flexibility in responding to changing schedules and in responding to unexpected events.

In Rwanda, APHL will focus on the establishment of a Laboratory Information System using the LIS implementation Process outlined in the Office of the Global AID Coordinator (OGAC) approved guidelines that were developed by APHL.

There is a need for a robust Laboratory Information System (LIS) at Ministry of Health (MOH) administered laboratories throughout Rwanda. Demand for prompt and reliable laboratory testing services has increased as voluntary counseling and testing (VCT) for HIV and anti-retroviral (ARV) treatment programs expand across the country. In addition, laboratories face an increased demand for aggregate statistical data reporting from MOH and USG.

In FY 2010, APHL proposes providing TA to Rwanda for the expanded deployment of a sustainable LIS solution in MOH administered laboratories based on the business needs of the laboratory personnel, the MOH and the USG. APHL proposes to ensure proper management of the LIS system by training local LIS staff to support these activities. APHL will also explore further implementation of appropriate LIS capabilities to additional sites as identified by the National Reference Laboratory (NRL). APHL will purchase needed hardware required for the implementation of an electronic LIS in the selected sites and will continue to work with the identified LIS vendor to roll-out systems to additional sites. This shall also include instrument interfaces between key equipments. APHL will support a LIS subject matter expert to provide technical assistance to this project and to work closely with the MOH and the USG during the course of the year. The LIS technical consultants will also provide training on the management of LIS data and data mining. This training will have a special focus on how LIS data interfaces with care and treatment programs can be maximized.

APHL will work with the MOH to ensure capacity is built within the Ministry to sustain the ongoing initiatives. Super-user training and software customization will continue targeting key representatives from the local pilot LIS sites. This will ensure knowledge transfer to the local laboratory community on LIS implementation. APHL will continue these sustainability initiatives into the next phase of the LIS roll out.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12133**		
Mechanism Name:	**Strengthening Blood Transfusion Services**		
Prime Partner Name:	**Association of Public Health Laboratories**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	222,750	

Narrative:

The Association of Public Health Laboratories (APHL) implements specific short-term best practices to strengthen laboratory services while working systematically to gain long-term improvements in quality management and infrastructure of laboratories. APHL adapts its work plans and training materials to meet the specific needs and outcome objectives of each country plan. Once the set of activities is identified for the year, APHL organizes the technical assistance (TA) teams and logistical support to complete the activity successfully. A hallmark of APHL performance has been flexibility in response to changing schedules and responding to unexpected events.

In Rwanda, APHL will focus on the establishment of a Laboratory Information System using the LIS implementation process outlined in the Office of the Global AIDS Coordinator (OGAC) approved guidelines that were developed by APHL.

There is a need for a robust Laboratory Information System (LIS) at Ministry of Health (MOH) administered laboratories throughout Rwanda. Demand for prompt and reliable laboratory testing services has increased as Voluntary Counseling and Testing (VCT) for HIV and anti-retroviral treatment programs expand across the country. In addition, laboratories face an increased demand for aggregate statistical data reporting from MOH and CDC.

In FY 2010, APHL will provide TA to Rwanda for the expanded deployment of a sustainable LIS solution in MOH administered laboratories based on the business needs of the laboratory personnel, MOH-Rwanda and of CDC-Rwanda. APHL proposes to ensure proper management of the LIS system by training local LIS staff to support these activities. APHL will also explore further implementation of appropriate LIS capabilities to additional sites as identified by Rwanda. APHL will purchase needed hardware required for the implementation of an electronic LIS in the selected sites, and will continue to work with identified LIS vendor to roll-out systems to additional sites. This shall also include instrument interfaces between key equipment. APHL will support a LIS subject matter expert to this project to work closely with MOH-Rwanda and CDC-Rwanda during the course of the year. The LIS technical

consultants will also provide training on the management of LIS data and data mining. This training will have a special focus on how LIS data interfaces with care and treatment programs. APHL will work with the Rwanda Ministry of Health to ensure capacity is built within the Ministry to sustain the ongoing initiatives. Super-user training and software customization will continue targeting key representatives from the local pilot LIS sites. This will ensure knowledge transfer to the local laboratory community on LIS implementation. APHL will continue these sustainability initiatives in the next phase of the LIS roll-out.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12134	**Mechanism Name: Targeted Interventions for Prevention**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 796,950	
Funding Source	**Funding Amount**
GHCS (State)	796,950

Sub Partner Name(s)

CNLS	MOH CCC	TBD
TracPlus		

Overview Narrative

BACKGROUND AND OBJECTIVES:

In 2009, CDC funded FHI to launch a project with TRAC Plus that aims to make the VCT encounter more

effective for primary prevention. By: (i) increasing access to and uptake of VCT by highest risk HIV-negative non-testers, (ii) improving the identification of highest risk HIV-negative VCT clients, and (iii) providing these clients with intensified and personalized intervention counseling, the goal of this project is to reduce HIV transmission in Rwanda.

Over the past 7 years, testing and counseling (TC) services have been radically scaled up as part of the Rwanda's efforts to expand access to care and treatment. However, the VCT encounter has not fundamentally changed since its introduction. It remains principally intended to serve purposes of care and treatment (i.e., to detect and refer HIV-positive persons to treatment services) rather than to serve a more holistic purpose of prevention and referral to care. Structured around national guidelines, the current counseling session within VCT is formulaic rather individualized. While there is tremendous uptake of VCT in Rwanda, little is known about who the clients are, their motivations for testing, or their individual risk behaviors.

With the wide availability of VCT services now in Rwanda, there is an important but unexploited prevention opportunity. Inspired by theory-based counseling approaches with demonstrated efficacy in other contexts, FHI will assist TRAC Plus to develop and introduce intensive intervention counseling to HIV-negative clients with high risk behaviors who come to VCT.

With the aim of reaching more high-risk individuals who do not use VCT, FHI will also work with the CNLS, TRAC Plus and select health facilities to conduct VCT outreach.

LINKAGES TO THE PARTNERSHIP FRAMEWORK:

This project contributes to VCT and prevention objectives outlined in the Partnership Framework. Importantly, in making better use of now widely available VCT for purposes of primary prevention, the project promises to have a long-term positive impact in new infections averted. As the single most important strategy for reducing costs for programming and to the health system, preventing new HIV infections is an essential aspect of transition strategies aimed at reducing Rwanda's dependency on external aid to confront the HIV epidemic.

COVERAGE AND TARGET POPULATIONS:

The target population for this project is HIV-negative VCT clients with high risk behaviors. For non-testers, the project will extend services out to them through VCT outreach campaigns. Under COP10, the geographic scope will remain confined to select areas of Kigali with the intent of developing the guidelines and the tools for later expansion by TRAC Plus to other service sites throughout the country.

COST-EFFICIENCIES:

FY 2009 is the first year of project implementation. The major expenses for the activity will be consulting services from highly skilled and experienced psychiatrists who have pioneered successful approaches in other contexts. Once the guidelines and tools are developed and integrated into TRAC Plus's training and support activities, the costs of implementing the project will be significantly reduced and eventually eliminated as the approach is adopted as part of standard practice.

M&E:

Per the proposal and plan submitted to CDC, progress in meeting the project's specific objectives and purpose will be assessed through quality assurance (QA), outcome indicators and project evaluation.

QA: Periodic reviews of client files will be conducted to test the sensitivity and specificity of the referral system by examining whether those identified by information in the file as at high risk actually received the appropriate referrals. Counseling supervisors will periodically observe VCT and intervention counseling sessions to evaluate counselor performance and provide supportive supervision. Using the data from the monitoring system, the rates of repeat testing in HIV-negative high risk clients, partner disclosure and sexual risk behaviors will be compared across various counselors to determine if there are issues to be mediated in the performance of specific counselors. In addition, periodic data quality audits will be conducted.

Outcome indicators: In consultation with TRAC Plus, FHI will finalize outcome indicators for this project. An illustrative list of these indicators follows:

• Increase VCT-seeking in persons at high risk
1. Number of VCT clients (high risk and others) who report having heard one of the outreach messages
2. Proportion of VCT clients testing HIV-positive
• B. Empirically-identified high risk clients in VCT
1. Number and proportion of VCT clients (HIV-positive and negative) who are identified during VCT counseling as at high risk
2. Number and type of high risk clients referred to intensified intervention counseling who complete the referral
• C. High risk clients receiving intensive intervention counseling
1. 5. Where interventions consist of several points of contact, proportion of high risk clients that complete each stage of the intervention

2. 6. Proportion and type of high risk clients having disclosed their status and to whom
3. 7. Percentage and type of high risk clients who self-disclosed or who disclosed with facilitation

Evaluation: As a proxy for failure to achieve change in risky-behaviors, TRAC Plus and FHI will review client records to identify clients who have come back to VCT after receiving intensified intervention counseling services. Mid-term and end-of-project evaluations are proposed with subsets of randomly selected clients who prospectively agree to be contacted after a short (e.g. 2-month) period. During these follow-up interviews with clients, we will concentrate on 3 domains:

• Knowledge and skills learned in counseling sessions, measured by administering adapted scales related to partner communication and problem solving, condom negotiation, and sexual communication.
• Current self-reported risk behaviors. Since evaluation participants by definition will have been identified during counseling as at high risk, they will be re-assessed at follow-up to determine if they still satisfy the high risk criteria (as identified in the risk score algorithm). The interviews will also refer back to the risk reduction plans that were made in counseling sessions to examine obstacles and facilitators to achieving the plan.
• Client satisfaction with counseling services received.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12134**		
Mechanism Name:	**Targeted Interventions for Prevention**		
Prime Partner Name:	**Family Health International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	351,450	
Narrative:			
The key Testing and Counseling (TC) activities that will be supported during this period are described			

below.

IDENTIFYING MOST-AT-RISK VCT CLIENTS FOR INTENSIFIED PREVENTION COUNSELING:

Often "most-at-risk persons" are identified by membership in particular social group (e.g., armed forces, sex workers, truckers) rather than by their personal behaviors. This means of identifying who needs intensified counseling is neither sensitive nor specific enough to correctly capture all most-at-risk persons (MARPs). Under this project, TRAC Plus and FHI will develop a risk score algorithm within VCT to empirically identify high risk VCT clients. The intent is thus to add an objective, and potentially more sensitive and specific, dimension to the correct identification of most-at-risk VCT clients, thus going beyond generalizations based on social characteristics which can also be stigmatizing. Once identified, high risk negative clients will receive personalized risk reduction counseling.

INTENSIFIED HIV COUNSELING FOR HIGH RISK HIV-NEGATIVE CLIENTS:

In the health facilities implementing this intervention, HIV-positive clients will be referred directly to care and treatment services, wherein they will receive the standard package of care and follow-up, including comprehensive positive prevention services (STI screening, risk reduction education, counseling on reproductive choices and contraception, support for disclosure, and couples VCT).

In FY 2010, FHI will implement interventions where high risk HIV-negative clients will be systematically screened for STI and referred for individualized intervention counseling. To avoid or minimize possible stigmatization of individuals referred for special, intervention counseling, these sessions will be offered within the already-existing generalized Social Work Services at participating health facilities.
Modeled on a successful program targeting high-risk repeat HIV testers in North America, TRAC Plus and FHI will introduce a structured counseling session that facilitates client self-awareness of their sexual decision-making. The counseling session begins by prompting the client to describe in detail her/his most recent act of risky sexual intercourse and to recall their thoughts and feelings as experienced during the state of heightened sexual arousal, referred to as "on-line" thinking. The purpose of this provocation is to enable the client to clearly recognize, in an "off-line" counseling session, her/his altered risk perception during this aroused state. The client and counselor then critically examine the "self-justifications" for the risk-taking and emphasize how the client can incorporate new self-knowledge to adopt safer sex practices in future encounters.

