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2006

Rwanda

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Country Contacts

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Table 1: Country Program Strategic Overview

Will you be submitting changes to your country's 5-Year Strategy this year? If so, please briefly describe the changes you will be submitting.

☑ Yes ☐ No

Description:

DHS HIV prevalence and behavioral information will be available in December 2005. This information will be taken into account as COP06 funds are programmed.

The SAVVY surveillance tool mentioned in the strategy will not be implemented in Rwanda because of financial constraints and the absence of donor and GOR support to institutionalize this methodology.

The Rwanda program will strengthen links between alcohol and HIV in prevention, care and treatment activities.

Table 2: Prevention, Care, and Treatment Targets

2.1 Targets for Reporting Period Ending September 30, 2006

	National 2-7-10	USG Direct Target End FY2006	USG Indirect Target End FY2006	USG Total target End FY2006
Prevention				
	Target 2010: 157,643			
Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		76,156	29,924	106,080
Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT		3,717	2,424	6,141
Care				
	Target 2008: 250,000	71,791	43,444	115,235
Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care (excluding those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis) during the reporting peri		45,176	26,250	71,426
Number of OVC served by an OVC program during the reporting period		25,959	15,250	41,209
Number of individuals who received counseling and testing for HIV and received their test results during the reporting period		199,411	42,439	241,850
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period		656	1,944	2,600
Treatment				
	Target 2008: 50,000	14,834	10,500	25,334
Number of individuals receiving antiretroviral therapy at the end of the reporting period		14,834	10,500	25,334

2.2 Targets for Reporting Period Ending September 30, 2007

	National 2-7-10	USG Direct Target End FY2007	USG Indirect Target End FY2007	USG Total target End FY2007
Prevention				
	Target 2010: 157,643			
Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		91,171	29,924	121,095
Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT		4,365	2,424	6,789
Care				
	Target 2008: 250,000	120,247	29,205	149,452
Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care (excluding those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis) during the reporting peri		82,901	5,405	88,306
Number of OVC served by an OVC program during the reporting period		36,309	21,200	57,509
Number of individuals who received counseling and testing for HIV and received their test results during the reporting period		264,816	42,439	307,255
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period		1,037	2,600	3,637
Treatment				
	Target 2008: 50,000	*21,065*	*12,635*	*33,700*
Number of individuals receiving antiretroviral therapy at the end of the reporting period		21,065	12,635	33,700

Table 3.1: Funding Mechanisms and Source

Mechanism Name: Unallocated

Mechanism Type: Unallocated
Mechanism ID: 3728
Planned Funding($):
Program Area: *Treatment: Unallocated*

Mechanism Name: Data Analysis and Use

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3495
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes
Early Funding Request: Yes
Early Funding Request Amount:
Early Funding Request Narrative: Analysis and use of HIV/AIDS data in Rwanda is essential to evidence-based decision-making and the improvement of service quality. Currently, there is no system in place to ensure the regular examination and analysis of HIV/AIDS data provided by TRACnet and other reporting systems. Early funding is requested for this activity in order to build capacity as quickly as possible for the joint review of HIV/AIDS program data by *central- and district-level decision-makers.*

Mechanism Name: HIV/AIDS Reporting System

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3494
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Health District IT/Procurement

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2568
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: *Yes*

Mechanism Name: Refugees AHA

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3512
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: African Humanitarian Action
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3644
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: Africare
New Partner: No

Mechanism Name: Refugees - Rwanda

Mechanism Type: *Headquarters procured, country funded (HQ)*
Mechanism ID: 3453
Planned Funding($):
Agency: Department of State
Funding Source: GAC (GHAI account)
Prime Partner: American Refugee Committee
New Partner: Yes

Mechanism Name: American Society of Clinical Pathology

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3498
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: American Society of Clinical Pathology
New Partner: Yes

Mechanism Name: Lab Support/APHL

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2569
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Association of Public Health Laboratories
New Partner: No

Mechanism Name: APHL - deferred

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2588
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Association of Public Health Laboratories
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3643
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: Associazione Volontari per il Servizio Internazionale
New Partner: No

Mechanism Name: AIDS Relief

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2562
Planned Funding($):
Agency: HHS/Health Resources Services Administration
Funding Source: N/A
Prime Partner: Catholic Relief Services
New Partner: *No*

Sub-Partner: Bungwe Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes
Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes
Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: *Treatment: ARV Services*

Mechanism Name: CRS Track 1

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2587
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: Catholic Relief Services
New Partner: No

Mechanism Name: Catholic Relief Services Supplemental

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3493
Planned Funding($):
Agency: HHS/Health Resources Services Administration
Funding Source: GAC (GHAI account)
Prime Partner: Catholic Relief Services
New Partner: No

Sub-Partner: Bungwe Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Mechanism Name: Rapid Expansion

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2603
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Columbia University
New Partner: No

Sub-Partner: Voxiva
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Mechanism Name: Columbia/MCAP

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2565
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: N/A
Prime Partner: Columbia University Mailman School of Public Health
New Partner: No

Sub-Partner: Treatment and Research AIDS Center
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: National Reference Laboratory
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Mechanism Name: Columbia MCAP Supplement

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2572
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Columbia University Mailman School of Public Health
New Partner: No

Sub-Partner: Treatment and Research AIDS Center
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: National Reference Laboratory
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services
Other/policy analysis and system strengthening

Sub-Partner: National Leprosy and Tuberculosis Programme
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: TB/HIV
Treatment: ARV Services

Mechanism Name: Columbia UTAP

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2549
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Columbia University Mailman School of Public Health
New Partner: No

Sub-Partner: National Reference Laboratory
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Laboratory Infrastructure

Sub-Partner: National Leprosy and Tuberculosis Programme
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: TB/HIV

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Treatment and Research AIDS Center
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: Palliative Care: TB/HIV

Mechanism Name: Rapid Expansion

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2602
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Columbia University Mailman School of Public Health
New Partner: No

Mechanism Name: Columbia UTAP - deferred

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2590
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Columbia University Mailman School of Public Health
New Partner: No

Mechanism Name: CHAMP

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2576
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Community Habitat Finance International
New Partner: No

Mechanism Name: HIV Support to RDF

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2554
Planned Funding($):
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: Drew University
New Partner: No

Mechanism Name: Call to Action/EGPAF

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2555
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
New Partner: No

Sub-Partner: Butamwa Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Gikomero Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Kabuga Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Masaka Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Muhima Dispensary
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Rwankuba Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Shyrongoni Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Nzige Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Nyagasambu Health Center, Rwanda
Planned Funding: $35,000.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Kabusunzu Health Center, Rwanda
Planned Funding: $15,000.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Jali Health Center, Rwanda
Planned Funding: $15,000.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Rubungo Health Center, Rwanda
Planned Funding: $32,000.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Program for Appropriate Technology in Health
Planned Funding: $70,000.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding: $95,000.00
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding: $215,000.00
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding: $25,000.00
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding: $25,000.00
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support

Sub-Partner: To Be Determined
Planned Funding: $25,000.00
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support

Mechanism Name: Rapid Expansion

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2601
Planned Funding($): [redacted]
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
New Partner: No

Mechanism Name: FHI Bridge

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3356
Planned Funding($): $5,264,120.00
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: *Family Health International*
New Partner: No

Sub-Partner: Muyanza Health Center, Rwanda
Planned Funding: $51,476.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Byumba Hospital, Rwanda
Planned Funding: $25,000.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Treatment: ARV Services

Sub-Partner: Kigeme Hospital, Rwanda
Planned Funding: $25,000.00
Funding is TO BE DETERMINED: *No*
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Treatment: ARV Services

Sub-Partner: Kirambi Health Center, Rwanda
Planned Funding: $40,971.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Ruramba Health Center, Rwanda
Planned Funding: $44,871.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Kivumu Health Center, Rwanda
Planned Funding: $51,476.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Mugina Health Center
Planned Funding: $20,167.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Treatment: ARV Services

Sub-Partner: Nyarusange Health Center, Rwanda
Planned Funding: $51,574.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Ruhango Health Center, Rwanda
Planned Funding: $51,574.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Kabgayi Hospital, Rwanda
Planned Funding: $51,574.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Gitwe Hospital, Rwanda
Planned Funding: $39,200.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Treatment: ARV Services

Sub-Partner: Remera-Rukoma Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Masaka Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Treatment: ARV Services

Sub-Partner: Nyamata Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Treatment: ARV Services

Sub-Partner: Ruli Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Biryogo Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: Health Center Gikondo
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
Treatment: ARV Services

Sub-Partner: Bungwe Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Rugege Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing

Sub-Partner: Kayove Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing

Sub-Partner: Kigufi Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing

Sub-Partner: Murara Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing

Sub-Partner: Gitarama Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing

Sub-Partner: Nyabikenke Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing
Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support
Counseling and Testing

Sub-Partner: Mukungu Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Palliative Care: Basic health care and support

Mechanism Name: IMPACT

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2558
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: *Family Health International*
New Partner: No

Sub-Partner: Africare
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Association Rwandaise Pour le Bien-Etre Familial
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Archdiocese of Kigali
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Caritas Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Biryogo Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Gikondo Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Collectif PRO-FEMMES Twese Hamwe
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Country Response Information System
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Bungwe Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Gitarama Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Kabgayi Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No

New Partner: No

Sub-Partner: Kivumu Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Masaka Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Muyanza Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Nyarusange Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Rugege Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Ruhango Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Runyombyi Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Ruramba Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Diocese of Byumba, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Diocese of Kabgayi, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Diocese of Kibungo, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Diocese of Nyundo, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Byumba Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No

New Partner: No

Sub-Partner: Gitwe Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Kabgayi Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Kibungo Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Kibuye Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Kigeme Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Kirlinda Hosptial, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Mugonero Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Ngarama Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Nyamata Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Remera-Rukoma Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Ruli Hospital, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Reseau Rwandais de Personnes Vivant avec le HIV
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Society of Women Against AIDS, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Mukungu Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Karengera Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Murara Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Kayove Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Kigufi Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Kirambi Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Mugina Health Center
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Nyabikenke Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Mechanism Name: Transport Corridor Initiative

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3451
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Family Health International
New Partner: No

Mechanism Name: Capacity

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2559
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: IntraHealth International, Inc
New Partner: No

Mechanism Name: Intrah-deferred

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2582
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: IntraHealth International, Inc
New Partner: No

Mechanism Name: Rapid Expansion

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2600
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: IntraHealth International, Inc
New Partner: No

Mechanism Name: Safe Injection

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2575
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: N/A
Prime Partner: John Snow, Inc.
New Partner: No

Mechanism Name: Measure DHS

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3461
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Macro International
New Partner: Yes

Mechanism Name: RPM+

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2557
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Management Sciences for Health
New Partner: No
Early Funding Request: Yes
Early Funding Request Amount:
Early Funding Request Narrative: USG participates in a coordinated procurement of ARVs with all donors supporting ARV service in country. The next scheduled procurement is Jan 2006. MSH is the financial mechanism used by all USG partners to procure ARVs. USG will need to procure ARVs in January 2006 to avoid a rupture in stock. USG requests 50% of the ARV budget for this early procurement.

Early Funding Associated Activities:

Program Area:Treatment: ARV Drugs
Planned Funds:
Activity Narrative: This activity relates to activities #2757, #2777, #2772, #2787, #2798, #2783, #4849, #4003, and #497

Mechanism Name: HIV/AIDS Performance Based Financing

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2577
Planned Funding($): [redacted]
Agency: [redacted]ternational Development
Funding Source: GAC (GHAI account)
Prime Partner: Management Sciences for Health
New Partner: No
Early Funding Request: Yes
Early Funding Request Amount: [redacted]
Early Funding Request Narrative: Performance-based Financing of HIV/AIDS services has recently been awarded. The amount of funding available for this activity in COP05 [redacted]s not adequate to meet the actual needs of rapid start until COP06 funds arrive. Rapid access to COP06 funds are necessary to support initiation and achieve targets of performance-based contracting. The four year amount of the award is within budget.

Early Funding Associated Activities:

Program Area:Other/policy analysis and system strengthening
Planned Funds: [redacted]
Activity Narrative: See related Activities: #2812, #2814, #2815, #2798, #4001, #4003, #4771, #4972. In coordination with

Program Area:Treatment: ARV Services
Planned Funds: [redacted]
Activity Narrative: This activity relates to PBF CT (2812), Pol SS (2813), PMTCT (2814), BHC (2815), TBHIV (4001) and F

Sub-Partner: IntraHealth International, Inc
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: PMTCT
Other/policy analysis and system strengthening

Mechanism Name: Strengthening Blood Transfusion Services

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2564
Planned Funding($): [redacted]
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: N/A
Prime Partner: National Program for Blood Transfusion, Rwanda
New Partner: No

Mechanism Name: National Reference Laboratory

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3497
Planned Funding($): [redacted]
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: National Reference Laboratory
New Partner: No

Mechanism Name: ORISE

Mechanism Type: *Locally procured, country funded (Local)*
Mechanism ID: 2570
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Oak Ridge Institute of Science and Education
New Partner: No

Mechanism Name: ORISE - deferred

Mechanism Type: *Locally procured, country funded (Local)*
Mechanism ID: 2591
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: *Oak Ridge Institute of Science and Education*
New Partner: No

Mechanism Name: AIDSMark -deferred

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3742
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Population Services International
New Partner: *No*

Mechanism Name: HIV/AIDS School Based Program-Procurement

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2571
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Population Services International
New Partner: No

Sub-Partner: Ministry of Education, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Abstinence/Be Faithful
Other Prevention

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2561
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Population Services International
New Partner: No

Sub-Partner: Internews
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: Aidons-nous Mutuellement, Kibungo
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other Prevention

Sub-Partner: Health Unlimited
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Sub-Partner: World Relief Corporation
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Sub-Partner: Catholic Church Network
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: Muslim Association
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: Forum des Jeunes Anti-SIDA
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: CNLS
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Sub-Partner: Catholic Relief Services

Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Sub-Partner: Rwandan Scout Association
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Mechanism Name: Rapid Expansion

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2599
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Population Services International
New Partner: No

Mechanism Name: PSI Bilateral

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3515
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: *Population Services International*
New Partner: No

Mechanism Name: PSI-DOD

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2574
Planned Funding($):
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: Population Services International
New Partner: No

Mechanism Name: Blood Safety Technical Assistance

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2586
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: N/A
Prime Partner: Sanquin Diagnostic Services
New Partner: No

Mechanism Name: TRAC Cooperative Agreement

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2551
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Treatment and Research AIDS Center
New Partner: No

Mechanism Name: TRAC deferred

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2589
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Treatment and Research AIDS Center
New Partner: No

Mechanism Name: HCP- Tulane University

Mechanism Type: *Headquarters procured, country funded (HQ)*
Mechanism ID: 2578
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Tulane University
New Partner: No

Mechanism Name: Tulane UTAP - deferred

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2593
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Tulane University
New Partner: No

Mechanism Name: UTAP

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2552
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Tulane University
New Partner: No

Mechanism Name: Tulane - USAID deferred

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2597
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Tulane University
New Partner: No

Mechanism Name: Measure Eval

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2556
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: University of North Carolina
New Partner: No

Sub-Partner: John Snow, Inc.
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Strategic Information

Mechanism Name: QAP

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2560
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: University Research Corporation, LLC
New Partner: No

Mechanism Name: Central Contraceptive Procurement

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3516
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: US Agency for International Development
New Partner: No

Mechanism Name: USAID Rwanda

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3169
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: US Agency for International Development
New Partner: No

Mechanism Name: USAID Rwanda Mission

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2563
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: US Agency for International Development
New Partner: No

Mechanism Name: CDC - deferred

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2592
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: US Centers for Disease Control and Prevention
New Partner: No

Mechanism Name: CDC Country Office GAP/TA

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2567
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Base (GAP account)
Prime Partner: US Centers for Disease Control and Prevention
New Partner: No

Mechanism Name: CDC Country Office GAP/TA

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2598
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: US Centers for Disease Control and Prevention
New Partner: No
Early Funding Request: Yes
Early Funding Request Amount:
Early Funding Request Narrative: CDC Rwanda requests early funding in the amount of to finance the implementation of technical activities in the first quarter of FY2006. This is a stop-gap measure which will allow CDC to continue its programs uninterrupted while awaiting the arrival of regular FY2006 Emergency Plan funds (CDC functions according to the US Government fiscal year, and therefore was required to spend all FY2005 funds by September 30, 2005.) The early funding requested will finance national CT policy revision (to include separate norms and guidelines for PIT and VCT), site surveys and equipment purchases for the expansion of the Health District IT Connectivity project, and the salary of CDC's Care and Treatment Officer.

Early Funding Associated Activities:

Program Area:Management and Staffing
Planned Funds:
Activity Narrative: This activity also relates to activity #2791. Most CDC Global AIDS Program management and staff po

Program Area:Counseling and Testing
Planned Funds:
Activity Narrative: This activity, part of the Healthy Schools Initiative, relates to activities in CT (#2796), AB (#279

Program Area:Treatment: ARV Services
Planned Funds:
Activity Narrative: This activity is related to activities ARV Services (2798, 2787, 2736, 4849), Basic Health Care (279

Program Area:Laboratory Infrastructure
Planned Funds:
Activity Narrative: This activity relates to activities 2848, 2739, 2734, 4976 (CDC SI, TRAC SI, Columbia UTAP Laborator

Program Area:Strategic Information
Planned Funds:
Activity Narrative: This activity relates to activities 2739, 2792, 2747 (TRAC SI, Health District IT SI, Tulane UTAP SI

Program Area:Palliative Care: TB/HIV
Planned Funds:
Activity Narrative: This activity relates to activities in ARV services (4849), Counseling and Testing (2741) and TB/HIV

Mechanism Name: DOD Program Mgt

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2573
Planned Funding($):
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: US Department of Defense
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2550
Planned Funding($):
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: US Department of Defense Naval Health Research Center
New Partner: No

Mechanism Name: Embassy Rwanda

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2579
Planned Funding($):
Agency: Department of State
Funding Source: GAC (GHAI account)
Prime Partner: US Department of State
New Partner: No

Mechanism Name: WR Track 1.0

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2566
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: World Relief Corporation
New Partner: No

Mechanism Name: WR Supplement

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2580
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: World Relief Corporation
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: No

New Partner: Yes

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Other Prevention

Mechanism Name: WR bilateral

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3622
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: World Relief Corporation
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: CARE International
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Palliative Care: Basic health care and support

Table 3.3.01: Program Planning Overview

Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01

Total Planned Funding for Program Area:

Program Area Context:

ANC sentinel surveillance from 2003 indicates a 5.2% HIV prevalence among pregnant women in Rwanda. As 83% of the population lives in rural areas, the GOR has aggressively expanded PMTCT services throughout the country, primarily with Global Fund and EP resources. By the end of COP05, nearly half of healthcare facilities in Rwanda will offer PMTCT services, with EP supporting 89 sites in 20 health districts. USG has provided technical and financial support to TRAC for the standardization and utilization of PMTCT tools including guidelines, training curricula and reporting tools. TRAC, in collaboration with EP and other partners, is advancing PMTCT decentralization and incorporating district-level planning and TOT.

Both ANC and PMTCT use in Rwanda is high, with more than 95% acceptance of HIV testing. Nationally, only 65% of HIV-positive pregnant women received NVP prophylaxis; but at EP-supported sites, 75-80% of HIV-positive women completed the NVP regimen. Some EP implementing partners increased male involvement in PMTCT, with select sites testing up to 55% of male partners of ANC clients. In FY2005, USG supported an innovative QA network approach which resulted in higher utilization and improvements in key PMTCT indicators.

In FY2006, the PMTCT program will expand HIV care services to include systematic CD4 and clinical staging for pregnant women, triple therapy for clinically eligible pregnant women, and early infant diagnosis through PCR. The program will continue to reinforce existing components like CTX prophylaxis for all HIV-exposed infants and systematic tracking and follow-up of mother-infant pairs. The MOH, with EP support, will introduce routine opt-out CT for ANC clients to streamline services and improve quality. The EP will also assist TRAC and USS in the regular functioning of the PMTCT TWG.

EP will build upon MOH's decentralization strategy and expand district-level capacity by providing a standard DHT package for planning, training, supervision, reporting and monitoring. The successful "collaborative approach" for problem-solving and best practice dissemination will be replicated in every EP-supported district. The PBF will strengthen the quality and sustainability of PMTCT service delivery through the introduction of incentive payments at sites that have graduated from international partner support.

The PMTCT program faces many challenges, including low rates of ANC attendance during the first trimester, ANC follow-up visits, and facility deliveries (30%). EP partners can improve these rates by better tracking and follow-up of pregnant mothers and mother-infant pairs postpartum. The PBF will strengthen tracking and follow-up by tying performance monitoring to incentive indicators. The EP will promote the use of MCH and PMTCT services through mass media messages and outreach activities developed under CHAMP. Also the further development of referral and treatment protocols and tracking tools and systems will contribute to improving the monitoring of HIV-positive women, infants and their families.

Exclusive breastfeeding with early weaning continues to be a challenge, with less than 20% of lactating mothers exclusively breastfeeding. UNICEF and TRAC developed IYCF guidelines, a training curriculum, and job aids to assist in addressing this issue. During FY2005 and FY2006, UNICEF will train providers on infant feeding in PMTCT sites across the country using the revised national training curriculum. Through the WFP, EP partners will also leverage food support for HIV-positive pregnant women and their infants in accordance with the minimum package of nutritional support developed by the Nutrition Task Force.

Program Area Target:

Number of service outlets providing the minimum package of PMTCT services according to national or international standards	117
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	4,365
Number of health workers trained in the provision of PMTCT services according to national or international standards	910
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	91,171

Table 3.3.01: Activities by Funding Mechanism

Mechanism: TRAC Cooperative Agreement
Prime Partner: Treatment and Research AIDS Center
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 2743
Planned Funds:
Activity Narrative: This activity relates to activities in CT (#2741) and ARV services (#2745). This activity supports the training of district-level trainers in PMTCT service delivery as well as the revision of national norms and guidelines for PMTCT.

TRAC will conduct four TOT sessions on PMTCT service provision. These training sessions will cover all aspects of the expanded national PMTCT protocol, including: opt-out testing and informed consent for ANC clients, bi-therapy ARV prophylaxis, PCR testing and CTX for all exposed infants, routine CD4 testing and/or clinical staging for all HIV-positive pregnant women, and counseling on infant feeding and nutrition for HIV-positive pregnant women. The participants at these trainings – trainers in Rwanda's 29 health districts – will subsequently train PMTCT service providers from all PMTCT sites. TRAC will conduct quarterly supervision of these decentralized trainings. In addition, TRAC will conduct two training sessions for district-level supervisors, who will make regular visits to PMTCT sites to assure the quality of services.

In collaboration with the EP Prevention TWG and other partners, TRAC will revise and replicate national PMTCT norms, guidelines and tools (e.g. client forms, reporting forms, educational tools) and disseminate them to all health facilities providing PMTCT services.

The budget for this activity includes salary support for a PMTCT master trainer and a PMTCT program officer within TRAC's PMTCT/VCT unit. This activity directly supports the Rwanda EP five-year strategy by scaling up PMTCT services and strengthening the capacity of local institutions.

Emphasis Areas	% Of Effort
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	0	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national or international standards	*116*	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of SDPs offering PMTCT services graduated to the PBF		☑

Indirect Targets

TRAC is the national agency responsible for developing policies, norms and guidelines for clinical HIV/AIDS services. In addition, TRAC trains district-level PMTCT trainers and supervisors. The funding in this activity directly supports TRAC for PMTCT policy revision, four training-of-trainers sessions, and two training-of-supervisors sessions. Through TRAC's policy and training support, 240 health facilities will be providing PMTCT services by the end of FY2006; 2424 pregnant women will be provided with a complete course of ARV prophylaxis for PMTCT; and 29924 pregnant women will receive HIV counseling and testing for PMTCT

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Call to Action/EGPAF
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: *01*
Activity ID: 2755
Planned Funds:
Activity Narrative: This activity relates to EGPAF HBHC (5111), ARV (2757), and PMTCT partners (IntraHealth 2774, PBF 2814, FHI (4764), and CHAMP (2805).

In partnership with the GOR and other donors, the EP will improve the quality, efficiency, and sustainability of PMTCT service delivery at existing and new sites through innovative approaches for quality assurance, performance improvement, and health financing. EGPAF will ensure access to a comprehensive network of services for PMTCT clients and their families and link PMTCT services with other HIV and MCH interventions. All EP-funded clinical partners will offer a standard package of PMTCT service delivery; the narratives are consistent for clinical partners, with some variations according to expertise.

EGPAF will support PMTCT services for 20,150 pregnant ANC women, including 1,610 HIV-positive women at 18 existing, 5 new and 6 PBF-graduating sites. EGPAF will ensure the provision of the full package of PMTCT services, including a revised strategy to include opt-out CT with informed consent; male partner testing; ARV prophylaxis using an expanded bi-therapy regimen; IF counseling and support; and referral for FP and MCH services. EGPAF will provide limited technical support to the 6 graduating sites to ensure PMTCT service delivery corresponds with PBF graduation criteria. Targets for the six graduated sites will be divided evenly between the PBF and EGPAF. HIV rapid test kits will be procured through RPM-plus, and ARVs and hemoglobin testing materials for PMTCT will be procured through Columbia MCAP.

Health center staff will receive 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 DHTs, EGPAF 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. EGPAF will closely monitor adherence to the new regimen and document lessons learned in its implementation. Through targeted district support, Ngarama and Kabuga DHTs will build their QA and M&E skills, including in data collection, data use, and reporting.
Linking with MCH services, EGPAF will work with IntraHealth to incorporate safe motherhood, FP, and GBV into PMTCT activities. EGPAF will strengthen the follow-up and tracking systems postpartum to ensure the following: routine provision of CTX PT and PCR testing for all exposed infants; ongoing infant feeding counseling and support in collaboration with UNICEF and PATH sub-partner; CD4 testing for HIV-positive mothers; management of OIs, including TB and other HIV-related illnesses; psychosocial support services at clinic and community levels; and access to prevention care and treatment services for family members. This could include use of referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To reduce the risk of illness among malnourished mothers and infants, EGPAF will leverage food through WFP for pregnant and lactating women and weaned or non-breastfed infants. Recognizing the links between violence, alcohol and HIV transmission, facility-level lay counselors trained under CHAMP will also help to identify and refer women who may be victims of violence to appropriate care and support. In collaboration with CHAMP and CS coordinators, 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.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	23	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	1,610	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	250	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	20,150	☐
Number of SDPs offering PMTCT services graduated to the PBF	6	☐

Target Populations:

Faith-based organizations

Nurses (Parent: Public health care workers)

Men (including men of reproductive age) (Parent: Adults)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Public health care workers

Laboratory workers (Parent: Public health care workers)

Key Legislative Issues

Gender

Addressing male norms and behaviors

Stigma and discrimination

Reducing violence and coercion

Wrap Arounds

Food

Microfinance/Microcredit

Coverage Areas

Kigali (Rurale)

Kigali-Ville

Byumba

Table 3.3.01: Activities by Funding Mechanism

Mechanism: IMPACT
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 2765
Planned Funds:
Activity Narrative: [Activity continuing with COP06 funds under different mechanism - see narrative in Activity #4764].

USG supports PMTCT services in primary health centers in combination with other clinic based services (CT and OI/ARVs). This USG partner presently supports PMTCT in 21 health facilities. With additional funding in FY05, this partner will (i) continue ongoing services and (ii) inititate PMTCT at 5 additional sites in preparation for expanding ARV services in Byumba, Gikongoro, and Gitarama Provinces in FY06. (National GOR policy requires that integrated PMTCT/CT/OI/palliative care services be established in a site before ARV services can be offered). USG will work closely to support implementation of performance-based financing of PMTCT services as sites graduate to Ministry of Health management. Initial sites for pilot graduation would be combined Global Fund/USG sites.
Work with Community Services Coordinator funded through Community Services procurement to provide outreach services to patients.

Targets

Target	*Target Value*	*Not Applicable*
Number of service outlets providing the minimum package of PMTCT services according to national or international standards		☑
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national or international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of SDPs offering PMTCT services graduated to the PBF		☑

Target Populations:

Pregnant women

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibuye

Kigali (Rurale)

Kigali-Ville

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Capacity
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: *01*
Activity ID: 2774
Planned Funds:
Activity Narrative: This activity relates to the following activities: HBHC IntraHealth (5112), ARV services - IntraHealth (2770), ARVs - IntraHealth (2777), PMTCT- PBF (2814), PMTCT - CHAMP (2805).

In partnership with the GOR and other donors, the EP will improve the quality and efficiency of PMTCT service delivery at existing and new sites, and in line with EP goals, will prioritize sustainability of PMTCT services through innovative approaches for quality assurance, performance improvement, and health financing. In accordance with the Rwanda EP five-year strategy and GOR priorities, the EP 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 engage communities to seek and promote PMTCT interventions. All EP-funded clinical partners will offer a standard package of PMTCT service delivery; the narratives are thus consistent with some variations according to expertise.

Capacity/IntraHealth will support PMTCT services for 21,000 pregnant ANC women, including 1,000 HIV+ women at 10 existing, 6 new, and 15 graduating PMTCT sites. In line with GOR national guidelines and protocols, IntraHealth will ensure the provision of the full package of PMTCT services, including a revised CT strategy to include opt-out CT with informed consent; male partner testing; ARV prophylaxis using an expanded bi-therapy regimen; IF counseling and support; and provision or referral for FP and MCH services. IntraHealth will prepare 15 graduating sites for PBF through limited technical support to the PBF contractor. Targets will be divided evenly between PBF and IntraHealth for the 15 graduated sites. HIV rapid test kits will be procured through RPM+, and ARVs and hemoglobin testing materials for PMTCT will be procured through Columbia MCAP base funding.

Health center staff will receive new and refresher on-the-job training in the expanded national PMTCT protocol, including use of site-level algorithms and checklists, as well as laboratory monitoring. IntraHealth will conduct ongoing performance improvement, QA and supervision of PMTCT services, in particular of adherence to the revised PMTCT regimen. To complement PBF and site-level QA activities, IntraHealth will continue and expand their successful community-provider partnership committees (PAQs).

As the lead family planning agency in the country, CAPACITY/IntraHealth will take advantage of synergies with IntraHealth Twubakane's family planning and reproductive health activities by incorporating appropriate FP policies and training into all CAPACITY-supported PMTCT activities. CAPACITY/IntraHealth will work with Twubakane, TRAC, USS and the districts for the development of tools, job aids, and tracking systems for FP in the context of PMTCT. CAPACITY/IntraHealth will also continue to strengthen safe obstetric practices to reduce the risk of MTCT through integration of their training module for safe motherhood into PMTCT training activities. This will support TRAC to integrate safe motherhood, neonatal care, family planning, and GBV into the national TRAC training curriculum and will be included into the pre-service nurse training curriculum currently being developed in FY2005 (See ARV 2777). The partner will continue to emphasize their successful male partner testing activity to reach 50% of ANC male partners, particularly partners of HIV+ PMTCT clients, and disseminate lessons learned to other EP partners, donors, and GOR stakeholders. In collaboration with TRAC and UNICEF, CAPACITY/IntraHealth will integrate national infant feeding counseling tools and guidelines developed by UNICEF and TRAC, and establish adequate mechanisms for monitoring infant feeding practices among HIV-positive women.

IntraHealth will ensure the provision of, or referrals for, a comprehensive package of prevention, care, and treatment services. This includes systematic provision of CTX PT for and PCR testing of HIV-exposed infants; routine CD4 testing and/or clinical staging of all HIV-positive pregnant and postpartum mothers and infants; clinical monitoring, referral for ART and treatment adherence support; TB screening, diagnosis, and treatment; management of other OIs and HIV-related illnesses; psychosocial services; and access to prevention, care and treatment services for family members. Recognizing that violence and alcohol are facilitating factors in HIV transmission in Rwanda, facility-level lay counselors trained by the CSP will also help to identify and refer women who may be victims of violence to appropriate violence prevention centers. In collaboration with the CSP and CS Coordinators, CAPACITY/IntraHealth will ensure referral of PMTCT clients and their families to HBC services, OVC support programs, PLWHA Associations, 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 can 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.

To ensure the success of the network system, CAPACITY/IntraHealth will fund a clinical services coordinator at sites when applicable, and will work with CHAMP, DHTs and referral facilities to develop monitoring and tracking mechanisms between facility and community-based services.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	16	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	1,000	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	200	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	21,000	☐

Target Populations:

Nurses (Parent: Public health care workers)

Discordant couples (Parent: Most at risk populations)

Pregnant women

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Laboratory workers (Parent: Public health care workers)

Key Legislative Issues

Gender

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Wrap Arounds

Food

Coverage Areas

Byumba

Gitarama

Kibungo

Kibuye

Umutara (Mutara)

Kigali (Rurale)

Kigali-Ville

Table 3.3.01: Activities by Funding Mechanism

Mechanism: QAP
Prime Partner: University Research Corporation, LLC
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 2778
Planned Funds:
Activity Narrative: [ACTIVITY NOT RECEIVING FUNDING IN COP06]
URC/QAP Rwanda will emphasize transfer of Continuous Quality Improvement capacity to the Department of Health Services as URC/QAP finalizes the multi-year effort through Collaborative Approach to PMTCT service delivery. The activity will support a PMTCT collaborative that includes 18 sites in 12 provinces. With monthly coaching visits and learning sessions every three months, sites have measurably increased their use of best practices and evidence-based approaches. After 12 months of activity, the percentage of women receiving NVP was significantly increased (from 38% to 100% in 2/3 of QAP sites) as was the percentage of partners tested. QAP has been in Rwanda for over 6 years and plans to transfer all technical capacity and management to the Department of Quality Services at the end of FY05. Site improvements are usually changes in standard procedures that result in improved outcomes.

DSS will use CQI capacity in monitoring of quality of care in sites that receive PMTCT performance-based financing.

During COP05, QAP will assist the Department of Health Services in training district supervisors coach quality assurance teams at each participating health facility, to initiate and host collaboratives at the district level, and to develop communication systems so that communication can continue to occur among sites in between learning sessions. "The Collaborative Approach in Rwanda PMTCT" will be evaluated. If evaluation recommends, QAP will develop a manual to assist with transfer of capacity, including lessons learned.

Note: QAP's contribution to PMTCT targets - "number of pregnant women provided with PMTCT services" and "number of pregnant women provided with a complete course of antitretroviral prophylaxis" - is reflected in those PMTCT targets of other PMTCT implementing agencies (FHI, HCD and EGPAF).

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards		☑
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national or international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of SDPs offering PMTCT services graduated to the PBF		☑

Target Populations:

Family planning clients

Doctors (Parent: Public health care workers)

Discordant couples (Parent: Most at risk populations)

Pregnant women

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Butare

Byumba

Cyangugu

Gikongoro

Gisenyi

Gitarama

Kibungo

Kibuye

Kigali (Rurale)

Kigali-Ville

Ruhengeri

Umutara (Mutara)

Table 3.3.01: Activities by Funding Mechanism

Mechanism:	CHAMP
Prime Partner:	Community Habitat Finance International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	2805
Planned Funds:	
Activity Narrative:	This activity relates to the other CHAMP activities – AB (#2807), OP (#2808), CT (#2806), OVC (#2810), HIV/TB (#5129), BHC (#2811), ARV Services (#2809), and Systems Strengthening (#5183).

B5

CHAMP will support the national PMTCT program through interpersonal and mass media communication activities to promote early ANC attendance, facility deliveries, infant feeding practices, early infant diagnosis and male involvement. Currently, Rwanda has high ANC attendance for the first visit but low attendance for the recommended four ANC visits. The majority of Rwandan women come for ANC for a new pregnancy during their second trimester or later. Facility delivery rates in Rwanda are low at around 30% or less, which increases the risk of intrapartum transmission and complicates the monitoring of compliance to the PMTCT regimen. To achieve the goals of Rwanda's national PMTCT program, CHAMP will provide training, supervision, and support to community-based volunteers and health providers to promote and support PMTCT services at community level. CHAMP will develop or adapt a community PMTCT training module for 200 health animators, PLWHA association members, and TBAs. These individuals will be trained to promote PMTCT services as well as CT, IMCI and MCH services in order to reduce fear and stigma around infant and pediatric testing and care. These individuals will also receive training on the promotion and support of exclusive breastfeeding for HIV-positive lactating mothers and on provision of support to mothers during the cessation period.

CHAMP will link PMTCT services with other MCH services, such as community growth monitoring programs and community malaria programs (supported by UNICEF and IRC) to support the monitoring and follow-up of mother-infant pairs. CHAMP will foster productive interactions between clinics and communities to strengthen referrals, case management, and follow-up of mother-infant pairs and to increase the number of infants tested. Health Animators should also refer HIV positive mothers and their children to other community care activities for OVC and PLWHA. CHAMP will also integrate PMTCT messages into its mass media communication activities. These messages will be developed in keeping with the National Prevention Strategy and will complement CHAMP community-based activities promoting PMTCT and MCH services. CHAMP's use of health animators and TBAs to promote PMTCT services will ensure adherence to the new regimen, early infant diagnosis, and the monitoring of IF practices. These activities will indirectly contribute to the PMTCT targets achieved by EP clinical partners and will contribute to the goal of averting new HIV infections.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards		☑
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national or international standards	150	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑

Target Populations:

Community-based organizations

Faith-based organizations

HIV/AIDS-affected families

Infants

Pregnant women

Volunteers

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibungo

Kibuye

Kigali (Rurale)

Kigali-Ville

Umutara (Mutara)

Table 3.3.01: Activities by Funding Mechanism

Mechanism: HIV/AIDS Performance Based Financing
Prime Partner: Management Sciences for Health
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 2814
Planned Funds:
Activity Narrative: See related activities of clinical PMTCT partners: Capacity/IntraHealth (2774), CHAMP (2805), FHI (4764), EGPAF (2755) and PBF BHC (2815).

PBF of HIV/AIDS services is a key tool for achieving sustainability as outlined in the Rwanda EP five year strategy. PBF of PMTCTservices will be piloted at a minimum of nine health facilities in 2005 and scaled up to an additional 35 sites in 2006.

In 2006, 35 health centers offering PMTCT will transition from traditional input financing and technical support of an international clinical partner to a "performance-based contract" with the PBF partner. PBF contracts will have payment targets tied to EP targets, quality indicators or other needed interventions. The PBF and current implementing partners will share both targets and financing for these 35 HCs during the transition year. DHTs, current implementing partners and the PBF partner will develop a common transition plan to assure continued technical support in needed areas, such as PMTCT bi-therapy. The PBF partner will provide management training in planning, budgeting, and quality improvement. The PBF partner will support the DHT to develop capacity to monitor the quality of PMTCT care, to coach and provide supportive supervision and to manage finances. The DHT will monitor health center performance using clinical audits to verify quality and volume of target attainment

The PBF will finance targets for the expanded package of PMTCT care and treatment services to mother-infant pairs and their families, including opt-out counseling and testing; an expanded bi-therapy ARV prophylaxis regimen; routine CD4 testing and clinical staging of all HIV positive women; ARV treatment when indicated, provision or referral for family planning and maternal child health services; strengthened infant feeding counseling; PCR testing of infants, and CTX to all exposed infants until their status is determined to be negative.

Through BHC and CHAMP, HIV positive mothers will access key preventive interventions, community MCH activities, and nutritional support for mothers and children provided by other non-EP programs. HIV positive mothers will access OI treatment and community home based care. Health Centers will hire Community Services Coordinators to assure strong linkages between the health centers' clinical services and needed community based services. Community support programs will support women at risk for violence. Community volunteers will promote early ANC attendance, facility deliveries, postnatal follow-up, infant feeding, and infant testing. Existing community resources will assist in tracking and monitoring pregnant and postpartum women and exposed infants for follow-up care and treatment. More women will access PMTCT as a result of strengthened networks and referral systems, from community to the pyramids of clinical services.

The Rwanda EP five-year strategy seeks to roll out PMTCT services in a sustainable manner to all health facilities. This goal will be supported through the PBF in partnership with GOR and other donors.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	44	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	700	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	18	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	20,000	☐

Target Populations:

Discordant couples (Parent: Most at risk populations)

Pregnant women

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Public health care workers

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Refugees - Rwanda
Prime Partner: American Refugee Committee
USG Agency: Department of State
Funding Source: *GAC (GHAI account)*
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 4748
Planned Funds:
Activity Narrative: This activity relates to other ARC activities under CT (#4867), AB (#4864), and HBHC (#4865).

Over 50,000 refugees live in camps across Rwanda. ARC provides support to about 20,000 refugees in Gihembe (15,000) and Nyabiheke (5,000) refugee camps in Byumba province. In partnership with the GOR, ARC, UNHCR and other agencies support ongoing efforts for HIV prevention, care and treatment services for refugees. In FY2005, CAPACITY/IntraHealth will support PMTCT/VCT services in Gihembe camp in collaboration with ARC, with the goal of building capacity of these partners to take over services in FY2006. GLIA will also support HIV/AIDS services in Gihembe Camp with a limited amount of funding starting in FY2006. All EP activities will be coordinated with GLIA to ensure complementarities and non-duplication of services. The Nyabiheke facility is new and lacks the structure and funding for any coordinated HIV/AIDS prevention, testing or treatment activities at the present time. EGPAF and ARC are currently developing a formal plan to ensure access to CT services and training of Nyabiheke health providers. ARC will support the provision of PMTCT services for 1,600 pregnant ANC women, including 40 HIV-positive women, at Gihembe and Nyabiheke refugee camps, linking PMTCT services with other HIV and MCH interventions and engaging communities to seek and promote PMTCT services. In line with GOR guidelines and national protocols, ARC will ensure the provision of the full package of PMTCT services to mother-infant pairs and their families, including a revised CT strategy to include opt-out CT with informed consent; ARV prophylaxis using an expanded bi-therapy regimen; infant feeding counseling and support; and provision of, or referral for, FP and MCH services. Test kits will be procured through RPM-plus.

ARC will support on-the-job provider training in both refugee camps to train and update providers in the expanded national PMTCT protocol, and monitor provider performance through ongoing supervision and QA activities. Given Nyabiheke's small camp size and limited number of pregnant women, ARC will collaborate with EGPAF at Ngarama District Hospital to facilitate referral for the PMTCT regimen, or on-site provision of the ARV regimen, contingent on GOR's approval. Health center staff at both camps will support and monitor provision and use of the new regimen through the use of existing national checklists and algorithms, routine data collection, laboratory monitoring, and supervision of providers. Linking HIV with other MCH interventions, ARC will integrate safe motherhood and FP into PMTCT training and services. In collaboration with TRAC and UNICEF, ARC will also integrate national IF counseling tools and guidelines developed by UNICEF and TRAC, establish adequate mechanisms for monitoring IF practices among HIV-positive women, and leverage food support for weaned infants. Recognizing that violence and alcohol are facilitating factors in HIV transmission in Rwanda and are frequently prevalent in refugee camp settings, ARC will integrate GBV sensitization and counseling in training for health providers, lay counselors and community groups, and ensure appropriate provision of, or referral for, GBV and trauma counseling for female victims of violence. Refugee camp health center staff will use screening tools to assist in identifying potential victims of violence. ARC will also support improvements in supervisory and M&E skills of refugee health center providers, including routine data collection, use of data for PMTCT program improvement, and reporting within the national reporting system.

To ensure appropriate follow-up care and support for HIV-positive mother-infant pairs and their families, ARC will support the network model through the establishment of systematic and formalized referral systems within the camp health center, with other clinical partners in the surrounding catchment area of the camps (FHI at Byumba

Hospital and EGPAF at Ngarama Hospital), and with refugee community-based services. This will include provision of, or referral for: ART; TB screening and treatment; management of OIs and other HIV-related illnesses; leveraging for food support for mothers and infants; PCR and PT CTX for HIV-exposed infants; and access to prevention, care and treatment services for family members. ARC will ensure referral of PMTCT clients and their families to HBC services, OVC support programs, PLWHA associations, IGA, and facility- and community-based MCH services promoting preventive interventions such as bednets, immunizations, hygiene/safe drinking water and nutritional support. Refugee camp services will take advantage of these networks of refugee community leaders, TBAs, refugee women's groups and PLWHA associations to promote services and messages that focus on stigma reduction, infant testing, GBV reduction, male partner testing, infant feeding promotion and promotion of HIV care and treatment services, and to assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants, particularly OVC.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50
Community Mobilization/Participation	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	2	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	40	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	50	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	1,600	☐

Target Populations:

Refugees/internally displaced persons (Parent: Mobile populations)

Pregnant women

Men (including men of reproductive age) (Parent: Adults)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

Laboratory workers (Parent: Private health care workers)

Nurses (Parent: Private health care workers)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Wrap Arounds

Food

Coverage Areas

Byumba

Table 3.3.01: Activities by Funding Mechanism

Mechanism: FHI Bridge
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 4764
Planned Funds:
Activity Narrative: This activity relates to FHI-BHC (4767), FHI CT(4769), CHAMP-OVC (2810), CHAMP PMTCT (2805), PBF PMTCT (2814), and FHI ART(4770).

In partnership with the GOR and other donors, Rwanda EP will improve the quality and efficiency of PMTCT service delivery and will prioritize sustainability of PMTCT services through innovative approaches for quality assurance, performance improvement, and health financing. In line with the Rwanda EP five-year strategy and GOR priorities, 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 engage communities to seek and promote PMTCT interventions.

In line with GOR national guidelines and protocols, FHI will ensure the provision of the full package of PMTCT services, including revised CT strategy to include opt-out CT with informed consent; ARV prophylaxis using an expanded bi-therapy regimen; IF counseling and support; and provision or referral for FP and MCH services at 21 existing and 10 new sites. To support the EP goal for sustainability, FHI will prepare 14 sites for graduation to the PBF to ensure quality of services meet PBF technical critera. PBF and FHI will each be responsible for 6 months worth of targets for the 14 graduated sites. HIV rapid test kits will be procured through RPM+, and ARVs, hemoglobin testing materials for the new regimen will be procured through Columbia MCAP.

Providers will receive training in the expanded national PMTCT protocol. FHI will build capacity of sites to provide the new PMTCT regimen through the use of existing national checklists and algorithms, M&E, supervision of providers, and appropriate documentation of implementation of the new regimen. FHI will incorporate additional safe motherhood, FP and GBV counseling into PMTCT activities in collaboration with IntraHealth. Sites will increase testing of male partners, particularly partners of HIV-positive PMTCT clients, and will work to facilitate disclosure and mitigate the impact of GBV. FHI will support HCs to use national infant feeding counseling tools and guidelines developed by UNICEF and TRAC, monitor infant feeding practices among HIV-positive women, and leverage food support for pregnant and lactating mothers and weaned or non-breastfeeding infants.

FHI will support the network model through the provision of, or formal referral for, a comprehensive package of prevention, care, and treatment services. This package includes systematic provision of CTX PT for and PCR testing of HIV-exposed infants; routine CD4 testing and/or clinical staging of all HIV-positive pregnant and postpartum mothers and infants; clinical monitoring, referral for ART and treatment adherence support; TB screening, diagnosis, and treatment; management of other OIs and HIV-related illnesses; psychosocial services; and access to prevention, care and treatment services for family members. In collaboration with the CHAMP and CS Coordinators, FHI will ensure referral of PMTCT clients and their families to HBC services, OVC support programs, PLWHA Associations, IGA, and facility- and community-based MCH services promoting key preventive interventions. These community-based services will assist HCs to monitor and track pregnant and postpartum HIV-positive women and their infants, as well as promote MCH and PMTCT health seeking behaviors.

To ensure the success of the network system, FHI will fund a CS Coordinator at their sites when applicable, and will work with CHAMP partners, the CS Coordinators, DHTs and referral facilities to develop monitoring and tracking mechanisms between facility and community-based services. This could include use of referral slips, community-based registers, patient cards and other monitoring tools to facilitate

transfer of information between facilities and communities. Through targeted program support for DHTs, FHI will also build the supervisory and monitoring and evaluation skills of 8 DHTs, including routine data collection, data use and reporting for PMTCT services at facility and community levels. See FHI-ARV (4770).

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	31	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	985	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	217	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	27,521	☐

Target Populations:

Nurses (Parent: Public health care workers)

People living with HIV/AIDS

Pregnant women

Men (including men of reproductive age) (Parent: Adults)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

Public health care workers

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibuye

Kigali (Rurale)

Kigali-Ville

Table 3.3.01: Activities by Funding Mechanism

Mechanism: ORISE - deferred
Prime Partner: Oak Ridge Institute of Science and Education
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 4830
Planned Funds:
Activity Narrative: *[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]*

This deferred funding from FY 2004 will complete support for a long-term technical advisor to the PMTCT/VCT Unit at TRAC for FY 2005. Specific PMTCT activities associated with this technical advisor are detailed under ORISE PMTCT activity narrative.

Table 3.3.01: Activities by Funding Mechanism

Mechanism:	Columbia MCAP Supplement
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	4832
Planned Funds:	
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

USG will place an ORISE fellow at TRAC as a technical advisor to the PMTCT/VCT unit. The advisor will: • Provide technical assistance to facilitate PMTCT/VCT technical committee; • Improve TRAC's technical capacity in integrated PMTCT/VCT supervision, training, and program management; • Assist with the revision and dissemination of CT norms/guidelines, training and supervision materials to incorporate new testing modalities; • Provide follow-up training for health care providers on new guidelines for CT service delivery; • Support TRAC and DSS in the development of a national PMTCT/VCT implementation plan; • Support TRAC for the analysis of CT service delivery data; (NOTE: The cost for this activity is distributed between ORISE PMTCT and ORISE CT program areas to reflect the advisor's support to the integrated PMTCT/CT unit at TRAC.)

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Refugees AHA
Prime Partner: African Humanitarian Action
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 4871
Planned Funds:
Activity Narrative: This activity relates to AHA actitivies under CT (#4874) and BHC (#4873).

Over 50,000 refugees live in camps across Rwanda. AHA provides support to a total of about 17,000 refugees in Kiziba refugee camp in Kibuye District. AHA, UNHCR and other agencies support ongoing efforts for HIV prevention, care and treatment services in partnership with Kibuye District Hospital. CAPACITY/IntraHealth will be supporting VCT and PMTCT in collaboration with AHA in FY05. GLIA will also support HIV/AIDS services in Kiziba Camp starting in FY2006 with a limited amount of funding. All EP activities will be coordinated with GLIA to ensure complementarities and non-duplication of services. AHA will reach 900 pregnant women, including 30 HIV+ women and their infants in the Kiziba refugee camp, through the provision of a comprehensive package of PMTCT services, including a revised CT strategy to include opt-out CT for ANC women, ARV prophylaxis using an expanded bi-therapy regimen, IF counseling and support, and provision or referral for FP and MCH services. Test kits will be procured through RPM-plus.

AHA will support on-the-job and refresher training of health center camp providers on the expanded PMTCT ARV regimen and mother-infant follow-up and support. Health center staff will support and monitor use of the new regimen through existing national checklists and algorithms, routine data collection, laboratory monitoring, and supervision of providers. AHA will also monitor provider performance through ongoing supervision and QA activities, and will strengthen capacity of refugee camp providers in M&E, including routine data collection, use of data for PMTCT program improvement, and reporting within the national reporting system. Linking HIV to other MCH and RH services, AHA will integrate its existing safe motherhood and FP activities into the PMTCT program. AHA will integrate the national IF counseling tools and guidelines developed by UNICEF and TRAC, establish adequate mechanisms to monitor IF practices among HIV+ women, and leverage food support for weaned infants. Using existing tools and curricula, AHA will incorporate GBV training for refugee camp health providers, lay counselors, and community groups to mitigate the risk for GBV in the refugee camps and ensure appropriate provision of, or referral for, GBV and trauma counseling for female victims of violence. Refugee camp health center staff will use screening tools to assist in identifying potential victims of violence.