For those individuals who are identified as at-risk because their partners are known or suspected to be HIV- and/or STI-infected, conventional, individually-focused risk reduction education needs to be supplemented with counseling that addresses relational dimensions of high risk behaviors and situations.

To address these specific needs, TRAC Plus and FHI will introduce relationship-based counseling that, beyond condom acquisition and skills, emphasizes self-efficacy, negotiation and personal empowerment within (or outside) the risky relationship.

This counseling approach draws upon a number of studies wherein clients, mainly women, are provided with negotiation and refusal skills (e.g., pre-foreplay decision-making, and where and when to ask for safer sex), learn about alternative risk reduction strategies (e.g., engaging in "outercourse"), and encouraged to reflect on their relationship and communication about sex within it. In order for individuals to negotiate effectively with their partners, they need to be comfortable talking about sex, yet also to feel agency and self-efficacy as relates to their own sexual pleasure and protection.

For both self-justification and relationship-based counseling sessions, the counselor will elicit risk reduction intention and help the client develop a personalized behavior change plan. Not only will the plans concretize the client's commitment to take action in the counseling setting, they will also provide a means for TRAC Plus and FHI to assess efficacy of the intervention.

At each level of intervention, TRAC Plus and FHI will work with health facilities to ensure that messages and services are youth-friendly. For instance, flexible opening hours, nonjudgmental communications style and content, assurances of privacy and confidentiality, and making sure that youth are considered when deciding where outreach campaigns will be conducted. At the same time, the project will refer youth clients to Youth Centers supported by Population Services International (PSI) for additional support.

Given that HCT is an important prevention strategy, it should be noted that this "HVCT" component is very much related to and intertwined with the HVAB and HVOP elements.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	99,000	

Narrative:

In the Targeted Interventions for Prevention (TIP) project sexual risk reduction education is part of FHI/TIP's promotion and implementation of comprehensive, science-based approaches to primary, secondary, and tertiary prevention of HIV. In FY 2010, the second year of the project, FHI/TIP will prioritize cross-referrals spanning community and clinical contexts to provide individuals with multiple behavioral and biomedical prevention services and, where indicated and feasible, these will include reducing socio-economic vulnerabilities that lead to high-risk situations.

In the clinic setting, primary prevention activities will entail behavior change education to reduce sexual risk, including delayed sexual onset for youth, partner reduction, partner testing and couples VCT, and improved STI diagnosis and management. With this funding, FHI/TIP will work with TRAC Plus in FY 2010 to establish an effective approach for identifying most-at-risk HIV-negative clients within VCT and provide intensified and personalized risk reduction counseling. As guidelines and tools from this initiative become available, TRAC Plus and FHI/TIP will work with districts and health facilities to introduce the approach as part of routine, clinic-based primary prevention activities in FY 2010 and beyond.

These prevention activities will be comprehensive, linked, positive prevention programs that target HIV-positive persons and HIV-affected couples for secondary and tertiary prevention. Systematic and expanded positive prevention programs will include:

• Behavior change education and support to HIV-positive persons to reduce risk of transmission to HIV-negative partners.
• Condom promotion and delivery to HIV-positive individuals and -affected couples.
• PMTCT, dual method promotion and family planning delivery for HIV-positive women and -affected couples.
• HIV testing for partners of HIV-positive persons and couples VCT.
• Counseling and support for HIV sero-discordant couples.
• Routine STI screening and treatment for HIV-positive patients.
• Referral to care, treatment and support services for HIV-positive persons.

FHI/TIPs HVAB activities are integrally related to HVCT and HVOP activities and form part of a comprehensive package. In terms of supportive supervision and QA, FHI/TIP will work hand in hand with TRAC Plus to implement supportive supervision, using standardized supervision tools, and will carry out program evaluation to inform program design and implementation. A client intake form and a risk score algorithm will be used to screen high-risk youth and assess primary or secondary abstinence. Pre-post tests will assess training quality and performance.

Description of targets: Targets will be developed with TRAC Plus.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	346,500	

Narrative:

In the Targeted Interventions for Prevention (TIP) project, FHI/TIP will promote and implement interventions targeting most-at-risk individuals as part of a comprehensive, science-based approach to primary, secondary, and tertiary prevention of HIV. In FY 2010, the second year of the project, FHI/TIP

will prioritize cross-referrals spanning community and clinical contexts to provide individuals with multiple behavioral and biomedical prevention services and, where indicated and feasible, these will include reducing socio-economic vulnerabilities that lead to high-risk situations.

In the clinic setting, primary prevention activities will entail behavior change education to reduce sexual risk, including delayed sexual onset for youth, consistent and correct condom use for youth and adults, partner HIV testing and couples VCT, and improved STI diagnosis and management. With this funding, FHI/TIP will also work with TRAC Plus in FY 2010 to establish an effective approach for identifying most-at-risk HIV-negative clients within VCT and provide intensified and personalized risk reduction counseling. As guidelines and tools from this initiative become available, TRAC Plus and FHI/TIP will work with other districts and health facilities to introduce the approach as part of routine, clinic-based primary prevention activities in FY 2010 and beyond.

These prevention activities will be comprehensive, linked, positive prevention programs targeting HIV-positive persons and HIV-affected couples for secondary and tertiary prevention. Systematic and expanded positive prevention programs will include:
• Behavior change education and support to HIV-positive persons to reduce risk of transmission to HIV-negative partners.
• Condom promotion and delivery to HIV-positive individuals and -affected couples.
• PMTCT, dual method promotion and family planning delivery for HIV-positive women and -affected couples.
• HIV testing for partners of HIV-positive persons and couples VCT.
• Counseling and support for HIV sero-discordant couples.
• Routine STI screening and treatment for HIV-positive patients.
• Referral to care, treatment and support services for HIV-positive persons.

As such, the activities categorized as HVCT and HVAB are very integrally related to this HVOP component. In terms of supportive supervision and QA, FHI/TIP will work hand in hand with TRAC Plus to implement supportive supervision, using standardized supervision tools, and will carry out program evaluation to inform program design and implementation. A client intake form and a risk score algorithm will be used to screen high risk youth and assess primary or secondary abstinence. Pre- and post-tests will assess training quality and performance.

Description of targets: Targets will be developed with TRAC Plus.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12135	**Mechanism Name: New: DOD**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 693,000	
Funding Source	**Funding Amount**
GHCS (State)	693,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Research on Male Circumcision demonstrates a 60% reduction in female-to-male HIV transmission, generating new hope for changing the course of the pandemic. Rwanda responded to the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommendations to pursue MC by establishing the goal to create and scale up MC services in the Rwandan military. MC coverage is less than 20% in the country and even if it is not a panacea, MC provides a greater protective benefit than any potential vaccine studied to date.

The overall goal of this activity is to decrease new HIV infections through male circumcision in the Rwanda Defense Forces (RDF) with emphasis that circumcision be offered as part of an expanded approach to reduce HIV infections in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted infections, promotion of safer-sex practices and condom distribution. Male circumcision (MC) will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package. Jhpiego's major goal is to develop "Troop Level" HIV/AIDS prevention capability within the RDF through the following objectives: a) To increase RDF capacity to deliver safe male circumcision services by training 120 clinicians including 16 master trainers by the end of the program year and b) To increase informed demand among the RDF for MC by training 155 health professionals who administer provider-initiated counseling and testing for HIV/AIDS including 16 master trainers by the end of the program year. These goals will be achieved by utilizing Jhpiego's signature, competency-based training pathway and Jhpiego's expertise, to provide the RDF with master trainers who will fill long-term clinical and counseling needs and by assisting the RDF to

utilize a performance and quality improvement (PQI) methodology—Standards-Based Management and Recognition (SBM-R), to enable providers to progressively improve the provision of high-quality MC services and control for adverse events.

To scale up MC in the RDF, Jpiego will identify and address gaps at target sites, facilitate policy environment for confidential informed consent for male circumcision as an HIV/AIDS reduction strategy, expand HIV voluntary counseling and testing (VCT) curriculum to include MC and train counselors, train health care personnel to be able to conduct MC and counsel individuals, develop a cadre of national level trainers who are skilled in MC and implement Standards-Based Management and Recognition (SBM-R) in each facility. The goals and objectives are linked to the overall Partnership Framework goals of decreasing new HIV infections in high HIV prevalence regions with low male circumcision rates, and building the capacity of local bodies to implement and manage the various components of male circumcision programs.

The geographic coverage of MC activities within the RDF will be at eight (8) model sites delivering MC surgery services including counseling and testing at country level. As announced by the GOR, the initial target population of male circumcision activities will be the soldiers in the Rwandan Defense Force (RDF) and activities will be performed in accordance with RDF policies concerning recommended testing of active duty soldiers and mandatory testing of new recruits and denial of entry for those found to be positive. In addition to the biological benefits of MC, the program activities will contribute to strengthening of health systems by supporting the RDF in building standardized, competency-based systems to in-service education and providing a standardized approach to procurement of MC supplies.

In FY 2010, Jhpiego will build capacity of the RDF health providers to perform MC at the RDF sites, improve system strengthening, provide standardized supervision and put in place measures to improve the MC strategy's cost efficiency over time. Such measures include coordinating service delivery with partners such as Drew University, who will be designing and providing standardized MC kits; and utilizing PSI's expertise in behavior change communication as a complement to Jhpiego's training expertise. Jhpiego will also be collaborating with the necessary officials, such as the RDF's Directorate of Medical Service (DMS) in order to reduce duplication of efforts.

Monitoring and Evaluation (M&E)

To measure and report progress toward achieving project objectives, Jhpiego will implement a detailed and focused M&E plan and will rigorously monitor project activities, objectives and purpose. A Management Information System (MIS) will track inputs and outputs, such as: number and type of providers trained; equipment and consumables used; and number of clients seeking and receiving MC. Jhpiego's training database, known as TIMS , will be used to track the number of health personnel

trained, including master level trainers. Staff will regularly monitor and measure project progress and performance according to a data collection schedule for a particular monitoring indicator. The philosophy of the project is, where resources permit, to measure the indicators as frequently as possible in order to avail information and feedback to the project implementation process in as timely a manner as possible. Data for the illustrative indicators will be collected through project and facility records. The needs assessment will include a facility survey and focus group discussions with hospital staff and military personnel, and will contribute to the project baseline with which to compare results.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12135**		
Mechanism Name:	**New: DOD**		
Prime Partner Name:	**JHPIEGO**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	693,000	

Narrative:

The overall goal of this activity is to decrease new HIV infections through male circumcision among Rwanda Defense Forces (RDF) personnel. The program will be presented as part of an expanded approach to reduce HIV infections, and will be promoted in conjunction with other prevention programs, including HIV testing and counseling, treatment for other sexually transmitted infections, promotion of safer-sex practices and condom distribution. Male circumcision (MC) will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package.