To ensure appropriate follow-up care and support for HIV-positive mother-infant pairs and their families, AHA will support the network model through the establishment of systematic and formalized referral systems within the camp health center, with other clinical partners in the surrounding catchment area (Columbia MCAP and Intrahealth at Kibuye DH or other health facilities in the district), and with refugee community-based services. This will include provision of, or referral for, systematic CD4 testing, ART, TB screening, diagnosis, and treatment; management of OIs and other HIV-related illnesses; PCR and PT CTX for exposed infants. AHA will also ensure referral of PMTCT clients and their families to HBC services, OVC support programs, PLWHA Associations, IGA, and facility- and community-based MCH services promoting key preventive interventions such as bednets, immunizations, hygiene/safe drinking water and nutritional support. Refugee camp services will take advantage of these networks of refugee community leaders, TBAs, refugee women's groups and PLWHA Associations to promote services and messages that focus on stigma reduction, infant testing, GBV reduction, male partner testing, infant feeding promotion and promotion of HIV care and treatment services, and to assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants, particularly OVC.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Infrastructure	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50
Community Mobilization/Participation	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	1	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	30	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	25	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	900	☐

Target Populations:

Refugees/internally displaced persons (Parent: Mobile populations)

Pregnant women

Volunteers

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

Laboratory workers (Parent: Private health care workers)

Nurses (Parent: Private health care workers)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Wrap Arounds

Food

Coverage Areas

Kibuye

Table 3.3.02: Program Planning Overview

Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02

Total Planned Funding for Program Area:

Program Area Context:

The EP emphasizes AB programs to prevent the spread of HIV. During FY2005, the EP supported Rwanda's 2005-2009 National Prevention Plan, targeting high-risk groups and the general population with AB messages. As of March 31, 2005, AB prevention programs had reached 442,105 individuals and trained over 10,000 individuals to provide AB prevention messages, using a variety of interventions ranging from mass media radio dramas to interpersonal peer education. EP assistance increased the role of FBOs in raising AB awareness and dialogue among pastors, youth, young couples and parents. The EP also used the network of health care providers to deliver AB messages during pre- and post-test counseling. Other channels for prevention education included school-based AB curricula and life skills classes for young people; OVC programs which trained mentors and caregivers in delivery of AB prevention messages; and post-test club support programs emphasizing prevention for positives. In April 2005, EP prevention partners assisted CNLS in finalizing the National Guidance on BCC Programming which identifies high-risk groups and outlines appropriate BCC activities by target population. In an effort to better coordinate and ensure accuracy of messages, the CNLS also created a BCC Steering Committee, which includes EP partner participation.

In FY2006, CHAMP will program the majority of EP AB prevention assistance through Rwandan FBOs and CBOs. CHAMP will harmonize AB messages among EP partners, ensuring that training curricula, mass media spots, and other IEC materials address the links between alcohol abuse, violence and HIV. EP AB programs will take a holistic approach to prevention, targeting both individual behavior and community and societal norms. Programs will address risky behaviors including transactional sex, cross-generational sex, GBV, coercive sex and sex among discordant couples. These interventions will help females to recognize and prevent "risky actions" and target men to increase their understanding and awareness that sex with young girls is an unacceptable behavior. Parents will be encouraged to talk openly with their children about sex, HIV/AIDS, and girls' vulnerability. Some of the prevention activities targeted at youth will specifically promote abstinence-only, encouraging young people to delay sexual debut until marriage. This will build on the Rwandan cultural norm of late sexual debut for both boys and girls (20.4 and 20.8, respectively - DHS 2000).

The EP will mobilize the religious community, making a greater effort to reach Muslim communities in Rwanda. FBOs play an important leadership role in reaching Rwanda's active religious communities with AB information and behavior change messages. EP assistance will increase efforts to target high-risk mobile populations with AB messages through the TCI and mobile CT. The EP will expand AB promotion to include workplace programs and community discussions among target audiences, such as women's groups, youth, former prisoners, and health care providers. By broadcasting community discussions and holding Listeners Club meetings after call-in radio shows, EP efforts will reinforce mass media with interpersonal communication interventions.

With the increase in AB resources, the EP estimates that over 463,950 individuals will be reached with face-to-face messages and 3,123 individuals will be trained to promote abstinence and fidelity in FY2006. AB activities support the Rwanda EP five-year strategy which calls for expansion of abstinence programs in secondary schools and support for peer education and parent-child counseling through religious networks.

Program Area Target:

Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	474,320
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	132,200
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	3,563

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Population Services International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 2780
Planned Funds:
Activity Narrative: [Continuing COP05 Activity - No New Funding for this Program]

This program will develop, in conjunction with Catholic, Anglican, Protestant and Muslim FBOs, targeted mass media and interpersonal communication interventions. The expected results of the campaign include increased abstinence (or delayed debut) for youth, partner reduction and a decrease in high-risk behaviors, such as infidelity and alcohol consumption. This USG partner will subcontract with the Catholic church network and Muslim religious organizations for each. Additional funds will go to World Relief to use these developed materials within their faith communities.

The youth mass media component will include the expansion and diffusion of a youth radio call-in program started under COP04, and the distribution of an abstinence-focused, youth-oriented magazine. The radio call-in program will include HIV/AIDS education and prevention themes developed by PSI staff in conjunction with youth and faith-based partners. It will address topics such as the importance of delaying sex, reducing partners, getting tested for HIV if exposed, cross-generational sex, and will allow youth to call-in with questions and concerns. A qualified radio staff and guests will respond to these questions in a frank and open manner. The youth magazine will mix HIV/AIDS educational articles with popular topics for youth, such as sports, music, and hobbies in a dynamic and interactive manner. Question & Answer columns will allow youth to anonymously ask questions and receive answers, and magazine-based competitions with prizes will encourage youth to read and contribute to the magazine. The proposed mass media interventions will reach 50% of the target audience (youth) and will result in increased numbers of youth reporting abstinence, delayed sex debut, reduced partners, and going for CT services if at risk.

PSI will also develop IEC materials for a mass media and interpersonal communication campaign on Alcohol Awareness and Fidelity which will target married men and couples. These materials will be developed for wide-use among FBOs and CBOs. Main activities will include: baseline research; production and promotion of a radio show via alternate channels (billboards, flyers); produce and distribute newspaper articles; and on-going monitoring and evaluation.

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	1,600	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of A8)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	132	☐

Target Populations:

Adults

Faith-based organizations

Coverage Areas:

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: WR Track 1.0
Prime Partner: World Relief Corporation
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 2790
Planned Funds: [redacted]
Activity Narrative: This Track 1.0 activity is linked to supplemental AB funding in activity #2820.

Since the March 2004 inception of the Mobilizing for Life program, WR reached over 400,000 youth through a combination of activities in over 1,800 churches, 520 schools, 684 clubs and other community settings. In FY2006, WR Rwanda will expand existing skills-based education activities, continue to stimulate broad social discussions on safer sexual norms and behaviors, and introduce interventions that address sexual coercion, exploitation, and cross- generational and transactional sex, especially among adolescent girls. This program will add messaging on alcohol abuse and HIV and will work to raise awareness of GBV through the WR training curriculum, mass media and IEC materials. WR will also disseminate AB prevention materials developed under the CHAMP and promote youth activities and community discussions supported by the CHAMP. WR will focus on reaching the Muslim community and leaders through participation of one mosque in WR activities and sensitization of three mosques to issues related to HIV.

The program will train youth leaders and peer educators to use the field tested Choose Life curriculum (Hitamo Kubaho) to guide 250,000 new youth in churches, mosques, clubs and schools to understand personal risk and to commit to abstinence and/or being faithful. In addition, for 200 most at-risk vulnerable street youth, WR will communicate age-appropriate messages that promote self-protection. The Choose Life curriculum was developed for specific age groups: 8-10, 11-15 and 16-18 year olds. WR will provide training to 400 religious leaders and 480 teachers to improve their capacity to discuss sexual matters with youth. The pastors and Muslim leaders will then train 8,000 parents in their congregations and communities. Parents and community leaders play an invaluable role in encouraging youth to maintain abstinence and to choose healthy behaviors. The project will also develop and air radio spots reinforcing abstinence and fidelity. These messages will be developed in coordination with CHAMP. WR plans to strengthen the capacity of 140 churches to incorporate HIV prevention messages into all church youth activities, such as choir practice and drama groups.

In FY2005, WR program sites were coordinated with district-level authorities and activities began in five provinces: Kibungo, Kigali Ngali, Kigali Ville, Ruhengeri and Umutara. In FY2006, WR will expand to three new provinces: Cyangugu, Gikongoro and Gisenyi. This youth-focused HIV prevention program will support the youth who have already made a commitment to abstinence while encouraging other youth aged 10-24 to personally pledge to protect their lives from the HIV virus and other STIs through abstinence. These efforts to delay youth's sexual debut, promote abstinence and increase mutual faithfulness and partner reduction are in line with the Rwanda EP five-year strategy to expand abstinence programs in secondary schools and to support youth peer education and parent-child counseling through church networks.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	129,000	☐
Number of individuals reached through community outreach that *promotes HIV/AIDS prevention through abstinence (subset of* AB)	62,500	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	640	☐

Target Populations:

Adults

Community leaders

Community-based organizations

Faith-based organizations

Teachers (Parent: Host country government workers)

Volunteers

Children and youth (non-OVC)

Religious leaders

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Gikongoro

Kibungo

Kigali (Rurale)

Kigali-Ville

Umutara (Mutara)

Cyangugu

Gisenyi

Ruhengeri

Table 3.3.02: Activities by Funding Mechanism

Mechanism: HIV/AIDS School Based Program-Procurement
Prime Partner: Population Services International
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 2795
Planned Funds:
Activity Narrative: This activity relates to activities in OP (#4837) and CT (#2796 and #2845).

This activity, part of the Healthy Schools Initiative, builds on school-based prevention activities initiated in FY2005 and consists of three main components. All components promote prevention of HIV among secondary school students and their peers through abstinence and faithfulness. The first component is an interpersonal communication intervention focusing on parent-child dialogue about HIV/AIDS. Parents and primary caretakers of adolescents aged 13-15 will participate in a series of small-group training sessions during which they will learn about and discuss the pressures their children face at school, among peers, within their communities, and away from home. Parents will develop the knowledge and skills necessary to speak confidently to their children about the realities of HIV/AIDS in Rwanda, including the special vulnerability of girls and young women vis-à-vis GBV and transactional and cross-generational sex, and about how they can protect themselves from HIV by practicing abstinence and faithfulness.

The second component consists of small grants, training and TA to anti-AIDS and Gender clubs in secondary schools to promote improved student knowledge of HIV/AIDS, behavioral risk factors and related problems like alcohol and GBV. PSI will provide TA and logistical support to these clubs for the student-led production of multi-media behavior change messages targeting in- and out-of-school youth, emphasizing abstinence and faithfulness, empowerment of girls and young women, and elimination of stigma and discrimination (a key legislative issue). Five hundred (500) student leaders will be trained in peer education skills or outreach methods, including magnet theatre. Peer education networks will be established to facilitate exchange of experiences and lessons learned among peer educators from different schools and regions.

The third and final component involves forming functional linkages with the school-based MVCT campaign (described in activities #2796 and #2845). Secondary school students and teachers will be encouraged to participate in the MVCT campaign, either by 1) being tested, 2) talking to their families and friends about being tested, or 3) assisting with community mobilization and logistics when the MVCT campaign comes to their school.

The populations targeted by this activity are secondary school students (aged 13-18), parents and caretakers of students, teachers and community members. PSI will implement this activity at 35 secondary schools in Kigali city and Gitarama province, reaching a total of 12,000 students with abstinence and faithfulness messages and training a total of 500 peer educators (an average of 15 per school). All interventions will be carried out in collaboration with MINEDUC's Health, Sports and Environment unit. This activity directly supports the Rwanda EP five-year strategy by expanding abstinence programs at secondary schools and increasing availability of CT services outside of health facilities.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	51 - 100
Local Organization Capacity Development	10 - 50
Training	10 - 50
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	12,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	1,200	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	500	☐

Target Populations:

Adults

Teachers (Parent: Host country government workers)

Children and youth (non-OVC)

Secondary school students (Parent: Children and youth (non-OVC))

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Gitarama

Kigali-Ville

Table 3.3.02: Activities by Funding Mechanism

Mechanism: CHAMP
Prime Partner: Community Habitat Finance International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 2807
Planned Funds:
Activity Narrative: This activity relates to other CHAMP activities: PMTCT (#2805), OP (#2808), BHC (#2811), HIV/TB (#5129),OVC (#2810), CT (#2806), ARV services (#2809) and Systems Strengthening (#5183) as well as the AB activities of PSI (#4878) and TCI (#4776).

The CHAMP program will mobilize and support community-based HIV prevention efforts that focus on abstinence and/or fidelity by providing technical and financial assistance to Rwandan CBOs and FBOs. The primary target populations for this activity include: community and religious leaders, youth, families affected by HIV/AIDS, including CHHs, and mobile workers on coffee and tea plantations. Using information gathered through a service gap assessment in FY2005, CHAMP will determine where AB prevention interventions are most needed, especially around EP-assisted health facilities. This activity will collect existing AB materials that are currently in use in Rwanda in order to review, update and coordinate future AB messages. The assembled prevention materials will be stored at the Rwanda Center for Health Communications, a unit within the MOH charged with improving IEC/BCC activities, to be used as a reference and resource for NGOs and GOR health officials working in prevention. CHAMP will also participate in the CNLS' BCC Steering Committee to ensure message cohesion and consistency with the National Prevention Plan and the Rwanda EP five-year strategy.

In coordination with the BCC Steering Committee, the CHAMP team will develop and produce a comprehensive, nation-wide, multi-media campaign that will focus explicitly on abstinence and fidelity. Activities will include a radio distance learning program, a youth-specific radio program, and a community outreach toolkit with IEC materials. For the mass media activities, CHAMP will contract a Rwanda-based advertising agency as a new partner to provide support in developing the AB campaign and IEC materials. Messages in the campaign will include the linkages between alcohol, violence and HIV; stigma reduction; abstinence; fidelity; partner reduction; the vulnerability of young women; the importance of family and knowing your status. The IEC materials will be disseminated through CBO and FBO sub-grantees, private sector businesses, other PEPFAR-funded community activities and USG-assisted health facilities, including those providing ARV/PMTCT/CT services, to strengthen their prevention interventions. CHAMP, through the EP, will also leverage resources from other USG programs, especially the Twubekane Decentralization and Health Project, to integrate HIV/AIDS prevention information into the training curriculum for maternal and RH providers; this ensures that individuals accessing RH and MCH services will also receive HIV prevention information. Through subgrants to Rwandan CBOs and FBOs, CHAMP will support interpersonal prevention activities that aim to increase youth and general population access to prevention services, through youth centers, premarital counseling for couples, anti-AIDS clubs, peer educators, life-skills training for out-of-school youth, school-based HIV prevention education and community discussions.

The AB campaign will pay particular attention to the ability of young women to negotiate sexual encounters with boys or older men. Girls are susceptible to predatory sexual behaviors of older men, as well as rape, domestic violence, child sexual abuse, and sexual harassment at school. Prevention efforts under this activity will focus on changing social acceptance of older men having sex with young girls. CHAMP will develop a set of strategies and role-plays for girls, boys and men that will illustrate the difficulties young women often face in compromising situations and how they can better prepare themselves for such encounters. Another important CHAMP strategy will be to provide training to journalists in HIV prevention and to health providers and community health agents in interpersonal communication and

counseling skills. CHAMP plans to combine communication media by supporting community discussions and town hall meetings which can then be broadcast on local or national radio to reinforce prevention activities taking place at the community level. Journalists trained in HIV prevention through CHAMP will provide additional coverage of the issues discussed by reporting on the meetings in the local media. The messages and tools developed in this AB campaign will greatly increase the effectiveness of efforts by health care providers, private sector businesses, CBOs and faith-based networks to change high-risk behaviors and norms and to promote abstinence before marriage and fidelity in marriage.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50
Human Resources	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	160,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	14,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	635	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
Children and youth (non-OVC)
Caregivers (of OVC and PLWHAs)
Migrants/migrant workers (Parent: Mobile populations)
Religious leaders

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas:

Populated Printable COP

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: WR Supplement
Prime Partner: World Relief Corporation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 2820
Planned Funds:
Activity Narrative: This activity is linked to World Relief's AB Track 1.0 program (#2790).

In FY2005, WR began this program in five provinces (Kibungo, Kigali Ngali, Kigali Ville, Ruhengeri and Umutara), and in FY2006 will expand into three new provinces with Track 1.0 funding (Cyangugu, Gikongoro and Gisenyi). Supplemental ABY funding will allow WR to expand Mobilizing Youth for Life activities to Rwanda's four remaining provinces - Butare, Byumba, Gitarama and Kibuye - ensuring national coverage. The project aims 1) to engage youth in interactive learning to establish standards of sexual protection, 2) to equip influential adults to guide youth in making wise life choices, and 3) to obtain commitments to abstinence before marriage and fidelity in marriage from youth aged 10-24 years old. In FY2006, WR will extend existing skills-based education activities, stimulate social discussions on safer sexual norms and behaviors, and carry out interventions that address sexual coercion, exploitation, cross generational and transactional sex, especially among adolescent girls who may be pressured to have sex with older men. WR will add messages on alcohol abuse and HIV and will raise awareness of GBV through its training curriculum, mass media and IEC materials. WR will also disseminate AB prevention materials developed under CHAMP and promote the youth radio program and community discussions supported by CHAMP. The project will focus greater effort on reaching the Muslim community and leaders through participation of one mosque in WR activities and awareness programs on issues related to HIV at three mosques.

The program will train 200 youth leaders and peer educators to use the Choose Life curriculum (Hitamo Kubaho) to guide 125,000 new youth in churches, mosques, clubs and schools to understand personal risk and to commit to abstinence and/or being faithful. In addition, for those most at-risk vulnerable street youth, WR will develop age appropriate messages that emphasize self protection and make referrals if necessary. The program developed the Choose Life curriculum for three different age groups: 8-10, 11-15 and 16-18 year olds. With the additional funding in FY2006, WR will train 200 religious leaders and 240 teachers in speaking to youth about sexual matters. The religious leaders will in turn reach over 4,000 parents to better equip them to talk to their children about sex and HIV. These influential adults play an invaluable role in encouraging youth to abstain from sex. The project will also develop and air radio spots reinforcing abstinence and fidelity. These messages will be developed in coordination with CHAMP. The project will strengthen the capacity of 70 churches and 4 mosques in order to integrate HIV prevention messages into all faith-based youth activities, such as choir practice and drama groups.

This youth-focused HIV prevention program will continue to support the youth who have already made a commitment to abstinence while encouraging other youth aged 10-24 to personally pledge to protect their lives from the HIV virus and other STIs through abstinence. These efforts to delay the sexual debut of youth, promote abstinence and increase mutual faithfulness and partner reduction are in line with the Rwanda EP five-year strategy of expanding abstinence programs in secondary schools and supporting youth peer education and parent-child counseling through church networks.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	129,500	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	50,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	640	☐

Target Populations:

Adults

Community leaders

Community-based organizations

Faith-based organizations

Teachers (Parent: Host country government workers)

Volunteers

Children and youth (non-OVC)

Religious leaders

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Gitarama

Kibuye

Butare

Byumba

Table 3.3.02: Activities by Funding Mechanism

Mechanism: CDC Country Office GAP/TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 2849
Planned Funds:
Activity Narrative: [CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

CDC will provide short-term technical assistance to the Ministry of Education for the adaption of a parent-child HIV/AIDS communication program (based on the Kenya model) for the expansion of Rwanda's school-based HIV prevention program. This program will be implemented in 30 schools in the FY05 period.

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful		☑
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful		☑

Target Populations:

Adults

Key Legislative Issues

Addressing male norms and behaviors

Coverage Areas:

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: PSI-DOD
Prime Partner: Population Services International
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: *Abstinence and Be Faithful Programs*
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4004
Planned Funds:
Activity Narrative: This activity links to DOD-funded OP (#2803) and CT (#4006) activities.

This activity will encourage soldiers to abstain and be faithful while they are away from their spouses and partners. Prevention of alcohol abuse and the link between alcohol, sexual risk behaviors and gender-based violence will be a focus of the peer education trainings and IEC materials promoting AB. These messages will be delivered as part of PSI's overall mobile CT program. According to a knowledge, attitude and practices (KAP) survey conducted in 2004, 4.3% of 1171 soldiers had abstained from sex during their lifetime. Consequently, PSI/Rwanda sees the importance of promoting AB as a stand-alone campaign with the goal of reducing the number of sexual partners per soldier to zero or one.

PSI/Rwanda and the Directorate of Military Services (DMS) will develop an AB campaign through a subgrant to DMS to train 22 officers and soldiers as TOT who will then train 120 soldiers as peer educators (to include soldiers living with HIV/AIDS). The peer educators and TOT will be trained in ABC prevention that addresses the links between HIV, alcohol and gender-based-violence. The peer educators will promote ABC messages, stressing AB or C to different sub-groups within the RDF based on KAP research and segmentation of the target population (married or single). The peer educators will be trained to encourage married members of the RDF who live far away from their families to practice abstinence (A) while on duty at the same time being faithful (B) to their spouses. Interpersonal and mass media communication strategy shall be employed in order to reach both primary and secondary (spouses and partners of soldiers) target audiences. Peer educators will also be trained to promote the benefits of abstinence, emphasizing the beneficial effects in terms of professional future and moral and cultural values.

This program will reach about 10,000 members of the RDF with risk-reducing messages promoting AB, prevention of alcohol abuse and gender-based violence and discouraging serial monogamy. Serial monogamy is the successive change of sexual partners that one has been loyal to for a given period of time but inevitably leaves him/her due to change of location or attitude. In the case of soldiers, this is widely influenced by change of deployments. PSI will develop IEC materials promoting AB (some of these will be developed by soldiers themselves e.g. through inter-brigade AB drama competitions). These activities support the Rwanda EP five-year strategy by developing the capacity of Rwandan individuals and institutions. Focusing prevention efforts at the military is a key strategy of both the EP and the Rwandan government. By 2008, the EP will reach all military personnel with prevention messages.

Emphasis Areas	% Of Effort
Information, Education and Communication	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	10,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	142	☐

Target Populations:

Military personnel (Parent: Most at risk populations)

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Increasing women's legal rights

Coverage Areas

Byumba

Gikongoro

Gitarama

Kigali (Rurale)

Kigali-Ville

Table 3.3.02: Activities by Funding Mechanism

Mechanism: Transport Corridor Initiative
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4776
Planned Funds:
Activity Narrative: This activity relates to the TCI activities under OP (#4777) and CT (#4778).

The overall goal of the multi-sectoral TCI is to stem HIV transmission and mitigate the consequences of HIV/ AIDS on vulnerable people along major East African transport corridors. This project will target high-risk mobile populations (long distance truck drivers and their assistants, CSWs, members of the uniformed services and stop-over site communities) with regionally coordinated messages and new or improved services tailored to meet their needs. The TCI works in Kenya, Uganda, Djibouti, and the Southern Sudan, and in 2005 initiated activities in Rwanda, Burundi and the DRC.

In Rwanda in 2006, the TCI will implement its regionally branded "SafeTStop" package of interventions in Kigali-ville and in two border sites: Gatuna on the Uganda/Rwanda border and Cyangugu on the DRC/Rwanda border. TCI will train local service providers and community organizations in these three sites to integrate and deliver HIV prevention messages on alcohol awareness, fidelity, and partner reduction to mobile populations. These Be Faithful messages will be integrated into the overall SafeTStop package which will include: basic health services, CT, syndromic STI diagnosis and treatment, condom awareness, and alternative recreational activities (sports, faith services, satellite TV, fitness centers, men's discussion groups, adult education). This project will link and make referrals to OVC and PLWHA services in the communities around the three sites. They will also work with the World Relief Microfinance project (#5118) in Byumba and Cyangugu to link interested women with IGA.

Partners will include the local Truckers Association and The Association of Wives of Truckers. Through subgrants these new partners will disseminate AB messages among their members and in their communities. The TCI will build the capacity of these local institutions by providing TA for financial and project management. In total the TCI will reach at least 5,500 high-risk persons with AB prevention messages. These targets will be recorded under Other Prevention (#4777) since an ABC approach will be applied with this high-risk population. This activity supports Rwanda's National Prevention Plan and the Rwanda EP five-year strategy by aggressively targeting high-risk populations with prevention messages.

Emphasis Areas	% Of Effort
Information, Education and Communication	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that *promotes HIV/AIDS prevention through abstinence and/or being* faithful		☑
Number of individuals reached through community outreach that *promotes HIV/AIDS prevention through abstinence (subset of* AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	150	☐

Target Populations:

Commercial sex workers (Parent: Most at risk populations)

Street youth (Parent: Most at risk populations)

Mobile populations (Parent: Most at risk populations)

Truck drivers (Parent: Mobile populations)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Increasing women's access to income and productive resources

Stigma and discrimination

Coverage Areas

Byumba

Cyangugu

Kigali-Ville

Table 3.3.02: Activities by Funding Mechanism

Mechanism:	Refugees - Rwanda
Prime Partner:	American Refugee Committee
USG Agency:	Department of State
Funding Source:	GAC (GHAI account)
Program Area:	*Abstinence and Be Faithful Programs*
Budget Code:	HVAB
Program Area Code:	02
Activity ID:	4864
Planned Funds:	
Activity Narrative:	This activity relates to activities CT (#4867), PMTCT (#4748), and Palliative care/basic health care and support (#4865). Rwanda continues to host substantial numbers of refugees. ARC provides support to about 20,000 refugees in Gihembe (15,000) and Nyabiheke (5,000) refugee camps in Byumba Province. ARC will work with the refugee committee, refugee youth clubs, women's groups, and other local groups to promote abstinence and/or fidelity messages in both camps, to reach a total of 11,000 refugees, including 4,500 with abstinence only messages. Activities will target in and out-of-school refugee youth, men, and vulnerable women of reproductive age. To ensure AB message cohesion and consistency with the GOR National Prevention Plan and with the HIV/AIDS Communication TWG, the partner will access AB prevention materials that are available at the MOH's Communication Unit for by all NGOs and government health officials working in prevention, and adapt them as necessary to the refugee context. ARC will train peer educators using locally developed abstinence and fidelity materials adapted for the refugee context, including a community-outreach toolkit. ARC will also develop video programs for youth and will support interpersonal prevention activities that aim to increase youth access to prevention services, such as anti-AIDS clubs for refugee youth, life-skills training for out-of-school youth, school-based HIV prevention education, and community discussions. Messages delivered will focus on abstinence and fidelity, but will also include topics on the relationship between alcohol, violence and HIV, particularly targeting men in refugee camps, 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 also focus on changing social acceptance of cross-generational and transactional sex. ARC will use the set of GBV strategies and role-plays developed by FHI/REDSO and the CSP for girls and for boys and men. Key influential community members such as traditional and religious leaders and refugee camp leaders will also reinforce the messages of abstinence, delay of sex, faithfulness, reduction of gender based violence and alcohol reduction.

B5

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	11,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	4,500	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	50	☐

Target Populations:

Adults

Community leaders

Mobile populations (Parent: Most at risk populations)

Refugees/internally displaced persons (Parent: Mobile populations)

Orphans and vulnerable children

Children and youth (non-OVC)

Girls (Parent: Children and youth (non-OVC))

Boys (Parent: Children and youth (non-OVC))

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

University students (Parent: Children and youth (non-OVC))

Men (including men of reproductive age) (Parent: Adults)

Widows/widowers

Religious leaders

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Byumba

Table 3.3.02: Activities by Funding Mechanism

Mechanism:	PSI Bilateral
Prime Partner:	Population Services International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Abstinence and Be Faithful Programs
Budget Code:	HVAB
Program Area Code:	*02*
Activity ID:	4878
Planned Funds:	
Activity Narrative:	This activity relates to PSI's CT (#4880) and OP (#4877) activities. PSI will engage in direct BCC activities that promote Abstinence and Fidelity and discourage alcohol abuse and GBV through its mobile CT program. This activity will address key behavioral issues among high-risk populations through print materials, mobile video screenings, and interpersonal communications. Through mobile CT events and local Rwandan subgrantees, this activity will disseminate ABC messages that focus on abstinence and fidelity to high-risk populations – prisoners, police, mobile populations and CSWs. This program supports the Rwanda EP five-year strategy by implementing an aggressive prevention education campaign aimed at prisoners. Rwanda continues to release thousands of prisoners whose HIV status is unknown. While the HIV prevalence rate in prisons remains unknown, the GOR expressed concern that it is higher than among the general population. PSI will continue serving on the CNLS-led Prisoners Steering Committee to ensure that the proper protocols and procedures are followed in the prisons. PSI will reproduce IEC materials developed in their FY2005 Alcohol Awareness and Fidelity campaign and revise their counselor training curriculum to include appropriate HIV prevention messages on abstinence and being faithful, as well as the links between alcohol use, violence and HIV. The program will train 10 counselors with this revised curriculum. In addition to the PSI-developed IEC materials, this activity will distribute and use AB brochures and tools developed through CHAMP. These IEC materials will be disseminated during outreach mobile CT as well as through Rwandan CBOs such as SWAA, that will be promoting CT and creating post-test clubs. Post-test clubs will be established at the community level to follow-up on referrals, provide care and support to clients who test HIV positive, and to promote behavior change and prevention (AB) among both HIV positive and negative clients. Gender-specific approaches will be integrated into CT promotion, IEC materials, and post-test clubs. All messages and materials will be developed in partnership with CNLS' BCC Steering Committee, TRAC and CHAMP for central-level coordination. In FY2006, PSI plans to reach 20,000 high-risk individuals with ABC messages; these targets appear under Other Prevention, Activity #4877.

Emphasis Areas	**% Of Effort**
Information, Education and Communication	51 - 100
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful		☑
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful		☑

Target Populations:

Adults

Commercial sex workers (Parent: Most at risk populations)

People living with HIV/AIDS

Prisoners (Parent: Most at risk populations)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas:

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: USAID Rwanda Mission
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4967
Planned Funds:
Activity Narrative: USAID/Rwanda has been providing local and international technical assistance to GOR agencies and limited direct grants to local NGOs since COP04. In COP06, the Emergency Plan will expand this to further build local capacity. These resources will cover the cost of sponsoring conferences, workshops and technical meetings on HIV prevention. A number of Rwanda NGOs, such as SWAA and RRP+, requested financial assistance from USAID in FY2005 for such activities. USAID anticipates continuing this financial and technical support role in FY2006. The MOH is requesting technical assistance for the new Rwanda Center for Health Communications (RCHC), a unit within the MOH charged with improving IEC/BCC activities. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS and MIGEPROF.

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Local Organization Capacity Development	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful		☑
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful		☑

Target Populations:

Community-based organizations

Faith-based organizations

Host country government workers

Coverage Areas:

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: CRS Track 1
Prime Partner: Catholic Relief Services
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 5233
Planned Funds:

B5

Activity Narrative: CRS, in collaboration with its main partner Caritas (Butare Diocese), will implement HIV/AIDS AB education and prevention activities focusing on abstinence, secondary abstinence and fidelity in marriage. The prevention activities in this program will relate to and be integrated into CRS's other Track 1.0 programs for OVC and ART. In addition, HIV prevention activities will also be coordinated with and linked to existing CRS programs for the promotion of good governance through the Justice and Peace Program and various nutritional support organizations including CBOs and through the Title II agro-business enterprise. CRS will work with the GOR, the Catholic church, USG supported groups, and through established community based groups like Parent-Teacher Associations to implement the below activities.

The Catholic Church is a major partner and investor in Rwanda's overall educational system. CRS will draw from its longstanding relationship with the Catholic church to build the capacity of Catholic schools and church institutions to facilitate skills learning and the transfer and communication of AB HIV/AIDS education. School teachers, clergy, peer educators, parents, and young adults from secondary schools and the University of Butare will be trained on an already-proven AB HIV/AIDS curriculum. These trainers will then reach out with life skills-building sessions to train five of their peers, reaching over 20,000 youth and young adults by the end of the first year. CRS will work in close collaboration with other NGOs, USG partners and the CNLS's BCC Steering Committee to ensure that consistent and quality AB messages are being delivered by all implementing partners.

CRS will work closely with its partners to coordinate and integrate activities with other diocesan departments, including the Department of Pastoral and Family Life and the Education Department, to focus on challenging unhealthy sexual behaviors such as cross-generational sex and sexual exploitation of youth. CRS will use existing best practices to lead discussions and actions to encourage risk-reducing behavior and to provide referrals to appropriate HIV/AIDS services such as VCT whenever necessary. In addition, CRS will partner with local FBOs and CBOs in a campaign to challenge social norms, attitudes, values and behaviors that increase one's vulnerability to HIV. CRS will use mass media, such as Radio Maria and a catholic newspaper to deliver the AB message and reach the larger population with challenges to change unhealthy practices. CRS will draw from other countries' experiences in using mass media and will work in close collaboration with World Relief, PSI, and CHAMP to make sure the AB messages are consistent. These activities support Rwanda's National Prevention Plan and Rwanda EP five-year strategy of using religious networks and church-based mass media campaigns to address HIV risk.

Emphasis Areas	% Of Effort
Information, Education and Communication	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	22,820	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	0	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	806	☐

Target Populations:

Adults

Community-based organizations

Faith-based organizations

Orphans and vulnerable children

Teachers (Parent: Host country government workers)

Volunteers

Children and youth (non-OVC)

Caregivers (of OVC and PLWHAs)

Religious leaders

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Butare

Table 3.3.03: Program Planning Overview

Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03

Total Planned Funding for Program Area:

Program Area Context:

The EP supports the CNTS through direct funding and through TA provided by Sanquin Diagnostic Services. The EP goal is to prevent HIV infections and improve blood transfusion safety by improving the infrastructure of the blood transfusion network, while simultaneously increasing donations, coverage, and QA.

EP activities in FY2004 and FY2005 focused on addressing the most urgent blood safety needs, such as equipment and commodity procurement and the basic physical infrastructure of Rwanda's blood transfusion network. Construction and renovation of Blood Transfusion Centers and the initial provision of equipment and supplies have been completed. Stock-outs of critical supplies and screening reagents, once fairly common in Rwanda, are no longer occurring. The number of blood units collected and screened nationally has increased from roughly 29,000 in 2004 to an estimated 36,000 units by the end of calendar year 2005.

The CNTS has faced challenges in its implementation of EP activities. Procurement of vehicles was delayed more than 10 months due to mid-year changes in the GOR policy on official and project vehicles. Activities dependent upon vehicles for travel outside of Kigali, such as donor recruitment and provider training at district hospitals, have been most seriously impacted by the lack of vehicles. CNTS recently requested, and expects to receive, an exemption from the new vehicle policy for the purchase of four new vehicles. In FY2006, training and donor recruitment activities are expected to expand as planned.

The provision and coordination of TA for blood safety activities has been challenging. Rwanda's Track 1.0 TA provider, Sanquin Diagnostic Services, is one of the few EP partners without a permanent in-country presence, and its consultants are spread thin across several countries. In FY2006, the EP will develop a more focused approach to provision of TA for blood safety, with visits planned well in advance and clear scopes of work developed. CNTS will receive additional TA from regional WHO consultants on key activities in 2005 and 2006, including the implementation of QA systems for all aspects of blood transfusion services.

With many of the infrastructure- and capacity-building activities well underway by the end of FY2005, FY2006 blood safety activities will focus on institutionalizing quality provision of transfusion services through intensive training of providers and through implementation of internal and external quality control measures.

Program Area Target:

Number of service outlets/programs carrying out blood safety activities	40
Number of individuals trained in blood safety	170

Table 3.3.03: Activities by Funding Mechanism

Mechanism: Strengthening Blood Transfusion Services
Prime Partner: National Program for Blood Transfusion, Rwanda
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: N/A
Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03
Activity ID: 2786
Planned Funds:
Activity Narrative: This activity relates to activity 2829 (Sanquin Diagnostics, Blood Safety). The CNTS will continue activities in FY 2006 to strengthen the national blood transfusion network through ongoing procurement of needed supplies and equipment, continued monitoring, supervision and training activities, and focused efforts on assuring the quality of all aspects of transfusion-related services.

Procurement of supplies and equipment is a major emphasis area in FY 2006, with materials purchased to support blood collection, transport, screening, processing and storage in 40 service outlets carrying out blood safety activities. In order to increase the overall blood supply nationally, 15 new blood collection sites will be established in FY 2006, and 90 new volunteers will be recruited and trained to conduct community mobilization and to organize blood collection drives in both new and existing collection sites. The data management system established at the central level in Kigali in 2005 will be expanded in FY 2006 to Ruhengeri and Butare and will improve data collection for reporting and for managing both supplies and blood donor information.

In FY 2006, EP funds will continue to support the CNTS to carry out its core functions of training, monitoring and supervision of all transfusion-related activities in Rwanda. This will include the training and retraining of health professionals involved in blood transfusion activities, with targets of 20 CNTS staff trained and 60 district hospital staff trained in three training zones, Kigali, Butare, and Ruhengeri. QA systems begun in FY 2005 will be enhanced in FY2006 and will cover procedures for collection, analysis, and distribution of blood and blood products. TA for these quality-related activities will be provided by WHO and Sanquin Diagnostic Services. Particular emphasis will be placed on establishing national and external quality control measures for blood screening and grouping laboratory analyses.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets/programs carrying out blood safety activities	40	☐
Number of individuals trained in blood safety	170	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Laboratory workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.03: Activities by Funding Mechanism

Mechanism: Blood Safety Technical Assistance
Prime Partner: Sanquin Diagnostic Services
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: N/A
Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03
Activity ID: 2829
Planned Funds:
Activity Narrative: This activity relates to activity 2786 (Strengthening Blood Transfusion Services / National Program for Blood Transfusion, Blood Safety).
Sanquin Diagnostic Services provides TA through a Track 1 award to support the rapid strengthening of blood transfusion services in Rwanda. In FY2006, Sanquin will provide focused TA for waste management, QA, and general training activities for blood transfusion services.

In collaboration with the CNTS, Sanquin will develop and implement a biological waste management policy specific to blood transfusion services. This activity will include development of technical guidelines, procedures, and support for training in waste management.

In collaboration with CNTS and WHO technicians, Sanquin will provide TA for the implementation of a QA system that encompasses blood processing, screening, grouping, and transfusion activities. Particular emphasis will be placed on establishing national and external quality control measures for laboratory analyses for blood screening and grouping by the end of FY 2006.

Sanquin will support CNTS training activities for central-level staff and for hospital personnel involved in blood transfusion by providing timely feedback and technical guidance on training materials and curricula as they are developed in Rwanda. Sanquin staff may also participate as trainers for some of these activities.

Emphasis Areas	% Of Effort
Local Organization Capacity Development	51 - 100
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets/programs carrying out blood safety activities		☑
Number of individuals trained in blood safety		☑

Target Populations:

Doctors (Parent: Public health care workers)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.04: Program Planning Overview

Program Area: Medical Transmission/Injection Safety
Budget Code: HMIN
Program Area Code: 04

Total Planned Funding for Program Area:

Program Area Context:

EP safe injection activities aim to reduce the burden of HIV transmission due to unsafe or unnecessary medical injections and contact with infectious medical waste. With EP assistance, Rwanda is implementing a three-step strategy recommended by WHO and the Safe Injection Global Network. The EP works closely with the MOH, Ministry of Environment and other multilateral partners to 1) establish and revise national policies and guidelines, 2) procure materials for safe injections and 3) implement improved medical practices throughout the health care system.

In the first two years of this program, a comprehensive assistance package for improving medical injection safety and medical waste management was piloted in two health districts and subsequently expanded to 10 additional districts. The package includes procurement of safe injection equipment and comprehensive training for all levels of medical providers. FY2006 activities will include the expansion of provider training and the provision of injection safety supplies to a total of 23 health districts, in accordance with the strategy of full national coverage for injection safety activities. In FY2006, the implementation of EP injection safety activities in selected districts will be coordinated with the waste management and infection control components of the WB MAP program, ensuring the most efficient use of resources available for injection safety.

Program Area Target:

Number of individuals trained in injection safety	5,428

Table 3.3.04: Activities by Funding Mechanism

Mechanism:	Safe Injection
Prime Partner:	John Snow, Inc.
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	N/A
Program Area:	*Medical Transmission/Injection Safety*
Budget Code:	HMIN
Program Area Code:	04
Activity ID:	2804
Planned Funds:	
Activity Narrative:	Through FY2005, the primary focus of JSI's Making Medical Injections Safer project has been the development of much-needed policy and guideline documents, training curricula and the limited scale piloting of safe injection technologies and medical waste management systems. Through the substantial increase in EP FY 2006 funding, and through the synergies developed with the WB MAP project's waste management and infection control components, FY 2006 will see major scale-up of injection safety activities. Training in safe medical practices, including universal precautions, safe injection, and medical waste management, will be conducted for 58 "provincial" level trainers, who in turn will train 4,200 health workers and 1,050 medical waste handlers in 21 districts. Additionally, 28 nursing school instructors will be trained in injection safety, medical waste management and BCC. Commodity procurement and management activities will increase in FY 2006. Ninety-two supply managers will be trained in supply management of safe injection materials, including the use of newly developed logistics management tools. Injection commodities will be procured for 23 districts in FY 2006. In FY 2006, JSI will assist the GOR in implementing the national behavior change strategy to reduce unnecessary injections. This activity will produce and use new BCC materials on injection safety and medical waste management. Through a series of one-day sessions, 4,500 lay health workers will be reached with BCC messages to help reduce demand for injections. These interventions will support the national behavior change strategy to reduce unnecessary injections.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Logistics	10 - 50
Policy and Guidelines	10 - 50
Training	51 - 100

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals trained in injection safety	5,428	☐

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
Policy makers (Parent: Host country government workers)
Teachers (Parent: Host country government workers)
Laboratory workers (Parent: Public health care workers)
Doctors (Parent: Private health care workers)
Nurses (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.05: Program Planning Overview

Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05

Total Planned Funding for Program Area:

Program Area Context:

To appropriately address the needs of the most at-risk populations affected by the HIV/AIDS epidemic in Rwanda, EP assistance will apply an ABC approach which focuses on abstinence and fidelity coupled with information on correct and consistent condom use in an age-appropriate manner. As of March 31, 2005, the EP had reached 37,221 individuals directly with face-to-face ABC messages. The high-risk populations targeted in FY2005 included CSWs, refugees, military, police, and older youth. In FY2006, the ABC focus will expand to include migrant workers on tea and coffee plantations, prisoners, discordant couples, and mobile populations along the major transport corridors. The Transport Corridor Initiative will specifically target long-distance truck drivers, CSWs, members of the uniformed services and stop-over site communities with regionally coordinated "SafeTStop" messages and CT services linked to care and treatment.

All interventions will focus on eliminating and reducing risky behaviors. Abstinence will be communicated as the only 100% effective method for eliminating contraction of HIV. Abstinence will be complemented by messages reinforcing the benefits of faithfulness and partner reduction. The EP will increase the target population's knowledge of and access to condoms through interpersonal counseling, condom demonstrations, mobile video screenings and an increased number of condom outlets. Condom messages will stress correct and consistent condom use. The prevention messages will be delivered during mobile CT pre- and post-test counseling sessions which will link individuals testing positive to HIV treatment and care services. CHAMP will mobilize CBO and FBO groups to disseminate ABC messages through community discussions, workplace interventions, youth centers, radio spots, peer education and community palliative care volunteers. These community activities will also address alcohol, GBV and HIV transmission in a gender-sensitive manner. Additionally, EP will support a Kigali CSW STI treatment program while adding a new program element of connecting CSWs to microfinance activities to offer CSW alternative means of income.

Rwanda faced an emergency condom shortage in late FY2005 to which USAID quickly responded by securing 10 million condoms using non-PEPFAR funds. To avoid future condom stock-outs, the EP will procure 8 million condoms which will be distributed through PSI's existing network of points-of-sale and newly identified areas of high transmission. This activity will be combined with targeted social marketing to high-risk segments of the population. Using data collected through the PLACE Study (2005) and the NCAS (2005), the EP will focus on zones with the highest rates of risky behaviors and establish high-risk condom outlets around bars, hotels, prisons, police academies, and CSW zones. There will be a major increase in the number of EP-supported condom service outlets from zero in FY2005 to 253 outlets by the end of FY2006. The EP will work with other donors such as KfW to ensure a pipeline of condoms and the resources needed to market them.

This targeted ABC approach for the delivery of prevention messages to high-risk populations conforms to both the Rwanda EP five-year strategy and OGAC's Guidance on Applying the ABC Approach.

Program Area Target:

Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	75,500
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	517
Number of targeted condom service outlets	253

Table 3.3.05: Activities by Funding Mechanism

Mechanism: IMPACT
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 2764
Planned Funds:
Activity Narrative: [Continuing Activity from FY2005 -- with Additional FY2006 Funding under the new TCI mechanism]

Safe T Stop concept and northern Transport Corridor: Rwanda will participate with other regional countries in a project to provide intensive information and education campaign along regional transport corridors. This program will target hig-risk mobile populations with prevention activities and services while identifying vulnerable PLWHA and PABA for community-based support in key corridor sites. A dual approach to reaching target populations includes: men reached in worksites and stop-over towns and women reached in stop-over border towns. Peer education is a core strategy. STD services will be promoted and referrals to other HIV services. These activities will include food/nutrition support, policy change, education , etc. This program is coordinated with other countries along the transport corridor.

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	500	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful		☑
Number of targeted condom service outlets		☑

Target Populations:

Commercial sex workers (Parent: Most at risk populations)
Most at risk populations
Mobile populations (Parent: Most at risk populations)
Truck drivers (Parent: Mobile populations)
People living with HIV/AIDS

Table 3.3.05: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Population Services International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 2781
Planned Funds:
Activity Narrative: [Continuing Activity from FY2005 -- with No New Funding under this mechanism in FY2006]

There are two distinct target populations that fall under this program area; Rwandan Local Defense Forces (LDF) and the National Police and Commercial Sex workers. The objective of this program is to increase awareness and knowledge about HIV/AIDS prevention practices among high risk groups, primarily law enforcement and secondarily, the high risk groups that law enforcement officers have frequent contact with, namely CSWs. Law enforcement and CSWs are both high risk groups that interact frequently. Law enforcement officers and CSWs can be key allies in reducing high risk sexual behavior if groups receive appropriate education and useful information about effective means of reducing infection. The program aims to achieve this objective through several different activities, specifically: peer education training using law enforcement and CSWs. Law enforcement can be critical means of providing information to CSWs. Materials will be tested through target audience focus groups, PSI proposes to work in close collaboration with the CNLS and the Message Approval Committee (CAM).

In FY05, working with the Rwandan Local Defense Forces (LDF) and the National Police, the program will increase awareness of and knowledge about HIV/AIDS prevention practices, and to increase access to HIV/AIDS prevention services, such as counseling and testing and condom use, among active members. To assist with program coordination, USG will design and implement all activities in partnership with: the National AIDS Commission (CNLS), Ministry of Defense (Directorate of Medical Services—DMS), Ministry of Internal Security, Ministry of Internal Affairs, and Ministry of Local Administration. Initial discussions have already taken place with the CNLS and the National Police, resulting in their input in suggested activities.

To ensure the sustainability of HIV/AIDS prevention programs among the LDF and the national police, trained peer education trainers will train 3000 LDF (2 per sector) and 500 police peer educators to conduct outreach sessions among their peers. Peer educators will be provided with training in communication techniques, HIV and STD prevention and treatment information, and key behavioral themes among the target groups. USG will furnish IEC materials for use during peer education activities. Sessions will be monitored for quality assurance by participant pre/post-evaluations, supervisory visits, regular refresher courses, and monthly/quarterly reporting. This initiative will serve to reach 75% of the total of both active LDF and police.
To facilitate peer educators, interpersonal communications materials will be designed and produced. Key themes will be personal risk perception and HIV/AIDS prevention awareness, with an emphasis on CT and the availability of care and support options. Specific risk taking behaviors such as alcohol use and paying for sex with prostitutes will also be included. Specifically, the IEC materials will be a flipchart, picture codes, and role plays for use during outreach sessions conducted by peer educators. Mobile video units will show spots produced displaying short-films targeting the two audiences, which will be produced by PSI and the collaborating partners to be shown during outreach sessions. Posters will be produced for distribution among units, and targeted radio spots will be produced and aired on national radio stations. IPC and mid level media materials will reach 90% of the target populations.

Peer educators will also be trained as condom community-based distribution agents to increase condom accessibility in and around LDF and police deployment areas and in areas of sex trade. They will be trained in sales communications techniques, stock management, and financial reporting. A condom stock management system will be put in place to regularly monitor condom availability among the LDF and police

organizations, to avoid stock-outs or non-availability among certain units/areas. A total of 500,000 condoms will be distributed through the peer educators and the national organizations during the project period.

CSWs will be referred to STI clinics for CT and STI treatment. IEC will be distributed in collaboration with the STI clinics.

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful		☑
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful		☑
Number of targeted condom service outlets		☑

Target Populations:

Military personnel (Parent: Most at risk populations)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: PSI-DOD
Prime Partner: Population Services International
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 2803
Planned Funds:
Activity Narrative: This activity is linked to the other DOD-funded Mobile CT activities under AB (#4004) and CT (#4006).

PSI/Rwanda and the DMS will work together to promote ABC messages among members of the RDF. While many soldiers practice sexual abstinence and fidelity, their living situation, mobility and age make them vulnerable to HIV. The Rwanda EP five-year strategy highlights the military as a high-risk group. The majority of RDF soldiers are single, hence susceptible to having multiple partners. A KAP survey conducted by PSI/Rwanda in 2004 (in Gitarama, Butare and Kigali-rural brigades) indicated that out of 1,171 soldiers, 60% were single and young, 90% were aged between 20 and 34. For married soldiers, the distance from their families and spouses can make it difficult to maintain stable relationships. DMS distributes a minimum of 1,000,000 condoms to soldiers annually.

This activity will address the stigma associated with condom use and will promote correct and consistent condom use among the military. PSI will develop a short movie demonstrating correct condom use, discussing the stigma of acquiring condoms (in military and non-military settings), promoting condom negotiation skills with partners, and demonstrating how alcohol use can lead to negative consequences. This program will also develop IEC materials that promote condom use by demonstrating and outlining all reasons for using condoms with regular and non-regular partners. These IEC materials will be developed in partnership with the DMS and the CNLS' BCC Steering Committee.

During military mobile CT events (both inside and around military camps), the implementer will present educational films and then lead open discussions on the barriers and solutions to condom use, using a Q&A approach, condom demonstrations, competitions, role-plays and sketches specific to the military. In FY2006, this program will reach at least 10,000 members of the RDF with ABC messages, including condom use and prevention of alcohol abuse and GBV. The program will train 120 peer educators and 22 TOTs. The program will select lower-level military leaders as TOTs, starting with section commanders, with the aim of promoting "condom preparedness" during parades and briefing moments. These activities support the Rwanda EP five-year strategy of preventing transmission among high-risk groups. Focusing prevention efforts on the military is a key strategy of both the EP and GOR. By 2008, the EP aims to reach all military personnel with prevention messages.

Emphasis Areas	% Of Effort
Information, Education and Communication	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	10,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	142	☐
Number of targeted condom service outlets		☑

Target Populations:

Military personnel (Parent: Most at risk populations)

Key Legislative Issues

Reducing violence and coercion

Addressing male norms and behaviors

Stigma and discrimination

Coverage Areas

Byumba

Gikongoro

Gitarama

Kigali (Rurale)

Kigali-Ville

Table 3.3.05: Activities by Funding Mechanism

Mechanism: CHAMP
Prime Partner: Community Habitat Finance International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 2808
Planned Funds:
Activity Narrative: This activity relates to the other CHAMP activities: PMTCT (#2805), AB (#2807), BHC (#2811), HIV/TB (#5129), OVC (#2810), CT (#2806), ARV Services (#2809) and Systems Strengthening (#5183) as well as the OP activities under TCI (#4777), FHI (#4765) and PSI (#4877).

With COP06 Other Prevention funding, CHAMP will target high-risk populations with ABC messages. The program will provide grants to new EP Rwandan partner organizations involved in HIV prevention (peer education, community discussions, youth centers). Grantees will disseminate ABC messages targeting migrant workers, discordant couples, HIV-positive individuals, and older CHHs. Grantees may include PLWHA associations, private-sector tea and coffee plantations, and FBOs implementing OVC and PLWHA activities. These messages will include information on abstinence, fidelity, condom awareness and use, partner reduction, alcohol abuse and violence, prevention for positives, and young women's vulnerability. ABC information will be disseminated through community discussions, workplace interventions, youth centers, pre- and post-test counseling, radio spots, peer education and community care volunteers. CHAMP will tailor IEC materials and messages for unmarried and married men, women and youth above age 14. All messages will be developed in collaboration with CNLS' BCC Steering Committee and follow the National Prevention Plan. Other high-risk populations (CSWs, prisoners, police, military, refugees and mobile populations) will be targeted with ABC prevention messages through the TCI, FHI's CSWs Project and PSI's Mobile CT Program. CHAMP will work closely with these other programs to share IEC materials and coordinate ABC prevention activities across Rwanda. For example, CHAMP will promote the existing Prudence Plus brand of condoms which PSI will be marketing and distributing in high-prevalent zones.

CHAMP will also use Other Prevention resources to train health animators, HBC volunteers, case managers, social workers, PLWHA and OVC caregivers, and health care providers in ABC prevention, interpersonal communication, and counseling in order to improve the delivery and content of HIV prevention education. These efforts address key legislative issues related to gender and support the Rwanda EP five-year strategy to target high-risk populations.