The following activities will be implemented during FY 2010 in order to reach MC goals.
• Target sites strengthening: Based on assessment results, JHPIEGO will work with SCMS to ensure that supplies and equipment needed for MC are available at the site level. JHPIEGO will build the

capacity of the RDF to project and budget for supplies they will need to operate independently.
• Facilitate policy environment for confidential informed consent for male circumcision as an HIV/AIDS reduction strategy: In an endeavor to scale-up MC and sustainability, JHPIEGO will collaborate with the MC Task Force, other PEPFAR implementing partners, district level health authorities, the Rwandan Association of Surgeons, the Faculty of Medicine and the RDF for a multi-sectoral, multi-level approach to scaling up MC and promoting integration with other HIV prevention, care and treatment activities.
• Expand HIV voluntary counseling and testing (VCT) to include discussion of MC and train counselors on MC: Building the capacity of counselors to communicate and disseminate information about MC is critical. Since MC only partially protects against HIV, it is important that MC is one aspect of a comprehensive package of HIV prevention services, and closely linked to effective counseling and testing for HIV. In accordance with WHO/UNAIDS guidance, JHPIEGO has incorporated an intense counseling effort into training program to educate clients as well as potential clients and their partners about the partial protective nature of MC and the need to use other prevention methods (such as abstinence, partner reduction and consistent condom use). To extend MC-related counseling and testing within the RDF and to build a referral system for HIV-negative males, JHPIEGO will support five-day MC counseling courses for existing VCT providers and lay counselors to increase their ability to answer questions about MC and refer HIV-negative men to MC services.
• Train health care personnel to be able to conduct MC and counsel individuals: JHPIEGO has developed and employed a competency-based trainer pathway designed to enable countries fill human resources for health needs into the future. Hence, this project will use a competency-based approach to training that emphasizes the acquisition of clinical and counseling skills. Trainings will be conducted using both classroom learning for theory and clinical settings for learning on a clinical caseload. All trainings will be based on the WHO/UNAIDS/JHPIEGO MC Reference Manual and will be tailored to any national guidelines. This training package includes five main competencies: 1 - Group Education; 2 - Individual Counseling; 3 - Client Assessment and Informed Consent; 4 - MC Procedure; and 5 - Postoperative Care. These modules will be tailored in length and emphasis depending on the specific audience. For example, providers of the procedure will receive reduced group education and counseling modules while counselors will receive abbreviated procedure modules with more emphasis on counseling and group education. JHPIEGO will also tailor training courses based on providers' surgical skills. On satisfactory completion of the training program, trainers will conduct follow-up visits to all providers in their place of work within 4–6 weeks. This is seen as an essential component to ensuring retention of information and mastery of skills. In addition to monitoring at least one procedure, the trainers will conduct a clinic audit to ensure that the clinic and the provider are meeting the minimum standards of quality for all aspects of service delivery. All providers completing the training program will agree to meet or exceed defined minimum standards of quality in their clinics and within their MC services. JHPIEGO will define these standards, taking into consideration: 1) a set of internationally agreed-upon performance standards for MC that the WHO is currently finalizing; and 2) relevant national guidelines.

These standards will include a ceiling of 4% on moderate and severe adverse events (AEs). It will also include a minimum number of procedures that providers must perform monthly to maintain accreditation. Develop a cadre of national level trainers who are skilled in MC: JHPIEGO will continue to support Kanombe military hospital as a training center and will build the capacity of a core group of MC training team. MC training team will consist of one proficient MC provider and one proficient MC counselor who will participate in an MC training course. Following successful completion, a JHPIEGO Master Trainer will co-train with these new trainers in order to mentor them as they lead their first MC training courses for other providers. JHPIEGO will also provide technical support to TRACPlus to conduct training-of-trainers courses on MC in military health facilities. This cascade approach to training and mentoring of national level trainers who also participate in the program and quality improvement has proven successful for building long-term local capacity.

• Implement Standards-Based Management and Recognition (SBM-R) in each facility: JHPIEGO recognizes that high-quality training alone is not sufficient for the introduction of new clinical services such as MC, especially given that it requires a surgical procedure and management of adverse effects. Therefore newly trained providers will require follow-up support. JHPIEGO has developed and implemented SBM-R, an internationally acclaimed system devised and first tested in Brazil, in 12 countries to address supporting quality implementation of training. JHPIEGO will use SMB-R to objectively measure, monitor performance standards so as to improve the quality of services of a range of HIV health care services, from HIV counseling and testing to antiretroviral therapy. Providers will be empowered to monitor the quality of their own health services, rather than waiting for outside supervision to make changes. JHPIEGO will establish an SBM-R system that will include the development of MC quality teams at the national level. The MC quality teams will include the national MC trainers, as well as other key stakeholders such as representatives of the national MC Task Force. These teams will develop, in collaboration with JHPIEGO, checklists, job aids and other tools to allow providers to measure performance based on minimum standards; these same tools will be used for external assessment. Internal and external measurement against the standards (by the providers themselves and by the external MC quality teams) will occur on a regular basis to ensure ongoing identification of problems and continuous improvement. Sites that have achieved the seal of quality will receive several external assessments in their first year of operation. In subsequent years, external assessments will occur at least once per year, provided they continue to meet or exceed the minimum standards. Those sites that are struggling will work with the MC quality teams to develop a plan to address those gaps and will be visited at least quarterly until quality improves. Via JHPIEGO's USAID-funded Maternal Health Program (ACCESS) in Rwanda, SBM-R is already operating effectively, and the GOR has drafted national guidelines to support scale-up.

• Managing Adverse Events (AEs): Maintaining a very low rate of AEs is critical to furthering ownership and scale-up of MC by the RDF. The training and quality assurance process will minimize the number and severity of AEs. JHPIEGO will also design a system for handling AEs that occur during or

immediately following the procedure, and those that present after the client has been discharged. Providers will be trained to handle many of the complications that may take place during the procedure as well as the common minor complications that can occur in the first week after MC. A system of referrals will be established for each site to address cases they cannot treat. Providers will be trained to complete the AE forms provided in the WHO/UNAIDS/JHPIEGO MC manual. AE forms for minor complications will be collected at follow-up visits, while JHPIEGO will require that moderate or severe complications be reported immediately. JHPIEGO will conduct M&E and data collection and report this information regularly to the Ministry of Health. +C20

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12136	**Mechanism Name: Integrated Health Systems Strengthening Project (IHSS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,398,291	
Funding Source	**Funding Amount**
GHCS (State)	3,398,291

Sub Partner Name(s)

Futures Group, South Africa	Health Development and Perfomance (HDP)	Innovative Development Expertise & Advisory Services (IDEAS)

Overview Narrative

Goals & Objectives: IHSSP will strengthen Rwanda's health systems for information, finance (including performance-based financing, PBF), human capacity development, quality assurance, and decentralization (including community-based service delivery systems.) IHSSP will build on results of

previous and current US Government investments in the health system in Rwanda. Strengthening the decentralized health system and workforce (with resulting positive impact on health) will reinforce good governance and improve productivity and economic opportunities, to help reach Rwanda's Vision 2020 national health goals. IHSSP will collaborate with USAID, CDC, the MOH, and other partners to build capacity in information and financial management systems at both the central and district levels; build on, refine and extend the utility of the national PBF program; and pursue with the MOH and district leadership the community PBF (c-PBF) initiative. IHSSP will partner with the MOH in analyzing and implementing innovative changes in MOH internal systems to improve functionality at the center and to strengthen decentralized systems. With support to the national community-based health insurance (CBHI) system, health management information system and support systems, the USG will ensure an effective PBF database and open systems documentation which will enhance effective management and financing of services. IHSSP will assist to expand the successful Young Professionals Program in Rwanda and work to reinforce the existing multi-donor support to this program. The project will support capacity building in planning and team-based problem-solving for service providers and health managers through the MSH Virtual Leadership Development Program.

2) Partnership Framework: IHSSP will contribute directly to Strategic Goal 4: addressing 5 of the 6 objectives: 4.1, 4.2, 4.3, 4.4, and 4.6.

3) The geographic coverage and target population(s). Nationwide with targeted support interventions in specific districts.

4) Health systems strengthening: IHSSP will work with the MOH to strengthen health systems and provide support to sustain progress already made. Information systems must be refined, integrated, and used. Financial resources flowing from the central government (and donors) must be aligned with those coming from the communities through the CBHIS, allocated appropriately, used efficiently, and accounted for in a fully transparent way. Community health workers, as a key strategy in Rwanda to resolve the crisis in supply of human resources for health, must be recruited, trained, supervised, and supported. The process of QA must be built into all levels of service delivery; norms and standards must be updated as needed; and performance must be tracked and openly documented. Those tasked with organizing and providing health services at the district and local levels must have the authority, training, and resources to meet their obligations. (See narrative for Budget code 1, OHSS Health Systems Strengthening, for details)

5) Cross-cutting programs: Human resources for health is included as a component of Health System Strengthening.

6) Cost-efficiency strategy: IHHSP Project will help consolidate the Rwanda health financing system and continue USAID's support to the MOH PBF Unit (CAAC) and the CBHI system and the Mutuelles Unitto integrate and build equity, efficiency, and transparency into the financing mechanisms. Doing so will tie the flow of financial resources from communities (through the mutuelles) and the GOR (through the PBF system) to enable cost-effective allocation decisions by managers at all levels in the system. The overarching strategy will be to align with the GOR's HSSP II and Imihigo performance-based contracting approach with district mayors. This project will provide regular data exchange with the district authorities so that they can meet the overall performance goals for public management at the district level agreed to and documented in performance management contracts they have signed with the Office of the President on behalf of their constituents. IHSSP will also support Rwanda's efforts for financial sustainability by helping MOH departments finance their strategic plans by developing proposals for direct or "basket-funding" opportunities.

7) M&E plan: IHSSP M&E data will be collected using both quantitative and qualitative methodologies. Improving efficiency and accountability are at the core of our strategy, routine monitoring and assessment are critical to the effective targeting of resources and effort to produce results. Data will derive from the national HMIS, and support will be provided to enhance the efficiency of the national system. Our M&E design recognizes five major data users: MOH, USAID and USG, the IHSSP and its management, the individual recipients of PBF funding (contracts) who are providing services to their communities, and the members of the communities themselves. The project will focus on using existing data and reinforcing MOH data collection system, avoiding parallel reporting systems for routinely collected data. IHSSP will include partners who are already collecting data, but may not have had much experience with donor funding and/or data analysis. IHSSP will extend data collection and tracking systems that are in use for PBF and CBHI to assure access and compatibility with data in the HIS already in use by the MOH. Furthermore, this partner will work collaboratively with data providers and data users to identify and address potential bottlenecks or incompatibilities.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12136**		
Mechanism Name:	**Integrated Health Systems Strengthening Project (IHSS)**		
Prime Partner Name:	**Management Sciences for Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	695,591	

Narrative:

At the national level the Integrated Health Systems Strengthening Project (IHSSP) will facilitate the clarification of the planning, monitoring and evaluation functions of the MOH Planning Department in relation to decentralization in the health sector. Building on the work of the GOR and USG partners, the project will help MOH design and implement a harmonized and simplified system that links data collection to planning.

IHSSP will support the roll-out of the new M&E and health information system policy and strategies. This will involve, among others, the development of norms and guidelines for data management and feedback; the revision of data collection and reporting tools; and the implementation of a centralized data warehouse and web portal that will enable managers at all levels to track trends in real time. The project will reinforce the capacity of the M&E Task Force and the eHealth Secretariat of the MOH to lead and provide oversight to the implementation of the national policy and strategies, to enhance the interoperability of computerized systems and to coordinate the periodic revision of the routine health indicator set.