Emphasis Areas	% Of Effort
Information, Education and Communication	10 - 50
Local Organization Capacity Development	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	40,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	215	☐
Number of targeted condom service outlets		☑

Target Populations:

Business community/private sector

Discordant couples (Parent: Most at risk populations)

Street youth (Parent: Most at risk populations)

HIV/AIDS-affected families

Non-governmental organizations/private voluntary organizations

Orphans and vulnerable children

People living with HIV/AIDS

Volunteers

Caregivers (of OVC and PLWHAs)

Migrants/migrant workers (Parent: Mobile populations)

Out-of-school youth (Parent: Most at risk populations)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Stigma and discrimination

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: FHI Bridge
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 4765
Planned Funds:
Activity Narrative: This activity is linked to FHI's CT activity (#4769) and PSI's condom distribution activity (#4877).

This project will focus on HIV prevention, CT, and STI screening and syndromic management for CSW in Kigali. FHI will continue this successful intervention which began under COP05 at the Biryogo HC. The project aims to improve CSWs' knowledge of how to prevent STIs and HIV/AIDS. FHI will expand outreach efforts, CT, clinical care, STI screening and treatment services to CSWs in Kigali. An FBO formed by current and former CSWs will continue outreach efforts to refer CSWs and their clients to the clinic for these services. CSWs and their clients receive both pre- and post-test counseling which includes ABC prevention information. For individuals testing HIV positive, Biryogo HC offers CD4 and ART services and referrals to community HIV care programs.

A new element to the program will involve connecting CSWs to local microfinance activities (both USG-funded and non-USG funded), in order to offer CSWs alternative means of income. This program will work with PSI to ensure condom availability at the Biryogo clinic as well as information for CSWs on other points-of-sale for condoms in the area. The information gathered from this project will contribute to the development of national guidelines on HIV prevention and STI screening and treatment. FHI will follow the National STI Protocol developed in 2002. This activity anticipates reaching at least 100 known CSWs and many more women who will not identify themselves as CSWs, although they engage in transactional sex. This project did not set a target for the number of men reached, acknowledging that men will not identify themselves as clients of CSWs. FHI will combine ABC prevention education, quality CT ensuring confidentiality and informed consent and STI services to reduce risky behaviors among CSW and their clients. This activity supports the Rwanda EP five-year strategy and the National Prevention Plan by targeting high-risk populations.

Emphasis Areas	*% Of Effort*
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	100	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	0	☐
Number of targeted condom service outlets	1	☐

Target Populations:

Commercial sex workers (Parent: Most at risk populations)

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Partners/clients of CSW (Parent: Most at risk populations)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Increasing women's access to income and productive resources

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Kigali-Ville

Table 3.3.05: Activities by Funding Mechanism

Mechanism: Transport Corridor Initiative
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 4777
Planned Funds:
Activity Narrative: This activity relates to TCI activities AB (#4776) and CT (#4778) and HBC activities under CHAMP (#2811) and World Relief (#5118).

The overall goal of the multi-sectoral TCI is to stem HIV transmission and mitigate the consequences of HIV/ AIDS on vulnerable people along major East African transport corridors. This project will target high-risk mobile populations - drivers and their assistants, prostitutes, members of the uniformed services and stop-over site communities - with regionally coordinated messages and new or improved services tailored to meet their needs. The TCI works in Kenya, Uganda, Djibouti, and the Southern Sudan and, in 2005, initiated activities in Rwanda, Burundi and the DRC.

In Rwanda in 2006, the TCI will implement its regionally-branded "SafeTStop" package of interventions in Kigali-ville and in two border sites - Gatuna on the Uganda/Rwanda border and Cyangugu on the DRC/Rwanda border. TCI will assist local health providers and community organizations to integrate HIV prevention messages for high-risk populations into community and health services. The TCI will encourage local institutions to reach out to the most at risk populations (e.g. by expanding CT hours, by inviting truckers to religious services) and to coordinate and collaborate their efforts. The TCI will provide ABC prevention messages on abstinence, fidelity, partner reduction, condom use, and the links between alcohol, violence and HIV to mobile populations. Other TCI prevention interventions include basic health services; marketing and distribution of condoms; CT, syndromic STI diagnosis and treatment; and alternative recreational activities (sports, faith services, satellite TV, fitness centers, men's discussion groups, adult education). This project makes referrals to the CHAMP to provide community care services to PLWHAs and their families. The TCI also refers individuals in Cyangugu and Byumba to the World Relief-supported Microfinance Project.

New partners will include the local Truckers Association and Truckers Wives Association. The TCI will build the capacity of these local institutions through subagreements and TA to manage "SafeTStop" and "other prevention" activities. In total for the three sites, TCI will train at least 150 community members in prevention interventions, provide support for three condom service outlets, and reach at least 5,500 high-risk persons with ABC prevention messages. USG will provide approximately 120,000 condoms for this activity. The TCI reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by focusing prevention efforts on high-risk groups.

Emphasis Areas	% Of Effort
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	5,500	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	150	☐
Number of targeted condom service outlets	3	☐

Target Populations:

Commercial sex workers (Parent: Most at risk populations)

HIV/AIDS-affected families

Truck drivers (Parent: Mobile populations)

People living with HIV/AIDS

Partners/clients of CSW (Parent: Most at risk populations)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Increasing women's access to income and productive resources

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Byumba

Cyangugu

Kigali-Ville

Table 3.3.05: Activities by Funding Mechanism

Mechanism: HIV/AIDS School Based Program-Procurement
Prime Partner: Population Services International
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 4837
Planned Funds:
Activity Narrative: This activity also relates to activities in AB (#2795) and CT (#2796 and #2845).

This activity, part of the Healthy Schools Initiative, builds on school-based prevention activities initiated in FY2005 and supports education in the ABC approach for secondary school students aged 15 and older. Messages on abstinence, faithfulness and condom use will be incorporated into an interpersonal communication intervention focusing on parent-child dialogue about HIV/AIDS. Parents and primary caretakers of adolescents aged 15-16 will participate in a series of small-group training sessions during which they will learn about and discuss the pressures their children face at school, among peers, within their communities, and away from home. Parents will develop the knowledge and skills necessary to speak confidently to their children about the realities of HIV/AIDS in Rwanda, including the special vulnerability of girls and young women vis-à-vis GBV and transactional and cross-generational sex, and about how youth can protect themselves from HIV by practicing abstinence, faithfulness and consistent and correct condom use.

The second component consists of small grants, training and TA to anti-AIDS and Gender clubs in secondary schools to promote student knowledge of HIV/AIDS, behavioral risk factors and related problems like alcohol and GBV. PSI will provide TA and logistical support to these clubs for the student-led production of multi-media behavior change messages targeting in- and out-of-school youth, emphasizing ABC, empowerment of girls and young women, and elimination of stigma and discrimination (a key legislative issue). Two hundred (200) student leaders will be trained in peer education skills or outreach methods, including magnet theatre. Peer education networks will be established to facilitate exchange of experiences and lessons learned among peer educators from different schools and regions.

The third and final component involves establishing functional linkages with the school-based MVCT campaign (described in activities #2796 and #2845). Secondary school students and teachers will be encouraged to participate in the MVCT campaign, either by 1) being tested, 2) talking to their families and friends about being tested, or 3) assisting with community mobilization and logistics when the MVCT campaign comes to their school. The concept of the ABCD (ABC plus Diagnosis) approach will be introduced, and all students will be encouraged to know their status.

The populations targeted by this activity are secondary school students (aged 15-18), parents and caretakers of students, teachers and community members. PSI will implement this activity at 35 secondary schools in Kigali city and Gitarama province, reaching a total of 8,000 students with ABC messages and training a total of 200 peer educators (an average of 5 to 6 per school). All interventions will be carried out and monitored in collaboration with the MINEDUC's Health, Sports and Environment unit. No condoms will be distributed at schools under this activity.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	51 - 100
Local Organization Capacity Development	10 - 50
Training	10 - 50
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	4,500	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	200	☐
Number of targeted condom service outlets	0	☐

Target Populations:

Adults

Teachers (Parent: Host country government workers)

Children and youth (non-OVC)

Secondary school students (Parent: Children and youth (non-OVC))

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Table 3.3.05: Activities by Funding Mechanism

Mechanism: Central Contraceptive Procurement
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 4876
Planned Funds:
Activity Narrative: This activity relates to OP activities under PSI (#4877) and TCI (#4777).

The EP will procure an estimated eight million condoms through the Central Contraceptive Procurement in order to prevent HIV infection among Rwanda's most-at-risk populations. In FY2005, Rwanda experienced an unexpected shortage of condoms and USAID stepped in to secure an emergency shipment of 10 million condoms. In order to avoid any future condom stock-outs, EP will contribute resources to ensure a full supply chain to target high-risk populations. These condoms will supplement the condoms that USAID's SO6 Health Unit will procure in FY2006 for FP, which will benefit individuals participating in PMTCT programs and receiving ARVs.

PSI currently markets, packages and distributes condoms purchased through USAID and KfW funding. Funding provided to PSI will support the continued marketing of the Prudence Plus brand of condom which PSI developed 12 years ago in Rwanda. PSI will continue to employ former and current CSWs in the packaging of the condoms which will be distributed among most-at-risk populations at mobile CT sites, in other high transmission areas, and in current CT facilities funded by EP and the Global Fund. This program will use the results of the PLACE Study and the National Condom Accessibility Study (2005) to identify high-transmission areas and establish "hotspot" condom outlets in these high-risk areas. These condoms will also be passed through the TCI (estimated 120,000 condoms) to reach CSWs, their clients, truck drivers, and communities along the heavily traveled corridors of Rwanda. These activities will increase the availability and accessibility of condoms by expanding the number of community-based condom distribution outlets. Purchasing condoms supports the ABC approach outlined in the Rwanda EP five-year strategy.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful		☑
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful		☑
Number of targeted condom service outlets		☑

Target Populations:

Most at risk populations

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: PSI Bilateral
Prime Partner: Population Services International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 4877
Planned Funds:
Activity Narrative: This activity relates to PSI's Mobile CT (#4880) and AB (#4878) activities, the TCI OP activity (#4777) and the condom procurement (#4876).

In FY 2006, PSI will implement BCC activities by promoting the ABC approach through its nation-wide mobile CT program. This prevention activity will address behavioral issues among high-risk populations through IEC print materials, mobile video screenings, and interpersonal communications. Through mobile CT and local subgrantees, this activity will disseminate appropriate messages of abstinence, fidelity and proper condom use to high-risk populations, mainly prisoners, police, and CSW. The program will to use two mobile rapid HIV testing units 15 days a month. Through these community and workplace testing events, 20,000 individuals will receive direct ABC messages through video screenings and group discussions facilitated by a PSI staff person. Of these individuals, an estimated 4,620 individuals will receive further ABC information during their pre- and post- test counseling session. Individuals testing positive will receive specific information on how to avoid transmitting HIV to others. They will be urged to inform and encourage their spouses and partners to be tested. PSI will revise its counselor CT training curriculum to include appropriate ABC prevention messages and to emphasize the links between alcohol use, GBV and HIV transmission. The program will train and supervise 10 CT counselors in the use of the new curriculum. This program will provide sub grants to SWAA and several local CSW Associations to establish post-test clubs to follow up on referrals, provide care and support to PLWHAs and promote behavior change among both HIV positive and HIV negative clients. Gender specific approaches will be integrated into CT promotion, IEC materials, and post-test clubs. All messages and materials will be developed with the CNLS' BCC Steering Committee, TRAC and CHAMP to ensure central-level coordination.

Under Other Prevention funding, PSI will use [redacted] to distribute and promote condom use among most-at-risk populations at mobile CT sites, in high HIV transmission areas, and in current CT facilities funded by EP and the Global Fund. Using a social marketing approach, PSI will increase availability and accessibility of condoms through the creation of condom outlets for high-risk populations, community-based distribution of condoms, and the promotion of condoms through mid-level media such as mobile video screenings, condom demonstration, interpersonal communications and promotional materials at the points-of-sale to increase visibility. This program will use the results of the PLACE Study (2005) and the National Condom Accessibility Study (2005) to identify 10 high-transmission areas. Evidence from initial data analysis reveals that towns with high concentrations of bars, motels and small kiosks selling alcohol and fast-moving consumer goods, are particular high-risk zones. The criteria for identifying the 10 "hotspot" areas are high HIV prevalence (information available through TRAC); low condom accessibility and/or knowledge of accessibility; and high levels of unprotected sexual activity, transactional and commercial sex (BSS, 2005). PSI's Measure Access and Performance methodology will be used to identify zones with the highest rates of risk behavior and to track all commercial high-risk outlets and BCC communications. PSI/Rwanda will establish at least condom outlets for high-risk populations in each "hotspot" zone, reaching a total of 100 "hotspot" outlets. As part of the mobile CT program, PSI will create a minimum of 100 condom outlets for high-risk populations within the catchment areas of the targeted prisons, police academies, and CSW zones where PSI provides mobile CT services and peer education. This program will establish at least five condom outlets for high-risk populations in each CT target site. PSI will also use community-based distribution agents among the most-at-risk target groups during the mobile CT weeks to promote correct and consistent condom use among the CT clients and to inform them where the nearest condom outlets are

located. This program will also establish condom outlets within at least 50 EP and Global Fund-supported health facilities, provide condoms to the TCI, and educate CT personnel on how to demonstrate correct condom use. This activity supports the National Prevention Plan and the Rwanda EP five-year strategy by targeting high-risk groups with ABC messages.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	20,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	10	☐
Number of targeted condom service outlets	250	☐

Target Populations:

Adults

Commercial sex workers (Parent: Most at risk populations)

Military personnel (Parent: Most at risk populations)

People living with HIV/AIDS

Prisoners (Parent: Most at risk populations)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: AIDSMark -deferred
Prime Partner: Population Services International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 5545
Planned Funds:
Activity Narrative: [Continuing FY2005 Activity - No New Funding in FY2006]

This activity was approved in COP04, some funds of which were deferred to FY05.

The objective of the youth program is to increase awareness and knowledge about HIV/AIDS prevention practices among Rwandan youth, ages 10 – 24. The program aims to achieve this objective through several different activities to build upon those started in FY04 with EP funds, specifically: peer education training. All activities will be done in coordination with the CNLS and TRAC and executed with local partners working with CHH and high-risk youth.

Peer education is a cornerstone of Centre Dushishoze activities, and has been a key element to its success among youth in Butare, both within the Center and through rural facilitations in outlying areas. The main activities include developing a peer educator curriculum to train 1,600 peer educators who will reach 60,000 youth with HIV prevention messages. PSI will train peer educators to use interactive, interpersonal communications to address key HIV behavior change themes, and will provide IEC materials for distribution. Trained peer educators will be regularly monitored by trained supervisors, and will be required to submit monthly reports.

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	122,500	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	61,600	☐
Number of targeted condom service outlets	300	☐

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Teachers (Parent: Host country government workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Stigma and discrimination

Reducing violence and coercion

Coverage Areas:

National

Table 3.3.06: Program Planning Overview

Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06

Total Planned Funding for Program Area:

Program Area Context:

Palliative and basic health care programs provide a range of palliative care services to encourage positive living and provide care and support from the point of diagnosis to the end of life, including medical, psychological, spiritual and economic support. Palliative care activities should occur across a continuum of care from facility to community to home and back, and should include clinical staging, management of opportunistic infections and other HIV-related illnesses, nutrition counselling, HIV prevention, including alcohol use, domestic violence and non-clinical aspects of care, such as psychological, emotional and spiritual care. Over the past few years, Rwanda has rapidly expanded HIV/AIDS care and treatment services with particular emphasis on access to ART. While PLWHAs have increased access to ART, the GOR and its partners have been less successful at ensuring access to basic care services in the clinical setting, in particular prevention and treatment of OIs and psychosocial support. There is currently no palliative care policy or strategy for the country. In FY2005, the CNLS formed a palliative care TWG to draft guidelines and policies for palliative care at all levels of the health system. The GOR and EP vision for the coming year is to ensure that PLWHAs at any stage of illness receive a comprehensive network of services between district hospitals, health centers and communities.

Starting in COP05 and expanding in COP06, the EP will support the GOR and local CBOs in providing a menu of services for PLWHA and their families. In clinical settings, this will include prevention and treatment of OIs, positive living and prevention counselling for positives, nutrition counseling and support, support for treatment adherence, CD4 testing, and general clinical staging and monitoring for both adults and children. Community and home-based palliative care interventions will focus on training community volunteers and caregivers who provide psychosocial support, home-based care kits, counseling on hygiene and nutrition, and care for vulnerable children in the family. USG implementers will link OVC and PLWHA services to ensure that orphans and vulnerable children in households affected by HIV/AIDS receive referrals to OVC services in the community. Emphasis will be placed on training community volunteers to deliver basic medical care in the home setting. In COP06, the EP will train home-based caregivers and OVC volunteers to provide basic HIV and symptom management for adults and children (IMCI and IMAI), to make appropriate and timely referrals to health facilities, and to support treatment adherence for ART and TB/HIV patients for a family-centered and holistic approach to HIV care.

In keeping with the GOR vision to integrate community and home-based care services into the health care system, the EP will support the development of formalized referral and patient tracking mechanisms between health facilities and HBC services. The consolidation of funding for community services through the CSP in COP05 will facilitate harmonization and standardization of EP interventions, producing similar incentive packages for volunteers, a standard home-based care kit, and a single beneficiary registry system. CHAMP will use the results from a COP05 service gap assessment to identify service needs in EP catchment areas and to leverage community palliative care funding from the WB and Global Fund for other areas. In addition, COP06 will leverage Title II Food for Peace resources to achieve a basic package of nutritional support for 5,000 PLWHA households. EP partners will continue working closely with other donors, CNLS, RRP+, the First Lady's Office, and the religious networks to ensure that PLWHAs and their families receive a network of services based on their needs, as outlined in the Rwanda EP five-year strategy.

Program Area Target:

Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	168
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	82,901
Number of individuals trained to provide HIV-related palliative care (including TB/HIV)	

Table 3.3.06: Activities by Funding Mechanism

Mechanism: TRAC Cooperative Agreement
Prime Partner: Treatment and Research AIDS Center
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 2744
Planned Funds:
Activity Narrative: [CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

In FY2005, USG will continue its support to the Treatment and Research AIDS Center (TRAC) through a cooperative agreement.

Currently, TRAC and Global Fund share responsibility in the medium-term for national clinical care activities under major project funding. In the long term, DSS will assume this responsibility. In FY2005, TRAC's Care and Treatment Unit will work with DSS and Global Fund to begin rationalizing national HIV clinical care efforts and advance the decentralization of these activities. Activities include:

- Monitoring and evaluating OI service delivery sites to determine the sustainability of activities.
- Creating a forum for information exchange between OI care service providers to identify weaknesses and constraints as well as methods for program improvement (this will include quarterly workshops for health center staff, district supervisors, TRAC and DSS).
- Defining the roles of different types of health facilities in OI service delivery in accordance with the network model (i.e. health center versus hospital)

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism:	HIV Support to RDF
Prime Partner:	Drew University
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	Palliative Care: Basic health care and support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	2752
Planned Funds:	
Activity Narrative:	Drew University will work with the RDF to improve HIV care for military personnel, their partners and families of military personnel, and community members who live in the surrounding areas. Approximately 60% of the people who receive VCT services within the military setting are civilians. Specifically, the project will improve treatment of OIs, STI and TB among people living with HIV by military providers, improve treatment adherence, psychosocial support services and diagnosis and treatment of mental health problems at Kanombe, Ngarama and Kadhua Hospitals, 4 fixed VCT sites and 2 mobile VCT sites. In addition, Drew University will strengthen the capacity of the RDF to link people with HIV diagnosed at military VCT sites to treatment, prevention and care services as well as link people seen at hospital sites to community services. Activities and Expected Accomplishments - Provide on site training and supervision to 21 providers in diagnosis and treatment of OI, STI and TB - Provide technical assistance for the development of training manual for treatment adherence - Develop guidelines on mental disorder diagnosis and treatment. - Train 18 providers in treatment adherence and mental health diagnosis and treatment (6 each hospital). - Train and support 15 HIV positive peers in treatment adherence and psychosocial support - Enroll all soldiers and civilians with HIV receiving staging evaluation and care at one of the military medical centers in 5 day intensive program in treatment adherence, prevention of OIs and HIV education, healthy living with HIV and HIV transmission risk reduction - Provide care to 1,100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	9	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	1,100	☐

Target Populations:

Adults

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

HIV/AIDS-affected families

Military personnel (Parent: Most at risk populations)

People living with HIV/AIDS

Key Legislative Issues

Addressing male norms and behaviors

Twinning

Stigma and discrimination

Coverage Areas

Byumba

Gikongoro

Kigali-Ville

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Columbia/MCAP
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: N/A
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 2788
Planned Funds:
Activity Narrative: This activity is related to activities in ARV services (2787 and 2736), basic health care (2811), SI (4985) and laboratory infrastructure (2734). Columbia will continue to provide basic clinical care services to 15,000 existing patients enrolled in care at 28 existing sites. Basic healthcare will include OI prophylaxis, diagnosis and treatment, counseling on positive living (including alcohol abuse prevention, nutrition counseling, malaria prevention, and HIV prevention). Columbia will assure the clinical management or referral of complicated cases to reference or district hospitals. Nurses at health facilities will be trained and mentored to stage all PLWHA reached through PMTCT, CT or PIT with informed consent. Through the EP OI procurement, Columbia will ensure that facilities in the target districts have a stock of drugs to treat OI, manage ART side effects and provide preventive treatment for medical staff exposed to suspected HIV-contaminated fluids and rape victims.

At the site level, linkages between clinical and community-based services will be assured through placement of social workers and community activities coordinators at health facilities. In cooperation with the CSP, these staff will enhance the quality of community-based care throughout the network by training HBC workers in adherence support and psychosocial counseling. The community activities coordinators will support CSP partners to monitor HBC workers through frequent field visits and joint supervision activities.

At the district level, a community services coordinator will ensure that all facilities are linked to community services providers and that community services such as food aid, social and economic support, and counseling and referrals for domestic violence and rape victims are available throughout the district. In collaboration with community services providers, Columbia will assist in the development of a standard nutritional package for patients enrolled in HIV care at sites. Guidelines for an appropriate minimum family package and a screening tool will be developed to help select recipients for nutritional support.

In collaboration with the Data Analysis and Use project (activity 4985), Columbia will strengthen the medical record system for each site and train DHTs to verify data reliability. In addition, Columbia will encourage and facilitate the use of routinely collected data for problem solving, quality improvement and program evaluation. This will include providing computer programs to sites for summary reports of their patient-level data and training in interpretation of data for program improvement. Columbia will also organize quarterly M&E workshops for staff from MCAP-supported sites to enhance the collection and use of data at the site-level.

These activities support the Rwanda EP five-year strategy goals for palliative care by rapidly expanding the availability of care services towards the USG goal of three health centers per district providing basic care, and by improving linkages between clinical and community care services in the network model.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	28	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	15,000	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

HIV/AIDS-affected families

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Caregivers (of OVC and PLWHAs)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Columbia MCAP Supplement
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 2799
Planned Funds:
Activity Narrative: This activity is related to activities in ARV services (2787, 2736), basic health care (2811), and laboratory infrastructure (2734). This activity provides supplemental funding to the Track 1.0 maintenance budget. Columbia will provide basic clinical care services to 7,000 new patients enrolled in care at seven new sites. Basic healthcare will include OI prophylaxis, diagnosis and treatment, and counseling on positive living (including alcohol abuse prevention, nutrition counseling, malaria prevention, and HIV prevention). Columbia will assure the clinical management or referral of complicated cases to reference or district hospitals. Nurses at health facilities will be trained and mentored to stage all PLWHA reached through PMTCT, CT or PIT with informed consent. Through the EP OI procurement, Columbia will ensure that facilities in the district have a stock of drugs to treat OI, manage ART side effects and provide preventive treatment for medical staff exposed to suspected HIV-contaminated fluids and rape victims.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	7	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	7,000	☐
Number of service outlets providing HIV-related palliative care (excluding TB/HIV) graduated to PBF		☑

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

HIV/AIDS-affected families

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.06: Activities by Funding Mechanism

Mechanism: CHAMP
Prime Partner: Community Habitat Finance International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: *Palliative Care: Basic health care and support*
Budget Code: HBHC
Program Area Code: 06
Activity ID: 2811
Planned Funds:
Activity Narrative: This activity relates to the other CHAMP activities – PMTCT (#2805), AB (#2807), OP (#2808), CT (#2806), HIV/TB (#5129), OVC (#2819), ARV Services (#2809), and Systems Strengthening (#5183).

Under this activity, CHAMP will increase basic health care and support to PLWHAs and their families from point of diagnosis to end of life by mobilizing and building the capacity of Rwandan CBOs and community members. The geographic focus of these interventions will be in the catchment areas of USG-assisted health facilities. The primary strategies for achieving the care and support target will be through the creation and strengthening of referral systems and by offering a menu of community-based services to PLWHA and their families. CHAMP will expand and enhance the quality of community-based palliative care and support services, including HBC, IGA, psychosocial and spiritual support, food assistance, HIV prevention, and legal and human rights support. CHAMP-supported partners will reach 34,000 individuals with such services with COP06 funding.

As Rwanda decentralizes its care to the lowest levels, EP partners will provide an increasingly larger portion of the basic HIV care outside of the facilities. CHAMP will produce an updated palliative care curriculum building on existing tools and ensuring inclusion of the following topics: basic non-clinical medical care; IMAI and IMCI; recognition of complications and when to refer to the clinic; adherence counseling for ART and TB/HIV patients; TB/HIV co-infection; basic pediatric HIV management; and counseling skills in nutrition, hygiene and prevention for positives. CHAMP will integrate into all training activities modules on gender, GBV, and how to manage and recognize victims of GBV, particularly young girls. This project will train or offer refresher training to over 5000 community volunteers, health animators, case managers, social workers and caregivers. CHAMP will also offer TOT courses to PLWA association members in order to build the knowledge and capacity of associations and other CBOs to further train their members as community volunteers. These community volunteers will take a family-centered approach during home visits to PLWHA, monitoring and referring the children of HIV-affected HH to OVC community services and encouraging parents and guardians to test their children. In this way, volunteers will help identify more HIV-infected children and link them to appropriate care and treatment. CHAMP will standardize incentives for volunteers, the contents of HBC kits, and a registry and monitoring system. Currently volunteer incentives range from bicycles to T-shirts and HBC kits vary greatly in content. In addition to standardizing these tools and services, CHAMP will coordinate all EP-funded HIV community care partners holding regular TWG meetings.

CHAMP will support the GOR, DHTs, and EP-funded partners in the development of referral systems between trained community volunteers, clinic-based case managers, and health center staff to ensure appropriate cross-referral and case management, and reporting of patient information between clinical and community services. USG envisions that once an HIV-positive individual makes a follow-up visit to a clinic for screening and a CD4 count, the health facility will create a patient file and assign a case manager to the patient. This case manager will link the patient to community care and support activities. This will include the development of guidelines, protocols, and patient referral, tracking and patient monitoring tools for community-based volunteers and clinic-based case managers. CHAMP will ensure appropriate monitoring and evaluation, and quality assurance of HIV care and support services. Health center nurses, case managers, and social workers will provide periodic supervision and monitoring of HBC volunteers. These volunteers or a HBC focal point will also participate in health center and district meetings. CHAMP will also build the capacity of local organizations in M&E of HBC activities including data collection, data use, and

reporting. Currently, the National HIV/AIDS Care and Treatment Guidelines contain a small mention of community palliative care. CHAMP will advocate for palliative care policy issues such as nurses' legal authority to dispense pain medication and inheritance/property rights laws. This program will collaborate closely with the CNLS, TRAC, USS, MOH, district authorities and Community Development Committees to guide policy discussions and coordinate activities. This program supports the EP five-year strategy to engage new partners, expand pediatric care, and link care to other USG efforts.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	5	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	34,000	☐
Number of service outlets providing HIV-related palliative care (excluding TB/HIV) graduated to PBF		☑

Indirect Targets

CHAMP will support the MOH with clinical leadership for palliative care which will indirectly benefit 5,405 ART clients from GF and MAP programs.

Target Populations:

Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
Orphans and vulnerable children
People living with HIV/AIDS
Volunteers
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)
Caregivers (of OVC and PLWHAs)
Host country government workers
Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Gender

Stigma and discrimination

Food

Microfinance/Microcredit

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibungo

Kibuye

Kigali-Ville

Umutara (Mutara)

Table 3.3.06: Activities by Funding Mechanism

Mechanism:	HIV/AIDS Performance Based Financing
Prime Partner:	Management Sciences for Health
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Palliative Care: Basic health care and support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	2815
Planned Funds:	
Activity Narrative:	This activity relates to activities: EGPAF-BHC (5111), FHI-BHC (4767), Capacity/IntraHealth BHC (5112) and PBF-Pol SYS (2813).

Performance-based contracting of HIV/AIDS services, including basic and palliative care, is a key tool to achieving the vision of sustainability as described in the Rwanda EP five-year strategy. PBF of BHC services will be expanded to an additional 35 additional health centers in 2006. In COP06, basic and palliative services will be supported at all USG facilities for the first time.

In 2006, the PBF partner will provide BHC to 4000 HIV-positive patients, including 714 HIV-exposed infants at 44 HCs. The PBF project will work closely with the district medical officers and DHTs to coordinate all PBF services. Graduating sites must meet BHC technical criteria developed by the PBF partner and DHTs. Clinical partners and PBF will divide BHC financing and targets for the graduating HCs during the transition year. Clinical partners, PBF and DHTs will develop transition plans for all graduating sites to assure necessary clinical support.

The PBF project will support comprehensive treatment and care of BHC patients by payment based on performance indicators, such number of unique PLWHAs and total number of PLWHA patient visits. HCs will have financial incentives for improving BHC. The PBF will work with DHTs and TRACNet to develop M&E systems to accurately and transparently report on performance. The PBF project will develop independent clinical audit systems in order to verify HC reports. To support HC quality and efficiency, the PBF partner will provide management, M&E and HR training to DHTs and health facilities.

The PBF will pay for indicators of the BHC services, including: initiation of an individual patient medical record, clinical staging and CD4 counts, CTX prophylaxis, OI care, palliative care, ARV treatment for eligible patients, prevention for positives and referral to community support services. In collaboration with CHAMP and community service coordinators, health staff and social workers will train, support and supervise community volunteer home-based care providers on BHC follow-up and referrals. Community basic and palliative care services will include food support, reinforcement of clinical services, improved pediatric/OVC identification and support. (See CHAMP 2811.)

PBF of HIV/AIDS care, including BHC services is a fundamental component of the Rwanda EP five-year strategy for Rwanda to build sustainability of HIV/AIDS services. The expansion of basic and palliative care is described in the Rwanda EP five-year strategy. Strengthening basic and palliative health care nationally will help to achieve goals of sustainability as outlined in the Rwanda EP five-year strategy.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	51 - 100
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	44	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	4,000	☐
Number of service outlets providing HIV-related palliative care (excluding TB/HIV) graduated to PBF		☑

Target Populations:

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Host country government workers

Private health care workers

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism: FHI Bridge
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 4767
Planned Funds:
Activity Narrative: This activity relates to activities under PBF in BHC (#2815) and under FHI under ARV Services (#4770).

FHI will expand palliative and basic health care in eight districts to reach 10,400 HIV-positive, including 6,431 ART patients at 10 new, 26 continuing and 14 graduating health facilities (See BHC-PBF #2815). In 2005, FHI is piloting expanding the role of nurses at HCs to include limited ARV support. This will enable ARV patients to receive basic and palliative care and ART at their local HC. In COP05, FHI supported CTX prophylaxis for eligible PLWHAs. In COP06, basic and palliative care support will provide for all PLWHAs: initiation of an individual patient medical record, clinical staging and semi-annual CD4 counts, CTX prophylaxis, OI care, palliative care, "prevention for positives" counseling, ARV treatment for eligible patients, and referral to community support services. FHI will support training and monitor the quality of practice of providers in basic and palliative care. The USG will procure OI and palliative care drugs for all USG supported health facilities. (See Activity #5116.)

FHI and PBF will develop a joint transition plan to graduate 14 HCs to performance-based contracting. BHC targets and COP06 financing for these 14 sites will be divided between the PBF and FHI for the transitional year. Sites will need to demonstrate sufficient technical and institutional capacity before transfer to PBF. FHI will also support eight health districts to strengthen their network of care.

FHI will treat 985 children with CTX prophylaxis. HCs will identify these children through follow-up of PMTCT mothers, identification of exposed infants at immunization, early infant diagnosis through PCR dry-blood spot technology and improved identification of older infected children. FHI will support HC nurses to monitor HIV-infected infants and to stage them for ART. FHI will support eight DHTs and district physicians to supervise HCs providing ARV and basic services to infants and children.

FHI will support HCs to coordinate their basic services with community basic and palliative services through a Clinical Care Coordinator at each health center. FHI will work with CHAMP (Activity #2811) to develop effective referral systems between clinical care providers and psycho-social and medical support services in non-clinical settings. Community services will support HBC services, adherence counseling, spiritual support, stigma reducing activities, OVC support, IGA activities, and legal support services. FHI will support HCs to refer children to OVC programming for access to education, medical, social and legal services. FHI will support HCs to identify and support women who may be vulnerable when disclosing their status to their partner. HC counseling will include the role of alcohol in contributing to high-risk behaviors. EP partners will leverage food aid, including therapeutic feeding, for PLWHA and for food insecure households (particularly for pregnant and lactating women and their infants). Strengthening basic and palliative health care nationally will help to achieve the goal of sustainability as outlined in the Rwanda EP five-year strategy.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	36	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	10,329	☐
Number of service outlets providing HIV-related palliative care (excluding TB/HIV) graduated to PBF	14	☐

Target Populations:

HIV/AIDS-affected families

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Host country government workers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Food

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibuye

Kigali (Rurale)

Kigali-Ville

Table 3.3.06: Activities by Funding Mechanism

Mechanism: AIDS Relief
Prime Partner: Catholic Relief Services
USG Agency: HHS/Health Resources Services Administration
Funding Source: N/A
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 4838
Planned Funds:
Activity Narrative: This activity is related to activities under ARV Services (4849, 4783), and Basic Health Care (2811).

CRS will continue to provide basic clinical care services to 2,100 existing patients enrolled in care at two sites. Basic healthcare will include OI prophylaxis, diagnosis and treatment, counseling on positive living, including alcohol abuse prevention, nutrition counseling, malaria prevention, and HIV prevention. CRS will assure the clinical management or referral of complicated cases to reference or district hospitals. Nurses at health facilities will be trained and mentored to stage all PLWHA reached through PMTCT, CT or PIT with informed consent. Through the EP OI procurement, CRS will ensure that facilities in the district have a stock of drugs to treat OI, manage ART side effects and provide preventive treatment for medical staff exposed to suspected HIV-contaminated fluids and rape victims.

At the site level, linkages between clinical and community-based services will be assured through placement of social workers and community activities coordinators at health facilities. In cooperation with the CSP, these staff will enhance the quality of community-based care throughout the network by training HBC workers in adherence support and psychosocial counseling. The community activities coordinators will support CSP partners to monitor HBC workers through frequent field visits and joint supervision activities. CRS will help the sites increase the enrollment of women identified in PMTCT and of persons identified through VCT. CRS will coordinate with Title II recipients to address the nutrition needs of HIV-infected patients.

CRS will strengthen the medical record system for each site, and train the DHT to verify data reliability. In addition, CRS will encourage and facilitate the use of routinely collected data for problem solving, quality improvement and program evaluation. This will include providing computer programs to sites for summary reports of their patient-level data and training in interpretation of data for program improvement. CRS will also organize quarterly M&E workshops for staff from CRS-supported sites to enhance the collection and use of data at the site level.

These activities support the EP five-year strategy for palliative care by 1) rapidly expanding the availability of care services towards the goal of three health centers in each district providing basic care and 2) improving linkages between clinical and community care services in the network model, including symptom management, OI care, end-of-life care, and integration of care services with prevention and treatment.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	2	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	2,100	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

HIV/AIDS-affected families

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Refugees - Rwanda
Prime Partner: American Refugee Committee
USG Agency: Department of State
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 4865
Planned Funds:
Activity Narrative: This activity relates to Activities PMTCT (#4748), CT (#4867), ARV services (#2757, #4770). Currently, over 50000 refugees live in camps around the country. ARC provides support to a total of about 20,000 refugees in Gihembe (15,000) and Nyabiheke (5,000) refugee camps in Byumba Province. In partnership with the Rwandan government and district hospitals, ARC, UNHCR and other agencies have supported ongoing efforts for HIV prevention, care and treatment services for the camps. CAPACITY/IntraHealth is supporting in FY05 PMTCT/VCT services Gihembe camp, in collaboration with ARC and local refugee partners, with the goal of building capacity of these partners to take over services in FY2006. GLIA will also begin supporting HIV/AIDS services in Gihembe Camp starting in FY2006 with a limited amount of funding. All USG EP activities will need to be coordinated with GLIA to ensure complementarity and non-duplication of services. The Nyabaheke facility is new and lacks the structure and funding for any coordinated HIV/AIDS prevention, testing or treatment activities at the present time. EGPAF and ARC are currently developing a plan to ensure access to prevention, care and treatment services for the refugees in FY2005.

In line with the USG EP vision and standard package of care to be provided by all USG EP partners, funding for this activity will support the provision of basic palliative care to 750 PLWHA and the training of 50 health providers in the Gihembe and Nyabiheke refugee camp health clinics. The basic care package will include provision of or referrals for prevention, diagnosis and treatment of OIs and other HIV-related illnesses, including TB; routine clinical staging and systematic CD4 testing, creation of medical records for all HIV-positive patients; prevention counseling for positives; nutritional assessment and counseling, and leveraging of food for malnourished PLWHA (particularly for pregnant and lactating women and exposed and infected infants); and active and comprehensive referrals to community-based psycho-social and palliative care services. Infants born to HIV-positive mothers will be provided CTX PT, early infant diagnosis through PCR DBS, and ongoing clinical monitoring and staging for ART. Palliative care drugs will be procured through RPM-plus.

In collaboration with FHI and EGPAF, ARC will work with the Byumba and Ngarama DHTs to ensure that health clinic providers receive training in basic management of PLWHA, including training in ART adherence support, and in the identification and management of pediatric HIV. ARC will monitor and evaluate basic care activities through ongoing supervision, QA, and data quality controls, and will build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS basic care activities through ongoing coaching and strengthening of routine data collection and data analyses for basic care.

ARC will also support the network model through the establishment of referral and tracking systems for comprehensive basic care and support services for PLWHA. ARC will work with FHI and EGPAF at Byumba and Ngarama District Hospitals to strengthen and formalize the referral system between the camps and ART and other HIV care and support services, such as transport of blood specimen CD4 and PCR testing, management of complicated OIs, and periodic monitoring of ART patients. ARC will also link with community services and counselors in the camps, including community and spiritual leaders, refugee PLWHA association members, and social workers to ensure access to community-based clinical and psychosocial support for HIV-positive refugees and their families. This will include referrals for GBV and trauma counseling for HIV-positive women, prevention counseling for positive and discordant couples, HBC and OVC support, ART and TB adherence counseling, and spiritual support. ARC will also ensure provision or referrals for other forms of palliative care activities in the camps including IGA, microfinance, and wrap around for food

support, with particular attention to OVC.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	2	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	750	☐
Number of service outlets providing HIV-related palliative care (excluding TB/HIV) graduated to PBF		☑

Target Populations:

Refugees/internally displaced persons (Parent: Mobile populations)

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Doctors (Parent: Private health care workers)

Nurses (Parent: Private health care workers)

Key Legislative Issues

Addressing male norms and behaviors

Stigma and discrimination

Coverage Areas

Byumba

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Refugees AHA
Prime Partner: African Humanitarian Action
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 4873
Planned Funds:
Activity Narrative: This activity relates to PMTCT (#4871) and CT (#4874).

Currently, over 50,000 refugees live in camps around the country. AHA provides support to a total of about 17,000 refugees in Kiziba refugee camp in Kibuye District. AHA, UNHCR and other agencies have supported ongoing efforts for HIV education and clinical services in partnership with Kibuye District Hospital. In collaboration with AHA, CAPACITY/IntraHealth will support CT and PMTCT services in FY2005. GLIA will also begin supporting HIV/AIDS services in Kiziba Camp starting in FY2006 with a limited amount of funding. All USG EP activities in Kiziba will coordinate with GLIA to ensure complementarity and non-duplication of activities.

In line with the USG EP vision and standard package of care to be provided by all USG EP partners, funding for this activity will support the provision of basic palliative care to 500 PLWHA and the training of 25 health providers in the Kiziba refugee camp health clinic. The basic care package will include provision of or referrals for prevention, diagnosis and treatment of OIs and other HIV-related illnesses, including TB; routine clinical staging and systematic CD4 testing, creation of medical records for all HIV-positive patients; prevention counseling for positives; nutritional assessment and counseling, and leveraging of food for malnourished PLWHA (particularly for pregnant and lactating women and exposed and infected infants); and active and comprehensive referrals to community-based psycho-social and palliative care services. Infants born to HIV-positive mothers will be provided CTX PT, early infant diagnosis through PCR DBS, and ongoing clinical monitoring and staging for ART. Palliative care drugs will be procured through RPM-plus.

In collaboration with MCAP, AHA will work with the Kibuye DHT to ensure that Kiziba health center providers receive training in basic management of PLWHA, including training in ART adherence support, and in the identification and management of pediatric HIV. AHA will monitor and evaluate HBHC activities through ongoing supervision, QA, and data quality controls, and will build the capacity of local refugee health care providers to monitor and evaluate HIV/AIDS basic care activities through ongoing coaching and strengthening of routine data collection and data analyses for basic care.

AHA will support the network model through the establishment of referral and tracking systems for comprehensive basic care and support services for PLWHA. AHA will work with existing partners at Kibuye District Hospital (ART supported by Columbia MCAP) to strengthen and formalize the referral system between the camps and ART and other HIV care and support services, such as transport of blood specimen CD4 and PCR testing, management of complicated OIs, and periodic monitoring of ART patients. AHA will also link with community services and counselors in the camps, including community and spiritual leaders, refugee PLWHA association members, and social workers to ensure access to community-based clinical and psychosocial support for HIV-positive refugees and their families. This will include referrals for GBV and trauma counseling for HIV-positive women, prevention counseling for positive and discordant couples, HBC and OVC support, ART and TB adherence counseling, and spiritual support. AHA will also ensure provision or referrals for other forms of palliative care activities in the camps including IGA, microfinance, wrap around for food support, and will train peer counselors and volunteers on home based care, as well as PLWHA in self-care and positive living, with special attention to refugee widows and their children, refugee OVC and other vulnerable refugee populations.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	1	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	500	☐

Target Populations:

Refugees/internally displaced persons (Parent: Mobile populations)
People living with HIV/AIDS
Volunteers
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)
Caregivers (of OVC and PLWHAs)
Widows/widowers
Doctors (Parent: Private health care workers)
Nurses (Parent: Private health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Increasing women's access to income and productive resources

Food

Microfinance/Microcredit

Coverage Areas

Kibuye

Table 3.3.06: Activities by Funding Mechanism

Mechanism: USAID Rwanda Mission
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 4968
Planned Funds:
Activity Narrative: USAID/Rwanda has been providing local and international technical assistance to GOR agencies and limited direct grants to local NGOs since COP04.

In COP06, the EP will expand this to further build local capacity. These resources will cover the cost of sponsoring and attending conferences, workshops and technical meetings on HIV treatment. A number of Rwanda NGOs requested financial assistance from USAID in FY2005 for such activities. USAID anticipates continuing this financial and technical support role in FY2006. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS.

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Local Organization Capacity Development	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑
Number of service outlets providing HIV-related palliative care (excluding TB/HIV) graduated to PBF		☑

Target Populations:

Community-based organizations
Faith-based organizations
Host country government workers

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism:	*Catholic Relief Services Supplemental*
Prime Partner:	Catholic Relief Services
USG Agency:	HHS/Health Resources Services Administration
Funding Source:	GAC (GHAI account)
Program Area:	Palliative Care: Basic health care and support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	4989
Planned Funds:	
Activity Narrative:	This activity is related to activities under ARV Services (4849, 4783), and Basic Health Care (2811).

CRS will provide basic clinical care services to 3075 new patients enrolled in care at *two new sites. Basic healthcare will include OI prophylaxis, diagnosis and treatment,* counseling on positive living, including alcohol abuse prevention, nutrition counseling, malaria prevention, and HIV prevention. CRS will assure the clinical management or referral of complicated cases to reference or district hospitals. Nurses at health facilities will be trained and mentored to stage all PLWHA reached through PMTCT, CT or PIT with informed consent. Through the EP OI procurement, CRS will ensure that facilities in the district have a stock of drugs to treat OI, manage ART side effects and provide preventive treatment for medical staff exposed to suspected HIV-contaminated fluids and rape victims.

At the site level, linkages between clinical and community-based services will be assured through placement of social workers and community activities coordinators at health facilities. In cooperation with the CSP, these staff will enhance the quality of community-based care throughout the network by training HBC workers in adherence support and psychosocial counseling. The community activities coordinators will support CSP partners to monitor HBC workers through frequent field visits and joint supervision activities. CRS will help the sites increase the enrollment of women identified in PMTCT and of persons identified through VCT. CRS will *coordinate with Title II recipients to address the nutrition needs of HIV-infected* patients.

CRS will strengthen the medical record system for each site, and train the DHT to verify data reliability. In addition, CRS will encourage and facilitate the use of routinely collected data for problem solving, quality improvement and program evaluation. This will include providing computer programs to sites for summary reports of their patient-level data and training in interpretation of data for program improvement. CRS will also organize quarterly M&E workshops for staff from CRS-supported sites to enhance the collection and use of data at the site level.

These activities support the EP five-year strategy for palliative care by 1) rapidly expanding the availability of care services towards the goal of three health centers in each district providing basic care and 2) improving linkages between clinical and community care services in the network model, including symptom management, OI care, end-of-life care, and integration of care services with prevention and treatment.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	2	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	3,075	☐
Number of service outlets providing HIV-related palliative care (excluding TB/HIV) graduated to PBF		☑

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

HIV/AIDS-affected families

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Call to Action/EGPAF
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 5111
Planned Funds:
Activity Narrative: See related activities: CHAMP BHC (2811) and PBF BHC (2815)

Consistent with the EP Rwanda's five-year strategy, COP06 financing will support the initiation of basic and palliative health care services for PLWHAs at all USG HCs. EGPAF will support a standard package of basic care and coordinate community support services outside the HC across a continuum of care in three districts, reaching 6300 HIV-positive patients, including 1700 pediatric patients and 1750 on ART. EGPAF will initiate palliative and basic care services at 15 existing HCs and five new HCs and will prepare six palliative and basic care sites for transfer to the PBF mechanism. Sites will need to demonstrate sufficient technical and institutional capacity before transfer to PBF. COP06 BHC targets and financing for these six sites will be divided between the PBF and EGPAF.

EGPAF will support a standard basic care package for PLWHAs that includes: initiation of an individual patient medical record; clinical staging and CD4 counts; ARV treatment for eligible patients; OI and palliative care (See RPM-Plus BHC 5116), and coordination with community support services. All eligible patients will be offered CTX prophylactic therapy. Consistent with MOH guidelines, EGPAF will support provider training for syndromic management of OIs, use of referral guidelines and management of common symptoms of HIV-related illnesses.

HCs will counsel all PLWHAs and their family members in ongoing "prevention for positives" counseling. Counseling will emphasize the role of alcohol in contributing to high-risk behaviors. HCs will work closely with CHAMP to coordinate community support of HIV/AIDS patients. EP partners will collaborate with other programs to leverage food aid, including therapeutic feeding, for PLWHA and for food insecure households. EGPAF-supported HCs will refer PLWHA and family members to clinical and psycho-social support services at health facilities and in the community. EGPAF will support a clinical care coordinator at each health to assure patients have community support of their clinical care.

EGPAF will pilot intensive pediatric care at HCs and collaborate with Columbia to develop national tools to improve outpatient pediatric care. EGPAF will reach HIV-exposed infants and children through follow-up of PMTCT mothers and identification of exposed infants at immunization. Infants born to HIV-positive mothers will receive CTX PT and early infant diagnosis through PCR. EGPAF will support HC nurses to monitor HIV-infected infants and to stage them for ART. Like other clinical partners, EGPAF will work with facilities, CHAMP and community support services to improve the system for identification of exposed and/or likely-infected infants and children.

EGPAF will provide support to the DHT in Ngarama and Kabuga districts (See EGPAF ARV 2855). EGPAF will also coordinate with ARC to assist in training providers in the Nyabiheke Refugee Camp and ensure a system of referral and support between Ngarama District Hospital and the camp. (See ARC 4865).

These clinical and community-based palliative care activities support the Rwanda EP five-year strategy to increase the national availability of palliative care through health facilities and HBC services.

Emphasis Areas	% Of Effort
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	20	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	6,300	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Host country government workers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Food

Coverage Areas

Byumba

Kigali (Rurale)

Kigali-Ville

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Capacity
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 5112
Planned Funds:
Activity Narrative: See related activities: CHAMP BHC (2811), PBF-BHC (2815), RPM-Plus BHC (5116).

In COP06, Consistent with the EP Rwanda's five-year strategy, CAPACITY/IntraHealth will initiate palliative and basic health care services to reach 6,150 HIV-positive, including 1,350 ART patients and 1000 pediatric patients at ten continuing and six new health facilities and will prepare 15 advanced palliative/basic care sites for transfer to performance-based contracting via the PBF.

Capacity/IntraHealth will support a standard basic care package for all PLWHAs that includes: initiation of an individual patient medical record, clinical staging and CD4 counts, ARV treatment for eligible patients, OI and palliative care, CTX PT for eligible patients, community support referral and "prevention for positives" counseling. Treatment protocols for OIs and for infant treatment and diagnosis will comply with MOH guidelines. CApacity/IntraHealth will support training of providers and M&E to assure quality of care. Counseling will emphasize the role of alcohol in contributing to high-risk behaviors.

CAPACITY/IntraHealth-supported HCs will leverage food, including referrals for therapeutic feeding, for PLWHA and for food insecure households (particularly for pregnant and lactating women and their infants). CAPACITY/Intrahealth will train providers in management of OIs and other HIV-related illnesses, use of referral guidelines, clinical staging and psychosocial support for positives. Capacity/IntraHealth will reach HIV-exposed infants and children through follow-up of PMTCT mothers and identification of exposed infants at immunization, OVC programs, or other points of entry. Infants born to HIV-positive mothers will receive CTX prophylaxis and early infant diagnosis through PCR. Capacity/IntraHealth will support HC nurses to monitor HIV-infected infants and to stage them for ART. This EP partner will support coordination with CHAMP to improve the system for identification of exposed and/or likely-infected infants and children.

Capacity/IntraHealth will collaborate with DHTs to roll out training and supervision of providers in existing and new facilities in basic care of PLWHA, including HIV-exposed and infected children. Routine supervision and monitoring through use of checklists and supervisor coaching will ensure high quality services. Capacity/IntraHealth also will support health centers and DHTs to implement PAQs (community-provider partnership) at HCs.

Before graduating to performance-based contracting, sites will need to demonstrate sufficient technical and institutional capacity. Capacity/IntraHealth will work with the HC, DHT and PBF to develop transition plans to assure needed technical support. BHC targets and COP06 funding for these fifteen sites will be divided between the PBF and Capacity/IntraHealth for the transition year.

Capacity/IntraHealth will work with CHAMP (Activity #2811) to develop effective referral systems between clinical care providers and psycho-social and medical support services in non-clinical settings, including HBC, adherence counseling, spiritual support, stigma reducing activities, OVC support, IGA activities, and legal support services. Women will be specifically encouraged to engage in IGA to increase their capability to support their children and improve their own health and well-being. Capacity/IntraHealth will actively support effective integration of home based care services and clinical health services by hiring a clinical-community coordinator in each health center.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	16	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	6,150	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Increasing women's access to income and productive resources

Stigma and discrimination

Wrap Arounds

Food

Microfinance/Microcredit

Education

Coverage Areas

Byumba

Gikongoro

Gitarama

Kibungo

Kibuye

Umutara (Mutara)

Table 3.3.06: Activities by Funding Mechanism

Mechanism:	RPM+
Prime Partner:	Management Sciences for Health
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Palliative Care: Basic health care and support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	5116
Planned Funds:	
Activity Narrative:	See related activities: MCAP BHC (2799), PBF BHC (2815), FHI BHC (4767), CRS BHC (4838), EGPAF BHC (5111), and Capacity/IntraHealth BHC (5112). These funds will procure OI drugs for 127 EP-supported health facilities providing HIV/AIDS care. RPM-Plus will ensure cost-efficient procurement, storage and distribution of all OI and other palliative care drugs on behalf of USG and its implementing agencies for 127 health facilities (ART and non-ART RPM-Plus will ensure that procurement of all HIV-related drugs is done according to EP, GOR, and international quality standards. Product selection will conform to the GOR's minimum package of care but will also provide a cost-effective stock of OI and other palliative care drugs up to a total average cost of $5,000 per year, and $25,000 USD per district hospital per year. RPM-Plus will assure these drugs are equitably distributed to USG-supported health facilities based upon level of care and numbers of PLWHAs, as well as assure that sites document that PLWHAs are receiving needed care for OIs. To ensure an appropriate and adequate supply of OI and other HIV-related medications at all levels, RPM-Plus will provide support to CAMERWA, district pharmacies, and EP partners and their supported sites in quantification, storage, distribution and stock management. This will include support for monitoring and supervision of data quality, inventory management, distribution, and reporting at all levels, development of tools and procedures to ensure data quality and good dispensing practices, and establishment of a mechanism for regular inventory control, including monthly reporting to districts and to CAMERWA. Building on the coordinated procurement system, the Quantification Committee (with support from RPM-Plus) will assist the MOH to quantify needed OI drugs. RPM-Plus will develop a plan for M&E of HIV/AIDS pharmaceutical management, including development of pharmaceutical indicators related to consumption and use of OI drugs as well as ARVs and other HIV/AIDS related commodities. During COP05 the EP partner supported a full-time pharmacist at CAMERWA, who was responsible for monitoring and reporting on the coordinated procurement and who will continue with this role in COP06. Senior short-term international TA from the RPM-Plus Kigali office and Arlington headquarters will provide support. This activity directly supports the Rwanda EP five-year strategy by strengthening supply chains and quality assurance through direct technical assistance to CAMERWA. This TA will improve commodity forecasting, procurement procedures, storage and distribution, quantification and information systems.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Logistics	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑
Number of service outlets providing HIV-related palliative care (excluding TB/HIV) graduated to PBF		☑

Target Populations:

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibuye

Kigali (Rurale)

Kigali-Ville

Table 3.3.06: Activities by Funding Mechanism

Mechanism: WR bilateral
Prime Partner: World Relief Corporation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: *Palliative Care: Basic health care and support*
Budget Code: HBHC
Program Area Code: 06
Activity ID: 5118
Planned Funds: [redacted]
Activity Narrative: This activity relates to activities under TCI in CT (#4778) and under CHAMP in BHC (#2811).

This activity will fund an increase in the number of HIV-infected and affected individuals served through World Relief's ongoing Microfinance Grant. In FY05 WR received a two-year, [redacted] extension from the USAID SO7 Agriculture team to continue its successful microfinance program in five provinces. EP funds will be used to target PLWHAs and their family members, especially women, and to more fully integrate HIV prevention and stigma reduction messages in the microfinance training. WR will work closely with other microfinance institutions, specifically Vision Finance and Care International, to train PLWHAs and oversee their micro-finance activities. This program will collaborate with local PLWHA associations to identify and select individuals interested in starting business activities. TCI will refer women to this program in Cyangugu and Byumba, and CHAMP will ensure linkages between the WR program and other community-based care activities in Kigali-Ngali and Gisenyi.

Using a curriculum developed by WR, the program will teach money management skills and encourage disciplined saving. The project will also create well-organized informal support groups where members pool savings against future emergencies. All beneficiaries will receive HIV prevention and treatment information for themselves and their family members with HIV/AIDS. WR will refer HIV-positive beneficiaries to the nearest health facility for clinical palliative care to better manage their AIDS-related illnesses and to other USG-funded palliative care activities to receive additional community care and support. In Cyangugu and Ruhengeri, this program will link to clinics supported by the Global Fund and MAP. This program supports the EP five-year HIV strategy to integrate prevention, care, and treatment services and link prevention to other USG programs. This program addresses a number of key legislative issues on gender and stigma. WR will seek to strengthen and improve the coping mechanisms of Rwandan women and families living with HIV/AIDS by improving their economic livelihood.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	*10 - 50*
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	3	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	1,200	☐

Indirect Targets

This project will indirectly benefit the family members in the 1200 participating HH. If each HH has an average of two children, then one can estimate that 2400 children will benefit from this activity.

Target Populations:

Adults

Community-based organizations

People living with HIV/AIDS

Caregivers (of OVC and PLWHAs)

Widows/widowers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Increasing women's access to income and productive resources

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Byumba

Cyangugu

Gisenyi

Kigali (Rurale)

Ruhengeri

Table 3.3.07: Program Planning Overview

Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07

Total Planned Funding for Program Area:

Program Area Context:

The EP, with WHO, takes a lead in setting the agenda for integrating TB and HIV programming. In FY2004, the EP began supporting PNILT through the placement of a technical advisor to oversee the integration of TB and HIV activities. In FY2005, the EP expanded its support for central-level coordination through a national TB/HIV coordinator and additional coordinators at PNILT and TRAC. As a result of this assistance, national TB/HIV policies, operational guidelines and screening tools were developed, and an integrated TB/HIV model was piloted at two sites. USG clinical partners developed systems for linking TB patients to counseling and testing services, as well as for referring HIV-positive clients to ARV and TB services.

In January 2005, PNILT began collecting and reporting preliminary surveillance data from the national TB program. Data collected from DOTS centers since January shows that HIV test results were recorded in TB registers for approximately half of TB patients, and that HIV prevalence among these patients ranged from 44% (in sputum smear-positive cases) to 67% among other diagnosed cases. There are currently 161 TB testing centers in the country, nine of which are located in prisons. The 152 TB detection centers offer VCT within the same facility, and 55 offer on-site ART services. In 2003, Rwanda reported an estimated overall TB incidence of 374 per 100,000 cases (161/100,000 new smear positive TB cases).

In FY2006, the EP will build on this TB/HIV integration progress.The EP TB/HIV technical advisor will work with PNILT, TRAC and USS to ensure the dissemination and implementation of national guidelines and protocols. These protocols will institutionalize routine HIV testing and referrals for all TB patients as well as regular TB screenings for HIV patients by using the tools developed in FY2005. In addition, EP partners will expand TB/HIV integration activities in all 20 EP-supported health districts, testing 7,689 TB patients for HIV and providing comprehensive ART services to all eligible co-infected patients (estimated at 1,600). The EP will expand testing for families, improve uptake and adherence to TB and ARV treatment, and strengthen support for TB/HIV patients through an innovative community-based TB pilot program.

The EP will strengthen TB/HIV surveillance, monitoring and evaluation. Reporting systems will be improved to accommodate better tracking and follow-up of TB/HIV patients, including diagnosis, referral, treatment and follow-up of co-infected patients - both adults and children. A targeted evaluation will be conducted to examine HIV testing uptake among TB patients, and the lessons learned from the evaluation will be applied to EP and national programming.

The EP will work in close coordination with the Global Fund, the Ministry of Health, PNILT, TRAC, USS, and Belgian Technical Cooperation. Where other donor resources focus primarily on DOTS expansion and improvement of quality TB diagnostic and treatment services, EP will provide resources that support integration of TB and HIV services and timely identification and treatment of co-infected patients.

Program Area Target:

Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	318
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	418
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	1,037
Number of HIV-infected clients given TB preventive therapy	0

Table 3.3.07: Activities by Funding Mechanism

Mechanism:	Columbia UTAP
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Palliative Care: TB/HIV
Budget Code:	HVTB
Program Area Code:	07
Activity ID:	2731
Planned Funds:	[redacted]
Activity Narrative:	This activity relates to activities in ARV Services (2736), CT (2800), and TB/HIV (4839, 4768, 5127, 5128). Columbia University will continue to provide support to PNILT, USS and TRAC through an existing long-term technical advisor position to ensure integration of TB/HIV activities, including the revision and implementation of policies, tools and guidelines, the functioning of the national TB/HIV integration group, the strengthening of M&E for national TB/HIV activities and the training of service providers in integration of TB and HIV. Columbia will continue support to two model centers established in FY2005 to evaluate the efficiency and effectiveness of new HIV/TB integration protocols and to provide feedback to the national TB and HIV programs. Columbia will assist the MOH in implementing routine HIV CT, prevention education, and referral for HIV care (if needed) for all TB patients at TB/DOT clinics and will implement standardized TB screening and intensified TB case-finding in HIV-infected patients, starting at Columbia-supported ART sites and then expanding nationwide. Integrated TB/HIV services for children will be strengthened through the development of standardized screening tools and diagnostic algorithms for latent TB infection and clinical TB. Other interventions will include integrating the TB services into programs providing care for HIV-exposed and HIV-infected children; implementing HIV testing for children with TB; and reinforcing contact-tracing and INH preventive therapy for children with latent TB infection. Columbia will collaborate with TRAC and PNILT to integrate TB/HIV data into the TRACnet system. The technical advisor will transfer skills and competencies to three locally recruited TB/HIV advisors at PNILT and one in TRAC to sustain TB/HIV integration in Rwanda. These activities support the Rwanda EP five-year strategic goal of integrating TB and HIV services into the overall health system. Columbia will provide periodic short-term periodic TA to ensure program quality and share lessons learned from other countries. Technical advisors will be supported to participate in international TB/HIV conferences to share Rwanda experience in rolling-out TB/HIV interventions and also learn from others countries' experiences.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Policy and Guidelines	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	161	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	25	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	2,600	☐
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF		☑

Target Populations:

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.07: Activities by Funding Mechanism

Mechanism: TRAC Cooperative Agreement
Prime Partner: Treatment and Research AIDS Center
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 2740
Planned Funds:
Activity Narrative: [CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

In the area of tuberculosis, TRAC collaborates with the National Integrated Program for the Fight Against Leprosy and Tuberculosis (PNILT) in issues concerning HIV/AIDS. In this role, TRAC will support the establishment of national norms for TB in HIV/AIDS patients, the creation of training programs and materials and any other assistance required by PNILT in this area. Six one-day training sessions on TB/HIV management will be organized. Funds from this program will be utilized to recruit, train and place one individual to provide technical assistance to the PNILT on national protocol and training materials concerning TB as an opportunistic infection of HIV/AIDS and to organize and conduct the training.

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease		☑
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF		☑

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.07: Activities by Funding Mechanism

Mechanism: IMPACT
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 2763
Planned Funds:
Activity Narrative: [Continuing Activity from FY2005 -- with No New Funding under this mechanism in FY2006. See Activity 4768.]

At ARV sites and at VCT sites that offer TB care or have it located close physically, USG will actively promote TB patients to avail themselves of VCT services and/or support bringing CT to TB patients. The first objective at these sites would be to encourage 70% of TB patients to go for or to receive HIV testing. The second objective is to develop procedures to link HIV CT, ART and TB services. The third objective is to determine HIV prevalence and yield rate of patients for ART initiation from TB patients at these sites. These TB/HIV patients will be treated according to WHO and national treatment guidelines for HIV and TB

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease		☑
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF		☑

Target Populations:

Adults

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Table 3.3.07: Activities by Funding Mechanism

Mechanism: CDC Country Office GAP/TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 2850
Planned Funds:
Activity Narrative: This activity relates to activities in ARV services (4849), Counseling and Testing (2741) and TB/HIV (2800, 2731, 4768). CDC will continue support to the national TB/HIV integration activities through TA from CDC HQ to oversee scale-up of national TB/HIV activities based on lessons learned from two model centers implemented in FY 2005. Specific activities will include TA to PNILT and TRAC to improve the quality and M&E of routine testing of TB patients and regular TB screening of HIV-infected patients. CDC will provide TA for an infection control assessment at sites caring for co-infected patients, and for evaluating the implementation of the national TB/HIV policy and operational clinical TB/HIV protocols. In addition, CDC will provide TA for a sentinel survey assessing HIV prevalence among TB patients. These activities fully support the Rwanda EP five-year strategic goal of integrating TB/HIV activities.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑

Target Populations:

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.07: Activities by Funding Mechanism

Mechanism: HIV/AIDS Performance Based Financing
Prime Partner: *Management Sciences for Health*
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 4001
Planned Funds:
Activity Narrative: See Related Activities: PBF PMTCT (2814), FHI TBHIV (4768), PBF Pol Sys (2813).

Performance-based contracting of HIV/AIDS services, including TB/HIV, is a key tool to achieving sustainability as outlined in the Rwanda EP five-year strategy. PBF of TB/HIV services will be piloted at 9 health facilities in 2005 and 35 health centers in 2006 to target 124 TB/HIV co-infected patients for treatment. Continued roll-out of TB/HIV and other HIV/AIDS services will occur in 2007-2008, based on an independent external evaluation of PBF. The PBF project will work with the district medical officers and DHTs to coordinate TB/HIV services. HCs will assure routine HIV testing of all TB patients, systematic TB screening of HIV-positive patients, provision or referral for TB treatment, and follow-up. PBF in collaboration with clinical partners will work with HCs to assure that patients complete TB treatment at national TB facilities and through the community DOTS program, coordinated by CHAMP.

The PBF will support effective treatment and care of TB/HIV patients at graduated health centers by reimbursement for performance based on pre-defined indicators, including percent of TB patients tested for HIV; effective diagnosis of TB in HIV-positive patients; referral for TB treatment; and appropriate follow-up of TB/HIV patients. The PBF project will support HCs to improve their reporting systems and will develop a clinical audit system to verify HC reports. PBF and DHTs will coordinate care with PNILT to strengthen routine data collection and tracking of patients referred for TB/HIV care.

In collaboration with CHAMP and community service coordinators, health staff and social workers will train, support and supervise community volunteer home-based care providers on TB/HIV follow-up and referrals. Health facilities supported by the PBF will integrate messages on the importance of TB/HIV co-infection into health center education activities.

PBF of HIV/AIDS care, including integrated TB and HIV services, is a fundamental component of the Rwanda EP five-year PEPFAR Strategy for Rwanda. It is expected that reimbursement for performance will enhance the patient referral and tracking systems and assure that TB/HIV patients both access and complete TB treatment in line with PNILT protocols. PNILT, which is a key coordinating entity for GFATM implementation of Rwanda's TB grant, is an active participant in this activity.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	51 - 100
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	44	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	18	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	124	☐
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF		☑

Target Populations:

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Host country government workers

Public health care workers

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Coverage Areas:

National

Table 3.3.07: Activities by Funding Mechanism

Mechanism:	FHI Bridge
Prime Partner:	Family Health International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Palliative Care: TB/HIV
Budget Code:	HVTB
Program Area Code:	07
Activity ID:	4768
Planned Funds:	
Activity Narrative:	This activity is also related to ARV services (#4770), CT (#4769), and HIV/TB (#5129). Integration of TB and HIV services is a fundamental component of the Rwanda EP five-year strategy, which describes training and supervision activities, HIV/TB surveillance, and the development of model centers for TB/HIV testing and treatment. This activity will support the strengthening of TB/HIV services at 38 health centers, including 28 existing and 10 new sites. FHI will also prepare 14 sites offering TB/HIV services for graduation to PBF through limited technical support provided to the MSH/PBF for the graduating sites to ensure TB/HIV service delivery in line with PBF graduation criteria. Targets for these graduating sites are divided evenly between FHI and MSH/PBF. FHI will reach 163 TB/HIV co-infected patients through routine testing of all TB clients for HIV, systematic screening of HIV-positive clients for TB, and provision or referral for TB treatment. FHI will provide TA to the health centers, hospitals and DHTs in eight districts in the development of referral systems for TB/HIV services. This will include the collection and transport of sputum samples for testing at TB referral sites, and when necessary, the referral of clients for chest x-rays or other TB services not available on site. Health providers will refer family members of HIV-positive co-infected patients for TB screening and treatment. In collaboration with PNILT, DHTs, and other partners, FHI will enhance provider capacity in management of TB/HIV through ongoing supervision and QA of TB/HIV activities, and use of job aids and site-level algorithms in line with PNILT guidelines. FHI will also integrate messages on the importance of TB/HIV co-infection into health center education activities. To strengthen follow-up and monitoring of TB/HIV patients, FHI will develop monitoring and tracking mechanisms within and across facilities to assure that patients access and complete treatment. This will include working with districts, sites and PNILT to strengthen routine data collection and reporting of TB/HIV co-infection. FHI will also coordinate with CHAMP to ensure community-based follow-up of HIV/TB co-infected patients through the pilot Community-Based DOTS activity. In collaboration with CHAMP, the facility-based CS Coordinator and facility staff will support and supervise community TB DOTS volunteers on TB/HIV follow-up and referrals.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	38	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	163	☐
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF	14	☐

Target Populations:

Nurses (Parent: Public health care workers)

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibuye

Kigali (Rurale)

Kigali-Ville

Table 3.3.07: Activities by Funding Mechanism

Mechanism: Columbia MCAP Supplement
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 4839
Planned Funds:
Activity Narrative: This activity is related to activities in TB/HIV (2731), laboratory infrastructure (2734), ARV services (2736) and CT (2800). This activity provides supplemental funding to the Track 1.0 maintenance budget.

Columbia will screen 75% of TB patients for HIV at 32 sites through its HIV and TB programs. In addition, Columbia will screen all patients enrolled in HIV care for TB (15,000 patients from FY2005 and 7,000 new patients in FY2006). Based an estimated 60% rate of co-infection and 10% annual risk of developing active TB among co-infected patients, Columbia will refer all suspected cases of co-infection among PLWHA for TB testing and 500 expected new cases of active TB for treatment. Columbia will ensure that community services coordinators collaborate with CSP staff to complete TB/HIV referrals and to ensure continuum of care to co-infected patients. Specific activities for this collaboration will be the joint training and supervision of HBC volunteers, peers and other staff employed by CSP for TB/HIV community-based activities such as referrals of suspect cases to health centers and community DOTS support to co-infected patients. Columbia will contribute to any collaborative activities designed to facilitate referrals between the levels of care including referrals tools revision and implementation. These activities support the Rwanda EP five-year strategy under its component of integration of HIV and TB care and treatment.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals *(diagnosed or presumed) in a palliative care setting*	32	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	50	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	250	☐
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF		☑

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

People living with HIV/AIDS

Laboratory workers (Parent: Public health care workers)

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.07: Activities by Funding Mechanism

Mechanism:	Catholic Relief Services Supplemental
Prime Partner:	Catholic Relief Services
USG Agency:	HHS/Health Resources Services Administration
Funding Source:	GAC (GHAI account)
Program Area:	Palliative Care: TB/HIV
Budget Code:	HVTB
Program Area Code:	07
Activity ID:	4982
Planned Funds:	
Activity Narrative:	This activity is related to activities in ART Services (4849), Counseling and testing (2741) and TB/HIV (2800). This activity provides supplemental funding to the Track 1.0 maintenance budget. CRS will screen 75% of TB patients for HIV at four sites with both HIV and TB programs. In addition, CRS will screen all patients enrolled in HIV care for TB (2,100 patients from FY 2005 and 3,075 new patients in FY 2006). Based an estimated 60% rate of co-infection and 10% annual risk of developing active TB among co-infected patients, CRS will refer all suspected cases of co-infection among PLWHA for TB testing and 100 expected new cases of active TB for treatment. CRS will ensure that community services coordinators collaborate with CSP staff to refer TB/HIV co-infection and to ensure continuum of care to co-infected patients. Specific activities for this collaboration will be the joint training and supervision of HBC volunteers, peers and other staff employed by CSP for TB/HIV community-based activities such as referrals of suspect cases to health centers and community DOTS support to co-infected patients. CRS will contribute to any collaborative activities designed to facilitate referrals between the two levels of care including referrals tools design and implementation. These activities support the Rwanda EP five-year strategy under its component of integration of HIV and TB care and treatment.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	4	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	42	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	100	☐
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF		☑

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

People living with HIV/AIDS

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

Coverage Areas

Byumba

Table 3.3.07: Activities by Funding Mechanism

Mechanism: Call to Action/EGPAF
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 5127
Planned Funds:
Activity Narrative: This activity is related to EGPAF-ARV services (#2757) EGPAF-CT (#2756), and TB-HIV-CHAMP (#5129).

Integration of TB and HIV services is a fundamental component of the Rwanda EP five-year strategy. EGPAF will reach 157 TB/HIV co-infected patients, including 65 pediatric patients, with TB treatment at 15 continuing, 5 new, and 6 graduating health centers. To support the Rwanda EP five-year strategy goal of sustainability, EGPAF will provide limited technical support to the PBF contractor for the six graduating sites to ensure high-quality and efficient TB/HIV service delivery in line with PBF graduation criteria.

As part of a standardized package of care for clinical care partners, HCs will integrate routine testing of all TB clients for HIV, systematic TB screening of HIV-positive clients, and provision of, or referral for, TB treatment, with a special emphasis on pediatric patients. Where TB services are not available, EGPAF will facilitate the collection and transport of sputum samples for testing at TB referral sites, and when necessary, the referral of clients for chest x-rays or other TB services not available on site. Should funds permit, EGPAF will procure a radiology machine at Ngarama District Hospital for TB x-ray capacity, and support the training of hospital staff in the use and interpretation of x-rays. EGPAF will also strengthen access to TB screening for family members, particularly HIV-exposed infants and children of HIV-positive co-infected patients. In collaboration with PNILT and Columbia, EGPAF will develop and pilot site-level level algorithms for diagnosing TB in HIV-positive children younger than 12 years. To increase provider capacity in management of TB-HIV, EGPAF will support on-the-job training and provide regular supervision and QA of TB-HIV activities. EGPAF will also integrate messages on the importance of TB/HIV co-infection into health center education activities.

To strengthen follow-up of TB/HIV patients, EGPAF will develop monitoring and tracking mechanisms within and between facilities to assure that patients access and complete treatment. This will include working with districts, sites and PNILT to strengthen routine date collection and reporting of TB/HIV co-infection, building on existing medical record systems from TB, ART, and PMTCT programs. EGPAF will also coordinate with CHAMP to ensure community-based follow-up of HIV and TB co-infected patients through HBC, including with the pilot community-based DOTS activity. In collaboration with CHAMP, the facility-based community services coordinator will train, support and supervise community volunteer HBC providers on TB/HIV follow-up and referrals.

PNILT, which is responsible for the National Tuberculosis Program in Rwanda and also serves as a key coordinating entity for implementation of Rwanda's Global Fund TB grant, is an active participant in this activity.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	20	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	25	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	157	☐
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF	6	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba

Kigali (Rurale)

Kigali-Ville

Table 3.3.07: Activities by Funding Mechanism

Mechanism: Capacity
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 5128
Planned Funds:
Activity Narrative: This activity is related to Capacity/IntraHealth ARV services (2777), CT (2775), and CHAMP HIV/TB (5129).

Integration of TB and HIV services is a fundamental component of the Rwanda EP five-year strategy. In coordination with all implementing partners, this activity will support the strengthening of TB/HIV services at 16 health centers with existing HIV services, including 10 continuing and 6 new sites. CAPACITY/IntraHealth will also prepare 15 sites offering TB/HIV services for graduation to PBF through limited technical support to ensure TB/HIV service delivery in line with PBF graduation criteria. Targets for these graduating sites are divided evenly between CAPACITY/IntraHealth and the MSH/PBF.

CAPACITY/IntraHealth will reach 150 TB/HIV co-infected patients through routine testing of all TB clients for HIV, systematic screening of HIV-positive clients for TB, and provision or referral for TB treatment. Where TB services are not available, CAPACITY/IntraHealth will facilitate the collection and transport of sputum samples for testing at TB referral sites, and, the referral of clients for chest x-rays or other TB services not available on site. Health providers will refer family members of HIV-positive co-infected patients for TB screening and treatment. In collaboration with PNILT, DHTs, and other partners, CAPACITY/IntraHealth will enhance provider capacity in management of TB/HIV through on-the-job training, use of job aids and site-level algorithms, regular supervision and QA of TB/HIV activities. CAPACITY/IntraHealth will also integrate messages on the importance of TB/HIV co-infection into health center education activities.

To strengthen follow-up and monitoring of TB/HIV patients, CAPACITY/IntraHealth will develop monitoring and tracking mechanisms within and across facilities to assure that patients access and complete treatment. This will include working with districts, sites and PNILT to strengthen routine data collection and reporting of TB/HIV co-infection, building on existing medical record systems from TB, ART, and PMTCT programs. CAPACITY/IntraHealth will also coordinate with the CSP to ensure community-based follow-up of HIV/TB co-infected patients through HBC, including with the pilot Community-Based DOTS activity in districts where the partner is working. In collaboration with CSP contractor, the facility-based community services coordinator will train, support and supervise community TB DOTS volunteers on TB/HIV follow-up and referrals.

PNILT (see activity #2731), which executes the National Tuberculosis Program in Rwanda and serves as a key coordinating entity for GFATM implementation of Rwanda's TB grant, is an active participant in this activity.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	16	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	150	☐
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals *(diagnosed or presumed) in a palliative care setting graduated to* the PBF	15	☐

Target Populations:

Nurses (Parent: Public health care workers)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba

Gitarama

Kibungo

Kibuye

Kigali (Rurale)

Umutara (Mutara)

Table 3.3.07: Activities by Funding Mechanism

Mechanism:	CHAMP
Prime Partner:	Community Habitat Finance International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Palliative Care: TB/HIV
Budget Code:	HVTB
Program Area Code:	07
Activity ID:	5129
Planned Funds:	
Activity Narrative:	This activity is also related to CHAMP BHC (#2811) and TB/HIV activities under Columbia UTAP (#2731), PBF (#4001), FHI (#4768), Columbia MCAP (#4839), CRS(#4982), EGPAF (#5127), and IntraHealth (#5128).

Scaling up the integration of TB and HIV services is a fundamental component of the Rwanda EP five-year strategy. Through the Global Fund TB grant, PNILT piloted community DOTS in three districts in Cyangugu, Butare and Umutara provinces. PNILT, which is responsible for the National Tuberculosis Program in Rwanda and also serves as a key coordinating entity for GFATM implementation of Rwanda's TB grant, is an active participant in the development and piloting of the community-based DOTS approach. In line with PNILT national protocols, CHAMP will fund additional community DOTS activities in five USG-supported districts to reach 100 HIV/TB co-infected patients. Building from the experiences of PNILT and Global Fund, CHAMP will train 50 volunteers in the following technical areas: TB DOTS, recognition of symptoms and signs of TB among HIV-positive patients and their family members, referrals for TB screening and treatment, and promotion of and referral for HIV testing of TB patients of unknown status. The TB DOTS approach includes selection of suspect cases in the community, directly observed treatment, adherence support, contact tracing, follow-up at clinics to ensure treatment completion, and regular communication with HIV/AIDS care service providers at health facilities. CHAMP will also train HBC volunteers to refer suspected family members and caregivers of PLWHA and OVC for HIV and TB testing and treatment. This will increase the identification of TB/HIV co-infected individuals and their access to clinical and community HIV/TB services.

CHAMP will collaborate and plan with other USG partners supporting clinical services in the five districts to establish a system of support and referrals between health facilities and the TB DOTS volunteers, including the use of referral slips and the provision of transport fees to the health facility. CHAMP will work with PNILT and the EP clinical service partners to integrate TB/HIV related indicators and patient information into volunteer monitoring tools and registers to better ensure TB treatment adherence and the quality of services. EP-supported health centers and PNILT-identified supervisors will provide periodic supervision and monitoring of community DOTS volunteers. With support from PNILT, EGPAF and Columbia/UTAP, CHAMP will integrate pediatric TB/HIV tools and messages into all TB/HIV activities. CHAMP will sensitize communities around USG-supported health facilities to TB/HIV co-infection and promote TB/HIV testing and treatment through the dissemination of IEC materials. CHAMP will also work with RRP+, district authorities, PNILT, Columbia UTAP, WHO and Global Fund to implement a national policy and scale-up plan for community-based DOTS. Expanding community DOTS activities will indirectly contribute to the TB treatment goals of the EP and increase adherence to the treatment.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	50	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	100	☐
Number of HIV-infected clients given TB preventive therapy		☑
☐ Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting graduated to the PBF		☑

Target Populations:

Community-based organizations

People living with HIV/AIDS

Volunteers

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibuye

Kigali (Rurale)

Kigali-Ville

Kibungo

Umutara (Mutara)

Table 3.3.08: Program Planning Overview

Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08

Total Planned Funding for Program Area:

Program Area Context:

The double impact of genocide and HIV/AIDS has resulted in Rwanda having one of the highest proportions of orphans in the world. There are 1.25 million orphans in the country, of which 160,000 were orphaned due to HIV/AIDS. Most PLWHAs in Rwanda reside in households with an average of five members, an indication that many more children are at risk of being orphaned due to HIV/AIDS. UNICEF estimates that by 2010, the majority of orphan cases will be attributable to the HIV/AIDS epidemic.

In compliance with UNGASS commitments, Rwanda adopted a National Policy for OVC in 2003, and in 2004 developed a National Plan of Action for OVC. MIGEPROF, the ministry responsible for children's social services, carried out a rapid assessment, analysis and action planning process for OVC last year. As a follow-up, the donor community projected the costs associated with implementation of the plan along with development of M&E indicators. Rwanda's PRSP establishes a program highlighting the vulnerability of OVC and proposing actions to assist them. To build on this momentum, MIGEPROF recently established a donor coordination cluster on children, which serves to coordinate all interventions that benefit children. As outlined in the Rwanda EP five-year strategy, our primary initial activity was to assist in coordinating OVC efforts country-wide.

In FY2006, the EP will work closely with the donor coordination cluster, the national children's steering committee, MIGEPROF, CNLS, primary OVC donors (DFID, EU, UNAIDS, DFID, UNICEF, WFP) and other OVC implementers, such as Save The Children UK, to better coordinate efforts. To assist in building GOR capacity to manage OVC, the EP will support a full-time staff position at MIGEPROF (to be seconded through a USG grantee). Capacity-building priorities include policy and legal reform, government and civil society coordination, and monitoring of OVC services. The EP will offer a package of comprehensive OVC services, including education, health, psychosocial support, nutrition, and economic interventions in a gender-sensitive manner to beneficiaries around EP-assisted facilities. HIV prevention messages will continue to be integrated into OVC programs as outlined in the EP five-year strategy. CHAMP will be the prime OVC implementing partner, supporting activities through sub-grants to Rwandan FBOs and CBOs. In addition, CHAMP will be responsible for coordinating all EP partners and standardizing EP OVC selection criteria, systems for beneficiary monitoring, and service packages.

As of March 31, 2005, EP assistance had reached over 15,000 OVC and trained 1,296 volunteers and caregivers in supporting OVC. In FY2006, the EP expects to increase the number of direct and indirect OVC served to 57,509. Anticipated challenges include ensuring uninterrupted services to beneficiaries while activities are transferred from current implementing partners to the CHAMP mechanism (which will include sub-grants to many new partners) and supporting MIGEPROF as it undergoes reforms, relocation, and restructuring. By building the capacity of national and district MIGEPROF structures and improving the quality of OVC services provided by Rwandan organizations, the EP will foster sustainable care and support for Rwanda's OVC.

Program Area Target:

Number of OVC served by OVC programs	36,309
Number of providers/caretakers trained in caring for OVC	3,076

Table 3.3.08: Activities by Funding Mechanism

Mechanism: CHAMP
Prime Partner: Community Habitat Finance International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 2810
Planned Funds:
Activity Narrative: This activity relates to other CHAMP activities under PMTCT (#2805), AB (#2807), OP (#2808), CT (#2806), HIV/TB (#5129), BHC (#2811), ARV Services (#2809), and Systems Strengthening (#5183).

CHAMP will serve as the main coordinating mechanism for EP-supported OVC activities, providing sub-grants to local CBOs and FBOs who will directly deliver services. CHAMP will provide TA, training and financial support to new Rwandan implementing partners to strengthen their capacity to care for Rwanda's most vulnerable children. CHAMP partners will facilitate a cohesive, community-led approach among the Track 1.0 OVC partners and the CHAMP subgrantees to ensure the delivery of quality OVC services. According to MIGEPROF's OVC Plan of Action (2004), the menu of essential OVC services includes: education, health, shelter, food, economic strengthening, psychosocial support, protection, and HIV prevention. As a health intervention to prevent malaria, this project will also provide mosquito bed nets to all beneficiaries in need since malaria is the number one killer of children in Rwanda. All subgrantees and Track 1.0 partners will work closely together in order to offer multiple services to beneficiaries and to refer OVC to other services in the community as appropriate. This project will maximize the network approach to increase linkages among HIV/AIDS care, support, and treatment partners, wrapping around EP and other donor supported activities for children and youth.

Under COP05, CHAMP will conduct a participatory OVC situation analysis and map multi-sector services (including IMCI, RH, malaria, education and girls scholarship fund, economic growth, HIV/AIDS prevention, care, and treatment, psycho-social support, food and agriculture) related to children and youth in priority geographic areas. Using these results, and with COP06 funding, CHAMP will fill gaps in services in the catchment areas around EP-supported health facilities. CHAMP will ensure current beneficiaries continue to receive EP-funded services regardless of geographic location. *In FY2006, the project will select new beneficiaries living in communities* around health facilities providing EP-supported clinical HIV/AIDS services and will prioritize CHH. This strategy fosters the network model and a more comprehensive package of community and clinical care services for OVC, PLWA, and their families. CHAMP will establish standards of practice and consensus-building on what constitutes a "child served" in collaboration with MIGEPROF, the EP OVC TWG, beneficiaries, the community and other OVC donors. This implementing partner will ensure active youth involvement in OVC programming decisions and implementation *at local and national levels. CHAMP will convene regular OVC partner meetings to* provide support and leadership on the implementation of quality, comprehensive services for Rwanda's OVC.

CHAMP will review current OVC and PLWHA training curricula to produce updated tools for caregivers and volunteers that address the following topics: bereavement counseling and communication skills for psychosocial support; basic human rights for children; nutrition; HIV prevention; links between alcohol abuse, violence and HIV; stigma reduction; ART literacy and adherence; and monitoring the status of OVC and their families. CHAMP will train 2,400 volunteers and caregivers who will link OVC to clinical care and follow-up on pediatric AIDS cases. CHAMP will encourage a family-centered, holistic approach by funding local projects that integrate OVC and PLWA care and support services. This approach supports the EP five-year strategy to integrate HIV prevention, care and treatment; expand pediatric HIV care; and mobilize community coordinated action. This program will also fund a technical advisor on OVC policy and programming at MIGEPROF to provide support in the implementation of the National Plan of Action on OVCs. In collaboration with MIGEPROF, CHAMP will establish a system for monitoring and evaluating OVC activities

at the community level and will devise a mechanism to move community-level OVC data up to district and national levels. CHAMP will provide TA and training at the national, provincial and district levels for systems strengthening and better monitoring of community-based OVC efforts. This project will facilitate the sharing of materials, best practices and lessons learned to avoid duplication of effort and to maximize efficient and effective delivery of services. CHAMP will formally engage USG partners in other sectors, especially in economic growth (e.g., vocational training, youth livelihoods, agri-business), to obtain state-of-the art practices for use by OVC partners. As directed by the USG, CRS will coordinate its Title II program to directly provide food rations to malnourished OVC supported under CHAMP.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	26,000	☐
Number of providers/caretakers trained in caring for OVC	2,400	☐

Indirect Targets

CHAMP will indirectly reach other members of CHH with IGA activities, HIV prevention information, housing repairs and home visits. Of the 26,000 OVC targeted, an estimated 30 percent will be from CHH with an average of two other children indirectly benefiting from the EP. Considering this, one can estimate that 15,600 OVC will directly receive benefits through this project.

Target Populations:

Community leaders
Community-based organizations
Country coordinating mechanisms
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
Caregivers (of OVC and PLWHAs)
Religious leaders
Host country government workers

Key Legislative Issues

Stigma and discrimination

Gender

Food

Education

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibungo

Kibuye

Kigali (Rurale)

Kigali-Ville

Umutara (Mutara)

Table 3.3.08: Activities by Funding Mechanism

Mechanism:	WR Supplement
Prime Partner:	World Relief Corporation
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Orphans and Vulnerable Children
Budget Code:	HKID
Program Area Code:	08
Activity ID:	2818
Planned Funds:	
Activity Narrative:	[Continuing FY2005 Activity through December 2005 - then CHAMP will pick up these beneficiaries under Activity #2810] This USG activity supports essential OVC activities until a new community services procurement can be take over. This USG activity's OVC care and support initiatives are based in a national network of congregations mobilized for AIDS programming. Activities include: 1. Raise awareness of OVC issues and recommendations for church response in all participating churches. Using existing "Our Children" curriculum designed for church audience, this USG partner will conduct one-day workshops with 800 new local church leaders and volunteers in six provinces on identification, care and support of OVC in their communities. 2. Support to churches for provision on minimal service package to OVC. Using churches' care programs, USG will subsidize unmet needs to provide a minimum package of benefits to all identified OVC within the criteria framework of the church. This package will include a) school fees, books and uniform for nearest government school, b) annual contribution to each OVC health expenses, c) regular monthly visits by church volunteers to assess needs, physical health and provide psycho-social support; Livelihood development program for select OVC. 3. WR will identify local crafts people (i.e. carpenters, tailors, bakers, bicycle repair) who are receiving small loans from local microfinance institutions, who are willing to serve as mentor/teachers for 30 OVC to learn a livelihood. USG will provide sub grants to at least 3 churches to develop their own sustainable OVC care programs. These structures may include care to OVC in the community, income generation activities for OVC and caregiver groups, etc.

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs		☑
Number of providers/caretakers trained in caring for OVC		☑

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Volunteers

Table 3.3.08: Activities by Funding Mechanism

Mechanism:	CRS Track 1
Prime Partner:	Catholic Relief Services
USG Agency:	U.S. Agency for International Development
Funding Source:	N/A
Program Area:	Orphans and Vulnerable Children
Budget Code:	HKID
Program Area Code:	08
Activity ID:	2830
Planned Funds:	
Activity Narrative:	This OVC project targets orphans, CHH and street children, some of which have lost their parents due to HIV/AIDS and are vulnerable to becoming HIV-positive themselves. The project aims to improve the quality of life of 5,750 OVC affected or infected by HIV/AIDS in four Rwandan Dioceses in order to strengthen family and community capacity to provide a supportive environment. CRS implements this project in partnership with Caritas Rwanda, working with its network of church-based community organizations in 70 parishes across Catholic dioceses in Butare, Byumba, Nyundo and Kibungo. CRS will continue coordinating its OVC activities with the CNLS, MIGEPROF, other OVC implementing partners and Community Development Committees at the district level. CRS will also participate in the EP TWG on OVC. CRS will offer a comprehensive menu of services for all OVC served, including: educational assistance, access to health care, nutritional information, economic strengthening opportunities, psycho-social support and child protection. This project will provide school materials (exercise books, pens) to 4,500 pupils in primary schools and pay school fees for 450 students in secondary school. CRS will pay for community health care insurance (Mutuelles de Santé) for 1,000 OVC and their families. To improve OVC nutritional status, this project will provide training on nutritional information, animal husbandry and small-scale gardening for OVC caregivers. CRS will provide 400 small animals (mainly goats) to 200 OVC households through vouchers during goat fairs. As directed by USAID, CRS's Title II Program will provide food rations to malnourished OVC households affected by HIV/AIDS. For economic strengthening, this activity will organize 400 OVC and OVC caregivers into savings and internal lending communities (SILC) using a methodology developed by CRS. CRS will train Caritas staff members on the SILC methodology to build the capacity of this FBO to implement, monitor and evaluate IGAs. Another strategy for ensuring sustainability will be to direct these nutrition-focused and savings-and-credits activities to women's' associations to improve women's access to income. This program will also pay for the vocational materials and fees for 100 CHH and/or street children so that they obtain income-generating skills such as hairstyling, carpentry, and tailoring. This program will conduct community mobilization and awareness meetings (targeting 2000 community leaders and OVC) on OVC care and support issues as well as on HIV/AIDS awareness, focusing on abstinence and fidelity prevention and information on ART. Caritas will sensitize an additional 500 OVC guardians on these topics. CRS will train 150 community volunteers on child welfare monitoring, HIV prevention, interpersonal communication and counseling, and child rights, using the Child Rights Training Manual developed under COP05. These community volunteers will make home visits to 600 OVC to provide emotional and psycho-social support and ensure that children's rights are respected and protected according to local laws. All cases of child abuse and trauma will be reported to appropriate authorities and these OVC will receive clinical care and additional support services as needed. The community volunteers will promote CT for OVC from HIV-positive families and will link HIV-positive OVC to ART services. CRS will also hold quarterly meetings for OVC in parishes in order to get feedback about the care and support services they are receiving. This program addresses key legislative issues concerning gender and women's access to income. This program also supports the Rwanda EP five-year strategy of strengthening the capacity of community and religious organizations to address the needs of vulnerable children.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	5,750	☐
Number of providers/caretakers trained in caring for OVC	150	☐

Indirect Targets

The indirect beneficiaries include OVC living in households that will benefit from agriculture, livestock, gardening and saving and credit activities. CRS expects to reach a total of 5,600 indirect beneficiaries.

Target Populations:

Faith-based organizations
Orphans and vulnerable children
Volunteers
Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Increasing women's access to income and productive resources

Stigma and discrimination

Addressing male norms and behaviors

Reducing violence and coercion

Food

Coverage Areas

Butare

Byumba

Gisenyi

Kibungo

Kibuye

Umutara (Mutara)

Table 3.3.08: Activities by Funding Mechanism

Mechanism:	USAID Rwanda Mission
Prime Partner:	US Agency for International Development
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Orphans and Vulnerable Children
Budget Code:	HKID
Program Area Code:	08
Activity ID:	4969
Planned Funds:	
Activity Narrative:	USAID/Rwanda has been providing local and international technical assistance to GOR agencies and limited direct grants to local NGOs since COP04. In COP06, the Emergency Plan will expand this to further build local capacity. These resources will cover the cost of sponsoring and attending conferences, workshops and technical meetings on OVC care. A number of Rwanda NGOs requested financial assistance from USAID in FY2005 for such activities. USAID anticipates continuing this financial and technical support role in FY2006. The MOH is requesting technical assistance for the new Rwanda Center for Health Communications (RCHC), a unit within the MOH charged with improving IEC/BCC activities. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS and MIGEPROF.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	51 - 100
Policy and Guidelines	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of OVC served by OVC programs		☑
Number of providers/caretakers trained in caring for OVC		☑

Target Populations:

Community-based organizations
Faith-based organizations
Host country government workers

Coverage Areas:

National

Table 3.3.08: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Associazione Volontari per il Servizio Internazionale
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 5242
Planned Funds:
Activity Narrative: This activity will provide quality, comprehensive care services to 2,209 OVC and their communities in collaboration with a network of 29 local community partners. AVSI uses a bottom-up approach in the identification of beneficiaries and the choice and delivery of support, thereby ensuring that the services provided are consistent with the real needs and expectations of the beneficiaries. AVSI will work closely with local partners and social workers to jointly establish and update selection criteria and services within each community, paying particular attention to the vulnerability of girls. This program will ensure that every child who is supported is cared for by an adult, either in the family or by someone in the community or from a CBO. The program strategy involves supporting and improving the operational capacity of the CBOs through close and continuous support and TA. AVSI also works in collaboration with community development committees, MIGEPROF and GOR authorities, as well as the other EP partners.

AVSI will use EP resources to expand ongoing efforts to provide education, health, economic and food assistance to OVC through a collaborative, multi-sectoral approach. Assistance with school requirements for OVC represents the main percentage of expenditures, with education being a main need of orphans and the best sustainable response for their growth and self-esteem. Other direct assistance includes developing community gardens and providing food assistance for food insecure CHHs through a partnership with the WFP. Indirect assistance consists of supporting quality education (improving classrooms and training teachers), IGA, community projects, and the dissemination of IEC materials promoting CT and educating the community on HIV prevention. AVSI developed the "Value of life" training module for use by secondary school teachers in after-school programs discussing the prevention of HIV/AIDS and emphasizing abstinence and delay of sexual debut. This activity will also provide OVC with referrals to CT and ART services.

Training and consultations will be provided for individual implementing partners and local networks to address institutional and operational weaknesses and to improve capacity, efficiency and quality. AVSI will provide financial support for operational costs in the form of direct payment for personnel, fuel, and stationery. AVSI will continue organizing quarterly meetings to oversee service delivery and ensure quality, transparency, efficiency and synergy of program activities with other implementing partners. This activity will build the capacity of CBOs by identifying their needs and supporting workshops to improve management skills, systems of accountability, and service delivery among CBOs providing OVC services. AVSI will also train OVC caregivers, which include family and community members, social workers and teachers. Ultimately, this approach of involving social workers, district authorities, CBOs and teachers enhances the community's overall ability to appropriately address the needs of OVC in their community. This activity supports the Rwanda EP five-year strategy of mobilizing and supporting local Rwandan organizations to provide community-based care for Rwanda's most vulnerable children.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	2,209	☐
Number of providers/caretakers trained in caring for OVC	86	☐

Indirect Targets

AVSI provides indirect support for ensuring quality education by improving classrooms, and training teachers on how to discuss prevention of HIV/AIDs with adolescents. In addition indirect support is provided through income generation activities (IGA), community projects, and the dissemination of IEC materials which promote CT and educate on HIV prevention. Currently, AVSI is not tracking indirect beneficiaries. In FY2006 and in collaboration with CHAMP, all OVC implementers will reach consensus on how to count and record indirect beneficiaries.

Target Populations:

Community-based organizations

Faith-based organizations

HIV/AIDS-affected families

Orphans and vulnerable children

Teachers (Parent: Host country government workers)

Volunteers

Caregivers (of OVC and PLWHAs)

Implementing organizations (not listed above)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Increasing women's access to income and productive resources

Stigma and discrimination

Food

Education

Coverage Areas

Byumba

Gitarama

Kigali-Ville

Table 3.3.08: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Africare
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 5262
Planned Funds:
Activity Narrative: The Expanded COPE project aims to provide a comprehensive menu of services to OVC while strengthening the capacity of OVC, their families, and the community to meet the needs of vulnerable children. The project will coordinate and expand social services for OVC, including educational assistance, access to health care, nutritional and psychosocial support, and economic opportunity. The project will oversee the selection of primary and secondary schools for the distribution of block educational grants and materials (uniforms, notebooks, pens) to facilitate the enrollment of approximately 2,000 OVC. District officials and community leaders will be instrumental in the selection process. This project will use 400 community volunteers from Africare's existing Home Care Program, providing them with additional training in psychosocial support, basic human rights for children, nutrition, trauma processing, HIV/AIDS prevention and monitoring the status of OVC and their families. These community volunteers will routinely visit the homes of beneficiaries using a family-centered, holistic approach in delivering emotional support and referrals to other services. Volunteers will link sick OVC to health care services and malnourished OVC to food assistance. The project will provide direct nutritional support through Africare's Title II program and linkages with WFP. The project will seek to expand and promote nutrient-rich food production in Gikongoro Province. This project will conduct market assessments in Gikongoro and Kigali Ngali Provinces in order to establish sustainable IGAs for OVC. The project will then provide vocational training and support for micro-enterprise activities to 350 OVC.

The program will train 40 Service Corps volunteers (20 per district) with Africare's 10-day training curriculum on HIV prevention, stigma, life skills, care and support for OVC, and monitoring and reporting. Service Corps volunteers will create 20 anti-AIDS clubs supported through CBOs, churches, schools and PLWHA associations. To avoid stigma, both OVC and non-OVC will participate in the club meetings which will serve to deliver HIV/AIDS education and recruit peer educators. Using a three month curriculum, Service Corps volunteers will train youth as peer educators who will provide OVC and other youth with correct information about HIV/AIDS; allow youth to understand their own risk factors; support youth in abstaining from sex; promote partners reduction and fidelity; and develop youth's negotiation skills to sustain these healthy practices. Particular attention will be given to the participation of OVC as peer educators.

Churches and other CBOs will organize caregiver support groups to provide additional psychosocial support for OVC and their caregivers. Africare will provide these new partner FBOs and CBOs with financial and program management assistance. Building the capacity of local Rwandan organizations and structures supports the Rwanda EP five-year strategy. Africare will assemble religious leaders, teachers, district authorities, and community members to form a multi-sectoral district-level Child Forum and Orphan Community Care (OCC) committees to determine selection criteria and identify beneficiaries. This project will not duplicate existing government structures, but work in close partnership with the existing Community District Committees, MIGEPROF and the other EP OVC implementers. Africare recognizes that gender often determines the needs and roles of youth in communities and families, as well as their access to services. Africare's approach ensures that both girls and boys are linked to appropriate services according to their age group and identified needs, and that girls have access to educational opportunities. Through this program AFRICARE will serve 2,350 OVC.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	2,350	☐
Number of providers/caretakers trained in caring for OVC	440	☐

Indirect Targets

In FY2006, Africare will work in collaboration with CHAMP and the other OVC implementers to reach consensus on how to count and record indirect beneficiaries.

Target Populations:

Community-based organizations

Orphans and vulnerable children

Volunteers

Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Increasing women's access to income and productive resources

Stigma and discrimination

Food

Coverage Areas

Gikongoro

Kigali (Rurale)

Table 3.3.09: Program Planning Overview

Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09

Total Planned Funding for Program Area:

Program Area Context:

To date, GOR has established VCT centers in more than 165 health facilities, with assistance from EP partners and the Global Fund. Even without a mass media campaign to promote VCT, many Rwandans are coming to these facilities to be tested, and those found to be HIV-positive are being referred to care and ARV treatment services.

A recent technical review of CT activities found that although VCT sites are located on the grounds of medical facilities and are often referred to as "integrated VCT" sites, the services they provide are not actually integrated with other medical services in the facility. In addition, there are indications that many health workers, even those trained in counseling, are not informing hospital patients of their HIV test results because of the belief that HIV test results can only be given in a VCT or PMTCT site. Following discussions with the MOH, TRAC is revising its CT policies to ensure that PIT occurs more routinely in medical settings, and that informed consent is always given.

In FY2006, the EP will expand its support to established VCT centers in keeping with the EP five-year strategy while ensuring that PIT is institutionalized and systematically recorded and reported. This will involve working with the government to establish policies and protocols for PIT, developing training tools for health workers, procuring test kits, and expanding CT reporting systems to capture PIT. The EP will collaborate with TRAC and USS to strengthen QA of all CT services through improved supervision, possible introduction of client exit interviews, and support to districts in M&E of CT activities.

Religious leaders encourage pre-marital testing in Rwanda, and a significant percentage of VCT clients come for this purpose. The majority of these pre-marital couples are found to be HIV-negative. Partners supported under COP06 will work with FBOs to make pre-marital testing more widely available, and will ensure that post-test counseling sessions, especially for couples testing negative, emphasize the importance of marital fidelity to ensure that the couple and their children remain free of HIV infection. For discordant couples identified in VCT sites, the EP will support innovative strategies, working through PLWHA associations to ensure that the HIV-negative partner does not seroconvert. The EP will also build on the home-based testing pilot initiated in FY2005 to expand home-based and *family testing through clinical partners and in collaboration with CHAMP. Through expanded mobile and* outreach testing activities, high risk populations, including the military, prisoners, refugees, and sex workers, will have increased access to prevention, care and treatment services.

Because of the large numbers of people requesting services at VCT centers, and due to the current protocol of conducting all tests in labs rather than in counseling rooms, the time available for post-test and prevention counseling for both HIV-positive and HIV-negative clients may be very abbreviated. This problem will be studied more thoroughly to identify ways to ensure that effective prevention *counseling does in fact occur for all persons tested, both during provider-initiated and client-initiated* testing. In COP06, the EP will implement new approaches designed to strengthen the prevention component of CT services, such as continuous counseling and testing sessions for all clients and the use of rapid tests rather than a complete blood draw.

Through these activities, USG will support CT services for a total of 307,255 individuals in FY2006 (264,816 direct and 42,439 indirect).

Program Area Target:

Number of service outlets providing counseling and testing according to national or international standards	162
Number of individuals who received counseling and testing for HIV and received their test results	264,816
Number of individuals trained in counseling and testing according to national or international standards	746

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	Columbia UTAP
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	2730
Planned Funds:	
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006] This deferred funding from FY 2004 will complete support for a long-term technical advisor to the PMTCT/VCT Unit at TRAC for FY 2005. Specific CT activities associated with this technical advisor are detailed under ORISE CT activity narrative.

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Columbia UTAP
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2732
Planned Funds:
Activity Narrative: This activity relates to CT activity 2800.