While IHSSP will continue USG efforts to enhance the capacity of national policy-makers to use data to revise and update policies, norms, and guidelines, an equally important focus will be on promoting the local use of data in Districts, health facilities and communities. Through its district sub-offices, the project will assist the MOH in the development and roll-out of a plan for building the capacity of health managers and health care providers at district and peripheral levels to analyze routine health data, and to use the generated information effectively to identify the root causes of unsatisfactory performance and solutions to problems. Assistance will also be provided for the development of a module on the routine health management information system (HMIS)/M&E for incorporation into the pre-service training curricula of health professional training institutions (nursing, midwifery, and the medical school). This activity will be initiated during FY 2010.

The project will also endeavor to strengthen the linkages between the M&E Unit and the departments of the MOH that have the responsibility for the development of supervision and quality assurance.

Moreover, the project will support the coordination function of the MOH to ensure that all partners involved in capacity building for data analysis and use are operating cohesively.

The IHSSP will also support various departments within the Ministry of Health to enhance and roll-out specific health information sub-systems. These include:
• Community-based Health Insurance membership and indicator databases
• Community Health Worker HMIS (SIScom)
• Performance-Based Financing Systems for Hospitals, Health Centers, Community Health Worker Cooperatives
• Human Resource Information System (iHRIS)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	2,702,700	

Narrative:

Integrated Health Systems Strengthening:
Recent health improvements in Rwanda are directly linked to the strong collaboration among implementing agencies, donors, and service delivery partners over the past several years. The Ministry of Health (MOH) has enjoyed the full support of the President and the Cabinet to roll out major policy initiatives. These efforts include PBF (which will focus action on desired results), establishment of CBHIS (to move toward universal access to health services with a clear community voice in quality), and integration of resources and services for AIDS, tuberculosis, and malaria in the primary health care package as services are scaled up. The IHSSP will work with the government, civil society, and communities to strengthen health systems, develop preventive interventions, and improve the quality of health services.

1) Systems barriers and strategies: To strengthen health systems, the IHSSP will reinforce the institutional capacity of the MOH and district managers through continued application of the Fully-Functional Services model used by the MOH in its functional analysis, adapted to target fully-functional districts, and other targeted performance improvement, leadership development, and training methodologies. The project will strengthen the ability of districts, facilities, and health workers to identify and develop creative solutions for priority health problems using the MSH Challenge Model. In addition, MSH will work at the central level to help align the QA mechanisms now being put into action with the already functioning PBF system. Through c-PBF and community-based policy work, IHSSP will collaborate with communities and civil society organizations to address barriers to the access and use of services and strengthen health workers' capacity to provide quality services which are integrated within the national health program. By refining health management information systems and processes, IHSSP

will enable policymakers, managers, health workers, and communities to make informed decisions.

Health finance, governance/leadership:
Selected Activities to be carried out with partial support in this budget code:
• Coordinate the secretariat functions of the PBF and CTAMS extended team mechanism
• Participate in the quarterly counter-verification mechanisms
• Document development experience (through small-scale qualitative operational research) and publish experience in peer-reviewed journals
• Conduct two-week Rwandan PBF short course in collaboration with the MOH and the School of Public Health
• Conduct capacity-building activities on PBF with the PBF Extended Team
• Provide technical assistance for the new and evolving central MOH performance assessments
• Organize district-level technical assistance to the sector steering committees that govern the c-PBF mechanism
• Promote the transfer of technical capacity related to data use from the district to the sector level, contributing to a more targeted approach to community health activities
• Assist the GOR in implementing the proposed four conditional cash transfer pilots at the community level in the areas of planning, training, and follow-up
• Train districts to raise funds and improve the financial management of Mutuelles
• Provide TA to improve the national PBF model for health centers and district hospitals
• Provide technical assistance to the CAAC and the TWG subcommittees to share knowledge related to the management of the PBF administrative system
• Reinforce contract management competencies within CAAC
• Provide Virtual Business Planning for Health program to support health centers
• Use the tool CORE Plus with CAAC for both facility PBF and c-PBF to build service costing capacity
• Provide continuous capacity building and system strengthening assistance to CTAMS
• Assist CAAC in establishing the standing peer evaluation committee and support the CTAMS in making its Mutuelle PBF system operational
• Facilitate advanced strategies at the national level, to augment the productivity and quality of health services, including HIV services
• Support the roll-out of community PBF model through trainings in collaboration with national Malaria, Community Health Desk, CAAC, TRAC Plus, CNLS, and USG partners,
• Provide technical assistance to the Extended Team and district health teams in data analysis on all PBF matters, using existing USG resources from CAs nationwide
• Incorporate QA mechanisms into PBF systems in collaboration with MOH
• Create a new coordination platform that involves actors from community health, HMIS department, and c-PBF actors, under the leadership of the Community Health Desk

• Build partnerships with educational institutions and existing mechanisms such as the Young Professionals Program
• Support the MOH to develop quality and quantity indicators with costs for University Teaching Hospital
• Conduct mentoring and targeted training to PBF steering committees at district level
• Implement cost effectiveness, impact and sustainability analyses of health and social services
• Contribute to the development of the national social protection policy in health

2) Linkages across functional areas, and leveraging: Recognizing and respecting the interdependence of the many actors and stakeholders in Rwanda's health system, IHSSP will seize the opportunity to establish partnerships and align goals and priorities with those of other donors and agencies working in Rwanda. As an example, the Belgian Technical Cooperation (BTC) will provide substantial funding to the Young Professionals Program while IHSSP will provide the technical assistance and guidance.

3) Selected Activities to be carried out with partial support in this budget code for Human Capacity Development, Supportive Supervision, and Quality Assurance:
• Support Human Resources (HR) Task Force to manage the implementation of HR capacity development initiatives
• Conduct HR assessment studies to update the knowledge on the current health work force (in terms of qualification, gender, age, deployment etc)
• Support the HRH technical working group strategic planning
• Provide TA to the Community Health Desk in roll-out of CHW strategy
• Coordinate with partners to harmonize community health worker training tools and support the desk to coordinate implementation of CHW strategy
• Support health professional bodies to carry out continuous professional development (CPD) and licensing of health providers to improve the quality of health workers
• Conduct the Blended Leadership Development Program for District managers and for Senior Management Team of MOH
• Develop and implement capacity building plans for the CHWs cooperatives with other organizations (such as the Ministry of Commerce, MINALOC)
• Review the HRMIS tool and upgrade the platform for an interactive and user-friendly software to facilitate the use of HRM norms and guidelines
• Collaborate with the Capacity Development Pooled-Fund Secretariat to coordinate planning and in-service training of different levels of workers in the healthcare sector.
• Use HRM Assessment Tool (with other tools) to assess the HRM system effectiveness to mitigate the impact of HIV &AIDS on the health workforce)
• Work with the central level to identify HRM components needing strengthening (HRM capacity, personnel policy and practice, HRM data, performance management and training)

• Assist the MOH in introducing changes at district level (hospitals and health centers) in collaboration with Ministry of Labor and Ministry of Local Government and the district teams
• Develop an action plan for interventions to facilitate a process of HRM improvement
• Conduct an inventory of HRM tools and develop a human resources management manual with operational policies and Develop a performance assessment tool
• Discuss with the MOH carrying out a health worker labor market study in the public and private sector to determine the demands and supply of labor
• Review staff retention strategies based on the available labor market data
• Support the MOH to develop measurable result oriented staff performance plans building on the staff productivity evaluations of the different cadres of health workers Support the establishment of a culture of ongoing learning and performance improvement,
• Work with the CDPF coordination organ to develop a strategic plan for institutionalization of the Young Professionals Program, identifying the unit home, hiring staff to manage and oversee program and make the program sustainable
• Help the MOH finalize the supervision tool by facilitating a workshop to get final feedback
• Create an integrated training on the supervisory framework
• Roll out supervision training in a cascade approach (starting with a central level training of trainers) for health management teams at the health center, district hospital, and referral hospital levels.
• Reinforce the implementation of the supervision system through mentoring
• Help develop/adapt tools for data use and assure that the data flows from the HMIS, QI, Mutuelles, and PBF databases and aligned and are used to reinforce the quality of the all the data
• Explore the idea of using the PBF and Mutuelle web-based database as a model for the QI database
• Help formalize the ad hoc M&E TWG to help in these processes
• In collaboration with the Ministry of Education and the MOH, work with schools of medicine nursing and public health to see that the QI framework is incorporated into pre-service training modules for health providers
• Train Health Management Committees at the district level so they can provide strong, transparent, and effective leadership for managing quality performance.
• Support and mentor HMC on a regular basis
• Support district management teams to bring facilities together to problem solve and learn from their experiences in QI
• Support and facilitate forums for sharing of best practices
• Support research on best practices
• Review norms and indicators to help the MOH develop accreditation standards and rankings for district hospitals and health centers
• Conduct an accreditation baseline survey to selected facilities
• Ensure that districts effectively disseminate the patient charter of rights, and introduce tools successfully

used by MSH in other countries

Indicator targets related to the budget code (if the optional indicator data is used).
To be determined in consultation with USAID.

New activities for FY 2010, and plans for transition.
IHSSP is a new project.

Selected Capacity building activities funded in FY 2010 to be carried out with partial support in this budget code:
• Conduct training of COGE and HMT in facility management, oversight of CHWs, validation of results, team building, and role clarification
• Facilitate facility- and community-based sessions to reinforce skills and adherence to protocols, standards, and guidelines
• Help coordinate meetings among the District Health Directors, pharmacists, and Mutuelle directors with mayors and vice-mayors for social affairs to foster integration of activities, common planning, and exchange of information
• Encourage the formation and strengthening of CHW cooperatives
• Link to the Mutuelle insurance system through the Imihigo contracts with district mayors by assuring that the financial and service data are available to these district managers.
• Support conversion of the MOH website to a content management system platform
• Establish an MOH website editorial committee
• Train departmental staff on site maintenance
• Train extended teams for PBF, Mutuelles, and eHealth/M&E (using e-learning courses and in-person trainings) in data use and data analysis.
• Help MOH institutionalize the District Health System Strengthening Framework by generating most data through the annual HMIS reports rather than as a parallel facility survey
• Work with the HIV Integration Task Force to establish standard planning procedures and guidelines at health facility as well as district levels
• Develop HMIS data use guidelines for community-based HMIS as well as for hospital and health center HMIS.
• Develop HMIS data use guidelines into curricula for interactive e-learning or blended courses
• Conduct trainings on data use
• Link with the QI initiative to strengthen use of qualitative indicator data gathered through supervision and accreditation
• Help develop personalized web-based dashboards that will enable the tracking of key indicators
• Continue support for implementation of the data warehouse and internet/intranet dashboard