In FY2005, Columbia University initiated innovative family and home-based testing activities to more effectively reach family members of PLWHAs with CT services. In FY2006, Columbia will scale up two of the models piloted in FY2005 with the goal of strengthening linkages between clinical services and home- or family-based care. These models are: 1) going to the homes of index patients to provide CT services to their family members, and 2) working with PLWHA associations to counsel and test family members of PLWHA. In the second model, CT services may be provided to relatives of PLWHAs either at the meeting place of the PLWHA association or at the ART center via whole-blood (finger-prick) rapid tests. Individuals targeted under this activity will not need to go to VCT sites for CT services. Counselors -- whether members of the PLWHA associations, case managers or site staff -- will maintain confidentiality in accordance with the MOH guidelines. Columbia will carry out these activities in collaboration with the Rwandan Network of PLWHA and staff at Columbia-supported ART sites. The target for the number of individuals tested in FY2006 is 2000. This activity advances the Rwanda EP five-year strategy of integrating care with prevention and treatment services and expanding CT services beyond the health facility.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	9	☐
Number of individuals who received counseling and testing for HIV and received their test results	2,000	☐
Number of individuals trained in counseling and testing according to national or international standards	36	☐

Target Populations:

Community-based organizations
HIV/AIDS-affected families
People living with HIV/AIDS

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	TRAC Cooperative Agreement
Prime Partner:	Treatment and Research AIDS Center
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	2741
Planned Funds:	
Activity Narrative:	This activity relates to activities in PMTCT (#2743) and ARV services (#2745) and consists of three main components. First, in collaboration with the EP Prevention TWG and other partners, TRAC will revise and replicate national CT norms, guidelines and tools (e.g. client forms, reporting forms, educational and supervision tools) and will disseminate these to all health facilities providing CT services. Second, TRAC will conduct four TOT sessions on CT service provision, including VCT and PIT. These training sessions will cover all aspects of the expanded national CT protocol, including: opt-out testing and informed consent for PIT, whole blood finger-prick tests and continuous testing sessions for VCT clients, and targeted prevention counseling for HIV-positive and HIV-negative clients. The participants at these trainings (trainers in Rwanda's 29 health districts) will subsequently train CT service providers from all CT sites. TRAC will conduct quarterly supervision of these decentralized trainings. In addition, TRAC will conduct two training sessions for district-level supervisors, who will make regular visits to CT sites to assure the quality of services. *Finally, TRAC will continue its support to CRIS, the standalone VCT site co-located* with TRAC in Kigali, by purchasing materials and renovating the facility. Five thousand (5,000) people will receive CT services as a result of TRAC's support to CRIS. The budget for this activity includes salary support for a CT master trainer and a CT program officer within TRAC's PMTCT/VCT unit, as well as medium-term TA for operations research on quality of CT services.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results	5,000	☐
Number of individuals trained in counseling and testing according to national or international standards	116	☐

Indirect Targets

TRAC is the national agency responsible for developing policies, norms and guidelines for clinical HIV/AIDS services. In addition, TRAC trains district-level CT trainers and supervisors. Both of these key functions are financed by the EP. Through TRAC's policy and training support, 240 health facilities will be providing VCT services by the end of FY2006, and a total of 42,439 individuals will receive counseling and testing for HIV (in addition to the 264,816 individuals who will be served directly by USG partners).

Target Populations:

Adults

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Call to Action/EGPAF
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2756
Planned Funds:
Activity Narrative: This activity also relates to activities in EGPAF BHC (#5111), EGPAF ART (#2757), ARC CT (#4867) and CHAMP CT (#2806). In line with the EP goals, EGPAF will reach 26700 individuals through a strategic mix of high-quality PIT and client-initiated CT services that ensure confidentiality, combat stigma and discrimination, and reach those individuals most likely to need treatment. This activity will strengthen CT services at 5 new and 15 existing health facilities (including two hospitals), and prepare 6 sites for graduation to the PBF through limited technical support to the PBF contractor for the graduating sites. At all EGPAF-supported health facilites, PIT CT services will target adult and pediatric inpatients, patients presenting with TB and other HIV-related OIs and symptoms, malnourished children and HIV-exposed infants, and STI patients, with the goal of achieving 25% PIT of all those counseled and tested. Providers will routinely encourage testing of family members, particularly children, of ART and PMTCT patients. In collaboration with CHAMP and the CS coordinator, health providers will work with PLWHA associations, churches, community DOTS programs, and OVC and HBC programs to identify infected patients, in particular HIV-exposed infants, family members of PLWHA, and OVC.

CT providers will continue to provide traditional VCT (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, and disclosure of test results. EGPAF will support training or refresher training of new and existing staff in confidential PIT that includes modified counseling messages, and enhanced prevention to promote abstinence and fidelity, alcohol reduction, GBV, and disclosure. In line with the revised GOR CT protocol, health facilities will modify testing procedures from venous blood draw to whole blood/finger prick to maximize efficiency of rapid tests. To enhance efficiency of client-initiated testing at sites, nurse counselors will also be trained to perform rapid tests under the supervision of a laboratory technician. Lay counselors, PLWHA association members, and other non-health professionals will be utilized to support counseling and testing activities at the health facility level under supervision of nurses or other health center staff. At the health center level, EGPAF will ensure a system for supportive supervision of nursing and counseling staff, including training of select staff in supervision for CT, use of quality control checklists, and data quality control.

To strengthen the network model for PLWHA and their families, the partner will establish a formalized referral system to link community care and clinical services. PLWHA will be offered or referred for CTX PT, TB screening, CD4 and clinical staging, and other prevention, care and treatment services. The CHAMP clinical-community coordinator will ensure HIV-positive patients are referred for community-based services, such as IGA, PLWHA associations, OVC, and HBC programs

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	20	☐
Number of individuals who received counseling and testing for HIV and received their test results	26,700	☐
Number of individuals trained in counseling and testing according to national or international standards	200	☐

Target Populations:

Adults

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

HIV/AIDS-affected families

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Laboratory workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Kigali (Rurale)

Kigali-Ville

Byumba

Table 3.3.09: Activities by Funding Mechanism

Mechanism: IMPACT
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2771
Planned Funds:
Activity Narrative: [Continuing Activity from FY2005 – with No New Funding under this mechanism in FY2006. See Activity 4769.] This USG activity is presently supporting CT services in 28 health facilities and in six community-based centers. In order to facilitate the effective and efficient transfer of authority of the most well-established and functioning sites to the MOH and local Rwandan organizations by mid-year, this activity will increase capacity of these organizations for management. In addition, USG will assist the MOH with scale-up by opening 5 new CT centers around new sites designated for ARV roll-out.

Specific activities include:
1. Work with Rwandan partners to transfer management for existing community-based CT sites. This includes assisting AFRICARE in Gikongoro transfer CT services to a close by health center to be managed by the Ministry of Health.

2. Continue to build capacity at the Department of Health Services and TRAC in order to hand over CT services at Kibungo Hospital and Kicukiro Health Center to the Ministry of Health and local authority;

3. Work with hospital staff to promote and extend CT services to hospital in-patients, especially to individuals at high risk for HIV;

4. In preparation for expanding ARV services in Byumba, Gikongoro and Gitarama Provinces in FY06, initiate CT services at 5 additional clinic-based sites in these three provinces; and

5. Work with hospital staff to promote and extend CT services to hospital in-patients, especially to individuals at high risk for HIV.

Print materials to support CT services will be developed in collaboration with TRAC and are budgeted separately from CT service budgets. Additionally,this USG partner is procuring test kits for other USG VCT sites, including those run by EGPAF and IntraHealth.

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Target Populations:

Adults

Most at risk populations

Non-governmental organizations/private voluntary organizations

Pregnant women

Coverage Areas

Butare

Gikongoro

Kigali (Rurale)

Gitarama

Kibungo

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Capacity
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2775
Planned Funds:
Activity Narrative: This activity also relates to activities in CAPACITY/IntraHealth BHC (#5112), CAPACITY/IntraHealth ART (#2777) and CHAMP CT(#2806). In line with the EP goals, IntraHealth will reach 49,000 individuals through a strategic mix of high-quality PIT and client-initiated CT services that ensure confidentiality, combat stigma and discrimination, and reach those individuals most likely to need treatment. This activity will strengthen CT services at 6 new and 10 existing health facilities. The new sites will be implemented in regions where Twubakane DHP is working to ensure synergies with family planning services. IntraHealth will also prepare 15 sites for graduation to the PBF through limited technical support to the PBF contractor for the graduating sites. All 15 sites will be allocated to the PBF contractor and CT targets will be divided between IntraHealth and the PBF.

At all IntraHealth-supported health facilites, PIT CT services will target adult and pediatric inpatients, patients presenting with TB and other HIV-related OIs and symptoms, malnourished children and HIV-exposed infants, and STI patients, with the goal of achieving 25% of all those CT. Providers will routinely encourage testing of family members, particularly children, of ART and PMTCT patients. In collaboration with CHAMP and the CS coordinator, health providers will work with PLWHA associations, churches, community DOTS programs, and OVC and HBC programs to identify infected patients, in particular HIV-exposed infants, family members of PLWHA, and OVC. IntraHealth will continue its successful VCT (client-initiated) services for pre- and post-nuptial couples and ANC male partners, and will build on its FP-PMTCT integration activities to offer routine counseling and testing for FP clients. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, and disclosure of test results. IntraHealth will support training or refresher training of new and existing staff in confidential PIT that includes modified counseling messages, and enhanced prevention to promote abstinence and fidelity, alcohol reduction, GBV, and disclosure. In line with the revised GOR CT protocol, health facilities will modify testing procedures from venous blood draw to whole blood/finger prick to maximize efficiency of rapid tests. To enhance efficiency of client-initiated testing at sites, nurse counselors will also be trained to perform rapid tests under the supervision of a laboratory technician. Lay counselors, PLWHA association members, and other non-health professionals will be utilized to support counseling and testing activities at the health facility level under supervision of nurses or other health center staff. At the health center level, IntraHealth will ensure a system for supportive supervision of nursing and counseling staff, including training of select staff in supervision for CT, use of quality control checklists, and data quality control.

To strengthen the network model for PLWHA and their families, IntraHealth will establish a formalized referral system to link community care and clinical services. PLWHA will be offered or referred for CTX PT, TB screening, CD4 and clinical staging, and other prevention, care and treatment services. The CHAMP clinical-community coordinator will ensure HIV-positive patients are referred for community-based services, such as IGA, PLWHA associations, OVC, and HBC programs

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	16	☐
Number of individuals who received counseling and testing for HIV and received their test results	49,000	☐
Number of individuals trained in counseling and testing according to national or international standards	200	☐

Target Populations:

Adults

Family planning clients

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

HIV/AIDS-affected families

Orphans and vulnerable children

Key Legislative Issues

Reducing violence and coercion

Addressing male norms and behaviors

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Byumba

Gitarama

Kibungo

Umutara (Mutara)

Kibuye

Kigali (Rurale)

Kigali-Ville

Table 3.3.09: Activities by Funding Mechanism

Mechanism: HIV/AIDS School Based Program-Procurement
Prime Partner: Population Services International
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2796
Planned Funds:
Activity Narrative: This activity, part of the Healthy Schools Initiative, relates to activities in AB (#2795), OP (#4837) and CT (#2845).

This activity supports the strengthening of community outreach and referral systems surrounding school-based MVCT (budgeted under CDC's direct budget for CT). PSI, in collaboration with the CDC-supported MVCT team, will provide TA to multi-sectoral *community advisory boards in Kigali city and Gitarama province. These advisory boards* will guide the introduction of mobile CT to school catchment areas and provide ongoing feedback about community reactions to MVCT (e.g. how services can be modified to better serve their clientele). PSI will solicit the involvement of peer educators trained through the Healthy Schools prevention component to help with community preparation and mobilization efforts targeting youth. PSI will also form linkages with NGOs, local businesses and associations of PLWHA in the catchment areas to maximize use of MVCT services by these constituencies; this may involve organizing Free VCT days that are tailored to specific groups, like university students. Working in partnership with the CSP and CNLS, the partner will establish referral systems and develop informational pamphlets to link HIV-positive clients to a comprehensive spectrum of care and support services, including STI services, CD4 testing, ART, spiritual support, FP services, PMTCT services, HBC, associations of PLWHA, legal services, trauma counseling, post-test clubs and nutrition therapy.

Targets for this activity are located under the CDC narrative for Counseling and Testing (#2845). This activity directly supports the Rwanda EP five-year strategy by increasing the availability of CT services outside of health facilities.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Target Populations:

Adults
Business community/private sector
Community leaders
Community-based organizations
Faith-based organizations
Non-governmental organizations/private voluntary organizations
Teachers (Parent: Host country government workers)
Children and youth (non-OVC)
Secondary school students (Parent: Children and youth (non-OVC))
University students (Parent: Children and youth (non-OVC))
Men (including men of reproductive age) (Parent: Adults)
Women (including women of reproductive age) (Parent: Adults)
Religious leaders

Coverage Areas

Gitarama

Kigali-Ville

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	Columbia MCAP Supplement
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	2800
Planned Funds:	
Activity Narrative:	This activity relates to other activities in CT including Columbia UTAP home and family-based testing (2732) and to the Columbia MCAP TB/HIV activity (4839). In FY 2006, to complement its family-based testing approach, Columbia MCAP will also expand PIT in nine hospitals and health centers. Through PIT, Columbia will reach the following patient populations: pediatric cases, expectant mothers who have not received PMTCT services, STI clients and, as described in activity 4839, those with TB/HIV. Providers will follow GOR MOH guidelines to ensure patient confidentiality. The target is 7,000 patients from PIT. This activity advances the Rwanda EP five-year strategy of integrating care with prevention and treatment services.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	9	☐
Number of individuals who received counseling and testing for HIV and received their test results	7,000	☐
Number of individuals trained in counseling and testing according to national or international standards	36	☐

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: CHAMP
Prime Partner: Community Habitat Finance International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2806
Planned Funds:
Activity Narrative: This activity relates to other CHAMP activities: PMTCT (#2805), AB (#2807), OP (#2808), ARV Services (#2809), OVC (#2810), BHC (#2811), HIV/TB (#5129), and OHPS (#5183). This activity will also collaborate with the Healthy Schools Program (#2796) and the Mobile CT programs under PSI/DOD (#4006) and PSI/USAID (#4880).

CHAMP will support the promotion of CT through mass media and training activities and transfer four youth-serving CT sites to local partners. Under CHAMP, Johns Hopkins University's Center for Communication Programs will develop a "Know Your Status" campaign to enhance CT efforts nationwide. The campaign will provide targeted messages for workplaces, markets, schools and universities to support and provide access to CT services. This activity will collaborate with the Healthy Schools Program, PSI's Mobile CT Program and other USG clinical implementers providing CT.

Currently, the EP supports three youth centers (Centre Dushishoze) in Butare, Ruhengeri and Kibungo through PSI. This partner will also begin providing CT services to a PACFA-supported youth center in Kigali-Ngali in early FY2006 with COP05 funding. These four youth centers offer a wide-range of youth-friendly RH and CT services as well as sports, recreation, and educational activities. In COP06, CHAMP will be responsible for transferring the three Centres Dushishoze to local partner organizations while providing them with TA and financial support. This TA will include administration and finance, stock management, proposal writing and fundraising. CHAMP will also continue to support the CT services offered at PACFA's youth center while building their capacity to sustain these services without EP assistance. CHAMP will also ensure that an effective referral system is in place to link those youth testing positive to care and treatment services. These approaches support the Rwanda EP five-year strategy to scale-up quality CT services.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	4	☐
Number of individuals who received counseling and testing for HIV and received their test results	3,000	☐
Number of individuals trained in counseling and testing according to national or international standards	0	☐

Target Populations:

Most at risk populations

Key Legislative Issues

Stigma and discrimination

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: HIV/AIDS Performance Based Financing
Prime Partner: Management Sciences for Health
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2812
Planned Funds:
Activity Narrative: See related Activities (EGPAF-CT 2756, FHI-CT 4769, Capacity/IntraHealth CT 2775, PBF-BHC 2815, PBF- PMTCT 2814)

Performance-based contracting of HIV/AIDS services, including CT, is a key tool to achieving the vision of sustainability outlined in the Rwanda EP five-year strategy. PBF of CT services will be piloted at a minimum of 9 health facilities in 2005 and expanded to 35 additional health centers in 2006. Continued roll-out of CT and other HIV/AIDS services will occur in 2007-2008, if recommended by an independent external evaluation of PBF.

In 2006, the PBF partner will test 40,000 patients (including 15,000 PIT patients and 663 exposed infants or children through PCR or rapid tests). The PBF project will work closely with the district medical officers and DHTs to coordinate and improve HIV services. Graduating sites must meet CT technical criteria developed collaboratively by the PBF partner, DHTs, other CT implementing partners, TRAC, and USS. Clinical partners and PBF will divide CT financing and targets for the graduating HCs during the transition year.

The PBF project will support effective treatment and care of CT patients by reimbursement of indicators, including effective diagnosis, referral and follow-up of CT patients. Once health center sites start performance-based contracting, the PBF will reimburse HCs based on their performance in attaining CT targets, such as percent of CT patients who were tested through PIT or percent of CT patients testing positive who follow up for basic care. HCs will have financial incentives for improving CT patient tracking systems, including their patient medical record systems from BHC, TB, ART, and PMTCT programs. PBF can reinforce the network model by reimbursing health facilities for the indicator "percent of CT patients testing positive who return for staging and CD4s." Both the PBF project and DHT support funds will support HCs to improve their reporting systems and develop clinical audit systems to verify HCs' reports. The improved patient tracking systems will assure that CT patients who test positive access basic health care services and the larger network of care, including community services through CHAMP.

Traditional VCT for the general public, partner testing, prenuptial and couple counseling and testing, and testing for youth will still be available but performance indicators and incentives will be developed with a particular emphasis on PIT target achievement to reach more at-risk and sick patients at health center and hospital level, including inpatients, patients presenting with TB and other HIV-related OIs and diseases, malnourished children and infants who fail to thrive, and STI patients. Through incentives for performance improvement and quality assurance methods, the PBF will help HCs and health districts identify mechanisms to reach more partners and family members of identified HIV-positives testing. To use existing health center staff more efficiently, lay counselors, PLWHA association members, or other non-health professionals will be utilized to support counseling and testing activities at the health facility level under appropriate supervision. Quality performance incentives may be used to assure quality supervision and quality of service delivery by non-health professionals.

In collaboration with CHAMP and community service coordinators, health staff and social workers will train, support and supervise community volunteer home-based care providers on CT follow-up and referrals.

PBF-CT is currently planned for HCs that are implementing performance-based contracting for the package of clinical services, including PMTCT, TB-HIV and BHC

and is not currently planned to reimburse mobile CT.

PBF of HIV/AIDS care, including CT services is a fundamental component of the Rwanda EP five-year strategy for Rwanda.

Emphasis Areas	% Of Effort
Health Care Financing	51 - 100
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	*10 - 50*

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	44	☐
Number of individuals who received counseling and testing for HIV and received their test results	40,000	☐
Number of individuals trained in counseling and testing according to national or international standards	18	☐

Target Populations:

Adults

Discordant couples (Parent: Most at risk populations)

HIV/AIDS-affected families

Infants

People living with HIV/AIDS

Public health care workers

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Increasing women's access to income and productive resources

Wrap Arounds

Food

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: CDC Country Office GAP/TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: *Counseling and Testing*
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2845
Planned Funds:
Activity Narrative: This activity, part of the Healthy Schools Initiative, relates to activities in CT (#2796), AB (#2795) and OP (#4837).

In FY2006, CDC will expand the Healthy Schools MVCT campaign to 20 new (30 total) secondary schools in Kigali City and Gitarama province. School-based Free VCT days will target upper secondary students, their families, teachers and community members. CDC, in collaboration with PSI, will train and support a team of six counselors and four community mobilizers who will be responsible for coordinating all aspects of the campaign. Training will emphasize best practices in MVCT, including uninterrupted CT sessions for all clients, client participation in interpreting rapid test results, confidentiality assurance, and focused prevention counseling for both HIV-positive and HIV-negative clients. The MVCT team will work with TRAC and the CSP to ensure that national CT protocol is respected and that all HIV-positive clients are referred to appropriate care and treatment services, both clinical and community-based. Prior to Free VCT days, the MVCT team will carry out community preparation campaigns in school catchment areas, targeting local government officials, religious leaders, community leaders and NGOs. The team will also organize special Free VCT days for populations requesting them, such as university students. A total of 8,250 individuals will receive CT services as a result of this activity. The budget for this activity includes fuel and maintenance for the MVCT unit and the purchase of a one-year supply of rapid test kits and other supplies.

In addition to the MVCT activity, CDC will provide policy input to the MOH on CT algorithms and protocol. Building on discussions initiated in FY2005, CDC staff from Kenya, Rwanda and Atlanta will provide direct TA to GOR in revising national CT norms and guidelines to define separate protocols for PIT and VCT.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Infrastructure	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	30	☐
Number of individuals who received counseling and testing for HIV and received their test results	8,250	☐
Number of individuals trained in counseling and testing according to national or international standards	10	☐

Target Populations:

Adults

Business community/private sector

Community leaders

Community-based organizations

Non-governmental organizations/private voluntary organizations

Teachers (Parent: Host country government workers)

Children and youth (non-OVC)

Secondary school students (Parent: Children and youth (non-OVC))

University students (Parent: Children and youth (non-OVC))

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

Religious leaders

Coverage Areas

Gitarama

Kigali-Ville

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Rapid Expansion
Prime Partner: Population Services International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2851
Planned Funds:
Activity Narrative: [Continuing FY2005 Activity - New Funding in FY2006 under PSI's Mobile CT Program (#4880)]

PSI will expand their CT activities to scale up their current work with high-risk prison populations in Rwanda. Currently PSI participates on the Prisoners Steering Committee which is working to develop a national strategy to define a minimum package of basic health care for prisoners. PSI is developing general guidelines for CT in prisons, which will be one component of the overall strategy. PSI has FY04 money available to develop and produce the needed IEC materials and to train prisoners as peer educators. To date, PSI has conducted a needs assessment through qualitative research in the form of focus group discussions in five selected pilot prisons (Nyanza, Gikongoro, Karubanda, Gisenyi and Ruhengeri). PSI has trained 120 peer educators in two of the five prisons (Nyanza and Gikongoro).

The additional [redacted] will be used to begin testing prisoners for HIV in two prisons. The Prisoners' Steering Committee advised PSI/Rwanda to target only two prisons in order to test a large percentage of the inmates, instead of testing a smaller percentage in more/all prisons. PSI/Rwanda will contribute to local capacity building by collaborating closely with and providing technical assistance to local prison staff and the nearby fixed health facilities whose counselors and lab technicians will be conducting the CT. Rwanda is in the process of defining a "Stratégie Avancée" which will involve training and using existing health and administration staff to act as VCT Site Coordinators and Counselors in prisons and refugee camps. When a fixed health facility is not located near a prison or other high-risk group, then the traditional mobile VCT could still be used. However, the GOR has voiced their desire to strengthen and employ existing health facilities and staff. With the additional COP05 funding, PSI will hire and train additional counselors and lab technicians for the health facilities located closest to Nyanza and Gikongoro prisons. These individuals will be responsible for VCT promotion, preparing lists of individuals willing to test, organizing the local logistics for the VCT Mobile Unit, coordinating and supervising peer education activities, ensuring post-counseling and referral to existing health structures providing care and treatment for PLWHIV. New CT staff will also be trained in management, supervision, and reporting on VCT.

Referral systems will be put in place to reach STI and TB patients in the prisons as well as to refer all positives to PLWHA support groups and to health facilities. The strength of this program is the combination of clinical interventions (CT) and on-going behavior change communication activities, such as peer education, condom awareness (for after prisoners' release), and VCT promotion. This innovative activity will addresses stigma and discrimination while expanding CT activities that link prevention to care and treatment.

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Target Populations:

Prisoners (Parent: Most at risk populations)

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Butare

Gikongoro

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Rapid Expansion
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 2852
Planned Funds:
Activity Narrative: [Continuing Activity from FY2005 under Activity #2775]

1. Funds for this activity will support rapid scale-up of additional PMTCT/VCT sites in Kibuye and Byumba Provinces. These sites will fill gaps in entry points for ART services. In Kibuye Province, it is proposed that Intrahealth partner with Columbia/MCAP by ensuring planned MCAP ART sites have the necessary VCT/PMTCT entry points for care and treatment. In Byumba Province, PMTCT/VCT will be established in two sites that can serve as entry points to ARV services in Rutare Health Center (See proposal for Intrahealth, three ART sites), and two Health centers that can serve as entry points to ARV services in Kinihira Health Center (approved COP05 funding for Intrahealth). All site selection is in accordance and collaboration with TRAC.

2. As this USG partner is also funded through non-Emergency Plan USAID funds to work in integration of FP/RH services, they will additionally support integration of counseling and testing into Family Planning services through training of family planning providers (if different from other providers) and strengthening referral system between counseling and testing and FP counseling services. High risk patients identified through family planning services and sexual history taking will be counseled and referred for testing. Intrahealth is currently working in Kibuye Province implementing PMTCT/VCT services, thus existing relationships with the Districts and partners on the ground will facilitate start-up and the necessary linkages for comprehensive care.

3. IntraHealth will carry out the following implementation activities:

a. Targeted CT of high risk patients identified through family planning provision.
b. Integration of proven male involvement successes for increased partner testing.
c. Strengthening capacity of health facilities to provide integrated counseling and testing services through training, ongoing technical assistance and supervision/monitoring of counseling and testing activities. Tools to integrate targeted CT into family planning services will be developed.
d. Formalized partnership with ART sites supported by Columbia MCAP as well as IntraHealth's ART sites, to ensure access to ART and HIV clinical management services for patients testing positive.
e. Strengthened linkages with community-based care and support organizations to ensure appropriate follow-up monitoring, care and support for mothers, infants and family members infected and affected by HIV/AIDS
f. Technical assistance to District Teams and Health provider staff in supervision, monitoring, and quality improvement of C&T/PMTCT services for national scale-up.

4. The Five-Year Strategy calls for rapid expansion of counseling and testing services to meet the high demand for counseling. There is a need to increase the capacity of districts and staff to ensure quality of service delivery and manage programs. IntraHealth plays a key role in building district capacity through its newly acquired cooperative agreement in Rwanda to build the capacity of the districts, which will further the goals of the GOR and USG. As mentioned above, this funding will ensure completion of the essential package of services around ART sites in selected districts of Kibuye, supported by Columbia MCAP, and Byumba Province to be supported by Intrahealth.

5. As mentioned above, IntraHealth works closely with local districts to build their capacity. The new bilateral, Decentralized Health Project will enable IntraHealth to further build on these capacity building activities.

6. Cost per client:

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Coverage Areas

Byumba

Kibuye

Table 3.3.09: Activities by Funding Mechanism

Mechanism: PSI-DOD
Prime Partner: Population Services International
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4006
Planned Funds:
Activity Narrative: This activity also relates to PSI's other military-focused activities in OP (#2805) and AB (#4004).

This activity will extend mobile CT services to underserved, hard-to-reach soldiers by providing military-specific CT services through a mobile CT outreach unit. The GOR estimates that the Rwandan military contains between 25,000 – 30,000 soldiers. Eighty percent of these soldiers are deployed in hard-to-reach areas with minimal access to CT and HIV treatment services. PSI/Rwanda will rely on its existing partnership with the Ministry of Defense to ensure the provision of quality CT services. An integrated mobile CT unit and a mobile video unit will travel to each of Rwanda's 12 brigades. "Advance visits" will employ the mobile video unit to sensitize and prepare the soldiers for testing days. The CT team (5 DMS counselors and 1 PSI counselor) will return shortly thereafter to conduct CT. The CT team will return to the brigade as many times as necessary to satisfy the demand and confirm tests.

This program will establish a global database for HIV case management in the RDF. PSI will incorporate data on CT and HIV prevalence into the existing military hospital database. This will ensure stronger linkages between mobile CT service delivery, referrals and follow-up for people testing HIV-positive. It will also help determine future need for HIV prevention outreach activities. With COP06 funding, this program will test at least 4000 soldiers in close collaboration with DMS. DMS and PSI will work together to improve the referral system for soldiers testing positive by drafting a military policy on HIV referrals to ensure soldiers' access to care and treatment services. This program will promote care and support services available to the Rwandan military through BCC activities, hence providing a link between community services and clinical services. CHAMP (#2811) will target military communities with care and support services, especially for the OVC of military members. PSI will also establish post-test clubs in each brigade or battalion to provide psychosocial care and support to HIV positives, to follow-up on referrals, to fight stigmatization and to promote behavior change and safe sexual practices.

To facilitate the gradual hand-over of program management to the DMS, this program will strengthen the capacity of 10 DMS technical staff to implement, coordinate and monitor ABC prevention activities and the mobile CT program. This will include formal trainings and on going TA in the following areas: high quality CT service delivery, use and analysis of client intake forms; data management (MIS); QA and mystery client surveys; supervision of CT counselors; referral systems; BCC and peer education activities; and impact monitoring to measure behavior changes in the military. PSI will conduct a TOT for 10 DMS staff and 12 peer leaders in the brigades in HIV/AIDS, STIs, adult training methodology, life skills, peer education and animation techniques, and prevention of alcohol abuse and GBV. These trainers will train peer educators in the brigades, who will educate and sensitize their peers. PSI will supervise the trainers and peer educators closely to strengthen their training skills, and will provide TA and support as needed during the trainings conducted by DMS and the TOT. During FY2006, PSI will train the DMS trainers to a high level of competency allowing them to conduct and manage an extensive TOT program in FY2007 without substantial assistance from external partners. With prevention funding, PSI will support a subgrant to DMS to provide ABC prevention education, peer education refresher trainings and supervision of activities in the brigades.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results	4,000	☐
Number of individuals trained in counseling and testing according to national or international standards	10	☐

Target Populations:

HIV/AIDS-affected families

Military personnel (Parent: Most at risk populations)

Orphans and vulnerable children

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Increasing women's access to income and productive resources

Stigma and discrimination

Coverage Areas

Byumba

Gikongoro

Gitarama

Kigali (Rurale)

Kigali-Ville

Table 3.3.09: Activities by Funding Mechanism

Mechanism: 'FHI Bridge
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4769
Planned Funds:
Activity Narrative: This activity also relates to activities in FHI- HBHC (#4767) and FHI-Other Prev (#4765). In line with the EP goals, FHI will reach 94,746 individuals including 9022, through a strategic mix of high-quality PIT and client-initiated CT services that ensure confidentiality, combat stigma and discrimination, and reach those individuals most likely to need treatment. This activity will strengthen CT services at 22 existing and 10 new health facilities, and will prepare 14 sites for graduation to the PBF through limited technical support to the PBF contractor for the graduating sites. All 14 sites will be allocated to the PBF contractor and CT targets will be divided evenly between FHI and the PBF.

At all FHI-supported health facilites, including eight DHs reaching 9022 patients (50% of expected in-patients), PIT CT services will target adult and pediatric inpatients, patients presenting with TB and other HIV-related OIs and symptoms, malnourished adults and children, HIV-exposed infants, and STI patients, with the goal of achieving 25% through PIT of all those counseled and tested. Providers will routinely encourage testing of family members, particularly children, of ART and PMTCT patients. In collaboration with CHAMP and the CS coordinator, health providers will work with PLWHA associations, churches, community DOTS programs, and OVC and HBC programs to identify infected patients, in particular HIV-exposed infants, family members of PLWHA, and OVC. Health facilities will continue to provide traditional VCT (client-initiated) services for pre- and post-nuptial couples, ANC male partners, and youth. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, and disclosure of test results. FHI will support training or refresher training of new and existing staff in confidential PIT that includes modified counseling messages, and enhanced prevention to promote abstinence and fidelity, alcohol reduction, GBV, and disclosure. In line with the revised GOR CT protocol, health facilities will modify testing procedures from venous blood draw to whole blood/finger prick to maximize efficiency of rapid tests. To enhance efficiency of client-initiated testing at sites, nurse counselors will also be trained to perform rapid tests under the supervision of a laboratory technician. Lay counselors, PLWHA association members, and other non-health professionals will be utilized to support counseling and testing activities at the health facility level under supervision of nurses or other health center staff. To strengthen the network model for PLWHA and their families, FHI will establish a formalized referral system to link community care and clinical services. PLWHA will be offered or referred for CTX PT, TB screening, CD4 and clinical staging, and other prevention, care and treatment services. The CHAMP clinical-community coordinator will ensure HIV-positive patients are referred for community-based services, such as IGA, PLWHA associations, OVC, and HBC programs

At the health facility level, FHI will ensure a system for supportive supervision of nursing and counseling staff, including training of select staff in supervision for CT, use of quality control checklists, and data quality control. Through FHI and PBF-funded district support, DHTs will gain skills in planning, monitoring, and evaluating CT services, through support for QA and supervision, data analysis and use, reporting, and financial management.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	32	☐
Number of individuals who received counseling and testing for HIV and received their test results	94,746	☐
Number of individuals trained in counseling and testing according to national or international standards	32	☐

Target Populations:

Adults

Faith-based organizations

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Discordant couples (Parent: Most at risk populations)

HIV/AIDS-affected families

Orphans and vulnerable children

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Laboratory workers (Parent: Public health care workers)

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kigali (Rurale)

Kigali-Ville

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Transport Corridor Initiative
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4778
Planned Funds:
Activity Narrative: This activity also relates to TCI activities listed in AB (#4776) and OP (#4777).

The goal of the multi-sectoral Transport Corridor Initiative is to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable people along major East African transport corridors. This project will target high-risk mobile populations (drivers and their assistants, prostitutes, members of the uniformed services and stop-over site communities) with regionally coordinated messages and new or improved services tailored to meet their needs. The TCI works in Kenya, Uganda, Djibouti, and the Southern Sudan and in 2005 initiated activities in Rwanda, Burundi and the DRC.

In FY2006, the TCI will implement its regionally branded "SafeTStop" package of interventions in Kigali-ville and in two border sites: Gatuna on the Uganda/Rwanda border and Cyangugu on the DRC/Rwanda border. TCI will assist local health providers and community organizations in integrating HIV prevention messages for high-risk populations. The TCI will encourage local institutions to reach out to the most at risk populations (e.g. by expanding CT hours or inviting truckers to religious services) and to coordinate and collaborate their efforts. The TCI will provide prevention messages that include alcohol awareness, fidelity, partner reduction, and condom use to mobile populations. Other TCI prevention interventions include: basic health services, marketing/distribution of condoms, counseling and testing, syndromic STI diagnosis/treatment, and alternative recreational activities (sports, faith services, satellite TV, fitness centers, men's discussion groups, and adult education). This project will link to CHAMP and the World Relief Microfinance Project to provide services to OVC and PLWHAs (such as HBC and IGA). This activity supports Rwanda's EP five-year strategy to scale-up CT and target high-risk populations with prevention, care and treatment.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	0	☐
Number of individuals who received counseling and testing for HIV and received their test results	5,500	☐
Number of individuals trained in counseling and testing according to national or international standards	3	☐

Target Populations:

Commercial sex workers (Parent: Most at risk populations)

Street youth (Parent: Most at risk populations)

Truck drivers (Parent: Mobile populations)

Partners/clients of CSW (Parent: Most at risk populations)

Key Legislative Issues

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Byumba

Cyangugu

Kigali-Ville

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Refugees - Rwanda
Prime Partner: American Refugee Committee
USG Agency: Department of State
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4867
Planned Funds:
Activity Narrative: This activity relates to Activities ARC HBHC (#4865) and ARC ABY (#4864).

There are over 50000 refugees currently living in camps around the country. ARC provides support to a total of about 20,000 refugees in Gihembe (15000) and Nyabiheke (5000) refugee camps in Byumba Province. ARC, UNHCR and other agencies working in refugee camps have supported ongoing efforts for HIV education and CT services in the Gihembe refugee camp. Even with a fairly coordinated effort, only 1358 refugees have come forward for VCT of whom 4.1% tested positive. In collaboration with ARC, CAPACITY/IntraHealth will support PMTCT/CT services in FY2005, with the goal of building capacity of these partners to take over services in FY06. The Nyabiheke refugee camp is new and lacks the structure and funding for any HIV prevention, care and treatment activities at the present time. With approval of Ngarama DHT, EGPAF and ARC are currently developing a formal plan to ensure access to CT services and training of Nyabiheke health providers .The Great Lakes Initiative for HIV/AIDS (GLIA) will also begin supporting HIV/AIDS services in Gihembe Camp starting in FY06 with a limited amount of funding. All EP activities will be coordinated with GLIA to ensure complementarity and non-duplication of services.

Through COP06 funding ARC will support the continuation of existing CT activities in Gihembe refugee camp and formalize the CT services in Nyabaheke in Byumba Province, to reach 10,000 people with CT services. Rapid test kits will be procured through another partner. Gihembe camp sees between 150-200 outpatients every day, including TB patients and STI patients, and malnourished under-fives. Nyabiheke health facility sees 100 outpatients every day. Given the high volume of outpatients, ARC will integrate routine PIT into all its health center activities with particular attention to reaching TB patients, STI patients, patients presenting with HIV-related symptoms and illnesses, HIV-exposed infants and patients receiving care in the therapeutic feeding centers. ARC will reach 30-40% of those tested through PIT, and will continue ensure the availability of traditional VCT, particularly for partners and youth. ARC will train existing and new staff in PIT as well as in counseling for youth, male partners, and other high risk populations in refugee camp settings. Taking advantage of on-site FP services, providers will also offer routine CT to FP clients. Counseling messages should emphasize risk reduction behaviors, GBV and alcohol reduction. ARC will also target partners and family members of identified HIV-positives for testing through outreach testing activities and campaigns, utilizing refugee groups, refugee community leaders, and refugee PLWHA Association activities

ARC will use CT curricula and tools that already exist for these populations and adapt them as necessary. Where curricula and tools are lacking, ARC will develop and integrate these as necessary. Using its long-term experience with promotion of health in refugee settings, ARC will integrate nutrition counseling and TB screening into all CT activities. To reduce the burden on existing health staff, lay counselors, refugee camp PLHA association members, and other non-health professionals will be utilized to support CT activities at the health facility level under supervision of nursing or other health center staff. To ensure quality CT service delivery, ARC will provide supportive supervision of CT staff through QA, monitoring provider performance, and data quality reviews. ARC will also strengthen the capacity of refugee health care providers to monitor and evaluate CT services, including supervision, routine data collection, use of data for program improvement, and QA methods.

Refugee camp health providers will support the network model through routine referral for comprehensive care and support services (CTX PT, OI diagnosis and

treatment, CD4 count testing, PCR testing, ART), either on site or at nearby health facilities. In collaboration with EGPAF at Ngarama District Hospital, FHI at Byumba Hospital, and the DHTs, ARC will develop referral plans for services not offered on site. To ensure a comprehensive network of services ARC will work with RRP+ to support the formation of PLWHA groups if they do not yet exist in the refugee camps. Where community services exist, establish a system of referral for HIV-positive patients, particularly for HIV-infected and other OVC, for community-based services, such as IGA, PLWHA associations, OVC, and HBC programs and ensure appropriate tracking and follow-up.

To reinforce abstinence, fidelity and partner reduction, ARC will support the promotion of CT services to refugee populations through interpersonal communication activities, with a particular emphasis on men and youth counseling to sensitize clients to issues related to GBV and stigma, and confront social norms that promote acceptance of GBV and cross-generation and transactional sex.

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	2	☐
Number of individuals who received counseling and testing for HIV and received their test results	10,000	☐
Number of individuals trained in counseling and testing according to national or international standards	50	☐

Target Populations:

Community leaders

Refugees/internally displaced persons (Parent: Mobile populations)

Out-of-school youth (Parent: Most at risk populations)

Religious leaders

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Byumba

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Refugees AHA
Prime Partner: African Humanitarian Action
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4874
Planned Funds:
Activity Narrative: This activity relates to Activities AHA HBHC (#4873) and AHA PMTCT (#4871).

There are over 50,000 refugees living in camps around the country. AHA provides support to a total of about 15,000 refugees in Kiziba Camp in Kibuye Province. AHA, UNHCR and other agencies working in refugee camps have supported ongoing efforts for HIV education, supplemental nutrition for PLWHA, CT, and some ARV treatment in partnership Kibuye District Hospital. In collaboration with AHA, CAPACITY/IntraHealth will support CT and PMTCT in FY2005. GLIA will also begin supporting HIV/AIDS services in Kiziba Camp starting in FY06 with a limited amount of funding. All USG EP activities will need to be coordinated with GLIA to ensure complementarity and non-duplication of services. Priorities as stated in the EP five-year strategy aim to deliver high quality CT services, linking CT clients with other HIV prevention, care and treatment services.

The Kiziba camp health facility sees between 150-200 outpatients every day, including TB and STI patients, and malnourished adults and children. Through this funding AHA will support the continuation of existing CT activities in Kiziba refugee camp to reach 5000 refugees and train 25 health care providers. Rapid test kits will be procured through another partner. Given the high volume of outpatients, AHA will integrate routine PIT with informed consent into all its health center activities with particular attention to reaching TB and STI patients, patients presenting with HIV-related symptoms and illnesses, HIV-exposed infants and patients receiving care in the therapeutic feeding centers. AHA will target 30-40% of all those tested through PIT, and will continue to ensure the availability of traditional VCT, particularly for partners and youth. AHA will also integrate CT into FP activities to offer routine CT to FP clients. AHA will also target partners and family members of identified HIV-positives, as well as widows and widowers, for testing through outreach testing activities and campaigns, utilizing refugee groups, refugee community leaders, and refugee PLWHA Association activities. AHA will

AHA will train existing and new staff in PIT with informed consent, as well as in counseling for youth, male partners, and other high risk populations in refugee camp settings. AHA will emphasize counseling in partner reduction, GBV and alcohol reduction to sensitize clients to issues related to GBV, stigma, and confront social norms. CT providers will be trained in GBV and trauma counseling for women, particularly for HIV-positive and negative women and widows who may be victims of violence. AHA will use CT curriculum and tools that already exist for these populations and adapt them as necessary. Where curriculum and tools are lacking AHA will develop and integrate as necessary. To reduce the burden on existing health staff, lay counselors, refugee camp PLWHA association members, and other non-health professionals will be utilized to support CT activities at the health facility level under supervision of nursing or other health center staff. To ensure quality CT service delivery, AHA will provide supportive supervision of CT staff through QA, monitoring provider performance, and data quality reviews. AHA will also strengthen the capacity of refugee health care providers to monitor and evaluate CT services, including supervision, routine data collection, use of data for program improvement, QA methods, and reporting of data within the national system.

AHA will also support the network model by ensuring routine referral for comprehensive care and support services, including CTX screening and PT; TB screening, diagnosis and treatment; management of other OIs and related HIV-illnesses; CD4 count testing; PCR testing and CTX PT for exposed infants; ART referral and support; nutritional counseling and support; and other psychosocial support services, either on site or at nearby health facilities. In collaboration with

Columbia, Intrahealth, FHI and other partners at health facilities surrounding the camp, AHA will develop referral plans for services not offered on site. AHA will also work with RRP+ to support the existing PLWHA groups and the formation of new PLWHA groups. Where community services exist, establish a system of referral for HIV-positive patients for community-based services, such as IGA, PLHA associations, OVC, spiritual support, community-based GBV and trauma counseling, HBC programs. AHA will work with these groups and the health facility ensure appropriate follow-up through development of referral, tracking and monitoring tools and registers.

Using existing resources in the camp, AHA will support the promotion of CT services to refugee populations through interpersonal communication activities, utilization of PLWHA support groups, refugee committee leaders, and women's groups. Messages will include stigma reduction, gender based violence sensitization, promotion of CT, and utilization of HIV/AIDS care and treatment services. AHA will target men and youth to sensitize clients to issues related to GBV and stigma, and confront social norms that promote acceptance of GBV and cross-generation and transactional sex.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing counseling and testing according to national or international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results	5,000	☐
Number of individuals trained in counseling and testing according to national or international standards	25	☐

Target Populations:

HIV/AIDS-affected families

Refugees/internally displaced persons (Parent: Mobile populations)

Caregivers (of OVC and PLWHAs)

Widows/widowers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Increasing women's access to income and productive resources

Stigma and discrimination

Coverage Areas

Kibuye

Table 3.3.09: Activities by Funding Mechanism

Mechanism: PSI Bilateral
Prime Partner: Population Services International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4880
Planned Funds:
Activity Narrative: This activity relates to PSI's activities under AB (#4878) and OP (#4877).

PSI will build upon its mobile CT experience with prisoners and the military to expand community-based CT promotion and service delivery on a national scale. PSI will use its existing CT mobile testing vehicle along with one new additional vehicle to provide CT services and ABC prevention messages to the following most-at-risk populations: commercial sex workers, prisoners, and national police (and their spouses or partners). Targeting high-risk groups through this mobile testing program will increase availability of CT and minimize stigma and discrimination that may be encountered at health facilities. PSI will promote their mobile CT through radio announcements and IEC materials approved by the CNLS' BCC Steering Committee and disseminated through subgrantees. All subgrant activities will focus on CT promotion and prevention education around gender issues with a goal of addressing male norms and behavior; increasing women's use of CT services; and reducing violence, sexual coercion, and stigma. In prisons, police stations and CSW organizations, staff and members will be trained as CT Site Coordinators, responsible for CT promotion, preparing lists of individuals willing to test, organizing the logistics for the Mobile CT Unit, and following up on referrals to link those testing HIV-positive to treatment and care services. This program will conduct mobile CT 15 days out of the month with two mobile testing units in order to test a total of 4,620 individuals.

This program will improve the competence of Rwandan staff, organizations and authorities to conduct mobile CT which supports the Rwanda EP five-year strategy of building local capacity. PSI will continue working closely with TRAC, CNLS, GOR Ministry of Internal Security, the National Police, MOH and other CT implementing partners to increase technical expertise in the area of mobile CT; to develop national guidelines for mobile CT that include protection of confidentiality and to develop a supplementary training curriculum for mobile CT counselors. Mobile CT counselors will receive training to encourage individuals to disclose their HIV status and to build interpersonal skills to enhance non-judgmental communication, particularly for highly stigmatized groups. PSI will support TRAC in the development of a database specific to mobile CT that will allow for quarterly data analysis. PSI will provide subgrants to SWAA, the Police Directorate for Medical Services and CSW organizations which will organize CT promotion and post-test clubs and disseminate HIV prevention materials. In close collaboration with TRAC and other ministerial partners, PSI will identify other local associations that can be trained to provide community-based CT promotion and outreach activities, including prevention.

PSI will ensure compliance with national protocols and international quality standards. It will use the national curriculum for testing in prisons and the referral system developed in FY2005 in conjunction with the GOR. To monitor the quality of services, PSI will conduct mystery client surveys, in-service supervision and evaluations of CT counselors. PSI's Technical CT Services Unit will work closely with TRAC and other clinical and non-clinical service delivery sites (including FOSAs, hospitals, integrated VCT centers, CBOs supporting PLWA, and PLWHA associations) to develop a strong and efficient referral system for HIV+ clients at each mobile CT site. For individuals testing positive, this program will immediately put them in touch by phone with the nearest health facility in order to arrange an appointment for a CD4 count. This program will also provide vouchers to cover the cost of transportation for HIV-positive individuals to reach a health facility (maximum 800 Frw per person). Individuals testing positive will be referred to post-test clubs and other community services that provide preventive, positive-living care and support for HIV-infected persons. All others will receive counseling to further prevent HIV transmission. PSI will follow up with the referral health centers and CBOs to monitor

the effectiveness of the referral system and to ensure that the clients testing positive are accessing the full package of services available to HIV-positive individuals. This activity delivers high-quality CT services to high-risk populations while supporting the network model, policy development and capacity building as part of the Rwanda EP five-year strategy.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Policy and Guidelines	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	2	☐
Number of individuals who received counseling and testing for HIV and received their test results	4,620	☐
Number of individuals trained in counseling and testing according to national or international standards	10	☐

Target Populations:

Commercial sex workers (Parent: Most at risk populations)

Military personnel (Parent: Most at risk populations)

Prisoners (Parent: Most at risk populations)

Key Legislative Issues

Gender

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: RPM+
Prime Partner: Management Sciences for Health
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: *Counseling and Testing*
Budget Code: HVCT
Program Area Code: *09*
Activity ID: 5155
Planned Funds:
Activity Narrative: This activity relates to all other CT activities.
RPM-plus will procure rapid HIV test kits for all EP implementing partners that provide PMTCT and CT. RPM-plus will be responsible for ensuring the most cost-efficient procurement, storage and distribution of all HIV rapid test kits for approximately 120 EP-supported CT and PMTCT sites and for EP supported mobile testing to test 370,000 individuals including pregnant women.

RPM-plus Rwanda, supported by the Procurement Unit based in Arlington HQ, will ensure that procurement of all test kits is done in accordance with USG, GOR and international requirements and quality standards and at the lowest possible cost. Quantities of HIV/AIDS rapid test kits will be procured based on EP partner targets, EP targets and historical trend data. To ensure an appropriate and adequate supply of HIV rapid test kits RPM-plus will provide support to CAMERWA, district pharmacies, and EP partners and their supported sites in quantification, storage, distribution and management of stocks of HIV test kits. RPM-plus will support monitoring and supervision of data quality, inventory management, distribution, and reporting at all levels, the development of tools and procedures to ensure data quality, and establishment of a mechanism for regular inventory control, including monthly reporting to districts and CAMERWA. Building on the coordinated procurement system and through support from RPM-plus, the quantification committee will assist in *the quantification of test kits. RPM-plus will develop a plan for monitoring and* evaluating the management of rapid test kits stocks, through the development of pharmaceutical indicators on consumption and use of HIV rapid test kits.

This activity will assure the availability of rapid HIV test kits for CT and PMTCT activities. This activity also directly supports the Rwanda EP five-year strategy to strengthen supply chains through direct technical assistance to CAMERWA. Technical support will improve commodity forecasting, procurement procedures, *storage and distribution, quantification and information systems.*

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Logistics	10 - 50

Target Populations:

National AIDS control program staff (Parent: Host country government workers)
Pharmacists (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	AIDSMark -deferred
Prime Partner:	Population Services International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	5546
Planned Funds:	
Activity Narrative:	[Continuing FY2005 Activity - New FY2006 Funding for these Four Youth Centers will Go through the CHAMP Mechanism (#2806, #2807 and #2808)] Based on the successful Centre Dushishoze youth center in Butare, youth friendly counseling and testing services at the center in Butare and three additional CT sites will be continued using these deferred funds. Centre Dushishoze provides voluntary counseling and testing for HIV/AIDS to adolescents aged 15 -24, including treatment of STIs. In 2005, Centre Dushishoze will test 4,500 high-risk youth. In addition to its counseling services, Centre Dushishoze serves as a recreational and educational youth center, with skills classes and leisure activities targeting out of school youth and street children. Main activities include: 4,500 youth provided with CT, 45,000 youth visit Centre Dushishoze and other CT sites, Facilitation sessions with youth in outlying areas, Parent/Community advocacy program and Promotion of services.

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Table 3.3.10: Program Planning Overview

Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10

Total Planned Funding for Program Area:

Percent of Total Funding Planned for Drug Procurement: 84

Amount of Funding Planned for Pediatric AIDS:

Program Area Context:

In October 2004, the MOH issued a Ministerial Order requiring that all ARVs be procured through CAMERWA, the national pharmaceutical procurement agency, in order to maximize purchasing power. The Ministerial Order required providers to prescribe ARVs according to WHO guidelines, use WHO-approved generic drugs as first line treatment, and limit the use of brand-name ARVs to patients requiring second-line ARVs. Thus, in December 2004, the first "coordinated procurement" took place, whereby donors purchased portions of Rwanda's overall ARV needs according to their individual procurement restrictions. EP funds were used to buy FDA-approved ARVs for second-line treatment, while Global Fund, MAP and other donors purchased WHO pre-qualified drugs for first-line use throughout Rwanda, including at EP-supported ARV sites. All donor partners contribute to the coordinated procurement based upon the proportion of total patients receiving ARVs at their facilities.

In January 2005, service providers started to migrate patients toward the new national treatment regimens. In the months following the first coordinated procurement, several stock problems occurred, including the expiration of $50,000 worth of Tenofavir, a brief rupture of stock of NVP syrup, and a near-rupture of stavudine stock. A second coordinated procurement order was placed in June 2005, which included significantly increased security stock. In July 2005, the GOR and USG signed an MOU on coordinated procurement, outlining overall governance and implementation responsibilities of each party.

To support coordinated procurement, RPM-plus, an EP implementing partner, intensified its TA for ARV quantification, procurement, distribution and management of ARV stock at CAMERWA and all facilities providing ARVs. An EP-supported pharmacist at CAMERWA tracks monthly inventories of ARVs and assists with the implementation of SOPs at pharmacies in all ARV sites. Currently, the MOH is considering requests to expand the formulary of approved ARVs to include FDA "tentatively approved" ARV generics as well as other ARVs approved by internationally recognized quality standards.

Advantages of the coordinated procurement include lower ARV drug costs, with an average annual cost per patient of $360 (including pediatric syrups); greater simplicity of scale-up due to standardized treatment regimens; standardized pharmacy operating procedures; and reduced work for clinical implementing partners. Providers report minimal problems starting new patients on the national regimen, despite a slower-than-anticipated migration of patients from old regimens. A potential disadvantage of the coordinated procurement is the dependency of all interveners on successful procurement management by CAMERWA, TRAC and the MOH. However, there have been no further cases of near stock-outs or expirations since intensive management of ARV inventory started. Intensive TA will be required in order to build the capacity of CAMERWA and the Department of Pharmacy to manage the procurement, but over time this will be more sustainable than depending on international commodity management.

Overall, experience with the coordinated procurement has been positive to the extent that there are continued requests for its expansion to include OI drugs, lab reagents, rapid test kits and other commodities related to HIV/AIDS scale-up. The EP will support an external audit of the coordinated procurement in FY2006 to ensure that drugs ordered and supplied are reaching patients in a timely and reliable manner.

Although the Clinton Foundation provided pediatric syrups to all providers in country for FY2005, this support will not be continued in FY2006. Instead, pediatric syrups will be purchased through the coordinated procurement. We estimate that 11.63% (2,368) of the total USG direct ARV targets (20,365 individuals) are pediatric and that one-half of pediatric patients (1184) will require pediatric syrups.

Table 3.3.10: Activities by Funding Mechanism

Mechanism:	Columbia UTAP
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Drugs
Budget Code:	HTXD
Program Area Code:	10
Activity ID:	2733
Planned Funds:	
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006] Columbia University will procure ART medications for 400 pediatric patients from CHK and University of Butare Hospital. Columbia will procure the medications from CAMERWA, the Rwandan para-statal drug procurement organization. CAMERWA will also be responsible for supply chain management, with support from TRAC and the Columbia University-Kigali and New York Offices. The pharmacists at each site will be trained and supported in storing and managing supply of ARVs.

Target Populations:

Pharmacists (Parent: Public health care workers)

People living with HIV/AIDS

Coverage Areas:

National

Table 3.3.10: Activities by Funding Mechanism

Mechanism: RPM+
Prime Partner: Management Sciences for Health
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10
Activity ID: 2762
Planned Funds:
Activity Narrative: *This activity relates to activities #2757, #2777, #2772, #2787, #2798, #2783, #4849, #4003, and #4972.* RPM+ will ensure the procurement, storage, and distribution of ARVs for 88 EP-supported ART sites, reaching 20,000 total (8,000 new) ART patients. This activity comprises two components: (1) ($7.6 million) Financing to procure ARV drugs for ART service delivery for EP-supported ARV sites; (2) ($1.3 million) TA to the GOR ARV coordinated procurement system developed in 2004 and 2005.

RPM-plus will strengthen the procurement, quantification, distribution and dispensing *of ARVs through training and TA to GOR institutions, USG partners and their* ART-supported sites and other ARV purchasers.

RPM-plus will support EP and its implementing partners, CAMERWA, TRAC, the Department of Pharmacy, and the USS in all activities associated with the management of the GOR coordinated procurement and ARV supply chain, including quantification, supplier selection, QA of ARVs, appropriate storage, and distribution. RPM+ will ensure that procurement of ARVs is conducted in accordance with national and international quality standards and policies. In collaboration with EP and GOR, *RPM+ will ensure that ARV procurement is in line with EP rules and regulations,* including the procurement of only FDA-approved or tentatively approved branded or generic drugs with EP funds. Quantification of procured ARVs will be based on clinic records, USG program plans, facility capacity, and trends of ART uptake, with the global target of reaching 20,000 patients by March 2007. RPM-plus will contract CAMERWA's services for pharmaceutical storage of ARVs which will simplify the coordination between RPM+ and CAMERWA with regard to its other procurement and system strengthening activities, mentioned above. A full-time pharmacist seconded to CAMERWA who is currently in charge of the monitoring and reporting *system for the coordinated procurement will continue with this role in COP06. In* addition, senior short-term international TA of RPM+ from the Kigali office and Arlington headquarters will provide support.

RPM+ will continue its TA to Rwanda's coordinated procurement system and to related TWGs to ensure good governance and administrative practices and a reliable and appropriate supply of ARVs at all ART sites (USG, Global Fund, MAP, MSF, Lux, Clinton Foundation and all other ARV providers in Rwanda). RPM+ will support the revision of governance procurement documents and reporting systems as needed *and will respond to requests from the EP, MOH, CNLS or other partners, will organize* meetings and provide TA for troubleshooting. (See ARV Drugs Country Context). RPM+ will provide TA to the quantification committee in quantification methods, supervision and QA of the quantification exercises, training as needed for local capacity building, and dissemination of quantification reports to the EP, implementing partners, GOR partners, and other non-EP donor stakeholders. RPM+ will also provide TA to the coordinated ARV procurement governing committee regarding procurement and distribution of ARVs, including QA, good procurement practices and systems for appropriate and timely distribution of ARVs to all levels of service delivery.

RPM-plus will strengthen the pharmaceutical management information system for reliable and valid site-level data collection and reporting, good ARV dispensing practices, and strengthening of stock management of ARVs (See Activity 2761). RPM-plus will also conduct joint monthly inventories at CAMERWA to review stocks on hand, expiration dates, and to identify any problems or potential stock outs, which would be reviewed and resolved in collaboration with the relevant governing committee. RPM-plus will also train district depot pharmacies and ARV site pharmacies to track ARV drug stocks. RPM-plus will also provide reports and updates on the

national pipeline of ARVs, distribution and consumption figures, and status of partners' orders to the updated list of products procured throughout the coordinated system. RPM+ will develop a plan for M&E of HIV/AIDS pharmaceutical management, with the development of pharmaceutical indicators related to the consumption and use of ARVs.

Pediatric syrups are included in the quantification estimation for ARVs for COP06, as the Clinton Foundation's donation will run out in March 2005. (Columbia MCAP is also procuring in FY2005 a limited amount of ARVs for PMTCT patients eligible for ARVs through the Coordinated Procurement.)

The EP will support an external performance audit in COP06 of the ARV coordinated procurement. (See Activity #4972). This performance audit will track procured ARVs from the point of placing the order to the patient to assure that there are no inappropriate diversions of ARVs.

Given the complexity of the coordinated procurement, RPM-plus will collaborate *closely with and provide ad hoc TA to other partners, in particular the Global Fund,* MSF, the Clinton Foundation, and World Bank MAP. This EP technical support and leadership will facilitate other programs to achieve Rwanda's national and goals and is consistent with the Rwanda EP five-year strategy.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Logistics	10 - 50

Target Populations:

Host country government workers

Public health care workers

Coverage Areas:

National

Table 3.3.10: Activities by Funding Mechanism

Mechanism: IMPACT

Prime Partner: Family Health International

USG Agency: U.S. Agency for International Development

Funding Source: GAC (GHAI account)

Program Area: HIV/AIDS Treatment/ARV Drugs

Budget Code: HTXD

Program Area Code: 10

Activity ID: 2769

Planned Funds:

Activity Narrative: [CONTINUING ACTIVITY UNDER COP05. NO NEW FUNDING IN COP06]
This partner will purchase ARV drugs according to the Rwandan Ministerial Order that requires all ARV-naive patients receive generic first line drugs and that only those patients with complications, treatment failures or adverse reactions be treated with second-line branded drugs. CAMERWA will purchase all drugs for national ARV treatment programs. The financing that this partner contributes will assure that patients treated with ARVs at USG funded facilities, including those managed by EGPAF and INTRAH, receive medication according to national protocols. The procurement will be made in joint collaboration with the government of Rwanda in accordance to the Rwandan Ministerial Instruction.

Target Populations:

Pharmacists (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.10: Activities by Funding Mechanism

Mechanism:	AIDS Relief
Prime Partner:	Catholic Relief Services
USG Agency:	HHS/Health Resources Services Administration
Funding Source:	N/A
Program Area:	HIV/AIDS Treatment/ARV Drugs
Budget Code:	HTXD
Program Area Code:	10
Activity ID:	2784
Planned Funds:	
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

CRS will assure that 665 individuals living with HIV are provided with ARVs. The procurement will be made in joint collaboration with the government of Rwanda in accordance to the Rwandan Ministerial Instruction.

Target Populations:

People living with HIV/AIDS

Coverage Areas

Butare

Byumba

Cyangugu

Gikongoro

Umutara (Mutara)

Table 3.3.10: Activities by Funding Mechanism

Mechanism:	Columbia/MCAP
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	N/A
Program Area:	HIV/AIDS Treatment/ARV Drugs
Budget Code:	HTXD
Program Area Code:	10
Activity ID:	2789
Planned Funds:	
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006] Columbia University will continue to procure medications for 2,389 existing and new patients at 24 sites in Kigali-Ville and Gisenyi and Kibuye Provinces. Adult and pediatric formulas will be supplied. Columbia will procure the medications from CAMERWA, the Rwandan para-statal drug procurement organization. CAMERWA will also be responsible for supply chain management, with support from TRAC and the *Columbia University-Kigali and New York Offices. The pharmacists at each site will be* trained and supported in storing and managing supply of ARVs.

Target Populations:

Pharmacists (Parent: Public health care workers)

People living with HIV/AIDS

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.10: Activities by Funding Mechanism

Mechanism:	Columbia MCAP Supplement
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Drugs
Budget Code:	HTXD
Program Area Code:	10
Activity ID:	2797
Planned Funds:	
Activity Narrative:	*[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]*

This activity is a supplement to Columbia University MCAP Track 1.0 mechanism. This supplement will expand ART services to the health center level in two provinces, Butare and Cyangugu. In FY2003 and 2004, USG provided technical assistance to the TRAC (MAP) for ART service delivery at the hospital level in these two provinces. With this additional support, USG will complete the network by linking health center, district hospital and provincial hospital sites.

In collaboration with the TRAC, Columbia will procure ARV medications for 400 new patients at 6 health centers in Butare and Cyangugu. The pharmacists at each of the 6 sites will be trained and supported in storing and managing supply of HIV medications.

Target Populations:

Pharmacists (Parent: Public health care workers)

People living with HIV/AIDS

Coverage Areas:

National

Table 3.3.10: Activities by Funding Mechanism

Mechanism: Rapid Expansion
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10
Activity ID: 2857
Planned Funds:
Activity Narrative: [CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

This proposed activity would cover the Columbia Track 1.0 program's unmet need to implement the growth scenario plan for FY 2005. (The Track 1.0 year 2 award for Columbia was funded at the no-growth scenario level) Specific activities include: the enrollment of 2,075 additional patients on ART at 14 existing FY 2004 sites, and the launching of 8 new ART treatment sites at health centers in 2 provinces outside of Kigali, serving a total of 400 patients in these new sites in FY2005. Columbia University will support direct treatment and purchase ARV drugs for these patients, including children and HIV+ women identified through PMTCT programs at ART sites. Because Columbia program activities are developed in direct collaboration with the GOR, geographic deployment and resource allocation are, by definition, supportive of local strategies.

Columbia University, with Ministry of Health/TRAC as a subgrantee, has successfully launched 7 ART treatment sites in Kigali, Gisenyi and Kibuye provinces through an innovative public-private partnership. Columbia has exceeded its FY 2004 ART target of 731 patients by more than 300%. Columbia's success has been largely founded on its close collaboration with TRAC in program planning: site selection, site assessment, sub-grant development for sites, theoretical training, practical on-site training and lab infrastructure development. With Columbia's support and technical assistance, TRAC has been successful in executing sub-grants with sites, assisting sites with renovation and staffing plans, and conducting national classroom training for ART service providers. The Columbia-TRAC partnership has been recognized by Rwandan stakeholders as a model for local capacity transfer and sustainability in ART scale-up. Through this partnership, the Ministry of Health has rapidly gained program experience and management expertise which will remain a GOR strength beyond the life of the Emergency Plan.

2. The proposed funding for additional patients and sites will allow Rwanda to achieve its FY05 COP targets, as the targets were based on the assumption of full funding of Columbia Track 1.0 activities. The proposed additional funds are necessary to meet the global treatment targets approved in the COP 05. The proposed funding directly contributes to attainment of five-year strategy goals in two ways: 1) national ART coverage is dependent upon full funding of the Columbia program; 2) Columbia's joint implementation approach with GOR is an essential step in successfully transferring international partner responsibility for ART service delivery to local partners, a cornerstone of the Rwanda Five-year Strategy.

3. The Columbia-TRAC partnership model directly increases both central Ministry of Health and local site and District Health Team capacity for ART service expansion, maintenance and supervision. At the central, district and site level, Columbia provides technical assistance for all aspects of scale-up. Activities are jointly planned and conducted by Columbia and TRAC personnel. In accordance with the USG strategy for capacity building, Columbia will transition from providing assistance through long-term technical advisors to providing select short-term assistance on an as-needed basis over the course of the Emergency Plan. The end goal is to build TRAC's capacity to the point where it is a fully autonomous technical assistance provider for District Health Teams and sites.

4. Cost per client on ART for this proposed activity is [redacted] This calculation also includes the purchase of ARVs drug costs for patients at 2 EGPA supported sites and 1 Intrah-supported sites. Track 1.0 year two funding would be leveraged, as basic operational and technical assistance costs are largely covered under the currently

funded maintenance scenario. Additional funds would result in decreased cost per client served.

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.11: Program Planning Overview

Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11

Total Planned Funding for Program Area:

Amount of Funding Planned for Pediatric AIDS:

Program Area Context:

Rwanda's national scale-up of ARV services has grown exponentially since the beginning of the EP. As of September 1, 2005, there were 14,692 individuals on ARV (including 1,049 children) at 68 sites. The present state of ART contrasts sharply with the situation three years ago when only 900 Rwandans were on treatment at eight sites, primarily in Kigali. MOH active management of EP, Global Fund and MAP programs facilitated this massive scale-up through a strategic and collaborative use of resources. Within this collaboration, the EP supported the MOH to develop national treatment tools and policies which are used by all donors, including Global Fund, MAP, and Lux Development. In COP04 and COP05, TRAC trained hundreds of physicians and nurses through a centrally-coordinated care and treatment training program. Through EP inputs, Rwanda established excellent standardization and infrastructure for the national ART program, benefiting all partners and programs.

In COP06, the EP will assist MOH in increasing quality and sustainability through integration and decentralization of the HIV treatment program. As outlined in the Rwanda EP five-year strategy, sustainability will be achieved by transferring capacity from international partners to individual districts in three ways: 1) clinical support to DHTs, hospitals and health centers; 2) gradual transfer of financial assistance from international clinical partners to local districts through an innovative PBF mechanism; and 3) technical and financial support to central GOR agencies for TOT and oversight of DHTs. By the end of COP06, 33,700 individuals will be on ART.

The expansion of the treatment network model to the most peripheral point of service, the health center, is a key programmatic element for sustainability. Network model expansion can only be realized through the development of strong DHTs which work with lower-level facilities to ensure quality roll-out of services to the most rural areas. The EP will provide a broad-based package of TA to districts for HIV program planning and monitoring, training, site supervision, data collection and use, and district-level meetings of service providers for problem-solving and sharing of best practices. The EP will also provide financial resources for transportation, personnel and infrastructure. The EP will build upon the district planning and management approaches which have been developed by Twubakane, the USAID health decentralization program.

With technical and financial assistance, DHTs and hospitals will realize their role as managers and implementers of the HIV care and treatment network model. Essential elements of this model include training and support of health centers; a coordinated system for specimen collection and patient transportation; and enrollment and follow-up of patients at health centers supported by doctors based at district hospitals. National HIV/AIDS policy is being amended to support limited ARV service and drug provision at nurse-directed health centers, under physician supervision. Adherence support and other care services will be provided through the development of linkages between health clinics and the community.

Over the past year, pediatric ARV care has been significantly strengthened. This will continue in FY2006 through pediatric training, guideline development, support for pediatric centers of excellence, and scale-up of early infant diagnosis and prophylaxis. Pediatric trainers based at centers of excellence will continue to build pediatric care and treatment capacity at sites throughout Rwanda. The EP will provide treatment services to 4,000 children by September 2007.

Tools developed with EP assistance will be implemented in Global Fund and MAP-supported programs. To ensure national coverage, the EP package of support to health district teams at 20 of the 29 total health districts will be complemented by Global Fund and MAP support to the 9 remaining health districts.

Program Area Target:

Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	96
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	8,250
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	21,510
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	21,065
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	1,146

Table 3.3.11: Activities by Funding Mechanism

Mechanism: *Columbia UTAP*
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2736
Planned Funds:
Activity Narrative: This activity is related to activities in ARV Services (2787, 2798, 4770, 4003, 4771 and 2776), basic health care (2788, 2799) and TB/HIV (4839).

Columbia will continue to support a care and treatment technical advisor at TRAC and USS to assist with the adaptation of HIV care and treatment norms and guidelines, national coordination, and district-level capacity building. District capacity building includes support to USS for district-level planning, implementation, coordination, supervision, and district performance improvement meetings. Columbia will support improved integration of HIV services into district health programs, as well as improved linkages between HIV programs and partners. The care and treatment advisor will also support TRAC and USS in conducting an assessment of HIV provider knowledge and skills. Other in-country technical advisors (M&E advisor and care coordination officer) and short-term consultants will assist TRAC in the selection and adaptation of an electronic medical record system, the use of national HIV care and treatment data, building operations research capacity and the development of a national patient confidentiality policy.

Columbia will continue its support to the MOH for the expansion of pediatric HIV care and treatment services at two pediatric HIV model centers, CHUB and CHK. CHK and CHUB will train staff at 20 ART sites to improve capacity for pediatric HIV care and treatment, as well as to improve linkages for HIV-exposed infants identified in PMTCT programs. In collaboration with Intrahealth and FHI, Columbia will support TRAC and USS to design clinical protocols and job aids to assist nurses in fulfilling their increasing responsibilities for treatment and care at health centers.

These activities fully support the Rwanda EP five-year strategic goal of institutional support for ART scale-up.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	51 - 100
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	20	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	300	☐
Number of individuals who ever received antiretroviral therapy by *the end of the reporting period (includes PMTCT+ sites)*	700	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	700	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	50	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

HIV/AIDS-affected families

Infants

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Implementing organizations (not listed above)

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	US Department of Defense Naval Health Research Center
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	2737
Planned Funds:	
Activity Narrative:	This activity will enable Rwandan military physicians to attend the Military International HIV Training Program. The mission of the program is to provide flexible training in support of prevention of HIV transmission and management of infected persons in military organizations. The training will transfer appropriate knowledge and technology to key Rwandan medical personnel. The training is developed in collaboration with each military organization to meet the specific needs. The program emphasizes training, consultation, and operational support for prevention and clinical management of HIV and its complications as well as courses in epidemiologic surveillance and laboratory diagnosis from a clinical physician perspective. A large emphasis is placed on the experiential part of the program to understand the military's policies and procedures regarding service members with HIV/AIDS. Participants observe and/or participate in groups supported by clinical social worker, clinical psychologist, clinical pharmacist, and public health/preventive medicine personnel. The Military International HIV Training Program emphasizes training, consultation and operational support for epidemiological surveillance, laboratory diagnosis, prevention and management of HIV and its complications. It seek to train key foreign military clinical physicians in state-of-the-art HIV prevention and clinical management and diagnosis and treatment with the expectation that those trained will transfer information into operational use in country. The program incorporates a "train the trainer" approach and provides the tools and educational materials to promote current, up-to-date instruction to be taken back to the Rwandan military medical community. Written assessments communicating participants' needs, personal educational goals and that of their medical community are obtained prior to the training. Targeted in-country training and ongoing telecommunication follows the US based program. NHRC is developing web-based education availability.

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Local Organization Capacity Development	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Doctors (Parent: Public health care workers)

Military personnel (Parent: Most at risk populations)

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	TRAC Cooperative Agreement
Prime Partner:	Treatment and Research AIDS Center
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	2745
Planned Funds:	
Activity Narrative:	This activity related to activities in PMTCT (#2743) and CT (#2741) and consists of three main components. First, TRAC will revise and replicate national norms and guidelines for care and treatment (including ARV, TB, OI, STI, palliative care and community linkages) and will disseminate these to all health facilities providing ARV services. TRAC will also revise national tools for care and treatment, including client forms, reporting forms, educational tools and supervision tools. Second, TRAC will conduct four training-of-trainers sessions on care and treatment, including ARV, TB, OI, STI, palliative care and pediatric AIDS. Trainings will include a practicum component emphasizing quality of care. The participants at these trainings (trainers in Rwanda's 29 health districts) will in turn train service providers at health facilities. In addition, TRAC will conduct two training sessions for district-level supervisors and two training sessions for medical doctors at new ART sites. Additional training on administrative and financial procedures will be provided to district personnel on an as-needed basis. Finally, in collaboration with Columbia University, TRAC will develop a training-of-trainers plan for nurses working in HIV/AIDS care and treatment. The budget for this activity includes salary support for a care and treatment master trainer, a TB/HIV program officer and a quality of care officer within TRAC's care and treatment unit, as well as technical assistance (TA) for operations research on quality of ARV and related services. Also included are funds to renovate the TRAC complex in preparation for the upcoming merger of TRAC with the national TB and malaria programs.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	174	☐

Indirect Targets

TRAC is the national agency responsible for developing policies, norms and guidelines for clinical HIV/AIDS services. In addition, TRAC trains district-level ART trainers and supervisors. Both of these key functions are financed by the EP. *Through TRAC's policy and training support, approximately 126 health facilities will be providing ART to a total of* 12,635 individuals by the end of FY2006 (in addition to the 21,065 to be directly supported by USG).

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2751
Planned Funds:
Activity Narrative: Drew University will work with RDF to improve the quality of HIV treatment for HIV+ military personnel and civilians receiving care in the military, and increase the number of military health care providers trained to provide care to people living with HIV.

- Modify existing SOPs for pharmacies and laboratories for ARTs to the military context.
- Provide on-site ART training and supervision to 2 providers (4 in each hospital)
- Set-up referral system to link cases of HIV identified in military mobile, brigade and hospital VCT sites to hospitals for HIV staging and, if needed, treatment
- Treat with ARTs all patients for whom they are clinically indicated.

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Infrastructure	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	1	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	300	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	500	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	500	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	4	☐

Target Populations:

Adults

Commercial sex workers (Parent: Most at risk populations)

Most at risk populations

HIV/AIDS-affected families

Military personnel (Parent: Most at risk populations)

People living with HIV/AIDS

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

Public health care workers

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Twinning

Coverage Areas

Byumba

Gikongoro

Kigali-Ville

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Call to Action/EGPAF
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2757
Planned Funds:
Activity Narrative: See related activities: FHI-ARV (#4771)

EGPAF ARV Services has two different components: 1. Direct ARV treatment and 2. Support package to two DHTs in Ngarama and Kabuga districts to strengthen the ARV network model.

In collaboration with other ARV implementing partners and consistent with the MOH vision, EGPAF will continue to provide a standardized package of ARV services to 1000 patients (including 125 pediatric patients) at 6 sites, will expand ARV services to 750 (including 250 pediatric) new patients and will open at least 6 new ARV satellite sites as part of a coordinated network of HIV/AIDS services in 2 districts. EGPAF will also coordinate with ARC, assist in training providers in the Nyabiheke Refugee Camp and ensure a system of referral and support between Ngarama District Hospital and the camp (See Activity 4748). EGPAF will provide full ARV services at larger health centers and a limited package of ART services at satellite health centers using nurses as the primary ARV provider. EGPAF will ensure that all eligible women in PMTCT and eligible PLWHA are enrolled for ART at the health-center level by a nurse, supported by a physician from the local district hospital or according to DHT plans. Through DHT support, USG will support 20 of 29 DHTs nationally for additional personnel, training, clinical and program management, transportation and community-clinical linkages to oversee the expanding network of care.

To reach 750 additional patients, EGPAF will ensure that all eligible women in PMTCT and all eligible PLWHA will receive ART at the health center level by a nurse supported by a physician from district hospital or according to DHT plan. The district hospital physician will visit health centers on a regular basis to support ART initiation and review complicated ART and other cases at the health center. This model of expanded ARV treatment by nurses with physician back-up will be implemented more broadly by all ARV implementing partners in 2006. District hospital physicians will support nurses through regular visits, on-going phone access for urgent questions and clinical protocols to guide nurses' routine ARV practice. Patients needing urgent medical care beyond nurses' scope of expertise will be referred to the appropriate level of care. The long term goal is to maximize the capacity of the most decentralized level of service, thus increasing patients' access to ARV care.

EGPAF will provide a package of support to two health districts, including personnel and transportation. EGPAF will support development of referral, supervision, transportation and communication systems to send specimens, patients, providers, information, etc or otherwise support the network of cost-efficient, decentralized ARV services. Best practices and lessons learned in clinical management of HIV/AIDS patients and district management will be shared using the collaborative quality improvement approach (developed by QAP in COP FY04-FY05) supported by USS and DHTs. The district health teams will ensure coordination of care between district hospital and health centers including coaching and supervision of nurses at health centers, lab specimen transport from health centers and district hospital, referral between different levels of care.

EGPAF will continue to expand pediatric ART outpatient services, as part of a coordinated pediatric project including early infant diagnosis through PCR, CTX prophylaxis, and ARV treatment of eligible infants and children. (See EGPAF BHC 5111 and MCAP 2787) EGPAF will integrate outpatient ART care with immunization, weight monitoring and treatment of acute childhood illnesses. EGPAF will provide women a respectful ARV services environment, appreciating unique gender specific

issues that provide obstacles to access.

ARV patients will receive community support services for adherence and retention via the CHAMP ARV (See Activity 2809). ARV services include systematic HIV patient referral to community-based services providing psychosocial and spiritual support; ongoing prevention through interpersonal community groups for those testing HIV-positive to prevent further transmission; linkages with local community for adherence support and treatment retention; nutrition support including assessment and food. Referrals will also be made throughout the network of care to reproductive health and child health services, particularly through PTMCT, basic care and CT activities. EGPAF will assure their services environment is sensitive to women's issues that may otherwise limit access to HIV/AIDS care. All USG-supported health facilities providing HIV/AIDS services will hire a community care coordinator to assure effective community support of clinical care, including ARV adherence and retention via CHAMP. Referrals will also be made throughout the network of care to reproductive health and child health services, particularly through PTMCT, basic care and CT activities.

These activities fully support the Rwanda PEPFAR country 5-year strategy by increasing institutional and human capacity for a district managed network model of HIV Clinical Treatment and Care services. In addition, this FY06 assistance will build district and site capacity to manage in 2007 graduated ARV sites through performnace-based contracting.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	12	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	750	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	1,750	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	1,750	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	50	☐

Target Populations:

Nurses (Parent: Public health care workers)

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Public health care workers

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Wrap Arounds

Food

Coverage Areas

Kigali (Rurale)

Kigali-Ville

Byumba

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	RPM+
Prime Partner:	Management Sciences for Health
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	2761
Planned Funds:	
Activity Narrative:	RPM-Plus will improve ARV services by strengthening ARV pharmaceutical management and rational drug use at district hospitals, health centers, and satellite ARV health centers. During COP05, RPM-Plus improved ARV inventory management at ART sites with implementation of SOPs, revised data collection tools and developed a decentralized system of pharmacy supervision at ART sites and district pharmacies. Planned activities for COP06 include revision and updating of SOPs and management tools for implementation in new and existing ARV sites. RPM-Plus will standardize all procedures and develop SOPs related to ARV drug quantification, requisition, reception, storage and distribution of medicines at district pharmacies. RPM-Plus will implement electronic and paper versions of the pharmacy management information system (ART Dispensing Tool) at all ARV sites to facilitate monthly aggregation of data on ARV consumption for CAMERWA's monitoring of national ARV stocks. RPM-Plus will continue to train health center and hospital pharmacists in SOPs and in inventory tracking and reporting. RPM-Plus will develop a curriculum for district pharmacy supervisors on pharmacy management of ARVs and other essential medicines according to the national SOPs and tools. RPM-Plus will support provincial pharmacists who will conduct trainings and provide on-going support to district supervisors. The pharmacy management information system will be adapted to report on national consumption of OI drugs as well as ARVs. RPM-Plus will support two additional provincial pharmacists (in addition to two financed in COP05) to strengthen peripheral and central pharmacies' communication, thus improving national-level ARV stock management. During COP06 RPM-Plus will renovate and upgrade 15 ART site pharmacies, with a basic package of $10,000/site. As part of decentralization, RPM-Plus will support district pharmacies to become district-level depots for pharmaceutical storage. With the participation of pharmacy and clinical staff, RPM-Plus will develop practical guides for the establishment of Drug Therapeutic Committees at selected ART sites. RPM-Plus will develop pharmacy indicators on rational prescribing and rational use of drugs and will report quarterly on these indicators from ART sites. In the continuation of COP05, RPM-Plus will develop curricula and conduct training for pharmacy staff to improve good dispensing practices and rational drug use. At satellite ARV sites, RPM-Plus will define the distribution channel of ARVs, either from district pharmacies or from the closest ART sites, and will elaborate simplified ARV distribution and consumption tools in order to track the use of ARVs at all levels. RPM-Plus will establish a TOT system for pharmacy staff at district pharmacies and ART sites to be trained on simplified tools for distribution and consumption. RPM-Plus will train the personnel of satellite ART sites. RPM-Plus will ensure that monthly reports from ART sites include required data from the ART satellite sites. RPM-Plus will purchase at least two vehicles to aid in managing the increasing decentralization of ARV stock at ARV health facilities throughout Rwanda. USG will support an external performance audit of the coordinated procurement (See SI Activity #4972) to ensure that all ARVs are appropriately tracked to actual patients at health facilities and to assure that there is no inappropriate diversion of ARVs.

Emphasis Areas	% Of Effort
Policy and Guidelines	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Infrastructure	10 - 50
Logistics	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	270	☐

Target Populations:

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

Host country government workers

Key Legislative Issues

Stigma and discrimination

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	IMPACT
Prime Partner:	Family Health International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	2772
Planned Funds:	
Activity Narrative:	[Continuing Activity from FY2005 -- This activity will transition to Activity # 4770 in FY2006] USG partner currently supports or is in the process of establishing ARV services at 12 health center and district hospital sites. In FY05 services will be expanded to an additional 7 sites throughout the country. Integrating ARVs into a health facility necessarily follows the roll-out of VCT and PMTCT services and requires the completion of three key steps: (i) upgrading health facility rooms and infrastructure to accommodate HIV patient care; (ii) procuring furniture, materials, and equipment; and (iii) training clinic and lab staff. In FY05 this USG partner will: 1.Initiate ARVs in an additional four health center sites in Gitarama, one additional health center in Ngarama, and one in Gikongoro, which will be supported by rotating MDs based at nearby district hospitals. 2. Initiate ARVs in Ngarama District Hospital in Byumba Province; 3.Develop and establish more CT and PMTCT services at clinic sites in Byumba and Gikongoro in preparation of ARV scale up in the provinces in FY06; and 4. Hire additional personnel, including MDs, nurses, and laboratory technicians as needed by individual sites. The mechanism for hiring will be developed in consultation with the GOR and the USG.

Target Populations:

Adults

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

HIV/AIDS-affected families

National AIDS control program staff (Parent: Host country government workers)

People living with HIV/AIDS

Pregnant women

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Capacity
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2777
Planned Funds:
Activity Narrative: This acvity is related to CHAMP (#2809) and Col UTAP Nursing (#2729).

Capacity/IntraHealth ARV Services has two different components: 1. Direct ARV treatment and 2. National-scale nurse training in comprehensive HIV/AIDS care, including expanding the role of nurses to include limited ARV care.

In collaboration with other ARV implementing partners and consistent with the MOH vision, Capacity/IntraHealth will continue to provide a standardized package of ARV services to 750 patients at 5 sites, expand ARV services to 600 new patients (including 108 pediatric patients) and open at least new 5 ARV satellite sites. Capacity/IntraHealth will provide full ARV services at larger health centers and a limited package of ART services at satellite health centers using nurses, with physician back-up, as the primary ARV provider. Capacity/IntraHealth will ensure that eligible women in PMTCT and PLWHA are enrolled for ART at the health-center level. ARV patients will receive community support services for adherence and retention via CHAMP (See Activity 2809).

District hospital physicians will support nurses through regular visits, on-going phone access for urgent questions and use of clinical protocols to guide nurses' routine ARV practice. Patients needing urgent medical care beyond nurses' scope of practice will be referred to the appropriate level of care.

Capacity/IntraHealth will expand pediatric ART outpatient services, as part of a coordinated pediatric project including early infant diagnosis through PCR, CTX prophylaxis, and ARV treatment of eligible infants and children.

Capacity/IntraHealth will wrap around reproductive health and family planning services through non-PEPFAR-funded support at its ARV and other HIV/AIDS services, as well as train other USG partners in integrating FP and RH into their ARV services. Capacity/IntraHealth will provide women a respectful ARV services environment. Capacity/IntraHealth will share its model of "Partenariat d'Assurance de Quality" with clinical partners and PBF. The PAQ approach includes community advisory board that engage the community in governance of service delivery and have been successful in Rwanda.

(See related activity ARV-CHAMP 2809). Capacity/IntraHealth will support effective referrals between community and clinical services. All USG-supported health facilities providing HIV/AIDS services will hire a community care coordinator to assure effective *community support of clinical care, including ARV adherence and treatment retention* via CHAMP. CHAMP will support PLWHA in prevention for positives to prevent further transmission.

Capacity /IntraHealth will have four nurse practice strengthening activities related to ARV services:
First: Capacity/IntraHealth will train the "Universal Precautions at Health Facilities" component of the TRAC ARV TOT nurse training program.

Second: Capacity/IntraHealth, jointly with Columbia (See activity 2729), will provide comprehensive refresher HIV/AIDS training to 1500 currently practicing nurses nationally over the course of four years. These nurse strengthening activities will prepare nurses to provide comprehensive HIV/AIDS services, including ARV support. The in-service training will be closely integrated with clinical practicums, based on practical HIV/AIDS experience. The role of nurses in HIV/AIDS care will expand to include uncomplicated routine ARV care, including prescription refills, evaluation of

new symptoms, medication side effects, adherence, monitoring lab test results, and initial clinical staging, to be done under distant physician supervision. Columbia will provide the ARV training component while HCD/IntraHealth will provide broader nursing skills also needed for ARV care, including basic/palliative care, PMTCT, CT and fundamental nursing skills (histories, physical exams, nursing assessments, care) retraining. Capacity will support District Health Teams to carry out in-service HIV/ART training for the first 300 out of 1500 first and second level nurses in select districts beginning with the provinces of Byumba, Umutara, Kibungo, and Gitarama, where 5 priority public nursing schools are located. This in-service training focuses on the expanding role of nurses in ARV/HIV services and will be competency-based, focusing on specific work-related tasks that nurses need to provide comprehensive HIV/AIDS care to patients in health centers without physicians on-site.

Third: Capacity/IntraHealth will revise the existing official undergraduate nursing curriculum to updated and strengthen HIV/AIDS, including ARV nursing care. The existing nurse curriculum does not reflect current practice in HIV/AIDS care, particularly Nurse ARV services. The curriculum for the HIV/AIDS refresher training will also be used to strengthen basic pre-service nursing education curriculum. HIV/AIDS care skills will be integrated throughout the curriculum. Leveraging non-PEPFAR funds, MOH Nursing faculty curriculum will also incorporate new IMCI protocols, including the HIV/AIDS module. This training will be supported in part by the Nursing and Midwifery Unit and the Belgium Cooperation with MOE and Kigali Health Institute (KHI). Launch of the A1 course will begin in January 2007 at 5 nursing schools, with training equipment and materials included.

Fourth: Capacity/IntraHealth will provide support and staffing to the Department of Nursing in the Ministry of Health. HCD/IntraHealth will hire a Nursing Management Specialist to work with the Nursing and Midwifery Unit Director to provide strategic management support to the 5 nursing schools, with responsibility for preparation and coordination for the launch of the A1 (highest level) nursing program in Jan 2007. Thus, the expanded role of nurses in ARV support care is supported at all levels of nursing in the country.

These activities fully support the Rwanda PEPFAR country 5-year strategy by increasing institutional and human capacity for a district managed network model of HIV Clinical Treatment and Care services.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	10	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	600	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	1,350	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	1,350	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	350	☐

Target Populations:

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Host country government workers

Public health care workers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Food

Coverage Areas

Byumba

Umutara (Mutara)

Table 3.3.11: Activities by Funding Mechanism

Mechanism: QAP
Prime Partner: University Research Corporation, LLC
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: *11*
Activity ID: 2779
Planned Funds:
Activity Narrative: [Continuing Activity from FY2005 -- with No New Funding under this mechanism in FY2006]
With Emergency Plan 1.5 and 2.0 funds, USG launched an improvement activity "ART Collaborative" where staff from 20 sites in 6 provinces in Rwanda collaborate, based upon site experiences, to improve the quality and efficiency of ART services.

In FY05, the ARV collaborative, which started in FY2004 will end and will transfer management capacity of continuous quality improvement to the Department of Health Services. After 2005, USG will contract directly with Department of Health Services, and work with the performance-based health financing TA activity (See HIV/AIDS financing procurement discussion) for quality improvement activities in HIV/AIDS services delivery.

With FY '05 funds, the current ART Collaborative will extend from 20 to 40 sites. In addition, USG will strengthen capacity of DSS by training 12 district supervisors (2 in each of the 6 provinces involved) and central DSS PIU staff to manage HIV/AIDS collaborative improvement activities

While QAP activities will contribute to individual treatment targets (12000), these targets are reflected in other partner ART service activities (eg. FHI) in order to avoid duplicate counting of patients. The number of health workers trained and number of sites participating is included.

An evaluation of "The Collaborative Approach in Rwanda" will be conducted under 2004 Emergency Plan funding. If results of the evaluation are positive, USG will write up their achievements, including lessons learned for specific ARV services improvement, as a manual to share nationally, via Department of Health Services.

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Butare

Byumba

Cyangugu

Gikongoro

Gisenyi

Gitarama

Kibungo

Kibuye

Kigali (Rurale)

Kigali-Ville

Ruhengeri

Umutara (Mutara)

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	AIDS Relief
Prime Partner:	Catholic Relief Services
USG Agency:	HHS/Health Resources Services Administration
Funding Source:	N/A
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	2783
Planned Funds:	
Activity Narrative:	*This activity relates to activities in ARV services (4770), Basic Health Care (4989), and* TB/HIV (4982). CRS will continue to provide ARV services to 320 patients at two existing health centers. As part of the network roll-out model, CRS will provide ARV services at health centers linked to FHI-assisted DHT in Byumba. Through this collaboration, the DH physician will undertake regular follow-up visits to the CRS-supported sites to review ART and non-ART complicated cases. Nurses at these two health centers will continue to receive training and mentoring in patient follow-up and to detect and refer complicated cases to the DH. Supported by international TA, CRS will expand its continuous quality improvement through regular review of indicators and medical dossiers to develop and strengthen clinical capacity for more efficient and quality-assured patient management. CRS program staff and partners will participate in the DHT to ensure better collaboration within the health district. CRS will ensure that social worker and community services focal point at facilities in collaboration with CSP train, support and supervise community-based volunteers and PLWHA peers providing ART adherence support for patients. CRS will fund the procurement of CD4 tests and non-CD4 lab reagents and consumables for patients at their sites. In addition, CRS will participate in regular district meetings for better coordination of ART roll-out networking. In addition CRS will increase the percentage of children enrolled on ART, and to identify those pregnant women who require initiation of ARV therapy. CRS will work with the National Reference Laboratory to expand the diagnostic resources for HIV at the sites. It 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. It will work to improve reporting linkages with TRAC and will add an M&E specialist to its country program staff to assist in mentoring health center staff in their ability to provide accurate and timely HMIS data. These activities fully support the Rwanda EP five-year strategy for ART scale- up and decentralization

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	2	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	320	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	300	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	20	☐

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
HIV positive pregnant women (Parent: People living with HIV/AIDS)
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Columbia/MCAP
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: N/A
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2787
Planned Funds: [redacted]
Activity Narrative: This activity relates to activities in ARV services (2736), TB/HIV (4839, 2731), laboratory infrastructure (2734), and CT (2800). At the site level, MCAP will continue to provide ARV services to a total of 6164 patients at 28 existing sites, including nine district hospitals, 17 health centers, a specialized site for genocide widows living with HIV and a referral system to provide ART to prisoners. To reach additional patients more efficiently, Columbia will develop the network model by building on services already available at district hospitals in Kibuye, Gisenyi and Kigali.

Columbia will continue to strengthen TRAC and USS, the MOH entities responsible for national HIV clinical treatment and care planning, implementation and coordination, through TA and contractual relationships for efficient HIV/AIDS patient management.

In addition, Columbia will support capacity building for district networks in nine health districts, strengthening their capacity to plan, implement and monitor district scale-up of HIV clinical care and treatment. Columbia's support to the DHT, hospitals and health centers will enable a further expansion of ARV services to the health center level. This assistance will build district and site capacity for future progressive transfer of EP directly-supported sites to direct management by local entities through the PBF approach.

Significant financial and technical support will be provided to DHTs for personnel, clinical and program management, coordination, and facility-community linkages. For each district, this support includes the placement of five additional staff, one vehicle, motorcycles, and funds for operational expenses. With these resources, the DHT will ensure coordination of care between the district hospital and health centers, including coaching and supervision of nurses at health centers, lab specimen transport from health centers to district hospitals, and referral between different levels of care. Columbia will ensure that all sero-positive women identified through PMTCT and other existing PLWHA who qualify for ART are enrolled at the health-center level by a clinician from the district hospital. The district hospital-based clinician will visit health centers on a regular basis to support ART initiation and review complicated ART and non-ART cases at the health center. The clinician will be in constant contact with nurses following patients on treatment, and will help nurses to detect and manage complicated cases, or to refer them to district or national referral hospitals.

In collaboration with the CSP, Columbia will support social workers and community services coordinator positions placed at health facilities. These staff will train, support and supervise HBC volunteers, peers and others community-based staff providing ART adherence support to patients enrolled at their facilities. They will ensure that best practices in community involvement in care and support to PLWHA developed by IntraHealth (PAQ) are used at MCAP-supported sites. Best practices and lessons learned in clinical management of HIV/AIDS patients and district management will be shared using the collaborative approach currently used at USS.

With non-EP funds awarded by USAID [redacted] for PMTCT-plus, Columbia will strengthen PMTCT activities by procuring commodities for improvement and expansion of HIV care to pregnant women. Specific activities include CD4 testing for all 6,000 HIV-positive pregnant women expected in FY 2006 ([redacted] Columbia will procure ARVs for pregnant women [redacted] pay for PCR reagents for testing of exposed infants [redacted] purchase hemoglobin meters for PMTCT sites ([redacted] to monitor anemia for patients on AZT), and purchase OI drugs for pregnant HIV-positive women [redacted]. To promote systematic PIT, Columbia will support PIT policy design, rapid test and PCR kits, and training for service providers

on PIT with informed consent in pediatric wards and OVC care and support centers. Columbia will support on-site training to nurses at PMTCT sites for patient staging, OI diagnosis and treatment, and ART patient follow-up and reporting.

These activities fully support the Rwanda EP five-year strategic goal for increasing *institutional and human capacity for a district-managed network model of HIV clinical* treatment and care services.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	28	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	6,164	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	6,000	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	40	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

HIV/AIDS-affected families

Orphans and vulnerable children

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Laboratory workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Lab Support/APHL
Prime Partner: Association of Public Health Laboratories
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2794
Planned Funds:
Activity Narrative: [CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

APHL will procure needed equipment and materials to maintain the uninterrupted functioning of a network of 13 ART sites, including 3 provincial ART laboratory sites *(Butare, Cyangugu, Umutara) that are providing comprehensive ART laboratory* services (including CD4), and 10 district hospital sites providing hematology, and blood biochemistry.

APHL will procure laboratory equipment and supplies needed for 6 new ART sites at health centers in Butare and Cyangugu. (See Columbia MCAP supplemental under ART Services section for ART service delivery activities for these sites)

APHL will procure ELISA and other lab equipment, as well as reagents needed to perform new OI laboratory diagnostics at provincial labs (Butare, Cyangugu, Umutara). New techniques include diagnosis of cryptococcal meningitis, PCP, Chlamydia, and ELISA capacity for diagnosing other viral diseases. (See CDC under ART Services for related technical assistance for training).

Target Populations:

People living with HIV/AIDS

Coverage Areas

Butare

Cyangugu

Umutara (Mutara)

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Columbia MCAP Supplement
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2798
Planned Funds:
Activity Narrative: This activity also relates to activities in ARV services (2736), TB/HIV (4839, 2731), laboratory infrastructure (2734), and CT (2800). This activity provides supplemental funding to the Track 1.0 maintenance budget. Columbia University will provide ART services to 2,800 new patients at seven new sites. To reach additional patients more efficiently, the ART network model will be further developed by building on services already at district hospitals in Kibuye, Gisenyi and Kigali

Columbia will continue to strengthen TRAC and USS, the MOH entities responsible for national HIV clinical treatment and care planning, implementation and coordination, through TA and contractual relationships for efficient HIV/AIDS patient management through a network model.

In addition, Columbia will support capacity building for district networks in nine health districts, strengthening their capacity to plan, implement and monitor district scale-up of HIV clinical care and treatment. Columbia's support to the DHT, hospitals and health centers will enable a further expansion of ARV services to the health center level. This assistance will build district and site capacity for future progressive transfer of EP directly supported sites to direct management by local entities through the performance-based financing approach.

Significant financial and technical support will be provided to DHTs for personnel, clinical and program management, coordination, and linking communities to facilities. For each district, this support includes the placement of five additional staff, one vehicle, motorcycles, and funds for operational expenses. With these resources, the DHT will ensure coordination of care between district hospital and health centers including coaching and supervision of nurses at health centers, lab specimen transport from health centers to district hospitals, and referral between different levels of care. Columbia will ensure that all sero-positive women identified through PMTCT and other existing PLWHA who qualify for ART are enrolled at the health center level by a clinician from the district hospital. The district hospital-based clinician will visit health centers on a regular basis to support ART initiation and review complicated ART and non-ART cases at the health center. The clinician will be in constant contact with nurses following patients on treatment, and will help nurses to detect and manage complicated cases, or to refer them to district or national referral hospitals.

In collaboration with the CSP, Columbia will support social workers and community services coordinator positions placed at health facilities. These staff will train, support and supervise HBC volunteers, peers and others community-based staff providing ART adherence support to patients enrolled at their facilities. They will ensure that best practices in community involvement in care and support to PLWHA developed by IntraHealth are used at MCAP-supported sites. Best practices and lessons learned in clinical management of HIV/AIDS patients and district management will be shared using the collaborative approach currently used at USS.

Under the leadership of the DHT and in collaboration with USS, TRAC and other EP implementing partners in the districts, new health centers will be selected for upgrading based on their distance from district hospital and the demography and epidemiology of PLWHAs in their catchments areas. A package of full ARV services will be provided at seven health centers where nurses will provide limited ARV support services and ARV refills; a more limited package excluding full lab capacity will be established at other satellite health centers.

These activities fully support the Rwanda EP five-year strategic goal of increasing

institutional and human capacity for a district managed network model of HIV clinical treatment and care services.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	7	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	2,800	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	2,800	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	2,600	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	21	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

HIV/AIDS-affected families

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Laboratory workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	CHAMP
Prime Partner:	Community Habitat Finance International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	2809
Planned Funds:	
Activity Narrative:	This activity relates to activities: PMTCT (#2805), AB (#2807), OP (#2808), CT (#2806), OVC (2810), HIV/TB (#5129), BHC (#2811), and Systems Strengthening (#5183). Rwanda is decentralizing all HIV/AIDS prevention, care and treatment services, with HIV services, including ART, being expanded to the lowest level of care. To reduce the burden on health center staff, CBOs will take on a larger role in the care and support of patients on ART. Community and HBC volunteers will provide follow-up treatment adherence counseling, basic nursing care and monitoring of ART patients in their homes and at approximately 90 ARV sites in collaboration with clinical ART service providers and DHTs. CHAMP will support TRAC, USS and CNLS in developing a training curriculum for HBC volunteers in coordination with HCs and DHTs. Training content will include basics of ARV treatment and care, including basic care, referrals recommendations, IMCI and growth monitoring for HIV-infected and exposed infants, and counseling for treatment adherence, nutrition, and ART support. TB/HIV will be integrated into the curriculum to build capacity of volunteers to identify and monitor TB and TB treatment adherence through DOTS for ART patients and their family members. CHAMP will support the DHT to develop formal referral plans, forms and registers to ensure appropriate referral for ART patients to HBC and community ART support services. CHAMP will support TRAC, USS, and CNLS to develop a system for transferring patient information between ART sites and community HBC services, including development of patient monitoring cards for use by medical facilities and HBC volunteers. CHAMP will support TRAC, USS and CNLS to integrate HBC ART patient information, such as deaths, into the national ART reporting system. CHAMP-trained community volunteers will refer family members of ART patients for HIV testing and treatment. CHAMP will identify wrap-around food support for ARV patients, particularly HIV-infected children and pregnant HIV-infected mothers. This program will promote ART treatment, stigma reduction, community support of PLWHA, and community-adapted IEC materials (building from existing IEC prevention, care and treatment materials developed by TRAC and FHI). No targets are counted for this activity because all sites and patients are included in direct ARV service counts. These activities contribute to successful attainment of direct ARV service targets and treatment adherence, as described in the Rwanda EP five-year strategy.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	51 - 100
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

HIV/AIDS-affected families

Orphans and vulnerable children

People living with HIV/AIDS

Volunteers

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Stigma and discrimination

Food

Coverage Areas

Byumba

Gikongoro

Gisenyi

Gitarama

Kibungo

Kibuye

Kigali (Rurale)

Kigali-Ville

Umutara (Mutara)

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	Columbia UTAP - deferred
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	2833
Planned Funds:	
Activity Narrative:	*[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]* Columbia will provide technical assistance to TRAC to develop specialized training curricula for ART service provision for nurses and social workers. These curricula will be incorporated into the national bi-monthly classroom training for ART service providers nationwide.

Target Populations:

Nurses (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	CDC Country Office GAP/TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	2846
Planned Funds:	
Activity Narrative:	This activity is related to activities ARV Services (2798, 2787, 2736, 4849), Basic Health Care (2799, 2788, 4989), TB/HIV (4839, 4849, 4982), and Laboratory Infrastructure (2847). CDC Rwanda will continue the support of a Care and Treatment Officer who will oversee planning, implementation, and M&E of all CDC-direct and partner activities in the area of HIV care and treatment, as well as provide technical input to the MOH through technical working groups. CDC will support the expansion of early infant HIV diagnosis nationwide through TA from CDC HQ for clinical aspects of program scale-up, such as protocol revision, training, and documentation of best practices. CDC will document different approaches to linking clinical services and community-based care for ART adherence. Documentation will be shared with stakeholders in Rwanda and internationally. These activities fully support ART roll-out, pediatric ART, PMTCT, lab, basic healthcare and are in line with Rwanda EP five-year strategy for treatment and care.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Policy and Guidelines	10 - 50
Strategic Information (M&E, IT, Reporting)	*10 - 50*
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Laboratory workers (Parent: Public health care workers)

Implementing organizations (not listed above)

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Rapid Expansion
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2853
Planned Funds:
Activity Narrative: [Continuing Activity from FY2005 -- with No New Funding under this mechanism in FY2006. See Activity 2777] In recent years significant resources (through the USG, MAP, Global Funds) have been made available to Rwanda to increase access to ARVs. Through these initiatives the GOR aspires to put 101,051 patients on ARVs by 2008, 50,000 of which are targeted through USG funds. As of this writing date, only 7,500 HIV patients are being treated with ARVs at 39 clinical facilities.

USG proposes to start-up ART services at two health centers in Byumba and Kibungo Provinces where Intrahealth already supports PMTCT and VCT services, and one site in Umutara Province where existing PMTCT/VCT services, currently being provided by Global Fund, will serve as an entry point to ART. Patients qualifying for ART are awaiting urgent treatment at these existing PMTCT/CT sites in all provinces supported by IntraHealth and Global Fund.

USG will conduct the following activities:

- Strengthen infrastructure and capacity of health facilities to provide ART services, including monitoring of ART patients, management of ART-related complications, general HIV care, and ensuring appropriate referral to secondary and tertiary care facilities
- Strengthen capacity of nursing staff to manage HIV-patients on ART and to implement strategies promoting adherence in ARV patients. Work jointly with other USG partners to expand the responsibilities of nurses in HIV care, including ART services.
- Develop referral mechanisms between ART/clinical services and PMTCT, counseling and testing, HBC, PLHA groups and other community-based organizations, including PAQs. Formal partnership will be developed between Global Fund-supported sites to ensure systematic referral of HIV+ PMTCT/VCT patients to ART and clinical care services.
- Build the capacity of district teams to provide ongoing supervision and monitoring of quality, in collaboration with other USG partners (See PFB-Quality proposal).
- Develop two way referral and supervisory links with relevant District Hospitals in each province.
- Improve laboratory capacity to include ARV monitoring.
- IntraHealth will ensure that sites have a continuous, timely and secure supply of ARV drugs and other HIV-related commodities, through coordination and communication with partners managing commodities.
- Columbia is purchasing ARVs for Intrah Health

2. This activity further contributes to the USG Five-Year Strategy and the GOR care and treatment plan for scaling-up ART services, building on existing services and ensuring equitable access to ART in an expanded number of districts. This funding will help USG and GOR reach treatment goals, and is complementary to the COP05 as Intrahealth is already providing existing PMTCT and VCT services, and will be able to ensure that a comprehensive package of care and support is being provided to additional districts in which it is working.