• Configure MOH-wide Exchange email server, shared calendars, etc., and train staff on use
• Develop automated methods for data exchange between HIS subsystems Introduce Voice over IP (VOIP) services in district hospitals and selected health centers (VPN)
• Support development of modules for the OpenMRS (electronic medical records system), in particular a module to support Mutuelles in tracking members, processing claims, and generating data for M&E
• Design (or enhance) and test tools for collecting and compiling quality of care data from supervisory checklists and health facility PBF quality assessments
• Facilitate a process to select a minimum package of indicators for the MOH, and develop and publish a metadata dictionary linked to the national data warehouse
• Revise existing data recording and reporting instruments for the HMIS Train M&E staff responsible for the data warehouse in database management
• Continue to advocate for strong links between HMIS subsystems and demonstrate the feasibility of integrating data from separate systems through the national data warehouse
• Support phased implementation of CTAMS databases, particularly for membership tracking and integration with EMR
• Support computerization of Community Health Information System (SISCom), eventually moving it from the PBF server to a new module of the HMIS
• Adapt and institutionalize data audit and data quality mechanisms control at all levels
• Develop an MOU with the Rwanda Development Board to complement internal functions with services provided by RDB, i.e., remote help desk support, hosting of web servers, data warehouse, and email server
• Provide continuing technical assistance for the upgrade, configuration, and management of the MOH Data Center
• Support the development of policies for data security and email and internet use
• Develop M&E management functions and structures, central MOH M&E unit, and M&E teams within departments and districts
• Conduct trainings for M&E teams on planning, coordination, routine- and non-routine data collection approaches, and data use
• Work with M&E teams and the Planning Division to develop standardized work planning formats and procedures for all MOH departments
• Lead local teams to develop learning modules for HMIS, M&E, and disease surveillance

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12137	Mechanism Name: CNLS Coag
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National AIDS Control Commission (CNLS)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 445,500	
Funding Source	**Funding Amount**
GHCS (State)	445,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The primary purpose of this proposed cooperative agreement is to enhance the capacity of the National AIDS Control Commission to effectively improve coordination of evidence-based HIV prevention, policy, operational research, and HIV information, education, and communication in Rwanda. Proposed activities include: 1) supporting coordination of evidence-based prevention interventions; 2) strengthening the capacity of CNLS to coordinate and to advocate for policy development and resource mobilization; 3) supporting data analysis, monitoring and evaluation, and operational research; 4) ensuring use of HIV/AIDS program data for evidence-based decision making; and 5) providing health information, education, and communication through the national HIV/AIDS hotline, virtual library, documentation center and radio programs. These activities are aligned with the 2009-2012 Rwanda National Strategic Plan (NSP) on HIV/AIDS, which aims to reduce HIV incidence by half by 2012, as well as with the PEPFAR II vision to gradually transition activities to host country entities.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12137**		
Mechanism Name:	**CNLS Coag**		
Prime Partner Name:	**National AIDS Control Commission (CNLS)**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	178,200	

Narrative:

Under the Strategic Information area and in line with PEPFAR II, this funding will support interventions previously under the MEASURE Evaluation mechanism. The first step in these efforts will focus on the support to the information management system through adequate staffing to ensure proper maintenance. The National HIV/AIDS Control Commission (CNLS) hosts the national repository of HIV/AIDS community-based information through the CNLSnet. The electronic information system includes data on orphans and vulnerable children and on HIV prevention (AB & OP) activities. Data are channeled to CNLSnet by the district level AIDS committees (CDLS). PEPFAR will support two staff to maintain up-to-date the data collected from the CDLS. A librarian will be also recruited to manage the CNLS documentation center. Additionally, the salaries of four drivers and the maintenance of four vehicles previously provided by PEPFAR to CNLS will be ensured through this mechanism.

Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	133,650	

Narrative:

In FY 2010, the USG will support the National AIDS Control Commission (CNLS) through a cooperative agreement with the US Centers for Diseases Control and Prevention (CDC). Funds will be used to improve coordination of evidence-based HIV prevention interventions, policy, operational research, and HIV information, education, and communication in Rwanda. Proposed activities will include:

1) Supporting coordination of evidence-based prevention interventions;
2) Strengthening the capacity of CNLS to coordinate and to advocate for policy development and resource mobilization;
3) Supporting data analysis, monitoring and evaluation, and operational research;
4) Ensuring use of HIV/AIDS program data for evidence-based decision making; and
5) Providing health information, education, and communication through the national HIV/AIDS hotline, virtual library, documentation center and radio programs.

CNLS will coordinate, approve and ensure that HIV prevention strategies in the field are derived from proven evidence-based interventions that aim at changing normative behaviors in at-risk groups based on the epidemiology of HIV in Rwanda.

In collaboration with TRAC Plus, the Rwandan Health Communications Center (RHCC), and other GOR institutions, CNLS will coordinate a comprehensive set of prevention activities targeting most-at-risk populations (MARPs) for which specific outreach strategies, intervention guidelines and tools must be developed. This populations includes young women aged 15-24, commercial sex workers (CSW), mobile workers, men and women in the uniformed services, men who have sex with men (MSM), prisoners and discordant couples.

The implementation of activities will fit into the overall CNLS M&E coordination framework. Data will be collected by the partners and validated at the national level by CNLS and USG. CNLS will carry-out coordination of HIV prevention meetings/workshops, support data analysis, monitoring and evaluation, and operational research, and ensure use of HIV/AIDS program data for evidence-based decision making, and provide health information, education, and communication to the general population through the national HIV/AIDS hotline.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	133,650	

Narrative:

In FY 2010, the USG will support the National AIDS Commission (CNLS) through a cooperative agreement with the US Centers for Diseases Control and Prevention (CDC). Funds will be used to improve coordination of evidence-based HIV prevention, policy, operational research, and HIV information, education, and communication in Rwanda. Proposed activities will include:

1) Supporting coordination of evidence-based prevention interventions;
2) Strengthening the capacity of CNLS to coordinate and to advocate for policy development and resource mobilization;
3) Supporting data analysis, monitoring and evaluation, and operational research;
4) Ensuring use of HIV/AIDS program data for evidence-based decision making;
5) Providing health information, education, and communication through the national HIV/AIDS hotline, virtual library, documentation center and radio programs.

CNLS will coordinate, approve and ensure that HIV prevention strategies in the field are derived from

proven evidence-based interventions that aim at changing normative behaviors in at-risk groups based on the epidemiology of HIV in Rwanda.

HIV prevention activities include but are not limited to: 1) increasing knowledge about how to protect oneself from HIV infection; 2) stigma reduction; 3) encouraging access to health services (e.g., HIV counseling and testing, diagnosis and treatment of sexually transmitted infections, use of antenatal and reproductive health services); 4) improving attitudes toward safer sexual practices; 5) reducing use of commercial sex workers; 6) increasing condom sales; 7) promoting recognition of early symptoms of sexually transmitted infections or HIV; 8) promoting recognition of the benefits and limitations of male circumcision for protection against HIV; 9) promoting HIV testing and disclosure of HIV serostatus within couples and families; 12) increasing access to treatment for HIV; 13) promoting the importance of adherence to antiretroviral drugs; and 14) promoting effective prevention of mother-to-child transmission programs. CNLS will also ensure that these interventions are implemented at a scale sufficient to reduce incident infections in order to achieve a sustainable HIV/AIDS response.

In collaboration with TRAC Plus, the Rwandan Health Communications Center (RHCC), and other relevant GOR institutions, CNLS will coordinate a comprehensive set of prevention activities targeting most-at-risk populations (MARPs) for which specific outreach strategies, intervention guidelines and tools must be developed. This populations includes young women aged 15-24, commercial sex workers (CSW), mobile workers, men and women in the uniformed services, men who have sex with men (MSM), prisoners and discordant couples.

The implementation of activities will fit into the overall CNLS M&E coordination framework. Data will be collected by the partners, validated at the national level by CNLS and USG. CNLS will carry-out coordination of HIV prevention meetings/workshops, support data analysis, monitoring and evaluation, and operational research, and ensure use of HIV/AIDS program data for evidence-based decision making, and provide health information, education, and communication to the general population through the national HIV/AIDS hotline.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12138	**Mechanism Name: Youth and MARP Friendly Services**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,390,950	
Funding Source	**Funding Amount**
GHCS (State)	1,390,950

Sub Partner Name(s)

National Youth Council		

Overview Narrative

CDC awarded PSI the Prevention Program Targeting Youth and Most-at-Risk Populations (MARPs) in 2009, with support from COP09 funding. The overall goal of this activity is to reduce HIV and STI prevalence among youth and young most-at-risk populations (MARPs) aged 15-34 in the geographic areas surrounding youth-friendly centers in 8 of 30 Districts. Prevention programs for youth remain a high priority for both the GOR and the EP. Since the overall national prevalence is 3.1%, Rwanda's prevention programming must account for its largely HIV-negative population; reaching the youth population is the most long-term solution and an important opportunity to affect the progression of the epidemic. Averting new infections in this age group is not only cost effective, but is also the most sustainable way to turn the tide against HIV/AIDS in Rwanda.

Employing national and international best practices, PSI will promote abstinence and safer sexual behaviors, encourage uptake of HIV and STI services, improve access to HIV and STI prevention and treatment referrals through 4 fixed sites, and improve evidence-based and targeted HIV and STI "moonlight" outreach services at another 4 sites for MARPs, while strengthening monitoring and evaluation systems for the project. Implementation activities include targeted youth- and MARPS-friendly outreach and VCT/STI service delivery (with a focus on couples testing), promotion of correct and consistent condom use (including targeted condom distribution), intensive trainings in life skills and parent child communications, peer education by trained youth, and support for multi-level multi-media campaigns, including continued support for a FY08 and FY 2009 cross-generational sex (CGS) campaign, and early development and implementation of a Concurrent Partnership (CP) campaign. This activity will also continue support for the HIV/AIDS hotline, managed through subaward with the National

AIDS Commission. AB messages will focus on combating CGS and CP. OP messages will address the identified barriers to correct and consistent condom use among youth and young MARPS. CT messages will emphasize the importance of couples testing.

This activity contributes to the Partnership Framework objective of halving HIV incidence in the general population by 2012 by reducing risky sexual behaviors through targeted, evidence-based prevention interventions for MARPs, evidence-based interventions among in-school and out-of-school youth, HIV prevention at youth centers, targeted CT for youth and MARPS, and promotion of correct and consistent condom use among MARPS and the general population. It will contribute to efforts to coordinate and harmonize prevention activities in Rwanda, including technical support for the development of a strategic plan for behavior change communications among youth. Training and peer education efforts will contain messaging about the link between alcohol use, GBV and HIV exposure, including messages that address gender norms as a barrier to safer sexual behaviors.

Working with and through a range of local partners, PSI will strengthen local capacity to manage and implement activities over time, including strengthening public providers to provide youth-friendly follow-on services, strengthening the National Youth Council representatives and community-based partners to lead subgranted youth center management, and training and supporting local providers to implement youth-friendly VCT and STI diagnosis and treatment services. PSI will also continue developing the Rwandan Social Marketing institution, transitioning day-to-day management to well trained and supported senior staff who will receive day-to-day capacity building and mentoring from "twinned" senior technical advisor staff. Cost efficiencies will be realized with CDC support for finger prick testing, particularly for mobile CT, by strengthening commercial distribution networks for condom distribution, and by monitoring the selling price for condoms, to reduce the subsidy requirement according to the willingness and ability of target populations to pay.

Monitoring and Evaluation (M&E) activities will include support for follow-on behavioral surveillance surveys among youth and MARPs, routine client intake and satisfaction data analysis from CT service delivery, quality assurance tools such as training pre- and post-test analyses, mystery client monitoring of service delivery points, and routine supervision.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12138		
Mechanism Name:	Youth and MARP Friendly Services		
Prime Partner Name:	Population Services International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	376,200	

Narrative:

FY 2010 will continue to support comprehensive voluntary counseling and testing (CT), STI services and family planning (FP) counseling for youth and young MARPs at, and in communities around Dushishoze ("Let's take care" in the Rwandan language) youth-friendly centers, with quality of services supervised by PSI and district health authorities. FY 2010 will continue to fully support management and technical implementation at 4 fixed sites and extend MARPs-targeted mobile outreach services to an additional 4 sites, improving youth and MARPs access to high quality CT in 8 of 30 districts.