3. Intrahealth will strengthen the capacity of sites where they have already been working, to expand on the PMTCT/VCT skills to provide HIV clinical management in conjunction with TRAC and District Health Teams. Existing work with community-based groups for follow-up will be expanded and built upon to ensure follow-up care and support for patients on ART.

4. Cost Per Client: [ ] (infrastructure strengthening, training, supervision, TA, excluding ARVs)

Coverage Areas

Byumba

Kibungo

Umutara (Mutara)

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Rapid Expansion
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2854
Planned Funds: [redacted]
Activity Narrative: [Continuing Activity from FY2005 -- with No New Funding under this mechanism in FY2006. See Activity 4770.] Nurses currently provide the majority of HIV care for patients, including support and counseling for ART patients. They are not however given the authority to prescribe ARVs and they are presently not responsible for initial clinical screening and history taking. There is a severe physician shortage in Rwanda and not enough physicians to meet the demand for ART scale-up in the country. There are approximately 300 physicians in Rwanda, with a population of 8 million. With approval from the Government of Rwanda, USG would like to support a pilot model of ART delivery by nurses, which will aim to increase nurses' capacity in clinical care, including initial patient screening, and provide them the authority to prescribe ARVs.

In concert with TRAC and MoH/DSS, The implementing CA would ensure close physician supervision for all activities and nurses delivering ARV care to assure safe practices, including development of needed clinical support tools, such as modified clinical protocols for nurses, establishment of on-going telephone communication between physicians and nurses for difficult cases, and routine review of all patient medical records by physician supervisors. District hospital medical staff will be involved in supervising activities and patient care provided at participating health clinics. A district hospital-based physician-supervisor will rotate to all participating sites (at least one time per month per site) to provide supervision, ongoing evaluation and monitoring and clinical support. A key feature would be use of cell telephone communication between the nurses and their supervising physicians, to provide on-going medical back-up to assure safety of nurses' practice.

The implementing partner currently supplements TRAC training in management of HIV including ART to both physicians and nurses in Rwanda with intensive on-site training for all clinic staff. This supplemental training will be further enhanced to ensure that nurse-prescribers have the skills and confidence to perform effectively in their expanded role.

Policy recommendations will be made to the GOR based on ongoing results from this activity. Specific clinical support tools, such as nurse-appropriate clinical protocols including clinical referral recommendations, will be identified for future development.

This activity directly contributes to USG's 5-year Strategy, as expanding the role of nurses for ART service delivery is necessary to reach Emergency Plan treatment targets, considering the severe physician shortage in Rwanda. It will also assist the implementing partner reach its targets in COP05.

This pilot would provide ART to 500 additional patients.

[redacted] Cost/ARV patient = [redacted] including medication.

Coverage Areas

Gitarama

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Rapid Expansion
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2855
Planned Funds:
Activity Narrative: [CONTINUING FY2005 ACTIVITY]

The availability and capacity to provide ART in Rwanda has increased over the past year. An estimated 13,000 patients will be on ART by the end of February, 2005. However the importance of inclusion of pediatric HIV care and treatment in the national expansion plan has lagged behind. Pediatric treatment is predominantly occurring at the Central Hospital of Kigali (CHK), where 300 children are on ART, the majority of whom are over the age of five. Identification of "symptomatic children only" fails to reach all young children at risk.

The majority of HIV-infected children will thus die before they are given a chance for treatment. This is due to a variety of reasons, including: (a) poor identification of HIV + children, in part due to poor linkages between PMTCT and clinical care services as well as HIV+ mothers' fear to get infant tested; (b) limited long-term monitoring and care of HIV-exposed infants; (c) limited number of health care personnel trained in pediatric ART;

In the COP05, the implementing agency is already funded to provide pediatric HIV/AIDS care for HIV-exposed and infected children in 1 of its 17 existing PMTCT / VCT sites. This first site and proposed expansion would entail a program of family-centered care with both adult and pediatric ART services. The implementing partner proposes expanding this model and creating a more extended network of ARV care linked to its PMTCT / VCT programs, so that many more clients can ultimately be served.

Additional Funding is proposed to: 1) rapidly start up ART services at 4 additional health centers where the partner already provides PMTCT / VCT services, building on existing relationships with these sites. Two of these sites have been support by EGPAF (Rubungo and Nygasambu) and two others have been supported by CRS under AIDSRelief (Bungwe and Muhura); 2) initiate all services (PMTCT / VCT / ARV) at Ngarama District Hospital, a proposal that address the needs of an under-served health district and which has the strong support of TRAC, the national AIDS agency; and 3) work closely with another USG partner (FHI) to build capacity for pediatric care and treatment at five new ART sites planned in Gikongoro province for FY05. (Collaboration with FHI at two existing ART sites is already funded in the FY05 COP.)

At all sites, PMTCT and CT would be used as entry points for care and treatment of mothers, children and families. This partner has successfully used PMTCT as an entry point to ART in South Africa, Tanzania, Zambia and Cote d'Ivoire over the past year through Project HEART, where more than 15,000 adults and 1,400 children are on ART.

USG would carry out the following specific activities under this proposal for Additional Funding:
1. Directly assist two existing partner sites and one new site to deliver adult and pediatric ART, including training and supervision, infrastructure and lab strengthening, commodity management, provision of SOPs, and clinical monitoring tools
2. Strengthen and formalize referral mechanisms between PMTCT/CT and ART/HIV clinical care programs
3. Strengthen ability to identify HIV-exposed infants through postnatal and well child visits, out patient services, and linking with PLHA groups and other community-based organizations.
4. Provide technical assistance to clinics, DSS and TRAC to possibly include mothers' PMTCT identification numbers on child health cards to facilitate identification of

HIV-exposed infants, and strengthen the patient tracking system between PMTCT and outpatient care and treatment departments.
5. Proactively identify infected and affected family members through increased partner testing of PMTCT clients and testing of family members of CT clients.
6. Strengthen the capacity of 3 district health teams, two of which are already working with the partner plus Ngarama, to provide supervision of the health centers implementing ART, particularly in pediatric ART
7. Provide technical assistance in appropriate dosing according to national and international pediatric treatment protocols and strengthen the capacity and confidence among health providers (doctors and nurses) in pediatric care and treatment.
8. Provide technical assistance, through training, development of protocols, guidelines, and recommendations to health center staff that can be transferred from partner sites to other ARV sites operating in Rwanda.
9. Work closely with TRAC and MOH to share experience and lessons learned in national support of pediatric ARV care.

This activity is directly in line with the Rwanda EP five-year strategy, which calls for the rapid expansion of and strengthened national capacity to deliver ARV services, including pediatric ART. Cost per client (direct EGPAF sites):

Coverage Areas

Byumba

Gikongoro

Kigali-Ville

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Rapid Expansion
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: *HIV/AIDS Treatment/ARV Services*
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2856
Planned Funds:
Activity Narrative: [CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

This proposed activity would cover the Columbia Track 1.0 program's unmet need to implement the growth scenario plan for FY 2005. (The Track 1.0 year 2 award for Columbia was funded at the no-growth scenario level) Specific activities include: the enrollment of 2,075 additional patients on ART at 14 existing FY 2004 sites, and the launching of 8 new ART treatment sites at health centers in 2 provinces outside of Kigali, serving a total of 400 patients in these new sites in FY2005. Columbia University will support direct treatment and purchase ARV drugs for these patients, including children and HIV+ women identified through PMTCT programs at ART sites. Because Columbia program activities are developed in direct collaboration with the GOR, geographic deployment and resource allocation are, by definition, supportive of local strategies.

Columbia University, with Ministry of Health/TRAC as a subgrantee, has successfully launched 7 ART treatment sites in Kigali, Gisenyi and Kibuye provinces through an innovative public-private partnership. Columbia has exceeded its FY 2004 ART target of 731 patients by more than 300%. Columbia's success has been largely founded on its close collaboration with TRAC in program planning: site selection, site assessment, sub-grant development for sites, theoretical training, practical on-site training and lab infrastructure development. With Columbia's support and technical assistance, TRAC has been successful in executing sub-grants with sites, assisting sites with renovation and staffing plans, and conducting national classroom training for ART service providers. The Columbia-TRAC partnership has been recognized by Rwandan stakeholders as a model for local capacity transfer and sustainability in ART scale-up. Through this partnership, the Ministry of Health has rapidly gained program experience and management expertise which will remain a GOR strength beyond the life of the Emergency Plan.

2. The proposed funding for additional patients and sites will allow Rwanda to achieve its FY05 COP targets, as the targets were based on the assumption of full funding of Columbia Track 1.0 activities. The proposed additional funds are necessary to meet the global treatment targets approved in the COP 05. The proposed funding directly contributes to attainment of five-year strategy goals in two ways: 1) national ART coverage is dependent upon full funding of the Columbia program; 2) Columbia's joint implementation approach with GOR is an essential step in successfully transferring international partner responsibility for ART service delivery to local partners, a cornerstone of the Rwanda Five-year Strategy.

3. The Columbia-TRAC partnership model directly increases both central Ministry of Health and local site and District Health Team capacity for ART service expansion, maintenance and supervision. At the central, district and site level, Columbia provides technical assistance for all aspects of scale-up. Activities are jointly planned and conducted by Columbia and TRAC personnel. In accordance with the USG strategy for capacity building, Columbia will transition from providing assistance through long-term technical advisors to providing select short-term assistance on an as-needed basis over the course of the Emergency Plan. The end goal is to build TRAC's capacity to the point where it is a fully autonomous technical assistance provider for District Health Teams and sites.

4. Cost per client on ART for this proposed activity is [redacted] This calculation also includes the purchase of ARVs drug costs for patients at 2 EGPA supported sites and 1 Intrah-supported sites. Track 1.0 year two funding would be leveraged, as basic operational and technical assistance costs are largely covered under the currently

funded maintenance scenario. Additional funds would result in decreased cost per client served.

Coverage Areas

Gisenyi

Kibuye

Kigali-Ville

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Rapid Expansion
Prime Partner: Columbia University
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 2858
Planned Funds:
Activity Narrative: [CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

USG will support the development and scale-up of the existing TRACnet system for expanded use by the National Reference Laboratory, the Treatment and Research AIDS Center, CAMERWA (the national drug procurement agency), SIS and the Ministry of Health. TRACnet, Rwanda's national phone- and internet-based reporting system for HIV/AIDS, was developed by Columbia and Voxiva in FY2004 and currently consists of 3 modules: a program indicators reporting module, an ARV drug stock monitoring module and a laboratory test results module. In FY2004, Columbia and Voxiva ensured the implementation of the first two modules at 21 ART sites through training and ongoing TA. The lab test results module was piloted at 2 ART sites using NRL for CD4 testing.

The TRACnet laboratory module will be adapted and expanded to the entire ART network. This will link the central and provincial lab network to all health care sites in the country providing ART, thereby ensuring timely and adequate laboratory monitoring of patients. The other modules -- program indicator reporting and ARV drug stock monitoring -- will also be expanded to all ART sites. The ARV drug stock monitoring will be especially beneficial to the strength of the network, as it will allow program planners to monitor regional drug stocks in real time and shift drug stocks between facilities according to need.

2. In FY2004, TRACnet was piloted at 21 sites. Expanding the system to all ART sites in FY2005 makes TRACnet the essential monitoring tool for collecting ART-related indicators nationally.

3. The expansion of the TRACnet system to all ART sites will enable HIV/AIDS program managers at the provincial and national levels to monitor the status of the national ART programs and make informed programmatic decisions. TRACnet orientation and training will be incorporated into the classroom and practical (on-site) components of the national training program for ART service providers, conducted by TRAC and Columbia University. The TRACnet system is managed locally by TRAC's ICT unit.

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	HIV/AIDS Performance Based Financing
Prime Partner:	Management Sciences for Health
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	4003
Planned Funds:	
Activity Narrative:	This activity relates to PBF CT (2812), Pol SS (2813), PMTCT (2814), BHC (2815), TBHIV (4001) and FHI-ARV (4770). PBF-ARV services will continue ARV services to 125 patients and add 125 new patients in FY2006. PBF of HIV/AIDS services is a key tool for achieving sustainability as outlined in the Rwanda EP five-year strategy. PBF of ARV services will be piloted in 2006 by "graduating" two mature ARV sites to the PBF and rolled out on a larger scale in 2007. Due to the complexity of ARV service delivery, ARV services will be piloted and transitioned to PBF one year (FY2006) later than other HIV/AIDS services (FY2005). FHI will transfer one full ARV service and one " satellite" ARV service to PBF in 2006. FHI and the PBF will evenly divide targets and financing for the transition year. The DHT, FHI and the PBF partner will develop a common transition plan to assure continued support in needed areas. PBF will provide management training in planning, budgeting, quality improvement, and M&E to health providers and DHTs. The PBF partner will support the DHT and HCs to "manage" the quality and efficiency of ARV care using M&E, MIS, external clinical audits and coaching and supportive supervision. The PBF partner will work with the Department of Health Services and DHTs to define ARV service quality and volume performance indicators indicators for reimbursement. PBF will provide incentives for greater efficiency and higher quality within the ARV Network. To support the MOH's plan for national implementation of PBF, PBF will also assist other non-USG HIV/AIDS and ARV service providers to develop performance-based contracts according to national and district guidelines. PBF will assist in developing health district capacity to manage all health facilities with performance-based contracts. USG will procure an external evaluation of PBF as a tool to sustainably finance ARV services and to improve health system performance in 2006. (See Activity 4972.) PBF of ARV services is a critical step to achieving the goal of sustainable, well-managed, high quality, and cost-effective ARV service delivery in a comprehensive HIV/AIDS treatment network.

Emphasis Areas	% Of Effort
Health Care Financing	51 - 100
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Needs Assessment	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	2	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	125	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	250	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	250	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

People living with HIV/AIDS

Policy makers (Parent: Host country government workers)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Other health care workers (Parent: Public health care workers)

Table 3.3.11: Activities by Funding Mechanism

Mechanism: FHI Bridge
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 4770
Planned Funds:
Activity Narrative: This activity relates to activities CHAMP-ARV (2809) and PBF-ARV (4003). This financing covers costs of sub-agreements with 25 health facilities for ARV service delivery and the cost of supporting eight DHTs to strengthen the ARV network of care.

ARV Service Delivery:
In collaboration with other ARV implementing partners and consistent with MOH vision, FHI will provide a standardized package of ARV services to 3960 patients (including 200 pediatric patients) at 18 sites and expand ARV services to 2575 new patients (including 636 new pediatric patients) at approximately 7 new sites through support and development of a coordinated network of HIV/AIDS services in eight districts. FHI will provide full ARV services at larger health centers and a limited package of ART services at satellite health centers using nurses as the primary ARV provider with physician back-up. FHI will ensure that eligible women in PMTCT and eligible PLWHA are enrolled for ART at the health-center level or according to DHT plans.

In COP05, FHI is piloting expanded role of nurses in the provision of ARV care. This model of care will be implemented more broadly by all implementing partners in 2006. District hospital physicians will support nurses through regular visits, on-going phone access for urgent questions and use of clinical protocols to guide nurses' ARV practice. Patients needing urgent medical care beyond nurses' scope of expertise will be referred to the appropriate level of care. The long term goal is to maximize the capacity of the most decentralized level of service, thus increasing patient access to ARV care in rural communities. CHAMP will similarly decentralize and provide ARV patients with community support services for adherence and retention.

Additionally, FHI will continue to expand pediatric ART outpatient services, as part of a coordinated pediatric project including early infant diagnosis through PCR, CTX prophylaxis, and ARV treatment of eligible infants and children. FHI will pilot the graduation of two ARV sites to performance-based contracting -- one full ARV site and one ARV satellite -- by the end of 2006. FHI will assure a service environment sensitive to issues that may limit women's access to HIV/AIDS care.

Strengthen the ARV Network Model:
Rwanda is actively decentralizing local government and has recently aligned administrative districts with health districts. Health districts now have budgetary and administrative authority over health service delivery. The USS has been charged with integrating all HIV/AIDS services into the minimum package of care to be provided in all health facilities and managed at the district level. Through PBF Pol System Strengthening (2813) USG will also support the USS and DHTs to coordinate performance-based contracting and quality assurance. FHI will provide a package of support to eight DHTs in Byumba, Gitwe, Kabgayi, Remera-Rukoma, Kigeme, Kibugo, Bugasera and Ruli districts to strengthen their capacity to coordinate an effective network of ARV and other HIV/AIDS medical services. Support to DHTs will focus on strengthening the linkages, referral systems, transport, communications and financing systems necessary to support an effective ART and other HIV/AIDS care network. This network focuses on maximizing access to ARVs and other HIV/AIDS services and improving quality of care at the most decentralized level. CHAMP will link community services to clinical care at decentralized health centers, reflecting a dual bottom-up/top-down approach to expansion of service outlets and entry points for care.

FHI will provide a basic package of financial and technical support to DHTs, including

staff positions, transportation, communication, training, and other support. Key responsibilities of DHTs include assuring access of patients to quality HIV/AIDS care, organization of specific care components (full and limited ARV services, ARV and OI medications, commodities, lab tests, community services) and good management of resources.

Strengthening the capacity of the USS and DHTs supports the sustainability and national scale-up goals outlined in the Rwanda EP five year strategy. The ARV network model fully supports the Rwanda EP five year strategy by pursuing ARV treatment targets through cost-effective utilization of Rwanda's limited human and financial resources. In addition, this FY2006 assistance will build district and site capacity for future transfer of USG partner- supported sites to local entities through the PBF project.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	25	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	2,575	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	7,240	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	6,431	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	120	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Public health care workers

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Wrap Arounds

Food

Coverage Areas

Byumba

Gikongoro

Gitarama

Kigali (Rurale)

Kigali-Ville

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Catholic Relief Services Supplemental
Prime Partner: Catholic Relief Services
USG Agency: HHS/Health Resources Services Administration
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 4849
Planned Funds:
Activity Narrative: This activity relates to activities in ARV services (4770), Basic Health Care (4989), and TB/HIV (4982).
CRS will provide ARV services to 800 new patients at two new and two existing health centers. As part of the network roll-out model, CRS will provide ARV services at health centers linked to FHI-assisted DHT in Byumba. Through this collaboration, the DH physician will undertake regular follow-up visits to the CRS-supported sites to review ART and non-ART complicated cases. Nurses at these four health centers will continue to receive training and mentoring in patient follow-up and to detect and refer complicated cases to the DH. Supported by international TA, CRS will expand its continuous quality improvement through regular review of indicators and medical dossiers to develop and strengthen clinical capacity for more efficient and *quality-assured patient management. CRS program staff and partners will participate* in the DHT to ensure better collaboration within the health district. CRS will ensure that social worker and community services focal point at facilities in collaboration with CSP train, support and supervise community-based volunteers and PLWHA peers providing ART adherence support for patients. CRS will fund the procurement of CD4 tests and non-CD4 lab reagents and consumables for patients at its sites. In addition, CRS will participate in regular district meetings for better coordination of ART roll-out networking. In addition CRS will increase the percentage of children enrolled on ART, and to identify those pregnant women who require initiation of *ARV therapy. CRS will work with the National Reference Laboratory to expand the* diagnostic resources for HIV at the sites. It 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. It will work to improve reporting linkages with TRAC and will add an M&E specialist to its country program staff to assist in mentoring health center staff in their ability to provide accurate and timely HMIS data. These activities fully support the Rwanda EP five-year strategy for ART scale- up and decentralization.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	4	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	800	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	800	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	750	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	43	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

HIV/AIDS-affected families

Orphans and vulnerable children

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba

Table 3.3.11: Activities by Funding Mechanism

Mechanism: USAID Rwanda Mission
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 4970
Planned Funds:
Activity Narrative: USAID/Rwanda has been providing local and international technical assistance to GOR agencies and limited direct grants to local NGOs since COP04.

In COP06, the EP will expand this to further build local capacity. These resources will cover the cost of sponsoring and attending conferences, workshops and technical meetings on HIV treatment. A number of Rwanda NGOs requested financial assistance from USAID in FY2005 for such activities. USAID anticipates continuing this financial and technical support role in FY2006.

The MOH is requesting technical assistance for the new Rwanda Center for Health Communications (RCHC), a unit within the MOH charged with improving IEC/BCC activities. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS.

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Adults
Community-based organizations
Faith-based organizations
Host country government workers

Coverage Areas:

National

Table 3.3.12: Program Planning Overview

Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12

Total Planned Funding for Program Area:

Program Area Context:

Through the Emergency Plan, USG provides support and technical assistance to the NRL and KHI to improve laboratory infrastructure and capacity at the national level for HIV/AIDS testing, care and treatment. (Note that laboratory support to specific service provision sites is detailed in the "ARV Services" program area). As in previous years, USG technical support for laboratory infrastructure in FY2006 will continue to focus on key reference laboratory functions, including training, quality assurance systems, and developing in-country expertise in performing new procedures for HIV-related care and treatment. Enhanced support for pre-service training at both KHI and NRL will assure sustained laboratory capacity in the years to come.

FY 2006 will mark an important shift in the utilization of USG resources and laboratory partner expertise to support laboratory infrastructure. The first change will be the start of direct USG support to the NRL through a CDC cooperative agreement to manage certain key training and logistical functions, as well as support for some quality assurance activities. USG will also fund a new laboratory partner, ASCP, to continue and expand support for pre-service training of laboratory technicians at KHI through curriculum development, direct training support. These two new partners are taking over activities that were initiated by CDC and Columbia UTAP in FY2004 and FY2005. These shifts will allow Columbia and CDC to focus more narrowly on laboratory service quality concerns. This realignment of laboratory support resources is consistent with the strategic objectives of infrastructure strengthening and sustainability outlined in Rwanda's EP five-year strategic plan.

USG partners continuing in FY2006 will have the following roles: CDC will continue to provide TA for training in diagnosis of opportunistic infections, HIV incidence testing for surveillance, and molecular virology techniques for HIV drug resistance surveillance. APHL will have a more limited role in FY2006, assisting with procurement for the HIV drug resistance surveillance activity, and HIV serology quality assurance activities. Columbia UTAP 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. In addition to technical laboratory support, Columbia UTAP will continue to bolster management and financial capacity at NRL through the continuation of a long-term laboratory management advisor and through support for data management system improvements for tracking specimens and reporting functions.

Program Area Target:

Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	15
Number of individuals trained in the provision of lab-related activities	280
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring	0

Table 3.3.12: Activities by Funding Mechanism

Mechanism: Columbia UTAP
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 2734
Planned Funds:
Activity Narrative: This activity relates to activities in laboratory infrastructure (2847, 2734, and 4979). Columbia University will continue its capacity building activities at NRL by supporting technical activities as well as strengthening institutional infrastructure and management capacity critical to sustain the national network of laboratories for the Rwandan HIV care and treatment program.

Direct TA will be provided through long-term advisors and periodic short-term assistance. Two long-term technical advisor positions funded in FY2005 will be continued in FY2006. The first is an international hire position providing support for quality HIV-related laboratory services including new technologies, technician trainings, research, and guidance on technical and policy issues. The second is a continuing local-hire senior lab technician responsible for development and implementation of national standards, QA systems, and training. The technical advisors will transfer skills, knowledge and capacity, ensuring sustained impact. Short-term advisors will also be utilized as needed for specific projects such as baseline assessments at new sites or the development of quality improvement tools. Columbia will also assist GOR in expanding pediatric diagnosis of HIV through increased HIV antibody testing for hospitalized children and other approaches.

Columbia will continue to improve reference laboratory management and infrastructure through support for two key management positions, an international hire management advisor and a local hire logistics coordinator. The laboratory management advisor, based at the NRL, will help develop management systems for finances, logistics, program data, transport and commodities. In addition, this person will assist NRL to coordinate the establishment of new ART sites throughout the country and will oversee planning for the national QA systems. The logistics coordinator will be responsible for laboratory assessments and renovations, equipment inventories, reagent supply chain management, and organization of new laboratory set-ups. Beyond staff support, Columbia will continue to fund operational costs associated with the implementation of NRL's HIV QA/QC activities in peripheral lab sites (supervision, transportation of QA/QC panels), small repairs and preventive maintenance in the ART site laboratories, warehouse storage, and transport of laboratory equipment and reagents to sites.

Columbia will expand FY2005 data management activities by providing TA to strengthen data collection and analysis at the NRL; this will include continuing support for a data manager position based at NRL. Columbia will also support the NRL to establish a system to electronically link the network of "provincial" ART laboratories. Columbia will also support the NRL to establish and pilot a laboratory-based surveillance system, which will include the development of laboratory requisition forms and a central surveillance database; TA with data cleaning, analysis and interpretation; and enhancement of communication between the NRL and feeder clinics so results from the surveillance system can be shared with clinics in a timely manner. Through Columbia's sub-agreement with NRL, it will support a local IT officer to maintain the data management system.

Columbia will also support a new HIV/AIDS pre-service laboratory internship program in collaboration with KHI and ASCP. Columbia will support KHI to plan and implement on-site training at ART-upgraded laboratories across the country. Practical training will be provided in HIV/AIDS techniques for 20 KHI laboratory technician degree candidates. Two new local hire positions will also be supported at NRL to coordinate all training activities at site and national levels, and to coordinate logistics for QA activities. Finally, Columbia will assist NRL in developing a training course for non-laboratory personnel in the use of HIV rapid tests currently in use in Rwanda to

maximize the utility of these tests for advanced HIV testing strategies.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	*10 - 50*
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50
Human Resources	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests		☑
Number of individuals trained in the provision of lab-related activities	30	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Laboratory workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 2753
Planned Funds:
Activity Narrative: Drew University will work with the RDF to improve the laboratory network system within Rwanda by more effectively linking the RDF and MOH laboratory systems. In addition, it will assist the RDF in upgrading the central laboratory to adequately enable providers based within the military system to provide laboratory diagnoses of HIV, immune function and related opportunistic infections, and hematological and metabolic status. On-site training of laboratory personnel will increase the number of laboratory technicians in the RDF.

- Procure and install laboratory equipment and commodities to aid in the diagnosis and treatment of HIV, including immune function analyses, evaluation of opportunistic infection and monitoring of hematological and metabolic functions.
- Provide on-site training and supervision of RDF laboratory staff in use of equipment

Emphasis Areas	% Of Effort
Infrastructure	51 - 100

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests		☑
Number of individuals trained in the provision of lab-related activities		☑

Key Legislative Issues

Twinning

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: Lab Support/APHL
Prime Partner: Association of Public Health Laboratories
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 2793
Planned Funds:
Activity Narrative: This activity relates to activities 2848, 2739, 4979, and 2734 (CDC SI, TRAC SI, ASCP Lab Infrastructure, Columbia UTAP Lab Infrastructure)

APHL will continue to provide support in procuring equipment and reagents for central-level laboratory functions at the NRL and KHI. As in FY2005, the procurement of supplies and reagents for the ARV drug resistance surveillance activity will continue, as Rwanda conducts its second HIV Drug Resistance Threshold Survey. APHL will procure small quantities of reagents and supplies needed to equip training laboratories at KHI. APHL will procure HIV test kits and supplies to maintain NRL's national HIV serology QA activities. Although these procurement activities are essential for the successful implementation of surveillance, training and quality assurance activities, no Laboratory Infrastructure targets are directly attributed to this partner, but are attributed instead to other implementing partners listed in the first line above.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Infrastructure	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests		☑
Number of individuals trained in the provision of lab-related activities		☑
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

People living with HIV/AIDS

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: CDC Country Office GAP/TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 2847
Planned Funds:
Activity Narrative: This activity relates to activities 2848, 2739, 2734, 4976 (CDC SI, TRAC SI, Columbia UTAP Laboratory Infrastructure, NRL Laboratory Infrastructure). CDC will continue direct support for lab infrastructure activities in FY2006 through a long-term lab position in the CDC office, short-term TA and support for procurement.

CDC's long-term technical position (new position funded in FY2005) will provide day-to-day oversight of EP-funded lab partner activities, including the NRL cooperative agreement and other clinical partners. The lab position will also provide ongoing assistance with development and implementation of national laboratory policy.

Because the current capacity of district hospital laboratories to diagnose opportunistic infections is limited, CDC will continue to support laboratory capacity for opportunistic infection diagnosis through CDC's DPDx program for diagnosis of parasitic diseases. This support will include procurement of diagnostic supplies and ongoing training at NRL for 15 technicians.

CDC will continue to provide TA to lab professionals in molecular virology techniques in order to continue HIV drug resistance surveillance for the second year. CDC will provide short-term TA for continuing efforts in HIV serology QA and HIV incidence testing (BED assay). CDC will procure supplies for FY 2006 BED testing activities.

CDC technical support to NRL is consistent with Rwanda EP five-year strategic goals of strengthening NRL capacity to manage a national network of laboratories, and standardization of technical approaches and QA of HIV-related services through a network model.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	1	☐
Number of individuals trained in the provision of lab-related activities	15	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Laboratory workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism:	National Reference Laboratory
Prime Partner:	National Reference Laboratory
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Laboratory Infrastructure
Budget Code:	HLAB
Program Area Code:	12
Activity ID:	4976
Planned Funds:	
Activity Narrative:	This activity relates to activities #2847, #2734, and #4979 (CDC direct Laboratory Infrastructure, Columbia UTAP Laboratory Infrastructure, ASCP Laboratory Infrastructure). In FY 2006, the EP will develop a cooperative agreement with the NRL to begin direct funding of certain key reference laboratory functions. As the lead institution in Rwanda's national laboratory network, the NRL plays a critical role in the successful expansion of HIV/AIDS prevention, diagnostic, care and treatment services nationally. The NRL has been a close collaborator in EP efforts for many years, and has benefited from EP technical and financial support through several implementing partners. As outlined in the Rwanda EP five-year strategy, FY 2006 will mark the beginning of a shift toward direct EP funding provided to NRL. Substantial resources have been invested in NRL to date by CDC and Columbia UTAP support for infrastructure, technical activities, and management capacity. Other support will continue in FY 2006 through the Columbia UTAP sub-agreement and through CDC direct technical support, although support from both of these sources is substantially decreased. NRL cooperative agreement activities in FY 2006 will include support for human resources (technical positions and training), infrastructure maintenance, and select QA activities. The NRL will train 160 laboratory technicians in good laboratory practices and HIV-related techniques, including CD4 testing, biochemistry, hematology, and HIV and OI diagnosis. This will include two-week trainings for technicians at new ART sites, and two-day refresher trainings for all previously trained lab technicians. These trainings will be carried out by a national team of six trainer/supervisors placed both centrally and in "provincial" laboratories. Salaries for these trainer/supervisors will be shifted from the Columbia UTAP mechanism to the NRL cooperative agreement in FY 2006. The cooperative agreement will support logistics and materials needed to continue QA activities for CD4 testing nationally, allowing NRL to continue to produce quarterly reports on this activity. This QA system will cover the 15 laboratories that will have CD4 testing capacity by the end of FY 2006. The NRL will also secure a maintenance contract for all of its central-level equipment through the MOH's maintenance unit. A modest amount of support will be made available to support participation of key senior technical staff in international trainings and/or conferences directly relevant to increasing capacity for HIV-related laboratory techniques.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Quality Assurance and Supportive Supervision	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	15	☐
Number of individuals trained in the provision of lab-related activities	160	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Laboratory workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: American Society of Clinical Pathology
Prime Partner: American Society of Clinical Pathology
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 4979
Planned Funds:
Activity Narrative: This activity relates to activity 2734 (Columbia UTAP, Laboratory Infrastructure).

In FY2006, the EP will begin a partnership with ASCP, building upon FY2005 activities by CDC and Columbia UTAP in support of KHI. ASCP will provide technical assistance to KHI to strengthen its laboratory training program. Support will include strategic planning for the laboratory program, support for laboratory curriculum development, direct support for laboratory training for 75 students, and continued infrastructure strengthening. ASCP will collaborate with Columbia UTAP on its laboratory pre-service internship training activity under which KHI lab students will be placed at district hospital laboratories to gain field experience in HIV/AIDS-related lab work.

KHI is the sole institution in Rwanda that provides pre-service training for laboratory technicians. As such, KHI is a key institution in Rwanda's efforts to provide quality clinical and laboratory services in support of national-scale HIV care and treatment. These activities address the Rwanda EP five-year strategic goal of building sustainable laboratory human capacity.

Emphasis Areas	% Of Effort
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	1	☐
Number of individuals trained in the provision of lab-related activities	75	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Teachers (Parent: Host country government workers)

Laboratory workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.13: Program Planning Overview

Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13

Total Planned Funding for Program Area:

Program Area Context:

CNLS and TRAC are the two GOR entities responsible for HIV/AIDS SI. CNLS oversees policy guidance and strategic leadership to coordinate M&E for the national multi-sectoral response to HIV/AIDS. TRAC is responsible for HIV surveillance, clinical policy and guidelines, national in-service curriculum development, training of trainers, national M&E of clinical services, and overall coordination of HIV/AIDS clinical programs.

The EP provides technical support and direct financial assistance to CNLS and TRAC to strengthen institutional capacity for SI. CNLS has faced challenges in developing a unified national monitoring and reporting tool. This has led to a significant quarterly reporting burden for the EP. However, the GOR is revising the five-year Strategic Framework for HIV/AIDS Control and the National M&E Plan. In the *context of Rwanda's rapidly expanding program environment*, the GOR conducted a multi-agency mid-term review of the national plan in December 2004, the results of which will be included in the revised Strategic Framework (2005 -2009). EP TA directly contributed to implementation of the national plan mid-term review.

CNLS and its district structures will continue to receive technical and financial assistance through the EP to strengthen capacity to plan, coordinate, monitor and report on the progress of the national response. Support will include assistance developing and implementing a decentralized reporting system for non-facility program level reporting, as well as systems for mapping community interventions and the activities of all HIV/AIDS implementing partners. EP will also support a SPA to assess progress at Rwanda's health facilities midway through the Emergency Plan.

In collaboration with Global Fund and MAP, the EP will support IT procurement and connectivity through satellite technology, expansion of TRACnet reporting modules, and the introduction of a national electronic medical record system for ART patients. Support for surveillance will continue in FY2006, including ongoing ANC sentinel surveillance, HIV drug resistance surveillance, and the use of new HIV incidence testing methods.

Four targeted evaluations will be conducted in FY2006 to inform ongoing programming in Rwanda, and to share innovative practices beyond Rwanda. The first will evaluate the EP-funded PBF model. The second will support the CNLS to do a triangulation of HIV/AIDS program coverage data with behavioral, *environmental and health status data from individuals frequenting high risk sites. The purpose of this* targeted evaluation is to conduct secondary analyses of four data sets to provide insight into ways HIV/AIDS prevention services in Rwanda can be better matched to the risk profile of local populations to increase uptake of prevention services such as condom use, VCT, and PMTCT. The third will support an external evaluation of its PBF strategy and activity to determine if they are meeting the sustainability needs of the EP as well as the improved health system performance desired by the MOH. This assessment will help inform the EP and GOR decision to continue, modify or cancel the PBF contract. The fourth will support external evaluation to review models of care for HIV/AIDS service delivery, including the minimum package of care (CT, PMTCT, basic/palliative, and TB/HIV) and expanded package of care: (ARV treatment, including ARV satellite sites, full outpatient service and hospital-based ARV services).

Note that the SAVVY tool explored in COP05 will not be implemented in Rwanda because of financial constraints and the absence of donor and GOR support to institutionalize this methodology over the long term.

Program Area Target:

Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	845
Number of local organizations provided with technical assistance for strategic information activities	35

Table 3.3.13: Activities by Funding Mechanism

Mechanism: Columbia UTAP
Prime Partner: Columbia University Mailman School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: *GAC (GHAI account)*
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 2735
Planned Funds:
Activity Narrative: [CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

Columbia University and Voxiva, Inc. will provide support to GOR for the expansion of the TRACNet pilot, a web- and telephone-based ART client information system, to new sites. The pilot system consists of three modules -- program indicators, ARV stock monitoring, and CD4 and viral load test results.

In FY2005, Columbia and Voxiva will:
- Conduct training on TRACNet 1.0 for 20 new sites and provide ongoing TA to the 20 sites launched in FY2004
- Conduct initial training for analyst-level users at TRAC, CAMERWA, NRL, SIS (Health Information System), CNLS.
- Conduct initial training at two sites for users of the lab results module.
- Begin using all functions of TRACNet, including data collection, communication and analysis
- Complete ICT assessment, compile and distribute results.
- Gather feedback from all levels of users and stakeholders on TRACNet 1.0 for future versions.

Additional ongoing activities will include:

- Transfer capacity to the TRACNet management team within TRAC through ongoing training and guidance. This management team will assume ongoing management and operation of TRACNet in the long term.
- Coordinate with national and international stakeholders and partners on cross-cutting issues affecting the use and management of TRACNet, such as program indicators, patient identification and drug supply management.
- Work closely with partners on the integration of TRACNet into the day-to-day management of key institutions.

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)		☑
Number of local organizations provided with technical assistance for strategic information activities		☑

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

Policy makers (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism:	TRAC Cooperative Agreement
Prime Partner:	Treatment and Research AIDS Center
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	*13*
Activity ID:	2739
Planned Funds:	
Activity Narrative:	This activity relates to SI activities #2747 and #4985. It consists of three main components: HIV surveillance, ICT for HIV data reporting and analysis, and M&E. In FY2006, TRAC will undertake multiple surveillance activities aimed at better understanding the state of the HIV/AIDS epidemic in Rwanda. TRAC, in collaboration with CDC, will lead sentinel surveillance at 30 ante-natal care facilities, training 60 site personnel, procuring tests and other materials, supervising sites, analyzing results and compiling a report. After being trained in BSS questionnaire design and revision from Tulane University (see activity #2747), staff in TRAC's epidemiological surveillance unit will collaborate with CDC to conduct a BSS for a high-risk group not included in the FY2005 BSS. TRAC will continue its collaboration with CDC and the NRL in the area of HIV incidence surveillance, carrying out a second phase of the BED assay using specimens from 2005 and 2006 sentinel surveillance and analyzing and disseminating the results. Finally, TRAC will participate with CDC and NRL in a second threshold survey of ARV drug resistance surveillance and will assist with the analysis and dissemination of its results. The budget for this component includes support for three positions in the TRAC epidemiological surveillance unit. In the area of ICT, TRAC will provide multi-pronged support to health districts and facilities in the management, reporting and use of HIV data. In the first three to four *months of FY2006, TRAC ICT and clinical staff will be primary recipients of training* and TA provided under the Data Analysis and Use activity (#4985). Once they have developed the skills and competencies necessary to analyze and use HIV/AIDS program data for decision-making and program improvement, they will participate in the training of district-level health personnel. By the end of FY2006, TRAC personnel will be carrying out district trainings in HIV data analysis and use independent of international TA. Where possible, these trainings will be coordinated with TRAC and Tulane University's training of DHTs in the use of productivity software (MS Office), a *continuing activity from FY2005. Finally, TRAC staff will provide on-site training to all* ART sites in the use of TRACnet (Rwanda's phone- and Internet-based reporting system for HIV/AIDS) for reporting of ARV drug and program indicators. All TRAC ICT activities will be guided by the findings and recommendations of the national HMIS assessment (which will be available by April 2006) and coordinated with broader HMIS activities. The budget for this component includes support for several positions in the TRAC ICT unit, as well as a high-speed Internet connection for TRAC. Targets for persons trained in TRACnet use and data analysis are located under the HIV/AIDS *Electronic Reporting System* activity and *Data Analysis and Use* activity, respectively. In the area of M&E, TRAC will undertake operations research on clinical care and treatment services as needed to monitor the quality of those services. The budget for M&E includes support for two TRAC M&E officers and TA for operations research on cross-cutting clinical issues.

Emphasis Areas	% Of Effort
AIS, DHS, BSS or other population survey	10 - 50
HIV Surveillance Systems	10 - 50
Information Technology (IT) and Communications Infrastructure	10 - 50
Monitoring, evaluation, or reporting (or program level data collection)	10 - 50
Proposed staff for SI	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	60	☐
Number of local organizations provided with technical assistance for strategic information activities	29	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Other health care workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: UTAP
Prime Partner: Tulane University
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 2747
Planned Funds:
Activity Narrative: This activity relates to SI activities #2739 and #2792. This activity builds on monitoring and reporting, capacity development, and other SI activities carried out in FY2005 with key Rwandan agencies and organizations working in the area of HIV/AIDS prevention, care and treatment.
This activity, to be carried out by Tulane University, has four main components. The first component consists of continuing TA to TRAC, CNLS, and MOH for the improvement of internal and national monitoring and reporting systems for HIV/AIDS. Tulane University will provide TRAC and MOH with TA for internal work plan monitoring and reporting and will train staff from these two entities in the use of the UNAIDS-developed Country Response Information System for reporting and retrieval of HIV/AIDS data by partner, project, reporting period, and so on. In addition, Tulane University will assist CNLS with 1) the revision of the Multi-sectoral National Plan for HIV/AIDS, 2) the monitoring of the corresponding National HIV/AIDS M&E Plan (including support for the collection, analysis and reporting of data on community-based HIV/AIDS programs), and 3) the development of its electronic reporting system for community-based programs.

The second component is comprised of TA to TRAC and districts for validation and improvement of PMTCT and VCT data. In FY2004 and FY2005, Tulane assisted TRAC in developing a national database for PMTCT and VCT data. In FY2006, Tulane will collaborate with TRAC's ICT unit to improve PMTCT/VCT data validation procedures at the central and district levels. This will include training district personnel in the use of productivity software to aggregate PMTCT and VCT data from health facilities (the targets for this training are located under SI activity #2739).

The third component focuses on expanding the content and usability of HIV/AIDS digital libraries developed at TRAC and CNLS in FY2004 and FY2005 with assistance from Tulane. A Tulane consultant will work with the ICT units at TRAC and CNLS to improve the content and organization of their existing digital libraries and to network these libraries so that all content is easily accessible from a single location (on- or off-line).

The fourth and final component will provide support to TRAC for the design of BSS questionnaires. Tulane will train TRAC's Epidemiologic Surveillance unit in BSS questionnaire design and revision so that TRAC can expand its role in the design phase of future behavioral surveillance and reduce its dependence on external TA for the same.

As a result of this activity, three central-level government entities leading the battle against HIV/AIDS will be provided with TA in the area of SI, and a total of 42 individuals will be trained in SI for HIV/AIDS prevention, care and treatment.

Emphasis Areas	% Of Effort
AIS, DHS, BSS or other population survey	10 - 50
Information Technology (IT) and Communications Infrastructure	10 - 50
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100
USG database and reporting system	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	42	☐
Number of local organizations provided with technical assistance for strategic information activities	3	☐

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: *Strategic Information*
Budget Code: HVSI
Program Area Code: 13
Activity ID: 2754
Planned Funds:
Activity Narrative: Drew University will assist the RDF in improving its infrastructure for data entry and monitoring at hospital and brigade clinic levels and to improve their ability to follow the health status of HIV positive soldiers and civilians receiving care within the military health system. In addition, Drew University will assist the RDF in monitoring the effectiveness of systems designed to link HIV cases diagnosed at brigade and mobile clinic levels to hospitals for evaluation and treatment. The RDF will also receive assistance in continuous quality improvement through the appropriate use and application of treatment, prevention and care related data.

- Implement data system being developed for the national HIV system within the *military setting.*
- Provide technical assistance to create a military data system that enables the military to conduct routine HIV testing of all military personnel.
- Provide computers for data entry at all military related VCT, PMTCT and HIV treatment sites.
- Conduct baseline evaluation of military heath system to objectively determine system-level gaps and strengths.
- Provide technical assistance for implementation of HIV surveillance of all military personnel
- Provide technical assistance in data management and analysis for monitoring and evaluation activities.

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)		☑
Number of local organizations provided with technical assistance for strategic information activities	1	☐

Target Populations:

Adults

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

HIV/AIDS-affected families

Military personnel (Parent: Most at risk populations)

People living with HIV/AIDS

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Twinning

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: Measure Eval
Prime Partner: University of North Carolina
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 2758
Planned Funds:
Activity Narrative: This activity is related to activities #4781 and #2747.

This activity builds on the progress achieved to date in monitoring and reporting, community mapping, and database development through MEASURE Evaluation support to the National AIDS Commission (CNLS) in FY2004 and FY2005, and will include continued TA and other support to the CNLS in four focus areas:

The first focus area – capacity building and skills transfer – includes TA to support the CNLS M&E Officer and Data Analysis Unit to prepare, collect, and synthesize data necessary to produce the quarterly service coverage, semi-annual and annual reports, in accordance with the National M&E Plan for HIV/AIDS. This will also include continued support to update tools (forms, tally sheets, checklists) and procedures necessary for data collection, to adapt curricula for the CNLS and procedural materials tested during the pilot stage in FY2005, and to support training for the CNLS regional and district teams to use these tools and procedures. MEASURE Evaluation will also identify and support training opportunities for the M&E officer.

In the second focus area – data reliability and data use – MEASURE Evaluation will train CNLS M&E staff to carry out data reliability studies on community services data, working in collaboration with Tulane UTAP which introduced data reliability studies for clinical services data at TRAC in FY2005. MEASURE Evaluation will continue support to the CNLS for data analysis and use at all levels of the decentralized HIV/AIDS structure, consistent with the application of the 'Three Ones.'

MEASURE Evaluation will also support the CNLS to do a triangulation of HIV/AIDS program coverage data with behavioral, environmental and health status data from individuals frequenting high risk sites. The purpose of this targeted evaluation is to conduct secondary analyses of four data sets to provide insight into ways HIV/AIDS prevention services in Rwanda can be better matched to the risk profile of local populations to increase uptake of prevention services such as condom use, VCT, and PMTCT. The evaluation builds upon work carried out by MEASURE Evaluation in FY2005 and responds directly to the GOR request to increase local HIV/AIDS research capacity. Outcomes will include providing practical descriptive and spatial analyses that will be disseminated to and used by local and national level decision makers and program planners to address identified program gaps.

The third focus area – enhanced IT capacity – includes IT support to the CNLS Data Analysis Unit to update and maintain the community mapping database, to support the harmonized work planning and reporting systems, and to implement the decentralized reporting system nationally. MEASURE Evaluation will also identify and support training opportunities for the Data Analysis Unit staff to maintain and improve its IT skills.

In the fourth focus area – dissemination – MEASURE Evaluation will continue support for the dissemination of the quarterly service coverage, semi-annual and annual reports. This will include the editing and translating of reports, printing, and other support related to the electronic posting of reports on the CNLS and other GOR (TRAC, MOH) websites, building on the CNLS website upgrade and staffing support for the electronic library supported by MEASURE Evaluation in FY2005. MEASURE Evaluation will also support the annual HIV/AIDS research conference in Rwanda.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	10 - 50
Information Technology (IT) and Communications Infrastructure	10 - 50
Monitoring, evaluation, or reporting (or program level data collection)	10 - 50
Targeted evaluation	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	60	☐
Number of local organizations provided with technical assistance for strategic information activities	10	☐

Target Populations:

Community leaders

Community-based organizations

Country coordinating mechanisms

International counterpart organizations

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

Policy makers (Parent: Host country government workers)

Program managers

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: Health District IT/Procurement
Prime Partner: To Be Determined
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 2792
Planned Funds:
Activity Narrative: This activity relates to SI activities #2739 and #4985.

This activity is a continuation of CDC's IT support to health districts in FY2004 and FY2005, which furnished Internet connectivity and basic IT equipment for 10 health districts engaged in the national HIV care and treatment program. In each health district, the district hospital, ARV service, DHT and decentralized structure of the CNLS were connected to each other (via a wireless local area network), to the Internet and to the TRAC wide area network. Health district personnel were provided with work stations and were trained in the use of basic software for management of HIV operations, recordkeeping and district-level data aggregation.

In FY2006, CDC will provide IT equipment (including a server, several computers, *printers and UPSs) and Internet connectivity* for 10 additional health districts, while continuing to support Internet connectivity for the 10 districts connected in FY2004 and FY2005. This will constitute coverage of two-thirds of Rwanda's health districts; the remaining districts would be covered in FY2007. Funds for the purchase of IT equipment in FY2006 are located under the CDC SI budget, as equipment will be procured directly by the CDC office. The $188,925 allocated to this activity will pay for high-speed connectivity and regular maintenance of IT hardware at a total of 20 health districts.

This activity will be rolled out in coordination with SI activities #2739, under which TRAC will train district health personnel in computer use/maintenance and exploitation of productivity software, and #4985, under which TA and training will be provided to DHTs for the analysis and use of PMTCT, VCT and ART data.

Emphasis Areas	% Of Effort
Information Technology (IT) and Communications Infrastructure	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)		☑
Number of local organizations provided with technical assistance for strategic information activities	20	☐

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism:	CDC Country Office GAP/TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	13
Activity ID:	2848
Planned Funds:	

Activity Narrative: This activity relates to activities 2739, 2792, 2747 (TRAC SI, Health District IT SI, Tulane UTAP SI). In FY 2006, CDC SI activities will include both short- and long-term TA in surveillance, IT, HMIS, M&E. CDC will also continue support for key SI positions and will procure necessary equipment for IT connectivity in selected health districts.

In FY 2004 and 2005, the EP scaled up key IT infrastructure in 10 health districts. This involved procuring the appropriate IT equipment (including servers, computers, printers, wireless cards) and assisting with installation. In FY 2006, EP will expand this activity to 10 new health districts. CDC will continue to directly procure the IT equipment needed at the health district level, while connectivity-related aspects of this activity, including installation and maintenance of satellite dishes or leased lines, will be performed by a local contractor. Through these efforts, CDC will equip 10 new districts for program reporting, secure transfer of patient information and access to national HIV databases. (Note that TRAC and Tulane UTAP will assure that DHTs will receive training in the use of productivity software – see activities 2739 and 2747.)

CDC will continue FY 2005 support for the EP HMIS coordinator who will coordinate EP HMIS activities with the GOR, USG agencies, USG contractors and grant recipients, and with multilateral organizations such as WHO and UNAIDS. The coordinator will assist GOR in strategic planning for information systems in the health sector and will help strengthen GOR capacity in information systems development, deployment, management and data use. An important result of this support will be the GOR's improved capacity to collect critical data for EP program management.

CDC's epidemiologist position is supported under the SI program area. The epidemiologist serves on the EP SI team as the surveillance focal point and provides ongoing TA to TRAC and the NRL for their surveillance activities. FY 2006 surveillance activities will include ANC sentinel surveillance, behavioral surveillance, HIV drug resistance surveillance, and HIV incidence testing for surveillance. This support will strengthen national capacity to collect, interpret and use surveillance data. These activities complement TRAC's proposed surveillance-related activities in FY 2006.

CDC will also provide short-term TA from HQ to support HMIS activities, behavioral surveillance and SI liaison activities. These funds will also continue to support two local hire positions: a data manager at TRAC, and a health specialist at the CDC office.

The Rwanda EP program is committed to addressing GBV and concomitant cultural practices that increase the risk of HIV/AIDS transmission to women and girls. Approximately 250,000 women experienced sexual violence during the genocide and many of them contracted HIV/AIDS. Women and girls today are also impacted by many types of violence including sexual and domestic. However, the USG and its partners have no reliable information on how many of these women currently require care or receive information on HIV/AIDS services. In FY2006, CDC will document 1) the situation of women affected by violence and 2) the barriers they encounter when seeking care. In order to effectively assess GBV, this activity will examine and survey cross-cutting groups within the Rwandan population including women, men, youth, and at risk populations including commercial sex workers. The USG will use this documentation activity to develop targeted programs that will better reach women and girls affected by violence. This activity is linked to the Rwanda EP five-year strategy and the commitment expressed therein to addressing gender issues in a systematic way.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	10 - 50
Information Technology (IT) and Communications Infrastructure	10 - 50
Other SI Activities	10 - 50
Proposed staff for SI	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	5	☐
Number of local organizations provided with technical assistance for strategic information activities	1	☐

Target Populations:

Adults

Commercial sex workers (Parent: Most at risk populations)

Discordant couples (Parent: Most at risk populations)

National AIDS control program staff (Parent: Host country government workers)

People living with HIV/AIDS

Children and youth (non-OVC)

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: Embassy Rwanda
Prime Partner: US Department of State
USG Agency: Department of State
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 4050
Planned Funds:
Activity Narrative: EP Rwanda will procure TA to develop and produce EP media and outreach materials. This activity will include, but is not limited to, the following components:

The first component includes the design and production of informational brochures. The EP team and implementing partners will contribute source material including technical and/or programmatic text and photographs. Required services include design and production of brochures including an EP overview and description of EP program areas. These brochures will come in the form of folding three-ply documents, plus a complete package of replicable and updatable cards within a folder featuring artwork illustrating the Rwanda program.

The second component includes the organization of media site visits. EP Rwanda is eager to develop relationships with the local print and televised media. The EP will support 12 media site visits for six journalists each. In consultation with the EP team, the contractor will select sites, assemble the journalists, and organize scheduling, lodging, transport and other logistics for the tours.

The third component includes the design of media materials to publicize EP events and programs. These will include program brochures consisting of replaceable cards or other materials in a folder with information about individual program elements, budget information, and photographs, that can be maintained by the USG team upon completion of the contract.

Working with the DOS, the contractor will prepare appropriate representations, mock-ups, draft materials, storyboards, of the products described above, for review by EP staff. Upon approval of each item, the Contractor will ensure production, printing, manufacture and distribution as appropriate.

This list is illustrative, and the specific products will be determined over the course of the contract period by the EP. The EP will provide guidance and textual research materials to the contractor and will obtain approvals, modifications and clearances as required.

The contractor will report directly to the EP State officer or his/her designee. The contractor will be required to coordinate closely with all EP Rwanda staff, other USG agencies in Rwanda and implementing partners to secure information about EP programs and strategies.

Emphasis Areas	% Of Effort
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)		☑
Number of local organizations provided with technical assistance for strategic information activities		☑

Indirect Targets

NA

Target Populations:

Adults
Children and youth (non-OVC)
Girls (Parent: Children and youth (non-OVC))
Boys (Parent: Children and youth (non-OVC))
Primary school students (Parent: Children and youth (non-OVC))
Secondary school students (Parent: Children and youth (non-OVC))
University students (Parent: Children and youth (non-OVC))
Men (including men of reproductive age) (Parent: Adults)
Women (including women of reproductive age) (Parent: Adults)

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism:	Measure DHS
Prime Partner:	Macro International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	13
Activity ID:	4779
Planned Funds:	
Activity Narrative:	This activity supports EP investment in health facility infrastructure, equipment and training by all EP partners and other non-EP funded health projects. The EP will procure TA for the design and implementation of a targeted facility survey through MEASURE/DHS, implemented by ORC Macro as the prime partner under MEASURE/DHS. ORC Macro will undertake a SPA to collect information on the national capacity to provide specific services and service quality using facility-based indicators required by the EP. The survey will cover all district and reference hospitals, the NRL, and both government and private facilities, for an estimated 250 facilities. The MOH and ONAPO conducted the 2001 Rwanda SPA. This assessment was the first nationwide survey of its kind in Rwanda, and was carried out with TA from ORC Macro and financial support from USAID. The EP team is required to report on health facility indicators twice during the EP (i.e., within the first 18 months, and again near the end of year five or early year six). A second SPA will be scheduled for FY2008. This activity will address increasing gender equity in HIV/AIDS programs by collecting data on availability of information, services, and care for women and girls; and by making policy recommendations to promote increased access for women and girls to prevention activities, treatment, and care services.

Emphasis Areas	% Of Effort
Facility survey	51 - 100
Health Management Information Systems (HMIS)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	30	☐
Number of local organizations provided with technical assistance for strategic information activities	2	☐

Indirect Targets

NA

Target Populations:

Faith-based organizations
Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
National AIDS control program staff (Parent: Host country government workers)
Non-governmental organizations/private voluntary organizations
Policy makers (Parent: Host country government workers)
Teachers (Parent: Host country government workers)
USG in-country staff
USG headquarters staff
Host country government workers
Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)
Public health care workers
Laboratory workers (Parent: Public health care workers)
Private health care workers
Doctors (Parent: Private health care workers)
Laboratory workers (Parent: Private health care workers)
Implementing organizations (not listed above)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: USAID Rwanda Mission
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 4972
Planned Funds:
Activity Narrative: This activity funds EP staff dedicated to SI and also funds targeted evaluations. USAID/Rwanda employs the SI Liaison Officer for the Rwanda EP Team. USAID provides local and international TA in SI to GOR agencies, as well as limited direct grants to local NGOs.

USAID will procure a performance and financial audit of the GOR coordinated procurement of ARVs. This audit will assess if jointly procured ARVs are reaching patients as intended by the governance documents of the coordinated procurement. The audit will track procured ARVs from placement of orders with CAMERWA to districts or facility depots and to ART patients. The audit will determine if any inventory of drugs is not fully accounted for or if there are missing stocks. The audit will evaluate the documentation of distribution of ARVs and determine if there is adequate documentation to assure appropriate management of ARVs procured through the coordinated procurement.

USAID will support an external evaluation of its PBF strategy and activity to determine if they are meeting the sustainability needs of the EP as well as the improved health system performance desired by the MOH. This assessment will help inform the EP and GOR decision to continue, modify or cancel the PBF contract. Specific questions to be answered by the evaluation include: Is the PBF activity helping to build capacity of the MOH and/or DHT to manage the quality and efficiency performance of HIV/AIDS service delivery? Will PBF mechanisms assist in building sustainable management systems to continue the prevention, treatment and care clinical activities of the EP? What changes are recommended to the current PBF program to improve its effectiveness? This assessment will take place at month 18 of the PBF and be completed in time to inform COP07 development.

The EP will support another external evaluation to review models of care for HIV/AIDS service delivery, including the minimum package of care (CT, PMTCT, basic/palliative, and TB/HIV) and expanded package of care: (ARV treatment, including ARV satellite sites, full outpatient service and hospital-based ARV services). After consultation with the GOR and the EP, the consultant will identify different models of care used by implementing partners as well as other donor or GOR-supported models. The consultant will compare and contrast models of HIV/AIDS care based upon all or some of the following characteristics: quality of care (including patient satisfaction, compliance with external standards, adherence), cost and cost-effectiveness, access, volume, resource needs, impact of HIV/AIDS model of care on other health services, capacity building, and sustainability.

Emphasis Areas	% Of Effort
Proposed staff for SI	10 - 50
Targeted evaluation	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)		☑
Number of local organizations provided with technical assistance for strategic information activities		☑

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: Data Analysis and Use
Prime Partner: To Be Determined
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 4985
Planned Funds:
Activity Narrative: This activity is related to SI activity #4987.

One of the major weaknesses with respect to HIV/AIDS data in Rwanda is the lack of its analysis and use at all levels of the health care system. TRACnet, Rwanda's phone- and Internet-based reporting system for ART, collects site-specific and aggregate program indicator data on a monthly basis. To date, however, these data have not been exploited for decision-making and program improvement.

In FY2006, a Task Order partner (TBD) will provide short- to medium-term TA for HIV/AIDS data analysis and use to central-level institutions (TRAC, USS, NRL, CNLS and others) as well as to DHTs. The first component of the activity will focus on building data analysis capacity at central MOH institutions and establishing a joint forum for reviewing and analyzing HIV/AIDS data on a monthly basis. Data reviewed will include TRACnet data on program indicators and drug stock, as well as other HIV/AIDS-related data compiled at the national level. The EP implementing partner will train a data use support team (composed of TRAC, USS, NRL and CNLS staff) to provide TA to health districts and CBOs in the analysis and use of this HIV/AIDS data for service improvement.

In the second component of the activity, the Task Order partner and the data use support team will conduct joint training of health districts in the analysis and use of HIV/AIDS data. In collaboration with DHTs, they will establish a system for quarterly review and analysis of ART, PMTCT and VCT program data in all districts, with semi-annual meetings to bring together district health personnel to compare data and trends.

This activity will build on the findings and recommendations of the national HMIS assessment (to be completed by April 2006) and will be carried out in collaboration with EP implementing partners, who will be responsible for reinforcing data analysis and use systems at the district and health facility levels. Tools and approaches for data analysis and use will be developed jointly by the Task Order partner and MSH, the prime EP partner for performance-based financing of HIV services.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	10 - 50
Information Technology (IT) and Communications Infrastructure	51 - 100
Monitoring, evaluation, or reporting (or program level data collection)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	100	☐
Number of local organizations provided with technical assistance for strategic information activities	29	☐

Target Populations:

Doctors (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Policy makers (Parent: Host country government workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Laboratory workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: HIV/AIDS Reporting System
Prime Partner: To Be Determined
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 4987
Planned Funds:
Activity Narrative: This activity is related to SI activity #4985 on data analysis and use.

In FY2004, USG initiated the development and implementation of TRACnet, a phone- and Internet-based reporting system for ART via a Columbia University sub-contract. This system is now functional and has been rolled out to all health facilities providing ART. Monthly program indicators data, weekly reports on drug stock, and as-need reports on CD4 test results are all managed by the reporting system.

In FY2006, USG will open this contract to competition. The winning contractor will provide technical support for the improvement and further development of TRACnet. The contractor will also provide ongoing TA and training to system users – *including central-level health policy and decision-makers, DHTs, implementing partners* and health service providers – for the reporting and retrieval of data. A total of 428 individuals will be trained in HIV/AIDS data reporting and retrieval using TRACnet. More targeted training and TA for HIV/AIDS data analysis and use will be provided to central- and district-level users under a separate activity (#4985).

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	51 - 100
Monitoring, evaluation, or reporting (or program level data collection)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	428	☐
Number of local organizations provided with technical assistance for strategic information activities	6	☐

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
National AIDS control program staff (Parent: Host country government workers)
Policy makers (Parent: Host country government workers)
Laboratory staff
Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)
Laboratory workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.14: Program Planning Overview

Program Area: Other/policy analysis and system strengthening
Budget Code: *OHPS*
Program Area Code: 14

Total Planned Funding for Program Area:

Program Area Context:

In FY2004 and FY2005, the EP made significant investments to develop Rwanda's national leadership in HIV/AIDS through support to the NUR School of Public Health for the MPH Program and the HIV/AIDS Public Interest Fellowship Program. The EP assisted TRAC to finalize their strategic plan and enhance their institutional capacity for technical leadership and coordination of surveillance and HIV/AIDS clinical services. CAMERWA and the Department of Pharmacy were strengthened to organize a coordinated procurement of ARV's including Global Fund, MAP and other donors which is demonstrating significant cost savings. In FY2006, the EP will continue to support these organizations and expand its support to the district level to facilitate the decentralization and integration of HIV/AIDS services.

The EP investment in central-level coordination of HIV/AIDS clinical services will continue in FY2006 *through the TRAC cooperative agreement, including support to renovate the TRAC office complex.* In line with Rwanda's decentralization activities, the EP will provide a package of support to the USS at central and district levels for strengthening supervision and quality of clinical services. USS will receive financial and technical assistance through a sub-contract with a USG partner, while 20 of Rwanda's 29 health districts will receive a minimum support package consisting of infrastructure, equipment, support for communication, supervision, management, transportation and human resources. While the districts are motivated to succeed, there is limited infrastructure, and funding under the EP is largely dedicated to technical interventions. While this will enhance district capacity, funds programmed under the plus-up will leverage these interventions to bolster district planning and management capacity to ensure sustainability.

The EP will also help strengthen HIV/AIDS policies and systems through CNLS across health and non-health sectors. Activities will include financial and technical assistance to the CNLS for monitoring of the 'Three Ones' through data-driven policy development; to the School of Nursing for curriculum revision to include HIV/AIDS as part of clinical education; to MIGEPROF for an OVC situation analysis and multi-sectoral OVC services assessment; and to RDF for the strengthened management of military HIV/AIDS services. In addition, EP partners will initiate an in-service training program in HIV/AIDS service strengthening for 1,500 nurses. The EP will work through partners to improve the capacity of NGOs, CBOs, FBOs, churches, and civil society to directly manage EP funds.

In coordination with the WB, other donors and the MOH, the EP will continue to support national-level coordination of PBF for HIV/AIDS services. The expected result of performance-based contracting is a stronger health network, a strengthened and motivated work force, and increased managerial autonomy for providers with greater financial and clinical accountability. Assessment of quality of clinical care is integrated into the PBF program to assure that both efficiency and quality of care are consciously promoted.

Program Area Target:

Number of local organizations provided with technical assistance for HIV-related policy development	50
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	100
Number of individuals trained in HIV-related policy development	180
Number of individuals trained in HIV-related institutional capacity building	110
Number of individuals trained in HIV-related stigma and discrimination reduction	60
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	7,000

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	Columbia UTAP
Prime Partner:	Columbia University Mailman School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	2729
Planned Funds:	
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006]

Additional funding is to support large scale (1500 nurses trained over 4 years) HIV/AIDS in-service retraining jointly with Intrahealth and the Ministry of Health Department of Nursing and District Health teams. This proposal is supported by Dr. Innocent, Minister of State for HIV/AIDS who met and discussed the need for nursing training with Ambassador Tobias.
Columbia University will perform the following:
1) Assist Intrahealth with Performance Needs Assessment of basic skills and performance of nurses for HIV/AIDS care, including basic health care, health promotion and disease prevention for PLWHA, PMTCT, CT, counseling, assessment of common patient presentations and expanded role of nurses managing ARV care.
2) Support the MOH to develop national protocols on the role of nurses in HIV/AIDS palliative and ARV care
3) Draft pre-service curricula for nurses on HIV/AIDS care and treatment
4) Field test and finalize training materials
5) Train MOH Nursing faculty in use of new HIV/AIDS care and treatment curriculum.
6) In service training of 1500 first and second level nurses in 11 provinces over four years.

Table 3.3.14: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: US Department of Defense Naval Health Research Center
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: I4
Activity ID: 2738
Planned Funds:
Activity Narrative: This activity will enable Rwandan military physicians to attend the Military International HIV Training Program. The mission of the program is to provide flexible training in support of prevention of HIV transmission and management of infected persons in military organizations. The training will transfer appropriate knowledge and technology to key Rwandan medical personnel. The training is developed in collaboration with each military organization to meet the specific needs. The program emphasizes training, consultation, and operational support for prevention and clinical management of HIV and its complications as well as courses in epidemiologic surveillance and laboratory diagnosis from a clinical physician perspective. A large emphasis is placed on the experiential part of the program to understand the military's policies and procedures regarding service members with HIV/AIDS. Participants observe and/or participate in groups supported by clinical social worker, clinical psychologist, clinical pharmacist, and public health/preventive medicine personnel.

The Military International HIV Training Program emphasizes training, consultation and operational support for epidemiological surveillance, laboratory diagnosis, prevention and management of HIV and its complications. It seek to train key foreign military clinical physicians in state-of-the-art HIV prevention and clinical management and diagnosis and treatment with the expectation that those trained will transfer information into operational use in country.

The program incorporates a "train the trainer" approach and provides the tools and educational materials to promote current, up-to-date instruction to be taken back to the Rwandan military medical community. Written assessments communicating participants' needs, personal educational goals and that of their medical community are obtained prior to the training. Targeted in-country training and ongoing telecommunication follows the US based program. NHRC is developing web-based education availability.

Target Populations:

Doctors (Parent: Public health care workers)
Military personnel (Parent: Most at risk populations)

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	TRAC Cooperative Agreement
Prime Partner:	Treatment and Research AIDS Center
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	2742
Planned Funds:	
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006] With financial support from the Emergency Plan and technical assistance from FHI, TRAC will strengthen its institutional capacity for producing client and provider materials for treatment, care and clinical prevention programs. Funds from this program will be utilized to recruit, train and place a behavior change communication specialist at TRAC to provide technical assistance for the development of instructional materials for client use at clinical service delivery sites (see Treatment/ARV services for funds for printing materials). This is a task that has been traditionally supported by FHI for which management responsibility is being transferred to TRAC.

Target Populations:

Adults

People living with HIV/AIDS

Pregnant women

Table 3.3.14: Activities by Funding Mechanism

Mechanism: UTAP
Prime Partner: Tulane University
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 2746
Planned Funds:
Activity Narrative: This activity relates to Tulane SI activity #2747.

This activity is a continuation of an activity originally approved in COP04, under which Tulane University established a public interest fellowship program to build the research and analysis capacity and program management ability of key Rwandan institutions engaged in HIV/AIDS work. The fellowship program seeks to prepare recent Rwandan graduates to work as program managers of HIV/AIDS prevention, care and treatment programs. Fellowship components include training, mentoring, and on-the-job experience, through placement of fellows in two-year paid internships with local host agencies. Program costs, such as fellows' stipends, training, and supervision logistics, will be funded and managed by Tulane University. In FY2006, Tulane University will recruit 15 Fellows for the program and train individuals at CNLS in the course of its SI activities with the curricula developed for this program.

In FY2006, the third year of this activity, Tulane University will focus on making the fellowship program sustainable through work with the NUR School of Public Health and sub-agreements, which will be determined in FY2006, with institutions that will oversee its daily operations. Tulane University will also seek to complete conversion of the training curriculum to a university-recognized and accredited certificate course. The fellowship will expand its geographic reach and place 40% more participants outside of Kigali. With the graduation of the first cohort of 10 participants anticipated in the fall of FY2006, the fellowship program will provide professional development support and leadership skills to alumni of the program as they begin to take local positions in HIV/AIDS program management. This activity is described on page 24 of the Rwanda EP five year strategy and contributes directly to the EP goal of human capacity development.

Emphasis Areas	% Of Effort
Human Resources	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development		☑
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	40	☐
Number of individuals trained in HIV-related policy development	70	☐
Number of individuals trained in HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related stigma and discrimination reduction	60	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☑

Target Populations:

Community-based organizations

Faith-based organizations

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

Program managers

Public health care workers

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: RPM+
Prime Partner: Management Sciences for Health
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 2760
Planned Funds:
Activity Narrative: [Continuing Activity from FY2005 -- with No New Funding under this mechanism in FY2006]
Rwanda does not have an effective system to register drugs or provide basic drug quality assurance, although its drug procurement agency, CAMERWA, per national policy will be procuring all ARVs for use in Rwanda. To improve ARV availability and assure quality, the Secretary General and the Direction of Pharmacy have requested technical assistance to facilitate establishing a National Drug Authority , one of the main priorities of the pharmaceutical sector. Developing and implementing a National Drug Authority usually requires several years for full implementation, and high investments of human and financial resources.

USG has agreed with the Direction of Pharmacy (DOP) to place an expert Senior Advisor in pharmaceutical policy, who will facilitate the design and first-stage implementation of the National Drug Authority, and who will also assist in the usual activities carried out by the DOP

USG will undertake the project activities described below, in collaboration with the Direction of Pharmacy and other partners such as the WHO.

1. Outline a conceptual framework describing the roles and responsibilities of a regulatory authority for pharmaceuticals, for ARVs and other pharmaceuticals in a severely resource-limited country setting. This will include,:
1.1. Identifying, defining, prioritizing, and establishing an appropriate sustainable mix of technically sophisticated activities to support the risk-based regulatory systems.
1.2. Identifying the conditions and resources necessary to justify, develop, and sustain a system capable of providing a comprehensive service Rwanda.

2. Assist the NDA in reviewing experience from other resource-limited countries to prioritize activities defined in scope, financial, technical, and human resources. USG will also assist the NDA to explore the need, justification, and potential for employing human and technical resources from outside of the NDA..

3. On the basis of activity #1, make recommendations on an appropriate scope of activities and developmental priorities for the NDA in Rwanda, including scope of product coverage (i.e., pharmaceuticals, food, medical devices, and/or cosmetics), and identify human, technical, and financial resources required..

4. Define role of National Drug Authority in the MOH, including technical, human and financial resources, existing organizational structure, management, and information systems, legal and regulatory framework.

5. Develop a comprehensive, prioritized, fully costed, multi-year, strategic plan to:

5.1 Establish and implement an appropriate drug registration activity for protecting public health.
5.2 Establish and implement a nationwide quality system program for all regulated areas including, as appropriate, testing, inspection, registration, and enforcement activities.
5.3 Establish and implement policies and procedures for regulation of imported products as well as those manufactured domestically to help ensure availability of quality products and implementation of appropriate quality systems.

6. Based on acceptance of the recommendations resulting from activity #3 and the strategic plan resulting from activity #5 by the Ministry of Health, develop:

6.1. A draft organizational structure and job descriptions for the NDA.
6.2. Draft policies and operational processes for a national system for drug registration and product quality assurance.
6.3. Draft legislation and regulations for instituting a national system of drug registration and product quality assurance.

Note: This activity covers development of the strategic plan (activity #5) and the specific products outlined in activity #6. Full implementation of the strategic plan would require additional financial support.

Target Populations:

Pharmacists (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	IMPACT
Prime Partner:	Family Health International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	2766
Planned Funds:	[redacted]
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 – NO NEW FUNDING IN FY2006]

USG partner (FHI) currently develops for national use IEC materials in support of ARV, PMTCT and CT services. TRAC, as the leading clinical institution for HIV-AIDS services needs to develop the institutional capacity to develop patient education materials for use by physicians and nurses in instructing patients in their own health care for ARV, HIV/AIDS services. USG will work closely with TRAC to train TRAC's staff to develop this capacity, including qualitative studies to inform design and development of these materials, focus group testing, layout/printing and instruction of providers in use of these materials. USG and TRAC will develop an MOU to define each organization's role in the capacity transfer process. Funds have been reallocated from FHI's budget to TRAC's budget so that TRAC will pay directly for staff and printing costs for material development. [redacted]s provided under COP05 to hire an additional staff to support training of TRAC in development of behavior change materials and IEC.

With the rest of the funding, FHI will contract with appropriate GOR institutions for the development of a national HIV-AIDS workplace policy to address work-related issues for public and private sector employment. This policy will address workplace issues, such as non-discrimination in hiring, supervision and termination, medical sick-leave, family leave for illness, and other issues.

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development		☑
Number of local organizations provided with technical assistance for HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related policy development		☑
Number of individuals trained in HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related stigma and discrimination reduction		☑
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☑

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Capacity
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 2776
Planned Funds:
Activity Narrative: This financing is for a Ministry of Health Human Resource Strengthening Activity. Strengthened Human Resource Management in the Ministry of Health: This activity will provide human resource expertise to the MOH to strengthen the national health workforce. Capacity/IntraHealth will support the MOH to address retention, performance and promotion of professional medical and nursing staff providing HIVAIDS care. Capacity/IntraHealth will support the development and implementation of HR strategy, policies and procedures with TA and staff support under the direction of the Secretary-General of the MOH.

The 2004 USG-supported HIV/AIDS Human Resources Assessment noted the severe shortage of physicians in Rwanda (270 physicians in the public workforce). The MOH appreciates the significant HR capacity needs necessary to provide HIV/AIDS care, related to the need to improve physician compensation and work environment. To strengthen human resource planning and management, Capacity/IntraHealth will support one Human Resource (HR) advisor to the central MOH office to provide personnel management support. This position will support the development and implementation of HR policies, including finalizing the MOH Rwanda HR Health Strategic Plan. The HR advisor will have responsibility for training senior managers and leaders at central and district levels in personnel management and in developing orientation training. The HR Advisor, with support from Capacity/IntraHealth, will research employee retention, through de-briefs and documented exit interviews conducted with departing health care workers (particularly rural postings where retention problems are the greatest). These activities will be coordinated through the Health Sector Cluster with other donors, who are developing a basket fund to augment low salaries of all providers.

Capacity/IntraHealth will support the development of a human resource classification system, including an HR Management data base accessible at the central and district levels. The secure data base will track medical and nursing continuing education, particularly HIV/AIDS training, as well as basic employee information, such as performance evaluations and employment history. Capacity/IntraHealth will provide IT and HR support to streamline, organize and improve the overall human resource system. Capacity/IntraHealth will support the MOH to develop clearly defined job descriptions for all employee categoriesand a performance management system to help create a culture of effective supervision, feedback, and goal setting in accordance with existing civil service procedures. To support long term adoption and implementation of solutions in human resources, A "Human Resource for Health Task Force" will be established to better understand and be able to address the human resource crisis. Capacity/IntraHealth will help the MOH form the HRH taskforce, launch routine meetings, and contract/hire a local facilitator to conduct the meetings that will take place in 2006.

Emphasis Areas	% Of Effort
Human Resources	51 - 100
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	20	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	20	☐
Number of individuals trained in HIV-related policy development	20	☐
Number of individuals trained in HIV-related institutional capacity building	20	☐
Number of individuals trained in HIV-related stigma and discrimination reduction		☑
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☑

Target Populations:

Policy makers (Parent: Host country government workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Population Services International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 2782
Planned Funds:
Activity Narrative: [Continuing FY2005 Activity through the end of December 2005; then CHAMP will pick up this TA support (#5183)]

This activity will place an Advisor on HIV/AIDS and Health Communication for the Minister of State and the Minister of Health who will work to develop and implement a national HIV/AIDS public information strategy. This National Public Information Strategy will be used to coordinate varying prevention activities, media campaigns and messages. The Advisor will work with donors, NGOs, departments within the MOH and in other Ministries to improve quality and consistency of HIV/AIDS messages to support National Prevention, Care and Treatment strategies.

The Advisors responsibilities will include the development of a National Public Information Strategy, preparation of speeches, letters, interviews and printed communication materials for the Office of the Minister of HIV/AIDS and improvements to the Ministry web sites. This staff person will also participate in the CNLS' BCC Steering Committee for the approval of all health communication messages related to HIV/AIDS.

Target Populations:

Community-based organizations

Faith-based organizations

National AIDS control program staff (Parent: Host country government workers)

Policy makers (Parent: Host country government workers)

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Increasing women's access to income and productive resources

Increasing women's legal rights

Twinning

Volunteers

Stigma and discrimination

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: HIV/AIDS Performance Based Financing
Prime Partner: Management Sciences for Health
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 2813
Planned Funds:
Activity Narrative: See related Activities: #2812, #2814, #2815, #2798, #4001, #4003, #4771, #4972.

In coordination with the World Bank, the Belgian Government, Global Fund and other donors, the PBF of HIV/AIDS services will support the GOR and the MOH to develop and implement an HIV/AIDS component within a national system of PBF for primary care. Other donors have worked successfully in Rwanda to pilot PBF of primary health care. The GOR wishes to extend this system nationally and has other donor support to do so for non-HIV health services. The WB, EP and Global Fund will support integration of HIV/AIDS PBF into the larger performance-based health financing program while the Belgian Government, GTZ and others will support financing of non-HIV/AIDS primary health care services. PBF will provide direct health financing expertise to develop a system of performance-based contracting for indicators tied to EP targets. The PBF will sub-contract with USS to develop a national implementation and coordination plan on Quality Assurance, building on experience to date with the "Collaborative Approach".

PBF will support, through sub-contracts, health districts to develop governance systems for performance contracts to increase both quality and productivity of HIV/AIDS care. Health districts will develop "performance plans" that define specific indicators and their incentive payments for each health facility that signs a "performance-contract". The PBF, with USS, will develop performance contracts for DHTs based on incentives for effective supervision and implementation of HC performance contracts. The PBF will support districts to develop quality, productivity and financial audit systems to verify the performance of health facilities. The PBF will support the GOR to develop legal and financial systems to transfer funds from the GOR and from donors to health providers, based upon performance contracts, consistent with GOR policy and donor requirements. Until such systems are developed, donors will directly transfer funds to providers in accordance with donor requirements based upon collaboratively developed performance contracts. The PBF will balance timely achievements of EP targets and health system strengthening. The anticipated role of the health district in managing performance contracts is well aligned with the recent national district reorganization and with other EP support to DHTs (Activity 4771, 2798).

Activities in 2006 will include: collaborative work with the MOH Health Sector Working Group to finalize national policy on PBF, identification of districts and facilities for initiation of performance-based contracts for HIV/AIDS service delivery, baseline and semi-annual surveys of these sites' performance, capacity building of the USS and DHTs to manage performance-based contracting, development of health district and health facility quality assurance and financial management systems, definition and agreement of specific indicators for performance-based contracting, preparation of sites for launch, development and signing of contracts with health facilities, regular monitoring of performance by DHT supervisors, and subsequent reimbursement based upon performance. The PBF will undergo an independent audit in month 18 to determine if PBF is achieving the sustainability and performance-improvement goals of the GOR and the EP. (See Activity 4972)

The PBF project will provide managerial training, including planning, budgeting, and human resources to health facilities and DHTs. PBF will support DHTs to develop systems to monitor provider performance as the basis for reimbursement.

Quality indicators will include adherence to clinical standards (PMTCT, CT, BHC, and ARV), patient satisfaction and patient safety indicators. PBF will train DHTs and HCs to involve the community and patients in their governance, using the established

PAQ model successfully implemented to date. PBF will work with USS and DHTs to continue and support national implementation of the successful "Collaborative Approach" for continuing quality improvement. PBF will expand these two established Rwandan quality improvement activities as well as introduce other performance-improving methods to DHTs and to providers with performance-based contracts.

The PBF project will strengthen the HIV/AIDS network model by reimbursing indicators reflective of network or system performance as well as individual site and provider performance. For example, reimbursable "network" indicators could include use of referral forms, numbers of patients jointly cared for by community and HCs or number of patients treated by satellite ARV services with district hospital physician support. For shared indicators, reimbursement would be shared among all participants based upon their level of effort. Such shared indictors require greater effort to manage, but are necessary to minimize patient hoarding. Similarly, the District Health Team will be reimbursed based on indicators of overall performance of the entire health district, from the community to the district hospital.

Sustainability of quality health provider performance in delivering HIV/AIDS services is part of the Rwanda EP five-year EP strategy as well as the GOR long term strategy for improved health care system performance.

Emphasis Areas	% Of Effort
Health Care Financing	10 - 50
Human Resources	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	18	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	9	☐
Number of individuals trained in HIV-related policy development	29	☐
Number of individuals trained in HIV-related institutional capacity building	29	☐
Number of individuals trained in HIV-related stigma and discrimination reduction	0	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	0	☐

Target Populations:

Policy makers (Parent: Host country government workers)

USG in-country staff

USG headquarters staff

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: HCP- Tulane University
Prime Partner: Tulane University
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 2816
Planned Funds:
Activity Narrative: This activity includes training and strategic information in order to strengthen cross-sector collaboration between the MOH and MINEDUC. The MOH contributes to curriculum development and participates in the recruitment and selection of candidates for training programs funded both by the EP and other non-HIV/AIDS sources. This activity builds upon an ongoing relationship between Tulane University and the School of Public Health (National University of Rwanda) that began in 2000 to strengthen institutional capacity at the SPH and enable it to produce experienced health officers with the competencies necessary for planning, managing, and assessing health needs in Rwanda. The re-creation of the SPH in 2000 with its new mandate was based upon a needs assessment of health and human resources conducted by the GOR in 1999. Focus on the skills and competencies, particularly in operations research and program evaluation, will be developed to meet the challenges of HIV/AIDS in Rwanda.

The Executive MPH Program targets host country government workers, select health care providers such as doctors and nurses, and individuals from the NGO and PVO communities. These individuals are primarily district health officers and district hospital directors who are directly and actively involved in the national implementation of HIV/AIDS initiatives funded by the EP. As such they are responsible for the scale-up, management, and supervision of clinical HIV/AIDS services, such as PMTCT and VCT. Other areas of responsibility include personnel and commodities management; the planning and implementation of community-based financing to pay for ARV costs; monitoring the adherence rates of ARV medications; and evaluating overall ART program performance. The Executive MPH Program provides intensive, graduate-level training that emphasizes applied skills through a combination of classroom participation and field assignments, focusing on strategic, information-based decision-making. Ten MPH candidates will complete four modules in year one of the program. The four modules are delivered in intensive, short courses; staggered throughout the year to minimize time away from professional responsibilities. These modules include instruction on Applied Analytical Methods, Health Policy and Planning, BCC and Applied Management. Field exercises are adapted to incorporate actual strategies and challenges related to the GOR's national HIV/AIDS program implementation. This training program supports the Rwanda EP five-year strategy by developing HR capacity through the strengthening of individuals' skills, knowledge and competencies necessary for improved HIV/AIDS programming in support of care, treatment, and prevention strategies.

The Certificate Training Program aims to strengthen SI capacity of host country government workers and technical members of the NGO community, primarily those in the health sciences sector of MINEDUC and educators in institutions of higher learning who provide pre-service education to Rwanda's health care providers and managers. The Certificate Training Program focuses on building participants' skills in evaluation, applied research, and program and data analysis as it relates to HIV/AIDS programming and planning. A course on pedagogic techniques and appropriate use of computer-and technology-assisted educational methods will enable professionals at the NUR, KHI, KIE and KIST to better train front-line mid-level managers of HIV prevention, care and treatment programs. Thirty students will complete nine credits of graduate level instruction in an executive format, enhanced with technology-assisted learning supplements in the form of CD-ROMS and online resources. Students will be required to conduct one operations research activity. Research priorities and topics will be determined in collaboration with key GOR HIV/AIDS agencies including TRAC and the CNLS. Graduate-level credit will be awarded on the basis of merit to the top two-thirds of the class. In terms of gender, women's participation in these training programs has increased substantially,

accounting for roughly 40% of all individuals trained in FY2005. This program contributes to the Rwanda EP five-year strategy by strengthening HR capacity and promoting cross-cutting linkages through the creation of a research cadre in the education sector that can support health sector agencies through targeted applied research and program evaluation.

Emphasis Areas	% Of Effort
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	0	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	1	☐
Number of individuals trained in HIV-related policy development	0	☐
Number of individuals trained in HIV-related institutional capacity building	130	☐
Number of individuals trained in HIV-related stigma and discrimination reduction	0	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	0	☐

Target Populations:

Non-governmental organizations/private voluntary organizations

Host country government workers

Public health care workers

Private health care workers

Key Legislative Issues

Twinning

Volunteers

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	TRAC deferred
Prime Partner:	Treatment and Research AIDS Center
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	2832
Planned Funds:	
Activity Narrative:	[CONTINUING ACTIVITY FROM FY2005 -- NO NEW FUNDING IN FY2006] The following activities were programmed for FY 2004, but had funds deferred to FY 2005: - Renovation of TRAC facility - Operating expenses and equipment purchases (e.g., office IT equipment, two vehicles for transport of samples and supervision activities) - Purchase and installation of office communication system (telephone, upgrade and expansion of local area network, and connectivity costs)

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Measure DHS
Prime Partner: Macro International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 4780
Planned Funds:
Activity Narrative: Funding for this activity will cover ORC Macro participation at the national dissemination seminar for the 2005 Rwanda Demographic and Health Survey (RDHS-III) in spring 2006, production of a key indicators report that can be unfolded *as a wall poster to display indicators by region for quick reference, and the English* translation of the final report.

ORC Macro will finalize the tables for the final report in November and December 2005, and write the report January through March 2006. The initial report will be written first in French because that is the main language of the technical group. The key indicators brochure should be produced about the same time as the final report. The national dissemination seminar will take place in April 2006, with ORC Macro participation at the seminar. When the French version of the final report is finalized, ORC Macro will translate it into English.

ORC Macro initiated discussions regarding the RDHS-III with ONAPO in December 2003. These discussions included the main topics to be added to model DHS questionnaires, including anemia and HIV sero-prevalence testing. This initial plan was delayed when the GOR dissolved ONAPO in May 2004. New discussions began with the Department of Statistics, the new implementing agency, in May 2004. Consequently, the MOU, work plan, budget and calendar of activities were revised and updated.

Development of survey instruments started in June 2004 through consultations with other partners and the RDHS-III steering committee; the household listing and mapping fieldwork took place from August to November 2004. Written approval of HIV testing procedures was obtained from the National Ethics Committee in September 2004 and pretest training and fieldwork, including biomarkers, took place in November to December 2004. The main survey training, including biomarkers, took place in January and February 2005.

Survey fieldwork took place from February to July 2005. The data entry for questionnaires took place from March to September 2005 and HIV analysis on blood samples also took place from March to September 2005. Data cleaning and merging of questionnaires and HIV results data began in September 2005. The preliminary report writing and dissemination is scheduled for October 2005.

Emphasis Areas	% Of Effort
Policy and Guidelines	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	1	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	1	☐
Number of individuals trained in HIV-related policy development		☑
Number of individuals trained in HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related stigma and discrimination reduction		☑
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☑

Indirect Targets

NA

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Measure Eval
Prime Partner: University of North Carolina
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 4781
Planned Funds:
Activity Narrative: This activity is related to activities #4783 (MEASURE Evaluation SI) and #2427 (Tulane UTAP SI).

MEASURE Evaluation will develop and promote cost-effective and efficient means to support the CNLS for data demand and use related to the implementation of the 'Three Ones'. The outcome of this assistance will be the smoother functioning of all planning and management procedures that are undertaken under the guidance of the EP Steering Committee (of which the CNLS is chair). Improved management and functioning of EP planning will facilitate the implementation of not only EP-funded activities, but of all HIV/AIDS activities in the country. The overarching strategy for this intervention will be to use SI to inform national policy development and implementation, strategic planning and resource allocation; to monitor and evaluate the impact of the national response (including those supported by the EP); and to inform the public, policy makers, and opinion leaders on the status of the epidemic and the effectiveness of efforts to contain it and mitigate its effects. An example of the kind of activity that will be included is the implementation of the "GOALS model" as an integral part of updating the National Strategic Framework.

MEASURE Evaluation will recruit and place a full time Rwandan resident advisor for policy and SI at the CNLS. The advisor will be the focal point for all activities included in this policy and systems strengthening intervention. This advisor will work closely with the EP Steering Committee to ensure the use of information to support the implementation of 'the Three Ones' in the planning and execution of all EP-funded activities. The resident advisor for Policy and SI and the external TA described below will contribute to the implementation of the harmonized work plan and reporting system as requested by the CNLS. This will include data use support to the EP Steering Committee to enhance its ability to oversee EP partner work plan development, work plan updates, quarterly joint field visits and use of information generated through these processes.

The resident advisor for policy and SI will be reinforced by practical consultancies to help the CNLS achieve 'the Three Ones'. Scopes of work for appropriate high-level international TA will be jointly agreed upon by MEASURE Evaluation, the CNLS and EP. Such TA will include, but not be limited to, designing data demand and use activities to advance the coordinating mandate of the CNLS; monitoring the implementation of the National HIV/AIDS Strategic Framework and M&E Plan, and providing technical guidance to the country-level monitoring and reporting system; incorporating data utilization plans in all country-level activities; and promoting innovative technologies for facilitating data use (e.g., GIS systems and mapping; decision-support systems; resource allocation models such as GOALS). All TA described here will be coordinated with and complementary to other TA to the CNLS through MEASURE Evaluation for the production and dissemination of quarterly service coverage, semi-annual and annual reports. (See MEASURE Evaluation #4783).

Emphasis Areas	% Of Effort
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	10	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	10	☐
Number of individuals trained in HIV-related policy development	60	☐
Number of individuals trained in HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related stigma and discrimination reduction		☑
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☑

Indirect Targets

NA

Target Populations:

Country coordinating mechanisms

National AIDS control program staff (Parent: Host country government workers)

Policy makers (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: USAID Rwanda Mission
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 4973
Planned Funds:
Activity Narrative: USAID/Rwanda has been providing local and international technical assistance to GOR agencies and limited direct grants to local NGOs since COP04.

In COP06, the EP will expand this to further build local capacity. These resources will cover the cost of sponsoring and attending conferences, workshops and technical meetings on HIV treatment. A number of Rwanda NGOs requested financial assistance from USAID in FY2005 for such activities. USAID anticipates continuing this financial and technical support role in FY2006.

The MOH is requesting technical assistance for the new Rwanda Center for Health Communications (RCHC), a unit within the MOH charged with improving IEC/BCC activities. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS.

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	51 - 100
Policy and Guidelines	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development		☑
Number of local organizations provided with technical assistance for HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related policy development		☑
Number of individuals trained in HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related stigma and discrimination reduction		☑
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☑

Target Populations:

Community-based organizations

Faith-based organizations

Host country government workers

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: CHAMP
Prime Partner: Community Habitat Finance International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 5183
Planned Funds:
Activity Narrative: This activity relates to other CHAMP activities: in PMTCT (#2805), AB (#2807), OP (#2808), BHC (#2811), HIV/TB (#5129), OVC (#2810), CT (#2806) and ARV Services (#2809).

CHAMP will support policy development and systems strengthening to ensure a comprehensive package of basic palliative care and support services for PLWHA and their families. CHAMP will work with TRAC, CNLS, USS, DHTs, and EP-funded implementers to develop a community and home-based palliative care policy and strategy, and to define community palliative care and the menu of services available for PLWHAs. In collaboration with the GOR, EP-funded partners, and other donors, CHAMP will support the creation of a Case Management TWG to discuss and formalize a standard case management system for EP- and other donor-funded HIV/AIDS activities. When an HIV-positive individual makes a follow-up visit to a clinic for screening and a CD4 count, the health facility will create a patient file and assign a case manager to the patient. This case manager will link the patient to community care and support activities. CHAMP will support the GOR, DHTs, and EP-funded partners in the development of referral systems between trained community volunteers, clinic-based case managers, and health center staff. This will include the development of guidelines, protocols, and patient referral, tracking and monitoring tools for community-based volunteers and clinic-based case managers.

Under COP06, CHAMP will also provide TA and training to at least 20 local CBOs, FBOs and NGOs to strengthen the network of local partners. CHAMP will also support an OVC Technical Advisor to MIGEPROF and a Communications Advisor to the MOH's Communication Unit. These activity facilitate sustainability and develop human capacity as outlined in the Rwanda EP five-year strategy. CHAMP will steadily transfer the management of EP-funded activities to local organizations as their managerial, financial and technical capacities increase through CHAMP workshops, trainings, and supervision. CHAMP will conduct M&E trainings and develop a transparent, competitive process for awarding, disbursing and managing subgrants.

Through local capacity building, CHAMP will train over 7,000 OVC and HBC community volunteers, case managers, health animators, TBAs, religious leaders, and caregivers to support and promote HIV/AIDS prevention, care and treatment services for PLWHA and their families, and educate communities on HIV/AIDS. To improve the quality of services offered by EP implementers, CHAMP will update and standardize a TOT and a training curriculum for these volunteers and community mobilizers to integrate a more comprehensive range of topics, including HIV prevention, counseling skills, clinical and non-clinical medical care services, and ART adherence.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	1	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	20	☐
Number of individuals trained in HIV-related policy development	0	☐
Number of individuals trained in HIV-related institutional capacity building	60	☐
Number of individuals trained in HIV-related stigma and discrimination reduction	0	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	7,000	☐

Target Populations:

Community-based organizations

Country coordinating mechanisms

Faith-based organizations

Non-governmental organizations/private voluntary organizations

Volunteers

Host country government workers

Coverage Areas:

National

Table 3.3.15: Program Planning Overview

Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15

Total Planned Funding for Program Area:

Program Area Context:

Under the leadership of the deputy chief of mission, the Rwanda Emergency Plan team works as an integrated whole, meeting on a weekly basis to discuss issues and resolve problems of implementation. The team meets on a regular basis with GOR and partner counterparts in the PEPFAR Steering Committee (PSC) and uses a consultative process for planning and implementing the program. The PSC is a key mechanism for the development of the COP, as it is the primary coordinating mechanism for technical working groups which advise the EP team. The GOR is satisfied with the methodology in the preparation of COP06. Both the GOR and the EP team feel that COP06 represents an integrated balance of USG and GOR inputs and priorities. The EP team works as a cohesive unit among the four agencies represented and in interaction with the GOR. Given the principle of "co-management" under which the Emergency Plan operates in Rwanda, requiring the EP team to respond to both GOR and USG requirements, resources, additional management staff is will be needed in FY2006.

Innovative staffing mechanisms developed in FY2005, and continuing in COP06, include four cross-agency positions: an SI liaison, an SI assistant, an HMIS coordinator, and an outreach coordinator. In FY2006 the EP will fill program assistant positions that remained vacant at DOD and State because of delayed arrival of COP05 funds.

The Rwanda EP team believes that program management staff should spend at least 20 percent of their time in the field to ensure that programs are being implemented according to the EP strategy. Due to demands of the COP process, the need for engagement at the central level, and inadequate staffing in FY2005, the EP team has not been able to devote sufficient time to field visits. Both USAID and CDC are planning on increases in field management staff in the coming year to address our obligations. Six new positions are proposed: four at CDC and two at USAID.

Recruitment of highly qualified local and international staff is increasingly challenging. Three dynamics are at play: the local pool of talented Rwandans is very limited and most are already employed with other agencies, the salary structure for local hires is not competitive with other agencies and international NGOs and recruitment of international staff is difficult due to perceptions of instability and hardship.

Table 3.3.15: Activities by Funding Mechanism

Mechanism: USAID Rwanda Mission
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 2785
Planned Funds:
Activity Narrative: This activity relates to all Emergency Plan activities in Rwanda. USAID Rwanda Mission has direct responsibility for a broad range of activities, and coordinates with HHS/CDC, DOD and State on EP activities in Rwanda. All USAID Rwanda Mission positions were filled in COP05, with modest additions anticipated in COP06. This activity includes partial funding for a Development Outreach Communications specialist that is shared with other functional areas within USAID/Rwanda and across EP agencies in Rwanda. This activity includes, in addition to personnel costs, equipment and services to support EP management.

Target Populations:

Community leaders

International counterpart organizations

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

USG In-country staff

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Increasing women's access to income and productive resources

Increasing women's legal rights

Twinning

Volunteers

Stigma and discrimination

Coverage Areas:

National

Table 3.3.15: Activities by Funding Mechanism

Mechanism:	CDC Country Office GAP/TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	Base (GAP account)
Program Area:	Management and Staffing
Budget Code:	HVMS
Program Area Code:	15
Activity ID:	2791
Planned Funds:	
Activity Narrative:	This activity also relates to CDC Direct M&S OGAC budget activity #2844. A few CDC Global AIDS program management and staff positions were filled in FY2004 & FY2005 including the Program Management Fellow (ASPH). In FY2005, the office also recruited a local health specialist with a medical background to oversee clinical and prevention services as well as provide support to current surveillance activities. The office continues to recruit for two FY2005 international hire positions: Medical Officer/Chief of Party and IT Officer. The Chief of Party position remains unfilled as CDC has encountered difficulty in recruiting a Chief of Party. In FY2006, the CDC-Rwanda office also proposes to recruit a budget analyst/specialist to strengthen fiscal knowledge and practices and 3 support staff. In addition to personnel costs, this activity includes equipment and services to support EP management. The office has projected ICASS expenditures greater than in FY2005, which was approximately [redacted] In addition to ICASS, this budget will support charges for the Capital Security Cost Sharing tax, which is estimated at [redacted] for FY2006.

Table 3.3.15: Activities by Funding Mechanism

Mechanism:	DOD Program Mgt
Prime Partner:	US Department of Defense
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	Management and Staffing
Budget Code:	HVMS
Program Area Code:	15
Activity ID:	2802
Planned Funds:	
Activity Narrative:	Funding for a Coordinator position at US DOD/Rwanda to assist in the coordination and support of Emergency Plan activites in Rwanda.

Target Populations:

Military personnel (Parent: Most at risk populations)

USG in-country staff

USG headquarters staff

Coverage Areas:

National

Table 3.3.15: Activities by Funding Mechanism

Mechanism:	Embassy Rwanda
Prime Partner:	US Department of State
USG Agency:	Department of State
Funding Source:	GAC (GHAI account)
Program Area:	Management and Staffing
Budget Code:	HVMS
Program Area Code:	15
Activity ID:	2817
Planned Funds:	
Activity Narrative:	Funding for PEPFAR program assistant position at the embassy to assist in the coordination and support of Emergency Plan activities.

Table 3.3.15: Activities by Funding Mechanism

Mechanism:	CDC Country Office GAP/TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Management and Staffing
Budget Code:	HVMS
Program Area Code:	15
Activity ID:	2844
Planned Funds:	
Activity Narrative:	This activity also relates to activity #2791. Most CDC Global AIDS Program management and staff positions were filled in FY2004 & FY2005. The salaries of technical and management positions are partially or fully supported through this activity including: current Public Health Advisor (COP), the ORISE Program Officer position, and other LES positions.

Table 5: Planned Data Collection

Is an AIDS Indicator Survey(AIS) planned for fiscal year 2006?	☐ Yes	☑ No
If yes, Will HIV testing be included?	☐ Yes	☐ No
When will preliminary data be available?		
Is an Demographic and Health Survey(DHS) planned for fiscal year 2006?	☐ Yes	☑ No
If yes, Will HIV testing be included?	☐ Yes	☐ No
When will preliminary data be available?		
Is a Health Facility Survey planned for fiscal year 2006?	☑ Yes	☐ No
When will preliminary data be available?		
Is an Anc Surveillance Study planned for fiscal year 2006?	☑ Yes	☐ No
if yes, approximately how many service delivery sites will it cover?		
When will preliminary data be available?		
Is an analysis or updating of information about the health care workforce or the workforce requirements corresponding to EP goals for your country planned for fiscal year 2006?	☑ Yes	☐ No

Other significant data collection activities

Name:
BSS

Brief description of the data collection activity:
After being trained in BSS questionnaire design and revision from Tulane University staff in TRAC's epidemiological surveillance unit will collaborate with CDC to conduct a BSS for a high-risk group not included in the FY2005 BSS.

Preliminary data available:
December 01, 2006

Name:
Models of care for HIV/AIDS service delivery targeted evaluation

Brief description of the data collection activity:
The EP will support another external evaluation to review models of care for HIV/AIDS service delivery, including the minimum package of care (CT, PMTCT, basic/palliative, and TB/HIV) and expanded package of care: (ARV treatment, including ARV satellite sites, full outpatient service and hospital-based ARV services). After consultation with the GOR and the EP, the consultant will identify different models of care used by implementing partners as well as other donor or GOR-supported models. The consultant will compare and contrast models of HIV/AIDS care based upon all or some of the following characteristics: quality of care (including patient satisfaction, compliance with external standards, adherence), cost and cost-effectiveness, access, volume, resource needs, impact of HIV/AIDS model of care on other health services, capacity building, and sustainability.

Preliminary data available:
December 01, 2006

Name:
HIV incidence surveillance

Brief description of the data collection activity:

TRAC will continue its collaboration with CDC and the NRL in the area of HIV incidence surveillance, carrying out a second phase of the BED assay using specimens from 2005 and 2006 sentinel surveillance and analyzing and disseminating the results.

Preliminary data available:
December 01, 2006

Name:
ARV drug resistance

Brief description of the data collection activity:
TRAC will participate with CDC and NRL in a second threshold survey of ARV drug resistance surveillance and will assist with the analysis and dissemination of its results.

Preliminary data available:
December 01, 2006

Name:
Sentinel surveillance

Brief description of the data collection activity:
TRAC, in collaboration with CDC, will lead sentinel surveillance at 30 ante-natal care facilities, training 60 site personnel, procuring tests and other materials, supervising sites, analyzing results and compiling a report.

Preliminary data available:
December 01, 2006

Name:
Coordinated ARV procurement targeted evaluation

Brief description of the data collection activity:
USAID will procure a performance and financial audit of the GOR coordinated procurement of ARVs. This audit will assess if jointly procured ARVs are reaching patients as intended by the governance documents of the coordinated procurement. The audit will track procured ARVs from placement of orders with CAMERWA to districts or facility depots and to ART patients. The audit will determine if any inventory of drugs is not fully accounted for or if there are missing stocks. The audit will evaluate the documentation of distribution of ARVs and determine if there is adequate documentation to assure appropriate management of ARVs procured through the coordinated procurement.

Preliminary data available:
March 01, 2006

Name:
PFB targeted evaluation

Brief description of the data collection activity:
USAID will support an external evaluation of its PBF strategy and activity to determine if they are meeting the sustainability needs of the EP as well as the improved health system performance desired by the MOH. This assessment will help inform the EP and GOR decision to continue, modify or cancel the PBF contract. Specific questions to be answered by the evaluation include: Is the PBF activity helping to build capacity of the MOH and/or DHT to manage the quality and efficiency performance of HIV/AIDS service delivery? Will PBF mechanisms assist in building sustainable management systems to continue the prevention, treatment and care clinical activities of the EP? What changes are recommended to the current PBF program to improve its effectiveness? This assessment will take place at month 18 of the PBF and be completed in time to inform COP07 development.

Preliminary data available:
March 01, 2007

Name:
Triangulation of HIV/AIDS program coverage data

Brief description of the data collection activity:

USG will also support the CNLS to do a triangulation of HIV/AIDS program coverage data with behavioral, environmental and health status data from individuals frequenting high risk sites. The purpose of this evaluation is to conduct secondary analyses of four data sets to provide insight into ways HIV/AIDS prevention services in Rwanda can be better matched to the risk profile of local populations to increase uptake of prevention services such as condom use, VCT, and PMTCT.
n

Preliminary data available:
September 01, 2006