Evidence-based CT promotion and MARPs-targeted outreach services will ensure improved targeting and effectiveness of CT services. In 2007 and 2008, approximately 44,000 youth were tested at 4 centers; 2.8% of youth aged 15-24 (3.3% in girls; 2.4% in boys) tested HIV-positive. The centers successfully targeted vulnerable youth: boys tested at the youth centers were 6 times more likely to be HIV-positive than the national average, while girls were twice as likely.

In FY 2010, "moonlight" HCT and STI services (provided on weekend evenings) will be expanded to hotspots in Kigali city and around an increased number of youth centers to further improve MARPs targeting. PSI will also continue to work through youth cooperatives (where PEs are trained) and Rwandan Partner Organizations so that more vulnerable youth and traditionally hard-to-reach groups, such as motoboys and domestic workers, will be encouraged to seek VCT, STI and FP counseling and services.

FY 2010 CT efforts will continue to emphasize the importance of couples testing. Youth-friendly centers are proving to be an effective entry point for couples testing and counseling, which is a critical HIV prevention intervention in Rwanda, given that new HIV infections are occurring primarily among married, discordant couples. On average in 2007 and 2008, 23% of all clients at youth centers came as couples,

90% of whom were not yet married. Among these young couples seeking VCT at youth centers, ~6% of married couples, and ~4.5% of not yet married couples were serodiscordant, compared to 2.2% of cohabiting couples in the general population who were discordant (DHS 2005). In FY 2010, a couples' VCT pamphlet developed in FY 2008 and produced in FY 2009 will be distributed to young couples (e.g. at universities and through faith based organizations) to promote couples' HIV testing. Young couples will be reached through anti-AIDS clubs at most universities and colleges in Rwanda, which were established following the Inter-Universities Conference of the FY 2008 anti-cross generational sex campaign.

While accurate STI statistics are not available in Rwanda, being HIV-positive is clearly associated with prior history of STIs among the general population (DHS 2005) and among youth seeking VCT services at youth-friendly centers. The Center for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics (TRAC Plus) is developing revised national guidelines for management of STIs in FY 2009 and FY 2010 activities would collaborate with TRAC Plus and the MOH in the implementation of these guidelines. STI services (including screening, diagnosis, and treatment) and FP counseling will be provided as part of VCT services, thereby ensuring that youth who access the centers receive a comprehensive package of services. An STI/HIV integration model will be developed that screens high risk youth with STIs for HIV, and those with HIV for STIs (including male clients of CSWs and their sexual partners). We will also promote "repeat testing" for high-risk groups and develop innovative approaches to provide condoms and STI services to high risk youth and ensure linkages of these services to care and treatment.

Condoms will be offered liberally to all CT clients to ensure that people who test positive can protect themselves and their partners as they seek follow-on referral services. By promoting condoms for dual protection to all clients, regardless of HIV status, the activity will avoid stigmatizing people who test positive. HIV-positive clients will be referred to nearby health centers for care and treatment and prevention for positives programs (condom distribution and promotion, promotion of FP, partner disclosure, etc). Referrals will be verified by the VCT team, through regular visits to health centers to pick up counter-referral slips. HIV negative young men will be referred to the health system to access MC services, as soon as they are available through the health system, and all CT counseling will stress the ongoing importance of safer sexual behaviors, including correct and consistent condom use. Screening tools for history of sexual abuse and history of concurrent partnerships piloted in FY 2009 will be scaled up to reach individuals vulnerable to HIV.

The existing FY 2008 and FY 2009 brand for youth and MARPs friendly service (YMFS) providers (Dushishoze) will extend from the youth-friendly centers to public providers who will be trained and receive support for providing youth- and MARPs-friendly follow-on services. In FY 2010, PSI will pilot this approach with 10 public and private providers working in areas surrounding each of 4 fixed-site youth-

and MARPs-friendly centers. Once certified, providers will receive branded signage and uniforms, as well as educational materials and assistance in refurbishing their offices to make them more youth- and MARP-friendly. The youth centers will host weekly youth- and MARPs-friendly clinics, with providers serving the youth center in rotation. Providers will have an opportunity to build relationships with Dushishoze Center staff, and bring services to youth who may not be empowered to seek services on their own.

Supportive supervision and QA:
Regular, joint supervision visits by will be carried out by district health authorities and technical PSI staff (VCT Specialist, VCT QA Manager, and/or M&E Manager) to provide support to VCT counselors and ensure high quality counseling and data collection. Client intake and satisfaction forms will be entered by PDA at site level and analyzed regularly to inform program activities. Dr. D providers will receive regular continuing education, and be monitored and supported through monthly visits to Dr. D clinics to reinforce and refresh skills and to ensure compliance with quality standards. Random mystery client visits to providers will confidentially assess provider quality.

Description of targets:
• Service outlets providing VCT and STI services according to national and international standards: 6. This target includes 4 fixed sites and 2 mobile sites for moonlight VCT. The 2 mobile sites will serve the 4 fixed sites and 4 additional fixed sites funded under other funding sources, increasing access in 8 total districts.
• Individuals trained in counseling and testing for HIV and STIs according to national and international standards: 120. This target assumes training of the local counselor team (~10) and 5 PSI VCT staff at each site, and 10 Dr. D providers in areas surrounding the 4 youth centers.
• Individuals who received VCT and received their test results: 30,800. This target maintains FY 2009 targets at or around fixed sites (6,500 per youth center) plus 100 clients per month per additional youth center through moonlight VCT.

New activities and plans for transition:
A team of ~10 local district-level VCT counselors will be established in each of 6 districts to meet counseling needs and promote sustainability of services. ~10 public providers from public and private clinics in each of 4 youth center districts will provide YMFS in their own clinics, and youth centers will host weekly provider clinics, with providers serving the youth center in rotation. This approach will maximize sustainability of YMFS services, giving providers an opportunity to build relationships with Dushishoze Center staff, and bringing services to youth who may not be empowered to seek them on their own. This activity will also support the development of the Rwandan Social Marketing institution. Finger prick VCT will significantly reduce the cost and complexity of outreach VCT services. Fixed CT

site management will increasingly be managed by sub-grant through Rwandan Partner Organizations, including the National Youth Council.

Capacity building activities:
Members of the VCT team (counselors, lab techs and a counselor supervisor) will be trained in a variety of topics related to VCT using, where possible, GOR curricula, including, but not limited to, general counseling, couples' counseling, stress management, FP, STIs, VCT supervision techniques, PDA data entry and high-quality data collection techniques. Public youth-friendly Providers will be trained in delivery of YMFS, STI treatment and FP counseling and product use. As with other training activities, participative, adult learning techniques will be used, as well as ongoing support and supervision. In addition, PSI will provide technical input to TRAC Plus and CNLS to the BSS and data triangulation exercises, as required.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	693,000	

Narrative:

FY 2010 AB activities will continue to strengthen activities developed in FY 2009, including evidence-based training and interpersonal communication (IPC) interventions to improve life skills and knowledge about HIV and STI prevention among youth and young MARPs. Youth and young MARPs will be reached with AB messages by multiple, reinforcing and evidence-based messages delivered through IEC materials, the ABAJENE! radio show, listening clubs and a youth newspaper, as well as through the national CNLS Hotline, a free telephone service where trained staff provide HIV prevention information to callers, 90% of whom are under the age of 30 and not yet married.

FY 2010 PE trainings will continue to primarily target out-of-school youth. FY 2008 PSI program data indicated that, among youth who sought VCT services, those who never went to school or only attained primary school were more likely to be HIV+. In addition, the out-of-school youth selected as peer educators (PEs) from youth cooperatives were less likely to have comprehensive HIV knowledge (UNGASS indicator) than their age equivalents from the general population (DHS 2005). These results underline the importance of focusing on out-of-school youth, and show that the FY 2008 and FY 2009 approaches reached out-of-school youth PEs who lacked sufficient knowledge about HIV prevention before training.

FY 2010 plans will support AB messages by expanding comprehensive Youth and MARPs Friendly

Services (YMFS) in and around an increased number of youth- and MARPs-friendly "Dushishoze" ("think about it" in the local language) centers. Efforts will continue to preferentially increase access to youth center services for vulnerable young girls, as FY 2008 attendance registers indicated that girls comprise only 31% of youth center visitors. In addition to ensuring gender balance in youth center staff members, a girl-friendly youth center promotional pamphlet developed in FY 2009 will be distributed, and girl-friendly interventions such as aerobics, sewing and girls-only sports competitions, will be used as an entry point to empower girls and disseminate AB messages.

FY 2008 PSI program data reinforced the continued need for fidelity messaging for youth and young couples: among youth who sought VCT services at Dushishoze Centers, those who had concurrent partnerships (CP) were twice as likely to be HIV+. A couples' VCT pamphlet developed in FY 2008 and produced in FY 2009 will be distributed to young couples (e.g. at universities and through faith based organizations) to promote couples' HIV testing. Trained PEs will facilitate ABAJENE! clubs for young couples.

Supportive supervision and QA:
Regular, joint supervision visits by will be carried out by PSI and youth center partners to out-of-school PEs at each anti-AIDS clubs in youth cooperatives, using standardized supervision tools. Bi-monthly meetings for PEs will be held at youth centers, to present activity reports, share successes and challenges, receive refresher training, and make work plans for the next 2 months. Message guidelines developed in FY 2009 by PSI's M&E Department will be used as tools to strengthen PE's capacity to carry out IPC sessions. In addition, film and comic book animation guides will guide PEs to conduct small group discussions.

Description of targets:
1. #of individuals reached through CNLS hotline with AB messages: 40,000. This target assumes AB messages will reach an average of 3,333 callers per month.

2. # of target population reached with individual and or small scale level HIV prevention interventions that are primarily focused on AB: 20,000.

3. # of individuals trained to promote HIV prevention programs through AB: 800. This target assumes that 8 groups of 25 out-of-school PEs at each fixed site, drawn from youth cooperatives or youth MARPs associations at district level, will be trained on peer education/life skills.

New activities and plans for transition:
If MC services for the general population are available in FY 2010, new activities will raise awareness

among young men about MC services will be developed and scaled up. Work planning, budgeting, reporting and day-to-day management of implementation will be carried out in close collaboration with youth center partners to increase local ownership and management for sustainability. Discussions to "second" youth center partner staff (e.g. National Youth Council) to function as center coordinators and health educators was initiated in FY 2009. In FY 2010 this approach is expected to be formalized at all 4 fixed site youth centers with sub-grants provided to the local partners to manage day-to-day running activities. This activity will also contribute to the development of the Rwandan Social Marketing institution.

Capacity building activities:
TOT and PE training activities are conducted jointly by PSI and youth center partners using standardized, evidence-based PE and PCC curricula as well as pre-post tests to evaluate the gains in knowledge (including comprehensive HIV knowledge) as a measure of the impact of trainings. Refresher trainings of PEs will take place at bi-monthly meetings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	321,750	

Narrative:

In FY 2010, OP messages will focus on the identified factors influencing correct and consistent condom use, including condom stigma, relationship trust, and knowledge of how to use a condom correctly. Delivered by comprehensive youth- and young MARPs-friendly services in and around 8 "Dushishoze" ("Think about it" in the local language) centers, these messages will target most-at-risk out-of-school youth, youth living in urban areas and high HIV transmission zones, youth frequenting hotspots, OVC above 15, youth and MARPs who test positive at CT sites, and young sexually active couples. PSI and Rwandan Partner Organizations will implement "moonlight" road show "edutainment" interventions at hotspots to promote correct and consistent condom use, VCT and the CNLS Hotline in communities around youth- and MARPs-friendly centers on weekend evenings, one weekend per month per center. Hotspots will include restaurants, bars and cabarets where young MARPs frequent. This strategy will provide an integrated youth and young MARPs prevention program. All condom outreach activities will employ a condom demonstration kit produced in FY09, which provides a flip chart of demonstration instructions and condom activities, consumer leaflets, and demonstration materials.

Different studies have demonstrated how a comprehensive package of interventions to reduce risk behaviors for an individually focused, state-of-the-art project in key populations can substantially increase health-seeking behaviors and reduce HIV incidence in CSWs. Many commercial sex workers do not have the power or self efficacy to demand condom use from their clients. To do so may bring a variety of risks,

including losing the client (and, therefore, the income) and being physically or sexually assaulted. The potential for repeated HIV exposure during sex work makes HIV prevention among this population especially important for HIV programming. Although criminalization and stigma make it difficult, all CSW must have access to effective, comprehensive HIV prevention, including HIV/AIDS education, condom negotiation skills building, peer education/outreach, and sexual/reproductive health education and services. Structural interventions, such as "100% condom use" with clients, should be encouraged and implemented in ways that will not hinder access of programs to CSW.

A model of night-time services called "moonlight VCT" with appropriate mix of interventions will be developed for CSWs. The program will employ a mix of condom promotion, one-on-one risk reduction counseling, periodic screenings and treatment for sexually transmitted and HIV testing. A network of CSWs will be generated using peer recruitment in hotspot areas. Mobile/User-friendly discreet services will be opened in those areas that are identified as "hotspots" such as hotels, bars, nightclubs, and certain neighborhoods.

To support OP communications efforts, PSI will work with Rwandan Partner Organizations and existing private networks to increase condom access and availability for youth and young MARPs, particularly in areas around hot spots and at night. This includes retail outlet creation efforts, and condom distribution at youth centers and through mobile outreach services.

FY 2010 PE trainings will continue to primarily target out-of-school youth. FY 2008 PSI program data indicated that, among youth who sought VCT services, those who never went to school or only attained primary school were more likely to be HIV+. In addition, the out-of-school youth selected as peer educators (PEs) from youth cooperatives were less likely to have comprehensive HIV knowledge (UNGASS indicator) than their age equivalents from the general population (DHS 2005). These results underline the importance of focusing on out-of-school youth, and show that the FY 2008 approach reached out-of-school youth PEs who lacked sufficient knowledge about HIV prevention before training.

Supportive supervision and QA:
Regular, joint supervision visits by will be carried out by PSI and youth center partners to out-of-school PEs at each anti-AIDS clubs in youth cooperatives, using standardized supervision tools. Bi-monthly meetings for PEs will be held at youth centers, to present activity reports, share successes and challenges, receive refresher training, and make work plans for the next 2 months.

Description of targets:
1. # of targeted condom service outlets created and supported: 400 (50 per 4 fully supported fixed site and per 4 sites receiving outreach services); 2. # of individuals reached through CNLS hotline with OP

messages: 40,000. This target assumes OP messages will reach an average of 3,333 callers per month; 3. # of target population reached with individual and or small scale level HIV prevention interventions that are primarily focused on OP: 20,000; and 4. # of individuals trained to promote HIV prevention programs through OP: 400 This target assumes that 4 groups of 25 out-of-school peer educators at each fixed site, drawn from youth cooperatives or youth MARPs associations at district level, will be trained to use the condom demonstration kit.

New activities and plans for transition:
Work planning, budgeting, reporting and day-to-day management of implementation will be carried out in close collaboration with youth center partners to increase local ownership and management for sustainability. Discussions to "second" youth center partner staff (e.g. National Youth Council) to function as center coordinators and health educators was initiated in FY 2009. In FY 2010 this approach is expected to be formalized at all 4 fixed site youth centers with sub-grants provided to the local partners to manage day-to-day running activities. This activity will also contribute to the development of the Rwandan Social Marketing institution.

Capacity building activities:
TOT and PE training activities are conducted jointly by PSI and youth center partners using standardized, evidence-based PE and PCC curricula as well as pre-post tests to evaluate the impact of trainings. Refresher trainings of PEs will take place at bi-monthly meetings.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12139	**Mechanism Name: Integrated Health Service Delivery Project (IHSDP)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**

Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID/Rwanda's new Integrated Health Service Delivery (IHSD) Project is a five year project that aims to increase the use of facility and community-based family health (FH) services. For the purpose of this activity, "family health" includes an integrated package of services related to family planning and reproductive health (FP/RH), HIV/AIDS, maternal, neonatal, and child health (MNCH), malaria, nutrition, and safe water and hygiene. "Integration" means the organization, coordination and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to costs, outputs, impacts and use.

The IHSD Project builds upon more than ten years of USAID support to the Government of Rwanda (GOR) and to non-governmental organizations (NGOs), community-based organizations (CBOs), and the private sector in several areas of FH. The IHSD Project will emphasize the integrated provision of the following core services:

• Voluntary FP services that enable delaying, spacing and limiting of births
• Maternal and neonatal services, including safe delivery, newborn care, and management of complications related to pregnancy
• Child survival interventions, including breastfeeding, integrated management of neonatal and child illnesses (IMNCI), community case management (CCM), and immunization

The IHSD will also integrate the following interventions with the core services:

• Malaria prevention and treatment
• HIV/AIDS primary and secondary prevention (emphasizing prevention with positives [PwP]), and referral for testing, treatment, care and support
• Nutrition
• Safe water, sanitation, and hygiene

The integrated health service delivery project (IHSDP) will improve the use of HIV/AIDS preventive and treatment services at all entry points (e.g., FP, ANC, delivery, postnatal visit, immunization, sick child) along the continuum of MNCH care at both facility and community levels. The focus will be on the use of theory-based health promotion strategies, such as information, education and communication (IEC) and BCC, by all levels of providers--from doctors to CHWs--to promote prevention and referral for testing, treatment, care and support.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12139**		
Mechanism Name:	**Integrated Health Service Delivery Project (IHSDP)**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	PDCS	Redacted	Redacted

Narrative:

This is a new activity and the RFA is underway.

Pediatric HIV Care

The Family Health Project (FHP) is a new USAID/Rwanda's five year Award that aims to increase the use of facility and community-based family health services. For the purpose of this activity, "Family Health" includes an integrated package of services related to family planning and reproductive health, HIV/AIDS, maternal, neonatal and child health, malaria prevention and management. This award will support multiple activities and resources to ensure the delivery of more efficient and coherent services aimed at improving use of services and measurable outcomes in an efficient way. The FHP builds upon more than fifteen years of USAID' support to the Government of Rwanda, non-governmental organizations, community-based organizations and the private sector in several areas of FH.

The FHP will support pediatric care through the implementation of the national IMCI guidelines that include early infant diagnosis (EID) of HIV, counseling and referral to appropriate services for initiation of treatment and follow -up. Through BCC, counseling and referral, the FHP will also link PMTCT services to MCH services, and to the extent possible promote collocation of integrated services to reduce loss to follow-up of exposed children and children on ART. The FHP will also strengthen referral of newly

diagnosed children and their enrollment into care program. The FHP will provide LLINs to pregnant mothers and all HIV-positive children, in order to reduce HIV/Malaria co morbidity.

At community level the FHP will work closely with CHWs to strengthen the link between facilities and the community; promote case management of diarrhea, fever and pneumonia and track referral and follow up of HIV-positive children in their catchment areas.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

The IHSD Project will primarily strengthen management and referral systems between facilities and communities, as well as within communities. At the community level and between communities and facilities, this project will initiate and/or reinforce:

• Supervision of CHWs by health center nurses
• Maintenance of CHW kits
• Referral systems, including emergency transport systems
• Accurate record keeping and reporting

Ensuring secure resupply along with a strengthened record/reporting system is essential for CHWs to have the supplies they require and the skills to track distribution to clients. Supply management at facility and community levels requires clear policies, plans and resources, and the use of data for monitoring and decision making. It may also require interventions to promote accountability and sound management of public goods.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

The Integrated Health Service Delivery Project (IHSD) overall goal is to focus on strengthening service provision, and/or building capacity of service providers in the context of the purchase/provider. The specific focus will be on integration, decentralization and quality service with a technical emphasis on HIV/AIDS, malaria and other infectious diseases, FP/RH, MCH, neonatal and child health, nutrition and water and sanitation. Specific to HIV prevention, under HVAB, the IHSDP will use theory-based health promotion strategies to promote sexual prevention using AB messages to promote family prevention (i.e., a multi-generational approach) by a cadre of providers, from doctors to community health workers. Proven approach will also be used to refer clients from all entry points for testing, treatment, care and support. Services such as family planning, antenatal and postnatal care visits, immunization, sick child points will be used to promote prevention with AB. Services will be provided in at least 12 to 15 of the 30

districts in Rwanda. Specific mechanisms to promote quality assurance include training to strengthen clinical supervision, commodity management and data use, and a monitoring and evaluation plan will be established by a TBD partner.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

The Integrated Health Service Delivery Project's (IHSD) overall goal is to focus on strengthening service provision, and/or building capacity of service providers in the context of the purchase/provider. The specific focus will be on integration, decentralization and quality service with a technical emphasis on HIV/AIDS, malaria and other infectious diseases, FP/RH, MCH, neonatal and child health, nutrition and water and sanitation.

The IHDS will use entry point such as family planning services, antenatal and post natal care visits, immunization, and sick child visits to promote other sexual prevention using proven and innovative IEC and BBC strategies at all levels targeting families and by a cadre of providers, from doctors to CHWs. Services will be provided in at least 12 to 15 of the 30 districts in Rwanda. Specific mechanisms to promote quality assurance include training to strengthen clinical supervision, commodity management and data use. A monitoring and evaluation plan will be established by a TBD partner.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

The IHSD project will improve the use of HIV/AIDS preventive and treatment services at all entry points at both facilities and community levels. Information, education and communication (IEC) and behavior change communication (BCC) will be used during family planning, antenatal and postnatal care visits, to promote the use of services to prevent mother to child transmission of HIV as well as to refer pregnant women for testing, treatment, care and support.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12140	**Mechanism Name: National University of Rwanda School of Public Health**

Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this proposed cooperative agreement is to strengthen the capacity of the National University of Rwanda / School of Public Health to provide quality and relevant pre- and in-service training in order to improve the quality of health and HIV/AIDS service delivery. It also supports the enhancement of evidence-based planning within the Rwanda health sector and PEPFAR II transition to the host country, Rwanda. PEPFAR currently supports the NUR/School of Public Health through CDC's cooperative agreement with Tulane University. The plan is to gradually transfer some activities from this cooperative agreement directly to the School of Public Health.

Key areas identified in collaboration with the School of Public Health and the Ministry of Health to be supported through this cooperative agreement, include:

• Improvement of teaching quality at the School of Public Health

• Capacity building of faculty and students in analysis and use of public health program data, operational research, and program evaluations

• Improvement of the School of Public Health infrastructure to support quality education

Interventions under this cooperative agreement fall under the fourth goal of the Rwanda Partnership Framework 2009-2012 (The human and institutional capacity of the public health system to plan, manage, and implement sustainable health programs is strengthened at all levels). To support these three intervention areas, key measurable outcomes have been defined with input from the School of Public Health and the PEPFAR team. These verifiable measurements are aligned with PEPFAR next generation indicators.

Empowering the School of Public Health to provide the Government of Rwanda and more specifically the Ministry of Health with skilled health professionals will help sustain PEPFAR interventions that are currently handled using the expertise of international NGOs. Moreover the School of Public Health will conduct special studies on hard to reach populations (i.e. MSM) to inform PEPFAR program implementation.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12140**		
Mechanism Name:	**National University of Rwanda School of Public Health**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	Redacted	Redacted

Narrative:

The National University of Rwanda School of Public Health (SPH) is a newly enrolled partner for the PEPFAR II program in Rwanda. The contribution of the SPH will be instrumental in improving and sustaining the strategic information component of the national response to the HIV epidemic. PEPFAR will support the strengthening of the pre- and in-service training capacity of the SPH as well as its research and evaluation capacity. The SPH will also conduct a key MARPs-related survey activity. More specifically, the following two interventions will be carried out:

A) Improvement of the scope and quality of education at SPH

• Develop curricula and conduct PhD programs in public health (biostatistics, epidemiology, health informatics, research) in collaboration with universities or institutions providing recognized post-graduate degrees in these areas

• Initiate training of 04 PhD students in biostatistics
• Conduct an assessment of the capacity of lecturers to meet the needs of the new training program
• Reinforce Master's degree programs (public health, epidemiology)
• Organize one short course on monitoring and evaluation, epidemiology, statistics and research for districts hospital and health center managers (15 participants)
• Co-organize with the national reference lab, TRAC Plus and African Field Epidemiology Network (AFENET) the short and long term FELTP trainings for 30 and 10 participants, respectively

B) Capacity building of lecturers, students, health care professionals, and program managers in research and program evaluation
• Build operational research capacity of teaching staff at SPH as well as of MOH technical staff at central and district levels
• Conduct a survey on men who have sex with men (MSM) including biomarkers as a follow-on of the formative assessment that was completed in FY 2009
• Support the development of a knowledge and information dissemination center for publications and research conducted in Rwanda (maintenance and upgrade of the website)
• Organize research dissemination workshops for studies and research conducted during the fiscal year
• Participate in and organize international conferences that contribute to improved teaching quality, research capacity and the dissemination of research findings generated by the SPH

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

PEPFAR has supported and strengthened Rwanda's response to the HIV epidemic over the past five years. During PEPFAR II it is envisioned that the management and oversight of mutually agreed strategies and interventions introduced and supported to date will be transitioned to Rwandan entities. In order to maintain the quality of service delivery the availability and quality of the appropriate health workforce must be addressed. Furthermore, reliable information is required to ensure programs are tailored to provide the services that best address the driving forces behind the epidemic and adhere to country specific needs.

Since 2002 Tulane University has been providing support to the School of Public Health both to provide quality training and build research capacity to meet these goals. In particular, Tulane has supported training in HIV program management, and provided assistance to the public health master's and doctoral programs. As a result of this continued support the School of Public Health is in a position to take over the management of certain activities to meet the overall goals of providing quality and appropriate human

resources and improve research capacity in Rwanda.

In this new award, in FY 2010 the School of Public Health, with continued support from Tulane University, will build on regional health alliances to build capacity in the institution. Leveraging the existing expertise and experience in neighboring country's universities is one of the steps planned towards establishing an internationally accredited PhD program in country. Currently only four faculty members have been awarded PhDs. The improvement in research and teaching capabilities of the current faculty through a national PhD program will provide a sustainable solution.

Dissemination of research findings and the hosting of international conferences in areas of public health interest have been a feature of Rwanda's PEPFAR program. Both activities have been recognized as key to the improvement of the country's response to the epidemic and for disseminating good practices to other countries in the region. These activities will be continued through this award, directly organized by the School of Public Health.

Both opportunities for PhD studies and presentation of research findings will help students gain recognition and improve retention of faculty. Other retention strategies will be explored and introduced under this award.

The Centers for Diseases Control and Prevention (CDC) has supported the sustainable management development program over the past two years. In FY 2009 a link was established with the School of Public Health through two returning students of the program. In FY 2010, the activities, which are aimed at strengthening national and district level management skills, will be continued with minimal support from CDC. Furthermore, partial responsibility for the CDC supported Field Epidemiology and Laboratory Training Program will be taken up by the School of Public Health as the program expands from short courses to a two-year masters level program.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12141	**Mechanism Name: Kigali Health Institute**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

By 1994, Rwanda had did not have a single private university or institution of higher learning and only one public university, which had graduated approximately three thousand people in its 31 year history. In 1994 the insufficient number of graduates were either killed during the genocide or fled in the aftermath. In addition to this, students training in the medical laboratory sciences could train to high school level only. After three years in secondary school, students who wished to join medical laboratory training would take a three year course in medical laboratory sciences and graduate with a general certificate of secondary education (A2) in "laboratory" sciences. There was no provision for higher learning in biomedical laboratory sciences.

In an effort to find a solution to this problem, in 1996 the Government of Rwanda (GOR) created a system of education which is composed of six years of primary education, six years of secondary/vocational education and between four and six years of University education. One of the main objectives of this effort was to provide and continually improve the health services of the Rwandan population thereby contributing to a reduction in poverty and enhance the general well-being of the population among others.

The GOR decided to establish the Kigali Health Institute (KHI) in 1996 with the mandate of training and awarding diplomas and degrees in paramedical sciences and nursing sciences. The Biomedical Laboratory Science department started at KHI in 1998, the purpose of which is to train graduates for the award of the advanced diploma in medical laboratory sciences. But still these graduates were limited in the knowledge and skills needed in the fast developing biomedical laboratory sciences field. In 2007, the department decided to introduce a four year bachelor's degree program. KHI has been supported by the American Society for Clinical Pathology (ASCP) through PEPFAR since 2006. ASCP provides technical assistance to KHI to improve their curriculum and to improve the teaching skills of its faculty. As the USG and KHI work to provide a more sustainable program and to allow for Rwandan leadership and ownership, support in FY 2010 will go directly to KHI. To continue improving the education of laboratory

technicians to provide testing for HIV/AIDS patients, KHI will focus on strengthening its educational program in the areas of faculty development, capacity building, curriculum improvement, infrastructure and training resources.

Faculty development and capacity building will focus on an assessment to determine the cadre and number of staff needed for the program. Once it is understood what is needed, the program will hire faculty to fill the gaps identified. KHI will focus on hiring and training Rwandan staff in an effort to build the capacity of Rwandan to sustain the program in years to come. KHI will identify training programs and short courses to improve their knowledge and teaching skills. In addition, resources will be procured for use by students and faculty to improve the curriculum and training in the program.

This project will support building and improving the capacity of faculty to train technicians to perform laboratory testing and provide quality patient care and health management required to support HIV/AIDS programs in Rwanda, and it will support the strengthening of the health educational system to close gaps that exist in the current training program.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12141**		
Mechanism Name:	**Kigali Health Institute**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	Redacted	Redacted
Narrative:			
By 1994, Rwanda had did not have a single private university or institution of higher learning and only one public university, which had graduated approximately three thousand people in its 31 year history. In			

1994 the insufficient number of graduates were either killed during the genocide or fled in the aftermath. In addition to this, students training in the medical laboratory sciences could train to high school level only. After three years in secondary school, students who wished to join medical laboratory training would take a three year course in medical laboratory sciences and graduate with a general certificate of secondary education (A2) in "laboratory" sciences. There was no provision for higher learning in biomedical laboratory sciences.

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programs in Rwanda, and it will support the strengthening of the health educational system to close gaps that exist in the current training program.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12142	**Mechanism Name: Ambassador's Self-Help Fund**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ambassador's Special Self-Help (SSH) program is a grass-roots assistance program that allows U.S. embassies to respond quickly to local requests for small community-based development projects. The purpose of the SSH program is to fund grants for small development activities that generate public awareness of U.S. foreign assistance efforts but that fall outside the structure of established USG projects. The program is intended to be flexible and allow for quick and direct responses to requests from local communities for assistance with small community projects that have immediate impact. Equally important, the SSH program is structured to encourage sustainability and long-term success.

PEPFARs contribution to the Rwanda SSH fund will go toward small, community based grants that help support communities in alleviating the affects of HIV/AIDS and become more resilient in supporting the health needs of the community.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12142**		
Mechanism Name:	**Ambassador's Self-Help Fund**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	Redacted	Redacted

Narrative:

The Ambassador's Special Self-Help (SSH) program is a grass-roots assistance program that allows U.S. embassies to respond quickly to local requests for small community-based development projects. The purpose of the SSH program is to fund grants for small development activities that generate public awareness of U.S. foreign assistance efforts but that fall outside the structure of established USG projects. The program is intended to be flexible and allow for quick and direct responses to requests from local communities for assistance with small community projects that have immediate impact. Equally important, the SSH program is structured to encourage sustainability and long-term success.

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Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business
U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				185,000		185,000
ICASS				988,000		988,000
Management Meetings/Professional Developement				200,000		200,000
Non-ICASS Administrative Costs				378,365		378,365
Staff Program Travel				831,675		831,675
USG Staff Salaries and Benefits				3,330,490		3,330,490
Total	**0**	**0**	**0**	**5,913,530**	**0**	**5,913,530**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		185,000
ICASS		GHCS (State)		988,000
Management Meetings/Professional Developement		GHCS (State)		200,000
Non-ICASS Administrative Costs		GHCS (State)		378,365

U.S. Department of Defense

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				1,600		1,600
ICASS				34,400		34,400
Institutional Contractors				70,000		70,000
Non-ICASS Administrative Costs				3,000		3,000
Staff Program Travel				16,800		16,800
USG Staff Salaries and Benefits				83,700		83,700
Total	**0**	**0**	**0**	**209,500**	**0**	**209,500**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount

Computers/IT Services		GHCS (State)		1,600
ICASS		GHCS (State)		34,400
Non-ICASS Administrative Costs		GHCS (State)		3,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing				554,000		554,000
Computers/IT Services				204,000		204,000
ICASS				1,200,000		1,200,000
Institutional Contractors				250,000		250,000
Management Meetings/Professional Developement				223,656		223,656
Non-ICASS Administrative Costs			278,004	491,280		769,284
Staff Program Travel				309,940		309,940
USG Staff Salaries and Benefits			856,996	1,189,912		2,046,908
Total	**0**	**0**	**1,135,000**	**4,422,788**	**0**	**5,557,788**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHCS (State)		554,000
Computers/IT Services		GHCS (State)		204,000
ICASS		GHCS (State)		1,200,000
Management Meetings/Professional Developement		GHCS (State)		223,656
Non-ICASS Administrative Costs		GAP		278,004
Non-ICASS Administrative Costs		GHCS (State)		491,280

U.S. Peace Corps

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Non-ICASS Administrative Costs				76,800		76,800
Peace Corps Volunteer Costs				468,200		468,200
Staff Program Travel				81,200		81,200
USG Staff Salaries and Benefits				98,371		98,371
Total	**0**	**0**	**0**	**724,571**	**0**	**724,571**

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Non-ICASS Administrative Costs		GHCS (State)		76,800